The Impact of Dutch Global Health and SRHR Investments (2020–2024)

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ABSTRACT

Background

No unified impact evaluation and reporting system exists across the Ministry of Foreign Affairs (MFA) Global Health and Sexual and Reproductive Health and Rights (SRHR) portfolio. We sought to systematically study outputs, results and outcomes across the portfolio to inform debates on Dutch Global Health and SRHR, as well as future evaluations.

Methods

Data were collected between October 2025 and March 2026 through document review, expert interviews, and structured surveys to MFA-funded organisations, including multilateral global health organisations, Dutch and international NGOs. Indicators were selected through a multi-stage process of consultation with a steering committee and review of available monitoring and evaluation (M&E) frameworks across organisation types. Reported metrics include directly observed and measured outputs, as well as outcomes estimated using established epidemiological models. For those activities which also received funding from other sources, results are reported as the proportion attributable to MFA funding.

Results

Between 2020 and 2024, a total of €2.6 billion was disbursed under MFA Budget Article 3.1. Funding supported 254 IATI-registered activities. MFA-funded activities resulted in an estimated additional 23 million diagnostic tests, 10 million treatments for major infections, 7.1 million children immunised, and prevention of 1.3 million unsafe abortions. Circa 65 million young people were reached with comprehensive sexual education, and contraceptive provision yielded 24 million couple-years of protection. This prevented 3.8 million unintended pregnancies and 1.1 million sexually transmitted infections, including 40,000 HIV-cases. MFA-funded activities are estimated to have saved 448,000-529,000 lives.

Dutch contributions also supported 111 countries with health system strengthening activities, contributed to 1,044 legal and policy changes across 113 countries, and supported response to 236 epidemic threats. Immunisation investments generated an estimated €1.4 billion in social value; Dutch entities supplied €4.5 billion in essential medicines and medical products to UN procurement systems.

Conclusions

Dutch global health and SRHR investments produced significant impact on health and wellbeing, SRHR, in addition to economic returns. These findings provide an evidence base for continued and well-targeted investment at a time of significant global aid reductions.

Keywords: global health; SRHR; official development assistance; impact evaluation; Netherlands; health systems; immunisation; reproductive health

1. INTRODUCTION

1.1. Background and Rationale

The Netherlands has long been recognised as a collaborative, innovation-oriented, and reliable partner in global health and SRHR. Its contributions span multilateral organisations, international and Dutch NGOs, and country-level programmes, reflecting a long-standing political commitment to health as a global public good and a human right.

This report was initiated against a backdrop of reductions in Dutch ODA budget allocations, including to global health and SRHR. In 2024, the coalition government announced new policy priorities for Dutch development assistance, including for health and SRHR, which in effect abandoned the commitment to allocate 0.7% of Gross National Income to ODA across all domains, and introduced significant cuts to the development assistance budget (1).
The last 10 years of actual expenditure data on Sustainable development across all domains (Figure 1) and within the Social development domain (Figure 2) are shown below.

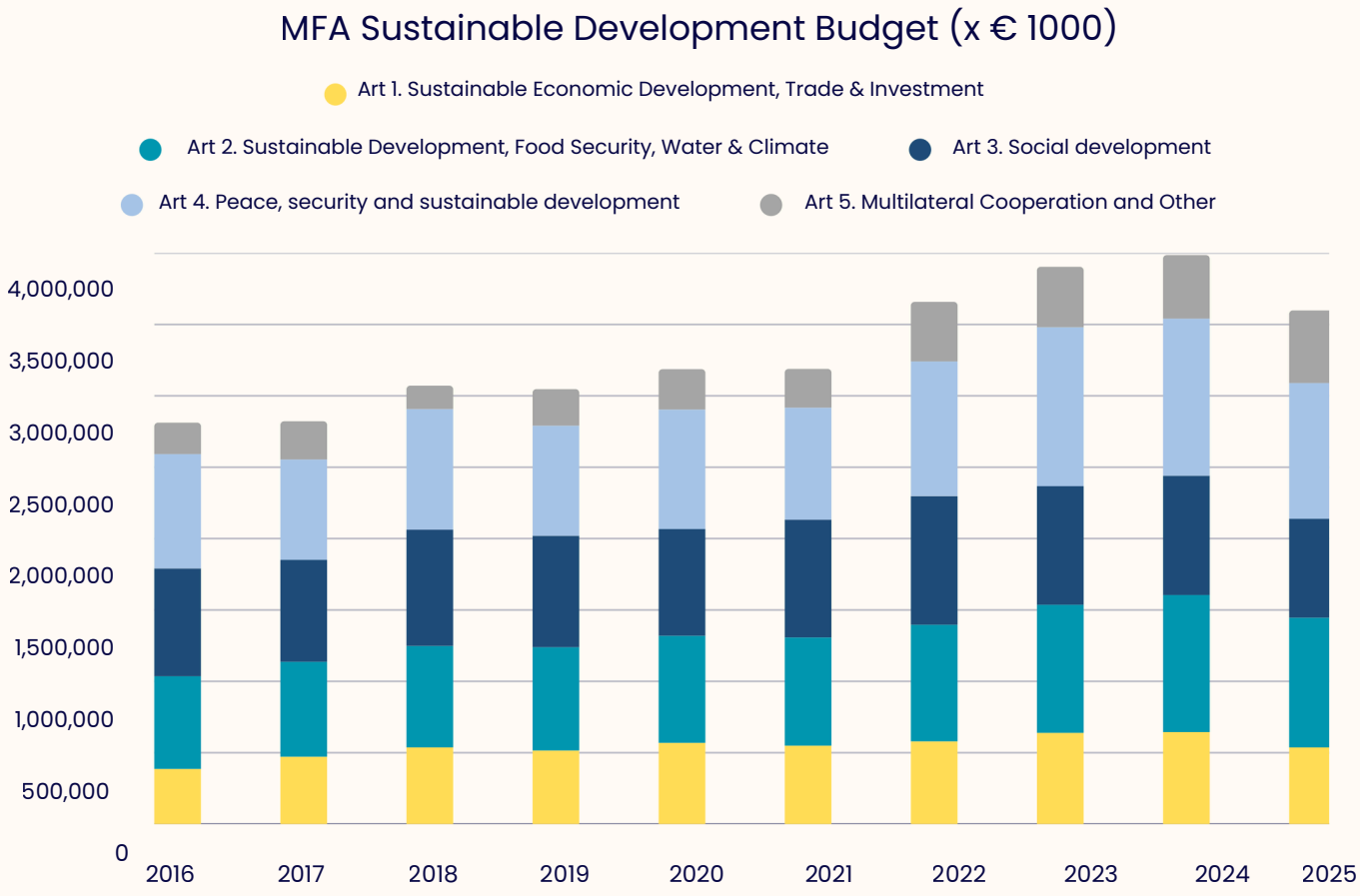

Figure 1. Dutch MFA Realisation of the Social and Sustainable Development budget (BHOS Articles 1-5)

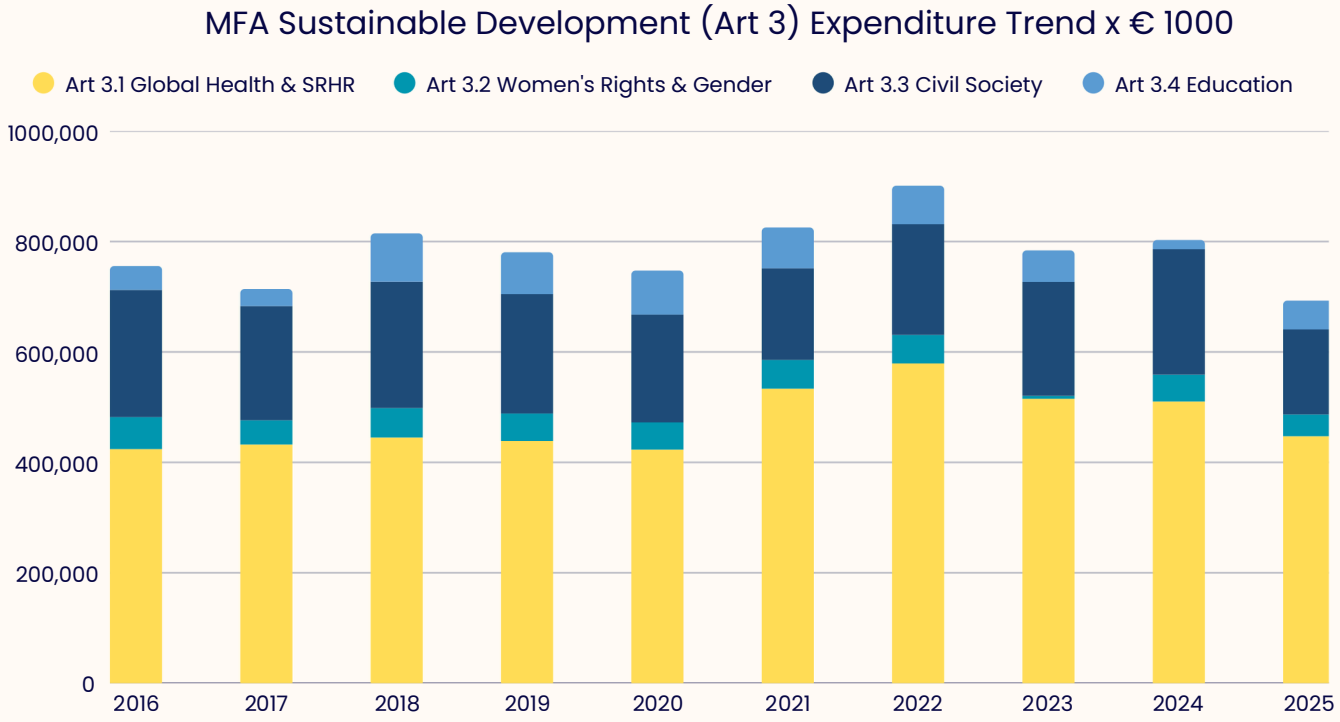

Figure 2. Dutch MFA Realisation of the Social Development budget (BHOS Art 3.1-4)

These cuts occurred at a moment of acute global vulnerability. For the first time in nearly 30 years, many high-income governments reduced their ODA contributions simultaneously in 2024. Overall ODA was estimated to decline by 21% in 2025 relative to 2023, with development assistance for health potentially falling by 40% (2). A modelling study published in The Lancet in early 2026 estimated that a severe defunding scenario could result in 16-30 million additional preventable deaths by 2030 (3).

Such estimates do not account for the responses of public and private actors in partner countries, including increased domestic resource mobilisation, or reprioritisation of resources towards the health sector. These large-scale withdrawals are expected to have significant consequences on health and continuity of care in the short and medium term. Assessment of these consequences is essential to hold an informed debate about current and future budget allocations.

Recent reports by the directorate for International Research and Policy Evaluation ('Internationaal Onderzoek en Beleidsevaluatie', or IOB) described the impact of Dutch SRHR contributions between 2012-2022, and of the Social Development portfolio more broadly between 2018-2024 (4,5). In the latter, IOB concluded that, while positive results have been achieved, the quality of program evaluations does not allow for inferences on the efficiency of the programs.

1.2. The global health and SRHR ecosystem

Achieving impact in global health and SRHR requires the coordinated effort of the whole ecosystem of diverse organisations in health systems and civil society. Different organisation types each perform distinct and complementary roles, carrying out distinct and complementary activities. Understanding this ecosystem is essential context for interpreting the results presented in this report.

First and foremost, global health and SRHR projects and funding support national and local governments in partner countries. The mandate for health and quality healthcare lies with national and local governments. External, international partners should aim to support national and local government, and not seek to replace their role or establish parallel systems. MFA-funded initiatives must aim to contribute to national priorities in ways that strengthen national capacity and autonomy. Decolonisation has been the key trend in international development work, seeking a deliberate shift towards local leadership, local priorities and local capacity (6).

National NGOs, community-based organisations (CBOs) and civil society organisations (CSOs) play an equally important role. These organisations provide services directly to communities, possess unique contextual knowledge and experience, and provide for sustainability and local ownership beyond project implementation phases and associated funding. They have the trust of local communities, including stigmatised, criminalised or hard-to-reach populations (e.g. youth, sexual minorities, people who use drugs, sex workers, persons with diverse gender identities and sexual orientations) who are hit hard by the absence of affordable health care and ill-functioning health systems. Their proximity allows them to support these communities in ways that neither governments nor multilateral organisations are structurally able to do. In addition, these organisations organise civic accountability, advocate against discrimination and legal barriers, build the capacity of local civil society, and create space for sensitive issues such as safe abortion and LGBTIQ+ rights, even when socio-political conditions make these topics contentious or dangerous.

International NGOs often bridge the gap between multilateral frameworks and local service delivery. They are involved in the (co-)design and implementation of programmes with national and local CBOs, build consortium partnerships between local and (inter)national partners, support research and advocacy, and deploy specialised technical expertise in areas such as sexual and reproductive health, HIV, and tuberculosis. They often operate across multiple countries, enabling knowledge transfer and cross-country learning. Among the international NGOs, Dutch organisations bring vast domestic and international expertise and longstanding relationships with partner organisations. Their engagement typically focuses on capacity building, coordination, lobby & advocacy, technical and financial support, often combined with a component of direct service delivery.

Lastly, there are the multilateral organisations, Global Health Organisations (GHOs) and international health initiatives, which include the World Health Organization (WHO), UNICEF, UNAIDS, Gavi the Vaccine Alliance, the Global Fund against AIDS, Tuberculosis and Malaria (GFATM), UNFPA, and the World Bank. The exact roles and activities of the GHOs in countries vary, in accordance with different levels of country ownership: from direct substitution in delivery (e.g. in humanitarian settings), where external actors (temporarily) fund, contract, and oversee execution of health service delivery, strategy, and monitoring; through financing support and technical assistance, to the generation of global public goods (7).

By virtue of their scale, mandate and international governance structures, these organisations can achieve results that no bilateral donor or organisation could accomplish. They set international health norms and standards, sustain SRHR and global health on the international agenda, provide technical and financial assistance to governments in drafting and implementing health policy, and through procurement of essential commodities at scale.

Their funding primarily comes from ODA contributions, complemented with private and corporate philanthropy. In return for the funding that they provide to these international initiatives, donor governments (including The Netherlands) have a seat at the governance table, with the ability to shape programme priorities, safeguard agreed language, and hold the organisations accountable to their mandates.

At times, GHOs cooperate in programs, each contributing their specific resources. For example, Gavi may be involved to design immunisation campaigns and procure the required commodities, with the Global Fund providing partial funding support (e.g. for malaria vaccines), and UNICEF organizing the actual service delivery in a country, in collaboration with the government and local organisations where possible.

This complex ecosystem functions through a network of relationships of funding, technical collaboration, sub-contracting, advocacy, and shared learning. No single development assistance organisation is able to achieve impact independently, and the value of Dutch contributions can only be seen through this cooperative ecosystem lens.

1.3. Impact, Monitoring & Evaluation in Global Health

As with all public expenditure, the impact and efficiency of global health and SRHR funding and efforts are subjected to scrutiny. As described above, Global Health and SRHR programmes operate in complex, multi-actor systems where impact results from the interaction of many simultaneous inputs, including clinical care, community behaviour changes, legal and policy reform, economic conditions, environmental factors, and broader health system capacity. Claims about the causal attribution of effects to any single intervention are thus inherently uncertain.

To report on results and impact, M&E architectures in global health distinguish between input tracking (budgets disbursed, commodities procured), output monitoring (services delivered, people reached), outcome evaluation (changes in health status, behaviour, or rights enjoyment), and impact assessment (population-level changes in mortality, morbidity, or wellbeing attributable to a programme). Different definitions of "impact" in global health and SRHR circulate. In this report, we understand impact to be “the long-term change in health or social outcomes attributable to an intervention”. As such, impact is distinguished from outputs (what was delivered) or outcomes (the immediate effects on individuals reached). The further along the input-output-outcome-impact chain, the more methodologically demanding and resource-intensive the measurement becomes, and the longer the time horizon required.

Most NGOs and CSOs in the development space produce output and some outcome data through their M&E systems. This is complemented by exit surveys, patient interviews, qualitative focus group discussions, and experiential evaluations. NGOs and CSOs at times commission independent evaluation of impacts, employing endline surveys with target populations or provider organisations. Lobby and advocacy results are among the most politically consequential work in the SRHR domain, but are particularly difficult to evaluate. The current methodological frontier is the use of outcome harvesting and contribution analysis, which retrospectively examines whether a specific program’s activities materially contributed to specific policy or legal changes.(8,9)

The methodological gold standard for impact attribution is the randomised controlled trial. While this is feasible for discrete clinical interventions in well-resourced environments, the instrument is largely unsuitable for complex multi-component programmes operating across diverse country contexts (10). Even alternative, more pragmatic approaches such as difference-in-difference, interrupted time series, and matched analysis require strong baseline data, control groups and adequate longitudinal follow-up. Global health and SRHR programs often aim to support communities or persons in contexts not well suited to such evaluations. For example, long-term repeated data collection is significantly more costly and difficult in vulnerable, remote, poor, or nomadic communities than it is, for example, in urban populations with phones and means of transportation.

In SRHR, it is challenging to distil the effects of specific interventions on quantitative indicators. Positive effects on, e.g. freedom from violence or the ability to make informed decisions about sexuality and reproduction occur in complex social systems. They also rely on social norm change and political, institutional, and cultural processes whose effects unfold over long time horizons. While proxy indicators and survey measures exist, they often fail to capture the full extent of these changes or to establish clear causal links between advocacy efforts and observed outcomes.

MFA-funded organisations are already required to monitor, evaluate and learn from activities. As part of this requirement, all MFA-funded development activities are required to report to the International Aid Transparency Initiative (IATI), and the M&E expectations include a basket of indicators which organisations must report if they are applicable. These indicators are not fully representative of the diversity, the breadth and depth of Dutch Global Health and SRHR activities, however. Moreover, a coordinating Global Health Strategy is in place since 2022, but it is not yet accompanied by a unifying M&E framework that allows to systematically and comprehensively report on the impacts of Dutch Global Health and SRHR (11). Thus, an up-to-date evidence base was sought to both improve M&E and learning, and to inform public discussions and political debate about the role Dutch ODA can and should play for global health and SRHR.

1.4. Objectives and scope

To inform policy and debate, this study started with three objectives:

1. To analyse the scope of MFA-funded Global Health and SRHR activities;
2. To co-produce a template for outputs, results, outcomes and impact assessment of MFA-funded global health and SRHR activities;
3. To pilot data collection and analysis on the outputs and outcomes of MFA-funded global health and SRHR activities over 2020–2024.

The Dutch ODA portfolio for sustainable development spans many domains that indirectly contribute to health, wellbeing and SRHR. In addition to ‘core’ global health and SRHR activities, efforts on water and sanitation, agriculture and food systems, humanitarian response, peacekeeping, and climate adaptation all have positive spillover effects on health and wellbeing (12–17). This analysis, however, has a more narrow scope, focusing on Global Health and SRHR, which in the Netherlands is funded through the separate budget line ‘Budget Article MFA BHOS 3.1’. The organisations represented in the Dutch Global Health Alliance and the Dutch SRHR Platform receive funding through this budget article. As a result, the impact reported in this report is on the conservative side, as contributions to health through the other channels produce significant health effects, for example by preventing spread of infectious disease, or treating acute and potentially life-threatening conditions in humanitarian settings.

METHODS

2. Study Design

We performed a cross-sectional, mixed-methods evaluation combining document review, expert consultation, and structured primary data collection. The methodology was co-created by the lead consultant and policy and M&E experts affiliated with the commissioning organisations. Data collection was carried out between October 2025 and March 2026.

2.1. Operationalising the Scope

The steering committee, through multiple rounds of discussion on eligible funders, implementing organisations, and target impacts, arrived at the final scope for data collection (**Table 1.**) This scope was to be used in screening and analysing potential data sources.

Category	In scope	Out of scope
A. Funder	1. MFA Budget Art 3.1 GH & SRHR	2. Other MFA Budgets 3. Min. VWS projects on GH&SRHR 4. Personal and corporate philanthropy
B. Primary organisation	1. UN system, international health organisations 2. Dutch NGOs/CSOs 3. Partner-country based NGOs/CSOs 4. RVO	*Unless funded through 3.1*: 5. EU organisations 6. Industry & for-profit organisations 7. Knowledge & education institutes
C. Impact area	1. Vaccine-preventable diseases 2. SRHR, incl. HIV/AIDS 3. Maternal, Neonatal and Child Health 4. Major infectious diseases, including malaria and tuberculosis 5. Neglected Tropical Diseases 6. Health systems strengthening	*Unless funded through 3.1*: 7. WASH 8. Humanitarian aid 9. Non-SRHR Civil Society Strengthening 10. Agri-tech, food security 11. Education 12. Peacekeeping

Table 1. Scope for data collection on GH & SRHR outputs, outcomes and impacts

2.2. Sampling Strategy

Based on the study scope, the study population comprised all organisations receiving MFA funding under Budget Article 3.1 during 2020–2024. All MFA-funded development activities are required to report to International Aid Transparency Initiative (IATI), making it a natural starting point for sampling. IATI is a global standard and open data platform for publishing information about development and humanitarian activities.

Each 'activity' in the IATI database corresponds to a funded project or program component, identified by a unique code. However, IATI coverage is imperfect: some organisations report at program rather than project level. In addition, a minority of projects have separate IATI codes for M&E sub-activities distinct from the main implementation activity.

The sample was constructed by accessing the nl.ontwikkelingshulp.nl data portal, with verification of IATI codes on the IATI Registry (www.d-portal.iatistandard.org) and the MFA-maintained METIS dashboards (www.public.tableau.com/views/METIS/Menu?:showVizHome=no).

Many funded projects are implemented by consortia of two or more organisations, with the lead partner holding the contractual relationship with MFA. The 254 IATI activities therefore reflect unique projects, not unique implementing organisations. The nlontwikkelingshulp.nl portal lists both named implementing organization, and untraceable “Local organisations” or “partner-country base organizations”. The lead consultant categorised these organisations into the following organisation types: Dutch NGO, international NGO, global health organisation, Product Development Partnerships (PDPs, funded via RvO) and Embassy-delegated projects (including local organizations).

2.3. Outcome Selection

The outcome framework was designed in a multi-step, collaborative approach by the lead consultant working with a steering group of policy and M&E experts from the DGHA and SRHR platform. The first step included scoping and defining which types of results across which results areas were prioritised for data collection, including core health and SRHR results, as well as financial and economic benefits, and lastly results related to health security and health diplomacy.

In the second step, the lead consultant collected a longlist of candidate results and metrics through screening impact reports, publicly accessible M&E systems, datasets and dashboards, and by performing key-informant interviews with experts among Dutch and international NGOs, Ministry of Foreign Affairs, and multilateral GHOs.

Third, through discussions with the steering committee, additional outcomes and metrics were proposed or identified, and added to the longlist.

In the fourth step, the confirmed indicator list was produced, specifying for each indicator: the data collection method (survey, interview, document review, or dataset extraction); the organisation types to which it applied; and whether it was an output, outcome, or impact-level metric.

2.4. Data collection by organisation type

Dutch and international NGOs were approached for participation in the structured survey (Table 4). The final survey was distributed to all funded Dutch and international NGOs (n=53), either directly to contact persons known to the DGHA and SRHR platform, or through general inquiry through public channels, predominantly webforms. Embassy-funded projects were not included in the survey, as project contacts for implementing organisations were typically not listed in available data sources.

MFA-funded Global Health Organisations (n=8) were approached for key informant interviews to identify which relevant indicators could be sourced from routine reporting and internal M&E datasets. PDPs (n=6) represent a unique category: data for this group was collected through interviews and document review of routine impact reporting, rather than through standardised surveys.

Organization and Activity Type	Global Health	SRHR
Global Health Organization	Document Review & Interviews	Document Review & Interviews
International NGO	Survey / Document Review & Interviews	Survey / Document Review & Interviews
Dutch NGO	Document Review & Interviews	Survey
Recipient country-based NGO / Embassy funded projects	Not contacted	Not contacted
Product Development Partnerships (via RvO)	Document Review & Interviews	Document Review & Interviews

Table 2. Data collection strategy per organisation and activity type and per impact domain

2.5. Data Sources and Collection

A structured survey was sent to 39 Dutch and International organisations, and Embassy-funded projects were not included in the survey or data collection, because no contact information was available systematically. Responding organisations were asked to provide project-level data including: geographic reach, consortium membership, external stakeholder engagement, MFA basket indicator values, and documented legal and policy outcomes.

Different M&E frameworks applied across the portfolio. Dutch NGOs, responding to competitive grant rounds, were required to adopt MFA basket indicators and submit Theories-of-Change. No structured M&E requirements were identified for international NGOs or GHOs.

2.6. Analytical Approach

Combination of output, outcome and impact data across organisations and projects requires careful consideration and calculation. Global Health and SRHR activities are typically carried out jointly, i.e. through collaborating consortia of multiple national and international organisations. In addition, many outcomes-of-interest are not directly observed, either because effects materialise over time, with a delay or outside the scope of (routine) data collection. In practice, many of the outcomes and impacts-of-interest are never observed, but rather modelled based on past results from large scale studies establishing the effectiveness of specific interventions.

2.6.1. Observed versus modelled outcomes

Observed or measured inputs and outputs are directly counted from available impact reports and surveys. Outcomes and impacts, e.g. deaths averted or infections prevented, cannot be directly observed and must be estimated using published epidemiological models. Modelled results are clearly distinguished from observed outputs throughout this report.

Data on outputs, outcomes and impacts are sourced from primary sources. GHO technical partners, including WHO and UNAIDS, use state-of-the-art mathematical models and widely accepted data sources to model the health impacts of selected outputs and outcomes. Mathematical models used to this end include Lives Saved Tool, TIME and OPTIMA-TB, and GOALS for HIV. Since no country-level sources were available to us, no new epidemiological or health impact modelling was performed in this study.

2.6.2. Causal and proportional attribution

Three attribution approaches are used in this assessment: direct attribution of observed results, proportional attribution of observed and modelled results, and contribution analysis of observed and modelled results.

Direct attribution is used where a single organisation implemented and reported on an activity with a clear causal pathway, and therefore clear attributable outputs. For example, if one implementing organisation or consortium reports the number of individuals reached with comprehensive sexuality education they provided, and no other organisation contributed to this activity in this geography.

Proportional attribution is applied when multiple countries or donors contribute to one organisation that reports a specific result indicator. Repeating the summary results as the impact of MFA contributions overestimates our impact. Proportional attribution entails multiplication of the outcome indicators by the relative share of funding MFA provided. This applied to numerical data on funding, procurement and individual-level outcomes.

For example, if a GHO reports 140 million vaccine doses procured, and MFA contributed 1.5% of funding, proportional attribution analysis estimates our impact as 2.1 million doses doses procured, rather than stating MFA contributed to procurement of 140 million doses.

Contribution analysis is used for outcomes in complex, multi-actor systems, particularly lobby and advocacy outcomes. Organisations themselves assessed whether a programme credibly contributed to a policy outcome, typically using outcome harvesting methodology (8).

The results reported by PDPs, NGOs/CSOs and GHOs were not independently evaluated by the consultant for this report.

2.6.3. Double-counting

Where multiple organisations reported results for the same intervention, geography, and time period, only the highest single reported value was retained. This 'highest reported value' rule makes estimates more defensible and credible, but conservative, i.e. it is likely to underestimate total results where multiple organisations delivered at least partly complementary, non-overlapping activities.

Within the scope of this report, double counting is expected for family planning and sexual health services. For example: UNFPA, International Planned Parenthood Federation Member Organisations and Marie Stopes International each reported family planning outputs, including consultations provided, couple-years of protection distributed, and modeled outcomes of unwanted pregnancies, unsafe abortions and maternal deaths averted across multiple countries in the same year. Even if UNFPA, IPPF and MSI report different numbers of deaths averted, only the highest of the values will be reported, as overlap and thus double counting cannot be excluded completely.

RESULTS

3.1. Final sample of IATI activities

Between 2020 and 2024, MFA disbursed €2.599 billion across 254 IATI-registered activities. Eight activities were removed, one because no funding was associated between 2020-2024, one that clearly focused solely on external evaluation of other projects, two represented Dutch-based academic activities, and four that represent MFA commissioning external expertise for program management. The remaining 246 activities constitute the final sample, representing a total disbursed value of €2.596 billion, and were classified into five organisation categories (**Figure 3**). The Global Health Organisations category represented 10 organisations and 74 activities. International NGOs represented 17 organisations with 42 activities. Dutch NGOs represented 26 organisations with 44 activities, the Dutch Embassy network represented 80 activities, and Product Development Partnerships (PDPs, represented as RVO) represented 6 activities. An overview of activities per category is found in **Figure 4**.

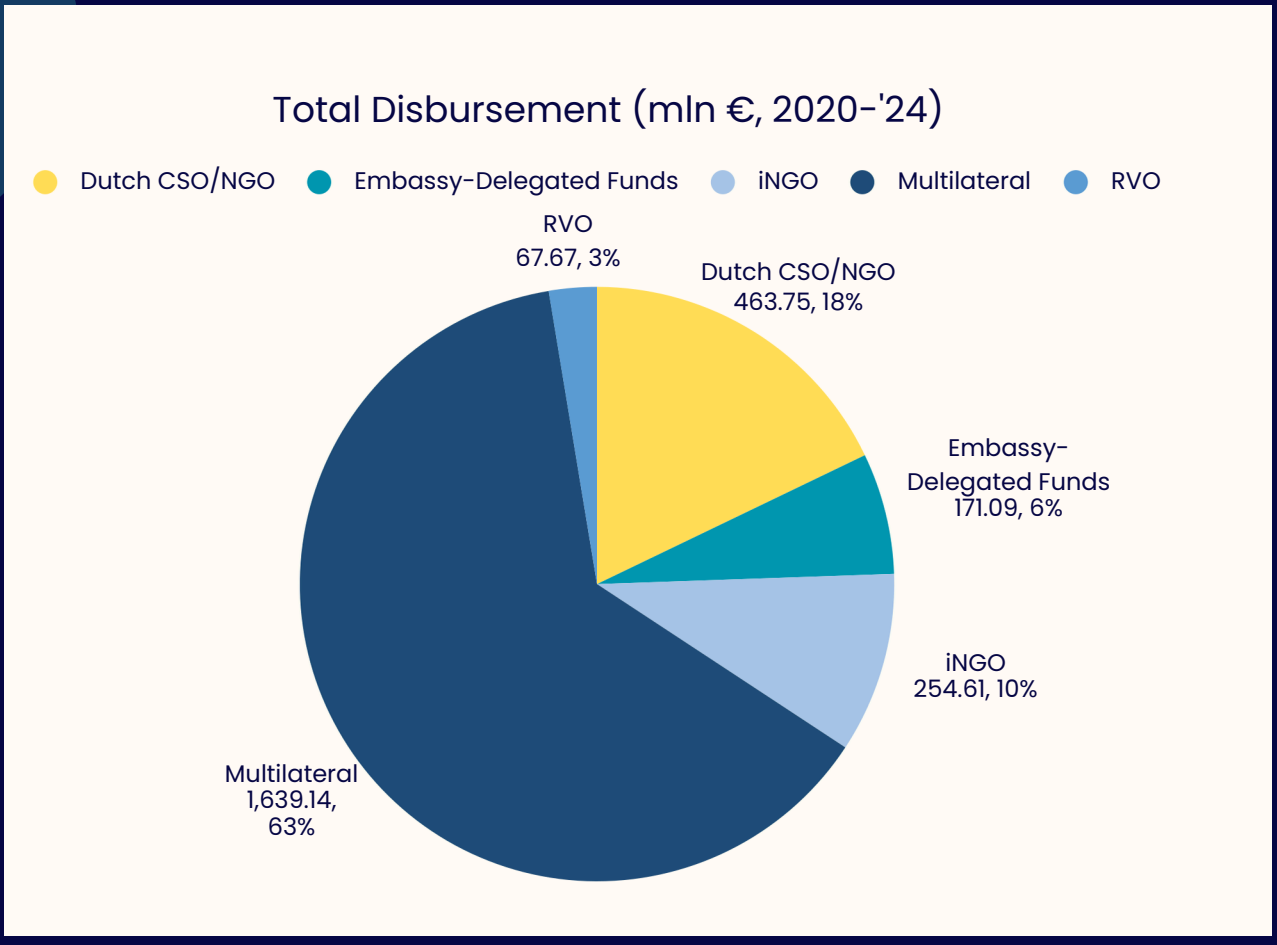

Figure 3. Total Art 3.1 Total disbursement in millions (2020-2024) per implementing organisation type.

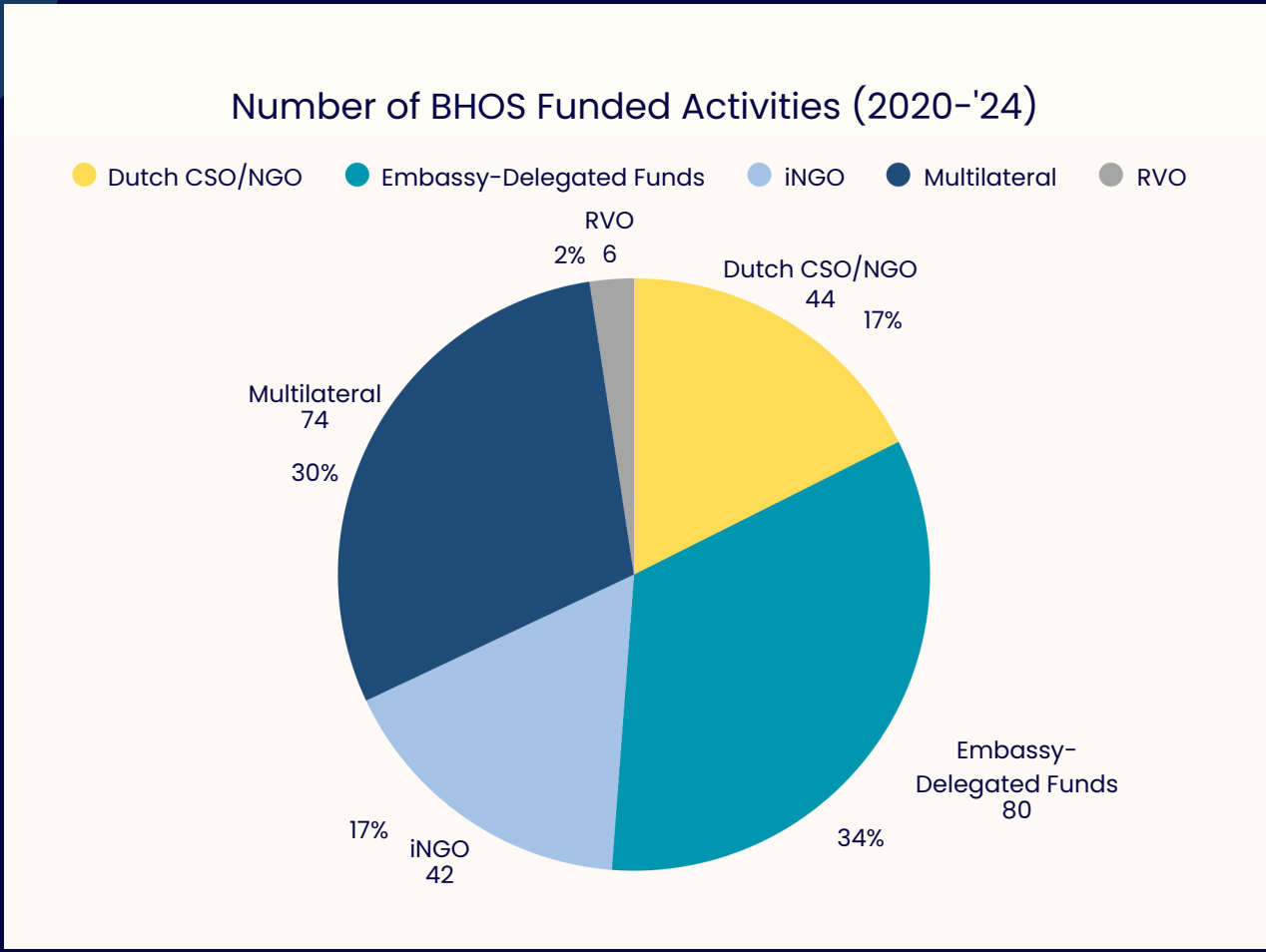

Figure 4. Number and percentage of funded activities per implementing organisation type.

3.2. Data collection process and timeline

Survey distribution started in November 2025, and final results were received in March 2026. Illustrative images of the final survey template are available in Annex A2, and the full survey in spreadsheet format is available upon request.

In total, 13 out of 23 Dutch NGO/CSOs completed the surveys, representing 57% of organisations, 59% of activities, and 75% of total disbursements (€350 million out of €464 million in total). For iNGOs, 9 out of 16 organisations (56%) completed surveys, representing 74% of activities and 58% of total disbursements (€149 million out of €255 million in total).

Out of 8 contacted GHOs, 7 were reached for structured interviews and querying of internal M&E datasets. In addition, all PDPs (6 IATI activities, 4 unique funds) were able to contribute documentation in the form of annual impact and financial reports.

3.3. Results indicators

Quantitative data could be collected for a total of 50 indicators, covering outputs and outcomes across six categories: Infectious Disease; SRHR outcomes; civil society strengthening, lobby & advocacy; health system strengthening; health security; and economic and financial returns **(Table 3).**

Indicator	Value	Unit	Data source	Attribution / method
Outcomes: lives saved, DALYs* averted				
Deaths averted	***448,000 - 529,400***	Deaths	*Combined*	*PA**, modelled*
Deaths averted through prevention and treatment of malaria, TB and HIV	***251,000 - 332,000***	*Deaths*	*Global Fund*	*PA, modelled*
Deaths averted through routine immunization	***139,038***	*Deaths*	*Gavi*	*PA, modelled*
Deaths averted through COVID-19 vaccination	***48,214***	*Deaths*	*COVAX*	*PA, modelled*
Maternal deaths averted	***10,148***	*Deaths*	*UNFPA*	*PA, modelled*
DALYs averted by immunisation	**6,310,000**	DALYs	*Gavi*	*PA, modelled*
Outputs: Infectious Disease				
Children immunised	**7,120,000**	Children	*Gavi*	*PA, observed*
Diagnostic tests conducted (malaria, HIV, TB)	**22,829,000**	Tests	*Global Fund*	*PA, observed*
Of which HIV tests taken	**3,800,000**	Tests	*Global Fund*	*PA, observed*
Of Which HIV tests taken by key populations	**629,000**	Tests	*Global Fund*	*PA, observed*
Infections treated (malaria, TB, HIV)	**9,962,000**	Treatments	*Global Fund*	*PA, observed*
Malaria cases treated	**9,300,000**	Treatments	*Global Fund*	*PA, observed*
People on ART for HIV	**300,000**	Treatments	*Global Fund*	*PA, observed*
TB patients treated	**362,000**	Patients	*Global Fund*	*PA, observed*

* DALY: disability-adjusted life year, a measure representing the health burden of a year of life lost or a year with maximum disability due to disease.
** PA: proportional attribution.

Indicator	Value	Unit	Data source	Attribution / method
Outputs: Infectious Disease				
Preventive treatments delivered (malaria, HIV, TB)	**3,794,000**	Preventive treatments	*Global Fund*	*PA, observed*
Seasonal malaria prophylaxis for children	**2,300,000**	Preventive treatments	*Global Fund*	*PA, observed*
Pregnant women receiving malaria preventive treatment	**830,000**	Preventive treatments	*Global Fund*	*PA, observed*
People reached with HIV prevention services	**452,000**	Preventive treatments	*Global Fund*	*PA, observed*
PLHIV who initiated TB preventive therapy	**172,000**	Preventive treatments	*Global Fund*	*PA, observed*
HIV-positive pregnant women who received antiretroviral therapy during pregnancy	**40,000**	Preventive treatments	*Global Fund*	*PA, observed*
Insecticide-treated mosquito nets distributed	**11,100,000**	Units	*Global Fund*	*PA, observed*
Buildings covered by indoor residual spraying against malaria vectors	**460,000**	Units	*Global Fund*	*PA, observed*
Outcomes: SRHR				
Couple-years of protection	**24,010,746**	CYP	*UNFPA, Survey*	*PA, modelled*
Unintended pregnancies prevented	**3,789,860**	Pregnancies	*UNFPA, Survey*	*PA, modelled*
Unsafe abortions prevented	**1,296,117**	Abortions	*UNFPA, Survey*	*PA, modelled*
Maternal deaths averted	**10,148**	Deaths	*UNFPA, Survey*	*PA, modelled*
STIs and HIV infections prevented by condom use	**1,067,368**	Infections	*UNFPA, Survey*	*PA, modelled*
STIs prevented by condom use	**1,026,959**	Infections	*UNFPA, Survey*	*PA, modelled*
HIV infections prevented by condoms	**40,409**	Infections	*UNFPA, Survey*	*PA, modelled*
Girls protected from FGM/C	**51,020**	Girls	*UNFPA*	*PA, modelled*
Health facilities that adopt and implement youth-friendly SRH and HIV/AIDS services	**2,339**	Facilities	*Survey*	*PA, observed*

Indicator	Value	Unit	Data source	Attribution / method
Outputs: SRHR				
Young people reached with CSE	**64,788,613**	People	*Survey*	*PA, observed*
Young people SRH services	**26,273,628**	People	*Survey*	*PA, observed*
Girls reached with life-skills programmes	**1,222,304**	Girls	*UNFPA*	*PA, observed*
Safe deliveries in conflict settings	**290,228**	Deliveries	*UNFPA*	*PA, observed*
GBV survivors receiving essential services	**180,296**	Survivors served	*UNFPA*	*PA, observed*
Outcomes and outputs: Civil Society Strengthening, Lobby & Advocacy				
Policy and/or legal changes achieved	**1,044**	Policy changes	*Survey*	*Contribution analysis*
Countries where Dutch-funded activities contributed to policy / legal change	**113**	Countries	*Survey*	*Contribution analysis*
CSOs trained in L&A	**3,919**	CSOs	*Survey*	*Contribution analysis*
Outputs: Health System Strengthening				
Countries where local organisations co-led or led implementing consortium	**37**	Countries	*Survey*	*Observed*
Countries receiving support to strengthen primary healthcare	**45**	Countries	*WHO*	*Contribution analysis*
Countries receiving support to strengthen immunization programs	**57**	Countries	*Gavi*	*Contribution analysis*
Countries with expanded national vaccine research capacities through PDPs	**28**	Countries	*PDP*	*Observed*

Indicator	Value	Unit	Data source	Attribution / method
Outputs : Health Security				
Epidemic threats responded to	**236**	Outbreaks	*WHO*	*Contribution analysis*
Countries receiving technical and operational assistance for outbreak detection and response	**89**	Countries	*WHO*	*Contribution analysis*
Countries receiving COVID emergency support	**111**	Countries	*World Bank*	*Contribution analysis*
Outcomes: Economic and industry results				
Social value generated in partner countries	**€9.1 billion**	EUR (social value)	*Global Fund, Gavi*	*PA, modelled*
Social value from prevention and treatment of malaria, TB and HIV	**€7.7 billion**	EUR (social value)	*Global Fund*	*PA, modelled*
Social value from immunisation	**€1.4 billion**	EUR (social value)	*Gavi*	*PA, modelled*
Procurement by UN/GHOs from Dutch entities	**€4.4 billion**	EUR (total value)	*UN System, Global Fund*	*Observed*

*A minority of Dutch NGOs also contributed to indicators under section 1 Health Outcomes, but as double counting could not be ruled out, the GHO estimates are reported.

Table 3. Summary of quantitative result and outcome indicators for Dutch Global Health and SRHR contributions

3.3.1. Lives Saved and DALYs averted

Summing the estimates of deaths averted modelled by GFATM, Gavi, COVAX and UNFPA, Dutch contributions are estimated to have saved 448,000 - 529,400 lives between 2020-2024. This number represents 251,000-332,000 lives saved through prevention and treatment of malaria, TB and HIV; 139,039 lives saved through routine childhood immunization against potentially life-threatening infectious diseases; 48,214 lives saved through COVID-19 vaccination; and 10,148 maternal deaths averted through prevention of unsafe abortions in unwanted pregnancies, pregnancy complications and by providing safe abortions in humanitarian settings. In addition, Gavi modelled the number of disability-adjusted lifeyears averted through its routine childhood immunization programs, which totalled an estimated 6,3 million years. This number combines years-of-life lost due to disease and years-lived-with-disability due to disease.

No country-level outputs or results were available to assess overlap or complementarity between GFATM activities and programmes by Dutch and international NGOs in this space. We therefore report the GFATM estimates following the “highest value reported” rule (see 2.6.3.)

3.3.2. Infectious Disease

Key informants with GFATM modelled the results representing Dutch proportional contributions to the Global Fund's replenishments during 2020-2024.

Dutch contributions resulted in an additional 3.8 million HIV tests taken, of which 629,000 were by priority and key populations. An additional 300,000 people were on antiretroviral therapy, including over 40,000 HIV-positive pregnant women receiving ART during pregnancy. Over 452,000 people were reached with HIV prevention services, of whom 171,000 were adolescent girls and young women.

Dutch contributions resulted in an additional 362,000 tuberculosis patients receiving life-saving treatment, including 7,000 with drug-resistant TB and 19,000 HIV-positive TB patients. In addition, 172,000 people living with HIV on ART were supported with TB prevention.

Dutch contributions resulted in an additional 18.4 million malaria tests performed and 9.3 million malaria cases treated. In addition, 2.3 million children and 830,000 pregnant women received preventive treatment. Over 11.1 million insecticide-treated mosquito nets were distributed and 460,000 buildings were covered by indoor residual spraying.

Similar to the results on lives saved, no country-level outputs or results were available to assess overlap or complementarity between GFATM activities and programmes by Dutch and international NGOs in this space. We therefore report the GFATM estimates following the "highest value reported" rule (see 2.6.3.)

Key informants with Gavi provided contextual information on annual impact and financial reports. Dutch contributions helped immunise 7.1 million children against deadly and preventable diseases. Dutch-supported immunisation programmes prevented an estimated 139,038 deaths.

3.3.3. Sexual and Reproductive Health

UNFPA provided documents and internal M&E datasets about service delivery results and outcomes, including modelling estimates of the number of maternal deaths averted. In addition, multiple international and Dutch NGOs/CSOs provided survey data on SRHR services they provided or supported.

Dutch contributions prevented an estimated 3.8 million unintended pregnancies and 1.3 million unsafe abortions, preventing an estimated 10,150 cases of maternal death. Over 290,000 safe deliveries were performed in conflict-affected settings.

Contraceptives delivered provided over 24 million couple-years of protection, also preventing an estimated 1.03 million sexually transmitted infections. Among these STIs, condoms distributed are expected to have prevented 40,400 HIV infections.

In addition, 1.2 million girls were reached with essential life-skills programmes. Over 51,000 girls were protected from female genital mutilation/cutting, and over 180,000 survivors of gender-based violence received essential services.

3.3.4. Civil Society Strengthening, Lobby and Advocacy

Civil society strengthening (CSS), movement building and lobby and advocacy (L&A) for SRHR operate across multiple levels: from international norm-setting and treaty frameworks, through national legislation and executive policy, to community-level policy implementation and local social norms (18,19). Typical objectives include improved access to SRH services and safe abortion; inclusion of marginalised communities; and protection from gender-based violence, female genital mutilation, and child marriage.

The majority of funded international and Dutch NGOs/CSOs were involved in CSS and L&A. They provided survey data on the organisations they supported, and the outcomes of L&A activities they carried out, as well as those they supported.

Dutch funding and efforts contributed to at least 1,044 policy changes and legal victories across 113 countries. These outcomes were reported by the majority of Dutch and international NGOs, including International Planned Parenthood Federation member organisations, as L&A is a core part of development assistance work. MFA-funded projects trained 3,908 civil society organisations in lobby and advocacy capacities.

3.3.5. Health System Strengthening

Strong health systems are prerequisites for equitable, sustainable health outcomes, including those supported by global health and SRHR programs. Evidence from health systems research consistently demonstrates that governance, supply chains, and human resources for health are primary drivers of quality and equitable access to services in LMICs (20). Primary healthcare in particular, is regarded as the most appropriate and cost-effective entry point for achieving adequate coverage of essential services without patients enduring catastrophic expenditures(21).

HSS results and outcomes were sourced in World Bank, WHO, Gavi and Product Development Partnership reports, as well as elicited in the survey to Dutch and international NGOs.

Dutch contributions enabled technical support to 45 countries to scale proven primary healthcare approaches (22). Through product development partnerships, over 28 countries expanded national vaccine research capacities during 2020-2024 (23,24). National immunisation programs were supported in 57 countries (25). Local organisations were co-decision makers on MFA-funded consortia and projects across 37 countries, and in 17 of these, local organisations were the final decision-maker, indicating full local ownership of design, planning and implementation of activities.

3.3.6. Health Security

Infectious disease does not respect national borders: outbreaks in partner countries threaten Dutch nationals working or travelling abroad, and create import risks domestically, as demonstrated by Ebola, COVID-19, and Mpox. Dutch investments in health security abroad therefore directly generate benefits for the Netherlands as well. Product Development Partnerships were introduced to share risk, cost and expertise for new drug and vaccine candidate development at a time when traditional pharmaceutical investment in antibiotics declined.

Data on health security was identified from published reports, and through interviews with key informants in WHO, Gavi and the World Bank. Analysis of Product Development Partnerships identified crucial innovations to combat infectious disease and antimicrobial resistance.

MFA contributions supported the detection, analysis, and response to 236 epidemic threats across 89 countries. MFA contributions to the World Bank helped support 111 countries with COVID-related emergency response and funding (26). In addition, MFA contributions to COVAX funded the procurement and distribution of vaccines that are estimated to have prevented 48,214 COVID-19 deaths.

MFA contributions to PDPs contribute to the testing and approval of 8 new antibiotic medicines, among which novel agents for antibiotic-resistant infections (27). In addition, these MFA contributions to PDPs contributed to clinical testing of 25 new HIV vaccine candidates (23).

3.3.7. Economic and Industry Results

Health investments generate economic returns in partner countries and domestically. In partner countries, improving health and wellbeing lowers healthcare expenditure, increases labour participation and productivity. In addition, a number of Dutch entities are key players in the global supply chain for commodities procured by global health organisations and international NGOs.

Limited information on the economic benefits of global health and SRHR was available. Gavi reports the economic value of immunisation programs. Key informant interviews with each GHO identified the procurement value with Dutch entities.

During 2020-2024, Dutch contributions to immunisation campaigns delivered an estimated €1.4 billion in social value through productivity gains and avoided healthcare costs (25). Applying the GFATM impact projection models to MFA contributions yield expected social value of €7.7 billion through health gains, the methods for which can be found supporting the GFATM Investment Case (28).

The Global Fund and multiple UN organisations procured over €4.4 billion worth of medicine, medical products and professional services from entities registered as Dutch during 2020–2024 (29–31). For two specific Dutch entities, i+Solutions and IDA Foundation, publicly available reports covered 2022-2024, but not 2020-2021, indicating that the total procurement value may in fact be higher still. The majority of the identifiable procurement value consisted of goods, i.e. €4.1 billion or 92% of the total, compared to ca. €300 million in services, or 8%. Of note, this amount is not a net profit to Dutch entities, but rather illustrates the scale.

DISCUSSION

This report documented the outcomes and impact achieved through Dutch global health and SRHR investments and activities between 2020 and 2024. The discussion reflects on the quality of the evidence presented, the representativeness of the indicators used, the broader implications of the results, and provides recommendations for future impact reporting.

4.1. Accuracy of chosen methods and quality of underlying models

The results in this report rest on two methodological pillars: observed data reported by funded organisations, and modelled estimates derived from published epidemiological parameters.
For observed outputs, the primary quality risk lies in self-reporting. While external evaluation of projects is routine practice - sometimes accompanied by independent verification of results – it cannot be ruled out that project implementers overestimate and overreport their performance. For multilateral organisations (Gavi, Global Fund, UNFPA), data were drawn from published annual reports and institutional M&E systems, which are typically subject to independent audit and validation, although this does not automatically guarantee the accuracy of all source data.

For modelled outcomes, the quality of results depends directly on the epidemiological models applied. The accuracy and credibility of modelled results rest on the underlying data sources and assumptions. While this report does not introduce new models, it is important to state that the models used by reporting organisations to generate outcomes are published in peer-reviewed literature, and adopted by authoritative bodies, including the WHO, Gavi, UNAIDS, et cetera. For the majority of the models, point estimates are reported, e.g. “48,214 COVID-19 deaths averted”, rather than ranges, which could look like “40,000-55,000 COVID-19 deaths averted. It is important to interpret these point estimates as indicative, and not exact measurements.

4.2. Validity and Reliability of Indicators

The indicators reported in this report were selected based on current availability in routine M&E systems, applicability to multiple organisations, and their links to Theories-of-Change. The definitions of MFA basket indicators remained consistent during the time period studied. The GHOs vary their reporting annually, but during the period studied, sufficient numbers of indicators were repeated to allow for aggregation of results across multiple years.

However, several important aspects of impact are not well captured by the current indicator set. First and foremost, most indicators collected reflect outputs, e.g. services delivered or treatments prescribed, rather than long-term impacts. Outputs (services delivered, commodities procured) are well represented because they are most reliably reported. Outcomes (lives saved, infections prevented) require modelling and carry greater uncertainty. Longer-term impacts (mortality trends, prevalence reduction, empowerment) are largely absent, as they cannot be attributed to a single funding period.

Second, little is reported about the quality of outputs. In part, this reflects measurement challenges. For example, quality of care measures are not reported systematically, but neither is care quality comprehensively recorded in high-income health systems. Other service aspects lack indicators, including whether services were person-centred, or whether utilisation promoted equity, i.e. whether the benefits of Dutch contributions reach communities based on need, disadvantage and priority. While these considerations are integral to program design, they're not made explicit and measured. Moreover, for L&A, reporting the number of policy changes achieved does not indicate the magnitude of change, effect or impact resulting from these policy changes.

4.3. Attribution and the ecosystem model of impact

Where direct attribution was not appropriate, the presented analysis addressed issues on causal attribution through proportional attribution, contribution analysis, and conservative estimation of potentially overlapping activities. These methods are pragmatic and transparent, and consistent with how the cited organisations report their results.

Even with careful consideration on double counting and appropriate attribution of impacts, the outcome and impact in a counterfactual scenario, i.e. where MFA did not fund global health and SRHR activities, cannot be established. For inputs and services delivered, this report assumes that Dutch contributions are catalytic, i.e. if funding was not made available, then the additional inputs and outputs listed in this report would not have been delivered. Perhaps reallocation of domestic resources or those of other donors would have secured delivery of the listed services, leading to a gap in service delivery elsewhere or in another domain.

4.4. Specific limitations and implications

The following limitations specific to this report warrant mention and discussion:
First, the low response rate both limits generalisability of results to the total scope of organisations and activities funded through MFA BHOS Article 3.1, specifically of Dutch and iNGOs. It also implies a significant potential undercounting of outcomes and impacts. It is unclear what the role of non-response bias is in this sample, as we could not assess and compare past indicator data between responders and non-responders.

Second, this report includes no long-term impact metrics. While the assessment covers a five-year period, long-term impact data such as mortality trends, prevalence reduction, and structural health system changes cannot feasibly be measured within this timeframe, nor could they be attributed to the funded activities alone.

Third, the 2020–2024 study period was profoundly shaped by the COVID-19 pandemic. The pandemic disrupted routine health service delivery across virtually all programme areas for national health systems, and by extension for international development partners. At the same time, the pandemic generated the need for emergency pandemic response. Many MFA-funded organisations and projects responded flexibly, pivoting resources (e.g. for the procurement of personal protective equipment) and activities to support COVID-related efforts. This has two major implications for the interpretation of the results.

One implication is that routine programme outputs and outcomes in this period are expected to be lower than they would have been in a non-pandemic period, further underscoring that this report may underestimate impacts. The other that the responsiveness of the ecosystem to the COVID pandemic demonstrates the value of investing in a broad, multi-actor portfolio as it allows for reorientation and reprioritization of investments.

Lastly, pertaining to policy relevance, this analysis aimed at a first iteration of a portfolio wide impact evaluation. Cost-effectiveness of spending was explicitly not in scope for this assignment. However, given its salience in international development, it would certainly merit analysis in future iterations.

CONCLUSION

Dutch MFA contributions to global health and SRHR have made significant impacts to health and well-being, sexual and reproductive rights, strengthened health systems and civil society, and contributed to labour productivity and health security across the globe. At a time when budget allocations to global health and SRHR are under scrutiny, the presented results can inform the public discussion on how best to contribute to health and social development.

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ANNEX TABLE A1. RESULTS LONGLIST AND EXPECTED DATA SOURCE BEFORE DATA COLLECTION

		Document review			**Survey**
	ID	**Impact metric**	**Source**	**ID**	**Impact metric**
Section 1: health	*1.1*	*Reached 100,000 young people reached with comprehensive, correct information on sexuality, HIV/AIDS, STIs, pregnancy and contraception (SRHR indicator B#)*	*Incomplete IATI data*	1.1	Reached 100,000 young people reached with comprehensive, correct information on sexuality, HIV/AIDS, STIs, pregnancy and contraception (SRHR indicator B#)
	1.2	*Supported 10,000 health facilities to adopt and implement youth-friendly SRH and HIV/AIDS services (SRHR indicator C #)*	*Incomplete IATI data*	1.2	Supported 10,000 health facilities to adopt and implement youth-friendly SRH and HIV/AIDS services (SRHR indicator C #)
	1.3	Saved 1,000,000 lives	Global fund*	1.17	Targeted 1,000 policies/laws across 100 countries
	1.4	Administered 100,000 life-saving vaccines	Gavi, GF	1.18	Supported 10,000 organisations across 100 countries (count of unique organisations for indicators SCS6-8)
	1.5	Provided 100,000 insecticide-treated malaria bednets	GF	1.19	Trained 1,000 organisations across 50 countries to use L&A (count of unique organisations for indicator SCS5)
	1.6	Served 100,000 women and couples with sexual and reproductive health education	GF, UNAIDS, UNFPA	1.20	Invested X% of ODA in projects that are supported by scientific evidence
	1.7	Prevented 100,000 unintended pregnancies	GF, UNFPA	1.21	Helped achieve 100 policy/legal changes in 10 countries, decriminalizing 10,000,000 individuals, and enabling access to essential health services (among others).
	1.8	Prevented 100,000 unplanned births	GF, UNFPA	1.22	Helped achieve 100 policy/legal changes in 10 countries, decriminalizing 10,000,000 individuals, and enabling access to essential health services (among others), which led to 2,000,000 fewer transmissions of STIs, HIV, and other conditions.
	1.9	Prevented 100,000 unsafe abortions	GF, UNFPA	1.23	2.1 SCS1 # of laws and policies for sustainable and inclusive development that are better implemented as a result of CSO engagement
	1.10	Prevented 100,000 maternal deaths	GF, UNFPA	1.23	2.2 SCS2 # of laws, policies blocked, adopted, improved for sustainable and inclusive development as a result of CSO engagement

1.11	Provided 100,000 antiretroviral therapy regimens to PLHIV	GF
1.12	Treated 100,000 mothers to prevent HIV transmission	GF
1.13	Provided 100,000 people with HIV counsel and testing	GF
1.14	Reached 100,000 KP members reached with HIV programs	GF
1.15	Treated 100,000 health workers to provide SRHR education	GF, UNFPA
1.16	Supported basic education for 100,000 health workers through grants and technical assistance (WB)	World Bank

1.24	2.3 SCS3 # of times that CSOs succeed in creating space for CSO demands and positions through agenda setting, influencing the debate and/or creating space to engage
1.25	2.4 SCS4 # of advocacy initiatives carried out by CSOs, for, by or with their membership/constituency
1.26	2.5 SCS5 # of CSOs with increased L&A capacities
1.27	2.6 SCS6 # of CSOs included in SPs programmes
1.39	2.7 SCS7 # of CSOs that have enhanced representation of constituencies
1.28	2.8 SCS8 # of CSOs using a Gender and Social Inclusion lens during all phases of the programming cycle with specific attention to youth
1.29	2.9 SCS9 # of actions in support to better NGO and/or labour/trade union legislation, policies, by-laws and codes of conduct that improve civil society space
1.30	3.1 # of youth using SRH services
1.31	3.2 SRHR indicator A # of youth who participate in policy and decision-making bodies who perceive their participation as meaningful
1.32	3.5 D # of innovative SRH (incl. HIV/AIDS) medicines and commodities or production/distribution options that have proof of concept or have successfully been brought to scale, according to own project definition
1.38	3.6 E.1.1 # of women and girls using modern contraceptives
1.33	3.7 E.1.4 # of service delivery points with continuous availability of commodities related to safe abortion in the reporting period
1.34	3.8 SRHR indicator F.1.1 # health workers trained in providing SRH services

				1.35	3.9 SRHR indicator F.1.2 out of which # including on safe abortion
				1.36	3.10 SRHR indicator F.2 # of comprehensive (post-) abortion care services provided
				1.37	3.11 SRHR indicator G # of initiatives to promote private sector involvement in SRH and HIV/AIDS services
Section 2: economic and financial returns	2.1	Prevented $1,000,000,000 in medical spending for households through avoided visits and freed up capacity	GF, WB	2.8	Helped introduce and scale 10 innovative SRH (incl. HIV/AIDS) medicines and commodities or production/distribution options in 25 countries
	2.2	Generated $1,000,000,000 in economic activity through health gains, e.g. through increased productivity	GF		
	2.3	Generated €1.0 billion in procurement from Dutch-affiliated private enterprises	CEPI, UN system, WHO/PAHO, etc.		
	2.4	Employed $1,000 Dutch professionals at multilaterals/IHOs active in GH & SRHR	CEPI, UN system, WHO/PAHO, etc.		
	2.5	Developed 10 patents and 100 new products through PDP	MoFA, RvO		
	2.6	*Enabled 1,000 businesses in the health sector to initiate activities in partner countries, that could otherwise not secure funding*	*Invest International, RvO*		
	2.7	Contributed to health care capacity and quality in 100 countries where 20 Dutch multinational companies generate €1,000,000,000 of economic activity	T.b.d.		

Section 3: health diplomacy and security	3.1	Contributed to health care capacity and quality in 100 countries receiving 1000000 Dutch military personnel, diplomats, businesspeople and tourists.	CBS and t.b.d.	3.3	In 100 partner countries, Dutch funded organisations liaised directly with national and subnational gov't, including elected politicians
	3.2	Contributed to the timely response to 50 outbreaks in 20 countries, preventing them from becoming society-disrupting epidemics and pandemics.	Combine WHO/Gavi data	3.4	Strengthened the autonomy and capacity of local and national health systems in 50 countries, with country-led framing, design and implementation of activities
				3.5	Increased the L&A capacities of 1000 CSOs in 50 countries, building autonomy for democratic engagement

ANNEX A2. STRUCTURED DATA COLLECTION SURVEY DISTRIBUTED TO DUTCH AND INTERNATIONAL NGOS

Dear colleagues,
The following impact data collection has been designed based on metrics prioritized by the MPI steering committee.
We kindly ask that you fill out this form ***separately for each project*** (*see IATI list*) funded by MoFA under budget item 3.1 GH & SRHR.
If you have any questions while filling out the survey, please do not hesitate to either e-mail or call.
These questions will be added to an **FAQ** list that Charlie will maintain and distribute.

Once you have completed the entire form, the indicator to the right should say 0.
Then, please **save the file** and add **IATI code** from F8 at the end, for example "as "DGH_Impact_Survey_10312"

Thank you in advance for your efforts in completing this data collection.
charlie.nederpelt@live.nl / +31 6 13016918

Required fields left: 41

ID	Question	Value / Answer	
Q1	What is your name?	*Free text...*	
Q2	What are your e-mail address, in case of follow-up	*Free text...*	
	May we use your business phone number for follow-up questions? If so, please provide your business phone number:	*Free text...*	
Q3	For which organization do you report? Please see the IATI	*Free text...*	
Q4	Please provide the IATI activity ID, select from a list of	*Please select*	
	Check: project reporting organization	#N/A	*This organization has 0 project(s) to report*
	Check: project name	#N/A	
	Check: disbursement between 1/1/2020-31/12/2024	€ -	
	Check: country, countries or region	#N/A	
Q5	Is the country shown correct?		
	If the country is incorrect, please list the correct countryies below:		
	Country 1	*If applicable, select country*	
	Country 2	*If applicable, select country*	
	Country 3	*If applicable, select country*	
	Country 4	*If applicable, select country*	
	Country 5	*If applicable, select country*	
	Country 6	*If applicable, select country*	
	Country 7	*If applicable, select country*	
	Country 8	*If applicable, select country*	
	Country 9	*If applicable, select country*	
	Country 10	*If applicable, select country*	

Legend

	Green fields for manual data entry, please check the data type in the ribbon.
	Gray fields retrieve information from MoFA database

Q6	What was the start date for project **implementation**?	*1-1-2020*	*Dd-mm-yyy*
Q7	What is/was the actual or planned end date of	*31-12-2024*	*Dd-mm-yyy*

Q8 Please select all stakeholder groups that were part of the implementing consortium (first column), and which stakeholder groups were liaised with directly (second

Stakeholder category	**Part of implementation consortium:**	**Liaised with directly:**
1. Non-elected **national government officials**, e.g. staff or representatives of national ministries, departments, or		
2. Non-elected **subnational government officials**, e.g. staff or representatives of local, or provincial departments or		
3. **Elected politicians** of the national parliament		
4. **Community-based organisations**, defined as "local, often non-profit entity that works to improve the well-being of residents within a specific geographic or demographic		
5. **NGOs;** non-governmental organisation from the partner		
6. For-profit enterprise **based in The Netherlands**		
7. For-profit enterprise **based in the partner country**		
8. **iNGO**, International non-profit, non-governmental organization that operates across national borders to pursue social, humanitarian, or environmental goals		
9. **Multilateral organizations**, defined as "entities created by three or more countries (their governments, red.) to work on issues of common interest", for example United Nations		
10. International knowledge-sharing or implementation support **networks** on SRHR or Civil Society Strengthening, such as Share-Net or ICFP.		
11. National knowledge-sharing or implementation support **networks** on SRHR or CSS, based in the partner country.		

Q9	To what extent were local actors/organizations in control of framing, designing, and delivering the activities? Use the Partos classification. Local actors/organizations were … (fill *1: not involved* *2: informed* *3: consulted* *4: co-decision maker* *5: decision maker*	

Q10	**Please provide any available data for MoFA basket indicators that apply to this project.**	**Does this apply to delivered activities, even if indicator wasn't in the M&E framework?**	**Was this data collected?**	**Baseline number/count** *Example: 0*	**Mid-term (baseline + gains)** *Example: 15*	**Current or end-term (total gains)** *Example: 25*	**Indicator result** *Example: 25 - 0 = 25*
	2.5 SCS5 #: How many CSOs were trained and supported to increase their L&A capacity?						0.0
	2.2 SCS2 #: How many laws or policies were blocked, adopted or improved that contribute to sustainable and inclusive development as a result of CSO engagement?						0.0

Q11	**Please provide any available data from prioritized IATI indicators that apply to this project.**	**Does this apply to delivered activities, even if indicator wasn't in the M&E framework?**	**Was this data collected?**	**Baseline value** *Example: 7*	**Mid-term value** *Example: 15*	**End-term value** *Example: 20*	**Indicator result** *Example: 20 - 7 = 13*
	3.1 # of **youth using SRH services**						0.0
	3.3 SRHR indicator B # of young people reached with **comprehensive, correct information** on sexuality, HIV/AIDS, STIs, pregnancy and contraception						0.0
	3.4 C # of health facilities that adopt and implement **youth-friendly SRH and HIV/AIDS services**						0.0
	3.5 D # of **innovative SRH (incl. HIV/AIDS) medicines and commodities** or production/distribution options that have proof of concept or have successfully been brought to scale, according to own project definition						0.0
	3.6 E.1.1 # of women and girls using **modern contraceptives**						0.0

Q13 Please select which benefits are expected from the achieved policy or legal victories that this project supported. You only need to enter the benefits once, at the

		Improved inclusion of:				Improved access to:						Protection from:				
International level	**International organisation, platform or process name:**	gender diverse identity	sexual orientation	People with HIV	People with disabilities	(safe) abortion	HIV/AIDS services	family planning	contraceptives	other SRH services	health services in	gender-based violence	female genital mutilatio	child marriage	Improved position to make	Improved affordability of health
International 1, e.g. WHO	*Free text…*															
International 2	*Free text…*															
International 3	*Free text…*															
International 4	*Free text…*															
International 5	*Free text…*															
International 6	*Free text…*															
International 7	*Free text…*															
International 8	*Free text…*															
International 9	*Free text…*															
International 10	*Free text…*															
Regional level	**Regional organisation, platform or process name:**															
Regional 1, e.g. African Union	*Free text…*															
Regional 2	*Free text…*															
Regional 3	*Free text…*															
Regional 4	*Free text…*															
Regional 5	*Free text…*															
Regional 6	*Free text…*															
Regional 7	*Free text…*															
Regional 8	*Free text…*															
Regional 9	*Free text…*															
Regional 10	*Free text…*															

		Improved inclusion of:				Improved access to:						Protection from:				
Country, national level	**Country name (from Q8):**	gender diverse identity	sexual orientation	People with HIV	People with disabilities	(safe) abortion	HIV/AIDS services	family planning	contraceptives	other SRH services	health services in	gender-based violence	female genital mutilatio	child marriage	Improved position to make	Improved affordability of health
National 1, e.g. Angola	*If applicable, select country*															
	If applicable, select country															
	If applicable, select country															