
Endline report – India, BVHA MFS II country evaluations

Capacity of Southern Partner Organisations (5C) component

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This report presents the findings of the endline of the evaluation of the organisational capacity component of the MFS II country evaluations. The focus of this report is India, FFID. The format is based on the requirements by the synthesis team and NWO/WOTRO. The endline was carried out in 2014. The baseline was carried out in 2012.

Key words: 5C (five core capabilities); attribution; baseline; causal map; change; CFA (Co-financing Organisation) endline; organisational capacity development; SPO (Southern Partner Organisation).



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The India 5C evaluation team

List of abbreviations and acronyms

5 C	Capacity development model which focuses on 5 core capabilities
ANM	Auxiliary Nurse Midwife
ANC	Ante Natal Checkup
BVHA	Bihar Voluntary Health Association
Causal map	Map with cause-effect relationships. See also 'detailed causal map'.
Causal mechanisms	The combination of parts that ultimately explains an outcome. Each part of the mechanism is an individually insufficient but necessary factor in a whole mechanism, which together produce the outcome
CBO	Community Based Organisation
CDI	Centre for Development Innovation
CFA	Co-Financing Agency
CHAI	Community Health and Advancement Initiative
CMAI	Christian Medical Association of India
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
Detailed causal map	Also 'model of change'. the representation of all possible explanations – causal pathways for a change/ outcome. These pathways are that of the intervention, rival pathways and pathways that combine parts of the intervention pathway with that of others. This also depicts the reciprocity of various events influencing each other and impacting the overall change. In the 5C evaluation identified key organisational capacity changes and underlying reasons for change (causal mechanisms) are traced through process tracing (for attribution question).
DLHS	District Level Household Survey
ED	Executive Director
General causal map	Causal map with key organisational capacity changes and underlying reasons for change (causal mechanisms), based on SPO perception.
HIV/AIDS	Human Immunodeficiency Virus infection/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
IDD	Iodine Deficiency Disorders
IDF	India Development Foundation
IEC	Information, Education, Communication
KAP	Knowledge, Attitude, Practice
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDR	Maternal Death Review
MFS	Dutch co-financing system
MHM	Menstrual Hygiene Management
MIS	Management Information System
NGO	Non-Governmental Organisation
NRHM	National Rural Health Mission
OCP	Oral Contraceptive Pills
OD	Organisational Development
PCPNDT	Pre Conception and Pre Natal Diagnostic Techniques (Act)
PHC	Primary health centre
PME	Planning, Monitoring and Evaluation
PNC	Post natal care
PRI	Panchayati Raj Institution
Process tracing	Theory-based approach to trace causal mechanisms

RCH	Reproductive and Child Health
RTI/STI	Reproductive Tract Infection/ Sexually Transmitted Infection
SPO	Southern Partner Organisation
SRHR	Sexual and Reproductive Health Rights
UFBRE	Unite for Body Rights (Alliance)
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VHSNC	Village Health, Sanitation and Nutrition Committee
TB	Tuberculosis
TFR	Total Fertility Rate
ToC	Theory of Change
VHA	Village Health Association
VHAI	Voluntary Health Association Of India
VO	Voluntary Organisation
Wageningen UR	Wageningen University & Research centre
WHO	World Health Organisation

1 Introduction & summary

1.1 Purpose and outline of the report

The Netherlands has a long tradition of public support for civil bi-lateral development cooperation, going back to the 1960s. The Co-Financing System (*Medefinancieringsstelsel*, or 'MFS') is its most recent expression. MFS II is the 2011-2015 grant framework for Co-Financing Agencies (CFAs), which is directed at achieving a sustainable reduction in poverty. A total of 20 consortia of Dutch CFAs have been awarded €1.9 billion in MFS II grants by the Dutch Ministry of Foreign Affairs (MoFA).

The overall aim of MFS II is to help strengthen civil society in the South as a building block for structural poverty reduction. CFAs receiving MFS II funding work through strategic partnerships with Southern Partner Organisations.

The MFS II framework stipulates that each consortium is required to carry out independent external evaluations to be able to make valid, evaluative statements about the effective use of the available funding. On behalf of Dutch consortia receiving MFS II funding, NWO-WOTRO has issued three calls for proposals. Call deals with joint MFS II evaluations of development interventions at country level. Evaluations must comprise a baseline assessment in 2012 and a follow-up assessment in 2014 and should be arranged according to three categories of priority result areas as defined by MoFA:

Achievement of Millennium Development Goals (MDGs) & themes;

Capacity development of Southern partner organisations (SPO) (5 c study);

Efforts to strengthen civil society.

This report focuses on the assessment of capacity development of southern partner organisations. This evaluation of the organisational capacity development of the SPOs is organised around **four key evaluation questions**:

What are the changes in partner organisations' capacity during the 2012-2014 period?

To what degree are the changes identified in partner capacity attributable to development interventions undertaken by the MFS II consortia (i.e. measuring effectiveness)?

Were the efforts of the MFS II consortia efficient?

What factors explain the findings drawn from the questions above?

The purpose of this report is to provide endline information on one of the SPOs involved in the evaluation: BVHA in India. The baseline report is described in a separate document.

Chapter 2 describes general information about the Southern Partner Organisation (SPO). Here you can find general information about the SPO, the context in which the SPO operates, contracting details and background to the SPO. In chapter 3 a brief overview of the methodological approach is described. You can find a more detailed description of the methodological approach in appendix 1. Chapter 4 describes the results of the 5c endline study. It provides an overview of capacity development interventions of the SPO that have been supported by MFS II. It also describes what changes in organisational capacity have taken place since the baseline and why (evaluation question is 1 and 4). This is described as a summary of the indicators per capability as well as a general causal map that provides an overview of the key organisational capacity changes since the baseline, as experienced by the SPO. The complete overview of descriptions per indicator, and how these have changed since the baseline is described in appendix 3. The complete visual and narrative for the key organisational capacity changes that have taken place since the baseline according to the SPO staff present at the endline workshop is presented in appendix 4.

For those SPOs involved in process tracing a summary description of the causal maps for the identified organisational capacity changes in the two selected capabilities (capability to act and commit; capability to adapt and self-renew) is provided (evaluation questions 2 and 4). These causal maps describe the identified key organisational capacity changes that are possibly related to MFS II

interventions in these two capabilities, and how these changes have come about. More detailed information can be found in appendix 5.

Chapter 5 presents a discussion on the findings and methodology and a conclusion on the different evaluation questions.

The overall methodology for the endline study of capacity of southern partner organisations is coordinated between the 8 countries: Bangladesh (Centre for Development Studies, University of Bath; INTRAC); DRC (Disaster Studies, Wageningen UR); Ethiopia (CDI, Wageningen UR); India (CDI, Wageningen UR); Indonesia (CDI, Wageningen UR); Liberia (CDI, Wageningen UR); Pakistan (IDS; MetaMeta); (Uganda (ETC). Specific methodological variations to the approach carried out per country where CDI is involved are also described in this document.

This report is sent to the Co-Financing Agency (CFA) and the Southern Partner Organisation (SPO) for correcting factual errors and for final validation of the report.

1.2 Brief summary of analysis and findings

Over the last two years BVHA has slightly improved in its capability to act and commit. The main improvements were: the director became more responsive, salaries were raised to the government standard, staff improved skills because of trainings and exposure visits, there are better operational plans and strategies, diversification of funding and improved fundraising capacity. In the capability to adapt and self-renew BVHA also improved slightly. This was mainly due to improved M&E application in the SRHR project, strategic use of M&E, better tracking of BVHA's operating environment and being more responsive to network members. BVHA improved slightly in the capability to deliver on development objectives. Operational plans have become more critical and realistic in budget utilisation, BVHA is working more cost-effectively and feedback mechanisms have been formalised. The organisation improved very slightly in its capability to relate. BVHA now involves their partners in PME and has increased the amount and different levels of networks they are active in. The organisation also works more with the government and pays more visits to target groups. Finally, there has been no change in the capability to achieve coherence.

The evaluators considered it important to also note down the SPO's perspective on what they experienced as the most important changes in the organisation since the baseline. During the endline workshop the key organisational capacity changes that were brought up by BVHA's staff were strengthened programme monitoring and operational planning; improved capacity for Sexual and Reproductive Health Rights (SRHR) advocacy at state level and increased capacity to leverage more funds. According to the SPO, these changes happened to partly overlap with the key organisational capacity changes that were selected for process tracing because the first two changes were linked to MFS II supported capacity development interventions and related to the capability to adapt and self-renew, and the capability to act and commit. Strengthened programme monitoring and operational planning, with specific reference to the SRHR project, can to a large extent be attributed to MFS II supported capacity development interventions, and in particular the five biannual PME meetings (also planned during the baseline) and the feedback by Simavi on progress of the SRHR project. The only non-MFS II factors that have played a minor role are the regular staff meetings and the training on project management funded by the International Union, New Delhi. Under the improved capacity for Sexual and Reproductive Health Rights (SRHR) advocacy at state level, most of the improvement in BVHA's competence to deliver SRHR services can be attributed to MFS II funded capacity development interventions. Under the same organisational capacity change improved knowledge on advocacy and lobbying on SRHR can partly be attributed to MFS II supported capacity development interventions.

A key organisational capacity change that was brought up by BVHA's staff but that was not selected for process tracing was: increased capacity to leverage more funds. This capacity increased because of improved visibility, due to improved SRHR advocacy at state level; improved networking, due to being a member of the SRHR Alliance (MFS II funded); and due to improved project outcomes (mostly of MFS II funded projects).

2 General Information about the SPO – BVHA

2.1 General information about the Southern Partner Organisation (SPO)

Country	India
Consortium	Sexual and Reproductive Health and Rights Alliance (SRHR)
Responsible Dutch NGO	Simavi (Rutgers WPF, Lead CFA for Consortium)
Project (if applicable)	Community awareness building on girl child and conscientiousness building on PC & PNDT Act through NGO Intervention; Community empowerment on Gender Equity to Access Reproductive Health Rights in 2 districts of Bihar
Southern partner organisation	Bihar Voluntary Health Association (BVHA)

The project/partner is part of the sample for the following evaluation component(s):

Achievement of MDGs and themes	
Capacity development of Southern partner organisations	X
Efforts to strengthen civil society	

2.2 The socio-economic, cultural and political context in which the partner operates

Bihar is one of India's poorest states and with a population of about 100 million (Census 2011), it is the third most populous state in India. For about two decades (1985-2005) the state has been especially affected by political turmoil, and bad governance. This has affected both the agricultural and industrial sectors, and governance wise resulted in allegations of widespread corruption and law and order problems. While natural or governance factors such as floods, poor infrastructure and high population density play their part, the state's backwardness also appears to be a function of its inequitable and exploitative socio-economic structure. These conditions have led to a lack of development and an environment in which large-scale poverty eradication programs have had little impact.

The state is overwhelmingly rural with 80 percent of its population living in rural areas and relying on subsistence agriculture for a livelihood. According to the Tendulkar Committee Report 2009¹, nearly 54.4 percent of the population lives below the poverty line, which is much higher than the national average of 37.2 percent. However, if factors beyond income are considered (Multidimensional Poverty Index), about 79.3 percent of the state's population lives below the poverty line. Migration takes place in large number as well as trafficking of children and women is on the rise due to poverty and unemployment.

¹ http://www.in.undp.org/content/india/en/home/operations/about_undp/undp-in-bihar/about-bihar/ Accessed on November 27,2014

Bihar ranks among the lowest in the country on indicators related to primary healthcare infrastructure and reproductive and child health care (District Level Household Survey 2002–04). Health indicators such as the infant mortality rate (44 per 1000 live births as per Sample Registration Survey 2011), maternal mortality ratio (261 per 100,000 live births as per Sample Registration Survey 2007-09) and total fertility rate (3.6 as per Sample Registration Survey 2011), among others, are amongst the highest in the country. Though certain health indicators such as infant mortality and child mortality are beginning to display a progressive arresting trend, the continued lack of adequate medical and paramedical staff and medicines continues to afflict the state's healthcare system. Given this context, it is not surprising that Bihar is a priority state under the central government's National Rural Health Mission (NRHM).²

Women have a relatively poor social status and are discriminated in many aspects of life, such as access to nutrition, health care and education. For instance, female literacy rates (53.3 percent in 2011) are lower than the national average (65.6 percent in 2011). Bihar has one of the highest rates of girl child marriages in the country. According to the National Family Health Survey conducted in 2005-06, the median age at first marriage for women in the 20-49 age group is 15.1 years thus exposing them to complications associated with teenage pregnancies. According to District Level Household Survey-3 (DLHS-3; 2007-2008) less than 40 percent of the women have heard of RTI/STI (reproductive tract infection/sexual transmitted infection) and a still lesser percentage 27 percent have heard of HIV/AIDS. Also only around 7.7 per cent of the currently married non-users have ever received counselling by health personnel to adopt family planning.

Although the government has shown willingness to improve health facilities in rural areas, health facilities are still scarce and poorly equipped. The government encourages NGOs to give support to building the capacity of health workers in the government facilities (e.g. auxiliary nurse maid as well as in the community hence BVHA's work is complementing the efforts of the government to improving health care and in particular sexual reproductive health at individual, community, organisational and institutional level by building mass scale awareness on the sexual reproductive health rights (SRHR) issues. It is also influencing policy makers, demanding for implementation of existing policies, e.g. for better services by collaborating with other stakeholders, including the SRHR alliance³ partners (Rutgers WPF, AMREF Flying Doctors, Dance4Life and Choice).

2.3 Contracting details

When did cooperation with this partner start: 2007

What is the MFS II contracting period:

- Project: Community awareness building on girl child and conscientiousness building on PC & PNDT Act through NGO Intervention, from 1st of November 2008 till 31st March 2012 (covered by MFS II funding from 1st of January 2011 till 31st March 2012).
- Project: Community empowerment on Gender Equity to Access Reproductive Health Rights in 2 districts of Bihar, from 1st of April 2012 till 31st December 2015.

Did cooperation with this partner end? No

If yes, when did it finish? NA

² For additional information on health indicators see http://nrhm.gov.in/nrhm-in-state/state-wise-information/bihar.html#ret_report. Accessed on November 26, 2014.

³ The SRHR alliance was formed to promote the sexual and reproductive health and rights of people of 9 countries in Africa and Asia with the help of local organisations. SIMAVI which is currently funding BVHA is a part of this SRHR alliance.

What is the reason for ending the cooperation with this partner: NA

Is there expected collaboration after the 31st of December 2015? Yes. Simavi started a new 3 year programme with BVHA in 2014. This means they will be collaborating after 2015. It is funded by the National Postal Code Lottery and the English name of this new programme is 'Making Periods Normal'. It is a programme on Menstrual Hygiene Management.

2.4 Background to the Southern Partner Organisation

History

Source: Historical timeline baseline report 2012

Bihar Voluntary Health Association (BVHA) is a secular and voluntary association of charitable Hospital and Health Centres established in the year 1969 by the Medical Mission Sisters. It got registered in February 1970 under the Societies Registration Act XXI of 1860 at Patna, Bihar. The organisation aims to make Health a reality for the people of Bihar especially the weaker section/unprivileged segment of the Society through Voluntary organization/institutions, Charitable Hospitals, Public health Service, groups/professionals/individuals engaged in health sector and with the active involvement and the participation of the community. The organisation not only works as a service provider but also actively involved in capacity building programmes of voluntary organizations and developing model programmes for major health problems e.g. Reproductive Health Issues Malaria, T.B., Diarrhoea, IDD, Kala-azar, Water Born Diseases ,Tobacco related diseases, Life style disorder etc.

During the initial years BVHA was mainly involved with the hospitals and relief activities (by organising health camps and distributing medicines) during the natural calamities. Gradually, it stepped down to the grass-root level NGOs and put effort to make a network of voluntary organizations (till 2013-14 it is involved with 124 network members and more than 270 associate non-member voluntary organizations) directly associated with the mass and responding to their health needs. It started off in 1969 with 10-15 founder members and 2 staff members and had grown to 18 staff (11 core staff and 7 project staff) during baseline. In 2014 it has grown to 34 staff (consist of core staff and project staff) and 11 board members.

In 1974, BVHA got involved in capacity building activities. Two workshops were organised by the Christian Aid on drug inventory management and cold chain management. In 1980 BVHA was asked by the state government to compile immunisation status of the entire state of Bihar.

In 1984 BVHA got involved in immunisation activities as cold chain facilities were not available at the district level in Bihar. Vaccines were collected from BVHA as it had a cold chain management system and taken to far off places. During this time BVHA was also involved in advocacy efforts with the state to install cold chain systems in all district headquarters to that vaccines could be sent to distant places. BVHA compiled the vaccine demand of all the districts.

In 1985 Capacity building activities started by Christian AID from London. Capacity building was in Community Health, School health, inventory management of drugs, documentation of medical records and issue diseases. In 1989-1990 BVHA had a training team of 4 people.

In 1986, a National Health Policy workshop was organised by BVHA and the Government for the assessment of the health scenario and to understand the role of the voluntary associations. After this a Community Health Medicinal Unit was formed whose role was to procure medicines and send it to the inaccessible areas. However since BVHA was a not for profit organisation and procuring drugs involved getting a drug licence and other tax issues the unit was registered as a separate legal entity in 1995-96.

In 1992, BVHA got involved in the Maternal and Child Health Care (MCH) programs which focussed on antenatal care and promotion of institutional delivery. It was also during this time that networking became a full-fledged program and from 1994-1995 BVHA's network not only consisted of diocesan partners but was also joined by the development sector members.

In 1995 BVHA was identified by MEMISA (STICHTING MEMISA MEDICUS MUNDI) for evaluating health programs in Bihar to assess refunding opportunities.

In 1998, Bihar Government made BVHA a nodal agency for AIDS. 31 field operating partners were trained for the purpose. Two MEMISA funded training programs were held in Rajgrih and West Champaran for advertising and raising awareness on AIDS.

In 1999, BVHA was identified as the Mother NGO for 5 districts namely Patna, Vaishali, Nalanda, Munger and Bhojpur for RCH I project and for AYUSH. In the same year BVHA was asked to identify Polio Cases as the Government had declared Bihar Polio free.

In 1999, BVHA got involved in the Malaria Microscopy Program in 6 districts in Jharkhand (undivided Bihar) as there was a Malaria outbreak. The role of BVHA was to observe slides for the malaria parasites and if a slide for a patient was found, positive treatment was provided through the local partners.

During this period BVHA also started procuring IEC materials from the Government, UNICEF, & other sources and started distributing IEC materials to its partners. Since last two years BVHA also collects IEC materials from WHO, UNDP, CHAI, CMAI other state VHAs, VHAI & all other sources and started developing its own IEC materials for various programmes such as Kala-Azar, SRHR, etc.

Between 1999-2000 BVHA was working on HIV/AIDS, RCH I, Polio, distributing IEC materials and Malaria

The period between 1988 and 2000 also witnessed growth in the number of members and before the division of Bihar BVHA had 249 members. In 2012 it had 115 registered members and over 300 non-member organisations. In 2014 it has 117 registered members and more than 300 non-registered members.

Christian AID was the main funder of BVHA for the period between 1985-2003. In 2003 funding from Christian AID stopped as it started focusing on the Dalits and BVHA had to make amendments so that donors looking for specific programs could fund them. Recent amendments are inclusion of water and sanitation, women and trafficking and abortions in the objectives. While the management was worried that BVHA might collapse, the staff showed integrity by working without regular salaries. This period was marked by planning for fund raising strategies.

In 2004-2005 BVHA started implementing small programs on the ground despite the fact that program implementation was not its strength. Donor policies did not allow funds to be transferred to 3rd parties and could give funds only if BVHA implemented the project. In 2006 onwards it started on a small scale in implementing projects along with networking partners.

In 2005-2006 when the new government came in it gave health a priority and did a lot in developing health infrastructure. In 2006 BVHA got its first foreign contribution to implement the PC & PNDDT act⁴ project on reducing female foeticide. Initially SIMAVI supported this project for one year on a pilot basis. On completion of one year it was extended further for three years and again in 2009 it was further extended till 2012. The objective was to reduce female foeticide by creating community awareness on girl child survival and conscientious building on Pre Conception and Post Natal Detection Act. It was supported by SIMAVI to implement in 14 selected districts of Bihar and the project was ended in 2012. Better outcome of this project increased visibility of BVHA at the state and national level and the motivation level of the staff. As a result it could leverage funds from Ministry of Health and Family Welfare, Government of India since 2013 for this project.

In 2007 it started implementing the project "Freedom from Arsenic" with the supported from MISEREOR, Germany. The objective of the project was to improve the quality of the health of the people by making them aware of the use of arsenic free drinking water. This project got over in 2010.

During the Kosi floods in 2008 BVHA not only involved in relief operations but also involved in psychosocial counselling of women and adolescent girls.

⁴ Pre-conception Prenatal Diagnostic Techniques is used for the purpose of detecting genetic or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex linked disorders. The act was enacted and brought into operation from 1st January, 1996 for the prevention of the misuse of such techniques for the purpose of pre-natal sex determination leading to female foeticide.

In 2008 BVHA received funding from Geneva Global, USA to improve Health Service Delivery System and assured quality care service in maternal health care. It was implemented in three districts of Bihar from 2009 to 2011.

In 2011 it started implementing Social mobilization and service delivery programme along with 20 networking partners in 31 districts of Bihar for malaria control and kala-Azar elimination amongst vulnerable communities supported by Voluntary Health Association of India, New Delhi. It was identified that Bihar accounts for 80% kala-Azar cases in the world. 50% of the population in Bihar including the tribal and other marginalised communities are vulnerable to Kala-azar⁵. This project aimed at social mobilisation and service delivery through creating awareness among communities and capacity building of health workers. This project got over in 2013.

In July 2011 it implemented 'Let Girls be Born' project with financial support from Plan India with an aim to empower the community to address sex selection, sex determination and ensure girl child's right to create a gender balanced society.

In 2012 considering improvement in maternal health system and empowering community to access quality health service in Bihar it implemented the Oxfam funded project 'Initiative to improve maternal health with social determinants approach'. It was implemented in three districts of Bihar and the project was over in 2013.

Over the period while implementing several projects on the development of health in Bihar the capacity of the organization improved in community approach, influence decision makers through advocacy and knowledge on Sexual Reproductive Health Rights (SRHR). Thus, the donor (Simavi) suggested the organisation to develop proposals on the SRHR issues. In 2011-12 it developed proposal for MFS II funding on SRHR issues as suggested by Simavi. In April 2012 it received the MFS II funding from Simavi for Community Empowerment on Gender Equity to access Reproductive Rights. This programme focuses on the most socially and economically backward and unprivileged communities of two districts of Bihar and is implemented through its networking partner organisations – Duncan Hospital, Raxaul (East Champaran) and Fakirana Sisters Society, Betiah (West Champaran). The project interventions were right based which created recognition in the community as well as in government departments especially with health and Integrated Child Development Society (ICDS).

In February 2014 the Maternity Death Review (MDR) project funded by UNICEF was initiated in two districts of Bihar. This is a pilot intervention to institutionalise MDR process and provide a road map for establishing a routine system for review of all maternal deaths as per the Maternal Death Review guidelines of Government of India.

While MFS II funding is continuing for the SRHR project BVHA garnered new funds from Simavi for two new projects: child marriage programme and menstrual hygiene management. Some other new donors have extended support such as: UNFPA, the Population Foundation of India, BMZ-KKS, and the Ministry of Health and Family Welfare of the government of India. Along with diversified funding sources, BVHA could attract government agencies by increasing its visibility at various levels through their new partnership with bilateral and multilateral agencies.

Over the last two years BVHA strengthened its internal capacity, networking and visibility for e.g. it formed Advisory Committee consist of a body of intellectuals from different member organizations which provides visionary approach for the improvement of the programs activities of the organisation, SRHR Forum at state level involving government officials and development agencies, became a member of State Technical Advisory group, core group member in the Reduction of Total fertility Rate (TFR) under "Bihar Manav Vikas Mission" (a Bihar Human Resource Development Mission, Government of Bihar programme).

⁵ Kala azar also known as Visceral Leishmaniasis is caused by bites from female phlebotomine sand flies the vector (or transmitter) of the leishmania parasite.

Vision

Source: <http://www.biharvha.org/aboutus.html> 23-10-2014

BVHA assists in making community health a reality for all the people of Bihar with priority for the less privileged millions, with their involvement & participation through the voluntary health sector.

Mission

Source: <http://www.biharvha.org/aboutus.html> 23-10-2014

The mission is to reach to the un-reached through Charitable Hospitals, Dispensaries, Health Centres & Voluntary Organizations/Institutions involved in health promotion and also groups, professionals & individuals engaged & dedicated with some concern in health promotion of the people of Bihar with priority for the less privileged millions with their involvement and participation through the Voluntary Health Sector.

Strategies

1. Support to voluntary organisations (VOs) & Community Based organisations (CBOs):
 - a. Educational Programme on health & other health related programmes – through IEC, Mass Education, Exhibitions & Camps and Capacity Building through its scheduled training & also conducting On-Request trainings.
 - b. Project Consultancy:
BVHA does a lot of consultancy for voluntary organisation for project formulation, monitoring, evaluation, survey, data analysis & report writing & also does consultancy services as per T.O.R. mostly on health & related aspects for 7 international donors such as UNICEF, MEMISA etc. BVHA does play a role for pre funding evaluation, monitoring and evaluation.
 - c. Information & Documentation & Dissemination of IEC Material Support:
Knowledge is power & hence BVHA's one of the main strategy for intervention is dissemination of health information & message. It collects health information from various sources like Government, WHO, UNICEF, UNDP, CHAI, CMAI other state VHAs, VHAIs & all other sources – and disseminates them as well as it documents health information's collected from paper clipping, books, journals, magazines on health & development. This facility is open for all organisations.
 - d. Relief Work:
BVHA does help in Medical relief to NGOs working in flood, famine areas & also provides training on preparedness.
2. Networking
The main objective of Networking is to provide synergic strength to the network of VOs working in the health & related sector to act as a united pressure group for proper implementation of health programme & policies as well as to bring positive change at the local, district, regional & state level. Decentralizing the support activities of BVHA respond more to the regional needs & also focusing on major health issues of state at State Level Network Forum. It has 7 regional forums (4 in Bihar and 3 in Jharkhand) and also initiated one State level forum in which other network agencies are also involved which are working or willing to work with the grass root people for raising their health status.
3. Advocacy
BVHA does Advocacy at various level – for grass-root & field level it advocates for promotion of healthy habits for promotion, prevention & presentation of health through Health Education, IEC and other Mass Education Media. By developing the capacities on NGOs, CBOs Panchayat representatives for policy & programme advocacy for health & related development aspect & also pressurizing & influencing the media, policy makers, legislators through appropriate study & information sharing on health & related issues for pro-people policy development. This is a major activity of BVHA.

BVHA mainly works through its member and non-member organisations in Bihar to create a healthy community. It conducts programmes to build up the capacity of voluntary agencies in Programme Planning, Implementation and Management. It facilitates community health action by promoting social justice in the provision and distribution of health care encouraging voluntary health action of people

and enabling them through various support services so that it addresses their health needs by accessing the Primary Health Services and basic health services rights through community and voluntary organisation's participation. However, the advocacy and liaising with the Government is the major activity of BVHA as the ultimate responsibility of Health is of the State Government.

3 Methodological approach and reflection

3.1 Overall methodological approach and reflection

This chapter describes the methodological design and challenges for the assessment of capacity development of Southern Partner Organisations (SPOs), also called the '5C study'. This 5C study is organised around **four key evaluation questions**:

1. What are the changes in partner organisations' capacity during the 2012-2014 period?
2. To what degree are the changes identified in partner capacity attributable to development interventions undertaken by the MFS II consortia (i.e. measuring effectiveness)?
3. Were the efforts of the MFS II consortia efficient?
4. What factors explain the findings drawn from the questions above?

It has been agreed that the question (3) around efficiency cannot be addressed for this 5C study. The methodological approach for the other three questions is described below. At the end, a methodological reflection is provided.

Note: this methodological approach is applied to 4 countries that the Centre for Development Innovation, Wageningen University and Research centre is involved in in terms of the 5C study (Ethiopia, India, Indonesia, Liberia). The overall approach has been agreed with all the 8 countries selected for this MFS II evaluation. The 5C country teams have been trained and coached on this methodological approach during the evaluation process. Details specific to the SPO are described in chapter 5.1 of the SPO report A detailed overview of the approach is described in appendix 1.

The first (changes in organisational capacity) and the fourth evaluation question are addressed together through:

- **Changes in the 5C indicators since the baseline:** standard indicators have been agreed upon for each of the five capabilities of the five capabilities framework (see appendix 2) and changes between the baseline, and the endline situation have been described. For data collection a mix of data collection methods has been used, including self-assessments by SPO staff; interviews with SPO staff and externals; document review; observation. For data analysis, the Nvivo software program for qualitative data analysis has been used. Final descriptions per indicator and per capability with corresponding scores have been provided.
- **Key organisational capacity changes – 'general causal map':** during the endline workshop a brainstorm has been facilitated to generate the key organisational capacity changes as perceived by the SPO since the baseline, with related underlying causes. For this purpose, a visual as well as a narrative causal map have been described.

In terms of the attribution question (2 and 4), '**process tracing**' is used. This is a theory-based approach that has been applied to a selected number of SPOs since it is a very intensive and costly methodology, although it provides rich information and can generate a lot of learning within the organisations. This approach was presented and agreed-upon during the synthesis workshop on 17-18 June 2013 by the 5C teams for the eight countries of the MFS II evaluation. A more detailed description of the approach was presented during the synthesis workshop in February 2014. The synthesis team, NWO-WOTRO, the country project leaders and the MFS II organisations present at the workshop have accepted this approach. It was agreed that this approach can only be used for a selected number of SPOs since it is a very intensive and costly methodology. Key organisational capacity changes/ outcomes of the SPO were identified, based on their relationship to the two selected capabilities, the capability to act and commit the capability to adapt and self-renew, and an expected relationship with CFA supported capacity development interventions (MFS II funding). It was agreed to focus on these two capabilities, since these are the most targeted capabilities by the CFAs, as established during the baseline process.

Please find below an explanation of how the above-mentioned evaluation questions have been addressed in the 5C evaluation.

At the end of this appendix a brief methodological reflection is provided.

3.2 Assessing changes in organisational capacity and reasons for change - evaluation question 1 and 4

This section describes the data collection and analysis methodology for answering the first evaluation question: **What are the changes in partner organisations' capacity during the 2012-2014 period?** And the fourth evaluation question: **"What factors explain the findings drawn from the questions above?"**

In order to explain the changes in organisational capacity development between baseline and endline (evaluation question 1) the CDI and in-country evaluation teams needed to review the indicators and how they have changed between baseline and endline and what reasons have been provided for this. This is explained below. It has been difficult to find detailed explanations for changes in each of the separate 5c indicators, but the 'general causal map' has provided some ideas about some of the key underlying factors actors and interventions that influence the key organisational capacity changes, as perceived by the SPO staff.

The evaluators considered it important to also note down a consolidated SPO story and this would also provide more information about what the SPO considered to be important in terms of organisational capacity changes since the baseline and how they perceived these key changes to have come about. Whilst this information has not been validated with sources other than SPO staff, it was considered important to understand how the SPOs has perceived changes in the organisation since the baseline.

For those SPOs that are selected for process tracing (evaluation question 2), more in-depth information is provided for the identified key organisational capacity changes and how MFS II supported capacity development interventions as well as other actors, factors and interventions have influenced these changes. This is integrated in the next session on the evaluation question on attribution, as described below and in the appendix 1.

How information was collected and analysed for addressing evaluation question 1 and 4, in terms of description of changes in indicators per capability as well as in terms of the general causal map, based on key organisational capacity changes as perceived by the SPO staff, is further described below.

During the baseline in 2012 information has been collected on each of the 33 agreed upon indicators for organisational capacity. For each of the five capabilities of the 5C framework indicators have been developed as can be seen in Appendix 2. During this 5C baseline, a summary description has been provided for each of these indicators, based on document review and the information provided by staff, the Co-financing Agency (CFA) and other external stakeholders. Also a summary description has been provided for each capability. The results of these can be read in the baseline reports.

The description of indicators for the baseline in 2012 served as the basis for comparison during the endline in 2014. In practice this meant that largely the same categories of respondents (preferably the same respondents as during the baseline) were requested to review the descriptions per indicator and indicate whether and how the endline situation (2014) is different from the described situation in 2012⁶.

Per indicator they could indicate whether there was an improvement or deterioration or no change and also describe these changes. Furthermore, per indicator the interviewee could indicate what interventions, actors and other factors explain this change compared to the baseline situation. See

⁶ The same categories were used as during the baseline (except beneficiaries, other funders): staff categories including management, programme staff, project staff, monitoring and evaluation staff, field staff, administration staff; stakeholder categories including co-financing agency (CFA), consultants, partners.

below the specific questions that are asked for each of the indicators. Per category of interviewees there is a different list of indicators to be looked at. For example, staff members were presented with a list of all the indicators, whilst external people, for example partners, are presented with a select number of indicators, relevant to the stakeholder.

The information on the indicators was collected in different ways:

1. **Endline workshop at the SPO - self-assessment and 'general causal map'**: similar to data collection during the baseline, different categories of staff (as much as possible the same people as during the baseline) were brought together in a workshop and requested to respond, in their staff category, to the list of questions for each of the indicators (self-assessment sheet). Prior to carrying out the self-assessments, a brainstorming sessions was facilitated to develop a 'general causal map', based on the key organisational capacity changes since the baseline as perceived by SPO staff. Whilst this general causal map is not validated with additional information, it provides a sequential narrative, based on organisational capacity changes as perceived by SPO staff;
2. **Interviews with staff members**: additional to the endline workshop, interviews were held with SPO staff, either to provide more in-depth information on the information provided on the self-assessment formats during the workshop, or as a separate interview for staff members that were not present during the endline workshop;
3. **Interviews with externals**: different formats were developed for different types of external respondents, especially the co-financing agency (CFA), but also partner agencies, and organisational development consultants where possible. These externals were interviewed, either face-to-face or by phone/Skype. The interview sheets were sent to the respondents and if they wanted, these could be filled in digitally and followed up on during the interview;
4. **Document review**: similar to the baseline in 2012, relevant documents were reviewed so as to get information on each indicator. Documents to be reviewed included progress reports, evaluation reports, training reports, etc. (see below) since the baseline in 2012, so as to identify changes in each of the indicators;
5. **Observation**: similar to what was done in 2012, also in 2014 the evaluation team had a list with observable indicators which were to be used for observation during the visit to the SPO.

Below the key steps to assess changes in indicators are described.

Key steps to assess changes in indicators are described

1. Provide the description of indicators in the relevant formats – CDI team
2. Review the descriptions per indicator – in-country team & CDI team
3. Send the formats adapted to the SPO to CFA and SPO – in-country team (formats for SPO) and CDI team (formats for CFA)
4. Collect, upload & code the documents from CFA and SPO in NVivo – CDI team
5. Organise the field visit to the SPO – in-country team
6. Interview the CFA – CDI team
7. Run the endline workshop with the SPO – in-country team
8. Interview SPO staff – in-country team
9. Fill-in observation sheets – in-country team
10. Interview externals – in-country team
11. Upload and auto-code all the formats collected by in-country team and CDI team in NVivo – CDI team
12. Provide to the overview of information per 5c indicator to in-country team – CDI team
13. Analyse data and develop a draft description of the findings per indicator and for the general questions – in-country team
14. Analyse data and develop a final description of the findings per indicator and per capability and for the general questions – CDI team
15. Analyse the information in the general causal map –in-country team and CDI-team

Note: the CDI team include the Dutch 5c country coordinator as well as the overall 5c coordinator for the four countries (Ethiopia, India, Indonesia, Liberia). The 5c country report is based on the separate SPO reports.

Please see appendix 1 for a description of the detailed process and steps.

3.3 Attributing changes in organisational capacity - evaluation question 2 and 4

This section describes the data collection and analysis methodology for answering the second evaluation question: ***To what degree are the changes identified in partner capacity attributable to (capacity) development interventions undertaken by the MFS II consortia (i.e. measuring effectiveness)?*** and the fourth evaluation question: ***“What factors explain the findings drawn from the questions above?”***

In terms of the attribution question (2), ‘process tracing’ is used. This is a theory-based approach that has been applied to a selected number of SPOs since it is a very intensive and costly methodology, although it provides rich information and can generate a lot of learning within the organisations. Key organisational capacity changes/ outcomes of the SPO were identified, based on their relationship to the two selected capabilities, the capability to act and commit the capability to adapt and self-renew, and an expected relationship with CFA supported capacity development interventions (MFS II funding). It was agreed to focus on these two capabilities, since these are the most targeted capabilities by the CFAs, as established during the baseline process.

Below, the selection of SPOs for process tracing as well as the different steps involved for process tracing in the selected SPOs, are further explained.

3.3.1 Selection of SPOs for 5C process tracing

Process tracing is a very intensive methodology that is very time and resource consuming (for development and analysis of one final detailed causal map, it takes about 1-2 weeks in total, for different members of the evaluation team). It has been agreed upon during the synthesis workshop on 17-18 June 2013 that only a selected number of SPOs will take part in this process tracing for the purpose of understanding the attribution question. The selection of SPOs is based on the following criteria:

- MFS II support to the SPO has not ended before 2014 (since this would leave us with too small a time difference between intervention and outcome);
- Focus is on the 1-2 capabilities that are targeted most by CFAs in a particular country;
- Both the SPO and the CFA are targeting the same capability, and preferably aim for similar outcomes;
- Maximum one SPO per CFA per country will be included in the process tracing.

The intention was to focus on about 30-50% of the SPOs involved. Please see the tables below for a selection of SPOs per country. Per country, a first table shows the extent to which a CFA targets the five capabilities, which is used to select the capabilities to focus on. A second table presents which SPO is selected, and takes into consideration the selection criteria as mentioned above.

For the detailed results of this selection, in the four countries that CDI is involved in, please see appendix 1. The following SPOs were selected for process tracing:

- Ethiopia: AMREF, ECFA, FSCE, HUNDEE (4/9)
- India: BVHA, COUNT, FFID, SMILE, VTRC (5/10)
- Indonesia: ASB, ECPAT, PtPPMA, YPI, YRBI (5/12)
- Liberia: BSC, RHRAP (2/5).

3.3.2 Key steps in process tracing for the 5C study

In the box below you will find the key steps developed for the 5C process tracing methodology. These steps will be further explained here. Only key staff of the SPO is involved in this process: management; programme/ project staff; and monitoring and evaluation staff, and other staff that could provide information relevant to the identified outcome area/key organisational capacity change. Those SPOs selected for process tracing had a separate endline workshop, in addition to the ‘general endline workshop. This workshop was carried out after the initial endline workshop and the interviews during the field visit to the SPO. Where possible, the general and process tracing endline workshop

have been held consecutively, but where possible these workshops were held at different points in time, due to the complex design of the process. Below the detailed steps for the purpose of process tracing are further explained. More information can be found in Appendix 1.

Key steps in process tracing for the 5C study

1. Identify the planned MFS II supported capacity development interventions within the selected capabilities (capability to act and commit and capability to adapt and self-renew) – CDI team
2. Identify the implemented MFS II supported capacity development interventions within the selected capabilities (capability to act and commit and capability to adapt and self-renew) – CDI team
3. Identify initial changes/ outcome areas in these two capabilities – CDI team & in-country team
4. Construct the detailed, initial causal map (theoretical model of change) – CDI team & in-country team
5. Identify types of evidence needed to verify or discard different causal relationships in the model of change – in-country teams, with support from CDI team
6. Collect data to verify or discard causal mechanisms and construct workshop based, detailed causal map (model of change) – in-country team
7. Assess the quality of data and analyse data and develop final detailed causal map (model of change) – in-country team with CDI team
8. Analyse and conclude on findings– CDI team, in collaboration with in-country team

3.3.3 Methodological reflection

Below a few methodological reflections are made by the 5C evaluation team. These can also be found in appendix 1.

Use of the 5 core capabilities framework and qualitative approach: this has proven to be a very useful framework to assess organisational capacity. The five core capabilities provide a comprehensive picture of the capacity of an organisation. The capabilities are interlinked, which was also reflected in the description of standard indicators, that have been developed for the purpose of this 5C evaluation and agreed upon for the eight countries. Using this framework with a mainly qualitative approach has provided rich information for the SPOs and CFAs, and many have indicated this was a useful learning exercise.

Using standard indicators and scores: using standard indicators is useful for comparison purposes. However, the information provided per indicator is very specific to the SPO and therefore makes comparison difficult. Whilst the description of indicators has been useful for the SPO and CFA, it is questionable to what extent indicators can be compared across SPOs since they need to be seen in context, for them to make meaning. In relation to this, one can say that scores that are provided for the indicators, are only relative and cannot show the richness of information as provided in the indicator description. Furthermore, it must be noted that organisations are continuously changing and scores are just a snapshot in time. There cannot be perfect score for this. In hindsight, having rubrics would have been more useful than scores.

General causal map: whilst this general causal map, which is based on key organisational capacity changes and related causes, as perceived by the SPO staff present at the endline workshop, has not been validated with other sources of information except SPO feedback, the 5C evaluation team considers this information important, since it provides the SPO story about how and which changes in the organisation since the baseline, are perceived as being important, and how these changes have come about. This will provide information additional to the information that has been validated when analysing and describing the indicators as well as the information provided through process tracing (selected SPOs). This has proven to be a learning experience for many SPOs.

Using process tracing for dealing with the attribution question: this theory-based and mainly qualitative approach has been chosen to deal with the attribution question, on how the organisational capacity changes in the organisations have come about and what the relationship is with MFS II supported capacity development interventions and other factors. This has proven to be a very useful process, that provided a lot of very rich information. Many SPOs and CFAs have already indicated that they appreciated the richness of information which provided a story about how identified

organisational capacity changes have come about. Whilst this process was intensive for SPOs during the process tracing workshops, many appreciated this to be a learning process that provided useful information on how the organisation can further develop itself. For the evaluation team, this has also been an intensive and time-consuming process, but since it provided rich information in a learning process, the effort was worth it, if SPOs and CFAs find this process and findings useful.

A few remarks need to be made:

- Outcome explaining process tracing is used for this purpose, but has been adapted to the situation since the issues being looked at were very complex in nature.
- Difficulty of verifying each and every single change and causal relationship:
 - Intensity of the process and problems with recall: often the process tracing workshop was done straight after the general endline workshop that has been done for all the SPOs. In some cases, the process tracing endline workshop has been done at a different point in time, which was better for staff involved in this process, since process tracing asks people to think back about changes and how these changes have come about. The word difficulties with recalling some of these changes and how they have come about. See also the next paragraph.
 - Difficulty of assessing changes in knowledge and behaviour: training questionnaire is have been developed, based on Kirkpatrick's model and were specifically tailored to identify not only the interest but also the change in knowledge and skills, behaviour as well as organisational changes as a result of a particular training. The retention ability of individuals, irrespective of their position in the organisation, is often unstable. The 5C evaluation team experienced that it was difficult for people to recall specific trainings, and what they learned from those trainings. Often a change in knowledge, skills and behaviour is a result brought about by a combination of different factors, rather than being traceable to one particular event. The detailed causal maps that have been established, also clearly pointed this. There are many factors at play that make people change their behaviour, and this is not just dependent on training but also internal/personal (motivational) factors as well as factors within the organisation, that stimulate or hinder a person to change behaviour. Understanding how behaviour change works is important when trying to really understand the extent to which behaviour has changed as a result of different factors, actors and interventions. Organisations change because people change and therefore understanding when and how these individuals change behaviour is crucial. Also attrition and change in key organisational positions can contribute considerably to the outcome.

Utilisation of the evaluation

The 5C evaluation team considers it important to also discuss issues around utility of this evaluation. We want to mention just a few.

Design – mainly externally driven and with a focus on accountability and standard indicators and approaches within a limited time frame, and limited budget: this MFS II evaluation is originally based on a design that has been decided by IOB (the independent evaluation office of the Dutch Ministry of Foreign Affairs) and to some extent MFS II organisations. The evaluators have had no influence on the overall design and sampling for the 5C study. In terms of learning, one may question whether the most useful cases have been selected in this sampling process. The focus was very much on a rigorous evaluation carried out by an independent evaluation team. Indicators had to be streamlined across countries. The 5C team was requested to collaborate with the other 5C country teams (Bangladesh, Congo, Pakistan, Uganda) to streamline the methodological approach across the eight sampled countries. Whilst this may have its purpose in terms of synthesising results, the 5C evaluation team has also experienced the difficulty of tailoring the approach to the specific SPOs. The overall evaluation has been mainly accountability driven and was less focused on enhancing learning for improvement. Furthermore, the timeframe has been very small to compare baseline information (2012) with endline information (2014). Changes in organisational capacity may take a long, particularly if they are related to behaviour change. Furthermore, there has been limited budget to carry out the 5C evaluation. For all the four countries (Ethiopia, India, Indonesia, Liberia) that the Centre for Development Innovation, Wageningen University and Research centre has been involved in, the budget has been overspent.

However, the 5C evaluation team has designed an endline process whereby engagement of staff, e.g. in a workshop process was considered important, not only due to the need to collect data, but also to generate learning in the organisation. Furthermore, having general causal maps and detailed causal maps generated by process tracing have provided rich information that many SPOs and CFAs have already appreciated as useful in terms of the findings as well as a learning process.

Another issue that must be mentioned is that additional requests have been added to the country teams during the process of implementation: developing a country based synthesis; questions on design, implementation, and reaching objectives of MFS II funded capacity development interventions, whilst these questions were not in line with the core evaluation questions for the 5C evaluation.

Complexity and inadequate coordination and communication: many actors, both in the Netherlands, as well as in the eight selected countries, have been involved in this evaluation and their roles and responsibilities, were often unclear. For example, 19 MFS II consortia, the internal reference group, the Ministry of Foreign Affairs, Partos, the Joint Evaluation Trust, NWO-Wotro, the evaluators (Netherlands and in-country), 2 external advisory committees, and the steering committee. Not to mention the SPO's and their related partners and consultants. CDI was involved in 4 countries with a total number of 38 SPOs and related CFAs. This complexity influenced communication and coordination, as well as the extent to which learning could take place. Furthermore, there was a distance between the evaluators and the CFAs, since the approach had to be synchronised across countries, and had to adhere to strict guidelines, which were mainly externally formulated and could not be negotiated or discussed for the purpose of tailoring and learning. Feedback on the final results and report had to be provided mainly in written form. In order to enhance utilisation, a final workshop at the SPO to discuss the findings and think through the use with more people than probably the one who reads the report, would have more impact on organisational learning and development. Furthermore, feedback with the CFAs has also not been institutionalised in the evaluation process in the form of learning events. And as mentioned above, the complexity of the evaluation with many actors involved did not enhance learning and thus utilization.

5C Endline process, and in particular thoroughness of process tracing often appreciated as learning process: The SPO perspective has also brought to light a new experience and technique of self-assessment and self-corrective measures for managers. Most SPOs whether part of process tracing or not, deeply appreciated the thoroughness of the methodology and its ability to capture details with robust connectivity. This is a matter of satisfaction and learning for both evaluators and SPOs. Having a process whereby SPO staff were very much engaged in the process of self-assessment and reflection has proven for many to be a learning experience for many, and therefore have enhanced utility of the 5C evaluation.

4 Results

4.1 MFS II supported capacity development interventions

Below an overview of the different MFS II supported capacity development interventions of BVHA that have taken place since 2011 are described. The information is based on the information provided by Simavi.

Table 1

Information about MFS II supported capacity development interventions since baseline

Title of the MFS II supported capacity development intervention	Objectives	Activities	Timing and duration	Budget
Strengthening advocacy capacity including evidence based lobby efforts	To develop the capacity of Partner Organisations on Policy influencing and Policy implementation with focus on SRHR, services/entitlements	Joint planning and training, having a national programme coordinator who advised on advocacy efforts, learning from other partners how they do it:		In the period 2011 till May 2014: Estimated 4500 Euro for BVHA (more than 5 occasions)
		Identifying the advocacy issue, what is advocacy by Simavi and VHAI	21-24 November 2011	
		Advocacy, continuation, what is advocacy by VHAI	18-20 April 2012	
		Advocacy, progress, joint agenda by Simavi	11-12 October 2012	
		Workshop joint advocacy (CINI) and state level visits	April, 7- 9 May and December 2013	
		3 day advocacy workshop: working on state level and national joint agendas by Simavi and Rineke van Dam	19-22 May 2014	
Planning, monitoring and evaluation sessions in workshops, multiple feedback on report, and documents. Training on HMIS; sharing examples from partners	To develop capacity of Partner Organisations on PME	Training and feedback, discussion on formats, explanations on evaluation methodologies, discussions on purpose of monitoring systems		Around 6100 Euro for BVHA (several occasions training was provided). This excludes travel/accommodation of the facilitators.
		Training given on baseline tools and methodology by Simavi	3 days in March 2011	
		Discussing results of baseline, planning, reporting and OCA's by Simavi and external	21-24 November 2011	

		consultant		
		Planning, discussion on second baseline by Simavi	17-18 May 2012	
		PME - how to measure results; planning 2013 by Simavi	11-12 October 2012	
		PME: how to measure results, discussion on output in annual report by Simavi	4-6 March 2013	
		Preliminary discussion on results, annual planning 2014 by Simavi	8-10 October 2013	
		Analysing results, are we on track, discussion on Midterm evaluation by Simavi	11 March 2014	
Training on SRHR and Comprehensive Sexual Education (CSE) through training sessions, exposure visits, feedback on implementation	To develop capacity of partner organisations on CSE.	All activities related to this contribute to stronger capacity, having more ideas and also feeling comfortably to talk about sensitive issues.		Around 3000 Euro in total, used during several occasions, - Estimation is only for BVHA
		Training SRHR with different speakers and topics	18 -20 April 2012	
		CSE training for all SRHR alliance partners (basic) by Restless Development	24 June 2012	
		Discussion on content of joint SRHR manual (all partners and external facilitator, government staff)	4-6 March 2013	
		Refresher CSE training for all partners (Restless Development and external consultants)	4-6 April 2013	
Workshop "Accountability and Compliance in Voluntary Sector" At Hotel Dee Emprasa, Esplande, Kolkata Organized by : Credibility Alliance	To develop capacity of Partner Organisations on governance and financial management. Compliance to national regulatory system and to improve transparency in financial management and practices.	<ul style="list-style-type: none"> •Accountable Governance & processes •Effective Financial Management •Importance and integration of transparency in organisational systems and practices •Recent developments in legal framework & Compliance (New FCRA 2010 and the impending Direct Taxes Code and its implications) 	17-18 January 2013	275 Euro
Review Meet at NEEDS covering topics of advocacy, PME and SRHR	Half Yearly review, PME and joint action planning.	Field exposure and Learning- one day. Presentation by PME buddy -SIMAVI and Joint capacity building planning.	10 October 2012	200 Euro

Exchange visit to SRHR YFS clinic of VHAI	To develop capacity of partners in Jharkhand and Bihar to promote ARSH services through government system	Visits to government run ARSH clinics in Ganjam district Odisha.	19 December 2012	300 Euros
Regional meeting Indonesia, focus on SRHR-CSE delivery (Indonesia team, alliance office)	Inter Country Learning Agenda -To learn what different activities (incl. CSE materials) and what approaches are implemented in the several countries' CSE programs. To identify successful strategies and success factors in the implementation of learning materials on SRHR.	CSE Workshop facilitated by Rutgers WPF in Indonesia. Exposure to SRHR Alliance programme in Indonesia. Sharing of experience by Bangladesh, India, Indonesia and Pakistan.	21-24 October 2013	2000 Euros (RWPF funds)

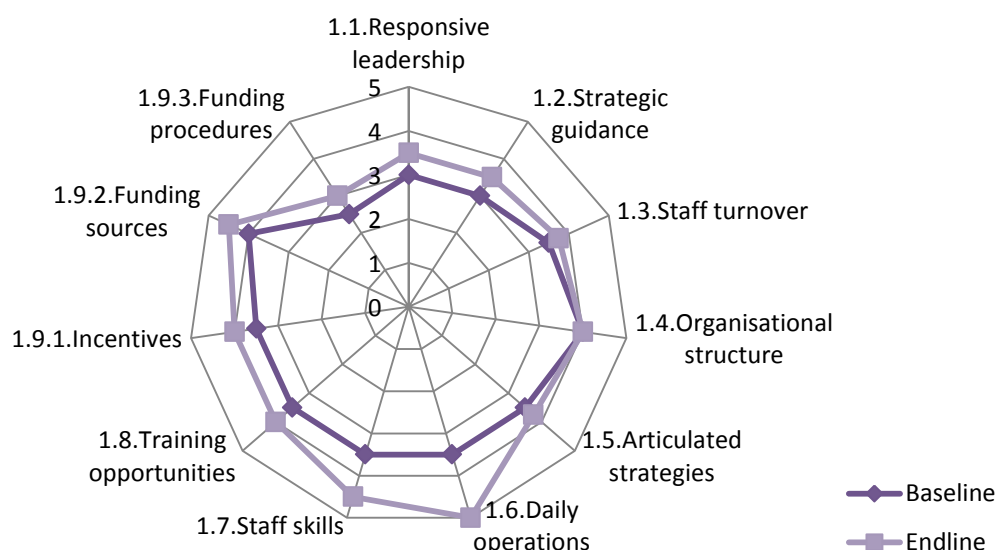
Source: 5C endline_support to capacity development sheet_CFA perspective_India_BVHA

4.2 Changes in capacity and reasons for change - evaluation question 1 and 4

Below you can find a description of the changes in each of the five core capabilities. This information is based on the analysis of the information per each of the indicators. This detailed information for each of the indicators describes the current situation, and how and why it has changed since the baseline. See also annex 3.

4.2.1 Changes in the five core capabilities

Capability to act and commit



The Executive Director is more responsive in his interaction with BVHA's partner organisations. This was initially triggered by a requirement of Simavi. The ED has been given more flexibility by the board to take up new projects and approach new donor agencies by getting more involvement in promotion and fundraising for the organisation. While the governing board still holds most authority for making decisions on funding of the projects and utilisation of funds, the executive director experiences less

opposition from the network members in terms of his strategic guidance to the organisation as he gains more support from the board.

There is still some staff turnover at the project level, where staff has left because of low salaries or better opportunities. The governing board is now looking more within the organisation to fill vacant senior positions and recognise the performance of existing staff by promoting them. This together with the revision of the salary structure after the baseline assessment and discussions with Simavi has improved the incentives of staff to work at BVHA. Other incentives still include freedom at work, skill development through training and the homely environment created by collaboration between staff. BVHA staff members are aware of the organisational structure in BVHA, and a written copy is available.

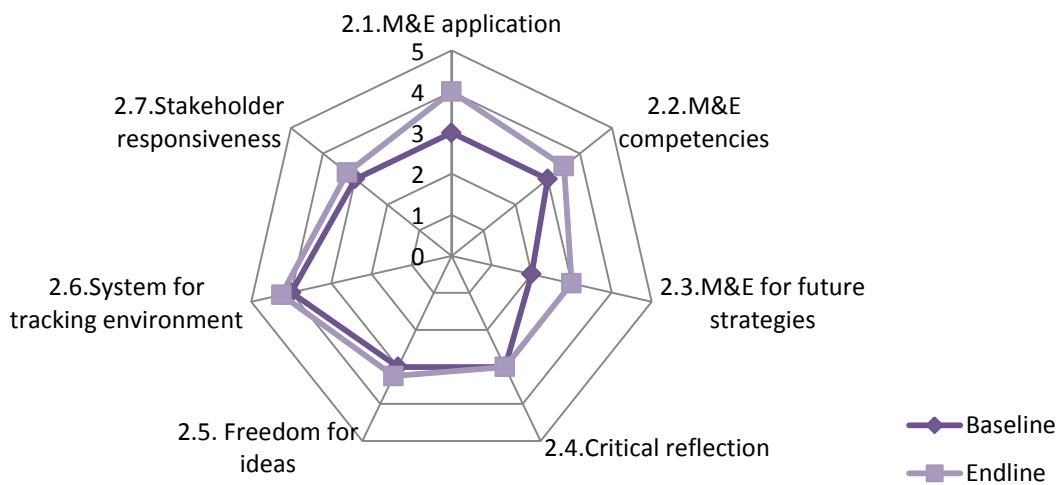
BVHA's strategies are now more based on project outcomes from its M&E system, rather than just on outputs. They continue to involve their target groups and link with like-minded NGOs and the government when formulating strategies. The organisation continues to work with annual, quarterly and monthly work plans and BVHA's work continues to rely on their partners' timeliness. However, partners have improved their timeliness because of the introduction of proper progress monitoring methods in the SRHR project by Simavi, that have had its effect on other project teams as well. Some of the core skills that needed to be upgraded during the baseline, have now been developed. This includes: PME and fundraising but also more specific skills and knowledge on SRHR. The presence of the national coordinator of the SRHR alliance at BVHA has contributed to this. Also all BVHA staff had equal access to more training programmes, as per their programme's need on the topics: SRHR, MIS, success story writing, government schemes, comprehensive sexual education, advocacy, output and outcome indicators, the PC and PNDT Act, financial compliance and communication.

BVHA has increased its visibility because of its involvement in the SRHR project and alliance. This attracted donors like UNFPA, UNICEF, the Population Foundation of India, BMZ-KKS and the government of India and Simavi approving two new projects. They also have other strategies to raise funds which include renting out their training facilities and providing training for paying participants. There are still no written funding procedures, but staff has become more motivated after the revision of the salary structure and better capable to write and send more and better proposals to new donor agencies.

Score baseline: 3.5

Score endline: 4.0 (slight improvement)

Capability to adapt and self-renew



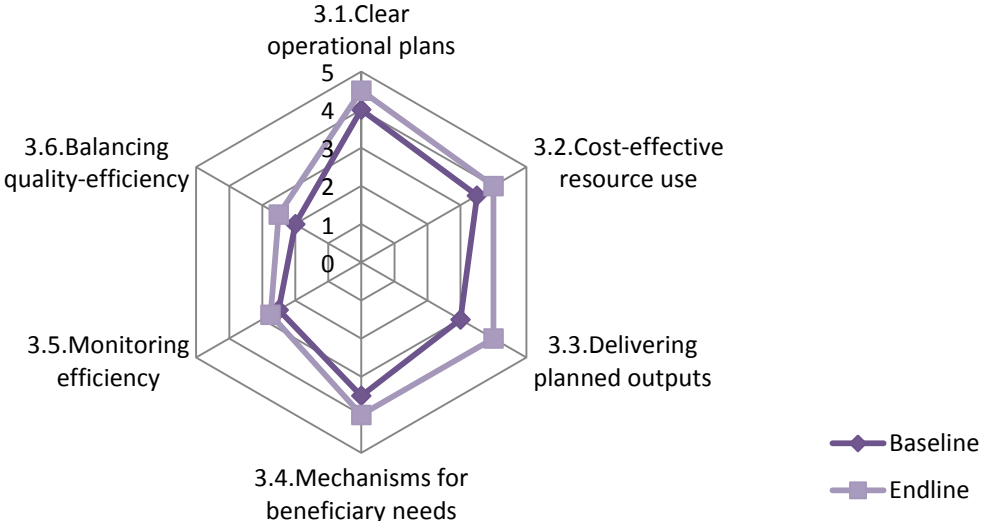
Already during the baseline evaluation, BVHA had a monitoring and evaluation system in place. The M&E is now focussing more on outcomes than during the baseline. This is evident from BVHA's

improved understanding of how to measure outcomes through discussing this within the SRHR alliance and guidance of Simavi. There is an overview of how M&E is organised in the SRHR project which provides very clear instructions on each output and outcome indicator and how to measure it. Use of MIS has also improved since the baseline: MIS formats are in place for advocacy officers and partner organisation for monthly reporting on progress in the SRHR project. While there is still no dedicated M&E person at BVHA, staff skills in M&E have improved with support from the national programme coordinator, PME workshops, individual supervision by Simavi and through inviting M&E experts for in-house training (sometimes funded by other donors). Project officers do most the monitoring of the projects, the Executive Director is now also more pro-actively involved in monitoring. There is more room for making strategic changes based on M&E, because of the focus now also on outcomes, not just outputs. Furthermore, Simavi stimulates this and BVHA has improved its M&E capacity so that they are now better at analysing (also strategic level) data and identifying strategic moves and more effective interventions based on this. Staff can raise issues with their project heads, who are now more empowered to take decisions, during regular monthly meetings or during quarterly governing board meetings. In the monthly meetings staff give a progress update and reflect upon their performance. The Executive Director continues to have limited power which causes delays in communicating decisions to staff and acting upon them. Staff is still free to come up with ideas that are welcomed by the ED. Through encouragement and learning from other organisations BVHA has been coming up with some new ideas like integrating different programmes. Through its involvement in the SRHR alliance, BVHA has improved its networking capability and is now better informed on what is happening in other states, and at national level and can respond proactively. BVHA also gets information through its network members and other NGOs on important new NGO laws and external changes that are then discussed with staff and in board meetings. BVHA continues to be open and responsive to their stakeholders, but this has still not been institutionalised. Inputs of network partners are used to identify projects and BVHA now holds at least two Governing Board Meetings per year so that the board can meet the management and staff of the hosting network organisation and identify their need and expectations from BVHA face to face.

Score baseline: 3.0

Score endline: 3.5 (slight improvement)

Capability to deliver on development objectives



Every project of BVHA still has an operational work plan and budget. BVHA is now more critical and realistic about efficient budget utilisation, asks timely for reallocation due to contextual changes and has improved its operational plans. This led to BVHA’s budgets being more realistic now and them being able to implement the plan within the budget. The organisation is still doing its level best to use its resources effectively by keeping an inventory, reducing on mailing and paper costs by using the internet and by using its own facilities for trainings and meetings. As operational plans of BVHA improved, so did the formats to monitor their partners’ progress. These are now easier to understand

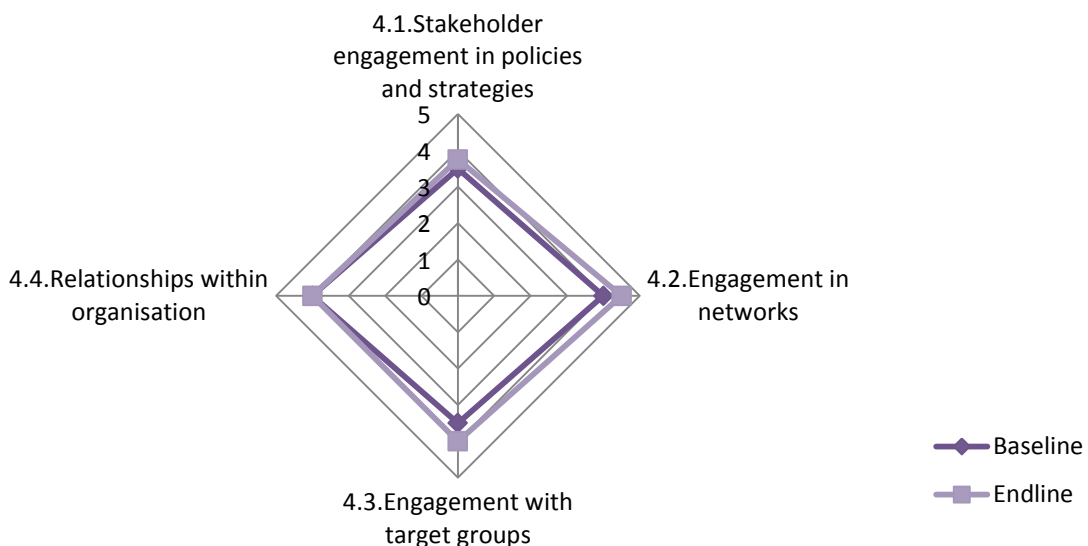
so that the information that reaches BVHA is more accurate and timely. BVHA is now reaching its output and outcome results and has monthly action plans in place through which staff report their progress and follow up on unaccomplished tasks.

In contradiction with the baseline scenario, BVHA now has a structured mechanism in place to verify that services meet beneficiary needs, as Simavi made client opinion and satisfaction surveys part of the monitoring framework for the MFS II funded project. BVHA also assesses the needs of its network partners through formats and regional meetings. There are still no formal input-output ratios calculated in BVHA. Although there are still no formal quality control mechanisms, the monitoring mechanisms of BVHA were strengthened. BVHA is now keener to discuss budget reallocations to increase the effectiveness or quality of their work. Efficiency is also discussed with Simavi through e.g. scaling up in areas where work is going well. Quality control has also been a topic of discussion during SRHR alliance meeting and review meetings with other donors. BVHA is continuously trying to upgrade its quality control.

Score baseline: 3.0

Score endline: 3.5 (slight improvement)

Capability to relate



The Board of BVHA, that is composed of network members, still has an important role in developing policies and strategies together with staff. BVHA still engage partner organisations in planning of projects, but now also involves them in developing M&E formats. A BVHA Programme Advisory Committee has been established that meets every six months to discuss strategies and give directions for effective implementation. An example of a project that was designed participatory is the SRHR initiative that was developed together with BVHA’s network partners. The organisational structure of BVHA is based on its engagement with partner organisations. BVHA continued to work in 38 districts of Bihar with 115 members and 300 associated non-members. Over the last two years the main change has been BVHA’s increased work on advocacy with different levels of government officials for better SRHR services specifically at the state, district and block level which has led to proper access of the required services for the community. With a view to be in a better position to carry out sustained lobbying and advocacy with policy targets, further capacity strengthening initiatives have been undertaken by BVHA: increased collaboration between SRHR partners; training of partner representatives of SRHR Alliance on CSE and SRHR.

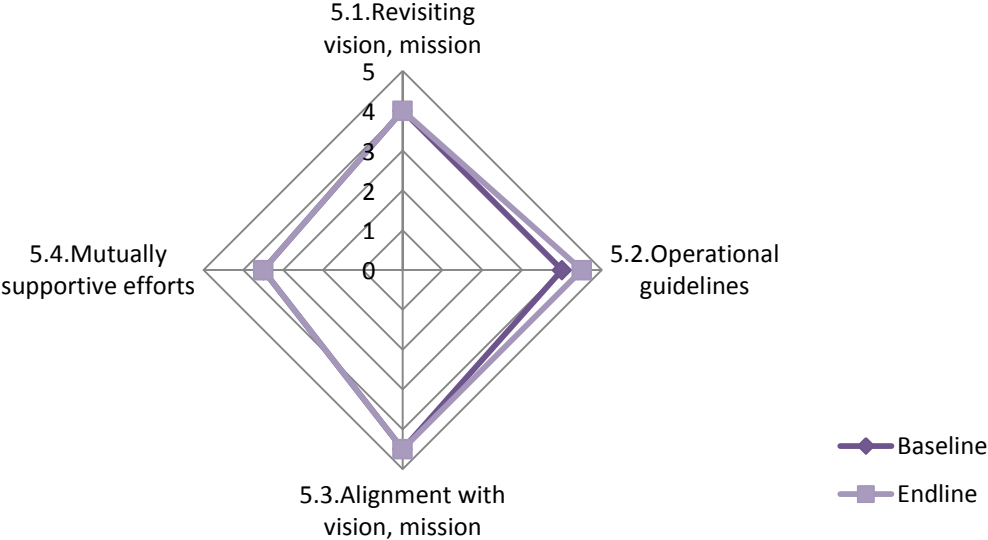
BVHA still works mostly through their network partners which they now visit more frequently (monthly) as this was in the requirements of the MFS II funded project. The Board and Executive Director also took the initiative to visit target groups themselves and make surprise visits. BVHA has also started implementing projects directly and has in that sense increased its interaction with the beneficiaries. Staff continue to be free to share their problems and opinion at any time. Staff can communicate their issues to top management during monthly and quarterly meetings. Issues or

grievances of staff are now first discussed with their immediate supervisors and if it is not solved there, then it is referred to higher level.

Score baseline: 3.75

Score endline: 4.0 (very slight improvement)

Capability to achieve coherence



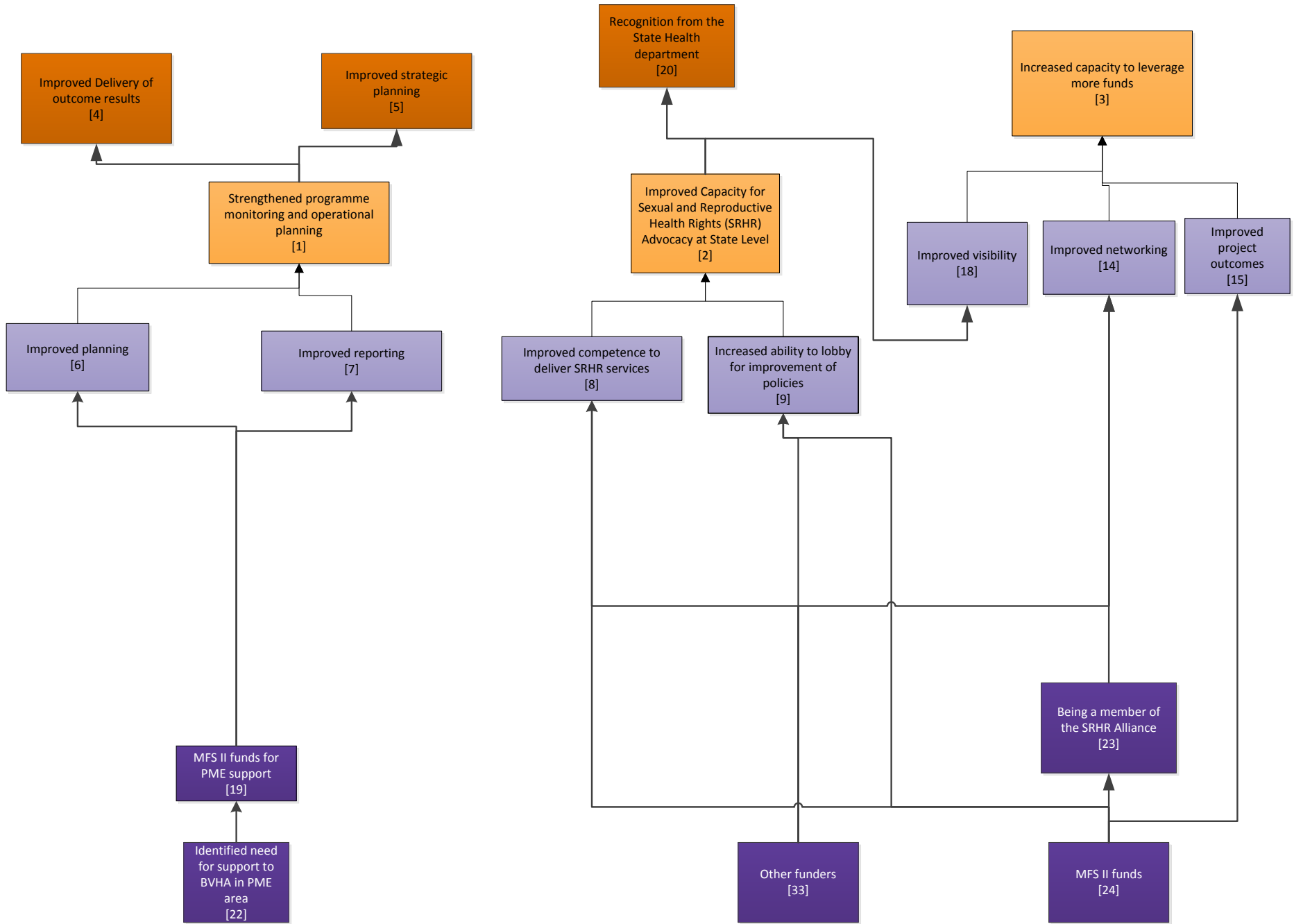
The vision and mission of BVHA have remained the same. BVHA’s projects remain to mostly focus on health related issues, where the availability of donor agencies determines the specific issue to focus on. Projects are mutually supportive. Personnel, admin, finance, gender and child protection policies remain in place. There are now detailed technical guidelines for the SRHR project, developed with the SRHR alliance since the baseline. Operations and strategies of BVHA which now include health and livelihoods remain aligned to their vision and mission.

Score baseline: 4.0

Score endline: 4.1 (no change)

4.2.2 General changes in the organisational capacity of the SPO

During the endline workshop at the SPO, a discussion was held around what were the main changes in organisational capacity since the baseline and why these changes have taken place. The discussion was visualised in a general causal map as can be seen below. The narrative for the general causal map is also described below. It gives a more general picture of what was seen as important changes in the organisation since the baseline, and how these changes have come about , and that tells the more general story about the organisational changes in the SPO. The evaluators considered it important to also note down the SPO’s story and this would also provide more information about reasons for change, which were difficult to get for the individual indicators. Also for some issues there may not have been relevant indicators available in the list of core indicators provide by the evaluation team.



The evaluation team carried out an end line assessment at BVHA from 18 to 20 June 2014. During this workshop, the team made a recap of key features of the organisation in the baseline in 2012 (such as vision, mission, strategies, clients, partnerships). This was the basis for discussing changes that had happened to the organisation since the baseline.

There were three main changes that happened in the organisation since the baseline in 2012:

1. Strengthened programme monitoring and operational planning [1];
2. Improved Capacity for Sexual and Reproductive Health Rights (SRHR) Advocacy at State Level [2];
3. Increased capacity in to leverage more funds [3].

These changes coincided partly with the outcome areas that were chosen for process tracing, so as to get detailed information on how these changes in organisational capacity came about. Therefore the general causal map overlaps strongly with the causal maps developed for each of these outcome areas/organisational capacity changes to be analysed during the process tracing. All the details about these changes in organisational capacity as well as the underlying factors that influenced these changes are described in the narrative and visual below. There is general causal map that explains the overview of these but for the details please see the separate causal maps for improved program monitoring and planning, and the causal map for improved capacity for SRHR advocacy.

The first three main organisational capacity changes are described in the light orange boxes and some of their key consequences are noted above these cards in dark orange. Light purple boxes represent factors and aspects that influence the key organisational capacity changes (in light orange). Key underlying factors that have impacted the organisation are listed at the bottom in dark purple. The numbers in the visual correspond with the numbers in the narrative.

1. Strengthened Programme Monitoring and Operational Planning [1]

Improved planning and monitoring has led to improved delivery on outcome results [4] as well as improved strategic planning [5].

According to the Executive Director, BVHA has strengthened its planning and monitoring activities in the past two years [1]. During the completion of the SRHR project and Oxfam India project, BVHA developed better M&E formats. These formats were shared with their partner organisations for systematic data collection and timely reporting. Through improved planning and monitoring The organisation was thus able to use timely information while planning for future activities. Programme monitoring and operational planning was strengthened because of:

- *Improved planning [6]:* BVHA has improved its planning over the last two years. Strategic planning has improved as "BVHA is now able to identify strategic moves, more effective interventions, such as use of multiple strategies, multi-stakeholder involvement at various levels, use of multimedia IEC strategies."
- *Improved reporting [7]:* BVHA participants that attended the endline workshop indicated that BVHA has improved reporting since the baseline. Evidence of this can be found in Simavi's response to a report submitted by the Project Manager.

2. Improved Capacity for Sexual and Reproductive Health Rights (SRHR) Advocacy at State Level [2]

Over the last two years BVHA has improved its capacity for sexual and reproductive health advocacy at the state level [2]. This has helped BVHA in getting recognition from the State Health department [20]. BVHA has brought up SRHR issues to the attention of the state government which is demonstrated by the examples described here. They wrote an advocacy paper with the objective of ensuring availability and accessibility of comprehensive Sexual and Reproductive Health services for adolescents & women at community and school level.

Improved Capacity for Sexual and Reproductive Health Rights (SRHR) Advocacy at State Level [2] is due to:

- *Improved competence to deliver SRHR services [8]:* BVHA's capacity for Sexual and Reproductive Health Rights (SRHR) Advocacy at State Level [2] occurred because BVHA as an organisation has been in the fore front in delivering SRHR services through its local partner organisations and thus is seen as one of the leading partners to take forward advocacy issues on SRHR. Over the last two years BVHA has improved its competence to deliver SRHR services through its local partner organisations
- *Increased ability to lobby for improvement of policies [9]:* BVHA is in a unique position to be working with a large variety of stakeholders. Thus, BVHA is in a very good position to create a base, generate awareness, harness the critical mass of stakeholders at all levels to carry out lobby and advocacy at the state level, mainly targeting state policies on SRHR.

3. Increased capacity to leverage more funds [3]

The capacity to leverage more funds has increased. Staff of BVHA is highly motivated and tries to go an extra mile to explore new funding opportunities especially with the corporate sector. Now, more new proposals are prepared and sent to different donor agencies the utilization of the BVHA training hall and facilities by other organisations has increased which provides a good source of income for BVHA. This increased due to:

- *Improved visibility [18]:* BVHA's visibility improved because of improved advocacy at state level [2]. Some of the advocacy interventions in the SRHR project have led to BVHA meeting the most senior officials and ministers to discuss on the SRHR issues in Bihar and it has helped for better recognition of BVHA at the state level.
- *Improved networking [14]:* Being a member of the SRHR Alliance , their credibility as SRHR alliance member, and ability to implement a comprehensive SRHR programme has attracted donors . For example UNICEF started funding the Maternal Death Review Project under the project title 'Piloting Review Maternal Death in two districts of Gaya and Purniya, Bihar' since February 2014.
- *Improved project outcomes [15]:* The project "Pre-conception and Prenatal Diagnostic Techniques (PC PNDT)" supported by Simavi since 2009 to 2012 resulted in improved perception of the community regarding female feticide. As a result BVHA could use this project results to leverage funds from the Ministry of Health and Family Welfare, Government of India since 2013 for the "Awareness Building Among communities on Girl Child Survival and PC & PNDT Act" project.

The main underlying causes for these three key organisational changes were:

- *Identified need for support to BVHA in PME area [22]* and the subsequent MFS II funds for PME support [22] have led to all the capacity changes under: strengthened programme monitoring and operational planning [1] through support of Simavi to BVHA mainly by providing feedback and holding biannual PME meetings.
- *Other funders [33]* have funded trainings and meetings that have contributed to improved competence to deliver SRHR services [8], increased ability to lobby for improvement of policies [9] and improved networking [14].
- *(General) MFS II funds [24]* for the SRHR project of BVHA, have allowed BVHA to become a member of the SRHR alliance [23] which has contributed positively to the networking [14] of BVHA.

4.3 Attributing changes in organisational capacity development - evaluation question 2 and 4

Note: for each country about 50% of the SPOs has been chosen to be involved in process tracing, which is the main approach chosen to address evaluation question 2. For more information please also see chapter 3 on methodological approach. For each of these SPOs the focus has been on the capability to act and commit and the capability to adapt and self-renew, since these were the most commonly addressed capabilities when planning MFS II supported capacity development interventions for the SPO.

For each of the MFS II supported capacity development interventions -under these two capabilities- an outcome area has been identified, describing a particular change in terms of organisational capacity of the SPO. Process tracing has been carried out for each outcome area. The following outcome areas have been identified under the capability to act and commit and the capability to adapt and self-renew. Also the MFS II capacity development interventions that could possibly be linked to these outcome areas are described in the table below.

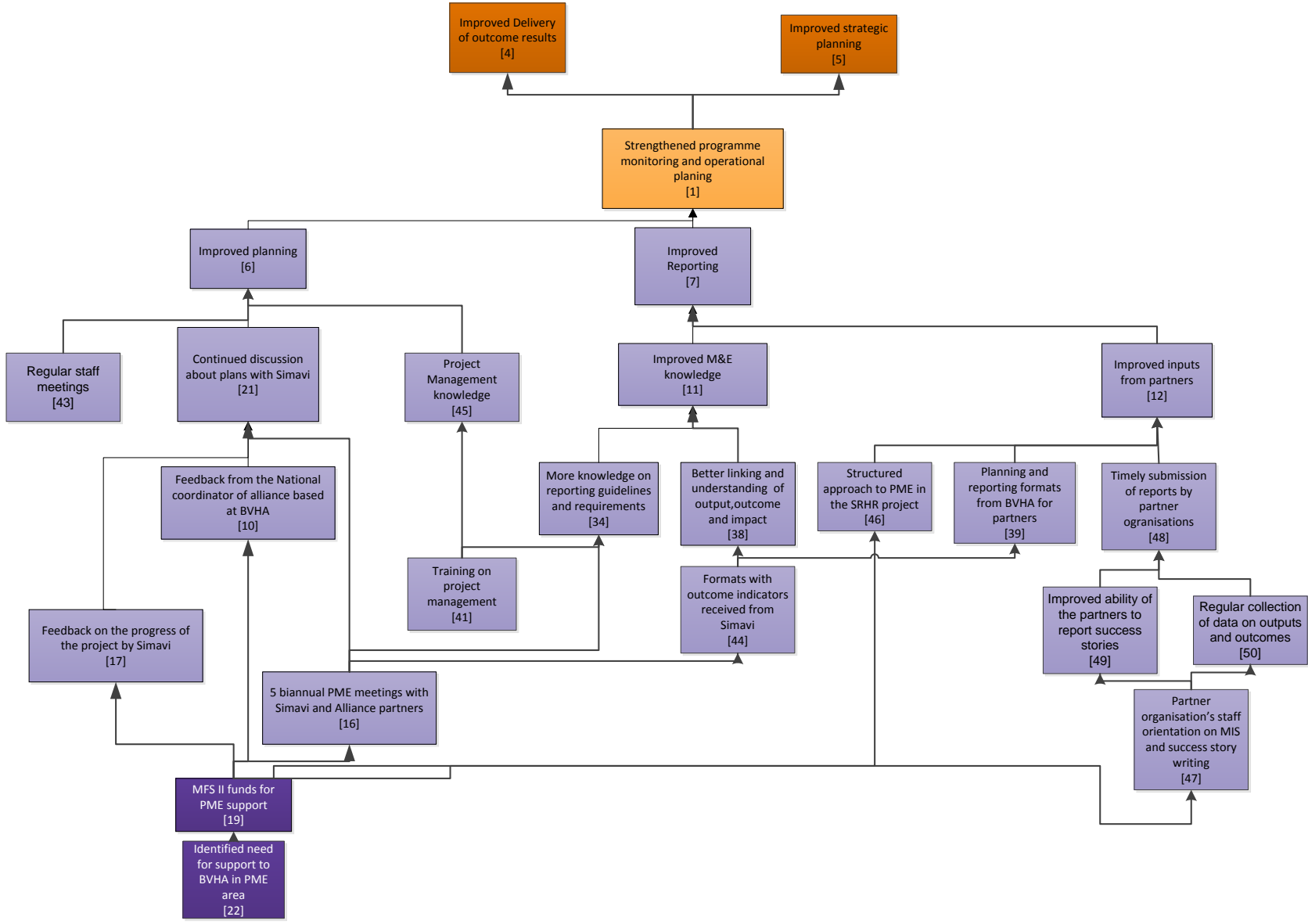
Table 2
Information on selected capabilities, outcome areas and MFS II supported capacity development interventions since the baseline

Capability	Outcome area	MFS II supported capacity development intervention(2)
Capability to act and commit	Improved Capacity for Sexual and Reproductive Health Rights (SRHR) Advocacy at State Level	Strengthening advocacy capacity including evidence based lobby efforts; Training on SRHR and Comprehensive Sexual Education (CSE) through training sessions, exposure visits, feedback on implementation; Review Meet at NEEDS covering topics of advocacy, PME and SRHR
Capability to adapt and self-renew	Strengthened Programme Monitoring and Operational Planning	Planning, monitoring and evaluation sessions in workshops, multiple feedback on report, and documents. Training on HMIS; sharing examples from partners

The next sections will describe the results of process tracing for each of the outcome areas, and will describe to what extent these outcome areas have taken place as a result of MFS II supported capacity development interventions and/or other related factors and actors.

4.3.1 Strengthened Programme Monitoring and Operational Planning

This is a summary of the final causal map of the key change: improved financial sustainability. For a detailed visual to which the numbers refer and narrative with sources please see Appendix 5.



According to the Executive Director, BVHA has strengthened its planning and monitoring activities in the past two years [1]. During the completion of the SRHR project and Oxfam India project, BVHA developed better M&E formats. These formats were shared with their partner organisations for systematic data collection and timely reporting. Through improved planning and monitoring The organisation was thus able to use timely information while planning for future activities. BVHA is now in the process of developing organisational M&E formats for tracking progress of the programs/projects as and when required.

Improved planning and monitoring has led to **improved delivery on outcome results** [4] as **well as improved strategic planning** [5]. This is evident from the fact that *"During the baseline, the current project was evaluated and they reached the outputs but not the outcomes. Now their outcome results were very good, this indicates improvement"*. The improvement in outcome results has been due to continuous and regular discussions on outputs/ outcomes and planning of achievements with the CFA and support provided through PME workshops.

Strengthened Program monitoring and planning was due to [1]: improved planning [6] and improved reporting [7]. Each of these changes are further discussed below.

Improved planning [6]:

BVHA has improved its planning over the last two years. This is due to having regular staff meetings [43], continued discussion about plans with Simavi [21], and project management knowledge [45]. Strategic planning has improved as *"BVHA is now able to identify strategic moves, more effective interventions, such as use of multiple strategies, multi-stakeholder involvement at various levels, use of multimedia IEC strategies."* And *"Simavi allows for strategic changes. In the case of BVHA, we were not encouraging working with in-school youth, but they lobbied for it, so we revised strategy together. Government was supposed to train midwives but because of insufficient quality, we asked BVHA to step into this issue and organise training"*.

- *Regular staff meetings [43]*. Every month, the staff has to present action plans stating details of activities they would be doing in the coming month and staff are also expected to explain the reasons for not fulfilling their stated objectives in the previous month.
- *Continued discussions about plans with Simavi [21]*: The support from Simavi has been in the form of feedback on project progress by Simavi [17], feedback from the National Coordinator [10] based at BVHA and through Biannual PME meetings with Simavi and the Alliance Partners [16].
 - As the National Coordinator of the SRHR alliance has been based in BVHA since February 2012 [10], there has been continued discussion about plans with Simavi [21]. This national coordinator gave constructive feedback to BVHA on plans in order to align them with Simavi's PME requirements.
 - The continued discussions [21] also took place because BVHA received support from Simavi, consisting of feedback on the progress of the project by Simavi [17] as is evident from the program appraisal form.
 - Furthermore, the biannual PME meetings of the alliance partners [16] have helped BVHA to improve its planning. These meetings provided in depth insight into the project interventions and BVHA also received feedback from the Country lead of Simavi and other Alliance members, as well as their experiences and comments to improve the project implementation and strategies. It helped them adopt best practices, strategies etc.
- *Project management knowledge [45]*.
 - Trainings such as the 5 Days Course on Project Management [41] at Goa organised and funded by the International Union against Lung Disease and Tuberculosis, New Delhi in which the Executive Director took part equipped the participants with required knowledge and skill on Project Life Cycle, situation analysis, stakeholders analysis, problem tree, cause effect relationship, means-end relationship, objective tree, strategy analysis, log frame analysis, activity detailing, Gantt Chart preparation, SWOT analysis, sustainability plan.

The national coordinator [10], biannual PME meetings [16] and feedback on project progress [17] were all PME support funded by MFS II [19]. Simavi supported the Planning, Monitoring and Evaluation capacity of BVHA in this way because they identified a need for this [22]. BVHA staff articulated their need to be trained in PME. This is evident from the minutes of the meeting of the inception workshop in November 2011.

Improved reporting [7]:

BVHA participants that attended the endline workshop indicated that BVHA has improved reporting since the baseline [7]. Evidence of this can be found in Simavi's response to a report submitted by the Project Manager. The improved reporting is due to improved PME knowledge [11] and improved inputs from partners through reports [12].

- *M&E knowledge improved [11]:* According to the National SRHR Coordinator, BVHA now has got the capacity to develop the M&E System for the SRHR Alliance which other alliance members can adopt. PME knowledge improved because of:
 - More knowledge on reporting guidelines and requirements [34]. Over the period as BVHA gained more knowledge on reporting guidelines and requirements it was capacitated in developing formats that are easy to understand for their network and partner organisations to collect systematic data. It fine-tuned the indicators which resulted in getting information as per the requirements. The staff linked the output, outcome and impact to assess the achievement. Knowledge on reporting guidelines and requirements improved because of a training on project management [41] and feedback, discussion on formats, explanations on evaluation methodologies and discussions on purpose of monitoring during the biannual PME meetings [16]:
 - Training on project management [41]: This training helped BVHA gain more knowledge on reporting guidelines and requirements. For example, they fine tune the indicators to better assess the progress and collect the data as required, the activities and the achievements are better linked to assess the impact.
 - Sharing and reflecting during the biannual PME meetings [16]: In these meetings the alliance members shared and reflected on various issues related to PME such as, reporting requirements of the PME group of the SRHR alliance, monitoring and evaluation requirements, detailed discussion on the field visits in terms of strengths and weaknesses of the project, partners reported on their project highlights, progress, successes and main bottlenecks, etc.
 - Better linking and understanding of output, outcome and impact [38] mainly by BVHA project officer, because of:
 - Formats with outcome indicators were given by Simavi [44] so that BVHA could assess the outcome and impact of the activities of their partners on the ground. Also during the Biannual PME meetings [16] there was detail discussion on how to select outcome indicators, Identifying sources of verification and tools for outcome indicator measurement, monitoring output indicators, etc. It helped the project staff of BVHA to link and better understand outcome and impact.
 - Sharing and reflecting during the biannual PME meetings [16]. During the Biannual PME meeting there is extensive discussion/sharing on monitoring output and outcome indicators, frame work for the outcome and output indicator, identifying sources of verification and tools for outcome indicator measurement, setting up of target indicator for 2015 etc. helped BVHA better linking output, outcome and impact.
- *Improved inputs from partners through reports [12].* BVHA has been implementing the project "Community empowerment on Gender Equity to access Reproductive Health Rights in 2 districts of Bihar" through its partner organizations – Duncan Hospital, Raxaul (East Champaran) and Fakirana Sisters Society, Bettiah (West Champaran).
 - The SRHR project follows a structured approach to PME [46]. There is dedicated staff for M&E: the district coordinator at the field level; the project manager and ED at BVHA are responsible for monitoring and evaluation. Simavi has provided planning and reporting formats that enable BVHA to track all the proposed activities, find reasons for the success or failure of completion of those activities and plan for the next quarter.
 - The partner organisations of BVHA involved in the programme implementation of BVHA were given formats for data collection and reporting [39] which they had received from Simavi [44]. This

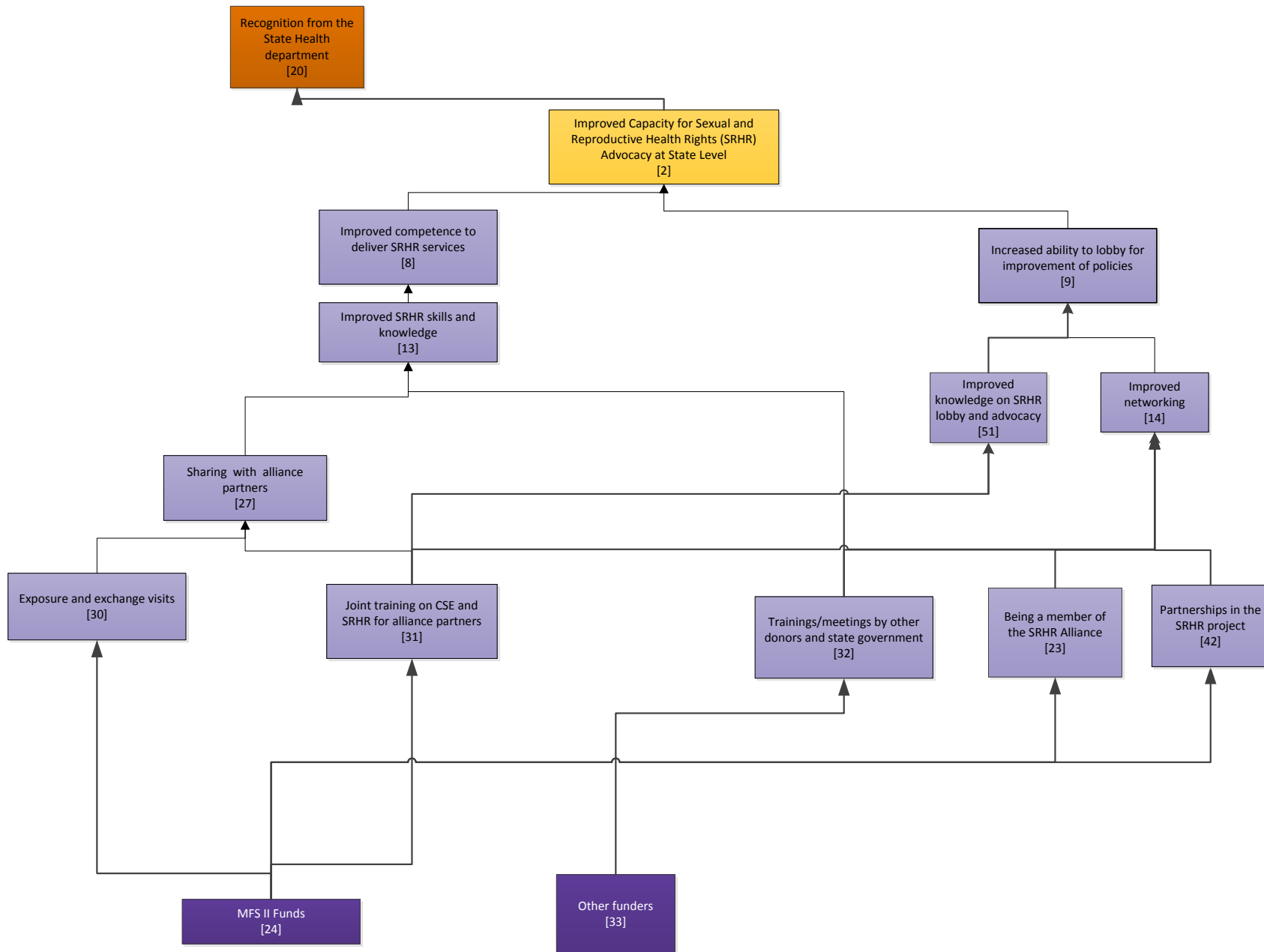
helped the partners not only improve the quality of their data collection but also ensured their timely input.

- There was timely submission of reports [48] with qualitative and quantitative inputs because:
 - The ability of the partners to report success stories improved [49] and
 - There was regular collection of data on outputs and outcomes [50].

Both [49] and [50] were a result of: *Two days orientation of the staff on MIS and success story writing was given to the partner organisations [47]* in September 2012 which further helped the staff of the partner organisation to fill the MIS formats with ease and regularly collect data on output and outcome indicator. This was funded by MFS II as PME support [19].

4.3.2 Improved Capacity for Sexual and Reproductive Health Rights (SRHR) Advocacy at State Level

This is a summary of the final causal map of the key change: improved financial sustainability. For a detailed visual to which the numbers refer and narrative with sources please see Appendix 5.



Improved Capacity for Sexual and Reproductive Health Rights (SRHR) Advocacy at State Level [2]

Over the last two years BVHA has improved its capacity for sexual and reproductive health advocacy at the state level [2]. This has helped BVHA in getting recognition from the State Health department [20]. BVHA has brought up SRHR issues to the attention of the state government which is demonstrated by the examples described here. They wrote an advocacy paper with the objective of ensuring availability and accessibility of comprehensive Sexual and Reproductive Health services for adolescents & women at community and school level.

Improved Capacity for Sexual and Reproductive Health Rights (SRHR) Advocacy at State Level [2] is due to: improved competence to deliver SRHR services [8] and increased ability to lobby for improvement of policies [9]. Each of these organisational capacity changes and how they have come about is described below.

Improved competence to deliver SRHR services [8]

BVHA's capacity for Sexual and Reproductive Health Rights (SRHR) Advocacy at State Level [2] occurred because BVHA as an organisation has been in the fore front in delivering SRHR services through its local partner organisations and thus is seen as one of the leading partners to take forward advocacy issues on SRHR. Over the last two years BVHA has improved its competence to deliver SRHR services through its local partner organisations [8].

BVHA's competences to deliver SRHR services improved [8] because of **improved SRHR skills and knowledge [13]**. The improved SRHR skills and knowledge are reflected in the special curriculum on Comprehensive Sexuality Education (CSE) which was developed by BVHA in consultation with the Government. BVHA developed a special curriculum for young people on CSE which they used through trained staff for educating young boys and girls and empower them to make their own choices around sexuality and reproduction and claim their rights. SRHR skills and knowledge have improved since the baseline [13] because of sharing with alliance partners [27], trainings and meetings by other donors and state government [32]:

- *Sharing with alliance partners [27]*. The continuous interaction and sharing of experiences of BVHA with the alliance partners through exposure visits and trainings in their respective target areas helped BVHA improve their SRHR knowledge and skills. These learnings were then shared with their partner organisations to improve programme implementation. Some details of the interactions with the alliance partners are given below:
 - Exchange and exposure visits [30]:
 - Exchange visit to NEEDS covering SRHR 10 October 2012. The aim of the visit to NEEDS- SRHR project was to share experiences, to understand the different project strategies; to give recommendations to the project, to identify strengths that can be replicated. NEEDS showed their community approach in SRHR, and innovations through mobile phone for SRHR. This visit helped in better program implementation and desired outcomes. They identified SRHR issues for advocacy, and program strengths that could be used by them for program implementation. This was funded by MFS II [24].
 - Exposure visit to SRHR-YFS/ARSHC clinic of VHAI 19 December 2012. The objective was to use the learning from the ARSH clinic visit to replicate it in developing adolescent reproductive health clinic services in the government system as well as bringing about improvement in the quality of the clinic. The Executive Director of BVHA could get a basic understanding of adolescent health problems, counselling techniques, how to establish and run such clinics, how to convince the government to take up such an initiative, and how to link with HIV testing and counselling centres and its linkages with the project at community level. This was funded by MFS II [24].
 - Joint training on CSE and SRHR for alliance partners [31]:
 - Meeting for Capacity Building of SRHR Alliance Partners' staff on 18-20 April 2012 in Delhi funded by MFS II. The aim was to improve the capacities of the alliance partners on SRHR by providing them technical information to be used later for training their field partners:

understanding the concept of "Sex and Sexuality," female reproductive system and the various methods of contraception. This was funded by MFS II [24].

- Regional meeting Indonesia, focus on SRHR-CSE delivery (Indonesia team, alliance office) in November 2013. The Executive Director of BVHA and the program manager went to Indonesia to see how their alliance partners worked with authorities on creating an enabling environment for Comprehensive Sexuality Education (CSE) activities and how the CSE curriculum was being implemented and benefiting a Muslim setting. This was funded by MFS II [24].
- Training on Comprehensive Sexuality Education (CSE): 3 days for project staff in April 2013. A refresher training of partners' staff in the SRHR alliance of India was facilitated by Restless Development India on Sexual and Reproductive Health Rights and on Adolescence Health care in Bihar Voluntary Health Association (BVHA), Patna. This was funded by MFS II [24].
- Discussion on content of joint SRHR manual (all partners and external facilitator, government staff) 5th March 2013. The objective of this meeting was to finalise the SRHR manual, initiated by VHAI and reviewed by a consultant. BVHA has contributed in developing the SRHR Guidelines which has now been turned into a Manual. This manual is used by all alliance partners. This was funded by MFS II [24].
- Comprehensive Sexuality Education (CSE) training for all partners (basic) by Restless Development in 25-29 June 2012. This training involved introduction to SRHR and 10 life skills through discussion, case study (field level), sharing and learning, physical, psychological and social changes during adolescence, male & female reproductive system, menstrual hygiene STI, HIV, gender, sex and sexuality; sexual abuse; pregnancy, miscarriage, unwanted pregnancy; ANC, PNC; preparation for delivery. This was funded by MFS II [24].
- Participation in trainings and meetings funded and organised by other donors and state government [32].

BVHA staff participated in various workshops, seminars, training programs related to SRHR organized by Government of Bihar (department of health) and other development agencies such as Population Foundation of India [33]:

- Meeting on Repositioning of Family Planning by Population Foundation of India (PFI), New Delhi on Dec. 2012. A half day workshop was organized by PFI. Here discussions were held around repositioning of family planning within a woman's empowerment and human rights framework so that every family is a planned family and every child is a wanted, healthy child. The staff of BVHA (Executive Director and Advocacy Officer, SRHR Project) learned about improving the quality of care of family planning and reproductive health, preventing sex selection, family planning and reproductive health services, spacing between births etc.

Increased ability to lobby for improvement of policies [9]

BVHA is in a unique position to be working with a large variety of stakeholders. These include NGOs and their workers, network organizations, state level SRHR Alliance members, frontline health service providers, Village Health and Sanitation Committee at Panchayat level, target population in need for SRHR services adolescents both male and female, newlywed couples, eligible couples⁷, District and Block level, PRI representatives at Panchayat level, mixed stake holders (religious leaders, opinion leaders, School teacher and other local identified reputed people), Self Help Groups for Dalit Women. Thus, BVHA is in a very good position to create a base, generate awareness, harness the critical mass of stakeholders at all levels to carry out lobby and advocacy at the state level, mainly targeting state policies on SRHR.

The increased ability to lobby is due to **improved knowledge on SRHR lobby and advocacy [51]** and **improved networking [14]**.

⁷ An eligible couple in India is a currently married couple wherein the wife is in the reproductive age, which is generally assumed to lie between the ages of 15-45 years. Such couples are target groups for family planning services.

- *Improved knowledge on SRHR lobbying and advocacy [51]* was mainly the result of joint training on CSE and SRHR for Alliance partners [31] and trainings/meetings from other donors and state government [32]:
 - The joint trainings on CSE and SRHR for Alliance partners [31] included capacity development of the alliance partners on the following issues: to identify and analyse advocacy issues, key strategies, building advocacy skills and for developing a work plan, to understand how a joint advocacy agenda defines a shared ambition which gives greater opportunities for reaching different stakeholders. The importance of identifying active key players and how to engage them in advocacy. This was funded by MFS II [24].
 - The trainings/meetings from other donors and state government [32] included:
 - Workshop on WASH was organized by Wada Na Todo Abhiyan at A.N.Sinha Institute, Patna on 12th December, 2012. The aim was to develop effective and communicative tools for awareness building program to mobilise, sensitize and motivate people to lobby for their rights as well as the discussions on various food security issues, nutrition for pregnant and lactating women etc., led to a common understanding to create a civil society force for advocacy with government to develop policy and plans in the interest of common people.
 - Workshop on Bitiya Bachao –Manavta Bachao Aandolan was organized by Action Aid, Patna on 26th December, 2012. This training enabled the staff to organize a meeting in January 2013 with the Minister of Health of the Government of Bihar to discuss on infant mortality rates, maternal mortality rates, sex selective abortion including Save the Girl Child. Thus networking with the government improved considerably and improved BVHA’s ability to lobby.
 - The improved networking [14] occurred also, as a result of training by other donors [32], BVHA being a member of the SRHR Alliance [23] and partnerships in the SRHR project [42]. These are further explained below:
 - Being a member of the SRHR Alliance [23] (through the Simavi supported projects under MFS II [24]). BVHA is an active part of the India SRHR Alliance which is continuously working on the SRHR related issues to advocate at national, state and district level. Several issues are jointly identified which are common in the three states involved in the alliance and strategies have been developed to address them. Besides that, BVHA is an active member of the Wada Na Toda Abhiyan⁸ Bihar and India Chapter. Many health issues were discussed with the community people in 16 MP (Member of Parliament) constituencies of Bihar and accordingly these issues were compiled and submitted to concerned Political Parties for inclusion in their Political Manifesto. Many of the issues are now included.
 - Partnerships in the SRHR project [42], which is MFS II funded [24], is another reason for improved networking. At the state level, BVHA formed the State level SRHR forum under the chairmanship of the Government authority and other international agencies such as Pathfinder International, Care-India, Population Foundation of India, two network partners, two SRHR Alliance partners and renowned NGOs at Patna. The government of Bihar recognizes BVHA as a member of the State Technical Advisory group in Bihar. Further BVHA is the member of the state level thematic sub groups on Total Fertility Rates (TFR), Maternal Mortality Rates (MMR) and Infant Mortality Rates (IMR) for policy level changes. At the district level too an SRHR forum was formed that liaised with District level authorities on SRHR issues such as Maternal Death Review, Rogi Kalyan Samitis (RKS, i.e. health facility management committees) orientation, Gaps in service delivery
 - Participation in trainings and meetings funded and organised by other donors and state government [32].
 - BVHA staff participated in various workshops, seminars, training programs related to SRHR organized by Government of Bihar (department of health) and other development agencies such as Population Foundation of India, Magic Bus India, World vision, Oxfam India, Future groups etc. [33]:
 - Meeting on Repositioning of Family Planning by Population Foundation of India (PFI), New Delhi in Dec. 2012.

⁸ Wada Na Todo ABHIYAN (WNTA) is a national campaign to hold the government accountable to its promise to end poverty and social exclusion

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- Workshop on WASH was organized by Wada Na Todo Abhiyan at A.N.Sinha Institute, Patna on 12th December, 2012. The aim was to develop effective and communicative tools for awareness building program as well as multi-departmental coordination approaches. This created a platform for various civil society organisations to come together and form a task force to lobby and advocacy with government and other policy makers for various health related policies.
 - Workshop on Bitiya Bachao –Manavta Bachao Aandolan was organized by Action Aid, Patna on 26th December, 2012. This training enabled the staff to organize meeting on January 2013 with health minister, Government of Bihar to discuss on IMR, MMR, sex selective abortion including Save the Girl Child. This also served as a preparatory meeting to organize 3day events to sensitize the people on the above mentioned issues. Due to this workshop, networking with the government improved considerably for BVHA to participate in the strategic planning for health development in Bihar.

5 Discussion and conclusion

5.1 Methodological issues

In order to get detailed information on the capacity development of the staff, self-assessment forms were filled in by the management (Executive Director), programme staff (Project Manager SRHR Project, Project Manager KKS Project, Project Manager MDR Project, Advocacy Officer SRHR Project) and HR/Admin staff (Administrator, Assistant Accountant). The agreed questionnaire was aimed at teasing out information from various levels of staff without putting them in any awkward situation. The modified and nuanced repetition of questions when translated to an audience not properly exposed to the English language, created a sense of repetitiveness. Evaluators tried to resolve this, by clarifying the responses by a follow-up interview.

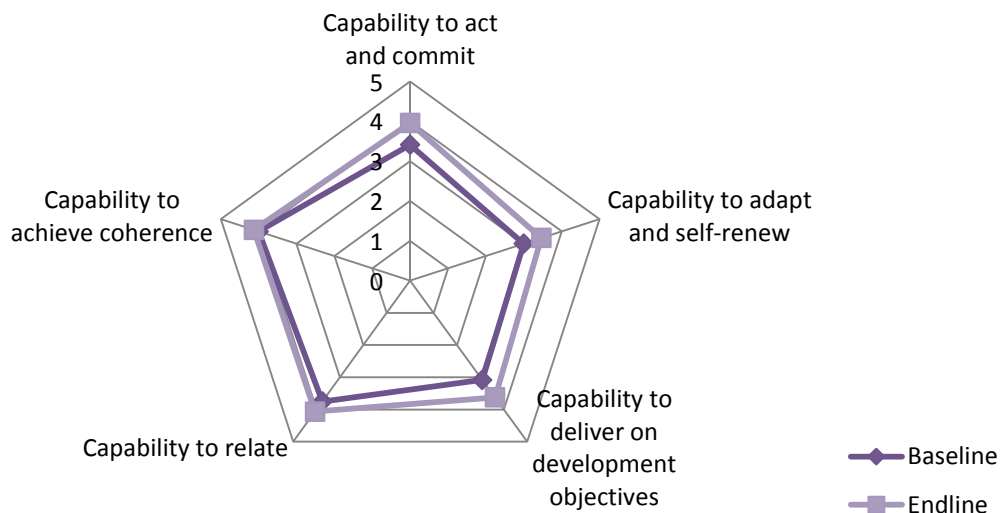
In the endline workshop, staff of BVHA who participated in the baseline workshop in 2012 was present, except for Project Manager KKS project and Assistant Accountant. As a result, the staff faced no difficulty in identifying the key organisational capacity changes in developing a general causal map. Two Organisational Development (OD) consultants were interviewed which provided deeper insight into the organisation with regard to its structure, MIS system, documentation, leadership, financial management, reputation and ability to deliver etc. The chairman of the State Level SRHR forum could not outline the details regarding the changes in the organisation over the period as he was only involved in giving technical and analytical inputs in the SRHR project. The national coordinator for the SRHR alliance highlighted BVHA's improved knowledge and skill in M&E system and improved leadership which led to better networking and funding opportunities. Two of BVHA's implementing partners were interviewed, who gave a deeper insight into the improved capacity of the organisation (BVHA) and its relationship with the partners/government.

In relation to process tracing, training questionnaires were filled in for the relevant trainings under MFS II supported funding. However, for the staff it was sometimes difficult to recall what they learnt during a specific training as they were exposed to various training programmes and exposure visits (both under MFSII programme and others) which at times were overlapping in themes and it was difficult for staff at all levels to know which training was sponsored by which donor. Therefore, the observed changes are attributed to various factors beyond a specific training programme. The training questionnaires provided details such as: knowledge acquired and skill developed by the staff and its impact on the organisational capacity. Training questionnaires were filled in for most of the trainings under MFS II interventions for BVHA such as: 1) Exchange visit to NEEDS covering PME, Advocacy and SRHR in Deoghar; 2) Exposure visit to Adolescent Reproductive & Sexual Health Clinic in Ganjam, Odissa; 3) Regional meeting Indonesia, focus on SRHR-CSE delivery (Indonesia team, alliance office); 4) Comprehensive Sexual Education (CSE) training all partners (basic) by Restless Development; 5) 2 day Orientation of the staff on MIS and success story writing; 6) Workshop joint advocacy and state level visit (CINI).

5.2 Changes in organisational capacity

This section aims to provide an answer to the first and fourth evaluation questions:

1. *What are the changes in partner organisations' capacity during the 2012-2014 period?*
4. *What factors explain the findings drawn from the questions above?*



Whilst changes took place in four of the five core capabilities, in some indicators the improvements were more pronounced than in others. Below the changes in each of the capabilities are further explained, by referring to the specific indicators that changed.

Over the last two years most improvements took place in the indicators under the capability to act and commit. Many of these were said to be triggered by donor requirements in general and for the SRHR project by Simavi in specific. The Executive Director became more responsive to BVHA's partner organisations. This was something that was triggered by discussions with Simavi. The ED is now experiencing that by being more responsive and cooperative he is also facing less opposition from the network members in the board. BVHA has taken the step to look to promote existing staff when a vacancy for a higher level position needs to be filled. This has helped in the motivation of staff. With regards to financial incentives, Simavi has had discussions with BVHA so that now they adhere to the government standard for salaries. The strategies that BVHA articulates are now not only based on M&E findings on the output level but also on the outcome level. Their operation plans have become more professional, because BVHA now has formats in place that are easier to understand for their partner organisations and has also trained their partners in this. Getting better inputs from their partners facilitates making better operational plans. This is the case for the SRHR project, but it has also influenced how BVHA works in its other projects. Staff have improved their skills in SRHRs, advocacy, record keeping in PME and in finance matters. The national coordinator of the SRHR alliance, who is based at BVHA and funded by MFSII has played a vital role in this by providing continuous discussions and feedback on these topics. In the SRHR project staff have been able to partake in many exposure visits, meeting and trainings, also funded by the government and other donors. Regarding its funding situation, BVHA has a pretty diversified resource base, as they receive funding from six different donors and are looking into possibilities of getting funding through the CSR Act and the government. Staff has become more motivated to explore these new funding opportunities and has also gotten better at writing proposals and looking at innovative funding strategies.

In the capability to adapt and self-renew BVHA has also improved slightly in various indicators. Through the MFSII funded biannual PME meetings, specific workshops and feedback from the national coordinator and Simavi, BVHA learned about a variety of monitoring tools to measure outcomes. The M&E in the SRHR project is organised in a very structured way and has been discussed through during the biannual PME meetings. BVHA now has MIS formats in place that are easy to understand for their partners at different levels in the project. Because of all this BVHA staff has become more expert in PME, they are better in designing formats and analysing the data that is collected. Through this improved PME system BVHA is better able to base its strategic moves on the M&E findings. Through the meetings with other SHRS alliance partners, BVHA has got some new ideas, including on M&E by learning from others. In the SRHR alliance and its other networks BVHA is better connected to stay abreast of the development in their operating environment of which they also inform their network

members. BVHA tries to be more responsive to their network member by holding at least two Governing Board meetings per year in the location of the members.

In terms of the capability to deliver on development objectives, there has been some improvements. Because of Simavi's requirements and feedback on the annual plans of BVHA, they have become more critical and realistic in their budget utilisation which has also led to better operational plans. BVHA is working more cost-effectively as they cut costs through using their own facilities for trainings and using technology to avoid printing costs. BVHA has also improved in formalising its mechanisms through which they make sure that their services meet their beneficiaries needs. They have feedback questionnaires in place for this. Through improved monitoring formats BVHA can now better see what has been achieved and is also reaching more of their planned outputs and now also outcomes. Finally, staff have gained a better understanding of the log frames that are used in its projects.

In the capability to relate BVHA has somewhat improved. They now involve their partners in the planning, implementation and M&E design phases of their projects. BVHA has improved on their networks as they are part of at least 10 networks at national, state and district levels. They are working more with the government on different levels, e.g. through their State level SRHR forum and are very active in the SRHR alliance. On Simavi's request, BVHA's Executive Director and Board members are now paying more visits to the target groups.

Finally, BVHA has slightly improved in one of the indicators in the capability to achieve coherence as they now have detailed guidelines on SRHR which was much needed in the SRHR project.

During the endline workshop some key organisational capacity changes were brought up by BVHA's staff: strengthened programme monitoring and operational planning, improved capacity for Sexual and Reproductive Health Rights (SRHR) advocacy at state level and increased capacity in to leverage more funds. The evaluators considered it important to also note down the SPO's story and this would also provide more information about reasons for change, which were difficult to get for the individual indicators. Also for some issues there may not have been relevant indicators available in the list of core indicators provide by the evaluation team. These changes happened to partly overlap with the key changes that were selected for process tracing. The increased capacity to leverage funding was not linked to a MFS II supported capacity development intervention and thus not selected for process tracing. This capacity increased because of improved visibility, due to improved SRHR advocacy at state level; improved networking, due to being a member of the SRHR Alliance (MFS II funded); and due to improved project outcomes (mostly of MFS II funded projects).

The funding of Simavi, especially the funding for PME support, has led to many of the changes mentioned above and also to the first key organisational capacity change. The active involvement of BVHA in the SRHR alliance, through their MFS II funded SRHR project, has also been very important for both key organisational capacity changes and comes back in many of the other changes mentioned above. This will further be explained below in 5.3.

5.3 Attributing changes in organisational capacity to MFS II

This section aims to provide an answer to the second and fourth evaluation questions:

2. *To what degree are the changes identified in partner capacity attributable to development interventions undertaken by the MFS II consortia (i.e. measuring effectiveness)?*
4. *What factors explain the findings drawn from the questions above?*

To address the question of attribution it was agreed that for all the countries in the 5C study, the focus would be on the capability to act and commit and the capability to adapt and self-renew, with a focus on MFS II supported organisational capacity development interventions that were possibly related to these capabilities. 'Process tracing' was used to get more detailed information about the changes in these capabilities that were possibly related to the specific MFS II capacity development interventions. The organisational capacity changes that were focused on were:

- Strengthened programme monitoring and operational planning;
- Improved capacity for Sexual and Reproductive Health and Rights (SRHR) Advocacy at state level.

The first organisational change area falls under the capability to adapt and self-renew, while the second one falls under the capability to act and commit. The organisational capacity change areas that were chosen are based on document review as well as discussions with the SPO and CFA.

Each of these organisational capacity changes is further discussed below.

The following issues are discussed for the MFS II funded activities that are related to the above mentioned organisational capacity changes:

- a. Design: the extent to which the MFS II supported capacity development intervention was well-designed. (Key criteria: relevance to the SPO; SMART objectives)
- b. Implementation: the extent to which the MFS II supported capacity development was implemented as designed (key criteria: design, according to plans during the baseline);
- c. Reaching objectives: the extent to which the MFS II capacity development intervention reached all its objectives (key criteria: immediate and long-term objectives, as formulated during the baseline);
- d. the extent to which the observed results are attributable to the identified MFS II supported capacity development intervention (reference made to detailed causal map, based on 'process tracing').

Please note that whilst (d) addresses the evaluation question related to attribution (evaluation question 2), the other three issues (a, b and c) have been added by the synthesis team as additional reporting requirements. This was done when fieldwork for the endline process had already started.

Strengthened programme monitoring and operational planning

The following MFS II capacity development interventions were linked to the key organisational capacity, change "strengthened programme monitoring and operational planning":

1. Biannual PME meetings of the alliance partners (planned during the baseline and details provided during the endline); and
2. Feedback by Simavi on progress of the SRHR project (not specifically planned during the baseline and no details provided during the endline).

Below the intervention will be discussed that was planned during the baseline and for which details were provided during the endline. The capacity development interventions for which no objectives have been provided during baseline or endline will only be discussed when addressing the attribution question (here: feedback by Simavi).

5 Biannual PME meetings of the alliance partners;

Design

During the baseline it was planned to have "continued capacity development in planning and monitoring for two staff members two times in 2012." The immediate objectives of these interventions were to ensure that "key staff is able to provide detailed and consistent project related plans and to understand monitoring on outputs and outcomes." The long term objective the CFA formulated was: "better project design and implementation to be able to achieve and demonstrate results." The agenda and minutes of the 5 biannual meetings that took place during 2012 and 2014 were shared. The PME meetings seemed to be designed well for achieving their objectives.

These objectives were relevant for BVHA. During the baseline workshop they formulated five conditions that needed to be in place in order for them to strengthen their position as a "State Health Resource Centre" in Bihar. One of these conditions was "Strengthened program monitoring and evaluation." The understanding of monitoring on outputs and outcomes is very much related to this condition that BVHA formulated.

These objectives were not formulated in a SMART way (specific, measurable, achievable, relevant and time-bound). Then again, the evaluation team did not ask the CFA for SMART objectives specifically,

but rather asked about the expected or observed immediate and long term effects of the interventions.

Implementation

This intervention was partly planned during the baseline in 2012. By then it was planned to have continued capacity development in planning and monitoring for two staff members, two times in 2012. The capacity development plans by the CFA for the SPO for 2013 were still in the making. The PME meetings took place two times a year: 17-18 May 2012, 11-12 October 2012, 4-6 March 2013, 8-10 October 2013 and on 11 March 2014. No judgement can be made on whether this intervention was implemented as designed, since the design was not completely known during baseline, and its objectives were not described in a SMART way. Looking at the agendas and minutes for the meetings, what happened during the meetings seems to match what has been planned in the meetings' agendas.

Reaching objectives

The focus of this evaluation has been the role of the MFS II funded capacity development interventions in the key organisational capacity changes that were identified. The 5 biannual PME meetings came up in the map and narrative on the organisational capacity change: strengthened programme monitoring and operational planning. In this regard we can conclude that these meetings led to continued discussions about plans with Simavi (which led to improved planning), receiving formats with outcome indicators (which further improved BVHA's M&E knowledge) and to more knowledge on reporting guidelines and requirements.

Though not the focus of this evaluation, we can conclude to some extent whether the expected immediate and long-term objectives of this intervention as formulated during the baseline have been achieved. The immediate objectives: "key staff is able to provide detailed and consistent project related plans and to understand monitoring on outputs and outcomes, " were achieved. The CFA observed that development of monitoring tools, documentation of results, case studies and the ability to do baseline and compare to midterm, improved. The long term objective: "better project design and implementation to be able to achieve and demonstrate results" has been achieved to some extent as BVHA has improved its reports (demonstrating results), according to Simavi. Achieving results has also improved, at least for the SRHR project. BVHA is reaching or even surpassing the targets that are set for output indicators in the different result areas, such as civil society strengthening, MDGs and increased capacity of partner organisations.

Attribution of observed results to MFS II capacity development interventions

The strengthening of BVHA's programme monitoring and operational planning in the SRHR project was due to improved planning and improved reporting (also see section 4.3).

The improved planning can be partly attributed to MFS II as improved planning was due to regular staff meetings (in which MFS II funding had no direct role), continued discussions about plans with Simavi (in the MFS II funded project) and project management knowledge (no direct role for MFS II). The continued discussions about plans with Simavi can be fully attributed to MFS II as these continued discussions consisted of feedback from Simavi on the MFS II funded project progress, feedback from the national coordinator of the SRHR alliance (of which BVHA was part because of the MFS II funded SRHR project) and finally the biannual PME meetings with Simavi and Alliance partners. These biannual meetings have been discussed in detail above. One of the non-MFS II factors that improved planning can be attributed to were the regular staff meetings. This was an internal organisational development through which reporting on staff's plans and activities became more streamlined. There was also one training the "5 Day Course on Project Management" that was not funded by MFS II but by The International Union against Lung Disease and Tuberculosis in New Delhi, to which the improved project management knowledge can be attributed. All in all, MFS II supported capacity building interventions played a considerable role in BVHA's improved planning.

The improved reporting of BVHA was due to improved M&E knowledge and improved inputs from partners. Improved M&E knowledge can almost completely be attributed to MFS II supported capacity building interventions. BVHA staff improved their M&E knowledge because of more knowledge on reporting guidelines and requirements, which can be attributed to the 5 biannual PME meetings

(funded by MFS II) and the training on project management that was mentioned before (not funded by MFS II). M&E knowledge also improved because of better linking and understanding of output, outcome and impact, which can be fully attributed to MFS II supported capacity development interventions as during the biannual PME meeting formats with indicators for the different levels were distributed and discussed with BVHA, Simavi and the other SRHR alliance partners.

Improved inputs from partners can be completely attributed to MFS II supported capacity building interventions because improved inputs from partners were due to a structured approach to PME in the SRHR project, planning and reporting formats from BVHA for partners, and all of these can be attributed to MFS support to capacity development of the organisation. Timely submission of reports by partner organisations can be attributed to a MFS II funded orientation for BVHA partner organisation's staff on MIS and success story writing in September 2012. Furthermore, the planning and reporting formats from BVHA for its partners led to the improved inputs from partners, and these formats were based on the formats that BVHA received from Simavi and were discussed during the biannual PME meetings. Finally the improved inputs from partners were also due to a structured approach to PME in the MFS II funded SRHR project. While this last factor is not directly linked to an intervention it can be attributed to the overall guidance and requirements of Simavi in the MFS II funded project.

All in all, strengthened programme monitoring and operational planning, with specific reference to the SRHR project, can almost completely be attributed to MFS II supported capacity development interventions, and in particular the five biannual PME meetings (also planned during the baseline) and the feedback by Simavi on progress of the SRHR project. The only non-MFS II factors that have played a minor role are the regular staff meetings and the training on project management funded by the International Union, New Delhi.

Improved capacity for Sexual and Reproductive Health and Rights (SRHR) Advocacy at state level.

The following MFS II capacity development interventions supported by Simavi are linked to the key organisational capacity change "improved capacity for Sexual and Reproductive Health and Rights (SRHR) Advocacy at state level." (please also see section 4.3):

1. Strengthening advocacy capacity including evidence based lobby efforts (planned during the baseline and details provided during the endline);
2. Training on SRHR and Comprehensive Sexual Education and (CSE) through training sessions, exposure visits, feedback on implementation (planned during the baseline and details provided during the endline);
3. Review Meet at NEEDS covering topics of advocacy, PME and SRHR (not planned during the baseline but details provided during the endline);
4. Exchange visit to SRHR YFS clinic of VHAI (not planned during the baseline but details provided during the endline); and
5. Regional meeting Indonesia, focus on SRHR-CSE delivery (Indonesia team, alliance office) (not planned during the baseline but details provided during the endline).

Strengthening advocacy capacity including evidence based lobby efforts

Design

During the baseline the following was planned for 2012: "Capacity development in advocacy on various occasions for one staff member and 2 partner staff members." It was not further specified which activities would fall under this capacity development in advocacy. The immediate objective of this (set of) interventions was that "key staff should be able to improve their advocacy plans in all aspects through a systematic approach and is keen to know the results of their advocacy efforts." The long term objective was "better organisational advocacy capacity."

These objectives were relevant for BVHA because during the baseline the staff felt a need for training in lobbying and advocacy. They wanted to focus on formation and strengthening of regional forums and have a focussed advocacy agenda. Both the short term and long term objectives that were formulated by Simavi are very much related to these goals of BVHA.

These expected effects were not formulated in a SMART way (specific, measurable, achievable, relevant and time-bound). Then again, the evaluation team did not ask the CFA for SMART objectives specifically during the baseline, but rather asked about the expected or observed immediate and long term effects of the interventions.

Implementation

During the baseline, capacity development in advocacy, on various occasions for one staff member and two partner staff members, was planned for 2012, but no specific activities were mentioned, and therefore it cannot be indicated with the planned activities took place. However, from Simavi's and BVHA's documents it can be seen that the following activities took place under the title of "strengthening advocacy capacity including evidence based lobbying": "Advocacy, continuation, what is advocacy" by VHAI (18-20 April 2012), "Advocacy, progress, joint agenda" by Simavi (11-12 October 2012), "Workshop joint advocacy" (CINI) and state level visits (April, 7-9 May and December 2013) and a "3 day advocacy workshop: "working on state level and national joint agendas" by Simavi and Rineke van Dam (19-22 May 2014).

Reaching objectives

The focus of this evaluation has been the role of the MFS II funded capacity development interventions in the key organisational capacity changes that were identified. Especially the activity on 18-20 April 2012 came up in the map and narrative on the organisational capacity change: improved capacity for Sexual and Reproductive Health and Rights (SRHR) Advocacy at state level. This activity has led (together with other interventions) to improved knowledge on SRHR lobby and advocacy.

Though not the focus of this evaluation, we can conclude to some extent whether the expected immediate and long-term objectives of this intervention as formulated during the baseline have been achieved. Simavi has observed some immediate effects of these interventions: there is an initiating SRHR forum at state level, BVHA brings in SRHR issues under the attention of the government and there is a stronger capacity to describe case-studies for lobby purposes. BVHA is on the way to achieving the long term objective. The immediate objective "key staff should be able to improve their advocacy plans in all aspects through a systematic approach and is keen to know the results of their advocacy efforts," is not directly reflected in these observed effects but these effects seem to indicate that BVHA is now having "better organisational advocacy capacity."

Training on SRHR and Comprehensive Sexual Education (CSE) through training sessions, exposure visits, feedback on implementation

Design

During the baseline the following was planned for 2012: "Capacity development in SRHR (general and specifically sex education for young people) (6 staff – including partners)." The immediate objective of this intervention was "Project staff is able to provide more comprehensive SRHR package." The long term objective was: "Strengthened organisation to support SRHR project run by partners." Details about the specific design cannot be provided, since this wasn't the focus of the evaluation.

These objectives do not directly relate to the goals and conditions that BVHA set out for themselves during the baseline. Indirectly these objectives are relevant for BVHA as they identified during the baseline that they wanted to strengthen their network of partners. Being able to offer a more comprehensive SRHR package can contribute to this goal.

These objectives were not formulated in a SMART way (specific, measurable, achievable, relevant and time-bound). Then again, the evaluation team did not ask the CFA for SMART objectives specifically during the baseline, but rather asked about the expected or observed immediate and long term effects of the interventions.

Implementation

During the baseline "Capacity development in SRHR (general and specifically sex education for young people) (6 staff – including partners)" was planned for 2012. The planning for 2013 was still in the

making at the time of the baseline. What actually took place was: Training SRHR with different speakers and topics (18-20 April 2012), CSE training for all SRHR alliance partners (basic) by Restless Development (24 June 2012), Discussion on content of joint SRHR manual (all partners and external facilitator, government staff) (4-6 March 2013) and Refresher CSE training for all partners (Restless Development and external consultants) (4-6 April 2013).

Reaching objectives

The focus of this evaluation has been the role of the MFS II funded capacity development interventions in the key organisational capacity changes that were identified. The trainings on SRHR and Comprehensive Sexual Education (CSE) came up in the map and narrative on the organisational capacity change: improved capacity for Sexual and Reproductive Health and Rights (SRHR) Advocacy at state level. These trainings led to sharing with alliance partners which resulted in improved SRHR skills and knowledge and improved knowledge on SRHR lobby and advocacy, as this was often a topic that was discussed.

Though not the focus of this evaluation, we can conclude to some extent whether the expected immediate and long-term objectives of this intervention as formulated during the baseline have been achieved. The short term objective has been achieved, as Simavi observed that BVHA now has strong project implementation in more aspects of SRHR and provides advice to government technical SRHR committees. Simavi also observed that BVHA now has the confidence to talk about sensitive SRHR issues and has increased knowledge on youth SRHR issues. Additionally, BVHA developed special curriculum for young people on CSE which they used through trained staff for boys and girls. The long term objective (a strengthened organisation that can support SRHR projects runs by partners) is therefore on the way to achievement.

Review Meet at NEEDS covering topics of advocacy, PME and SRHR

Design

This specific intervention was not planned for during the baseline by the CFA. Details about the specific design cannot be provided, since this wasn't the focus of the evaluation. According to a report of this meet, the aim of this visit was to share experiences, to understand the different project strategies, to give recommendations to the project and to identify strengths that can be replicated. No long term objective has been formulated.

These aims were relevant for BVHA as they identified during the baseline that they want to strengthen their network of partners in health to share information. This Review Meet at one of the partners within the SRHR alliance is therefore relevant for BVHA.

These expected effects were not formulated in a SMART way (specific, measurable, achievable, relevant and time-bound). Then again, the evaluation team did not ask the CFA for SMART objectives specifically, but rather asked about the expected or observed immediate and long term effects of the interventions.

Implementation

This intervention was not planned for during the baseline and details about the specific design cannot be provided, since this wasn't the focus of the evaluation. Therefore, no judgement can be made on whether this intervention was implemented as designed. However, it can be said that the Review Meet at NEEDS took place on October 10, 2014.

Reaching objectives

The focus of this evaluation has been the role of the MFS II funded capacity development interventions in the key organisational capacity changes that were identified. The NEEDS visit came up in the map and narrative on the organisational capacity change: improved capacity for Sexual and Reproductive Health and Rights (SRHR) Advocacy at state level. This visit led to sharing with alliance partners which resulted in improved SRHR skills and knowledge.

Though not the focus of this evaluation, we can conclude to some extent whether the expected immediate and long-term objectives of this intervention as formulated during the endline have been

achieved. The objective of this meet was mainly to share experiences. NEEDS showed their community approach in SRHR and innovations through mobiles phones for SRHR. This visit helped BVHA in better programme implementation. During the meeting SRHR issues for advocacy were identified and programme strengths of NEEDS that could be used by BVHA for their programme implementation were identified. To some extent these aims have thus been reached.

Exchange visit to SRHR YFS/ARSHC of VHAI

Design

This specific intervention was not planned for during the baseline by the CFA. Details about the specific design cannot be provided, since this wasn't the focus of the evaluation. From a report of the visit it can be concluded that the objective was to use the learning from the Youth Friendly Service/Adolescent Reproductive and Sexual Health clinic (YFS/ARSHC) visit to replicate it in developing ARSHCs in the government system as well as bringing about improvement in the quality of the clinic. These were the only objectives that were formulated.

These objectives do not seem to be directly relevant for BVHA, but they could learn from how such a clinic is run and see if some of this can be applied in their SRHR work with youth.

These expected effects were not formulated in a SMART way (specific, measurable, achievable, relevant and time-bound). Then again, the evaluation team did not ask the CFA for SMART objectives specifically, but rather asked about the expected or observed immediate and long term effects of the interventions.

Implementation

This intervention was not planned for during the baseline and details about the specific design cannot be provided, since this wasn't the focus of the evaluation. Therefore, no judgement can be made on whether this intervention was implemented as designed. However, it can be said that the visit to the clinic took place on 19 December 2012 and that the Executive Director of BVHA went on this visit.

Reaching objectives

The focus of this evaluation has been the role of the MFS II funded capacity development interventions in the key organisational capacity changes that were identified. The exchange visit came up in the map and narrative on the organisational capacity change: improved capacity for Sexual and Reproductive Health and Rights (SRHR) Advocacy at state level. This visit led to sharing with alliance partners which resulted in improved SRHR skills and knowledge.

Though not the focus of this evaluation and there is no information available on whether these specific objectives were reached, we cannot conclude whether the objectives of this visit, as formulated during the endline, have been achieved. From a report of the visit it can be concluded that the executive director of BVHA obtained a basic understanding of health problems, counselling techniques, how to run such a clinic, how to convince the government to take up such an initiative and how to link with projects at the community level.

Regional meeting Indonesia, focus on SRHR-CSE delivery (Indonesia team, alliance office)

Design

This specific intervention was not planned for during the baseline by the CFA. Details about the specific design cannot be provided, since this wasn't the focus of the evaluation. The objective of going to this meeting has been formulated by Simavi during the endline. The objective of this meeting was to see how their alliance partners worked with authorities on creating an enabling environment for CSE activities.

Within the SRHR project this objective became relevant for BVHA but it is only indirectly related to one of the goals that they formulated during the baseline which was to strengthen their networks with partners in health for sharing information.

These expected effects were not formulated in a SMART way (specific, measurable, achievable, relevant and time-bound). Then again, the evaluation team did not ask the CFA for SMART objectives specifically, but rather asked about the expected or observed immediate and long term effects of the interventions.

Implementation

This intervention was not planned for during the baseline and details about the specific design cannot be provided, since this wasn't the focus of the evaluation. Therefore, no judgement can be made on whether this intervention was implemented as designed. However, it can be said that the Executive Director and programme manager went to this meeting in November 2013.

Reaching objectives

The focus of this evaluation has been the role of the MFS II funded capacity development interventions in the key organisational capacity changes that were identified. The Regional meeting Indonesia came up in the map and narrative on the organisational capacity change: improved capacity for Sexual and Reproductive Health and Rights (SRHR) Advocacy at state level. This visit led to sharing with alliance partners which resulted in improved SRHR skills and knowledge and improved knowledge on SRHR lobby and advocacy.

Though not the focus of this evaluation, we can say something about to what extent the objective, as formulated by Simavi during the endline, of this meeting has been achieved. The objective was "to see how their alliance partners worked with authorities on creating an enabling environment for CSE activities." This objective seems to have been achieved to a certain extent, as the group presentations on the strategies and activities on CSE enabled the Executive Director to get knowledge on CSE and update it in Bihar.

Attribution of observed results to MFS II capacity development interventions

BVHA has improved its capacity for SRHR Advocacy at State Level because of increased competence to deliver SRHR services and because of increased ability to lobby for improvement of policies (see also section 4.3.2). MFS II funded capacity development interventions have played a significant role in both of these changes.

Improved competence to deliver SRHR services was due to improved SRHR skills and knowledge which can partly be attributed to MFS II funded interventions and partly to trainings and meetings funded by other donors and state government. BVHA staff improved their skills and knowledge on SRHR first of all because of sharing with alliance partners. This part can be completely attributed to MFS II funded interventions. Sharing with SRHR alliance partners took place during exposure and exchange visits, that is the Review Meet at NEEDS and the exposure visit to YFS/ASRHC of VHAI, which are described above (both MFS II funded). Sharing with alliance partners also took place during joint MFS II funded training on CSE and SRHR. These trainings have been further specified above.

Secondly, BVHA staff improved their skills and knowledge on SRHR because of trainings and meetings organised and funded by other donors and the state government. This includes seminars and trainings organised by the state government of Bihar and a meeting on repositioning of family planning, organised and funded by the Population Foundation of India, where BVHA staff learned about improving quality of family planning and reproductive health care, preventing sex selection etc. As the sharing with SRHR alliance partners took place on many occasions and during many trainings and visits that seem to have had an important effect on improving the skills of BVHA staff (especially of those involved in the SRHR project), and the trainings by others where less frequent and important, most of the improvement in BVHA's improved competence to deliver SRHR services can be attributed to MFS II funded capacity development interventions.

Improved ability to lobby for improvement of policies was due to improved knowledge on SRHR lobby and advocacy and improved networking. BVHA improved its knowledge on SRHR lobby and advocacy mainly because of the joint MFS II funded trainings on CSE and SRHR for the alliance partners. These trainings partly overlapped with the activities that were discussed under the MFS II interventions on strengthening advocacy capacity. For example a session and discussion on what is advocacy by VHAI was held during the training SRHR with different speakers and topics on 18-20 April 2012. BVHA's knowledge on this topic also increased because of two trainings by other funders. A workshop on WASH was organised by Wada Na Todo Abhiyan on the 12th of December 2012, where staff developed effective and communicative tools for awareness building and reached a common understanding to

create a civil society force for advocacy with government on various issues including nutrition for pregnant and lactating women. The second workshop was organised and funded by Action Aid on the 26th of December. This meeting enabled BVHA staff to organise a meeting with the Minister of Health in January 2013 to discuss among other things infant and maternal mortality rates and sex selective abortion. This improved knowledge on advocacy and lobbying on SRHR can therefore partly be attributed to MFS II supported capacity development interventions. It seems like both the trainings by other funders and the MFS II supported interventions have been of equal importance to improving BVHA's knowledge on SRHR advocacy and lobbying. BVHA's improved networking can be partly attributed to BVHA's involvement in the MFS II funded SRHR project and partly to the trainings funded by other funders and government. Through BVHA's involvement in the SRHR project, they became part of the SRHR alliance, which connected them to many new partners. Also through this project BVHA formed a state level SRHR forum under the chairmanship of the government of Bihar and many other agencies. On the other hand, trainings funded and organised by government departments and the Population Foundation for India, Wada Na todo Abhiyan and Action Aid, also allowed BVHA staff to improve on their networking. Although it is not directly an MFS II intervention, BVHA involvement in the MFS II funded SRHR project has had a slightly more important role on improving their networks than the trainings funded by other funders and government.

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PPT Advocacy Workshop India Day 1-Day3.pdf
SIMAVI - Agreement.pdf
2013-02-19_CINI-SRHR secretariate (f).xls
Financial Report April- Dec 2012 - SRHR project BVHA.xls

Financial Report Jan 13 to Dec 13 - BVHA SRHR Project.xls
2014-01-09_2014-2015 SRHR Project Budget (BVHA-f).xlsx
2014-06-12_overview training activities.xlsx
20111230 RWPF BVHA Budget - SRHR 2012 -2014.xlsx
Facility wise Services outcomes- Raxaul& Maujuli.xlsx
MIS - Advocacy Officer.xlsx
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CINI presentation advocacy Key steps for strategy formulation.ppt
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2013 6m CINI Advocacy Report.doc
2013-Dec, Revised MP 2014-15 (BVHA).doc
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9jan2012_Minute of India Workshop 21-24 November 2011.docx
19Jan12_Final Application Form (BVHA) Simavi-UFBR alliance.docx
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2014-02-22_Vs 2_Interactions with CSO and others.docx
2014-03-03_v3 BVHA SRHR Annual Report 2013.docx
2014-04-01_(f1) LINKING OUTPUTS TO OUTCOMES India.docx
2014-04-04_RA1-CSS (f1) India country paragraph.docx
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Annual Progress Project BVHA - SRHR Project 2012.docx
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Assessment of involvement of community leaders - Report.docx
attachment 2 UFBR PT Regional Learning Forum Indonesia Update PT.docx
Facility wise improvement Services - Outcome (Raxaul Majhulia) Dec 2013 (2).docx
India SRHR Alliance Advocacy Plan.docx
Interactions_with_CSO_and_others-22_2_2014%5b1%5d.docx
ME Overview India.docx
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No Picture Report from the Regional Learning Forum Indonesia (October 2013) draft.docx
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Project Proposal - SRHR - BVHA 2012-14.docx
Report - FinManagement.docx
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SRHR module -for translation.docx
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ToR Regional Learning Forum draft 3_to NPCs.docx
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2012-07-30 WU Contract_signed scan copy (1).pdf
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SRHR module -for translation.docx
training overview Simavi 12-06-2014.docx
CINI presentation advocacy Key steps for strategy formulation.ppt
2013 6m CINI Advocacy Report.doc
2014-06-12_overview training activities.xlsx

attachment 2 UFBR PT Regional Learning Forum Indonesia Update PT.docx
capacity support from contract 2012-2014.docx
8 th standard - manual Restless Development for training partners.docx
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CSE Refresher Training Report.pdf
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2014-03-03_v3 BVHA SRHR Annual Report 2013.docx
Letter of ED SHS Bihar for SRHR Project.jpg
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2014-02-20_Rev_Loan Agenda Delhi feb14.pdf

Fieldwork data:

Annex C_5C endline_support to capacity development sheet_BVHA.docx
5c endline interview guide_2nd partners_selected indicators_BVHA.docx
5c endline interview guide_OD consultants_selected indicators_BVHA_Dr. JM Dewan.docx
5c endline interview guide_partners_selected indicators_BVHA.docx
5c endline interview guide_OD consultants_selected indicators_(BVHA-Jose T).docx
5c endline self-assessment sheet_management_India_BVHA.docx
5c endline self-assessment sheet_programme staff_India_BVHA.docx
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5c endline_questionnaire_training_participant_perspective_India_BVHA_Workshop_5day CSE training
June 25-29_Ram Krishna.docx
5c endline_questionnaire_training_participant_perspective_India_orientation for the CSO
staff_Birendra &Kush.docx
5c endline_questionnaire_training_participant_perspective_India_Workshop joint advocacy and state
level visit (CINI) Dec 2013__nameparticipant.docx
5c endline_questionnaire_training_management_perspective_India_BVHA_Exposure visit Adolescent
RSH clinic dec 2012_Swapn Mazumder.docx
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2012_Malay Kumar.docx
5c endline_questionnaire_training_participant_perspective_India_BVHA_Exposure visit Adolescent
RSH clinic dec 2012_Swapn Mazumder.docx
5c endline_questionnaire_training_participant_perspective_India_BVHA_Exposure visit to
Indonesia_Malay Kumar.docx
5c endline_overview_trainings_BVHA_staff_India.docx
Annex K_5c endline workshop_key changes and factors_SPO perspective_country_name BVHA.docx
ATTENDANCE SHEET for BVHA 18-20 JUNE Workshop.docx
5c endline observation sheet - observations by in-country evaluators during the endline capacity
assessment at the SPO_BVHA.docx
5c endline_observable indicators at SPO_India_BVHA.docx

(LL2)5c_endline_assessment_sheet_India_BVHA_Simavi_NB.docx

2014-05-07_(LL2)

5C_endline_support_to_capacity_development_sheet_CFA_perspective_India_BVHA_Simavi_NB
(2).docx

List of Respondents

BVHA staff:

NAME	DESIGNATION	18 th June	19 th June	20 th June
Swapan Mazumdar	Executive Director	Present	Present	Present
Sashi Kumar	Project Manager	Present	Present	Present
Malay Kumar Dalal	Project manager (Sexual reproductive health rights)	Present	Present	Present
Binay Fidelis	Program officer	Present	Present	Present
Khurshid Ekram	Program officer	Present	Present	Present
Mrs. Benedicta Crasta	Personal Assistant to the Executive Director cum Admin Assistant	Present	Present	Present
Sadab Qureshi	Assistant Accountant	Busy with annual audit	Present	Present
Urmila Sharma	St Annes Dispensary Phulwarisharif	Not Selected for Process Tracing	Not Selected for Process Tracing	Not Selected for Process Tracing
Ramkrishna	AAAK Vaishali	Present	Not Selected for Process Tracing	Not Selected for Process Tracing

Partners:

Ramkrishna from Aulia Adhyatmik Anusadhan Kendra(AAAK),Vaishali. Interviewed on June 18, 2104.

Sister Ellis, Fakirana Sisters Socceity, Bettiah, West Champaran. Interviewed on June 19, 2014.

OD consultants:

Jose Thomas, National Programme Co-ordinator SRHR Alliance India. Interviewed on June 20, 2014.

Dr JM Dewan, Senior Professor and Former director at SIHFW, Chairman of the State level SRHR Forum. Interviewed on June 20, 2014.

CFA:

Loan Liem, Sr Programme Officer/ interim SRHR team manager at Simavi. Interviewed on April 3, 2014.

Appendix 1 Methodological approach & reflection

Introduction

This appendix describes the methodological design and challenges for the assessment of capacity development of Southern Partner Organisations (SPOs), also called the '5C study'. This 5C study is organised around four key evaluation questions:

1. What are the changes in partner organisations' capacity during the 2012-2014 period?
2. To what degree are the changes identified in partner capacity attributable to development interventions undertaken by the MFS II consortia (i.e. measuring effectiveness)?
3. Were the efforts of the MFS II consortia efficient?
4. What factors explain the findings drawn from the questions above?

It has been agreed that the question (3) around efficiency cannot be addressed for this 5C study. The methodological approach for the other three questions is described below. At the end, a methodological reflection is provided.

In terms of the attribution question (2), 'process tracing' is used. This is a theory-based approach that has been applied to a selected number of SPOs since it is a very intensive and costly methodology, although it provides rich information and can generate a lot of learning within the organisations. This approach was presented and agreed-upon during the synthesis workshop on 17-18 June 2013 by the 5C teams for the eight countries of the MFS II evaluation. A more detailed description of the approach was presented during the synthesis workshop in February 2014. The synthesis team, NWO-WOTRO, the country project leaders and the MFS II organisations present at the workshop have accepted this approach. It was agreed that this approach can only be used for a selected number of SPOs since it is a very intensive and costly methodology. Key organisational capacity changes/ outcomes of the SPO were identified, based on their relationship to the two selected capabilities, the capability to act and commit the capability to adapt and self-renew, and an expected relationship with CFA supported capacity development interventions (MFS II funding). It was agreed to focus on these two capabilities, since these are the most targeted capabilities by the CFAs, as established during the baseline process.

Please find below an explanation of how the above-mentioned evaluation questions have been addressed in the 5C evaluation.

Note: the methodological approach is applied to 4 countries that the Centre for Development Innovation, Wageningen University and Research centre is involved in in terms of the 5C study (Ethiopia, India, Indonesia, Liberia). The overall approach has been agreed with all the 8 countries selected for this MFS II evaluation. The 5C country teams have been trained and coached on this methodological approach during the evaluation process. Details specific to the SPO are described in chapter 5.1 of the SPO report. At the end of this appendix a brief methodological reflection is provided.

Changes in partner organisation's capacity – evaluation question 1

This section describes the data collection and analysis methodology for answering the first evaluation question: **What are the changes in partner organisations' capacity during the 2012-2014 period?**

This question was mainly addressed by reviewing changes in 5c indicators, but additionally a 'general causal map' based on the SPO perspective on key organisational capacity changes since the baseline

has been developed. Each of these is further explained below. The development of the general causal map is integrated in the steps for the endline workshop, as mentioned below.

During the baseline in 2012 information has been collected on each of the 33 agreed upon indicators for organisational capacity. For each of the five capabilities of the 5C framework indicators have been developed as can be seen in Appendix 2. During this 5C baseline, a summary description has been provided for each of these indicators, based on document review and the information provided by staff, the Co-financing Agency (CFA) and other external stakeholders. Also a summary description has been provided for each capability. The results of these can be read in the baseline reports.

The description of indicators for the baseline in 2012 served as the basis for comparison during the endline in 2014. In practice this meant that largely the same categories of respondents (preferably the same respondents as during the baseline) were requested to review the descriptions per indicator and indicate whether and how the endline situation (2014) is different from the described situation in 2012.⁹ Per indicator they could indicate whether there was an improvement or deterioration or no change and also describe these changes. Furthermore, per indicator the interviewee could indicate what interventions, actors and other factors explain this change compared to the baseline situation. See below the specific questions that are asked for each of the indicators. Per category of interviewees there is a different list of indicators to be looked at. For example, staff members were presented with a list of all the indicators, whilst external people, for example partners, are presented with a select number of indicators, relevant to the stakeholder.

The information on the indicators was collected in different ways:

1. **Endline workshop at the SPO - self-assessment and 'general causal map'**: similar to data collection during the baseline, different categories of staff (as much as possible the same people as during the baseline) were brought together in a workshop and requested to respond, in their staff category, to the list of questions for each of the indicators (self-assessment sheet). Prior to carrying out the self-assessments, a brainstorming sessions was facilitated to develop a 'general causal map', based on the key organisational capacity changes since the baseline as perceived by SPO staff. Whilst this general causal map is not validated with additional information, it provides a sequential narrative, based on organisational capacity changes as perceived by SPO staff;
2. **Interviews with staff members**: additional to the endline workshop, interviews were held with SPO staff, either to provide more in-depth information on the information provided on the self-assessment formats during the workshop, or as a separate interview for staff members that were not present during the endline workshop;
3. **Interviews with externals**: different formats were developed for different types of external respondents, especially the co-financing agency (CFA), but also partner agencies, and organisational development consultants where possible. These externals were interviewed, either face-to-face or by phone/Skype. The interview sheets were sent to the respondents and if they wanted, these could be filled in digitally and followed up on during the interview;
4. **Document review**: similar to the baseline in 2012, relevant documents were reviewed so as to get information on each indicator. Documents to be reviewed included progress reports, evaluation reports, training reports, etc. (see below) since the baseline in 2012, so as to identify changes in each of the indicators;
5. **Observation**: similar to what was done in 2012, also in 2014 the evaluation team had a list with observable indicators which were to be used for observation during the visit to the SPO.

⁹ The same categories were used as during the baseline (except beneficiaries, other funders): staff categories including management, programme staff, project staff, monitoring and evaluation staff, field staff, administration staff; stakeholder categories including co-financing agency (CFA), consultants, partners.

Below the key steps to assess changes in indicators are described.

Key steps to assess changes in indicators are described

1. Provide the description of indicators in the relevant formats – CDI team
2. Review the descriptions per indicator – in-country team & CDI team
3. Send the formats adapted to the SPO to CFA and SPO – in-country team (formats for SPO) and CDI team (formats for CFA)
4. Collect, upload & code the documents from CFA and SPO in NVivo – CDI team
5. Organise the field visit to the SPO – in-country team
6. Interview the CFA – CDI team
7. Run the endline workshop with the SPO – in-country team
8. Interview SPO staff – in-country team
9. Fill-in observation sheets – in-country team
10. Interview externals – in-country team
11. Upload and auto-code all the formats collected by in-country team and CDI team in NVivo – CDI team
12. Provide to the overview of information per 5c indicator to in-country team – CDI team
13. Analyse data and develop a draft description of the findings per indicator and for the general questions – in-country team
14. Analyse data and develop a final description of the findings per indicator and per capability and for the general questions – CDI team
15. Analyse the information in the general causal map –in-country team and CDI-team

Note: the CDI team include the Dutch 5c country coordinator as well as the overall 5c coordinator for the four countries (Ethiopia, India, Indonesia, Liberia). The 5c country report is based on the separate SPO reports.

Below each of these steps is further explained.

*Step 1. Provide the **description of indicators** in the relevant formats – CDI team*

- These formats were to be used when collecting data from SPO staff, CFA, partners, and consultants. For each of these respondents different formats have been developed, based on the list of 5C indicators, similar to the procedure that was used during the baseline assessment. The CDI team needed to add the 2012 baseline description of each indicator. The idea was that each respondent would be requested to review each description per indicator, and indicate whether the current situation is different from the baseline situation, how this situation has changed, and what the reasons for the changes in indicators are. At the end of each format, a more general question is added that addresses how the organisation has changed its capacity since the baseline, and what possible reasons for change exist. Please see below the questions asked for each indicator as well as the more general questions at the end of the list of indicators.

General questions about key changes in the capacity of the SPO

What do you consider to be the key changes in terms of how the organisation/ SPO has developed its capacity since the baseline (2012)?

What do you consider to be the main explanatory reasons (interventions, actors or factors) for these changes?

List of questions to be asked for each of the 5C indicators (The entry point is the the description of each indicator as in the 2012 baseline report):

1. *How has the situation of this indicator changed compared to the situation during the baseline in 2012? Please tick one of the following scores:*
 - -2 = Considerable deterioration
 - -1 = A slight deterioration
 - 0 = No change occurred, the situation is the same as in 2012
 - +1 = Slight improvement
 - +2 = Considerable improvement
2. *Please describe what exactly has changed since the baseline in 2012*

3. *What interventions, actors and other factors explain this change compared to the baseline situation in 2012? Please tick and describe what interventions, actors or factors influenced this indicator, and how. You can tick and describe more than one choice.*
- Intervention, actor or factor at the level of or by **SPO**:
 - Intervention, actor or factor at the level of or by the **Dutch CFA (MFS II funding)**:
 - Intervention, actor or factor at the level of or by the **other funders**:
 - **Other** interventions, actors or factors:
 - Don't know.

Step 2. Review the descriptions per indicator – in-country team & CDI team

Before the in-country team and the CDI team started collecting data in the field, it was important that they reviewed the description for each indicator as described in the baseline reports, and also added to the endline formats for review by respondents. These descriptions are based on document review, observation, interviews with SPO staff, CFA staff and external respondents during the baseline. It was important to explain this to respondents before they filled in the formats.

Step 3. Send the formats adapted to the SPO to CFA and SPO – in-country team (formats for SPO) and CDI team (formats for CFA)

The CDI team was responsible for collecting data from the CFA:

- 5C Endline assessment Dutch co-financing organisation;
- 5C Endline support to capacity sheet – CFA perspective.

The in-country team was responsible for collecting data from the SPO and from external respondents (except CFA). The following formats were sent before the fieldwork started:

- 5C Endline support to capacity sheet – SPO perspective.
- 5C Endline interview guides for externals: partners; OD consultants.

Step 4. Collect, upload & code the documents from CFA and SPO in NVivo – CDI team

The CDI team, in collaboration with the in-country team, collected the following documents from SPOs and CFAs:

- Project documents: project proposal, budget, contract (Note that for some SPOs there is a contract for the full MFS II period 2011-2015; for others there is a yearly or 2-yearly contract. All new contracts since the baseline in 2012 will need to be collected);
- Technical and financial progress reports since the baseline in 2012;.
- Mid-term evaluation reports;
- End of project-evaluation reports (by the SPO itself or by external evaluators);
- Contract intake forms (assessments of the SPO by the CFA) or organisational assessment scans made by the CFA that cover the 2011-2014 period;
- Consultant reports on specific inputs provided to the SPO in terms of organisational capacity development;
- Training reports (for the SPO; for alliance partners, including the SPO);
- Organisational scans/ assessments, carried out by the CFA or by the Alliance Assessments;
- Monitoring protocol reports, especially for the 5C study carried out by the MFS II Alliances;
- Annual progress reports of the CFA and of the Alliance in relation to capacity development of the SPOs in the particular country;
- Specific reports that are related to capacity development of SPOs in a particular country.

The following documents (since the baseline in 2012) were requested from SPO:

- Annual progress reports;
- Annual financial reports and audit reports;
- Organisational structure vision and mission since the baseline in 2012;
- Strategic plans;

- Business plans;
- Project/ programme planning documents;
- Annual work plan and budgets;
- Operational manuals;
- Organisational and policy documents: finance, human resource development, etc.;
- Monitoring and evaluation strategy and implementation plans;
- Evaluation reports;
- Staff training reports;
- Organisational capacity reports from development consultants.

The CDI team will code these documents in NVivo (qualitative data analysis software program) against the 5C indicators.

Step 5. Prepare and organise the field visit to the SPO – in-country team

Meanwhile the in-country team prepared and organised the logistics for the field visit to the SPO:

- **General endline workshop** consisted about one day for the self-assessments (about ½ to ¾ of the day) and brainstorm (about 1 to 2 hours) on key organisational capacity changes since the baseline and underlying interventions, factors and actors ('general causal map'), see also explanation below. This was done with the five categories of key staff: managers; project/ programme staff; monitoring and evaluation staff; admin & HRM staff; field staff. Note: for SPOs involved in process tracing an additional 1 to 1½ day workshop (managers; program/project staff; monitoring and evaluation staff) was necessary. See also step 7;
- **Interviews with SPO staff** (roughly one day);
- **Interviews with external respondents** such as partners and organisational development consultants depending on their proximity to the SPO. These interviews could be scheduled after the endline workshop and interviews with SPO staff.

General causal map

During the 5C endline process, a 'general causal map' has been developed, based on key organisational capacity changes and underlying causes for these changes, as perceived by the SPO. The general causal map describes cause-effect relationships, and is described both as a visual as well as a narrative.

As much as possible the same people that were involved in the baseline were also involved in the endline workshop and interviews.

Step 6. Interview the CFA – CDI team

The CDI team was responsible for sending the sheets/ formats to the CFA and for doing a follow-up interview on the basis of the information provided so as to clarify or deepen the information provided. This relates to:

- 5C Endline assessment Dutch co-financing organisation;
- 5C Endline support to capacity sheet - CFA perspective.

Step 7. Run the endline workshop with the SPO – in-country team

This included running the endline workshop, including facilitation of the development of the general causal map, self-assessments, interviews and observations. Particularly for those SPOs that were selected for process tracing all the relevant information needed to be analysed prior to the field visit, so as to develop an initial causal map. Please see Step 6 and also the next section on process tracing (evaluation question two).

An endline workshop with the SPO was intended to:

- Explain the purpose of the fieldwork;
- Carry out in the self-assessments by SPO staff subgroups (unless these have already been filled prior to the field visits) - this may take some 3 hours.
- Facilitate a brainstorm on key organisational capacity changes since the baseline in 2012 and underlying interventions, factors and actors.

Purpose of the fieldwork: to collect data that help to provide information on what changes took place in terms of organisational capacity development of the SPO as well as reasons for these changes. The baseline that was carried out in 2012 was to be used as a point of reference.

Brainstorm on key organisational capacity changes and influencing factors: a brainstorm was facilitated on key organisational capacity changes since the baseline in 2012. In order to kick start the discussion, staff were reminded of the key findings related to the historical time line carried out in the baseline (vision, mission, strategies, funding, staff). This was then used to generate a discussion on key changes that happened in the organisation since the baseline (on cards). Then cards were selected that were related to organisational capacity changes, and organised. Then a 'general causal map' was developed, based on these key organisational capacity changes and underlying reasons for change as experienced by the SPO staff. This was documented as a visual and narrative. This general causal map was to get the story of the SPO on what they perceived as key organisational capacity changes in the organisation since the baseline, in addition to the specific details provided per indicator.

Self-assessments: respondents worked in the respective staff function groups: management; programme/ project staff; monitoring and evaluation staff; admin and HRM staff; field staff. Staff were assisted where necessary so that they could really understand what it was they were being asked to do as well as what the descriptions under each indicator meant.

Note: for those SPOs selected for process tracing an additional endline workshop was held to facilitate the development of detailed causal maps for each of the identified organisational change/ outcome areas that fall under the capability to act and commit, and under the capability to adapt and self-renew, and that are likely related to capacity development interventions by the CFA. See also the next section on process tracing (evaluation question two). It was up to the in-country team whether this workshop was held straight after the initial endline workshop or after the workshop and the follow-up interviews. It could also be held as a separate workshop at another time.

Step 8. Interview SPO staff – in-country team

After the endline workshop (developing the general causal map and carrying out self-assessments in subgroups), interviews were held with SPO staff (subgroups) to follow up on the information that was provided in the self-assessment sheets, and to interview staff that had not yet provided any information.

Step 9. Fill-in observation sheets – in-country team

During the visit at the SPO, the in-country team had to fill in two sheets based on their observation:

- 5C Endline observation sheet;
- 5C Endline observable indicators.

Step 10. Interview externals – in-country team & CDI team

The in-country team also needed to interview the partners of the SPO as well as organisational capacity development consultants that have provided support to the SPO. The CDI team interviewed the CFA.

Step 11. Upload and auto-code all the formats collected by in-country team and CDI team – CDI team

The CDI team was responsible for uploading and auto-coding (in Nvivo) of the documents that were collected by the in-country team and by the CDI team.

*Step 12. Provide the **overview of information** per 5C indicator to in-country team – CDI team*

After the analysis in NVivo, the CDI team provided a copy of all the information generated per indicator to the in-country team for initial analysis.

*Step 13. **Analyse the data and develop a draft description** of the findings per indicator and for the general questions – in-country team*

The in-country team provided a draft description of the findings per indicator, based on the information generated per indicator. The information generated under the general questions were linked to the general causal map or detailed process tracing related causal map.

*Step 14. **Analyse the data and finalize the description** of the findings per indicator, per capability and general – CDI team*

The CDI team was responsible for checking the analysis by the in-country team with the Nvivo generated data and to make suggestions for improvement and ask questions for clarification to which the in-country team responded. The CDI team then finalised the analysis and provided final descriptions and scores per indicator and also summarize these per capability and calculated the summary capability scores based on the average of all indicators by capability.

*Step 15. **Analyse the information** in the general causal map –in-country team & CDI team*

The general causal map based on key organisational capacity changes as perceived by the SPO staff present at the workshop, was further detailed by in-country team and CDI team, and based on the notes made during the workshop and where necessary additional follow up with the SPO. The visual and narrative was finalized after feedback by the SPO. During analysis of the general causal map relationships with MFS II support for capacity development and other factors and actors were identified. All the information has been reviewed by the SPO and CFA.

Attributing changes in partner organisation's capacity – evaluation question 2

This section describes the data collection and analysis methodology for answering the second evaluation question: **To what degree are the changes identified in partner capacity attributable to (capacity) development interventions undertaken by the MFS II consortia (i.e. measuring effectiveness)?**

In terms of the attribution question (2), 'process tracing' is used. This is a theory-based approach that has been applied to a selected number of SPOs since it is a very intensive and costly methodology, although it provides rich information and can generate a lot of learning within the organisations. Key organisational capacity changes/ outcomes of the SPO were identified, based on their relationship to the two selected capabilities, the capability to act and commit the capability to adapt and self-renew, and an expected relationship with CFA supported capacity development interventions (MFS II funding). It was agreed to focus on these two capabilities, since these are the most targeted capabilities by the CFAs, as established during the baseline process. The box below provides some background information on process tracing.

Background information on process tracing

The essence of process tracing research is that scholars want to go beyond merely identifying correlations between independent variables (Xs) and outcomes (Ys). Process tracing in social science is commonly defined by its addition to trace causal mechanisms (Bennett, 2008a, 2008b; Checkle, 2008; George & Bennett, 2005). A causal mechanism can be defined as "a complex system which produces an outcome by the interaction of a number of parts" (Glennan, 1996, p. 52). Process tracing involves "attempts to identify the intervening causal process – the causal chain and causal mechanism – between an independent variable (or variables) and the outcome of the dependent variable" (George & Bennett, 2005, pp. 206-207).

Process tracing can be differentiated into three variants within social science: theory testing, theory building, and explaining outcome process tracing (Beach & Pedersen, 2013).

Theory testing process tracing uses a theory from the existing literature and then tests whether evidence shows that each part of hypothesised causal mechanism is present in a given case, enabling within case inferences about whether the mechanism functioned as expected in the case and whether the mechanism as a whole was present. No claims can be made however, about whether the mechanism was the only cause of the outcome.

Theory building process tracing seeks to build generalizable theoretical explanations from empirical evidence, inferring that a more general causal mechanism exists from the fact of a particular case.

Finally, explaining outcome process tracing attempts to craft a minimally sufficient explanation of a puzzling outcome in a specific historical case. Here the aim is not to build or test more general theories but to craft a (minimally) sufficient explanation of the outcome of the case where the ambitions are more case centric than theory oriented.

Explaining outcome process tracing is the most suitable type of process tracing for analysing the causal mechanisms for selected key organisational capacity changes of the SPOs. This type of process tracing can be thought of as a single outcome study defined as seeking the causes of the specific outcome in a single case (Gerring, 2006; in: Beach & Pedersen, 2013). Here the ambition is to craft a minimally sufficient explanation of a particular outcome, with sufficiency defined as an explanation that accounts for all of the important aspects of an outcome with no redundant parts being present (Mackie, 1965).

Explaining outcome process tracing is an iterative research strategy that aims to trace the complex conglomerate of systematic and case specific causal mechanisms that produced the outcome in question. The explanation cannot be detached from the particular case. Explaining outcome process tracing refers to case studies whose primary ambition is to explain particular historical outcomes, although the findings of the case can also speak to other potential cases of the phenomenon. Explaining outcome process tracing is an iterative research process in which 'theories' are tested to see whether they can provide a minimally sufficient explanation of the outcome. Minimal sufficiency is defined as an explanation that accounts for an outcome, with no redundant parts. In most explaining outcome studies, existing theorisation cannot provide a sufficient explanation, resulting in a second stage in which existing theories are re-conceptualised in light of the evidence gathered in the preceding empirical analysis. The conceptualisation phase in explaining outcome process tracing is therefore an iterative research process, with initial mechanisms re-conceptualised and tested until the result is a theorised mechanism that provides a minimally sufficient explanation of the particular outcome.

Below a description is provided of how SPOs are selected for process tracing, and a description is provided on how this process tracing is to be carried out. Note that this description of process tracing provides not only information on the extent to which the changes in organisational development can be attributed to MFS II (evaluation question 2), but also provides information on other contributing factors and actors (evaluation question 4). Furthermore, it must be noted that the evaluation team has developed an adapted form of 'explaining outcome process tracing', since the data collection and analysis was an iterative process of research so as to establish the most realistic explanation for a particular outcome/ organisational capacity change. Below selection of SPOs for process tracing as well as the different steps involved for process tracing in the selected SPOs, are further explained.

Selection of SPOs for 5C process tracing

Process tracing is a very intensive methodology that is very time and resource consuming (for development and analysis of one final detailed causal map, it takes about 1-2 weeks in total, for different members of the evaluation team). It has been agreed upon during the synthesis workshop on 17-18 June 2013 that only a selected number of SPOs will take part in this process tracing for the purpose of understanding the attribution question. The selection of SPOs is based on the following criteria:

- MFS II support to the SPO has not ended before 2014 (since this would leave us with too small a time difference between intervention and outcome);
- Focus is on the 1-2 capabilities that are targeted most by CFAs in a particular country;
- Both the SPO and the CFA are targeting the same capability, and preferably aim for similar outcomes;
- Maximum one SPO per CFA per country will be included in the process tracing.

The intention was to focus on about 30-50% of the SPOs involved. Please see the tables below for a selection of SPOs per country. Per country, a first table shows the extent to which a CFA targets the five capabilities, which is used to select the capabilities to focus on. A second table presents which SPO is selected, and takes into consideration the selection criteria as mentioned above.

ETHIOPIA

For Ethiopia the capabilities that are mostly targeted by CFAs are the capability to act and commit and the capability to adapt and self-renew. See also the table below.

Table 1

The extent to which the Dutch NGO explicitly targets the following capabilities – Ethiopia

Capability to:	AMREF	CARE	ECFA	FSCE	HOA- REC	HUND EE	NVEA	OSRA	TTCA
Act and commit	5	4	5	5	5	3	4	4	3
Deliver on development objectives	2	1	1	1	2	1	1	2	1
Adapt and self-renew	4	2	3	4	2	5	3	3	3
Relate	3	1	2	2	3	2	1	3	1
Achieve coherence	2	2	1	1	1	1	1	1	1

Note: Number 1 stands for not targeted, 5 for intensively targeted. These scores are relative scores for the interventions by the CFA to strengthen the capacity of the SPO. The scores are relative to each other, a higher score means that this capability gets more attention by the CFA compared to other capabilities.

Source: country baseline report, Ethiopia.

Below you can see the table describing when the contract with the SPO is to be ended, and whether both SPO and the CFA expect to focus on these two selected capabilities (with MFS II funding). Based on the above-mentioned selection criteria the following SPOs are selected for process tracing: AMREF, ECFA, FSCE, HUNDEE. In fact, six SPOs would be suitable for process tracing. We just selected the first one per CFA following the criteria of not including more than one SPO per CFA for process tracing

Table 2

SPOs selected for process tracing – Ethiopia

Ethiopia – SPOs	End of contract	Focus on capability to act and commit – by SPO	Focus on capability to act and commit – by CFA	Focus on capability to adapt and self-renew – by SPO	Focus on capability to adapt and self-renew – by CFA	CFA	Selected for process tracing
AMREF	Dec 2015	Yes	Yes	Yes	Yes	AMREF NL	Yes
CARE	Dec 31, 2015	Partly	Yes	Yes	Yes – slightly	CARE Netherlands	No - not fully matching
ECFA	Jan 2015	Yes	Yes	Yes	Yes	Child Helpline International	Yes
FSCE	Dec 2015	Yes	Yes	Yes	Yes	Stichting Kinderpostzegels Netherlands (SKN); Note: no info from Defence for Children – ECPAT Netherlands	Yes
HOA-REC	Sustainable Energy project (ICCO Alliance): 2014 Innovative WASH (WASH Alliance): Dec 2015	Yes	Yes	Yes	Yes - slightly	ICCO	No - not fully matching
HUNDEE	Dec 2014	Yes	Yes	Yes	Yes	ICCO & IICD	Yes
NVEA	Dec 2015 (both)	Yes	Yes	Yes	Yes	Edukans Foundation (under two consortia); Stichting Kinderpostzegels Netherlands (SKN)	Suitable but SKN already involved for process tracing FSCE
OSRA	C4C Alliance project (farmers marketing): December 2014 ICCO Alliance project (zero grazing: 2014 (2 nd phase)	Yes	Yes	Yes	Yes	ICCO & IICD	Suitable but ICCO & IICD already involved for process tracing - HUNDEE
TTCA	June 2015	Partly	Yes	No	Yes	Edukans Foundation	No - not fully matching

INDIA

For India the capability that is mostly targeted by CFAs is the capability to act and commit. The next one in line is the capability to adapt and self-renew. See also the table below in which a higher score means that the specific capability is more intensively targeted.

Table 3

The extent to which the Dutch NGO explicitly targets the following capabilities – India¹⁰

Capability to:	BVHA	COUNT	DRISTI	FFID	Jana Vikas	Samar thak Samiti	SMILE	SDS	VTRC
Act and commit	5	3	4	4	4	4	4	3	5
Deliver on development objectives	1	5	1	1	1	1	1	2	1
Adapt and self-renew	2	2	1	3	1	1	4	1	4
Relate	3	1	1	1	1	1	2	1	2
Achieve coherence	1	1	1	4	1	1	1	1	2

Note: Number 1 stands for not targeted, 5 for intensively targeted. These scores are relative scores for the interventions by the CFA to strengthen the capacity of the SPO. The scores are relative to each other, a higher score means that this capability gets more attention by the CFA compared to other capabilities.

Source: country baseline report, India.

Below you can see a table describing when the contract with the SPO is to be ended and whether SPO and the CFA both expect to focus on these two selected capabilities (with MFS II funding). Based on the above-mentioned selection criteria the following SPOs are selected for process tracing: BVHA, COUNT, FFID, SMILE and VTRC. Except for SMILE (capability to act and commit only), for the other SPOs the focus for process tracing can be on the capability to act and commit and on the capability to adapt and self-renew.

Table 4

SPOs selected for process tracing – India

India – SPOs	End of contract	Focus on capability to act and commit – by SPO	Focus on capability to act and commit – by CFA	Focus on capability to adapt and self-renew – by SPO	Focus on capability to adapt and self-renew – by CFA	CFA	Selected for process tracing
BVHA	2014	Yes	Yes	Yes	Yes	Simavi	Yes; both capabilities
COUNT	2015	Yes	Yes	Yes	Yes	Woorden Daad	Yes; both capabilities
DRISTI	31-03-2012	Yes	Yes	No	no	Hivos	No - closed in 2012
FFID	30-09-2014	Yes	Yes	Yes	Yes	ICCO	Yes

¹⁰ RGVN, NEDSF and Women's Rights Forum (WRF) could not be reached timely during the baseline due to security reasons. WRF could not be reached at all. Therefore these SPOs are not included in Table 1.

\	End of contract	Focus on capability to act and commit – by SPO	Focus on capability to act and commit – by CFA	Focus on capability to adapt and self-renew –by SPO	Focus on capability to adapt and self-renew – by CFA	CFA	Selected for process tracing
Jana Vikas	2013	Yes	Yes	Yes	No	Cordaid	No - contract is and the by now; not fully matching focus
NEDSF							No – delayed baseline
RGVN							No - delayed baseline
Samarthak Samiti (SDS)	2013 possibly longer	Yes	Yes	Yes	No	Hivos	No - not certain of end date and not fully matching focus
Shivi Development Society (SDS)	Dec 2013 intention 2014	Yes	Yes	Yes	No	Cordaid	No - not fully matching focus
Smile	2015	Yes	Yes	Yes	Yes	Wilde Ganzen	Yes; first capability only
VTRC	2015	Yes	Yes	Yes	Yes	Stichting Red een Kind	Yes; both capabilities

INDONESIA

For Indonesia the capabilities that are most frequently targeted by CFAs are the capability to act and commit and the capability to adapt and self-renew. See also the table below.

Table 5

The extent to which the Dutch NGO explicitly targets the following capabilities – Indonesia

Capability to:	ASB	Daya ikologi	ECPAT	GSS	Lem bage Kita	Pt. PPMA	Rifka Annisa	WIIP	Yad upa	Yayasan Kelola	YPI	YRBI
Act and commit	4	4	4	5	4	4	5	3	3	2	5	4
Deliver on development objectives	1	1	1	2	2	1	2	1	1	1	1	1
Adapt and self-renew	3	1	2	4	2	3	4	4	1	1	4	3
Relate	1	1	2	3	3	2	1	2	2	2	3	2
Achieve coherence	1	1	1	2	1	1	2	2	1	1	2	1

Note: Number 1 stands for not targeted, 5 for intensively targeted. These scores are relative scores for the interventions by the CFA to strengthen the capacity of the SPO. The scores are relative to each other, a higher score means that this capability gets more attention by the CFA compared to other capabilities.

Source: country baseline report, Indonesia.

The table below describes when the contract with the SPO is to be ended and whether both SPO and the CFA expect to focus on these two selected capabilities (MFS II funding). Based on the above-mentioned selection criteria the following SPOs are selected for process tracing: ASB, ECPAT, Pt.PPMA, YPI, YRBI.

Table 6

SPOs selected for process tracing – Indonesia

Indonesia – SPOs	End of contract	Focus on capability to act and commit – by SPO	Focus on capability to act and commit – by CFA	Focus on capability to adapt and self-renew – by SPO	Focus on capability to adapt and self-renew – by CFA	CFA	Selected for process tracing
ASB	February 2012; extension Feb,1, 2013 – June,30, 2016	Yes	Yes	Yes	Yes	Hivos	Yes
Dayakologi	2013; no extension	Yes	Yes	Yes	No	Cordaid	No: contract ended early and not matching enough
ECPAT	August 2013; Extension Dec 2014	Yes	Yes	Yes, a bit	Yes	Free Press Unlimited - Mensen met een Missie	Yes
GSS	31 December 2012; no extension	Yes	Yes	Yes, a bit	Yes	Free Press Unlimited - Mensen met een Missie	No: contract ended early
Lembaga Kita	31 December 2012; no extension	Yes	Yes	No	Yes	Free Press Unlimited - Mensen met een Missie	No - contract ended early
Pt.PPMA	May 2015	Yes	Yes	No	Yes	IUCN	Yes, capability to act and commit only
Rifka Annisa	Dec, 31 2015	No	Yes	No	Yes	Rutgers WPF	No - no match between expectations CFA and SPO
WIIP	Dec 2015	Yes	Not MFS II	Yes	Not MFS II	Red Cross	No - Capacity development interventions are not MFS II financed. Only some overhead is MFS II

Indonesia – SPOs	End of contract	Focus on capability to act and commit – by SPO	Focus on capability to act and commit – by CFA	Focus on capability to adapt and self-renew – by SPO	Focus on capability to adapt and self-renew – by CFA	CFA	Selected for process tracing
Yayasan Kelola	Dec 30, 2013; extension of contract being processed for two years (2014-2015)	Yes	Not really	Yes	Not really	Hivos	No - no specific capacity development interventions planned by Hivos
YPI	Dec 31, 2015	Yes	Yes	Yes	Yes	Rutgers WPF	Yes
YRBI	Oct, 30, 2013; YRBI end of contract from 31st Oct 2013 to 31st Dec 2013. Contract extension proposal is being proposed to MFS II, no decision yet.	Yes	Yes	Yes	Yes	ICCO	Yes
Yadupa	Under negotiation during baseline; new contract 2013 until now	Yes	Nothing committed	Yes	Nothing committed	IUCN	No, since nothing was committed by CFA

LIBERIA

For Liberia the situation is arbitrary which capabilities are targeted most CFA's. Whilst the capability to act and commit is targeted more often than the other capabilities, this is only so for two of the SPOs. The capability to adapt and self-renew and the capability to relate are almost equally targeted for the five SPOs, be it not intensively. Since the capability to act and commit and the capability to adapt and self-renew are the most targeted capabilities in Ethiopia, India and Indonesia, we choose to focus on these two capabilities for Liberia as well. This would help the synthesis team in the further analysis of these capabilities related to process tracing. See also the table below.

Table 7

The extent to which the Dutch NGO explicitly targets the following capabilities – Liberia

Capability to:	BSC	DEN-L	NAWOCOL	REFOUND	RHRAP
Act and commit	5	1	1	1	3
Deliver on development objectives	3	1	1	1	1
Adapt and self-renew	2	2	2	2	2
Relate	1	2	2	2	2
Achieve coherence	1	1	1	1	1

Note: Number 1 stands for not targeted, 5 for intensively targeted. These scores are relative scores for the interventions by the CFA to strengthen the capacity of the SPO. The scores are relative to each other, a higher score means that this capability gets more attention by the CFA compared to other capabilities.

Source: country baseline report, Liberia.

Below you can see the table describing when the contract with the SPO is to be ended, and whether both SPO and the CFA expect to focus on these two selected capabilities (with MFS II funding). Also, for two of the five SPOs capability to act and commit is targeted more intensively compared to the other capabilities. Based on the above-mentioned selection criteria the following SPOs are selected for process tracing: BSC and RHRAP.

Table 8

SPOs selected for process tracing – Liberia

Liberia – SPOs	End of contract	Focus on capability to act and commit – by SPO	Focus on capability to act and commit – by CFA	Focus on capability to adapt and self-renew – by SPO	Focus on capability to adapt and self-renew – by CFA	CFA	Selected for process tracing
BSC	Dec 31, 2015	Yes	Yes	Yes	Yes	SPARK	Yes
DEN-L	2014	No	No	Unknown	A little	ICCO	No – not matching enough
NAWOCOL	2014	Yes	No	No	A little	ICCO	No – not matching enough
REFOUND	At least until 2013 (2015?)	Yes	No	Yes	A little	ICCO	No – not matching enough
RHRAP	At least until 2013 (2014?)	Yes	Yes	Yes	Yes	ICCO	Yes

Key steps in process tracing for the 5C study

In the box below you will find the key steps developed for the 5C process tracing methodology. These steps will be further explained here. Only key staff of the SPO is involved in this process: management; programme/ project staff; and monitoring and evaluation staff, and other staff that could provide information relevant to the identified outcome area/key organisational capacity change. Those SPOs selected for process tracing had a separate endline workshop, in addition to the ' general endline workshop. This workshop was carried out after the initial endline workshop and the interviews during the field visit to the SPO. Where possible, the general and process tracing endline workshop have been held consecutively, but where possible these workshops were held at different points in time, due to the complex design of the process. Below the detailed steps for the purpose of process tracing are further explained.

Key steps in process tracing for the 5C study

1. Identify the planned MFS II supported capacity development interventions within the selected capabilities (capability to act and commit and capability to adapt and self-renew) – CDI team
2. Identify the implemented MFS II supported capacity development interventions within the selected capabilities (capability to act and commit and capability to adapt and self-renew) – CDI team
3. Identify initial changes/ outcome areas in these two capabilities – CDI team & in-country team
4. Construct the detailed, initial causal map (theoretical model of change) – CDI team & in-country team
5. Identify types of evidence needed to verify or discard different causal relationships in the model of change – in-country teams, with support from CDI team
6. Collect data to verify or discard causal mechanisms and construct workshop based, detailed causal map (model of change) – in-country team
7. Assess the quality of data and analyse data and develop final detailed causal map (model of change) – in-country team with CDI team
8. Analyse and conclude on findings– CDI team, in collaboration with in-country team

Some definitions of the terminology used for this MFS II 5c evaluation

Based upon the different interpretations and connotations the use of the term causal mechanism we use the following terminology for the remainder of this paper:

A **detailed causal map (or model of change)** = the representation of all possible explanations – causal pathways for a change/ outcome. These pathways are that of the intervention, rival pathways and pathways that combine parts of the intervention pathway with that of others. This also depicts the reciprocity of various events influencing each other and impacting the overall change.

A **causal mechanism** = is the combination of parts that ultimately explains an outcome. Each part of the mechanism is an individually insufficient but necessary factor in a whole mechanism, which together produce the outcome (Beach and Pedersen, 2013, p. 176).

Part or cause = one actor with its attributes carrying out activities/ producing outputs that lead to change in other parts. The final part or cause is the change/ outcome.

Attributes of the actor = specificities of the actor that increase his chance to introduce change or not such as its position in its institutional environment.

*Step 1. Identify the **planned MFS II supported capacity development interventions** within the selected capabilities (capability to act and commit and capability to adapt and self-renew) – CDI team*

Chapter 4.1 and 4.2 in the baseline report were reviewed. Capacity development interventions as planned by the CFA for the capability to act and commit and for the capability to adapt and self-renew were described and details inserted in the summary format. This provided an overview of the capacity development activities that were originally planned by the CFA for these two capabilities and assisted in focusing on relevant outcomes that are possibly related to the planned interventions.

*Step 2. Identify the **implemented capacity development interventions** within the selected capabilities (capability to act and commit and capability to adapt and self-renew) – CDI team*

The input from the CFA was reviewed in terms of what capacity development interventions have taken place in the MFS II period. This information was be found in the 'Support to capacity development sheet - endline - CFA perspective' for the SPO, based on details provided by the CFA and further discussed during an interview by the CDI team.

The CFA was asked to describe all the MFS II supported capacity development interventions of the SPO that took place during the period 2011 up to now. The CDI team reviewed this information, not only the interventions but also the observed changes as well as the expected long-term changes, and

then linked these interventions to relevant outcomes in one of the capabilities (capability to act and commit; and capability to adapt and self-renew).

*Step 3. Identify **initial changes/ outcome areas** in these two capabilities – by CDI team & in-country team*

The CDI team was responsible for coding documents received from SPO and CFA in NVivo on the following:

- 5C Indicators: this was to identify the changes that took place between baseline and endline. This information was coded in Nvivo.
- Information related to the capacity development interventions implemented by the CFA (with MFS II funding) (see also Step 2) to strengthen the capacity of the SPO. For example, the training on financial management of the SPO staff could be related to any information on financial management of the SPO. This information was coded in Nvivo.

In addition, the response by the CFA to the changes in 5C indicators format, was auto-coded.

The in-country team was responsible for timely collection of information from the SPO (before the fieldwork starts). This set of information dealt with:

- MFS II supported capacity development interventions during the MFS II period (2011 until now).
- Overview of all trainings provided in relation to a particular outcome areas/organisational capacity change since the baseline.
- For each of the identified MFS II supported trainings, training questionnaires have been developed to assess these trainings in terms of the participants, interests, knowledge and skills gained, behaviour change and changes in the organisation (based on Kirkpatrick's model), one format for training participants and one for their managers. These training questionnaires were sent prior to the field visit.
- Changes expected by SPO on a long-term basis ('Support to capacity development sheet - endline - SPO perspective').

For the selection of change/ outcome areas the following criteria were important:

- The change/ outcome area is in one of the two capabilities selected for process tracing: capability to act and commit or the capability to adapt and self-renew. This was the first criteria to select upon.
- There was a likely link between the key organisational capacity change/ outcome area and the MFS II supported capacity development interventions. This also was an important criteria. This would need to be demonstrated through one or more of the following situations:
 - In the 2012 theory of change on organisational capacity development of the SPO a link was indicated between the outcome area and MFS II support;
 - During the baseline the CFA indicated a link between the planned MFS II support to organisational development and the expected short-term or long-term results in one of the selected capabilities;
 - During the endline the CFA indicated a link between the implemented MFS II capacity development interventions and observed short-term changes and expected long-term changes in the organisational capacity of the SPO in one of the selected capabilities;
 - During the endline the SPO indicated a link between the implemented MFS II capacity development interventions and observed short-term changes and expected long-term changes in the organisational capacity of the SPO in one of the selected capabilities.

Reviewing the information obtained as described in Step 1, 2, and 3 provided the basis for selecting key organisational capacity change/ outcome areas to focus on for process tracing. These areas were to be formulated as broader outcome areas, such as 'improved financial management', 'improved monitoring and evaluation' or 'improved staff competencies'.

Note: the outcome areas were to be formulated as intermediates changes. For example: an improved monitoring and evaluation system, or enhanced knowledge and skills to educate the target group on

climate change. Key outcome areas were also verified - based on document review as well as discussions with the SPO during the endline.

*Step 4. Construct the **detailed, initial causal map** (theoretical model of change) – CDI & in-country team*

A detailed initial causal map was developed by the CDI team, in collaboration with the in-country team. This was based on document review, including information provided by the CFA and SPO on MFS II supported capacity development interventions and their immediate and long-term objectives as well as observed changes. Also, the training questionnaires were reviewed before developing the initial causal map. This detailed initial causal map was to be provided by the CDI team with a visual and related narrative with related references. This initial causal map served as a reference point for further reflection with the SPO during the process tracing endline workshop, where relationships needed to be verified or new relationships established so that the second (workshop-based), detailed causal map could be developed, after which further verification was needed to come up with the final, concluding detailed causal map.

It's important to note that organisational change area/ outcome areas could be both positive and negative.

For each of the selected outcomes the team needed to make explicit the theoretical model of change. This meant finding out about the range of different actors, factors, actions, and events etc. that have contributed to a particular outcome in terms of organisational capacity of the SPO.

A model of change of good quality includes:

- The causal pathways that relate the intervention to the realised change/ outcome;
- Rival explanations for the same change/ outcome;
- Assumptions that clarify relations between different components or parts;
- Case specific and/or context specific factors or risks that might influence the causal pathway, such as for instance the socio-cultural-economic context, or a natural disaster;
- Specific attributes of the actors e.g. CFA and other funders.

A model of change (within the 5C study called a 'detailed causal map') is a complex system which produces intermediate and long-term outcomes by the interaction of other parts. It consists of parts or causes that often consist of one actor with its attributes that is implementing activities leading to change in other parts (Beach & Pedersen, 2013). A helpful way of constructing the model of change is to think in terms of actors carrying out activities that lead to other actors changing their behaviour. The model of change can be explained as a range of activities carried out by different *actors* (including the CFA and SPO under evaluation) that will ultimately lead to an outcome. Besides this, there are also '*structural*' elements, which are to be interpreted as external factors (such as economic conjuncture); and *attributes* of the actor (does the actor have the legitimacy to ask for change or not, what is its position in the sector) that should be looked at (Beach & Pedersen, 2013). In fact Beach and Pedersen, make a fine point about the subjectivity of the actor in a dynamic context. This means, in qualitative methodologies, capturing the changes in the actor, acted upon area or person/organisation, in a non sequential and non temporal format. Things which were done recently could have corrected behavioural outcomes of an organisation and at the same time there could be processes which incrementally pushed for the same change over a period of time. Beach and Pedersen espouse this methodology because it captures change in a dynamic fashion as against the methodology of logical framework. For the MFS II evaluation it was important to make a distinction between those paths in the model of change that are the result of MFS II and rival pathways.

The construction of the model of change started with the identified key organisational capacity change/ outcome, followed by an inventory of all possible subcomponents that possibly have caused the change/ outcome in the MFS II period (2011-up to now, or since the baseline). The figure below presents an imaginary example of a model of change. The different colours indicate the different types of support to capacity development of the SPO by different actors, thereby indicating different pathways of change, leading to the key changes/ outcomes in terms of capacity development (which in this case indicates the ability to adapt and self-renew).

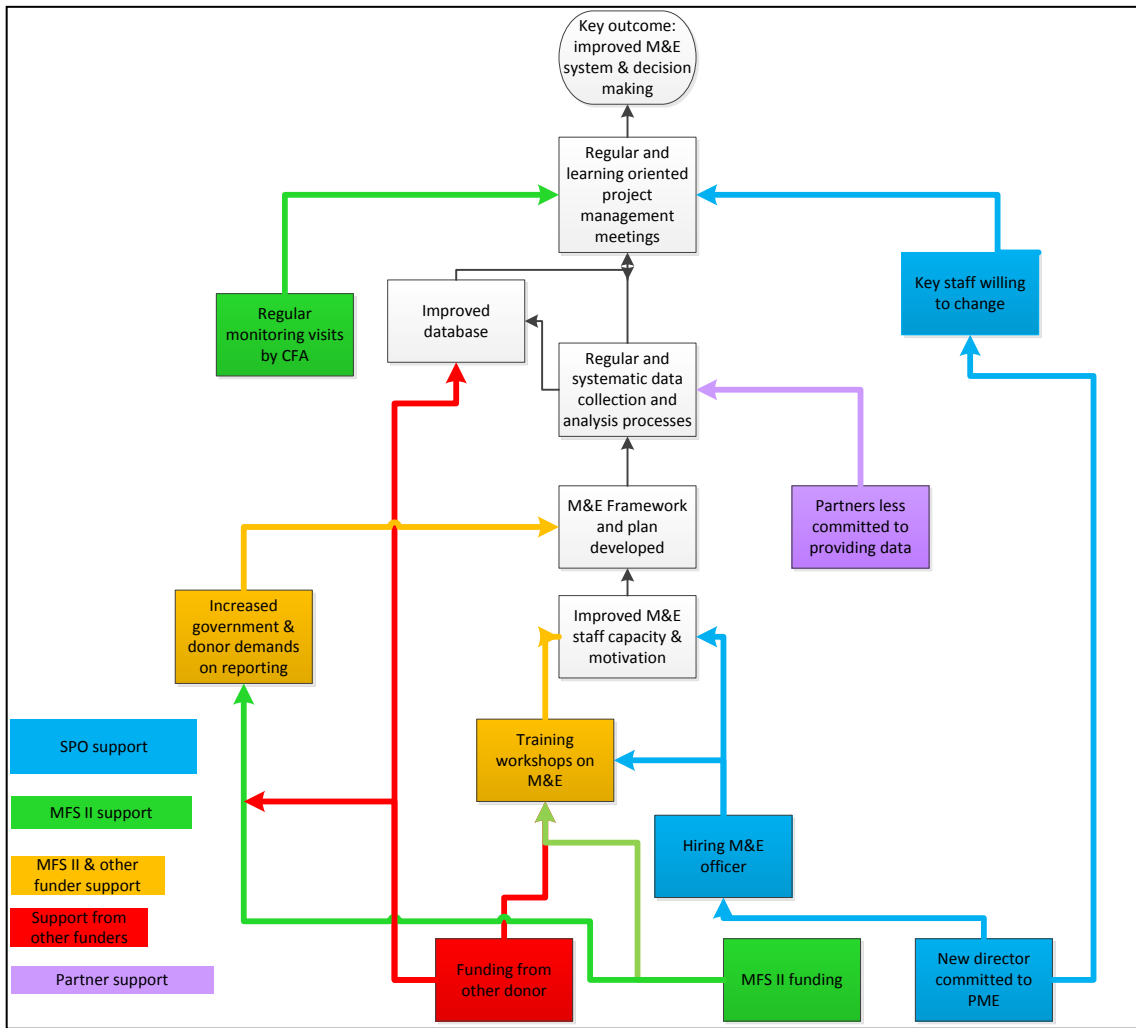


Figure 1 An imaginary example of a model of change

Step 5. Identify **types of evidence** needed to verify or discard different causal relationships in the model of change – in-country teams with support from CDI team

Once the causal mechanism at theoretical level were defined, empirical evidence was collected so as to verify or discard the different parts of this theoretical model of change, confirm or reject whether subcomponents have taken place, and to find evidence that confirm or reject the causal relations between the subcomponents.

A key question that we needed to ask ourselves was, "What information do we need in order to confirm or reject that one subcomponent leads to another, that X causes Y?". The evaluation team needed to agree on what information was needed that provides empirical manifestations for each part of the model of change.

There are four distinguishable types of evidence that are relevant in process tracing analysis: *pattern*, *sequence*, *trace*, and *account*. Please see the box below for descriptions of these types of evidence.

The evaluation team needed to agree on the types of evidence that was needed to verify or discard the manifestation of a particular part of the causal mechanism. Each one or a combination of these different types of evidence could be used to confirm or reject the different parts of the model of change. This is what is meant by robustness of evidence gathering. Since causality as a concept can bend in many ways, our methodology, provides a near scientific model for accepting and rejecting a particular type of evidence, ignoring its face value.

Types of evidence to be used in process tracing

Pattern evidence relates to predictions of statistical patterns in the evidence. For example, in testing a mechanism of racial discrimination in a case dealing with employment, statistical patterns of employment would be relevant for testing this part of the mechanism.

Sequence evidence deals with the temporal and spatial chronology of events predicted by a hypothesised causal mechanism. For example, a test of the hypothesis could involve expectations of the timing of events where we might predict that if the hypothesis is valid, we should see that the event B took place after event A took place. However, if we found that event B took place before event A took place, the test would suggest that our confidence in the validity of this part of the mechanism should be reduced (disconfirmation/ falsification).

Trace evidence is evidence whose mere existence provides proof that a part of a hypothesised mechanism exists. For example, the existence of the minutes of a meeting, if authentic ones, provide strong proof that the meeting took place.

Account evidence deals with the content of empirical material, such as meeting minutes that detail what was discussed or an oral account of what took place in the meeting.

Source: Beach and Pedersen, 2013

Below you can find a table that provides guidelines on what to look for when identifying types of evidence that can confirm or reject causal relationships between different parts/ subcomponents of the model of change. It also provides one example of a part of a causal pathway and what type of information to look for.

Table 9

Format for identifying types of evidence for different causal relationships in the model of change (example included)

Part of the model of change	Key questions	Type of evidence needed	Source of information
Describe relationship between the subcomponents of the model of change	Describe questions you would like to answer a so as to find out whether the components in the relationship took place, when they took place, who was involved, and whether they are related	Describe the information that we need in order to answer these questions. Which type of evidence can we use in order to reject or confirm that subcomponent X causes subcomponent Y? Can we find this information by means of : Pattern evidence; Sequence evidence; Trace evidence; Account evidence?	Describe where you can find this information
Example: Training workshops on M&E provided by MFS II funding and other sources of funding	Example: What type of training workshops on M&E took place? Who was trained? When did the training take place? Who funded the training? Was the funding of training provided before the training took place? How much money was available for the training?	Example: Trace evidence: on types of training delivered, who was trained, when the training took place, budget for the training Sequence evidence on timing of funding and timing of training Content evidence: what the training was about	Example: Training report SPO Progress reports Interviews with the CFA and SPO staff Financial reports SPO and CFA

Please note that for practical reasons, the 5C evaluation team decided that it was easier to integrate the specific questions in the narrative of the initial causal map. These questions would need to be addressed by the in country team during the process tracing workshop so as to discover, verify or discard particular causal mechanisms in the detailed, initial causal map. Different types of evidence was asked for in these questions.

*Step 6. **Collect data** to verify or discard causal mechanisms and develop workshop-based, detailed causal map – in-country team*

Once it was decided by the in-country and CDI evaluation teams what information was to be collected during the interaction with the SPO, data collection took place. The initial causal maps served as a basis for discussions during the endline workshop with a particular focus on process tracing for the identified organisational capacity changes. But it was considered to be very important to understand from the perspective of the SPO how they understood the identified key organisational capacity change/outcome area has come about. A new detailed, workshop-based causal map was developed that included the information provided by SPO staff as well as based on initial document review as described in the initial detailed causal map. This information was further analysed and verified with other relevant information so as to develop a final causal map, which is described in the next step.

*Step 7. **Assess the quality** of data and **analyse data**, and develop the **final detailed causal map** (model of change) – in-country team and CDI team*

Quality assurance of the data collected and the evidence it provides for rejecting or confirming parts of causal explanations are a major concern for many authors specialised in contribution analysis and process-tracing. Stern et al. (2012), Beach and Pedersen (2013), Lemire, Nielsen and Dybdal (2012), Mayne (2012) and Delahais and Toulemonde (2012) all emphasise the need to make attribution/contribution claims that are based on pieces of evidence that are rigorous, traceable, and credible. These pieces of evidence should be as explicit as possible in proving that *subcomponent X causes subcomponent Y* and ruling out other explanations. Several tools are proposed to check the nature and the quality of data needed. One option is, Delahais and Toulemonde's Evidence Analysis Database, which we have adapted for our purpose.

Delahais and Toulemonde (2012) propose an Evidence Analysis Database that takes into consideration three criteria:

Confirming/ rejecting a causal relation (yes/no);

Type of causal mechanism: intended contribution/ other contribution/ condition leading to intended contribution/ intended condition to other contribution/ feedback loop;

Strength of evidence: strong/ rather strong/ rather weak/ weak.

We have adapted their criteria to our purpose. The in-country team, in collaboration with the CDI team, used the criteria in assessing whether causal relationships in the causal map, were strong enough. This has been more of an iterative process trying to find additional evidence for the established relationships through additional document review or contacting the CFA and SPO as well as getting their feedback on the final detailed causal map that was established. Whilst the form below has not been used exactly in the manner depicted, it has been used indirectly when trying to validate the information in the detailed causal map. After that, the final detailed causal map is established both as a visual as well as a narrative, with related references for the established causal relations.

<i>Example format for the adapted evidence analysis database (example included)</i>	<i>Confirming/ rejecting a causal relation (yes/no)</i>	<i>Type of information providing the background to the confirmation or rejection of the causal relation</i>	<i>Strength of evidence: strong/ rather strong/ rather weak/ weak</i>	<i>Explanation for why the evidence is (rather) strong or (rather) weak, and therefore the causal relation is confirmed/ rejected</i>
<i>Description of causal relation</i>				
e.g. Training staff in M&E leads to enhanced M&E knowledge, skills and practice	e.g. Confirmed	e.g. Training reports confirmed that staff are trained in M&E and that knowledge and skills increased as a result of the training		

Step 8. Analyse and conclude on findings– in-country team and CDI team

The final detailed causal map was described as a visual and narrative and this was then analysed in terms of the evaluation question two and evaluation question four: *"To what degree are the changes identified in partner capacity attributable to development interventions undertaken by the MFS II consortia (i.e. measuring effectiveness)?"* and *"What factors explain the findings drawn from the questions above?"* It was analysed to what extent the identified key organisational capacity change can be attributed to MFS II supported capacity development interventions as well as to other related factors, interventions and actors.

Explaining factors – evaluation question 4

This paragraph describes the data collection and analysis methodology for answering the fourth evaluation question: **"What factors explain the findings drawn from the questions above?"**

In order to explain the changes in organisational capacity development between baseline and endline (evaluation question 1) the CDI and in-country evaluation teams needed to review the indicators and how they have changed between baseline and endline and what reasons have been provided for this. This has been explained in the first section of this appendix. It has been difficult to find detailed explanations for changes in each of the separate 5c indicators, but the 'general causal map' has provided some ideas about some of the key underlying factors actors and interventions that influence the key organisational capacity changes, as perceived by the SPO staff.

For those SPOs that are selected for process tracing (evaluation question 2), more in-depth information was procured for the identified key organisational capacity changes and how MFS II supported capacity development interventions as well as other actors, factors and interventions have influenced these changes. This is integrated in the process of process tracing as described in the section above.

Methodological reflection

Below a few methodological reflections are made by the 5C evaluation team.

Use of the 5 core capabilities framework and qualitative approach: this has proven to a be very useful framework to assess organisational capacity. The five core capabilities provide a comprehensive picture of the capacity of an organisation. The capabilities are interlinked, which was also reflected in the description of standard indicators, that have been developed for the purpose of this 5C evaluation

and agreed upon for the eight countries. Using this framework with a mainly qualitative approach has provided rich information for the SPOs and CFAs, and many have indicated this was a useful learning exercise.

Using standard indicators and scores: using standard indicators is useful for comparison purposes. However, the information provided per indicator is very specific to the SPO and therefore makes comparison difficult. Whilst the description of indicators has been useful for the SPO and CFA, it is questionable to what extent indicators can be compared across SPOs since they need to be seen in context, for them to make meaning. In relation to this, one can say that scores that are provided for the indicators, are only relative and cannot show the richness of information as provided in the indicator description. Furthermore, it must be noted that organisations are continuously changing and scores are just a snapshot in time. There cannot be perfect score for this. In hindsight, having rubrics would have been more useful than scores.

General causal map: whilst this general causal map, which is based on key organisational capacity changes and related causes, as perceived by the SPO staff present at the endline workshop, has not been validated with other sources of information except SPO feedback, the 5C evaluation team considers this information important, since it provides the SPO story about how and which changes in the organisation since the baseline, are perceived as being important, and how these changes have come about. This will provide information additional to the information that has been validated when analysing and describing the indicators as well as the information provided through process tracing (selected SPOs). This has proven to be a learning experience for many SPOs.

Using process tracing for dealing with the attribution question: this theory-based and mainly qualitative approach has been chosen to deal with the attribution question, on how the organisational capacity changes in the organisations have come about and what the relationship is with MFS II supported capacity development interventions and other factors. This has proven to be a very useful process, that provided a lot of very rich information. Many SPOs and CFAs have already indicated that they appreciated the richness of information which provided a story about how identified organisational capacity changes have come about. Whilst this process was intensive for SPOs during the process tracing workshops, many appreciated this to be a learning process that provided useful information on how the organisation can further develop itself. For the evaluation team, this has also been an intensive and time-consuming process, but since it provided rich information in a learning process, the effort was worth it, if SPOs and CFAs find this process and findings useful.

A few remarks need to be made:

- Outcome explaining process tracing is used for this purpose, but has been adapted to the situation since the issues being looked at were very complex in nature.
- Difficulty of verifying each and every single change and causal relationship:
- Intensity of the process and problems with recall: often the process tracing workshop was done straight after the general endline workshop that has been done for all the SPOs. In some cases, the process tracing endline workshop has been done at a different point in time, which was better for staff involved in this process, since process tracing asks people to think back about changes and how these changes have come about. The word difficulties with recalling some of these changes and how they have come about. See also the next paragraph.
- Difficulty of assessing changes in knowledge and behaviour: training questionnaire is have been developed, based on Kirkpatrick's model and were specifically tailored to identify not only the interest but also the change in knowledge and skills, behaviour as well as organisational changes as a result of a particular training. The retention ability of individuals, irrespective of their position in the organisation, is often unstable. The 5C evaluation team experienced that it was difficult for people to recall specific trainings, and what they learned from those trainings. Often a change in knowledge, skills and behaviour is a result brought about by a combination of different factors, rather than being traceable to one particular event. The detailed causal maps that have been established, also clearly pointed this. There are many factors at play that make people change their behaviour, and this is not just dependent on training but also internal/personal (motivational) factors as well as factors within the organisation, that stimulate or hinder a person to change behaviour. Understanding how behaviour change works is important when trying to really understand the extent to which behaviour has changed as a result of different factors, actors and interventions. Organisations change because people

change and therefore understanding when and how these individuals change behaviour is crucial. Also attrition and change in key organisational positions can contribute considerably to the outcome.

Utilisation of the evaluation

The 5C evaluation team considers it important to also discuss issues around utility of this evaluation. We want to mention just a few.

Design – mainly externally driven and with a focus on accountability and standard indicators and approaches within a limited time frame, and limited budget: this MFS II evaluation is originally based on a design that has been decided by IOB (the independent evaluation office of the Dutch Ministry of Foreign Affairs) and to some extent MFS II organisations. The evaluators have had no influence on the overall design and sampling for the 5C study. In terms of learning, one may question whether the most useful cases have been selected in this sampling process. The focus was very much on a rigorous evaluation carried out by an independent evaluation team. Indicators had to be streamlined across countries. The 5C team was requested to collaborate with the other 5C country teams (Bangladesh, Congo, Pakistan, Uganda) to streamline the methodological approach across the eight sampled countries. Whilst this may have its purpose in terms of synthesising results, the 5C evaluation team has also experienced the difficulty of tailoring the approach to the specific SPOs. The overall evaluation has been mainly accountability driven and was less focused on enhancing learning for improvement. Furthermore, the timeframe has been very small to compare baseline information (2012) with endline information (2014). Changes in organisational capacity may take a long, particularly if they are related to behaviour change. Furthermore, there has been limited budget to carry out the 5C evaluation. For all the four countries (Ethiopia, India, Indonesia, Liberia) that the Centre for Development Innovation, Wageningen University and Research centre has been involved in, the budget has been overspent.

However, the 5C evaluation team has designed an endline process whereby engagement of staff, e.g. in a workshop process was considered important, not only due to the need to collect data, but also to generate learning in the organisation. Furthermore, having general causal maps and detailed causal maps generated by process tracing have provided rich information that many SPOs and CFAs have already appreciated as useful in terms of the findings as well as a learning process.

Another issue that must be mentioned is that additional requests have been added to the country teams during the process of implementation: developing a country based synthesis; questions on design, implementation, and reaching objectives of MFS II funded capacity development interventions, whilst these questions were not in line with the core evaluation questions for the 5C evaluation.

Complexity and inadequate coordination and communication: many actors, both in the Netherlands, as well as in the eight selected countries, have been involved in this evaluation and their roles and responsibilities, were often unclear. For example, 19 MFS II consortia, the internal reference group, the Ministry of Foreign Affairs, Partos, the Joint Evaluation Trust, NWO-Wotro, the evaluators (Netherlands and in-country), 2 external advisory committees, and the steering committee. Not to mention the SPO's and their related partners and consultants. CDI was involved in 4 countries with a total number of 38 SPOs and related CFAs. This complexity influenced communication and coordination, as well as the extent to which learning could take place. Furthermore, there was a distance between the evaluators and the CFAs, since the approach had to be synchronised across countries, and had to adhere to strict guidelines, which were mainly externally formulated and could not be negotiated or discussed for the purpose of tailoring and learning. Feedback on the final results and report had to be provided mainly in written form. In order to enhance utilisation, a final workshop at the SPO to discuss the findings and think through the use with more people than probably the one who reads the report, would have more impact on organisational learning and development. Furthermore, feedback with the CFAs has also not been institutionalised in the evaluation process in the form of learning events. And as mentioned above, the complexity of the evaluation with many actors involved did not enhance learning and thus utilization.

5C Endline process, and in particular thoroughness of process tracing often appreciated as learning process: The SPO perspective has also brought to light a new experience and technique of self-assessment and self-corrective measures for managers. Most SPOs whether part of process tracing or not, deeply appreciated the thoroughness of the methodology and its ability to capture details with robust connectivity. This is a matter of satisfaction and learning for both evaluators and SPOs. Having a process whereby SPO staff were very much engaged in the process of self-assessment and reflection has proven for many to be a learning experience for many, and therefore have enhanced utility of the 5C evaluation.

Appendix 2 Background information on the five core capabilities framework

The 5 capabilities (5C) framework was to be used as a framework for the evaluation of capacity development of Southern Partner Organisations (SPOs) of the MFS II consortia. The 5C framework is based on a five-year research program on 'Capacity, change and performance' that was carried out by the European Centre for Development Policy Management (ECDPM). The research included an extensive review of the literature and sixteen case studies. The 5C framework has also been applied in an IOB evaluation using 26 case studies in 14 countries, and in the baseline carried out per organisation by the MFS II organisations for the purpose of the monitoring protocol.

The 5C framework is structured to understand and analyse (changes in) the capacity of an organization to deliver (social) value to its constituents. This introduction briefly describes the 5C framework, mainly based on the most recent document on the 5C framework (Keijzer et al., 2011).

The 5C framework sees capacity as an **outcome** of an **open system**. An organisation or collaborative association (for instance a network) is seen as a system interacting with wider society. The most critical practical issue is to ensure that relevant stakeholders share a common way of thinking about capacity and its core constituents or capabilities. Decisive for an organisation's capacity is the context in which the organisation operates. This means that **understanding context issues** is crucial. The use of the 5C framework requires a multi-stakeholder approach because shared values and results orientation are important to facilitate the capacity development process. The 5C framework therefore needs to **accommodate the different visions** of stakeholders and conceive different strategies for raising capacity and improving performance in a given situation.

The 5C framework defines capacity as '**producing social value**' and identifies five core capabilities that together result in that overall capacity. Capacity, capabilities and competences are seen as follows:

Capacity is referred to as the overall ability of an organisation or system to create value for others;

Capabilities are the collective ability of a group or a system to do something either inside or outside the system. The collective ability involved may be technical, logistical, managerial or generative (i.e. the ability to earn legitimacy, to adapt, to create meaning, etc.);

Competencies are the energies, skills and abilities of individuals.

Fundamental to developing capacity are inputs such as human, material and financial resources, technology, and information. To the degree that they are developed and successfully integrated, capabilities contribute to the overall capacity or ability of an organisation or system to create value for others. A single capability is not sufficient to create capacity. All are needed and are strongly interrelated and overlapping. Thus, to achieve its development goals, the 5C framework says that every organisation or system must have **five basic capabilities**:

- The capability to act and commit;
- The capability to deliver on development objectives;
- The capability to adapt and self-renew;
- The capability to relate (to external stakeholders);
- The capability to achieve coherence.

In order to have a common framework for evaluation, the five capabilities have been reformulated in outcome domains and for each outcome domain performance indicators have been developed.

There is some overlap between the five core capabilities but together the five capabilities result in a certain level of capacity. Influencing one capability may have an effect on one or more of the other capabilities. In each situation, the level of any of the five capabilities will vary. Each capability can become stronger or weaker over time.

Appendix 3 Changes in organisational capacity of the SPO - 5C indicators

Below you will find a description for each of the indicators under each of the capabilities, what the situation is as assessed during the endline, how this has changed since the baseline and what are the reasons for change.

Capability to act and commit

Level of Effective Leadership

1.1.Responsive leadership: 'Leadership is responsive, inspiring, and sensitive'

This is about leadership within the organisation (operational, strategic). If there is a larger body then you may also want to refer to leadership at a higher level but not located at the local organisation.

The Executive Director (ED) of BVHA continues to be responsive, democratic and gives space for decentralized decision-making. The present leadership has also shown increased interaction with the partner organisations which in turn led to partners becoming more responsive towards their work, which is said to be visible through the feedbacks received by the ED. While this change was triggered by the demand of Simavi, nevertheless it brought about overhauling in the working of the present leadership. The ED has also engaged more proactively in promotion, networking, fundraising and management. However, the division of authority between the board and Executive Director continues to be imbalanced with the former taking major decisions, especially decisions on funding of the projects and utilization of the funds received.

Score baseline: 3.0

Score endline: 3.5 (slight improvement)

1.2.Strategic guidance: 'Leaders provide appropriate strategic guidance (strategic leader and operational leader)'

This is about the extent to which the leader(s) provide strategic directions

There could be no denying of the fact that the Executive Director's ability to single-handedly take major decisions is tied to the governing board that is composed of the network members. Due to this, the decision of the leadership has to be in tune with the larger mandate of the governing board members. The composition of the governing board itself poses difficulty in the ED's independent decision-making. With overlapping and conflict views of network members, the ED's work sometimes gets hampered.

However, in the last two years there has been a slight improvement in the leadership position. The network members offer less opposition to the ED, because over the period he is has become more approachable, cooperative and responsive and as a result of which he is able to get support for his decisions from the board members. He is thus able to implement his decisions and guide his staff better.

The Executive Director has now more flexibility to take up new projects as per the need and demand and can send it to different donor agencies. This has resulted in getting projects from UNICEF on MDR

(maternal child death review)¹¹ and from Simavi on MHM (menstrual hygiene management) and Child Marriage. This in turn has led to increased financial and other resources not only for BVHA but also for its partners as well as increased job satisfaction for the senior and junior management staff. BVHA has also formed Advisory Committees comprising 15 visionary intellectuals who contribute/assist ideas/suggestions in the strategic planning process.

Score baseline: 3.0

Score endline: 3.5 (slight improvement)

1.3. Staff turnover: 'Staff turnover is relatively low'

This is about staff turnover.

BVHA's staff turnover is not uniform. While the top leadership continued to remain in the same position for the last two decades, over the last two years some project staff have left the organisation. The main reason for this is linked to the amount of salaries (salaries cannot be more than 15 % of the budget as a donor requirement) received by them in comparison to the work done; better opportunities found in other places and absence of any scope of promotion within the organisation. To deal with the high programme staff turnover, Simavi demanded a clause in the contracts of recruits and the ED has brought in a new policy with the approval of the Board that when project staff join the organisation they cannot leave a project before completion.

Earlier the Governing Board members were not very interested in giving promotions to staff who were working in BVHA for many years as they were more interested in conducting interviews with people from outside for vacant posts at senior positions. But now, the Governing Board has taken a positive step to promote the existing staff to higher levels based on their dedication, performance and years of service at BVHA. This is a major motivating factor at the staff level.

Score baseline: 3.5

Score endline: 3.75 (very slight improvement)

Level of realistic strategic planning

1.4. Organisational structure: 'Existence of clear organisational structure reflecting the objectives of the organisation'

Observable indicator: Staff have copy of org structure and understand this

BVHA staff members are aware of the organisational structure in BVHA, and a written copy is available.

Score baseline: 4.0

Score endline: 4.0 (no change)

1.5. Articulated strategies: 'Strategies are articulated and based on good situation analysis and adequate M&E'

Observable indicator: strategies are well articulated. Situation analysis and monitoring and evaluation are used to inform strategies.

For all the programmes BVHA's strategies are now based more on situational analysis and project outcomes rather than just outputs. There are now continuous and regular discussions on outputs/outcomes, planning of achievements, use of multimedia IEC strategies and multi-stakeholder

¹¹ A project funded by UNICEF was initiated in two districts of Bihar. This is a pilot intervention to institutionalise MDR process and provide a road map for establishing a routine system for review of all maternal deaths as per the Maternal Death Review guidelines of Government Of India.

involvement at various levels which facilitates strategic planning. For example: training and support is given to Civil Society Organisations (CSOs) and target groups on SRHR issues which increases the meaningful participation of target groups in monitoring the health delivery services/system. For example, in implementing the project 'Initiative to improve maternal health with social determinants approach' they formed Village Health Sanitation and Nutrition Committees (VHSNCs) as taskforces to monitor the maternal health services in the villages. This facilitated the organisation to analyse the situation on how maternal deaths are not reported properly though it is mandatory under NRHM. Moreover, the actual reason for death (e.g. socio-economic, health facility and other) are neither analysed nor addressed. It is very much necessary for the service providers and policy makers to identify the root cause for to create healthy maternity in Bihar. In the light of this situational analysis BVHA initiated a pilot intervention project 'Maternal Death Review' funded by Oxfam to institutionalise MDR process, documentation of the reports and provide a road map for establishing a routine system for review of all maternal death. On another instance, discussions with the local partners especially those working in the bordering districts (adjacent to Nepal) identified the big problem regarding the sexual reproductive health issues. Being bordering districts there is high prevalence of trafficking especially for women/adolescent girls leading to SRHR problems, which make the situation more critical. This situational analysis helped BVHA to initiate the "Community empowerment on Gender Equity to access Reproductive Health Rights" project in these regions. BVHA has also been working on establishing linkages and collaboration with likeminded NGOs and government for sharing and learning SRHR issues. It conducts monthly meeting with Integrated Child Development Service (ICDS) staff, medical officers, ANM etc., where the status of the immunisation, ANC, PNC etc. are discussed and monitored. This further facilitates the organisation to develop strategies for its programmes.

Score baseline: 3.5

Score endline: 3.75 (very slight improvement)

Level of translation of strategy into operations

1.6.Daily operations: 'Day-to-day operations are in line with strategic plans'

This is about the extent to which day-to-day operations are aligned with strategic plans.

In the baseline assessment it was pointed out that the overall operational plan of BVHA was not prepared professionally. BVHA still makes annual plans that are broken down to quarterly and monthly plans that are in line with its strategic goals. However, the implementation of the project continues to depend upon partner/network organisations. Since the baseline BVHA has improved its capability with regard to operational plans by developing formats that are easy to understand for their network and partner organisations, which resulted systematic data collection and timely reporting. The data is further analysed by the project staff to monitor the output and outcome of the project. Proper methods for monitoring progress are now in place, and training of the partners on M&E helped the partners to articulate the work done by them to BVHA by aligning their daily operations with the larger plans. This was a requirement of Simavi for the SRHR project, but its progress in this project has become a motivating factor for other team members to follow such PME methods and as result now reports (qualitative and quantitative) are sent to concerned donors. The district project coordinators conduct monthly review meeting at the field level; the project manager and ED at BVHA are taking more responsibility for monitoring and evaluation of the projects and Simavi has provided planning and reporting formats that enable BVHA to track all the proposed activities, feedback from the donor. All these systems and processes contribute in tracking whether the day to day operations are in line with the strategic plan.

Score baseline: 3.5

Score endline: 4.0 (slight improvement)

Level of staff capacity and motivation

1.7. Staff skills: 'Staff have necessary skills to do their work'

This is about whether staff have the skills necessary to do their work and what skills they might they need.

BVHA's success in the SRHR programme was an outcome of various processes including developing the skills of the members of the project. Enhanced skill sets of BVHA staff members (as an outcome of ARSH clinic visit) led them to replicate it in developing adolescent reproductive health clinic services in the government system as well as bringing about improvement in the quality of the clinic. For instance, the Adolescent Friendly Health Clinics is a case in point. The Executive Director of BVHA could get a basic understanding of adolescent health problems, counselling techniques, how to establish and run such clinics, how to convince the government to take up such an initiative and its linkages with the project at community level. As a result BVHA convinced the Government of Bihar to take up the East Champaran District in the first phase for setting up the ARSH (Adolescence Reproductive Sexual Health) clinics. Staff skills have also been developed with regard to improving their results-oriented activity, inter-staff coordination, cooperation between BVHA personnel and their project partners. Broadly, skill development of the staff has taken place in three broad areas: advocacy, record keeping of PME and financial training.

A new national coordinator of the SRHR alliance has been appointed by the Dutch organisation Rutgers WPF. He plays a vital role in strengthening the SRHR alliance partners through capacity building workshops, review meetings and by providing technical support in the areas of strategy development. He has triggered various discussions on SRHR issues and has been working closely with the BVHA programme manager. He gives constructive feedback to BVHA on plans in order to align them with Simavi's PME requirements. As a result the staff of BVHA has improved, compared to the baseline, its knowledge on SRHR and its 'core skills' such as planning, monitoring and evaluation; data collection; report writing and giving training to its partners. The organisation has also worked on the 'core skill' fundraising: a core committee has been formed at BVHA level for new project proposal development, liaising with new donors and meeting with senior level officials and policy makers for advocacy.

Score baseline: 3.5

Score endline: 4.5 (improvement)

1.8. Training opportunities: 'Appropriate training opportunities are offered to staff'

This is about whether staff at the SPO are offered appropriate training opportunities

The Executive Director provides equal opportunity to all his staff to participate in various workshops and training programmes so that each and everybody is able to enhance his or her skills. For example, the third category level staff (assistants) is given opportunities to participate in the BVHA organised capacity building programmes and also in the programmes organised by other agencies. The number of training programmes for the staff has increased since the baseline. This includes trainings on SRHR, MIS, success story writing, government schemes, comprehensive sexual education, advocacy, output and outcome indicators, the PC and PNDD (Preconception and Prenatal Diagnostic Treatment) Act, financial compliance and communication. All the programme level staff is participating in the capacity building programmes; this is as per the need of the project. In the SRHR project that is funded under MFS II, BVHA staff participated in all workshops and training that were offered via the SRHR alliance. The training topics were identified with BVHA's input and in some cases detailed assessment took place to tailor the training to the participants. Staff also felt strong to give advice to other alliance partners (e.g. on HMIS) and to showcase their project, as best practises so that others could learn from them. BVHA developed a structured capacity building programme for its partner organizations. The capacity building programmes were divided into 2 components – one is to enhance the knowledge of the project staff on the issues related to SRHR and the other is to increase capacity of the staff to conduct sessions in the villages with effective communication skills. This was possible only after the programme staff of BVHA was trained through exposure visits, six monthly regional meetings with alliance partners and training by other donors and state government.

Score baseline: 3.5

Score endline: 4.0 (slight improvement)

1.9.1.Incentives: 'Appropriate incentives are in place to sustain staff motivation'

This is about what makes people want to work here. Incentives could be financial, freedom at work, training opportunities, etc.

In the baseline assessment BVHA's staff indicated that they were not receiving adequate financial incentives. Especially the payments of the programme staffs were not enough, which in turn led to employees leaving the organisation for a better salary. This triggered a major change after the 2012 baseline leading to revision of the salary structure of the BVHA staff members. This was after Simavi asked BVHA to adhere to government standards and agreed to increase their salaries (minimum wage plus 10% provision fund). This was made possible through the accumulation of a corpus fund.

Apart from the changes in the salary structure, additional incentives have been provided through: freedom at work without interference of ED and the board; skill building through training programmes; homely environment as a result of cooperation amongst staff members.

Score baseline: 3.5

Score endline: 4.0 (slight improvement)

Level of Financial Resource Security

1.9.2.Funding sources: 'Funding from multiple sources covering different time periods'

This is about how diversified the SPOs funding sources are over time, and how the level of funding is changing over time.

BVHA has diverse funding sources, following a detailed budget structure. The utilization of money is done accordingly. BVHA receives 100 percent funding from SIMAVI for the MFS II programme on Sexual Reproductive Health Rights. BVHA has also been able to garner funds from Simavi for two new projects: child marriage programme and menstrual hygiene management. Other donors include: UNFPA, UNICEF, the Population Foundation of India, BMZ-KKS, and the Ministry of Health and Family Welfare of the government of India.

Along with diversified funding sources, BVHA could attract government agencies by increasing its visibility at various levels through their new partnership with bilateral and multilateral agencies. This in turn has helped them to attract new funding from different sources. They have also partnered with the alliances formed during the SRHR programme. The SRHR programme of BVHA also became a reference for them to draw the attention of the funding agencies. After the introduction of the CSR Act, BVHA is also exploring funding opportunities with the corporate sector.

The staff is highly motivated and they try to go an extra mile to explore new funding opportunities especially with the corporate sector. Now, more new proposals are prepared and sent to different donor agencies. There is also a tight booking plan for BVHA's training halls and facilities which they rent out to raise funds and they have also planned to conduct various capacity building training programmes and charge the participants to raise money. BVHA has started taking one year to five years subscription fee by making members of its Quarterly NEWS letter to meet the NEWS letter printing costs.

Score baseline: 4.0

Score endline: 4.5 (slight improvement)

1.9.3.Funding procedures: 'Clear procedures for exploring new funding opportunities'

This is about whether there are clear procedures for getting new funding and staff are aware of these procedures.

In BVHA, there are no written, official fund raising procedures but exploring of funding opportunities is done on a regular basis as per the direction and suggestion of the Governing board of BVHA. With the revision of the salary structure there is a new lease of energy amongst the staff. The staff is highly motivated and they try to go an extra mile to explore new funding opportunities especially with the corporate sector. Now, more and better proposals are prepared and sent to different donor agencies.

Other strategies for raising funds including on request training (where participants pay), selling of books, membership fees, renting out its training facilities, and exploring funding possibilities under the CSR act, are being implemented.

Score baseline: 2.5

Score endline: 3.0 (slight improvement)

Summary of capability to act and commit

The Executive Director is more responsive in his interaction with BVHA's partner organisations. This was initially triggered by a requirement of Simavi. The ED has been given more flexibility by the board to take up new projects and approach new donor agencies by getting more involvement in promotion and fundraising for the organisation. While the governing board still holds most authority for making decisions on funding of the projects and utilisation of funds, the executive director experiences less opposition from the network members in terms of his strategic guidance to the organisation as he gains more support from the board.

There is still some staff turnover at the project level, where staff has left because of low salaries or better opportunities. The governing board is now looking more within the organisation to fill vacant senior positions and recognise the performance of existing staff by promoting them. This together with the revision of the salary structure after the baseline assessment and discussions with Simavi has improved the incentives of staff to work at BVHA. Other incentives still include freedom at work, skill development through training and the homely environment created by collaboration between staff. BVHA staff members are aware of the organisational structure in BVHA, and a written copy is available.

BVHA's strategies are now more based on project outcomes from its M&E system, rather than just on outputs. They continue to involve their target groups and link with like-minded NGOs and the government when formulating strategies. The organisation continues to work with annual, quarterly and monthly work plans and BVHA's work continues to rely on their partners' timeliness. However, partners have improved their timeliness because of the introduction of proper progress monitoring methods in the SRHR project by Simavi, that have had its effect on other project teams as well. Some of the core skills that needed to be upgraded during the baseline, have now been developed. This includes: PME and fundraising but also more specific skills and knowledge on SRHR. The presence of the national coordinator of the SRHR alliance at BVHA has contributed to this. Also all BVHA staff had equal access to more training programmes, as per their programme's need on the topics: SRHR, MIS, success story writing, government schemes, comprehensive sexual education, advocacy, output and outcome indicators, the PC and PNDT Act, financial compliance and communication.

BVHA has increased its visibility because of its involvement in the SRHR project and alliance. This attracted donors like UNFPA, UNICEF, the Population Foundation of India, BMZ-KKS and the government of India and Simavi approving two new projects. They also have other strategies to raise funds which include renting out their training facilities and providing training for paying participants. There are still no written funding procedures, but staff has become more motivated after the revision of the salary structure and better capable to write and send more and better proposals to new donor agencies.

Score baseline: 3.5

Score endline: 4.0 (slight improvement)

Capability to adapt and self-renew

Level of effective application of M&E

2.1.M&E application: 'M&E is effectively applied to assess activities, outputs and outcomes'

This is about what the monitoring and evaluation of the SPO looks at, what type of information they get at and at what level (individual, project, organisational).

Already during the baseline evaluation, BVHA had a monitoring and evaluation system in place. The M&E is now focussing more on outcomes than during the baseline. The project officer of BVHA for the SRHR project took part in the M&E activities and is now better equipped to understand outcomes and impacts. BVHA has learned to understand better how outcomes are measured through frequent interactions with Simavi, workshops on PME, biannual PME meetings with other SRHR alliance partners in which BVHA compared strategies, learned from best monitoring examples and did peer-reviewed organisational assessment exercises.

Various tools for monitoring outcomes in the SRHR project were discussed during these SRHR alliance meetings and interaction with Simavi, for example:

- List of questions measuring Knowledge, Attitude and Practice (KAP) on SRHR issues linked to the different outcomes. A list of essential KAP questions and possible answers is given in the template.
- Use of an exit satisfaction questionnaire for the outcome: 40% of maternal health facilities show an increase in satisfaction by women. This allows project managers to analyse surveys per 3 months and compare the level of satisfaction in the first 3 months with the last 3 months.

In the overview on how the M&E is organised in India for the SRHR alliance it can be seen that for the BVHA SRHR project:

- Planned outputs are monitored and reported on;
- There is an outcome plan for 2013, with per outcome indicator: a definition, notes of the discussion that has taken place on the indicator during the PME meetings with Simavi and other alliance partners, source of verification (what is planned on how to measure it) and frequency of measurement;
- For each indicator on both outcome and output level agreements on the definition and how to measure it, were made during the alliance meetings in May and October 2012;
- In this overview BVHA filled in for each indicator which method for data collection they intend to use, which sample and the period for when this is planned. Simavi gives her feedback on this and makes suggestions for improvement.

BVHA visits the partner organisations for a monthly review and invites them for a quarterly review in the BVHA office. The Executive Director also does independent and regular monitoring of the projects through personal visits, phone calls and monthly review meetings. There are also surprise visits by the board members. Community based monitoring is done by filling up monitoring sheets. In the SRHR project BVHA has MIS formats in place for the advocacy officer of BVHA to create monthly reports, for district coordinator of the partner NGO to produce monthly NGO District consolidation reports based on the monthly MIS formats of the Panchayat level motivator of partner NGOs and the project manager of BVHA to produce monthly state reports of the SRHR project.

Score baseline: 3.0

Score endline: 4.0 (improvement)

2.2.M&E competencies: 'Individual competencies for performing M&E functions are in place'

This is about whether the SPO has a trained M&E person; whether other staff have basic understanding of M&E; and whether they know what information to collect, how to process the information, how to make use of the information so as to improve activities etc.

While there is still no dedicated M&E person at BVHA, at least one staff member has become much more expert in M&E through support from the national programme coordinator, PME workshops and individual supervision by Simavi. Other staff have also improved their skills to design formats for data

collection and analyse data through participating in various training programmes organized by development agencies on M&E and through inviting M&E experts themselves for in-house training.

Project officers do the monitoring of the projects. In the SRHR project, M&E is very structured with formats for monitoring and report writing and the project manager makes monthly monitoring visits.

The Executive Director is also involved in monitoring by taking pro-active measures in the form of surprise visits to the partners, and being on call in case there is a need. This has also inspired the Board members to do the same. Every month the project officers send project progress reports and plans to the ED through e-mail.

Score baseline: 3.0

Score endline: 3.5 (slight improvement)

Level of strategic use of M&E

2.3.M&E for future strategies: 'M&E is effectively applied to assess the effects of delivered products and services (outcomes) for future strategies'

This is about what type of information is used by the SPO to make decisions; whether the information comes from the monitoring and evaluation; and whether M&E info influences strategic planning.

BVHA has since the baseline improved its M&E capacity and is better able to analyse collected data, now also at outcome level, not only output level, which helps them to inform future strategies. This enables them to identify strategic moves, develop more effective interventions, such as multiple strategies. BVHA was able to develop this because of learning from others, workshops on strategies and joint analysis of project results within the SRHR alliance. Simavi (as a funder) allows for strategic changes in the programme and budget. An example of this is that BVHA lobbied for working with in-school youth, while Simavi was not encouraging this, but together they revised the strategy to include this group. There is thus more room for making strategic changes based on M&E, particularly because the results of a focus on outcomes and not only outputs and engagement of stakeholders in strategic development.

Score baseline: 2.0

Score endline: 3.0 (improvement)

Level of openness to strategic learning

2.4.Critical reflection: 'Management stimulates frequent critical reflection meetings that also deal with learning from mistakes'

This is about whether staff talk formally about what is happening in their programs; and, if so, how regular these meetings are; and whether staff are comfortable raising issues that are problematic.

Regular monthly meetings, quarterly governing board meetings, submission of reports and discussion of programmes where staff feel comfortable to raise issues, continue to be the norm. The project heads are now empowered to take decisions related to their projects when issues arrive and only need to follow administrative formalities and accounting principles when this happens. In the monthly meetings that are held each staff member has to give an update on the work done in the previous month and give reasons if they have not been able to deliver an output. While this is a stock taking exercise it also allows the staff to critically reflect upon the reasons for their under/non-performance. The Executive Director continues to have limited power and still has to consult the board often which causes delays in communicating decisions to staff and acting upon them.

Score baseline: 3.0

Score endline: 3.0 (no change)

2.5. Freedom for ideas: 'Staff feel free to come up with ideas for implementation of objectives

This is about whether staff feel that ideas they bring for implementation of the program are welcomed and used.

The Executive Director is very friendly, approachable and open to ideas of his staff members. There has been some improvement in that BVHA staff has now been able to come up with some new ideas, albeit donor driven, through learning from other organisations and encouragement by Simavi to look for innovations or new strategies. For example, the idea of integrating different programmes has now been taken on board. Staff ideas are still welcomed and supported.

Score baseline: 3.0

Score endline: 3.25 (very slight improvement)

Level of context awareness

2.6. System for tracking environment: 'The organisation has a system for being in touch with general trends and developments in its operating environment'

This is about whether the SPO knows what is happening in its environment and whether it will affect the organization.

Over the last two years BVHA has improved its networking capability. By virtue of its involvement in the SRHR forum, BVHA interacts with many organisations and the government. This has enabled BVHA to continue to follow trends and developments by getting information through its network members, board members, government officials, UN agencies, donors and media at various forums such as meetings, seminars, training sessions and workshops. BVHA asks VANI (Voluntary Action Network India), New Delhi or VHAI for any new laws related to NGOs and also shares it with its network organisations. Besides this, BVHA meets the different concerned stakeholders to find out the actual situation which is then discussed in staff meetings, Governing Board Meetings and also in the General Body Meetings if an imported external change is noted or a new NGO law is implemented.

Also through BVHA increased involvement in the SRHR alliance, there is an exchange of information so that they are better informed of what is happening in other states or at national level to pro-actively explore what is happening in their own environment.

Score baseline: 4.0

Score endline: 4.25 (very slight improvement)

2.7. Stakeholder responsiveness: 'The organisation is open and responsive to their stakeholders and the general public'

This is about what mechanisms the SPO has to get input from its stakeholders, and what they do with that input.

BVHA continues to be open and responsive to their stakeholders, but this has still not been institutionalised. Inputs of network partners during network meetings are used to identify projects for proposals. BVHA has started to hold at least two Governing Board Meetings in the area of any network member organisation and also invite them to BVHA's office twice a year. In this way, the Governing Board has the opportunity to meet the management and staff of the hosting network organisation and at the same time BVHA can meet other network partner organisations to discuss and identify their need and expectations from BVHA face to face.

Score baseline: 3.0

Score endline: 3.25 (very slight improvement)

Summary of capability to adapt and self-renew

Already during the baseline evaluation, BVHA had a monitoring and evaluation system in place. The M&E is now focussing more on outcomes than during the baseline. This is evident from BVHA's improved understanding of how to measure outcomes through discussing this within the SRHR alliance and guidance of Simavi. There is an overview of how M&E is organised in the SRHR project which provides very clear instructions on each output and outcome indicator and how to measure it. Use of MIS has also improved since the baseline: MIS formats are in place for advocacy officers and partner organisation for monthly reporting on progress in the SRHR project. While there is still no dedicated M&E person at BVHA, staff skills in M&E have improved with support from the national programme coordinator, PME workshops, individual supervision by Simavi and through inviting M&E experts for in-house training (sometimes funded by other donors). Project officers do most the monitoring of the projects, the Executive Director is now also more pro-actively involved in monitoring. There is more room for making strategic changes based on M&E, because of the focus now also on outcomes, not just outputs. Furthermore, Simavi stimulates this and BVHA has improved its M&E capacity so that they are now better at analysing (also strategic level) data and identifying strategic moves and more effective interventions based on this. Staff can raise issues with their project heads, who are now more empowered to take decisions, during regular monthly meetings or during quarterly governing board meetings. In the monthly meetings staff give a progress update and reflect upon their performance. The Executive Director continues to have limited power which causes delays in communicating decisions to staff and acting upon them. Staff is still free to come up with ideas that are welcomed by the ED. Through encouragement and learning from other organisations BVHA has been coming up with some new ideas like integrating different programmes. Through its involvement in the SRHR alliance, BVHA has improved its networking capability and is now better informed on what is happening in other states, and at national level and can respond proactively. BVHA also gets information through its network members and other NGOs on important new NGO laws and external changes that are then discussed with staff and in board meetings. BVHA continues to be open and responsive to their stakeholders, but this has still not been institutionalised. Inputs of network partners are used to identify projects and BVHA now holds at least two Governing Board Meetings per year so that the board can meet the management and staff of the hosting network organisation and identify their need and expectations from BVHA face to face.

Score baseline: 3.0

Score endline: 3.5 (slight improvement)

Capability to deliver on development objectives

Extent to which organisation delivers on planned products and services

3.1. Clear operational plans: 'Organisation has clear operational plans for carrying out projects which all staff fully understand'

This is about whether each project has an operational work plan and budget, and whether staff use it in their day-to-day operations.

Every project of BVHA still has an operational work plan and budget. The concerned programme staff has full knowledge of the implementation plan and budget of their respective budgets. BVHA is now more critical and realistic about efficient budget utilisation, asks timely for reallocation due to contextual changes and has improved its operational plans. There is now a core group that sits together to discuss certain issues and prepare the budget for proper project implementation. BVHA is consulting its partners in the preparation of formats that guide the project implementation in the SRHR project, but is now also applying this in other programmes. The improvement of operational plans and corresponding budgets is because of stronger requirements from Simavi and the support and feedback BVHA receives from them in planning and using the budget.

Score baseline: 4.0

Score endline: 4.5 (slight improvement)

3.2. Cost-effective resource use: 'Operations are based on cost-effective use of its resources'

This is about whether the SPO has the resources to do the work, and whether resources are used cost-effectively.

BVHA's budgets are now more realistic. They are able to implement the plan within the budget and ask timely for reallocation due to contextual changes. For the SRHR project the budget per year per beneficiary (block population) is 0,67 Euro.

To cut costs BVHA conducts most of their meetings in their own facilities, uses the internet to cut the costs of mailing and paper, uses PowerPoint during meetings to save paper costs and schedules visits to network member organisations when they are on the way during visits to ongoing projects. Furthermore, BVHA has started to enrol participants of its member organisations in the capacity building programmes of any ongoing projects based on the theme. This way they reduce travel costs and save on organising separate capacity building events. BVHA is maintaining a proper inventory and stock register, which has helped in the proper use of the resources. Some costs are still there in sending annual general body meetings letters and a few important letters through post to some of the partners that do not have access to internet services.

Score baseline: 3.5

Score endline: 4.0 (slight improvement)

3.3. Delivering planned outputs: 'Extent to which planned outputs are delivered'

This is about whether the SPO is able to carry out the operational plans.

In the baseline assessment it was pointed out that the overall operational plan of BVHA was not prepared professionally. Since the baseline BVHA has improved its capability with regard to operational plans by developing formats that are easy to understand for their network and partner organisations. Information from its partners is now reaching BVHA on time and according to the requirements. It has therefore become easier to monitor what has been achieved and done by the partner organisations. These changes in BVHA are attributed to the donor driven requirements of Simavi, NPC and Alliance partners. While during the baseline BVHA only reached their outputs, they are now reaching outcome results, which indicates improvement. For example in the annual report for the SRHR project it can be seen that BVHA is reaching or even surpassing the targets that are set for output indicators in the different result areas, such as civil society strengthening, MDGs and increased capacity of partner organisations. Monthly action plans help staff to carry out the operational plans, report on their progress and in case of not accomplishing a particular task, give reasons for it and complete it in the next month.

Score baseline: 3.0

Score endline: 4.0 (improvement)

Extent to which delivered products and services are relevant for target population in terms of the effect they have

3.4. Mechanisms for beneficiary needs: 'The organisation has mechanisms in place to verify that services meet beneficiary needs'

This is about how the SPO knows that their services are meeting beneficiary needs

Despite working through network partners, who in turn are directly involved with the beneficiaries, BVHA is still aware of the needs of the beneficiaries by sending their staff on household visits in the target area and through close interaction with partners. In addition to this, BVHA is now monitoring its programmes through feedback questionnaires to stay informed about the actual situation in beneficiary areas. With the help of Simavi, client opinion and satisfaction surveys are now included in the monitoring framework, as a way for clients to provide feedback on the project. Contrary to the baseline situation, now structured mechanisms to verify whether services meet beneficiary needs are in place, at least for the MFS II funded project. BVHA has also developed formats to assess the needs

of its network partner organisations and it has sent this to its member network organisations. Furthermore, management has started to conduct regional meetings with its partner organisations to find out their needs and what they expect from BVHA.

Score baseline: 3.5

Score endline: 4.0 (slight improvement)

Level of work efficiency

3.5. Monitoring efficiency: 'The organisation monitors its efficiency by linking outputs and related inputs (input-output ratios)'

This is about how the SPO knows they are efficient or not in their work.

There are still no formal input-output ratios calculated in BVHA, even though monitoring and evaluation generally has improved. Staff is monitored through monthly action plans and progress reports. Periodical staff appraisal has been initiated to monitor efficiency. Most projects have a log frame matrix in which activities are linked to outputs and outcomes, as per demand of the donor. Regular meetings with the SRHR alliance partners and periodic guidance from Simavi and the national coordinator of the SRHR alliance who is based at BVHA have led to a better understanding of these log frames. An advanced monitoring training and sharing in meetings with other project donors have further enhanced BVHA's skills in this.

Score baseline: 2.5

Score endline: 2.75 (very slight improvement)

3.6. Balancing quality-efficiency: 'The organisation aims at balancing efficiency requirements with the quality of its work'

This is about how the SPO ensures quality work with the resources available

There are still no formal quality control mechanisms. The monitoring mechanism at BVHA has been strengthened. Close monitoring has increased and is now done by the concerned project head as well as by management. In the last financial year BVHA's Governing Board took the decision to hold its quarterly meetings at the site of the projects that are either directly implemented by BVHA or that are implemented by its network organisations to see the progress, gaps and challenges.

The accounting system of BVHA has been upgraded as per the standard norms. BVHA is now keener to discuss budget reallocations to increase the effectiveness or quality of their work. Efficiency is then also discussed with the donor, for example through scaling up in areas where the work is going well. Quality control was a topic of discussion during the SRHR alliance meetings, joint capacity building programmes and in ongoing review meetings with other donors. Accordingly corrections were made and BVHA is continuously trying to upgrade its quality control mechanisms.

Score baseline: 2.0

Score endline: 2.5 (slight improvement)

Summary of capability to deliver on development objectives

Every project of BVHA still has an operational work plan and budget. BVHA is now more critical and realistic about efficient budget utilisation, asks timely for reallocation due to contextual changes and has improved its operational plans. This led to BVHA's budgets being more realistic now and them being able to implement the plan within the budget. The organisation is still doing its level best to use its resources effectively by keeping an inventory, reducing on mailing and paper costs by using the internet and by using its own facilities for trainings and meetings. As operational plans of BVHA improved, so did the formats to monitor their partners' progress. These are now easier to understand so that the information that reaches BVHA is more accurate and timely. BVHA is now reaching its

output and outcome results and has monthly action plans in place through which staff report their progress and follow up on unaccomplished tasks.

In contradiction with the baseline scenario, BVHA now has a structured mechanism in place to verify that services meet beneficiary needs, as Simavi made client opinion and satisfaction surveys part of the monitoring framework for the MFS II funded project. BVHA also assesses the needs of its network partners through formats and regional meetings. There are still no formal input-output ratios calculated in BVHA. Although there are still no formal quality control mechanisms, the monitoring mechanisms of BVHA were strengthened. BVHA is now keener to discuss budget reallocations to increase the effectiveness or quality of their work. Efficiency is also discussed with Simavi through e.g. scaling up in areas where work is going well. Quality control has also been a topic of discussion during SRHR alliance meeting and review meetings with other donors. BVHA is continuously trying to upgrade its quality control.

Score baseline: 3.0

Score endline: 3.5 (slight improvement)

Capability to relate

Level of involving external parties in internal policy/strategy development

4.1. Stakeholder engagement in policies and strategies: 'The organisation maintains relations/ collaboration/alliances with its stakeholders for the benefit of the organisation'

This is about whether the SPO engages external groups in developing their policies and strategies, and how.

The Governing Board of members continues to play a very important role to the extent of sometimes being authoritative. It is the responsibility of the executive director of BVHA to arrange meetings with the Board and keep them updated on all important issues. The board members, trained staff of BVHA and consultants take part in developing policies and strategies for BVHA. BVHA has formed a BVHA Programme Advisory Committee which sits after every six months to help BVHA in developing and setting strategies, quality programmes and direction for effective implementation. Besides direction of the Governing Board of BVHA, now BVHA is engaging its partner organisations in planning the programme, designing the implementation plan as well as also in developing the M&E and data collection formats.

BVHA has been able to play a pivotal role in the SRHR Alliance. BVHA's SRHR initiative aims at Community empowerment on Gender Equity to access Reproductive Health Rights in 2 districts of Bihar. This initiative was identified through discussion with the network partners especially those working in the bordering districts who experience problems due to sexual reproductive health issues.

Score baseline: 3.5

Score endline: 3.75 (very slight improvement)

Level of engagement of organisation in networks, alliances and collaborative efforts

4.2. Engagement in networks: 'Extent to which the organization has relationships with existing networks/alliances/partnerships'

This is about what networks/alliances/partnerships the SPO engages with and why; with they are local or international; and what they do together, and how do they do it.

The organisational structure of BVHA is based on its engagement with partner organisations. Their networks can be broadly divided into (1) SRHR or NGO network; (2) National or local level and (3) formal or informal. Some of the organisations with which they have networked are as follows:

Network	Level
Jan Adhikar Manch	State Level, formal, (only NGOs)
Public Health Resource Network (PHRN)	National level, formal, only NGOs, lawyers, activists
Health Watch Forum Bihar	State Level, formal, only NGOs, Activists
Vada Na todo Abhiyan	National Level, formal, only NGOs, Activists
Christian Health Association of Bihar & Jharkhand	State Level (Bihar & Jharkhand), formal, only health clinics and NGOs
Jan Swasthya Abhiyan	National level, formal,
VHAI – New Delhi	National Level, State voluntary Health Associations
VANI (Voluntary Action Network of India)	National Level, formal, NGOs
State Level SRHR forum at Patna	State Level, Formal, NGOs, Govt. and networks.
District level SRHR Forum at West Champaran	District Level, Formal, NGOs, development partners

BVHA has networked with government, Panchayati Raj Institutions (PRIs), the education and health department and NGOs to improve health conditions for individuals, especially sexual and reproductive health for women as well as the promotion of preventive and curative measures. Engagement with these networks has been mainly through workshops. Some of the examples of these workshops are: training on advocacy, progress, joint agenda; three day advocacy workshop: working on state level and national joint agendas; state level visit; three day capacity building workshop for SRHR Alliance by CINI on policy and advocacy.

BVHA continued to work in 38 districts of Bihar with 115 members and 300 associated non-members. Over the last two years the main change has been BVHA's increased work on advocacy with different levels of government officials for better SRHR services specifically at the state, district and block level which has led to proper access of the required services for the community. This has been a component of the SRHR project with the aim for BVHA to serve as a link between the government and the beneficiaries so that the beneficiaries get quality services. In networking with various agencies BVHA has been initiated as a state level network for SRHR issues that led to enhanced recognition and rapport with government officials and development agencies. With a view to be in a better position to carry out sustained lobbying and advocacy with policy targets, further capacity strengthening initiatives have been undertaken by BVHA: increased collaboration between SRHR partners; training of partner representatives of SRHR Alliance on CSE and SRHR.

BVHA is now an active part of the India SRHR Alliance which is continuously working on the SRHR related issues to advocate at national, state and district level. Several issues are jointly identified which are common in the three states and strategies to address them by for example developing the SRHR manual. Besides that, BVHA is an active member of the Wada Na Toda Abhiyan-Bihar and the India Chapter. BVHA has also discussed many health issues with the community people in 16 Member of Parliament constituencies of Bihar and accordingly these issues were compiled and submitted to the concerned political parties for inclusion in their political manifesto and many of the issues are now included. BVHA is in collaboration with the Health Watch Forum Bihar and Centre for Health and Social Justice, New Delhi, addressing the quality of family planning issues in Bihar. Besides that, BVHA is raising health issues in different other forums and is making regular correspondences with its network partners to visit and meet the Civil Surgeon and District Magistrate to make the District Health Society and other government formed Committees functional.

A last example of BVHA's network at work is when they were able to help their sister organisation in Bettiah by getting permission from the district collector for the civil surgeon and the medical officer in charge of the community health centre to implement their SRHR in the sister's organisation hospital without any resistance. This has led to improving their quality of work and strengthening of their relationship with BVHA.

Score baseline: 4.0

Score endline: 4.5 (slight improvement)

Extent to which organisation is actively engaging with target groups

4.3.Engagement with target groups: 'The organisation performs frequent visits to their target groups/beneficiaries in their living environment'

This is about how and when the SPO meets with target groups.

The organisational structure of BVHA is still such that their direct target groups are their network partners, who in turn interact with the beneficiaries. It is only during the Annual General Body meetings and workshops organised by BVHA that there is an opportunity for direct interaction with the beneficiaries. Over the last two years, board members and the Executive Director of BVHA have taken the initiative to visit the target groups when invited by the partners, and surprise visits are also made. This change has been attributed to the demands made by the donor. When the concerned project head goes to their concerned project operational areas, they also visit the other network partners who are close by or on the way. The BVHA Governing Board also took the decision to hold at least two Governing Board Meetings in the project network partner's place so as to meet and interact with them and other network organisations located nearby. BVHA has also started implementing some projects directly in the community where they are continuously interacting with the target beneficiaries in the Maner and Phulwarisharif blocks of the Patna district and in the Bidupur block of the Vaishali district. Regular engagement with the partner organisations is also in the mandate of the MFS II funded project on SRHR. Within this project BVHA visits the partner projects on a monthly basis and reviews the activities and progress on quarterly basis. Partners received frequent supervision from BVHA and got new exposures through the SRHR alliance.

Score baseline: 3.5

Score endline: 4.0 (slight improvement)

Level of effective relationships within the organisation

4.4.Relationships within organisation: 'Organisational structure and culture facilitates open internal contacts, communication, and decision-making'

How do staff at the SPO communicate internally? Are people free to talk to whomever they need to talk to? When and at what forum? What are the internal mechanisms for sharing information and building relationships?

Staff continue to be free to share their problems and opinions at any time. Some of the forums where staffs can communicate their issues to top management are: monthly staff meetings, quarterly financial meetings, quarterly meetings with board members and meetings with the core group and project coordinators. For issues or grievances staff now first discuss this with their immediate supervisors and if it is not solved there, then it is referred to higher level. Many such issues are also discussed in the one to one meetings and sometimes jointly in the monthly staff meetings. Sometimes, if the matter is very serious, then it is referred to the Governing Board. If staff members want to discuss an issue on the programme part, then they first discuss the matter with the programme manager and if it is required to discuss it at the higher level, then, the concerned project head on an individual basis or along with the programme manager comes to the Executive Director to sort out the matter.

Score baseline: 4.0

Score endline: 4.0 (no change)

Summary of capability to relate

The Board of BVHA, that is composed of network members, still has an important role in developing policies and strategies together with staff. BVHA still engage partner organisations in planning of projects, but now also involves them in developing M&E formats. A BVHA Programme Advisory Committee has been established that meets every six months to discuss strategies and give directions

for effective implementation. An example of a project that was designed participatory is the SRHR initiative that was developed together with BVHA's network partners. The organisational structure of BVHA is based on its engagement with partner organisations. BVHA continued to work in 38 districts of Bihar with 115 members and 300 associated non-members. Over the last two years the main change has been BVHA's increased work on advocacy with different levels of government officials for better SRHR services specifically at the state, district and block level which has led to proper access of the required services for the community. With a view to be in a better position to carry out sustained lobbying and advocacy with policy targets, further capacity strengthening initiatives have been undertaken by BVHA: increased collaboration between SRHR partners; training of partner representatives of SRHR Alliance on CSE and SRHR.

BVHA still works mostly through their network partners which they now visit more frequently (monthly) as this was in the requirements of the MFS II funded project. The Board and Executive Director also took the initiative to visit target groups themselves and make surprise visits. BVHA has also started implementing projects directly and has in that sense increased its interaction with the beneficiaries. Staff continue to be free to share their problems and opinion at any time. Staff can communicate their issues to top management during monthly and quarterly meetings. Issues or grievances of staff are now first discussed with their immediate supervisors and if it is not solved there, then it is referred to higher level.

Score baseline: 3.75

Score endline: 4.0 (very slight improvement)

Capability to achieve coherence

Existence of mechanisms for coherence

5.1.Revisiting vision, mission: 'Vision, mission and strategies regularly discussed in the organisation'

This is about whether there is a vision, mission and strategies; how often staff discuss/revise vision, mission and strategies; and who is involved in this.

Vision and mission of BVHA remain unchanged. There continues to be discussion on the vision and mission of the organisation once a year in the Annual General Body Meeting. Members, programme officials and management are involved in the discussion. A Programme Advisory Committee that has been formed for effective programme management and future strategy development. Strategy related changes that were adopted by BVHA as a result of donor's demands only led to strengthening of the organisation's mission.

Score baseline: 4.0

Score endline: 4.0 (no change)

5.2.Operational guidelines: 'Operational guidelines (technical, admin, HRM) are in place and used and supported by the management'

This is about whether there are operational guidelines, which operational guidelines exist; and how they are used.

BVHA has a personnel, admin, finance, gender and child protection policy which remain unchanged. The detailed technical guidelines for the SRHR project that were missing during baseline are now in place. BVHA developed with the SRHR alliance a detailed SRHR manual with guidelines for better implementation of the SRHS project.

Score baseline: 4.0

Score endline: 4.5 (slight improvement)

Level of coherence of various efforts of organisation

5.3. Alignment with vision, mission: 'Projects, strategies and associated operations are in line with the vision and mission of the organisation'

This is about whether the operations and strategies are line with the vision/mission of the SPO.

BVHA continues to keep its projects; strategies and operations in line with the vision and mission of the organisation.

Score baseline: 4.5

Score endline: 4.5 (no change)

5.4. Mutually supportive efforts: 'The portfolio of project (activities) provides opportunities for mutually supportive efforts'

This is about whether the efforts in one project complement/support efforts in other projects.

Health remains the focus area for BVHA and projects are chosen in consonance with it and are mutually supportive. While health remains a focus area, availability of donor agencies determines the particular area under health issues to be focussed on.

Score baseline: 3.5

Score endline: 3.5 (no change)

Summary of capability to achieve coherence

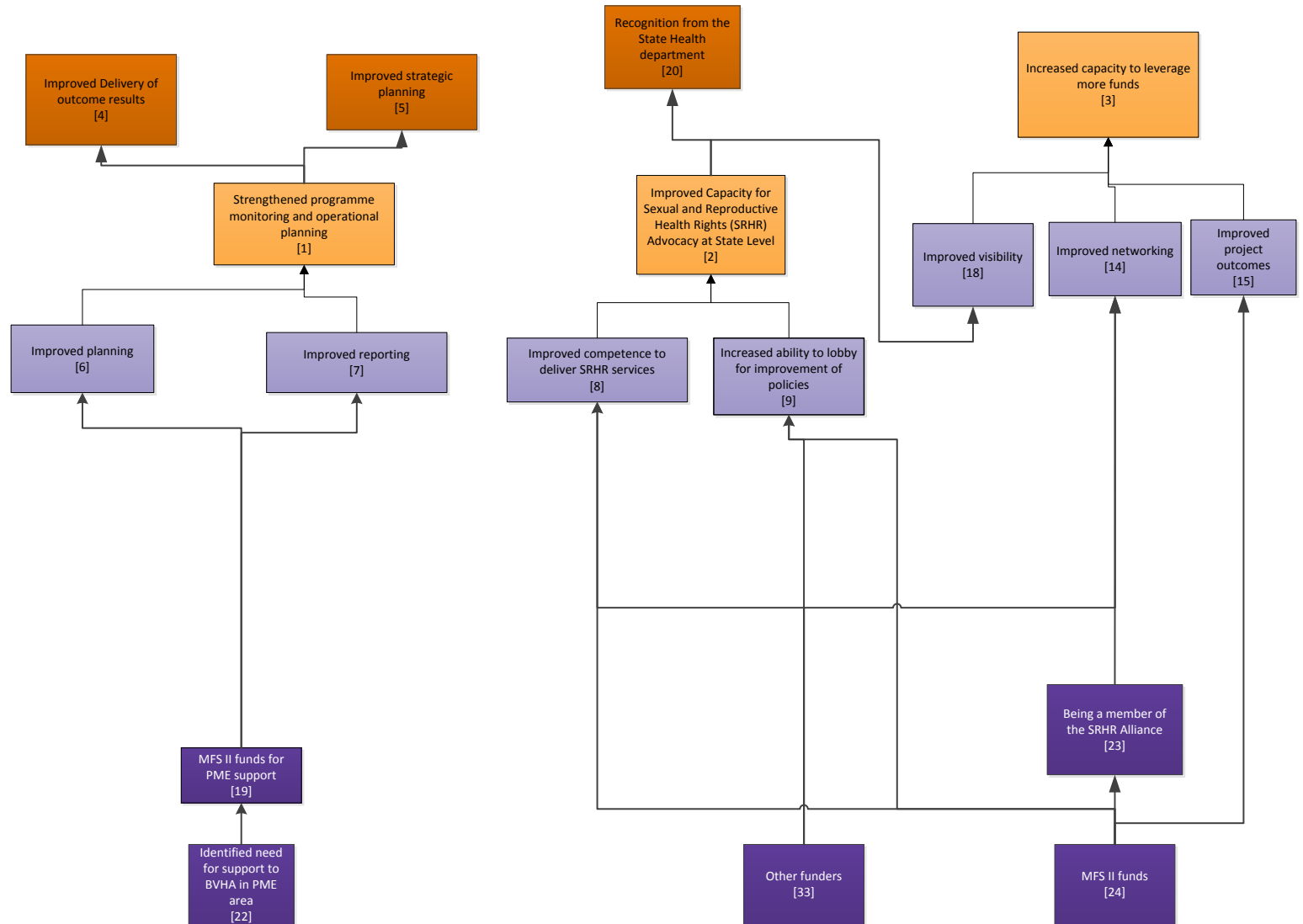
The vision and mission of BVHA have remained the same. BVHA's projects remain to mostly focus on health related issues, where the availability of donor agencies determines the specific issue to focus on. Projects are mutually supportive. Personnel, admin, finance, gender and child protection policies remain in place. There are now detailed technical guidelines for the SRHR project, developed with the SRHR alliance since the baseline. Operations and strategies of BVHA which now include health and livelihoods remain aligned to their vision and mission.

Score baseline: 4.0

Score endline: 4.1 (no change)

Appendix 4 Results - key changes in organisational capacity - general causal map

As the changes in organisational capacity in the general causal map and the detailed causal maps partly overlap, you will find the detailed causal map of increased capacity to leverage more funds here, for the other two key outcome changes, please refer to Appendix 5 for the details.



Increased capacity to leverage more funds [3]

This was another key organisational change that was mentioned by the staff present at the endline workshop. This increased due to: improved networking [14]; improved project outcomes [15] and improved visibility [18].

The capacity to leverage more funds [3] has increased. Staff of BVHA is highly motivated and tries to go an extra mile to explore new funding opportunities especially with the corporate sector. Now, more new proposals are prepared and sent to different donor agencies the utilization of the BVHA training hall and facilities by other organisations has increased which provides a good source of income for BVHA. Besides this, BVHA has planned to conduct various capacity building training programmes and charge the participants to raise money. BVHA has also started collecting a subscription fee for its Quarterly NEWS letter to meet the costs of producing NEWS [Source: 5c endline self-assessment sheet_management_India_BVHA].

- Improved visibility [18] was another reason for improved capacity to leverage funds.
 - BVHA's visibility improved because of *improved advocacy at state level* [2]. Some of the advocacy interventions in the SRHR project have led to BVHA meeting the most senior officials and ministers to discuss on the SRHR issues in Bihar and it has helped for better recognition of BVHA at the state level. This evident from the fact that BVHA could get the approval of the state government to undertake East Champaran district (one of the SRHR project districts) and set up Adolescent Friendly Health Clinics. Further, the Government of Bihar recognizes BVHA as a member of the State Technical Advisory group in Bihar and invites BVHA for consultation whenever there is a meeting related to SRHR issues. Also BVHA is the member of state level thematic sub groups on TFR, MMR and IMR for policy level changes. Improved capacity and visibility facilitated BVHA to leverage funds from government and other sources. For example, as a result BVHA leveraged funds from the Ministry of Health and Family Welfare of the Government of India since 2013 for the "Awareness Building Among communities on Girl Child Survival and PC & PNDT Act" project [Source: 5c endline self-assessment sheet_management_India_BVHA, discussion during endline evaluation, thematic group 11, stag meeting-PFI].
- Improved networking [14] is one of the reasons for this improved capacity to leverage more funds. BVHA's networking improved because of:
 - *Being a member of the SRHR Alliance* [23] (through the Simavi supported projects under MFS II [24] [Source: 5c endline self-assessment sheet_management_India_BVHA]. Their credibility as SRHR alliance member, and ability to implement a comprehensive SRHR programme has attracted donors . For example UNICEF started funding the Maternal Death Review Project under the project title 'Piloting Review Maternal Death in two districts of Gaya and Purniya, Bihar' since February 2014 [Source: discussion during endline workshop, BVHA Annual Report 2013-14].
- Improved project outcomes [15]. The project "Pre-conception and Prenatal Diagnostic Techniques (PC PNDT)" supported by Simavi since 2009 to 2012 resulted in improved perception of the community regarding female feticide. For example BVHA Annual Report 2011-12 indicates that over the three year period (2009-12) due to this project there is gender balance in child care, improvement in social and educational status of girls, decline of child marriage and violence against women, pre-sex detection for girl feticide stopped etc. It not only increased visibility and capacity of BVHA at the state and national level but also motivated the staff to approach new funders. As a result BVHA could use this project results to leverage funds from the Ministry of Health and Family Welfare, Government of India since 2013 for the "Awareness Building Among communities on Girl Child Survival and PC & PNDT Act" project [Source: discussion during endline workshop]. This project was funded under MFS II [24].

Appendix 5 Results - attribution of changes in organisational capacity - detailed causal maps

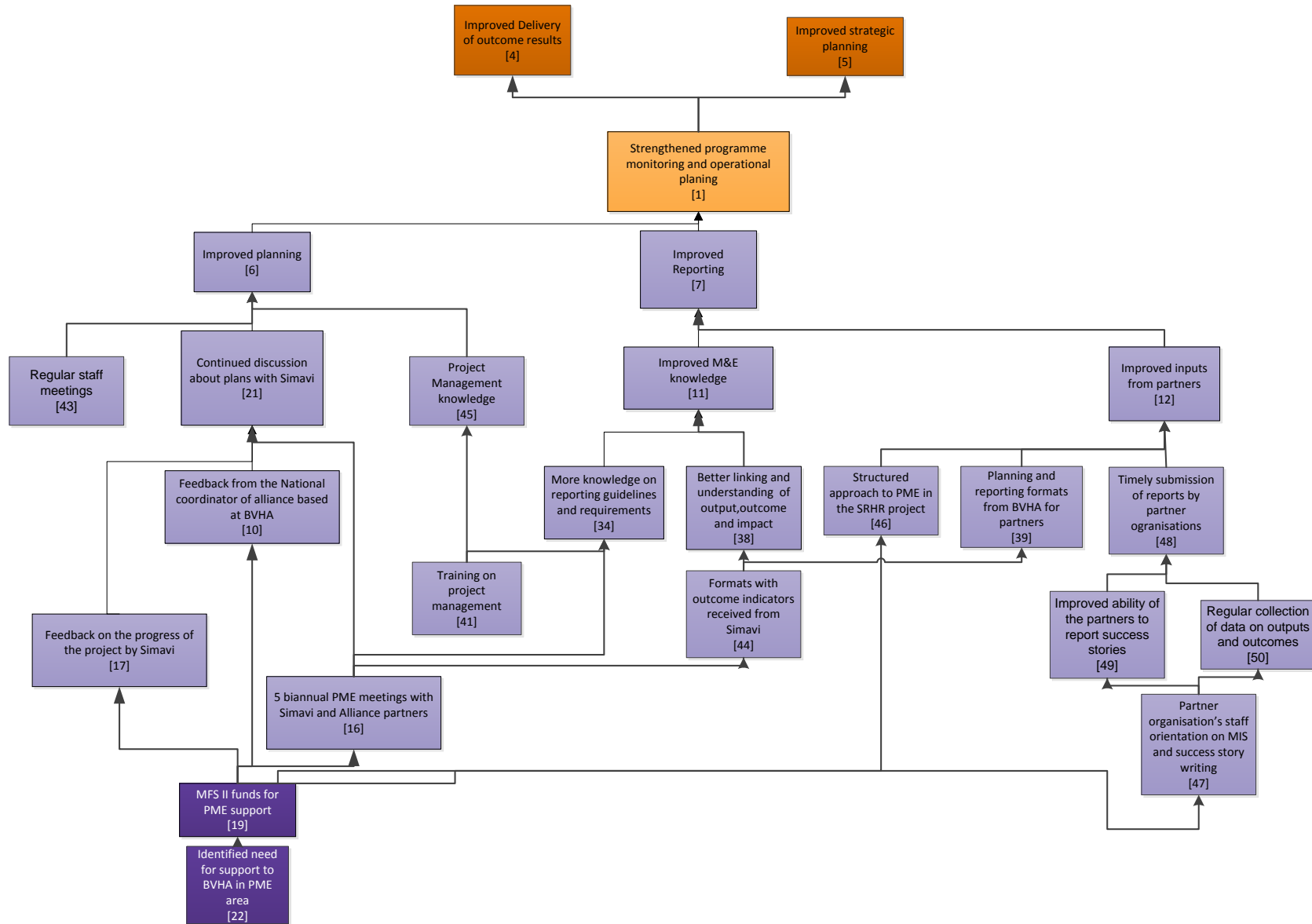
The evaluation team carried out an end line assessment at BVHA from 18 to 20 June 2014. During this workshop, the team made a recap of key features of the organisation in the baseline in 2012 (such as vision, mission, strategies, clients, partnerships). This was the basis for discussing changes that had happened to the organisation since the baseline.

There were three main changes that happened in the organisation since the baseline in 2012:

1. Strengthened programme monitoring and operational planning;
2. Improved Capacity for Sexual and Reproductive Health Rights (SRHR) Advocacy at State Level;
3. Increased capacity in to leverage more funds.

These changes coincided partly with the outcome areas that were chosen for process tracing, so as to get detailed information on how these changes in organisational capacity came about. Therefore the general causal map overlaps strongly with the causal maps developed for each of these outcome areas/organisational capacity changes to be analysed during the process tracing. All the details about these changes in organisational capacity as well as the underlying factors that influenced these changes are described in the narrative and visual below. There is general causal map that explains the overview of these but for the details please see the separate causal maps for improved program monitoring and planning, and the causal map for improved capacity for SRHR advocacy.

The first two main organisational capacity changes are described in the light orange boxes and some of their key consequences are noted above these cards in dark orange. Light purple boxes represent factors and aspects that influence the key organisational capacity changes (in light orange). Key underlying factors that have impacted the organisation are listed at the bottom in dark purple. The numbers in the visual correspond with the numbers in the narrative.



Strengthened Programme Monitoring and Operational Planning [1]

According to the Executive Director, BVHA has strengthened its planning and monitoring activities in the past two years [1] [Source: 5c_endline assessment_sheet _ India_BVHA _ Simavi_NB]. During the completion of the SRHR project and Oxfam India project, BVHA developed better M&E formats. These formats were shared with their partner organisations for systematic data collection and timely reporting. Through improved planning and monitoring The organisation was thus able to use timely information while planning for future activities. BVHA is now in the process of developing organisational M&E formats for tracking progress of the programs/projects as and when required [Source: 5c_endline self-assessment sheet_management_India_BVHA].

Improved planning and monitoring has led to **improved delivery on outcome results** [4] as well as **improved strategic planning** [5]. This is evident from the fact that *"During the baseline, the current project was evaluated and they reached the outputs but not the outcomes. Now their outcome results were very good, this indicates improvement"* [Source: 5c_endline assessment_sheet _ India_BVHA _ Simavi_NB]. The improvement in outcome results has been due to continuous and regular discussions on outputs/ outcomes and planning of achievements with the CFA and support provided through PME workshops [Source: 5c_endline assessment_sheet _ India_BVHA _ Simavi_NB].

Strengthened Program monitoring and planning was due to [1]: improved planning [6] and improved reporting [7]. Each of these changes are further discussed below.

Improved planning [6]:

BVHA has improved its planning over the last two years [Source: 5c_endline self-assessment sheet_management_India_BVHA]. This is due to having regular staff meetings [43], continued discussion about plans with Simavi [21], and project management knowledge [45]. Strategic planning has improved as *"BVHA is now able to identify strategic moves, more effective interventions, such as use of multiple strategies, multi-stakeholder involvement at various levels, use of multimedia IEC strategies."* And *"Simavi allows for strategic changes. In the case of BVHA, we were not encouraging working with in-school youth, but they lobbied for it, so we revised strategy together. Government was supposed to train midwives but because of insufficient quality, we asked BVHA to step into this issue and organise training"* [Source: 5c_endline assessment_sheet _ India_BVHA _ Simavi_NB].

- Regular staff meetings [43]. Every month, the staff has to present action plans stating details of activities they would be doing in the coming month and staff are also expected to explain the reasons for not fulfilling their stated objectives in the previous month. There are pre-designed formats in which the staff has to report on their plans in the meetings [Source: Action plan]. This exercise has helped the staff individually to improve their capacities in making plans as well as keeping their commitments. This in turn has improved the planning process of the organization.
- Continued discussions about plans with Simavi [21]: The support from Simavi has been in the form of feedback on project progress by Simavi [17], feedback from the National Coordinator [10] based at BVHA and through Biannual PME meetings with Simavi and the Alliance Partners [16].
 - *As the National Coordinator of the SRHR alliance has been based in BVHA since February 2012 [10], there has been continued discussion about plans with Simavi [21]. This national coordinator gave constructive feedback to BVHA on plans in order to align them with Simavi's PME requirements [Source: interview with National coordinator, discussion during workshop; 20130923-SRHR Programme and NGB meeting TT(oct)].*
 - The continued discussions [21] also took place because BVHA received support from Simavi, consisting of *feedback on the progress of the project by Simavi [17]* as is evident from the program appraisal form [Source: 2014-01-09_PAF BVHA UFBR ct 2014-2015].
 - Furthermore, *the biannual PME meetings of the alliance partners [16]* have helped BVHA to improve its planning [Source: Dates May 2012, October 2012, March 2013, October 2013; 5c_endline self-assessment sheet_management_India_BVHA; 20120501-SRHR review meeting plan; 20121002-SRHR review and planning meeting; 20130211-SRHR program and NGB meeting TT(Oct)]. These biannual meetings with alliance partners included the following activities:

- There was organised sharing of and reflection on results with alliance partners;
 - A field visit to the area of intervention of one of the partners;
 - Detailed discussion on learnings from the visit in terms of strengths and weaknesses of the project ;
 - Presentation by partners on their project highlights, progress, successes and main bottlenecks.
 - These meetings provided in depth insight into the project interventions and BVHA also received feedback from the Country lead of Simavi and other Alliance members, as well as their experiences and comments to improve the project implementation and strategies. It helped them adopt best practices, strategies etc. [Source: Annex C_5C endline_support to capacity development sheet_BVHA].
- Project management knowledge [45]
 - Trainings such as the *5 Days Course on Project Management [41]* at Goa funded and organized by the International Union against Lung Disease and Tuberculosis, New Delhi in which the Executive Director took part equipped the participants with required knowledge and skill of proposal development on Tobacco Control and other social development issues. The major topics covered under the five days course were: Project Life Cycle, situation analysis, stakeholders analysis, problem tree, cause effect relationship, means-end relationship, objective tree, strategy analysis, log frame analysis, activity detailing, Gantt Chart preparation, SWOT analysis, sustainability plan [Source: BVHA Annual Report_2012-2013]

The national coordinator [10], biannual PME meetings [16] and feedback on project progress [17] were all PME support funded by MFS II [19]. Simavi supported the Planning, Monitoring and Evaluation capacity of BVHA in this way because they identified a need for this [22]. BVHA staff articulated their need to be trained in PME. This is evident from the minutes of the meeting of the inception workshop in November 2011. In this workshop there was a “marketplace” exercise, where partners put forward the capacities they could offer, and the capacities they required for the SRHR project. Skills (both offered and required) were grouped by topic, and those relevant to the SRHR issues were taken up in the Joint Capacity Building Plan. Thus building capacities of BVHA in PME were incorporated in the plan [Source: 9jan2012_Minute of India Workshop 21-24 November 2011].

Improved reporting [7]:

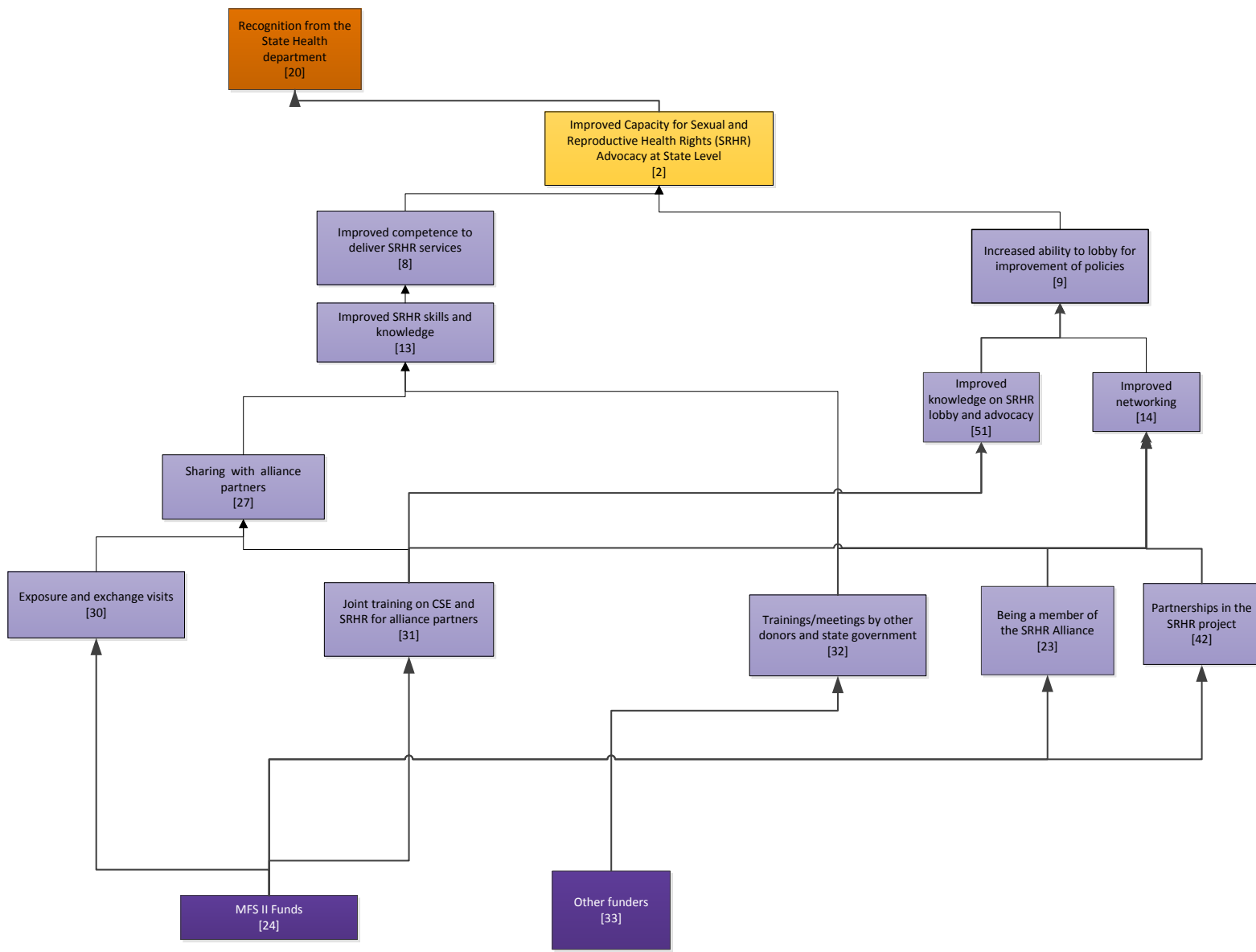
BVHA participants that attended the endline workshop indicated that BVHA has improved reporting since the baseline [7]. Evidence of this can be found in Simavi’s response to a report submitted by the Project Manager [Source: Approval of revised Annual Report and Financial report 2012]. The improved reporting is due to improved PME knowledge [11] and improved inputs from partners through reports [12].

- M&E knowledge improved [11][Source: CFA endline assessment, and support to capacity development sheet – CFA]. According to the National SRHR Coordinator, BVHA now has got the capacity to develop the M&E System for the SRHR Alliance which other alliance members can adopt [Source: 5c endline interview guide_OD consultants_selected indicators_(BVHA-Jose T)]. PME knowledge improved because of:
 - More knowledge on reporting guidelines and requirements [34] [Source: 2014-04-04_RA1-CSS (f1) India country paragraph]. Over the period as BVHA gained more knowledge on reporting guidelines and requirements it was capacitated in developing formats that are easy to understand for their network and partner organisations to collect systematic data. It fine-tuned the indicators which resulted in getting information as per the requirements. The staff linked the output, outcome and impact to assess the achievement. Proper methods for monitoring progress are now in place and the partners are trained on this which resulted in the partners to better articulate their work to BVHA. Project staff analyse and monitor the data to identify practical gaps for further planning [Source: 2014-04-04_RA1-CSS (f1) India country paragraph, 2014-03-03_v3 BVHA SRHR Annual Report 2013, 2014-04-18 vs4 (FINAL for distribution India 2013 UFBR AReport, 20120501-SRHRreview meeting-plan)]. Knowledge on reporting guidelines and requirements improved because of a training on project management [41] and feedback, discussion on formats, explanations on evaluation methodologies and discussions on purpose of monitoring during the biannual PME meetings [16] [Source: 2014-05-07_(LL2)]

5C_endline_support_to_capacity_development_sheet_CFA_perspective_India_BVHA_Simavi_NB (2)]

- Training on project management [41]: 5 Days Course on Project Management at Goa by the International Union against Lung Disease and Tuberculosis, New Delhi. The major topics covered under the five days course was- Project Life Cycle, situation analysis, stakeholders analysis, problem tree, cause effect relationship, means-end relationship, objective tree, strategy analysis, log-frame analysis, activity detailing, Gantt Chart preparation, SWOT analysis, sustainability plan. This resulted BVHA to learn various evaluation methodologies and monitoring process to improve its planning and monitoring process. This training helped BVHA gain more knowledge on reporting guidelines and requirements. For example, they fine tune the indicators to better assess the progress and collect the data as required, the activities and the achievements are better linked to assess the impact [Source: BVHA Annual Report_2012-2013].
- Sharing and reflecting during the biannual PME meetings [16]: In these meetings the alliance members shared and reflected on various issues related to PME such as, reporting requirements of the PME group of the SRHR alliance, monitoring and evaluation requirements, detailed discussion on the field visits in terms of strengths and weaknesses of the project, partners reported on their project highlights, progress, successes and main bottlenecks, etc. As a result BVHA received feedback from Country lead of Simavi and other Alliance members, their experiences, comments to improve the reporting structure, setting up formats as per requirement, linking up the activities, outcome and impact etc. It also helped them adopt best practices, strategies etc., to improve their planning and monitoring process [Source: Annex C_5C_endline_support to capacity development sheet_BVHA,p5, 20121002-SRHR review and planning meeting TT(2), 20120501-SRHRreview meeting-plan].
- Better linking and understanding of output, outcome and impact [38] mainly by BVHA project officer [Source: (LL2)5c_endline_assessment_sheet_India_BVHA_Simavi_NB; reports of biannual PME meetings and document;2014-04-01_(f1) LINKING OUTPUTS TO OUTCOMES India].
 - Formats with outcome indicators were given by Simavi [44] so that BVHA could assess the outcome and impact of the activities of their partners on the ground. Also during the Biannual PME meetings [16] there was detail discussion on how to select outcome indicators, Identifying sources of verification and tools for outcome indicator measurement, monitoring output indicators, etc. It helped the project staff of BVHA to link and better understand outcome and impact. This is evident by the fact that BVHA assessed the satisfaction level of beneficiaries in their partner organisation project area i.e. in Raxaul and Majhulia. Also an assessment of the involvement of Community Leaders and their awareness levels with respect to SRHR was made by the BVHA project staff as per a given set of indicators in the M&E format [Source: Assessment of involvement of community leaders – Report]. During the completion of the SRHR project and Oxfam India project, BVHA developed better M&E formats. These formats were shared with their partner organisations for systematic data collection and timely reporting. Through improved planning and monitoring. The organisation was thus able to use timely information while planning for future activities. BVHA is now in the process of developing organisational M&E formats for tracking progress of the programs/projects as and when required [Source: 5c_endline_self-assessment sheet_management_India_BVHA].
- Sharing and reflecting during the biannual PME meetings [16]. During the Biannual PME meeting there is extensive discussion/sharing on monitoring output and outcome indicators, frame work for the outcome and output indicator, identifying sources of verification and tools for outcome indicator measurement, setting up of target indicator for 2015 etc. helped BVHA better linking output, outcome and impact. For example, as indicated in the Linking Output and Outcome report for 2014 reveals that because of improved ability to link output and outcome BVHA could identify the impact of the SRHR project and the gaps in between plan and implementation of government programmes [Source: 20121002-SRHR review and planning meeting TT(2), 20120501-SRHRreview meeting-plan]
- Improved inputs from partners through reports [12]. BVHA has been implementing the project “Community empowerment on Gender Equity to access Reproductive Health Rights in 2 districts of Bihar” through its partner organizations – Duncan Hospital, Raxaul (East Champaran) and Fakirana Sisters Society, Bettiah (West Champaran).

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- *The SRHR project follows a structured approach to PME [46]. There is dedicated staff for M&E: the district coordinator at the field level; the project manager and ED at BVHA are responsible for monitoring and evaluation. Simavi has provided planning and reporting formats that enable BVHA to track all the proposed activities, find reasons for the success or failure of completion of those activities and plan for the next quarter. On the basis of the results based monitoring concept there are quarterly monitoring formats and BVHA compiles the collected data from the partners. Reports are sent to Simavi biannually. Simavi sends feedback on the data [Source: 19Jan12_Final Application Form (BVHA) Simavi-UFBR alliance, 5c*
endline_questionnaire_training_participant_perspective_India_orientation for the CSO staff and 5c_endline assessment_sheet _ India_BVHA _ Simavi_NB].
 - *The partner organisations of BVHA involved in the programme implementation of BVHA were given formats for data collection and reporting [39] which they had received from Simavi [44] [Source: Outcome monitoring templates]. This helped the partners not only improve the quality of their data collection but also ensured their timely input.*
 - *There was timely submission of reports [48] with qualitative and quantitative inputs because:*
 - *The ability of the partners to report success stories improved [49] and*
 - *There was regular collection of data on outputs and outcomes [50] [Source: Annex C_5C endline_support to capacity development sheet_BVHA].*
 - *Both [49] and [50] were a result of: Two days orientation of the staff on MIS and success story writing was given to the partner organisations [47] in September 2012 which further helped the staff of the partner organisation to fill the MIS formats with ease and regularly collect data on output and outcome indicator. This was funded by MFS II as PME support [19] [Source: Annex C_5C endline_support to capacity development sheet_BVHA].*



Improved Capacity for Sexual and Reproductive Health Rights (SRHR) Advocacy at State Level [2]

Over the last two years BVHA has improved its capacity for sexual and reproductive health advocacy at the state level [2] [Source:

5c_endline_support_to_capacity_development_sheet_CFA_perspective_India_BVHA_Simavi_NB; discussion during the endline workshop]. This has helped BVHA in getting recognition from the State Health department [20] [Source: 5c endline self-assessment sheet_management_India_BVHA, Letter of ED SHS Bihar for SRHR Project, stag meeting-PFI] BVHA has brought up SRHR issues to the attention of the state government which is demonstrated by the examples described here. They wrote an advocacy paper with the objective of ensuring availability and accessibility of comprehensive Sexual and Reproductive Health services for adolescents & women at community and school level [Source: Bihar advocacy paper _ 4 pager].

BVHA has brought about and showcased successful models and approaches that have either been mainstreamed or promoted by the government as 'replicable models.' An example to substantiate the above claim is the newly launched 'Dus kadam Ka Dum' which translated into English means 'The power of 10 steps'. This is a campaign initiated by the Government of Bihar that promotes a package of practices for better maternal and child health seeking behaviour of communities. BVHA as a partner of the Government of Bihar on health issues, contributed significantly to this process, especially on matters pertaining to use of contraceptives [Source: Interactions_with_CSO_and_others-22_2_20141].

Another example of translation of advocacy efforts into success has been the way, the SRHR Alliance got the government health service delivery mechanism to upgrade the infrastructure in the rural health centres (RHC) and district maternity homes (DMH). Lack of privacy for pregnant women especially during the delivery process was a major deterrent for women to visit these RHCs and DMHs. As a result of constant advocacy by BVHA, the district maternity homes have been provided with curtains and better amenities to ensure privacy during delivery. Presence of a qualified medical practitioner has also been made mandatory for all institutional deliveries [Source: Interactions_with_CSO_and_others-22_2_20141].

BVHA was closely involved in the core group of – Reduction of Total fertility Rate (TFR) under "Bihar Manav Vikas Mission (Bihar Human Resource Development Mission)" [Source: 2014-03-03_v3 BVHA SRHR Annual Report 2013]. BVHA has also been able to convince the Government of Bihar to take up the East Champaran District in the first phase for setting up the ARSH (Adolescence Reproductive Sexual Health) clinics [Source:

5cendline_questionnaire_training_participant_perspective_India_BVHA_Exposure visit Adolescent RSH clinic dec 2012_Swapan Mazumder].

Improved Capacity for Sexual and Reproductive Health Rights (SRHR) Advocacy at State Level [2] is due to: improved competence to deliver SRHR services [8] and increased ability to lobby for improvement of policies [9]. Each of these organisational capacity changes and how they have come about is described below.

Improved competence to deliver SRHR services [8]

BVHA's capacity for Sexual and Reproductive Health Rights (SRHR) Advocacy at State Level [2] occurred because BVHA as an organisation has been in the fore front in delivering SRHR services through its local partner organisations and thus is seen as one of the leading partners to take forward advocacy issues on SRHR. Over the last two years BVHA has improved its competence to deliver SRHR services through its local partner organisations [8] [Source: Interactions_with_CSO_and_others-22_2_20141, 2014-01-09_PAF BVHA UFBR ct 2014-2015, 5c endline self-assessment sheet_management_India_BVHA]. The SRHR program supported by Dutch Alliance is working through its local partner organizations namely NEEDS, VHAI, SEWA, BVHA, CINI and Restless Development in the states of Jharkhand, Odisha and Bihar for a period of five years: 2011 - 2015. The programme covers five districts in Bihar, three districts in Jharkhand and two districts in Odisha [Source: ARSH clinic visit, SRHR Training Manual & Resource book hindi].

BVHA's SRHR initiative aims at "Community empowerment on Gender Equity to access Reproductive Health Rights in 2 districts of Bihar". This initiative was identified through discussion with the local partners especially those working in the bordering districts since they have experienced a big problem regarding the sexual reproductive health issues. These districts are adjacent to NEPAL and there is high prevalence of trafficking especially for women/adolescent girls as well as the above mentioned problems, which make the situation more critical [Source: 2012Jan19_PDF_BVHA 3312001]. BVHA's improved competence to deliver SRHR services [8] is evident from the fact that the Government of Bihar recognizes BVHA as a member of State Technical Advisory group in Bihar and invites BVHA for consultation whenever there is a meeting related to SRHR issues. Further, BVHA is the member of state level thematic sub groups on TFR, MMR and IMR for policy level changes [Source: thematic group 11; BVHA Annual Report 2012-2013]. Also, Magic bus organized a two day state consultation on Adolescent Reproductive and Sexual health with the government of Bihar and development Partners at Patna and the BVHA staff were invited to participate in this event [Source: BVHA Annual Report 2013-2014].

BVHA's competences to deliver SRHR services improved [8] because of **improved SRHR skills and knowledge [13]** [Source: (LL2)5c_endline_assessment_sheet_India_BVHA_Simavi_NB; 2014-05-07_(LL2)

5C_endline_support_to_capacity_development_sheet_CFA_perspective_India_BVHA_Simavi_NB (2)].

The improved SRHR skills and knowledge are reflected in the special curriculum on Comprehensive Sexuality Education (CSE) which was developed by BVHA in consultation with the Government. BVHA developed a special curriculum for young people on CSE which they used through trained staff for educating young boys and girls and empower them to make their own choices around sexuality and reproduction and claim their rights. This is modelled on the Compendium on Young People's SRHR Policies in Europe, which was developed as part of SAFE II Project (Sexual Awareness for Europe). BVHA also organised Refresher Trainings on CSE in April 2013. BVHA conducted sessions for young people to provide proper SRHR education. Newly wed young couples were given education on family planning, delaying early pregnancy, sex selective abortions, mutual understanding and faithfulness with their counter parts etc. They also held sessions with the adolescent boys and girls to discuss topics like life skill education, gender, changes during adolescence, reproduction system, sexual violence, HIV/AIDS, RTI/STI, early marriage, early pregnancy, restart of school education, etc.

[Source: CSE definition SRHR Alliances Asian Countries; SRHR Training Manual & Resource book hindi, 2014-03-03_v3 BVHA SRHR Annual Report 2013]. SRHR skills and knowledge have improved since the baseline [13] because of sharing with alliance partners [27], trainings and meetings by other donors and state government [32]:

- Sharing with alliance partners [27]. The continuous interaction and sharing of experiences of BVHA with the alliance partners through exposure visits and trainings in their respective target areas helped BVHA improve their SRHR knowledge and skills [Source: 2014-04-18 vs4 (FINAL for distribution India 2013 UFBR A Report)]. These learnings were then shared with their partner organisations to improve programme implementation. Some details of the interactions with the alliance partners are given below:
 - *Exchange and exposure visits [30]:*
 - Exchange visit to NEEDS covering SRHR 10 October 2012. The aim of the visit to NEEDS- SRHR project was to share experiences, to understand the different project strategies; to give recommendations to the project, to identify strengths that can be replicated. NEEDS showed their community approach in SRHR, and innovations through mobile phone for SRHR. This visit helped in better program implementation and desired outcomes. They identified SRHR issues for advocacy, and program strengths that could be used by them for program implementation[Source: 5C_endline_support_to_capacity_development_sheet_CFA_perspective_India_BVHA_Simavi_NB,p. 37; discussion during the endline workshop; 20121002-SRHR review and planning meeting TT(2);5c endline_questionnaire_training_participant_perspective_India_BVHA_Exchange visit NEEDS Oct 2012_Project Manager].This was funded by MFS II [24].
 - Exposure visit to SRHR-YFS/ARSHC clinic of VHAI 19 December 2012 [Source: 5C_endline_support_to_capacity_development_sheet_CFA_perspective_India_BVHA_Simavi_NB; ARSH clinic visit]. The objective was to use the learning from the ARSH clinic visit to replicate it in developing adolescent reproductive health clinic services in the government system as well as bringing about improvement in the quality of the

clinic. The Executive Director of BVHA could get a basic understanding of adolescent health problems, counselling techniques, how to establish and run such clinics, how to convince the government to take up such an initiative, and how to link with HIV testing and counselling centres and its linkages with the project at community level [Source: Training questionnaires: 5c
endline_questionnaire_training_participant_perspective_India_BVHA_Exposure visit Adolescent RSH clinic dec 2012_Executive Director & management; ARSH clinic visit]. This was funded by MFS II [24].

- *Joint training on CSE and SRHR for alliance partners [31]:*

- Meeting for Capacity Building of SRHR Alliance Partners' staff on 18-20 April 2012 in Delhi funded by MFS II [Source: Minutes of the Meeting (April SRHR 2012) revised]. The aim was to improve the capacities of the alliance partners on SRHR by providing them technical information to be used later for training their field partners: understanding the concept of "Sex and Sexuality," female reproductive system and the various methods of contraception. Various apprehensions were faced on the field while providing sex education or counselling on Reproductive and Child Health (RCH) issues. This was funded by MFS II [24].
- Regional meeting Indonesia focus on SRHR-CSE delivery (Indonesia team, alliance office) in November 2013. The Executive Director of BVHA and the program manager went to Indonesia to see how their alliance partners worked with authorities on creating an enabling environment for Comprehensive Sexuality Education (CSE) activities and how the CSE curriculum was being implemented and benefiting a Muslim setting. Group presentations on the strategies and activities on CSE enabled the Executive Director to get knowledge to update CSE in Bihar [Source: 5C_endline_support_to_capacity_development_sheet_CFA_perspective_India_BVHA_Simavi_NB, Facilitation Guide Regional Learning Event_IDN version]. The program manager learnt to implement the adolescent awareness program more smoothly in their project area [Source: Training questionnaires: 5c
endline_questionnaire_training_participant_perspective_India_BVHA_Regional meeting Indonesia SRHR-CSE delivery Nov 2013_Malay Kumar.docx & participants]. This was funded by MFS II [24].
- Training on Comprehensive Sexuality Education (CSE): 3 days for project staff in April 2013 [Source: Training for SRHR partners on Comprehensive Sexual Reproductive Health Rights ;CSE Refresher Training Report]. A refresher training of partners' staff in the SRHR alliance of India was facilitated by Restless Development India on Sexual and Reproductive Health Rights and on Adolescence Health care in Bihar Voluntary Health Association (BVHA), Patna. The consultant from Restless Development Odisha facilitated the session on adolescence and the social, physical and emotional changes that take place during that period, gender, sex and sexuality, abortion, HIV/AIDS. This resulted in the staff of BVHA to improve in SRHR communication skills, coordination and awareness generation with stakeholders. It further resulted in the target groups becoming aware of their rights and they started demanding health services by putting pressure on the government. Also stakeholders had meetings with UNICEF Officials and Principal Secretary Health, Bihar to discuss on various health issues like, Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), Malnutrition, Anaemia and prepare a strategy document to submit to the state government [Source: thematic group 11, discussion during workshop]. This was funded by MFS II [24].
- Discussion on content of joint SRHR manual (all partners and external facilitator, government staff) 5th March 2013 [Source: 20130211-SRHR Programme and NGB meeting TT(2); 5c endline interview guide_OD consultants_selected indicators_BVHA_Dr. JM Dewan]. The objective of this meeting was to finalise the SRHR manual, initiated by VHAI and reviewed by a consultant. BVHA has contributed in developing the SRHR Guidelines which has now been turned into a Manual (SRHR Training Manual & Resource book hindi). This manual is used by all alliance partners (Evaluation Workshop, SRHR Manual). This was funded by MFS II [24].
- Comprehensive Sexuality Education (CSE) training for all partners (basic) by Restless Development in 25-29 June 2012. This training involved introduction to SRHR and 10 life skills through discussion, case study (field level), sharing and learning, physical, psychological and social changes during adolescence, male & female reproductive system, menstrual hygiene STI, HIV, gender, sex and sexuality; sexual abuse; pregnancy, miscarriage, unwanted pregnancy; ANC, PNC; preparation for delivery. Team Building exercises were carried out in order to strengthen the participant's

important skills such as leadership, communication, decision making, critical thinking etc. This training helped the partners to become efficient in their work and achieve program outputs easily[Source:

5cendline_questionnaire_training_participant_perspective_India_BVHA_Workshop_5day CSE training June 25-29_Ram Krishna, SRHR PRTNER TRAINING AT PATNA FROM]. This was funded by MFS II [24].

- *Participation in trainings and meetings funded and organised by other donors and state government [32].*

BVHA staff participated in various workshops, seminars, training programs related to SRHR organized by Government of Bihar (department of health) and other development agencies such as Population Foundation of India, Magic Bus India, World vision, Oxfam India, Future groups etc. [33]. By participating in these events, the capacity of the staff, especially SRHR project staff, enhanced and by sharing their field experience they are able to give input on health budget and strategic plan for health (related to SRHR, HIV/AIDS, etc.) to the Ministry of Health Bihar and on urban health issues to Plan India, New Delhi [Source: 2014-03-03_v3 BVHA SRHR Annual Report 2013]:

- Meeting on Repositioning of Family Planning by Population Foundation of India (PFI), New Delhi on Dec. 2012. A half day workshop was organized by PFI. Here discussions were held around repositioning of family planning within a woman's empowerment and human rights framework so that every family is a planned family and every child is a wanted, healthy child. The staff of BVHA (Executive Director and Advocacy Officer, SRHR Project) learned about improving the quality of care of family planning and reproductive health, preventing sex selection, family planning and reproductive health services, spacing between births etc. [Source: BVHA Annual Report- 2012-13, p. 48, discussion during endline evaluation].

Increased ability to lobby for improvement of policies [9]

BVHA is in a unique position to be working with a large variety of stakeholders. These include NGOs and their workers, network organizations, state level SRHR Alliance members, frontline health service providers, Village Health and Sanitation Committee at Panchayat level, target population in need for SRHR services adolescents both male and female, newlywed couples, eligible couples¹², District and Block level, PRI representatives at Panchayat level, mixed stake holders (religious leaders, opinion leaders, School teacher and other local identified reputed people), Self Help Groups for Dalit Women. Thus, BVHA is in a very good position to create a base, generate awareness, harness the critical mass of stakeholders at all levels to carry out lobby and advocacy at the state level, mainly targeting state policies on SRHR [Source: SIMAVI-Support to capacity sheet – CFA, 5C_endline_support_to_capacity_development_sheet_CFA_perspective_India_BVHA].

The increased ability to lobby is due to **improved knowledge on SRHR lobby and advocacy [51]** and **improved networking [14]**.

- Improved knowledge on SRHR lobbying and advocacy [51] was mainly the result of joint training on CSE and SRHR for Alliance partners [31] and trainings/meetings from other donors and state government [32]:
 - *The joint trainings on CSE and SRHR for Alliance partners [31]* included capacity development of the alliance partners on the following issues: to identify and analyse advocacy issues, key strategies, building advocacy skills and for developing a work plan, to understand how a joint advocacy agenda defines a shared ambition which gives greater opportunities for reaching different stakeholders. The importance of identifying active key players and how to engage them in advocacy. This was funded by MFS II [24].
 - *The trainings/meetings from other donors and state government [32]* included:
 - Workshop on WASH was organized by Wada Na Todo Abhiyan at A.N.Sinha Institute, Patna on 12th December, 2012 [Source: BVHA Annual Report- 2012-13, p. 48]. The aim was to develop effective and communicative tools for

¹² An eligible couple in India is a currently married couple wherein the wife is in the reproductive age, which is generally assumed to lie between the ages of 15-45 years. Such couples are target groups for family planning services.

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- awareness building program to mobilise, sensitize and motivate people to lobby for their rights as well as the discussions on various food security issues, nutrition for pregnant and lactating women etc., led to a common understanding to create a civil society force for advocacy with government to develop policy and plans in the interest of common people.
- Workshop on Bitiya Bachao –Manavta Bachao Aandolan was organized by Action Aid, Patna on 26th December, 2012 [Source: BVHA Annual Report- 2012-13, p. 48]. This training enabled the staff to organize a meeting in January 2013 with the Minister of Health of the Government of Bihar to discuss on infant mortality rates, maternal mortality rates, sex selective abortion including Save the Girl Child. Thus networking with the government improved considerably and improved BVHA’s ability to lobby.
- The improved networking [14] occurred also, as a result of training by other donors [32], BVHA being a member of the SRHR Alliance [23] and partnerships in the SRHR project [42]. These are further explained below.
 - *Being a member of the SRHR Alliance [23]* (through the Simavi supported projects under MFS II [24]). BVHA is an active part of the India SRHR Alliance which is continuously working on the SRHR related issues to advocate at national, state and district level. Several issues are jointly identified which are common in the three states involved in the alliance and strategies have been developed to address them. Besides that, BVHA is an active member of the Wada Na Toda Abhiyan¹³ Bihar and India Chapter. Many health issues were discussed with the community people in 16 MP (Member of Parliament) constituencies of Bihar and accordingly these issues were compiled and submitted to concerned Political Parties for inclusion in their Political Manifesto. Many of the issues are now included. BVHA in collaboration with Health Watch Forum Bihar and Centre for Health and Social Justice, New Delhi is addressing the quality of family planning issues in Bihar. Besides that, BVHA is raising health issues in different other forums and makes regular correspondences with its network partners to visit and meet the civil surgeon and district magistrate to make the District Health Society and other government formed committees functional [14] [Source: 5c endline self-assessment sheet_management_India_BVHA].
 - *Partnerships in the SRHR project [42]*, which is MFS II funded [24], is another reason for improved networking. At the state level, BVHA formed the State level SRHR forum under the chairmanship of the Government authority and other international agencies such as Pathfinder International, Care-India, Population Foundation of India, two network partners, two SRHR Alliance partners and renowned NGOs at Patna. The government of Bihar recognizes BVHA as a member of the State Technical Advisory group in Bihar. Further BVHA is the member of the state level thematic sub groups on Total Fertility Rates (TFR), Maternal Mortality Rates (MMR) and Infant Mortality Rates (IMR) for policy level changes. At the district level too an SRHR forum was formed that liaised with District level authorities on SRHR issues such as Maternal Death Review, Rogi Kalyan Samitis (RKS, i.e. health facility management committees) orientation, Gaps in service delivery [Source: 2014-03-03_v3 BVHA SRHR Annual Report 2013]. It is through discussions at the State level SRHR forum that BVHA identified 5 points for joint advocacy – Gender; Adolescence Reproductive Sexual Health (ARSH); Ante Natal Checkups (ANC); early marriage; Sexually Transmitted Infections (STI)/ Reproductive Tract Infection (RTI) [Source: BVHA Annual Progress Report, SRHR Project 2012]. Furthermore, BVHA as an organisation has been in the fore front in delivering SRHR services in its SRHR project through its local partner organisations and thus is seen as one of the leading partners to take forward advocacy issues on SRHR [Source: Interactions_with_CS0_and_others-22_2_20141, 2014-01-09_PAF BVHA UFBR ct 2014-2015, 5c endline self-assessment sheet_management_India_BVHA].
 - *Participation in trainings and meetings funded and organised by other donors and state government [32]*.
BVHA staff participated in various workshops, seminars, training programs related to SRHR organized by Government of Bihar (department of health) and other development

¹³ Wada Na Todo ABHIYAN (WNTA) is a national campaign to hold the government accountable to its promise to end poverty and social exclusion

agencies such as Population Foundation of India, Magic Bus India, World vision, Oxfam India, Future groups etc. [33] [Source: 2014-03-03_v3 BVHA SRHR Annual Report 2013]:

- Meeting on Repositioning of Family Planning by Population Foundation of India (PFI), New Delhi on Dec. 2012. A half day workshop was organized by PFI. Here discussions were held around repositioning of family planning within a woman's empowerment and human rights framework so that every family is a planned family and every child is a wanted, healthy child. This meeting facilitated BVHA to discuss on various health problems in Bihar and strengthen its relationship with PFI. For example, Population Foundation of India is the state nodal NGO and technical agency for the Community Based Planning and Monitoring Programme (CBPM) in Bihar. BVHA being the member of State Technical Advisory Group (STAG) and vast experience in community empowerment was invited to May 2014 CTAG meeting to give input to strengthen the CBPM project. As a result of better networking BVHA could advocate with the government for people friendly policies [Source: BVHA Annual Report- 2012-13, p. 48].
- Workshop on WASH was organized by Wada Na Todo Abhiyan at A.N.Sinha Institute, Patna on 12th December, 2012 [Source: BVHA Annual Report- 2012-13, p. 48]. The aim was to develop effective and communicative tools for awareness building program as well as multi-departmental coordination approaches. This created a platform for various civil society organisations to come together and form a task force to lobby and advocacy with government and other policy makers for various health related policies [Source: discussed during endline evaluation].
- Workshop on Bitiya Bachao –Manavta Bachao Aandolan was organized by Action Aid, Patna on 26th December, 2012 [Source: BVHA Annual Report- 2012-13, p. 48]. This training enabled the staff to organize meeting on January 2013 with health minister, Government of Bihar to discuss on IMR, MMR, sex selective abortion including Save the Girl Child. This also served as a preparatory meeting to organize 3day events to sensitize the people on the above mentioned issues. Due to this workshop, networking with the government improved considerably for BVHA to participate in the strategic planning for health development in Bihar.

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