Sida's Work Related to Sexual and Reproductive Health and Rights 1994–2003

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Sida Evaluation 04/14

Department for Democracy and Social Development

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Introduction

The International Conference on Population and Development (ICPD) that took place in Cairo in 1994 did fundamentally change the way that the world views the population issues. The earlier demographic perspective shifted to a broader view that focused on sexual and reproductive health and rights SRHR and placed the choices of the individual at the centre. And the needs and rights of women and young people were brought into focus.

Sweden took an active role in the preparations for the ICPD Conference with a strong belief in a broad SRHR view that was based on Sweden's own long experience.

The purpose of the present evaluation "Sida's work with Sexual and Reproductive Health and Rights 1994–2003" is to review Sida's contribution to the ICPD agenda and to assess the effect that the agenda has had on Sida's policies and actions, as requested in the Governments Letter of Appropriation for 2003.

The evaluation concludes that the SRHR issues have been carried forward by a strong Swedish political support and that Sida has developed and advocated the SRHR issues more intensively than most other donors. Sida has worked in the frontline and carried out a great number of activities related to SRHR. Furthermore, the evaluation considers that Sida's Strategy on Sexual and Reproductive Health and Rights from 1997 has been a useful tool for enhancing both the rights and the equity perspectives.

The evaluation gives a broad description of Sida's support to SRHR, but lack comprehensive analysis and innovative proposals. One general conclusion is however that there is a great need for continued strong support on various levels for SRHR which is particular important in times when global threats obstruct continued implementation of the ICPD agenda.

In order to guide Sida's future work with SRHR, Sida will elaborate a policy for Sexual and Reproductive Health and Rights that will be finalised in mid 2005. This evaluation will serve as one background document for this work.

The conclusions in the evaluation represent the view of the evaluators and are not necessarily shared by Sida.

Bernt Andersson

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Executive Summary

This report represents the findings of a process oriented evaluation of the work of Sida in the area of Sexual and Reproductive Health and Rights (SRHR). The original SRHR agenda was formulated at the International Conference on Population and Development in Cairo (ICPD) in 1994 and the evaluation first follows how this agenda has been brought into the core development discourses, bringing about paradigmatic change from 'population development' to a rights based holistic approach to SRHR, which places the choices of individuals at the centre. The report looks at how Sweden and Sida included this agenda in its policies and strategies, its dealing with various Swedish stakeholders, with the UN and other multi-lateral organisations, and within its funding priorities of international and regional NGOs. The study also reviews how the agenda has been operationalised in bilateral aid at country level.

Main findings

The report concludes that Sweden and Sida have played vital roles in influencing other major stakeholders from the basis of its own progressive and pioneering successes in this field within Sweden. Broad political support in Sweden has enabled a frank and open discussion of agendas which have remained controversial in most other countries, including acknowledging that some adolescents are sexually active, and that access to safe abortion is a right. The SRHR agenda has been carried forward by *Swedish political support* particularly strongly since the Global Gag Rule was reinstated.

Sweden's support to the ICPD agenda has also been reflected in *funding levels*, which has placed Sweden consistently among the top seven donors. Sweden is acknowledged as one of the most consistent and generous donors to the SRHR agenda, and there are indications that Sweden is stepping up funding, as other donors, particularly the US, are withdrawing funds.

Many organisations are very appreciative of Sida's funding, particularly since Sida has had a history of supporting organisations also with *core funding*. The International Planned Parenthood Federation (IPPF), United Nations Population Fund (UNFPA), International Women's Health Coalition (IWHC) and many of the regional networks and organisations have benefited from non-earmarked funds, which have enabled organisations to engage in core activities and to do more long-term planning.

Sida has also built the *capacity of many Swedish organisations*, NGOs as well as research institutions, in the SRHR field and has supported fruitful North-South linkages and twinning processes. These have in turn built the competence of organisations and researchers in the South.

Within Sida the progressive SRHR agenda is clearly reflected in the 1997 *Strategy for Development Cooperation: Sexual and Reproductive Health and Rights.* With its affirmation of sexual rights and the concept of fertility regulation it is *a step ahead of the ICPD consensus.* The strategy clearly links SRHR to human rights and gender equality, includes the rights and responsibilities of men. The 1999 HIV/AIDS strategy has a human rights approach and stresses sexuality education and advocates the need to mainstream HIV/AIDS intervention in all sectors, but it fails to draw links to SRHR and areas where the two overlap. The evaluation recommends that Sida should work towards defining those linkages and to *mainstream SRHR* together with gender, HIV/AIDS and poverty concerns.

The evaluation confirms that multilateral organisations – UNFPA, World Health Organisation (WHO), United Nations Children's Fund (UNICEF), United Nations Program on HIV/AIDS (UNAIDS) and the World Bank – have appreciated the *constant, generous and steady support* of Sida and

Sweden, both on political and technical levels and in terms of funding. This sentiment was also reflected by the international NGOs included in the study, namely IPPF, IWHC, Ipas and International Baby Food Action Network (IBFAN).

However, in almost all the organisations concerns were raised about a number of global trends that might create a *backlash against the SRHR agenda* and result in decreasing funding for SRHR. Reasons for this worry were, on the one hand, the Global Gag Rule and the suspension of US funds to a number of organisations connected with advocacy and delivery of abortion related activities. On the other hand, there is a worry that the shift of funding towards HIV/AIDS as well as Global Funds will divert resources from SRHR. Many stakeholders believe that this is leading to decline not only in support to safe abortion and post-abortion care, but also areas that are not as easily linked to HIV/AIDS, maternal health in particular. Given that maternal mortality ratios have stayed stagnant or increased in many African countries there is a future *role for Sida in stepping up its support* in these areas, which otherwise risk being neglected.

Another potential threat to the SRHR agenda has been identified as lying with the move to *health sector reform processes*, sector wide approach programmes (SWAps) and pooled funding mechanisms via central and local governments. Sida has been one of the firm proponents of this strategy and has in a number of partner countries discontinued vertically or separately funded projects. HIV/AIDS projects have been exceptions to this. While SWAps offer an opportunity to enhance donor coordination, avoid duplication, reduce transaction costs, increase donor influence at the policy level, and enhance accountability and transparency. In their transitional phases SWAps may, however, have negative impacts on health care delivery. There is *concern that SRHR might particularly suffer*, since the delivery of these services is not always prioritised by governments. The new dispensation means that NGOs. which in many of Sida's partner countries carry a large part of health care delivery, have to access funding directly from governments. This might disadvantage many, particularly those which engage in advocacy or deliver services that are deemed controversial.

Stakeholders at the international level felt that Sida is well placed to engage more forcefully in exploring *strategies on how to safeguard SRHR within SWAps*, to define the role of UN organisations with specific mandates, such as UNFPA, in such processes, and to collaborate with the World Bank in building the capacity of staff to successfully negotiate the inclusion of SRHR issues within both SWAps and also national poverty reduction strategies (e.g. PRSPs). Stakeholders at regional and national levels raised similar points, as successful sexual and reproductive health projects have found it difficult to find donor support to enable them to continue or scale up. Concerns at the country level also related to the fact that while donors increasingly moved into the adolescent sexual and reproductive health arena, which was piloted by Sida, too much focus was perhaps placed on behaviour change and too little attention on delivering services also to rural areas. Here again, stakeholders believed that Sida was well placed to *drive the adolescent SRHR further*, and to aim at coordinated approaches that close existing gaps between message and delivery of services.

The evaluation concludes that Sida has driven the SRHR agenda more than other donors, and has with reason, gained the reputation as being a "champion" of SRHR. Many of the interventions reviewed and many others that could not be included have been at the cutting edge of SRHR and have had indeed a great impact both at the global level as well as on the capacity of partners in developing countries to serve the target groups on the ground. In order to maintain this momentum Sida will have to *take on the current challenges as the leader in SRHR*, and move into neglected and threatened areas of the ICPD agenda and the Millennium Development Goals (MDGs), with political, technical and practical support. There is no lack of multi-lateral, international, regional and local partners who are ready to take the challenge in collaboration with Sida and Sweden.

Specific recommendations

Based on these overall findings, and feedback from key informants, the evaluation presents the following specific recommendations:

To help the *institutionalisation of SRHR* the evaluation proposes that:

- Sida considers to urgently update the Strategy for SRHR in order to reflect global changes and stress neglected areas. A revised strategy should reflect the emerging global challenges. An update is particularly important in view of the fact that the new 2003 Health Policy singles out only two of the original 7 areas of special concern in the SRHR strategy.
- Sida continues to use the full term 'Sexual and Reproductive Health and Rights' and encourages through advocacy other agencies to do so too. Sida should also support agencies such as WHO to finalise a definition of sexual health, and should support further development of reproductive rights as human rights.
- Sida should continue to build long-term collaborations with key technical SRHR centres inside Sweden, and maintain close links with Swedish NGOs active in the SRHR field, and discuss if these institutions could benefit from a core SRHR support grant.
- Sida provides continued support to twinning projects based on the RFSU. The success of the Kafue and MAMTA adolescent SRHR projects in Zambia and in India is proof of the evolving nature of RFSU collaboration with local partners.
- Sida considers replicating best practice in regional capacity building. Some regional networks have established institutional structures that have proven to be stable and well coordinated. Africa Midwives Research Network (AMRN), for example, has been a successful network, whose model of establishing focal points and offices in member countries and using a rotating chair could be replicated.
- Sida remains consistent in promoting and even initiating regional NGOs and networks and continues offering core funding. However, core funding should not mean that Sida does not support organisations with advice and advocacy.
- Sida continues to play an important role in supporting international NGOs, such as IPPF, in advocating the rights perspective in SRHR. Support must also include financial contributions at high levels in order to counteract the economic consequences of today's changes.
- Sida should make certain to be as transparent as possible when it comes to funding levels of various organisations. Abrupt changes really hit NGOs which are pursuing controversial issues and in the present political climate cannot be sure about many donors.

The evaluation report strongly emphasises that global trends in development paradigms have the potential to threaten the ICPD agenda. It is therefore important to link SRHR to new development themes.

HIV/AIDS

- Sida should, in the phase of intensified support to HIV/AIDS related activities, take a lead in developing the parameters of synergies between this area and a comprehensive SRHR agenda. The Swedish-Norwegian HIV/AIDS team in Lusaka could be an entry point for both the conceptualisation and the operationalisation.

Integration and mainstreaming

- Sida should take the lead in working on a model of combining the mainstreaming of HIV/AIDS, gender equity concerns, poverty and SRHR into national poverty reduction strategies. Initiatives do exist in the UN system which can be supported and collaborated with.
- The relationship between the PRSP processes and the SRHR agenda can usefully be pursued with the World Bank.
- Sida is funding organisations that use a model of starting pilot projects as a way of establishing best practices and combining research and local capacity building. This approach, exemplified by African Medical Research Foundation (AMREF) and RAINBO, is worthy of expansion and replication as an integrated approach, particularly in order the address synergies between HIV/AIDS, gender equity, poverty and SRHR, including female genital mutilation (FGM).

Health sector reform and SWAps

- Sida is both a champion of health sector reform and SRHR. It is therefore more then urgent that Sida takes a lead with regard to the discussion around SRHR in SWAps. In order to do this effectively Sida staff must be fully conversant with the SWAp processes and with the country they work in. High staff turnover is counterproductive in this regard.
- Sida should be more visibly involved in the training courses the World Bank Institute offers on Reproductive Health and Health Sector Reform. The idea is to build the capacity of country level staff to successfully negotiate SRHR issues within the SWAp context, in donor-government meetings and strategy negotiations and to make sure that SRHR issues are not sidelined in policy and priority decisions.
- There is an urgent need to include the technical expertise of UNFPA in SWAps. Sweden has recommended that UNFPA takes the role of lead advocate of SRHR and Sida should clarify UNFPA's relationship and position to SWAp and its mandate.
- The effort of putting into place SWAp modalities should not detract from the continuing need for service delivery, particularly in areas as important to Sida as SRHR.

Therefore:

- Sida should particularly consider that health sector reform almost always compromises maternal health. Temporary vertical support to maternal health, perhaps implemented by relevant UN agencies through special programmes or multi-bi support at country level, might have to be considered in the transitional phases of health sector reforms.
- In cases where government service delivery in certain areas is known to be weak and dependent on certain NGOs support to those NGOs should be continued and phased out only gradually.
- Sida should acknowledge that NGOs working on human rights advocacy, act as government watchdogs or deliver services that are not in line with cultural and social norms will find it impossible to obtain government funding and continue with their activities. Sida should seriously consider putting into place alternative funding mechanisms for NGOs in such cases.
- In general, Sida should therefore develop a plan on how to adequately support and maintain the capacity of NGOs in the SRHR field during health sector reform processes.

Millennium Development Goals

- Links and synergies between MDGs and the SRHR sector must also be made and be drawn on continuously. Sida is well-placed to take a lead.

Acronyms and abbreviations

AMREF	African Medical Research Federation
AMRN	Africa Midwives Research Network
ARHNe	Adolescent Reproductive Health Network
ARROW	Asian-Pacific Resource & Research Centre for Women
ASRHR	Adolescent Sexual and Reproductive Health and Rights
BCC	Behaviour Change Communication
BFHI	Baby Friendly Hospital Initiative
BPNI	Breastfeeding Promotion Network of India
CBoH	Central Board of Health, Zambia
CFNI	Caribbean Food and Nutrition Institute
CLAP	Latin American Centre for Perinatology and Human Development
Danida	Danish Agency for Development Assistance
DESO	Department for Democracy and Social Development, Sida
DfID	Department for International Development, UK
ECOSOC	United Nations Economic and Social Council
ECSAOGS	East, Central and Southern African Association of Obstetrical and Gynaecological Societies
ESCAP	Economic and Social Commission for Asia and the Pacific
ESDP	Education Sector Development Programme
FGM	Female Genital Mutilation
FORWARD	Foundation for Women's Health, Research and Development
FPA	Family Planning Association
FWCW	Fourth World Conference on Women
GNI	Gross National Income
HRP	Human Reproduction Research Programme
IBFAN	International Baby Food Action Network
ICDS	Integrated Child Development Services
ICPD	International Conference on Population and Development
IEC	Information Education Communication
IEPFPD	Inter-European Parliamentarian Forum for Population and Development
IHAA	International HIV/AIDS Alliance
IHCAR	Department of International Health/Karolinska Institute
ILO	International Labour Organisation
IMAP	International Medical Advisory Panel

IMCH	International Maternal and Child Health/Uppsala University
IPPF	International Planned Parenthood Federation
IUSSP	International Union for the Scientific Study of Population
IWHC	International Women's Health Coalition
JICA	Japan International Cooperation Agency
JPO	Junior Programme Officer
LACWHN	Latin American and Caribbean Women's Health Network
MAMTA	The Health Institute for Mother and Child, India
MDG	Millennium Development Goals
MFA	Ministry of Foreign Affairs
MR	Menstrual Regulation
NEPAD	New Partnership for Africa's Development
NORAD	Norwegian Agency for Development Cooperation
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organisation
P-MTCT	Prevention of Mother to Child Transmission of HIV
PPAZ	Planned Parenthood Association of Zambia
PRSP	Poverty Reduction Strategy Paper
RAINBO	Research, Action and Information Network for the Bodily Integrity of Women
RFSU	Swedish Association for Sex Education
RHR	Reproductive Health and Research
RH	Reproductive Health
SMI	Safe Motherhood Initiative
SAREC	Department for Research Cooperation, Sida
SIDA	Swedish International Development Authority (until 1995)
Sida	Swedish International Development Cooperation Agency
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach Programme
UMATI	Uzazi na Malezi Bora Tanzania (Family Planning Association of Tanzania)
UNAIDS	United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session

Preface

This evaluation was commissioned by the Health Division of the Department for Democracy and Social Development (DESO) of Sida in response to a request made in the Swedish Parliament to evaluate the work of Sida in the field of sexual and reproductive health and rights (SRHR) over the last ten years. This represents the period since the International Conference on Population and Development (ICPD) in 1994 in Cairo, which changed the paradigm of 'population development' to a rights based holistic approach stressing the needs and rights of individuals.

The purpose of the evaluation (cf. Terms of Reference enclosed as Annex 1) is twofold: (1) to "assess Sida's alignment to the ICDP agenda and the effectiveness of Sida's work related to SRHR ... in light of the various international agreements to which Sweden has been a signatory as well as of Sida's own strategies on SRHR"; and (2) to "identify the strategic issues that should guide Sida's future work related to SRHR".

The evaluation team interpreted its task to recapitulate the process of reorientation which ensued with the ICPD events, and to document and analyse the role Sida played and plays in this process at the global level, within Sweden, in relation to multilateral organisations and international and regional NGOs, and in bilateral aid at country level. This is indeed a complex analytical task, and within the relatively short time set aside for the evaluation the Team had to be selective with respect to aspects to cover, as well as institutions and countries to visit and projects to review. Choice was largely directed by the suggestions detailed in the Terms of Reference. Even so, timing and coordination of visits were not always optimal.

The findings of this evaluation will have to be interpreted in view of the *methodological constraints* experienced by the Team. While the core idea was to evaluate Sida's role and functions, it was sometimes impossible to differentiate between Sida, more specifically, and Sweden, in general, in the review of documents and the responses of interviewees. While the views of Sida's core target beneficiaries, namely ordinary men and women in partner countries, ideally should have been consulted, emphasis had to be placed on institutional intermediaries receiving Swedish development assistance. The Team sought to understand how Sida has prioritised its SRHR development aid by looking at the pattern and types of organisations and issues it has supported, and visiting a selected few.

The Team has assessed Sida's role as a development aid broker, lobbyist and advocate in some of the important international development debates in the field of SRHR with a focus on *current* debates and challenges, to be able to give Sida a forward looking evaluation. A detailed review of the methodology is included in Annex 2.

The Team wishes to acknowledge the support provided by the Health Division, and the many who shared important information and insights with the Team. While it hopes that their views are reflected in the way lessons from this ten year period have been distilled and formulated, some will no doubt take issue with some of the conclusions, for which the Team alone is responsible.

1 The global agenda on SRHR – a recapitulation

1.1 Cairo 1994 – setting the new agenda

The International Conference on Population and Development (ICPD) in Cairo was the third in the series of global population conferences with negotiation among governments. The first one was in Bucharest in 1974 and the second in Mexico City in 1984. All three of them have reflected the complex international debates and controversies linked to what is called 'population issues'. The ICPD differed significantly from the previous conferences in that NGO representatives were being heard in the process. There were NGO representatives on many of the governments' delegations, and NGOs lobbied and worked systematically to influence the outcome. There was also a series of separate events, such as the big NGO forum next to the negotiating hall in Cairo.

Box 1: WHO's definition of 'reproductive health'

WHO defines reproductive health within the framework of the definitions of health as a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity. Reproductive health addresses the reproductive processes, functions and systems at all stages of life. Reproductive health implies that people are able to have a responsible, satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide, if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed of and have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

WHO 1994, para 89

About twenty UN member states provided contributions, among them all the Nordic countries. A series of committees, expert groups, round-table conferences and panels were set up globally to discuss various issues and give inputs, and regional population conferences were held. Scientific events, such as of the International Union for the Scientific Study of Population (IUSSP), provided important knowledge to draw on.

There were many controversies over SRHR at ICDP that eventually found their solutions in a negotiated Plan of Action:

- *Problems related to definitions.* Most contentious was the term 'fertility regulation' used in the definition of reproductive health formulated by WHO (see Box 1) – a terminology which can be seen as implicitly containing abortion as one method.
- *Inclusion of sexual health (SH).* The compromise was that SH was mentioned, as being part of reproductive health (RH), but was not defined. There is, however, a section on human sexuality.
- *Reproductive rights.* This is clearly defined, namely as the human rights that pertain to reproductive health.
- *Sexual rights.* There was no consensus on this during ICPD, and the term does not appear in the Plan of Action. For many countries, the term sexual rights also refers to sexual preference like homosexuality and sexual practices outside marriage, and for some this is not culturally acceptable.

The Plan of Action defines reproductive health in a broad manner, and in a life-cycle perspective. It also contains specified targets for various components of reproductive health, such as a very ambitious target for maternal mortality reduction (which includes abortion related deaths, mostly due to unsafe abortion practices). It also has sections on reduction of HIV and conventional sexually transmit-

ted infections (STI), elimination of harmful traditional practices such as female genital mutilation (FGM), trafficking and violence etc.

More generally, the Plan of Action places sexual and reproductive health and reproductive rights in a broader context, where gender concerns are prominent, and the right to education is reaffirmed. The document also deals with more traditional "population issues" such as migration, environment and consumption patterns. But while earlier population discussions have had a heavy emphasis on food production and availability, that perspective was almost absent in ICPD.

The Fourth World Conference on Women (FWCW) in Beijing in 1995 reaffirmed many of the decisions taken during the ICPD, and placed the SRHR agenda firmly in a gender context. The FWCW made remarkable progress in one important area, namely in relation to abortion legislation. While strong efforts were made in the ICPD to highlight the danger of restrictive abortion legislation, especially where women are being punished, it was not included in the Plan of Action. The Platform for Action from the FWCW, however, specifically recommends changing laws that contain punitive measures against women who undergo illegal abortions.

1.2 Reviewing progress after five years

During the 1990s there was a series of international conferences, and there was a general consensus that the planned ICPD+5 review should not re-open the decisions of ICPD, but limit itself to stock taking of progress (or lack of progress) in relation to the Plan of Action. Two major events were central in the review, namely the Hague Forum, and a UN General Assembly Special Session (UNGASS). Again the controversies over sexual and reproductive health and reproductive rights flared up, but the ICPD+5 document was successful in creating consensus on several controversial issues and bring the ICPD decisions forward, despite changes in the global political climate.

The ICPD+5 document acknowledges that many countries have embarked on health sector reforms, and stresses that reproductive health should be given priority in these. It goes on to talk specifically about the quality of sexual and reproductive health services, and for involving men in a positive way. It is also specific concerning the fight against harmful traditions, and on monitoring of provision of services. In terms of reduction of maternal mortality, it upholds the target from the ICPD and introduces a proxy indicator, namely skilled attendance at delivery. It also states that reduction of maternal mortality should be used as an indicator for the success of health sector reform. In relation to abortion, it concretises the role of governments in securing access to safe abortion services, by stating that governments should make sure that health staff are skilled and equipped to perform safe abortion "in circumstances which are not against the law".

1.3 Backlash against the Cairo agenda

By the turn of the century, a number of factors had contributed towards less recognition of a comprehensive reproductive health approach and the reproductive rights agenda.

Box 2: The Millennium Development Goals

1. Eradication of extreme poverty
2. Achieve universal primary education
3. Promote gender equality and empowerment of women
4. Reduction of child mortality
5. Improve maternal mortality
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

On the positive side, it is striking that three of the eight Millennium Development Goals (MDGs), endorsed by the UN member states at the Millennium Summit in 2000, are health related, and that all three (goals 4 to 6) are on reproductive health (see Box 2). Furthermore, the first three goals cover areas that have been shown empirically to be very closely linked to reproductive health. Thus, the MGDs should in principle have the potential to give a solid boost to efforts aimed at improving reproductive health, but there is a global concern that focusing on the MDGs may cause fragmentation of RH strategies.

Other negative factors include the declining emphasis on SRHR within the context of health sector reforms and sector programmes (also referred to as sector-wide approach programmes – SWAps). The HIV/AIDS crisis further shifted direct attention from preventative and promotive services such as family planning and associated reproductive health care towards chronic and communicable diseases, including HIV/AIDS.

The most important negative factor was the reinstatement by the US government in January 2001 of the so-called "Global Gag Rule", which has worked against abortion and abortion related service delivery and the provision of reproductive health services, including contraceptives, to adolescents. It restricts foreign NGOs that receive USAID funds in their dealings with SRHR issues, and was later followed by withdrawal of US government's funding to UNFPA in 2002.

Furthermore, the "Global Gag Rule" states that NGOs receiving US funding may not offer pregnant women information about abortion, no matter what the legislation of the country says, unless they are directly asked. In addition, they are also barred from performing abortions, lobby their own governments to change the legal status of abortion, or even decriminalise abortion. Most serious perhaps is the fact that the Global Gag Rule has mandated segregation between abortion services and family planning. This restriction on counselling, information and referral violates medical ethics.

The Global Gag Rule has been seen by many as a violation of the ICPD agreements, and it has been shown to have a devastating effect on SRH delivery. The Global Gag Rule Impact Project, a collaborative research effort led by Population Action International together with Ipas and the Planned Parenthood Federation of America, established that the rule has already reduced access to family planning in the countries surveyed (Impact on lives 2003). The 2002 cancellation by the US government of USD 34 million to UNFPA has further compromised service delivery. IPPF, the world's largest NGO in the SRH sector, has refused to bow to US restriction and has lost considerable funding. As a result, funding levels for the financing of the ICPD Plan of Action have been lagging behind.

Efforts of the US to undermine the Cairo agenda have also been felt in international meetings. During the UNGASS on HIV/AIDS in 2001 the US delegation lobbied for language on HIV/AIDS prevention that emphasised abstinence, often at the expense of sexuality education and reproductive rights (Center for Reproductive Rights 2001:B023). During the Asian and Pacific Conference on Population in December 2002 in Bangkok the US delegation attempted to change the Cairo agreement by suggesting that the term 'reproductive rights' should be replaced by 'reproductive health services'. The Bangkok Plan of Action, however, instead forcefully reaffirmed the ICPD consensus (Rhoad 2002:15).

2 Sweden and the SRHR agenda

2.1 Sweden's follow up of the ICPD

The political commitment and supportive climate for SRHR in Sweden (see Annex 3 for a brief account of Sweden's engagement in this field prior to the Cairo conference) and Sweden's active engagement at the ICDP (see Annex 3) demanded an increased institutional responsibility in SIDA/Sida.[1] The results were noted already in the 1996 OECD/DAC Peer Review of Sweden's development assistance, which commended Sweden's experience in working in the field of "population" and noted that "Sweden has stepped up its work in the field of reproductive health and population, where it was a pacesetter two decades ago". It noted that "Sweden's policies have changed in the light of the Cairo population and development conference" (RFSU/IPPF 2000:3). In the 2000 Peer Review, OECD/DAC identifies Sweden has the "champion" of SRHR even more strongly.

An informal group of parliamentarians formed around the SRHR agenda transformed itself into a more formal all-party group in 2001, and the group pushed that 10 percent of international development assistance in Sweden should be used for SRHR. Group members participate in the Inter-European Parliamentarian Forum for Population and Development (IEPFPD) and act as "watchdogs" for SRHR issues in the Council of Europe and in EU's international development cooperation.

Sweden's ability to influence EU's views can be of great importance. The EU has recently adopted a strategy related to its development assistance, where the term 'Sexual and Reproductive Health and Rights' features. It is in itself striking that the document uses this full term, which is not agreed UN language, despite what Sweden and others fought for in ICPD. It is noteworthy that funds are budgeted for "...innovative initiatives in the field of HIV/AIDS and sexual and reproductive health and rights (S&RHR)..." (Commission of the European Communities 2003:101), as well as for areas where there has been little progress in reaching the Millennium Development Goals and other international targets. It is uncertain what role Sweden and Sida have played in the development of these priorities, but it is certainly very close to the language that Sida uses.

After the US government's re-imposition of the "Global Gag Rule" in 2001 the Minister of International Development Cooperation, Jan O. Karlsson, affirmed the importance Sida must place on guarding the Cairo programme against conservative forces and to meet the targets of financial contributions to the UN bodies for SRHR work to continue. He also stressed that Sweden must continue to raise controversial issues such as unsafe abortions, access of youth to contraceptives and sexuality information, violence against women, and that the issues of child and women trafficking must actively be addressed in international fora. In the same vein, Karlsson joined in April 2002, the Minister of Development Cooperation of Luxemburg, Charles Goerens, in spearheading a joint intervention to persuade the EU to increase funding to UNFPA. At the end of May 2002, the EU unanimously adopted a statement in support of UNFPA backed by extra funding of Euro 32 million for the organisation to be directed to measures in countries where maternal mortality was highest.

[1] SIDA (Swedish International Development Authority) was reorganised in November 1995, and the new organisation was named Swedish International Development Cooperation Agency – with 'Sida' as the official acronym.

2.2 The reflection of the ICPD agenda in overall Swedish development assistance

Reflection in policies and strategies

In the context of health sector cooperation reduction of poverty, sustainable development, gender equality and democracy and human rights have been stressed in Sida's 1997 sector policy – *Framework for Development Cooperation in the Health Sector* (Sida 1997d). The document maps a framework that is informed by the need to adapt health policy making and planning to the redefinition of the state, the introduction of market economy and the decentralisation of state decision making. It also emphasises the participation of beneficiaries. This spectre of overall political and economic reforms necessitated a new focus in health sector reforms:

- decentralised decision making and service delivery;
- capacity building of the main actors in the reform process;
- development of integrated health services;
- development of sustainable health financing strategies;
- inclusion of the private sector; and
- development of cost-effective health services through management capacity building and human resource development.

The sector policy document also stresses child health and immunisation, SRHR and an improvement of national drug policies. The emphasis on SRHR is based on an ethical and rights foundation. Noting that the consequences of the paradigm change of Cairo for health service delivery were still in the moulding, the policy promotes service delivery for both sexes and all ages through the promotion of gender equality and sexuality education. Furthermore, it emphasises the importance of maternal health care, fertility regulation and prevention, and care of sexually transmitted infections, including HIV/AIDS. It singles out the need to take measures against gender violence and female genital mutilation.

The Sida approach to SRHR is further elaborated in the 1997 *Strategy for Sexual and Reproductive Health and Rights.* The strategy bases itself very strongly on the concepts approved at the ICPD, such as 'women's empowerment', 'reproductive health and rights', and 'sexual health'. It also emphasises 'sexual rights', for which there was no approval during ICPD. It further subscribes to an approach that offers cost-effective and integrated delivery of services and decentralisation of decision making. And it stresses the need for public information and advocacy to alert policy makers to the new SRHR agenda.

The strategy boldly states that "all people are sexual beings and sexuality is necessary for the survival of humankind" (Sida 1997g:16) and Sida affirms that the goal of the strategy is to enable men and women to have the capacity for healthy, equitable and responsible relationships and sexual fulfilment, achieve their reproductive intentions with the desired number and timing of children, avoid illness and receive counselling and care, and to achieve equal rights in public and private life. The strategy thus clearly links SRHR to human rights and gender equality, includes the rights and responsibilities of men, and calls for the elimination of gender violence.

Box 3: The Sida SRHR Strategy

Main areas of intervention:

- Promotion of maternal health, including good quality care before, during and after birth, delivered if possible by trained midwives, functioning referral systems, the initiation of breastfeeding
- Provision of fertility regulation services for all sexually mature persons, including information and counselling on accessible range of contraception, delivered without coercion
- The right for safe abortions, and care for the consequences of unsafe abortion, as well as advocacy for the legalisation and decriminalisation of abortion
- The prevention and treatment of sexually transmitted infections, including HIV/AIDS and the availability of sexuality education to influence behaviour change
- The acknowledgement of the sexuality of adolescents through sexuality education, supply of SRHR services, including provision of contraceptives and seeking their active involvement;
- Support campaigns to reduce the incidence of female genital mutilation, including information, advocacy and monitoring
- Fighting gender-based discrimination and violence

Also in 1997, DESO published a *Handbook for Mainstreaming a Gender Perspective into the Health Sector,* which laid out the reasons for a gender perspective in health and the methods of achieving this in various sub-sector interventions. One of the main aims of the handbook is to redress a situation where women are very visible in the health sector as health workers only, while they are not represented as decision-makers, and not acknowledged as mothers and not represented in statistics – and in research.

Again in 1997, Sida's Health division published a position paper on *Population, Development and Cooperation* which draws links between poverty, democracy, gender equality, sustainable development and population development. Within it Sida boldly re-affirms its commitment to a rights based approach to SRH.

Two years later, in 1999, Sida and the Foreign Ministry jointly published a "response" to the HIV/AIDS crisis – *Investing for Future Generations.* The document lists four main strategic goals for HIV prevention and care, namely enabling people to protect themselves, encourage political commitment to HIV prevention, to enable people infected and affected people to live dignified lives and to develop coping strategies to alleviate long term effects. The strategy was in 2002 followed by *Guidelines for Integrating HIV/AIDS in Development Cooperation.* These guidelines, which cover seven sectors establish clearer than the 1999 strategy that HIV/AIDS requires a multi sector approach and that HIV/AIDS concerns need to be mainstreamed similarly to gender. The guidelines did not specifically address the overlaps between SRHR and HIV/AIDS prevention.

A *Manual for the Inclusion of HIV/AIDS in Country Strategies* was also developed at central level. Country Offices followed these with specific country policies. The Tanzania office published in 2002 the *Embassy Policy for Integrating a HIV/AIDS Perspective in Sweden's Bilateral Development Cooperation with Tanzania.* This is an attempt to further integrate HIV/AIDS concerns across all sectors.

Also concerned with mainstreaming is Sida's 2002 *Perspectives on Poverty.* The document outlines the various dimensions of poverty and the integrated nature of the approach that is needed to combat poverty. The document importantly outlines the importance of mainstreaming poverty concerns in the partner country dialogue, for instance, in connection with country owned PRSP (Poverty Reduction Strategy Paper) processes. While this overall approach does not include SRHR issues in any very explicit manner, it might form the basis to also mainstream SRHR in the future.

The new 2003 Health Policy *Health is Wealth* conceptually refined the basic assumptions of its 1997 predecessor. It stresses more forcefully the link between health and poverty, acknowledging the central role health plays in the fight against poverty and in the achievement of the Millennium Development Goals. It builds on the experience that the gaps between the rich and poor countries in the attainment of health is widening, particularly in countries of the former Soviet Union and countries with a high prevalence of HIV/AIDS. The policy stresses ownership of development planning goals in partner countries, and formulates two main goals of health related development coordination:

- the improvement of economic, social, cultural and environmental determinants of health in all relevant sectors of society by strengthening the health sector in influencing other sectors; and
- the promotion of sustainable and effective health systems offering universal access to quality health services in accordance with social equity and gender equality.

It identifies five areas of special intervention:

- health and environment;
- young people and healthy lifestyles;
- maternal survival;
- the promotion of good governance; and
- the global development of new pharmaceuticals and research on diseases prevalent in poor countries.

The new health policy offers a more integrated approach to health, and thus also to SRHR. This is visible in the attempts to include adolescents, for example, as a vulnerable group, whose access to health care delivery must be sought via an enabling infrastructure. The fact that the policy also stresses the need for the health sector to influence other sectors is important, and can, in theory at least, lead to increased cross-sectoral collaboration, also on issues such as SRHR.

However, it is somewhat disappointing that SRHR appear as special areas of attention only with regard to young people and maternal survival, and that linkages and crosscutting issues imbued in SRHR (including the areas of special intervention) have not been sufficiently drawn. This carries with it the danger that they might be overlooked or overridden by other concerns, such as ownership of partner countries, health sector reform, and good governance, for example.

During 2003 DESO also presented a report on *The Rights of Adolescents.* The report again stresses the overall importance Sida pays to adolescents in its projects and policy approach in the health, culture and media, governance and education sectors. It concludes that DESO supports over 50 youth projects which try to reach poor or otherwise disadvantaged young people taking overall a strong human rights perspective. The report also reaffirms Sida's intention on making youth even more visible in its programmatic interventions and to advocate for greater participation on policy and project development, to introduce adolescents as a category into statistics and to make sure that the importance of young people's sexual and reproductive health and their general development is better understood.

In May 2003 the government submitted a new development bill to Parliament, entitled *Our common responsibility – Sweden's policy for global development,* which reaffirmed the position of SRHR in Sweden's aid policy. The bill promises that Sweden will continue to promote difficult and controversial issues, such as women's rights and matters relating sexual and reproductive rights, including the right to abortion, contraceptives and sex education (Utrikesdepartementet 2003.05.23). In September 2003 the major

areas of Swedish development cooperation were further specified as HIV/AIDS, SRHR, narcotics and peace support, conflict management and common security (Utrikesdepartementet 2003.09.22).

Reflection in funding

Sweden's commitment to SRHR has perhaps been most visible in its funding strategies. Evaluations and peer reviews have consistently placed Sweden among the four donors reaching the ICPD agreed target of allocating at least 4 percent of total ODA to SRHR interventions. The 2002 DAC Peer Review of Sweden placed Sweden as the 7th biggest donor to the UNFPA and one of the largest and most consistent donors to the IPPF. After the withdrawal of US funds from UNFPA Sweden increased its contribution in 2002 by SEK 20 million to 185 million, making it the 6th largest donor of UNFPA. In 2003 the Swedish contribution to UNFPA was again raised by SEK 20 million. The 2003/2004 budget raised the contribution yet further from SEK 205 to SEK 270 million. The same budget also included an increase of SEK 40 million to UNAIDS, and announced the appointment of a special Ambassador for HIV/AIDS (Utrikesdepartementet 2003.09.22).

That increased support to SRHR is a firm commitment not only of the government but also a broader political spectrum became clear in the same month when the all-party parliamentary group on SRHR (mentioned above) demanded that the government increase its contribution to SRHR from 4 percent of ODA to 10 percent (Hägg et.al 2003). This demand is in line with the demand of RFSU (RFSU 2003).

Overall, contributions of Sweden and Sida have been difficult to measure exactly, since Sida has such a wide operational definition of SRHR, which moreover has changed over time. Thus it is not easy to extract SRHR from a number of changing budget lines. Table 1 (Annex 8) tries to do this, however inaccurately, and offers some interesting trends. According to this, while funding levels in absolute terms varied, SRHR made up approximately 33 percent of the total health budget in Sida. Exception to this is 1993/94 when the amount was 36.5 percent, and 1997 when it reached 41.9 percent. That year the absolute amount devoted to SRHR was the highest in the 10 years reviewed.

2.3 Building partnerships in Sweden

Sida has been exemplary in involving many partners and building networks. Much of the reason for Sweden's ability to influence the global agenda on SRHR has to do with the fact that so many different groups are involved, and keep a check on each other. Sida has been maintaining a number of very close contacts with Swedish NGOs, research institutions and individuals/consultancy firms working in the area of SRHR. Many of these relationships have been maintained over a long time, reaching back well before the ICPD. While Sida staff responsible for certain areas of SRHR have changed over time, as they transfer or leave the organisation, the expertise outside Sida has been more constant. Sida has been using these resources in order to build capacity in partner countries, which the many collaborative projects Swedish NGOs and research institutions are involved with are a testimony to.

Politicians from the whole range of political parties have followed Sida's work closely, and intervened and pushed. Bureaucrats in the Ministry for Foreign Affairs and in the Ministry of Social Affairs have also kept a keen eye on this and intervened if they have felt that Sida has not been active enough.

Working with NGOs

The most important Swedish NGOs in this field are RFSU, Kvinnoforum and Forum Syd (an umbrella organisation for smaller NGOs). Many individuals attached to these institutions have been working with Sida in the field of SRHR and represent to some extent the institutional memory of Sida.

The twinning projects of RFSU, for example, go back to 1988, when Sida funds enabled RFSU to realise the idea of taking Swedish competence in sexuality education to Africa. It was the beginning of a learning process for RFSU and their three partner organisations in Africa and Asia, namely UMATI, PPAZ, and MAMTA (see Chapter 5). RFSU has been able to feed back this new capacity into Sweden, and RFSU members have encouraged the vocal all-party parliamentary group on SRHR in the Swedish parliament. This group has worked towards keeping ICPD commitments alive in political circles in Sweden, and their twinning with Zambian parliamentarians might have won political support for the ICPD agenda in that country too.

Kvinnoforum has an important project in SRHR, namely Qweb. This is co-funded by Sida, and is a web-based network that disseminates information on local and global issues on gender, health and SRHR. It has initiated seminars and other initiatives on SRHR issues. It has (2003) 1522 registered members in 115 countries.

The new funding modalities connected to sector-wide approaches might extend the role of Swedish NGOs. In Tanzania, Sida has considered putting 'basket funds' for civil society projects – e.g. for HIV/AIDS, under the administration of Swedish NGOs. However, while the trend towards pooled funding might create opportunities for some Swedish NGOs, it may have other negative effects. Swedish NGOs active in the South are now required to engage in international bidding exercises and this might put them in competition with each other, making sharing of ideas and strategies more difficult, which for instance was the hallmark of the success of the RFSU twinning projects.

Working with research institutions

The research arm of Sida, SAREC, was a separate agency until 1995 when SIDA and SAREC merged into the new Sida. Besides funding international research, Sida/SAREC also funds national (Swedish) institutions and researchers. Project applications are assessed with regard to quality, relevance and development perspective. SRH research has generally to compete on equal terms with all health or medical related global research, including basic biomedical research. But SAREC has emphasised that SRHR related research is welcome, as is social health research, and has made sure that some members of the decision making board have academic qualifications to monitor and assess such applications (one of the evaluators, JS, has actually been a member of this board for two years, 2001–2002). SAREC has since 1987 had an active policy to support Swedish institutions in developing bilateral programmes in SRHR with several countries in the South. This has enabled IHCAR at Karolinska institutet, IMCH at the University of Uppsala and the University of Umeå to develop long standing research collaborations.

IHCAR has, for example, had projects in Zambia, Tanzania, Swaziland, Vietnam and Sudan, dealing with adolescent sexual health, fertility regulation, male SRH and female genital mutilation. The IMCH has had research and training programmes in SRHR in a broad range of countries, and currently it runs a research project, among others, on arsenic well water in Bangladesh and its impact on reproductive health and newborn care. SAREC has supported projects of University of Umeå in Indonesia and Ethiopia. Uppsala University had between 1995 and 1999 a project on male sexuality and reproduction in Zambia; and Lund University had a grant in 1994–97 on urban population pressure, human reproduction and natural resources in Tanzania.

Most of the research is multidisciplinary and involves partners in developing countries. An extensive network of research collaboration between Swedish institutions and developing countries has evolved, and includes countries such as Zimbabwe (Uppsala), the Baltic states, Sudan, Mozambique, South Africa and Vietnam (IHCAR), and Ethiopia and Nicaragua (Umeå). Several of these collaborative programmes have fostered local academics becoming advocates for and coordinators of SRHR programmes. It is also an important aim to build a critical mass of young Swedish researchers in SRHR.

2.4 The interface between SRHR and HIV/AIDS

HIV/AIDS undeniably a part of SRHR

HIV/AIDS and SRH share some common pathways. SRH problems (unwanted pregnancy, non-HIV sexually transmitted infections, cervical cancers, etc) are often a result of high risk sexual activity, similar to HIV. Advocacy for sexual health, sexual rights and safer sex is a core part of SRH activities. Behavioural change communication that addresses reducing HIV-related risks also reduces the risk for adverse SRH outcomes. Gender and power issues, commercial sex, male sexual patterns and preferences for younger female partners, multiple partner sexuality, etc are important barriers both for improved SRH and for reduction of HIV transmission. Condom promotion can, of course, use both the STI/HIV argument and the contraceptive argument.

The increasing demand for health services for people living with AIDS puts pressures on existing health services, and makes it even more important to build capacity, to improve linkages, reporting, and communication. Traditional family planning and MCH services have become important meeting points and vehicles for many HIV prevention activities such as voluntary testing and counselling and prevention of mother-to-child transmission of HIV (P-MTCT). To be successful, P-MTCT needs to build up better communication with pregnant women on preventive measures, and need to follow these women through delivery. Better and more focused antenatal care and maternity services become a key intervention.

Better general health services are a necessity for scaling up antiretroviral treatments. Improved control over conventional STIs, especially asymptomatic ones found in women, can reduce the HIV transmission rate substantially. Better STI control is also the basis for better SRH, including prevention of infertility and perinatal transmission of syphilis and other agents, including the higher risk for premature delivery when the mother is infected.

Most HIV infections come under the rubric of SRH, but not all (e.g., drug injection with infected syringes and blood for transfusion with infected blood). The underlying causes for high prevalence of HIV infections, such as in Sub-Saharan Africa, are identical to those of other SRH problems: widespread poverty, gender inequity, widespread culturally sanctioned promiscuity particularly among men and low quality of health care. The interventions for prevention therefore also become partly the same: empowerment, education, and safer sex. Still, reality shows a gap between the RH "community" and the community dealing with HIV/AIDS, and it seems that the gap is widening.

HIV/AIDS interventions increasingly delinked from SRHR

While HIV/AIDS is acknowledged to hamper general development, SHR is generally not seen as a major threat for development, and therefore is not generally approached with the same sense of urgency. Besides, reproductive health is by some groups seen as much more controversial than AIDS, and in the present political climate has become more and more contentious. This is normally attributed to abortion.

AIDS is increasingly seen primarily as a communicable disease, and less as part of the SRH package. In WHO, for example, this is illustrated by the fact that HIV has been taken out of the Department of Reproductive Health and Research (RHR). Another example is the Global Fund, which deals with HIV, tuberculosis and malaria, but not with SRHRs. The rationale for seeing HIV in context with tuberculosis is clear, since they often go together. The link with malaria is not so clear, except that they both are communicable.

The institutionalisation of HIV/AIDS in Sida

Sida has followed other organisations and subscribes to a multi-sector approach to HIV/AIDS which requires mainstreaming HIV/AIDS concerns and interventions. In order to facilitate this process Sida established in 2002 a HIV/AIDS Secretariat with a complement of three staff members. The unit is part of DESO and is funded through DESO, but its mandate is to influence the whole organisation. The overall goal of the secretariat is to oversee and initiate the integration of HIV/AIDS concerns in country strategies, project cycles, and into country level dialogue. Its mandate also encompasses capacity building of staff at headquarters,

On a regional level, a joint Norwegian-Swedish Team was established in Harare (in 2000) to provide support to the Swedish and Norwegian Embassies in Sub-Saharan Africa, in an effort to achieve a greater integration of HIV/AIDS into regular development cooperation. The Team is now based in Lusaka. Apart from assisting the embassies, the Team also identifies and funds regional programmes, follows up UN activities in the region, and identifies new areas for HIV/AIDS research and intervention.

It is worth noting that the Lusaka based team has not turned into a "HIV/AIDS exclusive" unit. It plays an important role, not only directly in HIV/AIDS prevention, but also dealing with its interrelation with broader aspects of health promotion, such as adolescent health and SRHR. The balance between prevention and care is another area of concern. A considerable part of the Team's support goes to projects and NGOs whose work is related with SRHR issues – e.g. the FEMINA project in Tanzania, youth clinics in Tanzania (see Chapter 5), and support to adolescent newsletters in Uganda, such as Straight Talk and Teacher Talk.

2.5 Challenges and recommendations

During the evaluation, it has become clear that there are several arenas and mechanisms where SRHR must continue to be in focus. This is part of the institutionalisation of SRHR within Sida, and part of its potential to maintain a strong position internationally. In this summary we address three such arenas; HIV/AIDS, NGO collaboration and support to technical institutions.

Better integration between HIV/AIDS and SRHR

The world's development focus on health is now mainly on HIV/AIDS, malaria and tuberculosis. During this evaluation, in became clear that many officials dealing with SRH are concerned with HIV taking over the interest and the funds. Sida has a clear policy of mainstreaming HIV/AIDS and the structures that have been established would indicate that the approach is taken seriously. As pointed out, SRHR, while Sida defines the term in a very holistic and correspondingly broad way, does not get the attention of mainstreaming. Again, from the HIV/AIDS side, aspects of SRHR are taken on board but the effort is rather haphazard. Regional UN bodies in Southern Africa are currently working on a model of combining the mainstreaming of HIV/AIDS, gender equity concern and poverty (arguing that all are interrelated) into PRSP processes.

- Sida is a unique organisation that could take a lead in seriously working on a conceptualisation of mainstreaming that also includes SRHR.

Sweden has more experience than perhaps any other country in pushing for a comprehensive SRH agenda. In addition, it has credibility among groups dealing with HIV and has a lot of resource persons, both among politicians, scientists and bureaucrats. The Swedish-Norwegian HIV/AIDS team in Lusaka could be one of the resources.

- Sida should work towards clarifying conceptually the interface between HIV/AID and SRHR in greater detail. Instead of seeing new funding mechanisms like the Global Fund, with its emphasis

on HIV/AIDS, malaria and tuberculosis as limiting the scope for pushing SRH issues, those who deal with the fund from Sweden's perspective can be proactive in promoting and addressing the overlapping areas.

Sida's support to Swedish NGOs

Sida has over the years built the capacity of a number of Swedish NGOs which has borne fruit both in the South and in Sweden. NGOs have always played a key role in delivering issues, ideas and progress in SRHR, bringing the agenda forward. Sida has always appreciated and supported this.

- This capacity should continue to be used optimally and should not be compromised by a more general health focus as expressed in the move toward SWAps. Civil society voices, even critical ones, are important also in SWAps. In order for Swedish NGOs to develop their capacity and strategy long-term framework agreements and/or core funding in addition to project funds would be beneficial.

Sida's collaboration with technical institutions at home and abroad

Sida will need continued core technical inputs and reports from the field. Some of Sweden's best SRHR research institutions receive important Sida and SAREC support to be able to form this critical technical mass, and assist developing country institutions through their networks and collaborations.

- It is important to continue and even expand core SRHR technical development grants also in the future, but the format for such grants would have to be determined.
- Sida should sustain and continue to build long term collaborations with key technical centres inside Sweden and abroad to provide Sida with the necessary technical inputs and updates on a regular basis.
- Sida can also play a role as a broker for SRHR moves, as happened in the past by calling together key people for discussions, workshops and meetings.

3 Support to multilateral organisations

Sida participates as an active partner in Sweden's involvement with major multilateral organisations. Below is an assessment of Sweden's and Sida's cooperation in the area of SRHR with the World Health Organisation (WHO), the Pan-American Health Organisation (PAHO), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), United Nations Programme on HIV/AIDS (UNAIDS) and the World Bank (WB). This is not an exhaustive list. Due to time constraints the Team did not visit the Population Council, for example, an important recipient of Swedish funds and a key actor in SRHR globally. Because of time and availability of staff in the visited agencies, what the study covers are more descriptive examples rather than an extensive review of Sida-supported activities. Furthermore, for some of these partners, it was difficult to differentiate between what 'Sida' says and what is general Swedish policy and support.

The general opinion of the staff of the six agencies visited was that Sida is a very important donor in the field of reproductive health. Sweden has supported the broad SRHR agenda, and at the same time been in the forefront in supporting innovative projects and initiatives particularly for the most controversial areas of SRHR.

3.1 World Health Organisation

General findings

Overall, Sweden and Sida are seen in WHO Headquarters as having been instrumental in putting SRH on the WHO agenda through the following different capacities:

- Politically, by raising important issues in the Executive Board and at the World Health Assembly, and also otherwise keeping the pressure on WHO to take up SRH, including in the Policy and Coordination Committee ("board") of the Human Reproduction Research Programme (HRP).
- Financially, by contributing generously, both to the core funding for main programmes that partly or fully rely on voluntary contributions (such as HRP and the child and adolescent health programme) and to specific requests in the area of SRH. Examples are funding of the Women's Desk in HRP (later Reproductive Health and Research, RHR) and the development of the technical manual for provision of safe abortion services.
- Technically, by taking part constructively in various technical consultations, including the ones taking up controversial issues, and by providing short term consultants.

While Sida support has been constant, the otherwise strong support could have been even stronger if messages and activities had been better harmonised. The term 'sexuality' is in some contexts felt to be offensive and even carrying obscene connotations in some languages and cultures, also for people who are supportive to the content. When Sida is waving the "sexuality flag" as a label, this may not always be strategically the most adantagous way to move this controversial field.

Supporting research

Sweden was instrumental during the setting up of the Human Reproductive Research Programme in 1972 (see Annex 4 for more information on the HRP set-up). While many countries have given support over the years, Sweden has been one of five countries that have given continuous support, and among these, may be the one with the most consistent support.

Well before the ICPD, Sweden supported an expansion of the research agenda to include sensitive themes, and also to expand in terms of disciplines, with increasing emphasis on social sciences. It is the perception at WHO that Sida through its representation on the board of HRP has persistantly pushed for research on abortion, and also been very supportive of research related to adolescent reproductive health. It is also felt that Sida has been aware of the constraints that WHO has as a UN organisation, and has therefore not pushed WHO beyond the constraints that it has. Thus Sida has appeared as a loyal partner, and at the same time been spearheading development in new areas.

Supporting policy dialogue

As a lead-up to the ICPD, Sweden was central in initiating a dialogue between women's NGOs and WHO, including provision of initial funding. This dialogue was important in building trust, and in creating a channel that women's NGOs could use in order to make themselves heard during the negotiations. Afterwards, Sweden funded the Women's Desk for an initial period of time.

One of the decisions from the ICPD+5 suggested that governments should be responsible for logistics and training towards the provision of safe abortion services "in circumstances which are not against the law". It was eventually decided that WHO should convene a technical consultation in order to operationalise this decision. A very successful consultation was held in September 2001, but it took almost two years before the guidelines were eventually published, due to a series of obstacles. Support from Sweden in different forms (political, technical and financial), from Stockholm as well as from the Swedish permanent mission in Geneva, has been very important in this difficult process. Other countries have also pushed the issue, notably the UK and the Netherlands, but Sweden has been extraordinary in consistence and endurance.

Technical assistance

Technical support mediated via the Swedish Consultancy Fund is generally very much appreciated in WHO. The intention was to recruit young and aspiring professionals and expose them to the work in WHO, but rather experienced and senior persons have also been funded in this way. It is a requirement that it be short term, which has excluded areas which require long term engagement, such as for some of the work related to gender concerns. As a spin-off effect, some short-term consultants therefore chose to continue their work in WHO as Junior Programme Officers. Others suggested that they would have liked to take advantage of the mechanism of the Swedish Consultancy Fund, had it not been so difficult to find out which consultants were available. Officials in WHO attributed the high quality of the Sweden's technical inputs to an extraordinary strong scientific infrastructure on this area in Sweden, partly built up with the aid of Sida.

Supporting gender mainstreaming

The RHR department is seen as exemplary for the way in which it has included gender concern in its ordinary work, via the Women's Desk and the Gender Advisory Panel. In addition, there is a Department on Gender and Women's Health in WHO. Recently this department has developed a document entitled 'En-gendering' the Millennium Development Goals (MDGs) on Health. This is an example of a very strategic move in view of the increasingly important role that MDGs are playing in priority setting in development assistance, including in allocation of funds.

Together with the Netherlands, Sweden is seen as the strongest supporter of gender mainstreaming in SHR and generally in WHO. These two countries, accompanied by others, are keeping the issue alive by constantly pushing it onto the political agenda, and by often responding positively to specific requests for financial and technical assistance – e.g. the provision of a consultant on mainstreaming gender concerns in WHO.

Supporting child and adolescent health issues

The main structure in WHO for normative work and technical assistance to countries related to children and adolescents is based in the Department of Child and Adolescent Health and Development (CAH). The Human Reproduction Programme (HRP) has had an increasing research portfolio on adolescents over the recent years, and the results have provided an important knowledge base for the CAH to build on.

Sweden's support for work related to adolescents is seen in WHO as having been of critical importance. As in the case of support for RHR, it has been sustained over the years and been political/moral, technical and financial. It has been especially strong technically, both in volume and in quality, and it has lasted over decades. An example of an area where Sweden's support has been important was when WHO started up its work related to boys and sexuality. Some women's NGOs were negative to this approach, which was seen as detracting attention away from women and girls. Sweden's advocacy work was important in leanding this important approach credibility.

Supporting safe motherhood and breastfeeding

Making Pregnancy Safer, which can be seen as WHO's contribution to the Safe Motherhood Initiative, has its own income generation. Since its inception in 1987, Sweden is the third biggest donor, with a total of USD 2.9 million, with decreasing contributions over the recent years. Also Programme Development for Reproductive Health (PDRH) is doing fundraising, and here Sweden is, cumulatively, number four since 1996, with USD 3.1 million.

Sida sees support to breastfeeding as a part of its activities in SRH and has generally been supportive of the actions that WHO has taken in the area. Sweden was also central in pushing the resolution in the World Health Assembly (WHA) on a prolongation of the period when exclusive breastfeeding is recommended. This has a lot of implications regarding the rights of women, particularly with regard to working conditions.

Pan-American Health Organisation

PAHO was established earlier than the WHO. It serves as the regional office for Latin America and the Caribbean of the WHO, but it often presents an image of itself as a more independent and progressive unit.

By PAHO staff, Sida is seen as one of the like-minded donors that have always been supportive. PAHO has had a strong commitment to SRH and gender issues, and this is where Sida support has been appreciated. No major conflict on content or orientation has been mentioned. Sida does contribute to the work of PAHO especially in the Central American region, and with a strong focus on Nicaragua, Honduras and Guatemala.

Support on gender issues

The main work of Sida has been in areas of health sector reform processes, but a substantial effort has also been put in place within a framework of an extended definition of Sexual and Reproductive Health (PAHO includes the terminology of 'sexual health' in its own documentation). The main emphasis has been on addressing gender issues in health, an area that has been supported by NORAD and Sida jointly, and Swedish experience and research on issues of gender based violence and adolescent sexual health, especially in collaboration with the University of Umeå, has contributed to a high technical standard on some of the work done. For PAHO, however, it is again difficult to differentiate strictly between activities and messages that come from Sida and those that are generated by Swedish researchers or technical people.

Other support

In collaboration with or supported by Sida, units of PAHO (see Annex 4) have produced an advocacy sheet on preventing HIV/AIDS among Latin American and Caribbean adolescents. Core Sida support has been given to a project aimed at the prevention of intra-family violence and the inclusion of domestic violence in public health.

There is also a collaborative PAHO/Sida/NORAD project on Sexual and Reproductive Health of Adolescents and Youth. It aims at improving the institutional and social responses of the participating countries (Nicaragua, Honduras, El Salvador, Guatemala and Belize) to the health and development needs of adolescents, with emphasis on sexual and reproductive health. As part of Nicaragua's health reform process, the project supports the development of a family and community-oriented integrated health system, which incorporates a risk assessment/management and gender approach and promotes social participation as well as the development of local initiatives to ensure its sustainability.

It has not been possible within the scope of this evaluation to evaluate the successes or impacts of these specific programmes, but the staff involved seemed keen to go a step further in discussions on gender mainstreaming tools as well as sexual violence prevention with "like minded" partners like Sida.

3.2 UNFPA

UNFPA has reproductive health as the emerging core activity of its programme, but core UNFPA competence has not really been in the area of health, rather it has been a host organisation for demographic competence like monitoring fertility patterns, international migration and similar issues (see Annex 4 for more background information).

UNFPA has now entered as a core strategic partner in raising the issue of HIV prevention in adolescents. The organisation has run pilot programmes in behavioural change communication and HIV/AIDS awareness in many countries, and is now approaching a scaling up of these programmes. Analysis of how these programmes should and could work seem to be evolving rapidly, but the expansion towards sexual health and especially sexual rights is not featuring sufficiently in advocacy. In the State of the World Population 2003 UNFPA draws attention to support by the Dutch and the Finnish in scaling up these activities. Sida is also a very important partner in pushing both the magnitude and the content in these new programmatic efforts.

Types of financial support

Sweden is one of UNFPA's largest donors, and has become even more important after the withdrawal of US funding. Sida's funding consists of both core budget support and untied extra budgetary support. Sweden has also initiated the extra budgetary contribution of the EU in 2001. Some of the important activities that have been financed by Swedish funds are:

- UNFPA Joint Advocacy against HIV/AIDS in Sub-Saharan Africa, initiated in 1999
- Fourth Conference of African Women Ministers and Parliamentarians, initiated in 2000
- Gender perspective and partnership with military, initiated in 2001
- Secondment of a Country Support Team advisor to the UNFPA office in Addis Ababa, Ethiopia, 2000–2002
- Project support from Ministry of Foreign Affairs to "cultural perspectives on reproductive health and rights", 2003

- Project support from Sida related to a ten year review of ICPD, linking ICP with the MDGs, 2003–2004
- Sida support to HIV/AIDS project in Ukraine

In addition, Sida has sometimes used multi-bi modalities of funding at the country level, such as in Mozambique on HIV/AIDS (starting 2003), and in Afghanistan (project support to implement the Census, 2003–2004).

Engaging in policy dialogue

Sweden has had a long relationship with UNFPA, which started when UNFPA was founded. Before and during ICPD Sweden played a very active role in promoting with and within UNFPA a holistic SRHR approach. Sida has also dialogued with UNFPA on how to implement the ICPD agenda at country level. Sida has also supplied UNFPA with expertise in the area of sexuality issues in the context of SRHR. For a period Sida has also held annual consultations with the UNFPA leadership. There have become only sporadic events in the last half decade. The role of donors in shaping UNFPA programmes and policy seems not to have been as strong as in, for example, WHO. Sida has, however, been seen as an important dialogue partner and supporter of UNFPA's core decision making and strategic change work.

Sweden does want UNFPA to adapt to global changes and challenges, including difficult ones like changing family types, reproductive patterns and gender norms. Messages from Sweden are to bring universal principles and cultural values closer together, to strengthen the institutional capacity of UNFPA, and to define goals in development (e.g. on reproductive health, sexual health, gender equity and population balance). Sweden also emphasises that UNFPA needs further development in the area of a rights based approach to SRH. Sweden also states that it is important to monitor UNFPA's role at the country level and urges embassies and country offices to report on this. The Team was not able to look into details on this issue.

Sida has recognised that UNFPA will in the future face greater challenges on account of the political and cultural sensitivity of its mandate and it has taken a lead role in supporting it politically against governments that question the SRHR agenda. The Swedish strategy Framework for UNFPA for 2002 to 2005 has been defined as to strengthen UNFPA capacity for advocacy and dialogue on issues that are its core mandate; to develop a rights' based approach in policies and programmes, and to enhance the intellectual and analytical capacity of the organisation to deal with emerging issues. Sweden also defined itself as a spokesperson for UNFPA on issues that might be too sensitive for UNFPA to raise.

The strategy framework also includes a stronger involvement of Sweden in UNFPA operations at country level, even in countries where Sweden is not collaborating or co-financing projects with UNFPA. Sweden sees the collaboration with UNFPA also at the level of technical support in the shape of seconded professionals, junior professional experts and consultants.

Adapting to SWAps

UNFPA sees itself in a problematic position with regards to SWAps, and has addressed this in a number of workshops and meetings. While SWAps offer a possibility for the integration of RH activities into health programmes, there are also problems. RH is both a technical and a political issue, and both positions are needed inside the SWAp negotiations. UNFPA can contribute to the negotiation of health sector strategies with technical competence, inputs toward methodologies, and advocacy for reproductive health and rights, as well as monitoring and evaluation. UNFPA is important for the successful implementation of SRHR within health sector reform processes and it should therefore be part and parcel of the health sector decision making, no matter what choice UNFPA takes with regard to its funding modalities.

In Tanzania, for example, UNFPA has been reluctant to enter the health sector "basket" funding mechanism, and has decided to commit only a small portion of the country budget in this way. The rest, however, will be spent in vertical programmes. UNFPA is aware that this contradicts the approach of many donors (including Sida), but stresses that maintaining service delivery, such as the supplies of condoms, is of utmost importance, particularly in a country like Tanzania, that is hit hard by the effects of the HIV/AIDS pandemic.

Because Sida contributes both as a donor to SWAps in bilateral support and as a donor to UNFPA in multi-lateral support, it is important for UNFPA to be placed where health sector reforms and funding mechanisms are discussed. Sweden's strategy towards the agency clearly identifies it as the lead-organisation with regards to SRHR, but does not elaborate how Sweden will support UNFPA to take the role as SRHR advocate in sector wide approaches to health, without compromising its mandate.

Adolescent SRHR

One of the areas Sida has been supportive of in UNFPA is a new approach to issues of adolescent reproductive health. The draft document (UNFPA and Young People, 2003) reviews country offices and country support teams annual reports and looks at how adolescent SRH programmes are moving in areas of Country Programme Strategies, gender issues, diversity of adolescents, rights based approaches, and youth participation, among other things. The challenge has been in scaling up the interventions that have been proven to be positive.

Sida has also supported a joint advocacy initiative in Africa and facilitated needs assessments in some countries. IPPF and UNFPA's adolescent reproductive health activities have recently been evaluated by a consortium of donors, and Sida should take notice of these reports in their future discussions with UNFPA. The programme for adolescent health and development in Namibia, where Sida was one of the collaborating agencies, is seen as an example of a successful country level collaboration.

3.3 UNICEF

The mandate of UNICEF and its key strategic role in the UN system is to advocate for the protection of rights of children, to help meet the basic needs of children and to expand their needs to reach their full potential. During the 1980s UNICEF has moved to a more rights based approached and has broadened its mandate to include all age groups between 0 and 18 years. Some of the priority areas of UNICEF include early childhood development and child protection, girls' education, HIV/AIDS, immunisation and child protection. Despite its low profile in the field of SRHR, the agency has always had a strong commitment towards maternal health and safe motherhood.

UNICEF has had a policy on gender equality and gender mainstreaming since 1994. During the 1990s UNICEF also adopted a more holistic perspective on the survival development and protection of children, which includes water and sanitation, the environment, and so on. Adolescents and their needs have also received a lot more attention than before, but UNICEF does not at all focus on sexual and reproductive health. It has not defined its mandate in terms of picking up controversial issues, including sexuality. The HIV/AIDS crisis has, however, opened the area somewhat and has offered opportunity for fruitful collaborations.

Sweden and SRHR in UNICEF

Sweden has supported UNICEF financially, politically and morally since its formation in 1946. From 1960 until 1999 Sweden was the second largest donor to UNICEF. By 2000 Sweden had fallen onto 4th place of the donor list, but still the organisation received 4.3 percent of Sweden's total ODA budget. A large part of Sweden's funding to UNICEF is earmarked and administered as multi-bi funds (see Annex 4).

Sweden has in the past funded programmes for advocacy of the rights of children, social mobilisation, education for development, baby-friendly hospitals, water and sanitation and programmes for children in emergencies. 40 percent of the ear-marked funds went to health related activities in 2000. Sweden has had large numbers of professional staff posted in UNICEF, ranging over the years from between 38 to 18. Currently there are 18 Swedish professionals and 20 Junior Professional Experts within UNICEF. Sweden has also been represented on the Executive Board of UNICEF in most years.

In its 2002–2005 Strategic Plan, Sweden has concentrated on the following priorities: consolidate a rights based approach, improve institutional learning mechanisms, enhance collaboration with other UN agencies and the World Bank, and develop approaches for children in need of protection and adolescents. Sweden also indicated that UNICEF should participate in SWAps and within the process take a lead on advocacy on children's rights in SWAp-processes.

3.4 UNAIDS

UNAIDS came into being in 1996, after a transformation from a global programme on Aids when it became clear that HIV/AIDS had devastating effects on all aspects of human life and that it was no longer a health challenge only. UNAIDS' areas of work cover all sectors, and all consequences of the HIV/AIDS epidemic including socio-cultural and human rights aspects, prevention, advocacy and treatment. It is now a co-sponsored UN agency owned and governed by eight UN organisations and the World Bank.[2] The function of UNAIDS is to promote and support global co-ordinated actions against HIV/AIDS. It is governed by the Policy Coordinating Board (PCB), which meets once a year. At country level, UNDP is normally the co-ordinating body.

With UNAIDS being a young organisation, there is ample opportunity for donors and others to influence its thinking and direction. The AIDS pandemic challenges our understanding of development, and calls for creative and strategic approaches. Both the structure of UNAIDS and the way in which the work is organised at the country level illustrate that the AIDS pandemic is seen as a threat to general development. While the ICPD claimed that there is a similar link between SRHR and general development, this notion has never really been acknowledged in the wider development community.

Swedish support

Besides political support, Sweden supports UNAIDS financially. The total budget of UNAIDS in 2002 was USD 92 million. The biggest donor was the US, followed by the Netherlands, Norway and then Sweden. Sweden's contribution to UNAIDS was SEK 72 million, channelled through the Ministry for Foreign Affairs. Contributions have more than doubled since UNAIDS was founded (see Annex 4). Sweden is seen as a loyal and solid donor by UNAIDS, and it is highly appreciated that the funds are not earmarked. In addition to this support, Sida provides bilateral funds for UNAIDS related activities at country level.

3.5 World Bank

The World Bank has supported population and reproductive health activities since 1970, and has helped finance more than 192 population and reproductive health projects in 83 countries. Although the Bank today is the largest development agency in the health sector – in financial terms, and has committed USD 4.2 billion to reproductive health programmes, the organisation depends on very few internal RH specialists.

[2] The UN organisations are: UNICEF, the World Food Programme, UNDP, WHO, UNFPA, International Labour Organisation, the UN Office on Drugs and Crime (UNODC) and UNESCO.

One weakness of the organisation, therefore, being a major player in the health sector reform in several countries, is its technical capacity, especially in conceptually demanding areas such as reproductive health. Therefor its aim has been to build stronger partnerships with other UN agencies and major NGOs. Another weakness, which the organisation is trying to improve on, is the need to increase involvement of national, non-governmental stakeholders like women's health advocates, professional societies and others.

Policy dialogue and technical support

Sida has been involved in policy dialogue with the World Bank in several areas, and on several occastions has challenged positions held by the Bank with regard to SRHR. Health reforms, health financing and health governance have always been WB issues, and a strategic move to include public health concerns and sexual and reproductive health as part of these areas is partly attributed to the push from prominent actors like Sida. Sida's support of the Safe Motherhood Initiative in the World Bank really stands out, and has not been repeated in the UN organisation, where Sweden's contribution to maternal health has been less visible.

Sida has been aware of the Bank's shortcomings with regards to technical SRHRs capacity and has attempted to support the WB both by secondments in critical areas and by providing extra budgetary support to special study projects. The more recent provision of Swedish expertise through a specific fund has created another avenue of doing this. Sida has the reputation in the WB of being reasonably generous, but concerns have been raised whether Sida is demanding sufficient accountability of the WB on these extra subsidies.

3.6 Challenges and recommendations

The evaluation team has identified a number of challenges facing these multilateral institutions with respect to SRHR and the Cairo agenda. There is, first and foremost, a need for Sida to advocate for the fulfilment of the commitments made at international conferences and to put them in an ethical and human rights context. Clearly, all relevant UN organisations need Sweden and Sida as spokesperson for the abortion issue.

The following more specific recommendations are forwarded as inputs to Sida's programme negotiations with the respective agencies. These recommendations are drawn from interviews with various stakeholders and only partly derive from the more descriptive presentation above.

- A stronger collaboration and co-ordination between the Nordic countries with regard to advocacy on SRHR issues in the UN system might be considered for increasing influence and for optimal use of resources.
- In WHO few regular budget sources have been made available for gender issues. Sweden might put pressure in relevant fora for allocation of regular funds for these activities.
- Sida should consider assisting WHO in their work on creating a working definition of 'sexual health', and should support further development of reproductive rights as human rights.
- Support to midwifery is a priority area in Sweden's strategy for working with WHO, but is not an area that stands out as a strong aspect of support. The area should be strengthened.
- Sida has been at the forefront of pushing the issue of adolescent boys but this needs to be followed up by concrete actions and programmes. Other possible areas to move the adolescent SRHR agenda further could include married adolescents, adolescent refugees, and poverty and youth.

- There is a need to strengthen the work of WHO on adolescent SRHR, particularly in relationship to HIV/AIDS. Gender aspects within this context are particularly important.
- Sida should consider special programmes in the area of adolescent SRHR within the World Bank also, where this expertise is weak.
- Sida should give the Safe Motherhood Initiative more attention, also within the multilateral organisations, particularly in UNICEF, where safe motherhood is the main SRHR field. This is particularly important where health service delivery has deteriorated.
- There is a need to scale up the analytical understanding of the linkages between HIV/AIDS and SRHR in order to be able to advocate for mainstreaming, also within the relevant UN organisations.
- Sida, as one of the strong proponents of health sector reforms and sector wide approaches coupled with basket funding, should be at the forefront of investigating the relationships between maternal health and SWAps in a critical manner.
- Sida has recommended that UNFPA takes the role as lead advocate of SRHR in SWAps. There is a need to include the technical expertise of UNFPA in sector wide approaches in a manner that does not compromise its mandate and goal. Sida should facilitate this.
- Sida should take active part in the training courses of the World Bank Institute on Reproductive Health and Health Sector Reform in order to strengthen the expertise of Sida staff. The idea is to build the capacity of country level staff to successfully negotiate SRHR issues within a SWAp context, in donor-government meetings and strategy negotiations, to make sure that SRHR issues are not sidelined in policy and priority decisions.
- Sida should work with the World Bank on the relationship between the PRSP processes and the SRHR agenda, including a re-analyses of the association between SRHR and poverty, using demographic and health Surveys.
- In order to pursue these issues further Sida should use the rich expertise in Sweden and second expert staff to the World Bank. This could be accomplished through trust funds.

4 Support to international and regional NGOs

The international and regional NGOs and networks presented in this chapter are merely a selection of the many NGOs that receive Sida funding. While important in their own right, they have been chosen to represent Sida funding to SRHR NGOs. The organisations reviewed fall, like the majority of organisations supported by Sida, into two categories, international and regional NGOs concerned mainly with advocacy of controversial aspects of SRHR (particularly abortion related issues, monitoring of both controversial aspects in light of international conventions and the marketing of breast milk) and, secondly, networks oriented towards capacity building and piloting of best practices. Many of the organisations reviewed here fulfil more than one of these functions, however, and their functions and levels of influence lock into each other in a manner that make them more effective together.

4.1 General findings

A long history of support to advocacy NGOs

Sida has with dedication and constancy supported international and regional NGOs and networks devoted to furthering the SRHR agenda. Some of the relationships to organisations go back a long time and are based on true thinking of like minds. International Planned Parenthood Federation (IPPF), for example, was co-founded by RFSU leader Ottensen-Jensen in 1952, who then acted also as IPPF's first president. Already in the 1930s Ottensen-Jensen and RFSU had SRHR principles at heart which were very advanced. IPPF's goals have remained very close to Swedish priorities, particularly after ICPD.

The relationship to women's health activist NGOs also goes back to the pre-ICPD time, when Sida cooperated with organisations like the International Women's Health Coalition (IWHC) and others to push the sexual and reproductive rights agenda. IWHC was at that time instrumental in both training Sida staff, in coordinating other likeminded NGOs and in advocating for paradigm changes. Support to organisations like RAINBO (Research, Action and Information Network for the Bodily Integrity of Women), its sister organisation Amanitare in Africa, and ARROW (Asian-Pacific Resource and Research Centre for Women) at the same time followed similar aims and helped first to prepare and then consolidate the gains of the ICPD. IWHC, for example, is a very effective advocate situated between the UN organisations and regional women's networks, such as ARROW, which in turn communicate with country level organisations.

In addition, Sida has also consistently supported international and regional NGOs concerned with mother and child health issues, particularly IBFAN (International Baby Food Action Network) and WABA (World Alliance for Breastfeeding Action) which have been strong allies in monitoring of the code of marketing of breast milk substitutes. Ipas has been another important partner of Sida. This is an international NGO supporting a rights based approached to SRHR and advocates towards changes in abortion legislation in addition to providing technology and training for abortion services.

Providing core funding

Sida's support to many organisations has been in the form of core grants which have made a lot of difference. Core funding has helped towards forward looking planning, enabled organisations to maintain staff and offices and offered opportunities to engage in basic research activities which are not tied to projects. In some cases Sida untied funds have helped organisations find themselves, as it were, and establish themselves properly. In many organisations Sida has been the only or one of very few donors to offer core funds. IPPF has always received core funds, and RAINBO, AMREF, ARROW and

IWHC, among other, benefited at various times from this possibility. AMREF has received core funding for strategic programmes and earmarked funds for adolescent SRHR projects from Sida at least since 1992.

While core funding has created much desired for freedom in some organisation it has created in others a feeling of being left on their own too much. A number of the organisations mentioned here thus would have preferred a more proactive stance of Sida, offering advice and dialogue. This has become particularly important in cases where funding has been reduced, with what appears to be little warning or explanation. In some cases Sida has been perceived of as rather arbitrarily moving funding from one organisation to another, again without giving the networks concerned sufficient explanations and time to reorganise and re-coup shortfalls of funding from other sources. With the withdrawal of US funding to several of Sida funded NGOs such as IPPF and Ipas as a result of theGlobal Gag Rule (see Box 4), the pressure on Sida to step up its core funding has increased.

A formative role

In some cases Sida went further in helping shape organisations. ARROW, for example, was at its formative stage almost entirely funded by Sida. The formation of the Amanitare African Network, coordinated from RAINBO in London, was actively encouraged by a member of the Sida Health Department. The Network remains the only regional organisation dedicated to further the SRHR agenda on the African continent, with 51 partner organisations in 18 African countries.

A number of other organisations have also been initiated by Sida and its Swedish partners, and been funded by Sida, at least in the initial stages. They too, are largely concerned with coordination and capacity building. The Africa Midwives Research Network (AMRN) is a case in point. It represents an innovative new approach aimed at combining coordination, increased information, capacity and professionalisation with possibilities for further education in Sweden. The Network is currently based at Muhimbili University College in Tanzania and has been able to expand membership also with the help of other donors. SPANe is another network with similar aims, which aims at facilitating exchange of information and capacity building of Sida funded NGOs in the adolescent SRHR field in Africa. SPANe is directly linked to Sida support and has remained dependent on Sida funding alone.

Building networks

Sida has been consistent in funding networks and coalitions working in the area of SRHR in all regions where Sida has development cooperation. These organisations strategically serve two purposes: they act as middle level co-ordinators between the larger international networks, such as IPPF, IWHC, Ipas and IBFAN, and mediate between the global and local levels, and they coordinate and implement research and capacity building. One of the main purposes of the regional organisations has been that of offering strategic support to smaller organisations, supplying them with advocacy tools, building capacity and facilitating South- South dialogue on research, best practices and the like. Sida has been very consistent in this approach so much so that networks were initiated where they did not exist – the African networks Amanitare and the Africa Midwives Research Network are examples of this.

Box 4: Effects of the Global Gag Rule on some NGOs

IPPF, after the imposition of the Global Gag Rule in 2001 IPPF experienced a withdrawal of US support at the tune of USD 17 million–12 million in grants and 5 million in condoms. This represented 25 percent of IPPF's total budget at the time. There was also a potential loss of USD 75 million over 4–8 years that IPPF had expected to receive in joint partnership funding. Unfortunately, at the same time, other donor also cut funds – for other reasons. Japan decreased its contribution from USD 120 to 70 million and Germany reduced funds by 50 percent due to economic problems. Denmark's support was also reduced due to a redefinition of priorities of the ODA distribution. These budget cuts have resulted in clinics all over the world closing and essential reproductive healthcare being denied or delayed.

UMATI, the Tanzanian FPA, has seen a reduction of funds from IPPF, and its director was adamant that his association would not accept US funding, even though UMATI's activities would not be affected by the Global Gag Rule. UMATI already experienced financial problems when Sida cut funding for one of its projects, the teenage mothers project in Temeke, having rendered the project untenable, and with JICA reducing funding to a youth friendly RH clinic – at the Temeke Youth Centre.

Ipas has also suffered cut-backs in funding. The Director of the Ipas Nairobi office partly linked decline in funding to the organisation's refusal to accept the Global Gag Rule as a matter of principle. The feeling in Ipas is, moreover, that there has generally been a cooling of support for SRHR, particularly with regard to aspects related to strategies for the reduction of maternal mortality, and post abortion care. This is evident with regard to the support of Denmark and Norway, in particular, both of which have previously been very supportive. According to Ipas staff, apart from Sweden and the Netherlands, most donors are rather ambivalent when it comes to reproductive health. The Netherlands continues to fund SRHR, but at a reduced level, while for the moment Sida's position, though supportive at the level of policy, is not very distinctive. As a consequence of funding constraints Ipas has had to close down much needed family planning projects in countries such as Kenya, Zambia and Ethiopia overnight.

ARROW suffered cutbacks due to the withdrawal of US funds from UNFPA, which had offered project support to ARROW. This problem has repercussions, for example, on the review process of the Beijing +5 conference and SRHR policies in general. However, as a response ARROW managed to launch with partners an effective advocacy campaign against the new US agenda during the ESCAP conference in 2003.

4.2 International Planned Parenthood Federation

IPPF represents a global network of member associations (see Annex 5 for more background information) that is able to speak with a single powerful voice, and it has the potential to provide for the exchange of experiences, best practice reviews and intra- and cross regional development of strategies. IPPF also lends advocating positions to local associations that might otherwise be too weak to take courageous advocacy stands and thus strengthens their position vis-à-vis their respective governments. This is particularly important in the context of the backlash against the SRHR agenda.

Overall, IPPF has a strong agenda on advocating SRHR and maintaining the intentions of the ICPD Plan of Action. As an international NGO IPPF has a unique role to play in dealing with questions that are too controversial for governmental organisations, building on a well developed organisation with regional offices and national agencies. IPPF has for long shared many of the commitments and ideals of Sweden and there is considerable overlap of Sida's SRHR strategy and IPPF's 2003 Plan of Action emphasising the five A-s: Access, Abortion, HIV/AIDS, Adolescence, and Advocacy. Sweden interacts with the IPPF in two different ways: as an affiliate member through RFSU and as a donor through Sida.

Influencing policy

Sweden has been represented on the Governing Council, which is the highest governing body at IPPF, consisting of 30 members, 5 from each region. For the period 2004-06 the president of RFSU will represent Sweden on the Council.[3]

Every year IPPF arranges consultative meetings with donors, recognising that they should have a constructive role in affecting IPPF's policy. Sweden took a specific initiative within IPPF in the mid eighties in order to strengthen IPPF's emphasis on gender equality and adolescents, and to that effect contributed USD 3 million in earmarked funds (in addition to the core funding) between 1983 and 1986. A tripartite evaluation by Sweden, Norway and UK in 1999 led to the development of an integrated management and accreditation system. Every five years each Family Planning Association in member countries is also assessed and if necessary asked to implement changes and reforms.

[3] The period is presently 2 years, but will be expanded to 3.

The International Medical Advisory Panel (IMAP) attached to IPPF has ten members of high professional capacity and prestige. IMAP advises IPPF based on consensus in the panel. IMAP's first chairman (1979) was Ulf Borell from ICHAR. In the nineties Kerstin Hagenfelt, also from ICHAR, has been a member.

The work IPPF has planned with other actors for the ICPD+10 NGO roundtable conferences and regional activities represent important strategies to improve national and global climates for SRHR. Sida has an important role to play here, through vocal support in advocating the rights perspective in SRHR.

Core funding

In terms of funding, Sida has been one of IPPF's most constant and generous funders, having covered from 19 to 8 percent of the total budget of IPPF. With few exceptions Sida funds have been administered as core funds. Swedish contributions have made up from between SEK 60 million annually, as in 1997, to as much as SEK 109 million in 2000, and the support to IPPF has constituted between 6 and 9.5 percent of the total Sida health budget (see Annex 5).

Following the withdrawal of US funds, European donors responded by supplying IPPF with additional, extra budgetary, funds to compensate for the shortfall, with Sweden contributing an extra USD 3.3 million and the European Union contributing an additional Euro 10 million. The IPPF Governing Council addressed the funding issue in its May 2002 session and decided to adjust its funding policy from project to budget support mechanisms and to stress capacity building in order to equip member organisations better to adapt to the changing realities of funding. If the IPPF is to follow these recommendations it will need to rely on increased funding from its remaining donors, Sweden included.

4.3 Ipas

Ipas is a non-profit international NGO that has been working for three decades to promote women's ability to exercise their sexual and reproductive rights, and to reduce deaths and injuries of women from unsafe abortion. Ipas' global and country programmes include training, research, advocacy, distribution of equipment and supplies for reproductive health care, and information dissemination. Ipas' work has thus been directed towards the reduction of maternal deaths, and particularly, those related to abortion and related injuries.

Ipas has been working in Africa since 1987. Apart from Kenya, where its African regional headquarter is based, Ipas has country programmes in Ethiopia, Nigeria and South Africa. In most countries where it has programmes, Ipas works closely with the Ministries of Health together with other partner organisations, such as Population Action International and Planned Parenthood Association, to improve the quality of post abortion care.

Promoting safe abortion

Sida has been one of Ipas' most ardent supporters not only financially, since Sida has also been in the forefront of advocating the right of every woman to safe abortion within the law. In December 2001, Sida co-funded a workshop in South Africa, Expanding Access: Advancing the Role of Midlevel providers in Menstrual Regulation and Elective Abortion Care. The focus was on access to quality abortion care in countries where abortion legislation is liberal but where services are poor or insufficient. Participants from ten countries in Africa and Asia discussed strategies and plans for training and promoting the role of midlevel professionals as providers of safe and elective abortion care within the health care system. With a strong emphasis on safe and legal abortion care this initiative answered the recommendations from ICPD and ICPD+5 that abortion should be safe in circumstances where abor-

tion legislation is liberal and that health providers should be trained and equipped and other measures taken to ensure that such abortion is safe and accessible. Apart from Sida the conference received financial support from NORAD and Danida.

Decline in funding

Members of the Ipas Africa office appreciate Sida having been one of the strongest supporters of Ipas'objectives. However, despite such support in the past, no donor has moved in to fill the gap left by the absence of US and other funding and to make up for the decreased commitment to Ipas' aims. For such reasons Ipas feels that Sida ought to be stronger in their support to counteract the loss of vital resources and support. Sida was the first bilateral development agency highlighting areas such as safe abortion, safe delivery, adolescent health, sexual health education and violence against women, all of which are high on the agenda of Ipas.

4.4 International Women's Health Coalition

IWHC is despite its name no coalition and it has no members. From its headquarters in New York it devotes its efforts towards adolescent sexual and reproductive health and rights, and in particular the development of the concept of Sexual Rights and access to safe abortion. IWHC was instrumental in moving the paradigm change from demographic control to SRHR in the Cairo process. Since then it has campaigned against the "Global Gag Rule", and in collaboration with various donors has developed policies and programmes on SRHR.

It works towards shifting contraceptive research priorities, and has addressed the issues of men's role in SRHR. More recently IWCH has taken on an examination of the effect of health sector reforms and sector wide pooled funding modalities on the achievement of ICPD goals.

Promoting "the voice of the women"

The relationship of the IWHC with Sida has been long standing and strong. Sida funding to the IWHC commenced in 1992, covering 3 percent of the budget. Between 1993 and 1995 Sida funding increased dramatically, covering between 15 and 21 percent of the total budget of IWHC before it again declined: in 2000 Sida funding had shrunk to only 1 percent. In addition to these non-earmarked funds, Sida also supplied project funds for the production of one of the books for the ICPD Population Policies Reconsidered, and for consultancies supporting Sida's Bangladesh health sector strategy between 1995 and 1997.

Cooperation with Sida peaked around the time of the ICPD, with IWHC mobilising women's health activists during the ICPD process and Sida pushing the agenda in the negotiation meetings. After the ICPD there was a need to operationalise the ICPD gains. In this process Sida proved a major advocate in implementing the "voice of the women" and that of civil society in general. The IWHC played a major role in moving these issues forward in Sida, and in some instances contributed to the training of core development aid staff in Sweden.

Shrinking contributions

IWHC also sees a clear role for Sida in making possible alliances between donors (in Europe), women's health advocates and other agencies in addressing abortion issues. Here the challenge is both the general shrinking of funding for SRH as well as bringing the issue of abortion rights forward. The steady presence of Sida's support to agencies that can do this work is appreciated. Therefore IWHC is worried about the shrinking contribution of Sida. Perhaps the IWHC needs to broaden its collaboration and alliances with grassroots organisations in developing countries to regain credibility.

4.5 International Baby Food Action Network

IBFAN was founded in 1979, and is a network of over 200 country level associations and groups in over 100 countries. These are grassroot and advocacy organisations that focus and function very differently, dealing with various aspects of breastfeeding protection, promotion and support.

The critical issues identified by IBFAN include: national commitments to adopt the global strategy on infant and young child feeding, improving implementation of the International Code on Marketing Breast Milk and to counter the propaganda of the commercial sector; and addressing how HIV affects infant feeding. Many of the above mentioned issues were addressed at the Asia Pacific Conference on Breastfeeding held in Delhi in 2003. Sida, the Netherlands, UNICEF, UNFPA, WHO and the World Alliance for Breastfeeding Action (WABA), co-funded this important event. The very fact that this conference was co-hosted by IBFAN Asia, the Breastfeeding Promotion Network of India and the Government of India is indicative of a potentially highly important strategic alliance between a resolute government and the breastfeeding movement.

Lobbying and monitoring

IBFAN takes an active role in lobbying for resolutions and other decisions in the UN system, and there is a strong alliance with Swedish delegates to the decision-making bodies and with the Swedish permanent mission to the UN. A recent example is the resolution adopted by the World Health Assembly in 2001 on the extension of the recommended length of exclusive breastfeeding. Sweden then held the presidency of the EU, and played a key role in creating consensus among the member states. One year later, the Assembly adopted the *Global Strategy on Infant and Young Child Feeding*.

Box 5: Monitoring the Code of Marketing of Breastmilk Substitutes

Commercial interests have for decades been a threat to breastfeeding. The baby food industry is already very strong and it is growing fast. The Innocenti Declaration of 1990 was the first international agreement on breastfeeding, and has been very important in its own right. It has worked as a basis for decisions related to the issue at the international conferences through the 1990s, most notably the International Conference on Nutrition in Rome in 1992 and during the ICPD in 1994.

The declaration spells out the kinds of operational goals that each country has to strive to achieve, protect, promote and support breastfeeding, including at legislative and policy levels. It refers specifically to the Baby Friendly Hospital Initiative and the International Code of Marketing of Breastmilk Substitutes.

Monitoring of the International Code of Marketing of Breastmilk Substitutes is a central activity of the IBFAN (see Box 5). Sida is among the few donors who have supported this monitoring. Sida has also indirectly facilitated the monitoring of the Code by making possible the capacity building of IBFAN affiliates for this important function. IBFAN has maintained technical co-operation with the Institute for Maternal and Child Health (IMCH) at the University of Uppsala.

Core funding

Funding from Sida has been vital in the life of IBFAN; during an interview for this evaluation it was simply stated by IBFAN that it would not have existed without financial support of Sida. Sida started funding the IBFAN Geneva office in 1981, then as the sole donor. Other important donors along the years have been the Netherlands and Norway, but Sida has been the most stable, that also provided funding for the regional offices in Africa and Asia, when they were established.

Recently, a new five-year agreement between Sida and IBFAN has been signed, for a support of SEK 750.000 yearly till 2007. An evaluation is foreseen as a basis for a decision for the years after 2007. IBFAN is in any case advised by Sida to seek a broader financial base for its work. From 2003 Sida is also granting support to IBFAN Asia Pacific, a relatively new structure governed by a managing committee

and coordinated by a regional coordinator. IBFAN Asia Pacific has its support secretariat at the Breastfeeding Promotion Network of India in New Delhi.

4.6 NGOs fighting female genital mutilation

RAINBO

Sida has been one of the biggest donors to the Research, Action and Information Network for the Bodily Integrity of Women – or RAINBO. This is an international NGO devoted to the fight against female genital mutilation (FGM). It is now based in London but works in Africa. RAINBO sees itself first and foremost as a technical agency, cooperating with and providing knowledge and training to African partners, national agencies, NGOs and multilateral organisations (WHO, UNICEF and UNFPA among others). RAINBO has established a well developed system for the distribution of money to local NGOs through a small grants fund, which has clear criteria for eligibility and reporting systems.

Sida has been instrumental in encouraging RAINBO to broaden its programme focus on FGM to include a more integrated SRHR approach. Between 2001 and 2002, Sida core funds helped RAINBO to conduct a basic research project – the *Female Genital Mutilation Review*. Four major approaches to the eradication of FGM were evaluated and the integrated approach, whereby FGM is addressed within a broader health context, literacy or economic development, was identified as the most promising. Based on this review, RAINBO developed a *Women's Empowerment-Community Consensus Model*, which stresses girls' and women's rights to control their own bodies (Toubia and Sharief 2003). This is integrated with other aspects such as health components, and literacy and economic development projects. This model will be further developed and refined in pilot projects in order to determine how to encourage communities to dialogue about human rights.

Other organisations

While RAINBO cooperates with FORWARD, working mainly in Great Britain, there is little cooperation with the *Inter-African Committee on Traditional Practices Affecting the Health of Women and Children* (ICA). This is another major regional NGO in the FGM field, formed 10 years prior to RAINBO, in 1984, and based in Addis Ababa. IAC focuses on fighting certain traditional harmful practices related to delivery, FGM, nutritional taboos and forced feeding of women, early marriage, and it has promoted "good" traditional practices, such as breastfeeding and baby massage. The IAC received Sida funding until 1994 when funds for Sida's FGM initiatives were transferred to RAINBO, which espouses a broader SRH and rights approach more in line with Sida's own vision and works efficiently with NGOs on the ground.

More recently Sida has started funding a smaller NGO, *Tostan*, directly through the Human Rights Department at DESO. Tostan is one of the examples of a successful integrated approach that has resulted in public declarations about ending FGM in a number of Senegalese villages. Sida supports the project with SEK 5 million between 2002 and 2005.

4.7 Regional networks

Amanitare

Amanitare (African Partnership for Sexual and Reproductive Health and Rights) is a RAINBO initiative launched in 2000 to bring together the voices and expertise of organisations and individuals across Africa that address issues related to women's reproductive and sexual health and rights including freedom from gender based violence. It aims to strengthen organisations by creating the space and opportunity for dialogue and consensus building, facilitating the exchange of leadership and technical skills, building common strategies, and disseminating information.

The partnership actively seeks to create opportunities for interaction between "the partners" and other professional and policy institutions to impact health service delivery, promote favourable policies and bring about legal reform. The partnership also aims at impacting policy at the regional level including engaging in negotiations with the African Charter and mechanisms such as NEPAD. The organisation also wishes to bring African women's voices to the international arena both within and outside the mechanisms of the United Nations. Amanitare has successfully hosted an international conference on SRHR and African women and girls in 2003 in South Africa. This event represented one of the first of its kind organised from within Africa.

In 2001 *Sida* commissioned an assessment of RAINBO and Amanitare that concluded that the African Partnership is an important initiative in line with Sida's priorities. It praised the well-experienced and dedicated members of the partnership and their determination and strength as a group. It also concluded that it has done successful work on FGM and that it is a respected authority in the field.

Asia Pacific Resource & Research Centre for Women

ARROW was formed in 1993 as a non-profit NGO with a mandate to establish a documentation centre, action-oriented research and monitoring (see also Annex 5). Already in 1995 ARROW established itself as the only regional feminist NGO committed to monitoring of ICPD/women-centred policies and programmes. Since 1996 the programme focus shifted to strengthening initiatives aimed at reorienting health policies and building the capacity of women-NGOs to influence these policies.

Sida was the pioneer donor of ARROW since its second year of existence in 1994 and Sida was the only provider of core funding until 1999 when the Dutch organisation Novib came in. The relationship with Sida has until to date been a funding relationship, largely unaccompanied by any regular policy dialogue or technical backup in either direction between the two parties. This rather erratic nature of contact has been also indicated by the sparse and irregular visits or any other form of collaborative endeavours in the region.

Between 1997 and 2000 ARROW experienced a number of cuts and also withdrawals of funding from committed donors resulting in delays in completion of activities. In 1999 ARROW participated in Sida's Health Division's global assessment of 4 international women's health organisations and networks. This assessment was overall very positive to ARROW's achievements so far. Further core funds later led to a strengthened management capacity through new recruitments. Novib has provided regular feedback on reports and attached short policy notes to contracts, giving the impression of being a more engaged donor than Sida.

ARROW's and Sida's relationship has thus been characterised by, on the one hand, a rather unconditional support and positive evaluation of ARROW's mandate and achievements. On the other hand, there has been a series of successive cuts in the financial support from Sida. These cuts may signal Sida's increased strategic emphasis on basket-funding and reduced capacity to deal with small individual NGOs. Partly due to Sida's interest in basket-funding ARROW has in recent years participated in two inter-regional meetings with the other 3 organisations organisations/networks (ESEA, IWHC, LACWHN) supported by Sida and evaluated in 1999. These meetings have notably highlighted the difficulties of a shift from individual NGO-support to basket-funding.

African Medical Research Federation

The African Medical Research Federation (AMREF) is an African network with headquarters in Nairobi, with outreach offices in a number of European countries. AMREF activities all aim at creating models which can be replicated, and create evidence of success. At the same time it puts emphasis on building the capacity of local cooperation partners – NGOs, community based organisations and

the private sector. The pilot project results are also used for higher level advocacy work. AMREF works largely in the areas of HIV/AIDS and "family health", but also runs a programme for surgical outreach with doctors who operate in outlying hospitals.

AMREF project interventions are similar to those run by RAINBO, integrated in nature aiming at combining economic, social and medical aspects. AMREF has also included FGM into these holistic approaches. In the field of adolescent SRHR AMREF combines service delivery, peer group approaches and vocational skills development, communal farming activities and the like.

Sida has supported AMREF both with core funds and with specific project funds largely in the area of adolescent SRHR. In Tanzania, Sida funded activities with AMREF are part of the Lake Victoria Initiative.

African Midwives Research Network

AMRN was formed in 1996 on the basis of a regional research network, including midwives, which had been coordinated by the universities of Uppsala and Umeå between 1991 and 1996 (see Annex 5 for more background information). It is currently coordinated from Muhimbili University College of Health Sciences in Dar es Salaam and has established focal point offices in several member countries. Network members now come from countries all over Africa, including Angola, Botswana, Eritrea, Kenya, Somalia and Swaziland. The network has also been able to find other donors funding the inclusion of new member countries. There is now a move to include francophone members also. The Network aims to serve as a base for sharing information, strategies and solutions based on scientific evidence for provision of quality midwifery care in the region, and to enhance the expanded role of midwives in sexual and reproductive health and rights.

AMRN's activities have gradually proliferated to encompass many of the broader issues connected to SRHR. For example, Network members are now involved in work to reduce maternal mortality, to promote safe abortion and access to post abortion care and they advocate for the expansion of access to such care. AMRN also covers issues such as female genital mutilation and violence against women. In 2001 the network was presented with a Rockefeller Award.

The current support agreement with *Sida* for 2002–2007 is for a collaborative project between AMRN and Karolinska Institute. It aims at improving AMRN capacity to network, further build the members capacity for research through training in methodology, further the skills of midwives by using research evidence and enhancing collaboration with Swedish midwives through the Karolinska Institute.

SPANe

It SPANe is a network of NGOs and government organisations in East and Southern Africa supported by Sida. It was established in 1997 in order to facilitate the regional sharing of experiences in the SRHR work with adolescents, building capacity through the sharing of best practices in project design, implementation and monitoring and evaluation. The network in turn is linked to the Adolescent Reproductive Health Network (ARHNe) funded by the EU, which links researchers and implementers of adolescent health issues and programmes. ARHNe focuses on applied research, while SPANe is more implementation oriented. Membership of the two networks overlaps and annual workshops and newsletters are coordinated.

The capacity building aspects of the networks have been enhanced by two pilot training courses on *Sexuality, Youth and Health in Africa*, held at the Institute of Public Health at Muhimbili University College in Dar es Salaam 2001 and 2002, and organised in collaboration with the Karolinska Institute. The two weeks training course drew on participants in the region and the networks involved in adolescent SRHR and aimed at offering a positive and gender sensitive approach to sexuality, to impart

knowledge and skills necessary to promote SRHR of adolescents, encouraging facilitators in the field to overcome taboos, equip them with knowledge on sexuality issues, advocacy skills, and methods of overcoming resistance to sensitive issues. The course drew on a multidisciplinary group of teachers and facilitators from Africa and Sweden. The course was meant to be replicated across the region, but SPANe has recently lacked the capacity to push the agenda forward.

4.8 Challenges and recommendations

Based on its brief review of the institutions presented above, the Team wishes to highlight the following observations and recommendations:

Sida has been instrumental in both forming and supporting regional capacity building networks and training initiatives. This is a very commendable activity that has been much appreciated. However, commentators have also suggested that some of these regional capacity building networks have remained too weak to make them sustainable.

- AMRN has been a successful network, whose model of establishing focal points and offices in member countries and using a rotating chair could be replicated with other organisations, such as SPANe, for example.

AMREF is an NGO that is highly organised and effective. AMREF's model of starting pilot projects as a way of establishing best practices and combining research and capacity building is worthy of expansion and replication. The integrated manner in which adolescent SRHR is addressed, working in a framework of poverty reduction, points the way to a mainstreamed approach to SRHR which might present a model for the future. The concept is also reflected in an integrated approach to FGM.

- Synergies between AMREF and RAINBO, both organisations that address integration, should be encouraged.

Normally, breastfeeding is seen as a nutrition issue, with few links to the overall agenda on SRHR. At the same time there is a parallel development of the use of human rights for promotion and support for breastfeeding. Unfortunately, however, there is very little dialogue between those groups. Another missed opportunity is the fact that there is very little collaboration between the groups dealing with facilitation of early initiation of breastfeeding, such as the Baby Friendly Hospital Initiative, and activities under the Safe Motherhood Initiative.

- In view of the present harsh climate for sexual and reproductive health, this may an opportune time to bring these groups together, to see how they could facilitate each other's work.

So far, women have dominated the global breastfeeding movement. Recently, awareness of the importance of men in this work has increased, but still men have only been involved to a smaller degree.

- Sweden has a long track record on promoting gender in general, and also for breastfeeding. Closer co-operation between IBFAN and Sweden on this issue is recommended.

Some organisations have experienced Sida support as being almost too distant. While core funding is very beneficial to NGOs this does not mean that Sida's expertise can be dispensed with.

- We recommend that Sida try and maintain a closer dialogue with organisations and seek to respond to their requests particularly in the area of capacity building.

NGOs which have been engaged in controversial aspects of the SRHR agenda, such as abortion related activities, have suffered not only financially but also ideological set-backs. Sida is seen by many

NGOs as the only agency able to address abortion, for example, and well placed to revive neglected issues such a maternal health.

- NGOs flagging controversial aspects of the SRHR agenda need serious support both with regard to increased financial contributions and increasingly vocal advocacy.

Some organisations find it hard to relate to what its members perceive as an on-off attitude. This makes planning difficult.

- Sida needs to be more transparent when it comes to funding levels.

Female genital mutilation is an important issue, despite it having somewhat disappeared on the Sida SRHR agenda. Integrated approaches are important, as are organisations that espouse a variety of approaches. Eradication of FGM is a relatively new agenda and support to a variety of approaches is vital. AMRN has been doing research on some of these practices and should be involved in defining what they are.

- Sida should consider pairing the rather specific interventions against FGM with work against other traditional harmful practices, and Sida should thus consider funding more than one organisation with a good track record in FGM.

Sida has been trying to build synergies between NGOs and networks which receive Sida funding (see SPANe, for example), and the adolescent SRHR course at Muhimbili University is an example. Such initiatives have the potential to bring a greater variety of actors together, also beyond the boundaries of Africa.

- Efforts to create meeting places for a diversity of actors could be strengthened considerably and even move beyond the Africa region.

5 SRHR in Sida's bilateral country programmes

The largest share of Sida's health development cooperation consists of support to bilateral country programmes. The evaluation looked particularly at three current Sida partner countries – Zambia, Tanzania and India – that offered interesting comparisons.

Within Africa, Zambia is a country where Sida is a central actor in the health sector reform and the sector-wide approach, while in Tanzania Sida has no longer a health sector programme, but has established a central role in the education sector reform. These two African countries, similar in many ways, thus offered opportunity to observe Sida in the role of health sector reform advocate as well as outsider in the health sector. It offered, furthermore, opportunity to look more closely at the ability of Sida to treat SRHR as a cross-sectoral issue. In addition, the case of India, while adding an Asian perspective, is interesting in that it has offered a third variant; a country where Sida is working entirely via NGOs rather than with the government.

In each of the three countries the Team decided to focus mainly on projects related to adolescent SRHR, namely the UMATI Youth Centre in Temeke, Tanzania; the Kafue Adolescent RH Project in Zambia; and the MAMTA project in India. All three projects involved RFSU as a Swedish partner – with the Family Planning Association of Tanzania (UMATI), the Planned Parenthood Federation of Zambia (PPAZ) and the Health Institute of Mother and Child in India.

The cooperation between RFSU and UMATI went back to 1986/87 with Sida being the main donor from 1990 to 1997/1998 coinciding with Sida phasing out of the health sector in Tanzania. The Kafue Adolescent RH Project received Sida funding from 1997 until recently, when discontinued seemingly because of Sida's entry into the health SWAp. MAMTA in India has been funded by Sida since 2000, and is considered the most successful example of Sida funded twinning between RFSU and local NGOs.

5.1 Tanzania – Sweden outside SWAp

Sweden has in the last two strategy agreements with Tanzania developed into the lead donor in the education sector, and changed the funding modality from project support to a sector wide approach (SWAp). Despite its involvement in the Education Sector Development Programme Sweden is, however, also funding complementary education projects through NGOs – e.g. a Tanzanian NGO, *HakiElimu*, and Student Partnership Worldwide.

The health sector has undergone similar changes as the education sector, including a health sector reform and a move from project funding to a SWAp managed by a consortium of donors, in which Denmark currently leads. But Sweden is not involved in this undertaking and maintains no direct health sector projects in its bilateral programme. With a few exceptions, such as DfID, who has opted for budget support, donors contributing to the health basket maintain vertical projects in addition to the SWAp, which has lead to a fragmented approach.

Tanzania is in its Second Health Sector Strategic Plan covering the period between 2003 and 2008. It includes HIV/AIDS control as one of its focal activities, while SRH has no prominent position. For instance, the introduction to the Strategic Plan notes the problem of high maternal mortality (529/100 000 live births), early pregnancies and declining numbers of health facilities but these concerns are not reflected in terms of activities. Indeed, the strategy praises the rising number of home-

births as an achievement, when other informed observers know that homebirths have increased because the quality of clinics has deteriorated so badly that a homebirth is preferable.[4]

Research published in 2003 suggests that health personnel at various levels either remained in confusion about the implementation modalities of integrated SRHS services, or they lacked integrated supply structures preventing them from offering integrated services. The Reproductive and Child Health Service (RCHS) in Ministry of Health was established in 1995, and has remained dependent on donor funding, USAID prominent amongst them, until it withdrew funds recently apparently on account of financial auditing problems (UNFPA is the other major donor). In the past, RCHS had problems integrating vertical programmes, because programme officers were apparently reluctant to comply because they feared loosing their positions and funding (Oliff et. al. 2003). The precarious financial situation of RCHS might make this task even more difficult and might compromise both quality and coverage.

Temeke Youth Centre: Sida ceased funding

The RFSU twinning project with UMATI represented RFSU's first entry into the international arena. UMATI was founded in 1959 with a mandate to develop knowledge and practice of 'family planning' in Tanzania, one of the first to offer this service in Africa. Combining provision of contraceptives, information, education and advocacy, family planning came to be better accepted. Since the Ministry of Health has taken over many of the tasks once offered exclusively by UMATI, the organisation moved into a broader, integrated approach to SRHR maintaining model clinics spread over the country.[5]

Sida supported initiatives in adolescent SRHR include the Temeke Youth Centre established as one of the UMATI models. Initially the Temeke Youth Centre started off as a project offering teenage mothers, who were expelled from school, an opportunity to continue primary education, or enter into vocational training in a supportive environment where care for the babies was combined with fertility regulation education and provision of contraceptives. Later the project extended into an adolescent SRHR centre, offering a youth friendly SRH clinic and behaviour change services.

The teenage mothers project was meant as an advocacy tool to persuade the Ministry of Education to revise the law forcing teenage mothers out of school and as a pilot project to be replicated elsewhere. Up to today the UMATI example of young mothers who made it even into secondary school has not managed to soften the hearts of ministry officials to their plight. Since Sida stopped funding to the teenage mother unit, the project has floundered. There are still a few young mothers who make use of the opportunities, but without funding, UMATI was forced to take in girls not afflicted by unwanted pregnancies and children on a commercial basis. Amongst the original target groups, joining in has become too expensive, even if it is just a matter of transport and food money that is lacking (and which previously was supplied by the project). The clinic is still attracting funds, but here too constraints are felt. These are forcing UMATI to consider opening the clinic to fee-paying adults even if this is certain to negatively affect the "youth-friendly" concept of the clinic.

The FEMINA HIP project: Sida continues

Another similar project supported by Sida, in the larger context of HIV/AIDS, is the FEMINA HIP project based in Dar es Salaam. It started in 1999 as an attempt to replicate an "edutainment" approach developed in South Africa. It is a health communication strategy which targets youth with a

[4] In 1990, 60 percent of all births in Tanzania were estimated to be attended by skilled health staff, by 2000 the percentage had declined to 35 percent (World Bank 2000). In fact, maternal mortality ratio is said to have increased from between 200–400 in 1992 to 530 in 2000 (World Bank 2000, Center for Reproductive Law and Policy 1998).

[5] UMATI has the largest network of "family planning" facilities in Tanzania. They maintain 30 youth centres, 12 youth friendly clinics and 8 centres with 22 attached peer-educators to do outreach work. It also maintains community based providers of condoms and other contraceptives such as the contraceptive pill.

glossy magazine which tries to appeal to young readers, offering lifestyle reportage mixed with health communication. It acts as a multi-sectoral channel as it seeks to set up partnerships with youth, other NGOs, political and religious leaders etc. The project started with a magazine and has now branched out to present a related TV show in 2002, which underlines the messages of the magazine (funded by USAID). It has also started to produce a second magazine directed at out-of school youth, Si Mchezo, using a somewhat less glossy format and a simpler style, such as photo novels addressing topics from traditional background often suggested by the readers. The latest project has been the establishment of a website (these are also initiatives which have found other donors). FEMINA HIP uses a participatory production process which seeks to involve readers and it uses feedback research to help keep the magazine content relevant and interesting to readers.

FEMINA HIP distributes subsidised magazines to 25 percent of all secondary schools in Tanzania, and 55 NGOs distribute more copies through their organisations. The message of the magazine is underlined by FEMINA Clubs in participating schools, and by FEMINA produced guidelines to teachers on how to use the magazine in SRHR information activities. Si Mchezo and FEMINA are also using a road show to seek information and gain support when moving into new areas. Subjects addressed touch on very taboo issues including masturbation, petting, concepts of love and affection between couples, rather than a conflation of sexuality to intercourse only. Even so, since the messages are couched in lifestyle articles, they appear not to cause too much resistance. Interviews and discussions with religious leaders, politicians and other key doorkeepers further help to get otherwise controversial messages accepted.

Even though an independent evaluation of the project in 2002 was rightfully very positive, the project has also been criticised for being too expensive and "glossy" and for having a relatively restricted impact in realationship to the cost. FEMINA staff maintains that edutainment is based on offering quality combined with the right message, in order to thus gain the confidence of the audience. In their experience glossy packaging increases the acceptability of the message as "modern" and thus desirable.
In order to be more effective, however, more subsidised copies of the magazine need to be distributed to schools. Incomes from the corporate and private sectors (advertising and sale of magazines) are not sufficient to support the magazine financially or to allow scaling-up. A new contract for scaling up has been signed with Sida for the magazine for the period 2002–2005.

After being handled by the Sida country office in Tanzania the project is now placed with the Regional HIV/AIDS Unit in Lusaka. FEMINA works together with UMATI and AMREF, and has been actively involved in ARHNe, SPANe and the Muhimbili training course discussed in Chapter 4.

5.2 Zambia – Sweden lead donor in SWAp

In Zambia, Sida has supported reforms in the health sector since 1992, when the newly elected MMD (Movement for Multiparty Democracy) government put forward a programme that would "provide Zambians with equity of access to cost effective, quality health care as close to the family as possible." A prerequisite for achieving the goals of the programme was the overhauling of the whole health sector through reforms, elaborated in National Health Strategies Plans that are revised every 4 to 5 years. A sector wide approach coupled with pooled funding from a consortium of donors active in the health sector in Zambia was chosen as the most suitable strategy for obtaining the goals of the health reform. A unit, the Central Board of Health (CBoH), was created within the Ministry of Health to deal with the provision and delivery of services, as well as the implementation of the reforms. Apart from Sweden, Denmark, the Netherlands, Ireland, the US and most UN agencies contribute to the health sector basket as cooperating partners. Slow progress towards a fully-fledged SWAp has been attributed to the reluctance of some "conservative" countries/organisations not be prepared to abandon their old bilateral systems of funding.

Sweden has been at the forefront of advocating a fully fledged SWAp and is currently committing 70 percent of its health sector budget in non-earmarked funding. The rest goes to capacity building, currently through some Swedish NGOs. The present Swedish policy is not to influence the use and prioritisation of funds by Zambia. This has meant that Sida no longer funds vertical health sector projects.

Sweden has traditionally been seen to promote SRHRs in Zambia's health sector and numerous past projects in this field attest to this (see the Kafue Project below). Currently Sida's *Sector Programme Support to Zambian Health Sector, Sida Assessment Memorandum 2001* does, however, not specifically highlight SRHR which together with gender equity are supposedly mainstreamed in other activities.

Sida is aware of the little progress made in the area of SRHR in Zambia. The current sector programme support document notes that the issue of gender differences in access to health care and the impact of this on health outcomes do not appear to have received the attention required. Zambia has one of the highest rates of maternal mortality in the world. In 2001 the ratio was 650 per 100.000 life births which has since further risen to 729. Sida has been addressing these issues continuously at the policy level, and has funded a position of Gender Advisor at the CBoH to help develop a strategy on how to mainstream gender into the health sector.

The Kafue Project case: a victim of SWAp?

The Kafue Adolescent Reproductive Health Project (KARHP) which is regarded as one of the more successful Sida funded projects in Zambia, started in 1996 with funding from Sida. Sida subcontracted RFSU to jointly implement the project with PPAZ (Planned Parenthood Association of Zambia), a member of the IPPF, and the Family Life Movement of Zambia.

Kafue is a transit town situated about 45 kilometres south of Lusaka on the main highway that runs south to Zimbabwe and South Africa, with a population of about 170,000, Kafue had been a boomtown in the 1970, when a number of vital industries were established in the area that attracted migrants from all parts of Zambia. However, by 1993 much of the local industry had closed down, mainly because of a declining national economy, but also partly as a consequence of the recently adopted Structural Adjustment Programme. Without regular employment most Kafue families had difficulties supporting school going children, and quite soon most of the local youth were out of school or unemployed. A study conducted in 1996 highlighted the sexual and reproductive health problems they were facing. STIs, teenage pregnancies, early marriages, and prostitution, as was substance abuse.

Targeting youths between the ages of 10 and 24 years, the objectives of the project were to develop strategies for the delivery of adolescent SRH information to the in and out of school youth, integrate family life education and sexual and reproductive health activities into the district public health and education systems and to strengthen the capacity of the two Zambian NGO partners.

Activities included the training of peer counsellors, sensitising teachers on the sexual and reproductive health needs of young people, the creation of a parent-elder strategy aimed at obtaining community support for the provision of reproductive health information, working for youth friendly health services, and community outreach activities. At the height of its achievement the project had been able to train teachers and establish Family Life Education clubs in 9 schools, and in 6 communities. A total of about 15.000 adolescent (53 percent females) had also been reached with SRHR information. Most of the youth were recruited to Family Life Education clubs where they provided information to other youth through drama, debates, poems and songs they had composed on sexual and reproductive health issues and family planning.

One of the project's activities that proved very successful was peer counselling, in which trained peer counsellors reached out to their fellow youth. The positive experience and success of the project were

such that it was quite often cited (Planned Parenthood Association 2001; World Bank 2003) as something worth replicating elsewhere. Indeed, the implementers had plans to scale up the activities, and to introduce the same project in other districts when funding came to an end. PPAZ was told that Sida was no longer funding projects in the health sector.

The ending of the Kafue Project came at a time when other support to organisations such as PPAZ had stopped as a result of the Global Gag Rule. According to PPAZ several of their projects suffered a similar fate. For example, PPAZ had signed an agreement for support for a project in Kasama on peer education and had started work when they were told by IPPF that support had to be terminated with immediate effect due to budget constraints. PPAZ was not able to obtain government funding or support from other donors, including Sida. The project in Kasama had to close down.

The implementers do not see any signs of new donors stepping in to support youth and adolescent projects. Loss of US funding has meant that NGOs such as PPAZ have had to cut down on administration costs, move to new and less costly premises, and to reduce staff. One consequence is that PPAZ has been unable to finish the final report from the Kafue Project because the coordinator of the project was made redundant before he could finalise it. This means that not only was it impossible to replicate the Kafue Project elsewhere, but it might also means that the lessons learned from the Kafue pilot might be lost for the future, not just in Zambia, but also elsewhere.

It must be mentioned, however, that the objective of strengthening the capacity of the Zambian NGO partners in the collaboration must be regarded as having been very successful. According to representatives of the two NGOs involved, the collaboration with RFSU was mutually rewarding. It is not quite clear why the Kafue Project was not treated as an element of SWAp, but as a vertical project that no longer had a place in the SWAp. In conclusion, it is neither clear nor convincing as to why a successful project of this kind had to end because it is a "project" and not part of SWAp, although its inception and conception appear to have been situated within the health sector reform programme.

5.3 India – Sweden no longer a bilateral partner

By the early 1990s India had become the recipient with by far the largest Swedish aid contribution. This changed when Sweden terminated the Agreement on Development Cooperation in 1998 following India's nuclear tests. Swedish development aid to India fell from SEK 200 million in 1997 to SEK 130 million in 1998 as a consequence. When Sida planned to re-instate bilateral relations with India recently, India announced that it was going to work with only four bilateral donors and Sweden was not amongst those. Sida's continued presence in India has since prioritised partnerships with multilateral organisations and NGOs. The *Guidelines for the continued development cooperation* (2000) prioritise support in the areas of primary health care, education, natural resource management and urban development. In addition, support will be given to human rights, decentralisation and research co-operation.

One of Sida's major "flagship" interventions has been support to the national UNICEF Programme (CSSM), aimed at reducing infant, child and maternal mortality. Reviews and evaluations indicate that the programme has succeeded better in impacting child survival than maternal survival. This project has nevertheless been relevant in pushing maternal mortality and safe abortion higher up on the national health agenda.

Sida began supporting the nationwide Integrated Child Development Services (ICDS) programme as early as in 1989. This scheme aims at improving survival and development among vulnerable children from poor sections of the society, and is probably one of the most evaluated programmes in the world. Surveys, evaluations and research studies document that the programme has impacted positively on nutrition and more composite health indicators as well as education. It thus remains perhaps the most

successful effort of the Indian government to improve the quality of life for disadvantaged children and also to some degree of women. Also the responsiveness of the Indian government to the new health agenda of the Cairo and Beijing Conferences has paved the way for NGOs who pursue a broad SRHR agenda. Sida's decision to support the Health Institute for Mother and Child (MAMTA) should be considered in this context.

Before the bilateral programme was terminated, Sida had plans to collaborate with the State government of Rajasthan in concentrating Swedish social sector assistance to that state. After the events in 1998, Sida decided to instead work with a network of NGOs to develop a demand at the local level for health services, and to ensure that the public health system could respond to the increased demand. A recent evaluation of the project Integrating Social Support in Reproductive and Child Health concluded that the project in the period 2000–2003 reached its overall objectives of increasing the demand for basic reproductive health services (Khanna and Kar 2002). The project offers interesting opportunities for replication and coordination with other ongoing projects in Rajasthan, such as UNFPA's Integrated Population and Development Project. Also, organisations part of MAMTA's Rajasthan state-level network could link with the Project to help expanding their approach beyond a maternal and child health framework to a more comprehensive SRHR approach.

In the HIV/AIDS field, Sida has in partnership with three Manipur-based NGOs (in northeast India) been addressing the health needs of drug users, people living with HIV/AIDS and young people at risk. Adolescent SRHR issues have become quite central in this project applying also peer education in the participatory youth programme component. Recently, a number of NGOs in Manipur formed a network in order to respond to the HIV/AIDS epidemic, and submitted a proposal for an advocacy, coordination and capacity building project to Sida.

Another important Sida supported project is the AIDS STD Health Action Project (ASHA) of the Mumbai Municipal Cooperation. This project has been supported through three consecutive phases (it ended in 2002). A major review in 2002 suggests that the ASHA Project over time developed an innovative model for HIV/AIDS/STI prevention in a commercial sex environment, working through the public health system (Stauffer et al 2002). The government-NGO collaboration model in this project should be considered for replication in other major Indian cities.

The MAMTA project: successful NGO partnership – RFSU

The MAMTA project is considered to be the most consolidated and successful of RFSU's twinning projects, and for RFSU it is also indicative of an internal learning process. MAMTA was formed in 1990 with an intervention area that focused on maternal and child health in urban areas, but gradually moved its agenda to cover also the SRH needs of adolescents and a widening coverage to rural areas. From 2000 a project component entitled *Evolving Strategies for Better Health and Development of Adolescent/Young People* has been funded by Sida through RFSU. In its activities MAMTA has offered activities ranging from education of teachers and service providers, development of teaching and advocacy tools, research and documentation, to advocacy at government, regional and local levels. The activities focus on early marriage, teenage pregnancy, sexuality education, gender gaps in the education system and other gender based imbalances.

MAMTA covers the country via a networking strategy involving 150 NGOs active in 7 states. It covers capacity building of local partners, the strengthening of communication among between them and with planners, service providers and clients. MAMTA's approach is process oriented, stressing learning through action and best practice. MAMTA has also established a resource centre and actively supports research relevant to its programme development.

In comparison with the twinning projects in Tanzania (with UMATI) and Zambia (with PPAZ in Kafue) there is evidence that MAMTA has perhaps been the most successful in integrating the broader adolescent SRHR agenda. Furthermore, the networking with local NGOs has meant that the organisation managed to move beyond the pilot stage, and might ultimately prove more sustainable than the two projects in Africa proved to be. However, while this is the case, MAMTA has grown into a large organisation that will require continued financial support while it consolidates its partnerships and programme development.

5.4 SRHR issues in the context of SWAp

Box 6: What is a SWAp?

SWAp is a process whereby all significant funding for a sector supports a single sector policy and expenditure programme under government leadership, adopting common approaches across the sector, and progressing towards relying on government procedures to disburse and account for all funds.

The advent of health sector reform and the concomitant donor response of using a sector wide approach (SWAp) combined with a pooling of donor funds ("basket funding") has since the late 1990s progressively changed the modalities of health sector support in many partner countries (see Box 6). SWAps often go hand in hand with local government reforms and decentralisation processes of decision making and financial control.

With its stress on integration and coordination, and the avoidance of piecemeal vertical projects with separate management systems, the SWAp has been hailed as an appropriate way of streamlining development efforts, decreasing duplication by coordination, and reducing transaction costs. In addition SWAp has been credited with creating "ownership" of the government, and with creating avenues for donors to build and support government structures and institutions.

As has become evident through this evaluation many of the actors in the SRHR field have expressed concern about the effects of SWAp processes and programmes on the SRHR agenda. These concerns can briefly be subsumed under three headings, namely (a) the need to protect and delink certain SRHR initiatives from broad, consensus-based national programmes, (b) the need for coordination between sectors and beyond the SWAp framework, and (c) the need to enhance, or at least retain, the scope for NGOs to promote controversial issues.

Protecting special initiatives

The reasons for keeping vertical programmes and direct funding might have different reasons, either to make sure that certain programmes considered essential will function, to push certain issues or projects which have not made it into the sector strategy or the underlying PRSP, or to make specific donor support to specific areas, such as HIV/AIDS, visible.

While SWAps give donors a potentially bigger role in influencing government policy, they also potentially constrict the ability to further aspects of development agendas that are controversial. There is also a danger that donor-government meetings are used by donors primarily to track financial procedures rather than concern themselves with substantive issues of priority areas of funding. A respondent in Zambia suggested that it seems that donors are no longer so interested in what governments concretely do with the basket funding and more concerned with how the money is spent (see Box 7). This indicates that the complexity of the SWAps draws attention away from concrete priorities, such as SRHR, to issues of accountability and transparency. While this is also important it might have negative effects for the delivery of overall strategic development goals in the health sector.

But even if sector policies and strategies prioritise certain important activities, this is no guarantee that they are prioritised by government and at district level, where the notion of adolescent SRH or maternal health might be either unacceptable or simply not recognised as a problem. Sida's experience with the health sector SWAp in Bangladesh, recounted below, is a case in question. Experiences from the country level seem to indicate that exclusive "basket" funding might disadvantage relevant SRHR issues. In Zambia a successful project, the Kafue SRH Project, was rather abruptly abandoned by Sida.

Box 7: A Zambian view on SWAp

One Zambian member of the Central Health Board held an opinion of the Health Sector Reform which is not at all uncommon and provides critical food for thought:

"In the old system Sida said: 'We particularly want to see the issue of adolescents prioritised and targeted.' The Sida person will go and speak to the local people to find out what the project is doing for them. She will come back and talk to the persons in the Ministry who are in charge of the project. She will tell them why she is not satisfied with how things are being done. Or she will say 'This is going well. We must scale up. We must introduce the same type of activity in another place.' There was some kind of commitment.

Now donors do not follow any particular project or any part within the sector. Perhaps, only HIV/AIDS is the exception. They meet in the various committees. They ask detailed questions, and try to make us clarify our agenda: what we are going to do to achieve a particular goal? They think that will make us believe they are interested in what we are doing. But mostly they are more interested in how we use their money – that we use the money in an accountable and transparent way.

They are not interested in what we use their money for, or whether we are actually able to use the money for the ordinary people we have been planning for.

All these weekly meetings, the many beautiful documents we are producing, the constant reviews and assessments take up most of our time. We spend more time in meetings and producing beautiful policy documents than on what we are going to do. No one is looking at what is actually being done. Our health index is worst now than many years ago. Very little time is spent on trying to find out whether our policies translate into improved healthcare provision at community level."

Coordination between sectors

While SWAp funding is likely to facilitate coordination within the sector it seems to make cross sector communication and coordination more difficult. There is evidence that engagement in one SWAp tends to go hand in hand with the withdrawal of (specialist) staff at country level in sectors not supported by a SWAp, effectively reducing a donors' ability to have a full overview of even the social sectors. In fact, stakeholders in the Tanzanian health sector SWAp have admitted that the SWAp work at the policy level requires much more time than was anticipated.

Other issues have emerged where in fact integration and advocacy might have proved the preferred strategy but did not happen, since artificial barriers are erected between sectors.

In Tanzania where Sweden supports the Education SWAp, not enough attention was perhaps paid using the place Sweden has at the education sector strategy table. For example, Sida might have advocated for the integration of sexuality and health information messages in regular curriculum development, making use of curricula that have already been developed (with funding from other donors) but not been released by the Ministry of Education. Instead a vertical HIV/AIDS adolescent project has been funded as part of the Swedish led HIV/AIDS initiative in the education sector.

Role of civil society

More important still is the reduction of influence of civil society. NGOs are usually not seriously involved in government policy decision making and they are not sufficiently (if at all) represented in donor-government fora. Sida clearly noted this problem in Bangladesh and tried to ensure that community and NGO voices were included in the negotiations. They also ensured that SRHR were included in government papers. This, however, was no guarantee to have either NGO participation or

SRHR feature in implementation, because government did not prioritise them and donors failed to set funds aside to build the capacity of NGOs to press for their inclusion. Thus weakened they could be silenced effectively.

In cases where NGOs will have to apply for funds from government, either at the central level or from local administrations at the district level, (local) governments might lack the capacity to contract NGOs or simply refuse to share funds with them. On their part NGOs might not feel comfortable applying for government funds for activities that are considered controversial or are not sufficiently prioritised, and they might find themselves competing against NGOs they cooperated with previously, weakening their own and other NGOs' reach and efficiency and their ability to be critical (Schleimann, Enemark and Byskop 2003).

NGOs which are engaged in advocacy on issues that seek to change legal frameworks, or are culturally and socially less acceptable, such as those that deal with abortion related services, advocate for legal changes in abortion legislation, promote safe sex among adolescents, and/or supply youth with condoms and other means of fertility regulation, might find it difficult to access funds altogether from government. The Bangladesh case study is again indicative of the problems that might be involved and the effects that can be encountered.

When NGOs find themselves thus without funds, they are more likely to move into less controversial areas of SRHR. They are perhaps also more likely to access USAID funding, which might involve a gradual change in focus away from issues considered controversial by the US. FEMINA, for example, accepted a USAID funding proposition for a television show. Given that USAID maintains large technical staff on the ground, opportunities might be lost for comparatively more progressive donors, such as Sweden.

It is also a concern among SRHR activists that decentralisation of decision making and a stress on community participation might create its own problems due to the lack of health insight of the population, resulting in a preference for curative rather than preventive measures. This again might leave SRHR at the wrong end of the priority list (Schleimann, Enemark and Byskov 2003:21).

The case of the Menstrual Regulation Programme in Bangladesh

The Menstrual Regulation (MR) programme in Bangladesh will be dealt with in some detail, because it provides valuable experiences in the context of health sector reform and SWAps.

In the past NGOs provided and coordinated both training in MR techniques and the distribution of medical supplies for MR. NGOs also provided an integrated service, including information and behaviour change communication, pre and post MR counselling, post MR provision of contraceptives and medical follow-up including management of post MR infection.

Today, even though MR services are offered widely, accessibility for clients is restricted because many government facilities and private providers offer sub-standard services. They do not offer confidential women-friendly services, which lack privacy and confidentiality and hygiene. They do not offer information of MR, do not counsel and fail to provide contraceptives, nor do they offer post MR care. Public serviceproviders often refuse to perform MR altogether, demand unofficial payments depending on gestation period, family status and degree of desperation of the client. They also redirect clients to the private sector where service delivery is at times even less adequate, with untrained persons performing the MR with overused and inadequately sterilised equipment. MR procedures are under-reported, which poses problems with regard to quality assurance, supervision and monitoring.

Sida was the main donor supporting the Menstrual Regulation Programme in Bangladesh from 1989 to 1998 with direct financial support to a number of NGOs and one government provider. Since 1998,

Sida funding to the health sector has been provided through a SWAp to the Ministry of Health and Family Welfare as pooled non-earmarked funds together with a donor consortium.

During the negotiations with government the donor consortium, and Sida prominently among them, put a number of conditions on the table, including that the health sector strategy and programme should mainstream gender equity and community participation, and should contain SRHR as part of an essential services package. Two consultants were hired by Sida to initiate a participatory process and act as catalysts to build a larger coalition of advocates of the SRHR and gender agenda drawn from civil society and the donors. The consultants were successful in managing broad stakeholder participation for the policy documents and getting ICPD inspired reproductive health included extensively into the essential service package. They also designed useful monitoring and evaluation indicators geared towards SRHR and gender equality.

However, during the implementation phase NGOs and community participation were ignored, largely because government was not keen to involve them, and donors were too focused on basket funding modalities to see the need for separate support to the NGOs: the health sector strategy became a government-donor driven programme, disconnected from engagement with civil society and strategies for partnerships between government and NGOs never developed (Jahan 2003).

The assumption at the onset of the SWAp was that the government would assume responsibility for issuing contracts to the NGOs as specified in the Health and Population Sector Programme (1998–2003). This has, however, not been the case. After a delay of four years the government only issued one contract to one NGO for one year (2002–2003). The other NGOs have been forced to lay off staff, cut back services and branch out into other activities. USAID has been stepping up direct support to NGOs in Bangladesh, working in the SRHR field. But with the coming into effect of the Global Gag Rule USAID funding only covers post-abortion care, and does not fund NGOs that also offer MR services. There is a real danger that fewer NGOs will be able or willing to provide MR services if they receive or wish to receive US funding.

The failure of the government to contract NGOs for MR service delivery under the SWAp funding mechanism has been marred by a lack of a separate budget line for MR activities in the sector strategy. Thus budget allocations to MR covered procurement of drugs and medical supplies only. The procurement rules for government contracting of NGOs under World Bank guidelines further complicated matters. They required government to enter into international competitive bidding, with government interpreting rules as stipulating that only one NGO with the lowest cost could be contracted. This contributed to a situation where the chosen NGO had quoted a price below cost and lacked capacity to cover all MR activities. The NGO was forced to subcontract other NGOs at even lower cost, reducing quality and coverage further.

Recognising these shortcomings the government asked Sida and the Netherlands to provide bridge funding for the NGOs to cover the transition to the next sector strategy due to come in force in 2004. Sida agreed to bridge funding under certain conditions, including a reflection of planned activities in the sector strategy and overall government supervision and monitoring. Sida also took the request as a reason to discuss with the donor consortium the establishment of a separate "NGO pool fund" together with simplified procurement instruments as part of the SWAp.

5.5 Challenges and recommendations

Sida has in the countries examined by the evaluation team, and in many other countries funded a variety of projects that have helped bring SRHR forward, both in terms of advocacy and service delivery. Many of the projects have been pilot projects that have developed new approaches to SRHR service

delivery and advocacy. In Africa, Sida has been particularly strong in promoting the SRH needs of adolescents. Many projects are aiming at changing perceptions and behaviour. The FEMINA project is piloting an edutainment approach developed in South Africa in Tanzania, successfully transferring the approach to a poor country.

The three adolescent projects evolved via a twinning process with RFSU has substantially built the capacity not only of the NGOs in partner countries but has also enabled RFSU to gain the capacity to expand its expertise from Sweden internationally. The success of the MAMTA project in India is proof of the evolving nature of RFSU collaboration with local partners. In addition, it is commendable that local NGOs have been brought into regional networks where capacity is further enhanced and best practices can be exchanged.

The efforts of Sida in Bangladesh in the area of menstrual regulation have in the years preceding the move to a SWAp built not only the capacity of local NGOs to deliver quality MR services to a broader group of women but it has also, via the NGOs, built the capacity of government service providers and thus helped to bring MR further into the mainstream of health service delivery.

However, the evaluation team has also noted with concern that certain areas could be improved. Two major areas have been identified: (i) the areas Sida has chosen to address in the broad SRHR agenda, and (ii) the extent to which SWAps in the social sectors facilitate the realisation of Sida's strategy on SRHR and the potential threat they might pose to gains that have already been achieved.

SRHR issues should be prioritised

Sida has a comparative advantage addressing adolescent sexual and reproductive health and rights, and has done so very courageously when other donors did not dare move into this area. However, the advent of the HIV/AIDS pandemic has brought more donors into this field, particularly in education and behavioural change activities.

- Sida should consider moving into project areas that have been neglected by donors and which have lost out to HIV/AIDS interventions, such as maternal health, and possibly FGM and gender violence. At the same time and within the area of adolescent SRHR perhaps closer attention to service delivery is also to be considered.

Dealing with SRHR in the context of SWAp

As regards SWAps, Sida has obviously been aware of potential problems as is exemplified by the special measures that were taken in Bangladesh to make gender equity and SRHR and NGOs part and parcel of the Health Sector Reform strategy from the very start. However, the lesson that this endeavour, while successful in the planning stage, failed in the implementation phase has not been sufficiently addressed since then. In fact, as the example of Zambia has indicated, special measures aimed at aiding the inclusion of SRHR in the reform process has been abandoned here entirely, with the result that a successful SRHR project previously funded by Sida has failed.

- The examples from Bangladesh and Zambia alone would suggest that Sida should rethink and adjust strategies, rather than just abandon SRHR projects.

SWAps are processes that evolve over time, and necessary adjustments should be made gradually. They involve a learning process and capacity building for donors and for government, as well as for NGOs, and this should be given adequate attention when dealing with priority areas such as SRHR. In order for SRHR not to be sidelined Sida might consider the following:

- The effort of putting into place the SWAp modalities should not detract from the continuing need for service delivery, particularly in areas as important to Sweden and Sida as SRHR. Even if strate-

gic sector plans take cognisance of SRHR there is no guarantee that government agencies, or even communities prioritise these.

- In cases where government service delivery in certain areas is known to be weak and dependent on NGOs, support to NGOs should be continued, and phased out gradually, while the capacity of government to deliver services and/or subcontract NGOs for service delivery is assured.
- At the same time the capacity of NGOs to comply with more complex tendering processes in their dealings with government should also be built. Care should be taken that NGOs that have hitherto worked together and collaborated are not forced to compete with each other for funds and for government favour. If this happens NGOs' ability to deliver quality services might be compromised.
- Sida should consider that NGOs working on advocacy of rights, act as government watchdogs or deliver services that are not in line with cultural and social norms will find it impossible to obtain government funding and continue with their activities. Controversial areas such as abortion related activities or even the supply of contraceptives to youth are then in danger to no longer be addressed and supplied.
- Given that in many of Sida's partner countries relationships between NGOs and government are not always as cooperative as they should be and given that many areas of SRHR are still controversial, Sida might see it fit to initiate NGO basket funds, either internal or pooled with other donors. These funds could be an explicit part of the SWAp but administered for government by an agency more in tune with NGOs.
- SWAps require donors to coordinate their efforts and strategies. This coordination should avoid duplication also of areas of expertise. There is room here for Sida to take the lead in SRHR leaving other areas to other collaborating donors. In order to do this effectively Sida staff must be fully conversant with the SWAp processes and with the country they work in. High staff turnover is counterproductive in this regard.

While SWAps increase coordination within one sector, they seem to make coordination between sectors more difficult. Crosscutting issues, such as gender, HIV/AIDS and SRHR do not only overlap with each other but also with other sectors. In the case of gender and HIV/AIDS this is given attention but in the area of SRHR no efforts to take a more holistic view have thus far emerged.

- Coordination between health and education sectors is the easiest linkage to make and in cases where Sida is an actor in education SWAps, SRHR will have to be considered in this context. Valuable opportunities to further the SRHR agenda, particularly with regard to youth, might otherwise be lost.

Generally speaking Sida should consider developing a lead role in designing approaches that ensure continued attention to SRHR within sector wide approaches.

6 Strategic issues for the future: needs for adjustment

Sweden has emerged both as a strong and persistent advocate and one of the most consistent and generous donors in the field of Sexual and Reproductive Health and Rights. Moreover, Sweden is seen by many organisations as the only country that commands the political support to address increasingly controversial issues, such as those related to adolescent sexuality and abortion. Sweden, and Sida, not only fully support the ICPD agenda, but have consistently stressed a rights based approach. The progressive stance of Sweden has remained firmly embedded in political support across political parties and constituencies at home.

This progressive agenda was clearly reflected in the 1997 *Strategy for Development Cooperation: Sexual and Reproductive Health and Rights.* The evaluation team, in consultation with a broad spectrum of resource persons both in organisations funded by Sida and in the health sector, have established that Sida has indeed followed this strategy and that its aims have overall remained valid. However, the Team feels that the strategy needs re-emphasis and adjustment, in order not loose momentum. This is both a matter of building on comparative strength and achievements, and adjusting to emerging global challenges.

6.1 Building on achievements

Gender equity

Sida has been acknowledged by all actors as a leader in the promotion of gender equity goals and there is a feeling that Sida has progressed well with regards to gender mainstreaming in the health sector and the SRHR sub-sector in particular. Sida has distinguished itself particularly in the efforts to advocate for the inclusion of the perspective of men into SRHR issues, on the one hand, and to acknowledge the linkages between gender inequalities, women's empowerment and HIV/AIDS prevention on the other hand. These factors also emerge in interventions,

- There has been, however, a feeling that Sida has not sufficiently followed up the theme of male involvement in SRHR with concrete interventions. Rather the discussion has remained at a more theoretical level, which is now in need of being operationalised.

Maternal health and newborn care

In this there have been a numerous interventions, particularly via UNICEF and the World Bank. The attention to breastfeeding, both in creating enabling environments and monitoring the marketing of breast milk substitutes, has been most visible in work related to UN organisations and NGOs. However, and considering that maternal health is both a Millennium Goal and is specifically singled out in Sida's new health sector policy, attention seems to have come to a standstill. This has not only been the case in Sida programming, but been a global trend. It has been attributed on the one hand to the new attention on HIV/AIDS and the fact that linkages between HIV/AIDS and maternal health are not obvious. On the other hand health sector reforms, including SWAps, tend during transitional phases of the reform process have negative effects on health service delivery. This has, particularly in Africa, had devastating effects on maternal mortality and morbidity ratios, which have further declined or remained stagnant. The fact that in Tanzania, for example, births with skilled attendants has declined considerably is a warning sign that the intended effects of Sida efforts in training and scaling up the competence of midwives do not optimally reach the main target group, namely rural poor women.

- Respondents felt that Sida is in fact well placed to adopt maternal health more forcefully and strategically and to safeguard service coverage, emergency obstetric care and referral and quality of care particularly in the context of health sector reform processes.

Fertility regulation

Fertility regulation has received Sida's attention in programmes, projects, advocacy and research, with the exception, however, of infertility prevention. The Team could not find that anything has been done with respect to infertility programming inside a comprehensive SRHR approach in primary health care. The Sida approach stresses a rights based approach, as exemplified in the provision of information and counselling of adolescents. Delivery and access to services has perhaps not received enough attention leaving, according to respondents, a gap between information and access. Again, since service delivery is often declining in transitional phases of health sector reforms, additional efforts in this area are particularly necessary.

- Even though infertility treatment is very expensive, a true rights based approach would suggest that some attention be paid to the widespread incidence of infertility in parts of Africa, which renders the women affected virtual outcasts.

Safe abortion

Sweden is perhaps the strongest voice advocating for medically safe abortions, quality care for abortion related complications, the liberalisation of abortion laws and the decriminalisation of women who have undergone illegal abortions. This role has become vital in the present global climate. Sida has in the period reviewed here supported many activities connected to the broader understanding of abortions in various settings, continued support to Ipas, and been engaged in providing MR services. However, as the case of Bangladesh indicates, Sida's support to MR in that country suffered a set-back as a direct result of the consequence of the shift from project to programme approach coupled with pooled funding through government. Given that abortion related activities are currently even more controversial than ten years ago these activities will perhaps have to remain vertically funded and supplied, no matter what the health sector reform programme might dictate. Service providers and advocates of abortion related activities also rightly pointed out that Sweden is the only country able to support abortion related activities, and should make this an immediate priority.

- The evaluation team agrees that issues related to abortion, especially provision of safe abortion services and effective post-abortion care activities are a niche, where Sida can really make a valuable contribution to SRHR.

HIV/AIDS

The HIV/AIDS pandemic is one of the major health challenges today and it needs serious attention. Sida has over the last 10 years stepped up its funding and interventions in this field. Project funding for HIV/AIDS related interventions increased over the years and regular core support to UNAIDS at least quadrupled. Sida has, in line with most donors, linked HIV/AIDS with gender and poverty. More recently Sida has followed trends elsewhere and declared the disease a cross sectoral issue, that requires mainstreaming. Institutional arrangements to this effect were made, both at headquarters and regional levels.

The SRHR strategy does not reflect these trends adequately, due obviously to time lags. The strategy links HIV/AIDS interventions mainly with the prevalence and treatment of STIs and gender. It calls for integration with services for fertility regulation, and behavioural change. While this is certainly important, the strategy is no longer adequate and needs revision.

- Attempts should be made, in light of the HIV/AIDS strategy of 1999, to clearly define the overlaps of HIV/AIDS prevention and SRHR issues and suggest common strategies.

Adolescent health

Sida's most visible and profiled presence in SRHR is by far the adolescent health agenda. It is perhaps not without reason that in fact adolescent health issues crop up under several headings in the strategy, such as with regard to fertility regulation, women's empowerment, and HIV/AIDS/STIs. Work in the area of adolescent SRHR (ASRHR) is truly the hallmark of Sweden, both at home and in development aid. The number of projects, approaches and interventions abound in many permutations; from peer education, over youth friendly clinics, IEC and BCC to more innovative edutainment approaches. Sida has been trying and supporting it. This has created a wealth of pilots and best practice models that other donors are now increasingly replicating. Once the whole area of adolescent sexuality was very taboo, it has come to be acceptable, mainly via the HIV/AIDS pandemic. There are, however, areas of ASRHR that are still neglected, and also controversial.

Many donors have moved into the IEC and BCC area, but actual service delivery has been neglected or shunned away from. Delivering condoms to youth would be acceptable, perhaps, as a measure to promote safe sex, but the delivery of contraceptives is still controversial. As a consequence youth are showered with messages about safe sex, but they often lack access to the means to practice what they learn. Service delivery also poses other problems where messages inadvertently cross each other because they are not sufficiently coordinated. Thus peer educators also supply contraceptive pills to young women and youth friendly clinics promote IUDs to prevent unwanted pregnancies. This works against unwanted pregnancies but hardly constitutes safe sex practice.

- There is thus a need for an integrated, coordinated service delivery on the one hand, and promotion of contraceptives that empower women to prevent unwanted pregnancies and also practice safe sex, such as female condoms and support for the further development of microbiocides. Sida should consider moving into this neglected area.

Female genital mutilation

This is another area of SRHR that has been highly controversial. Again Sweden has historically emerged as one of the driving forces behind the movement to eradicate the practice and it has for a long time been illegal to practice FGM in Sweden. Sida included FGM as a focal point of the SRHR agenda at a time when Western attention to FGM was not always welcome by African women. Since then the movement to eradicate FGM has grown also amongst African stakeholders. Sida has historically funded small project components with WHO and UNICEF, and has channelled funds through one or the other main NGO which then redistributes funds to smaller local NGOs. There has also been a shift from a more medical to a more human rights based approach, indicated also through different funding channels in Sida, i.e. from the Health Division to the Division of Democracy and Human Rights.

- Sida should consider broadening its approach to FGM to include other harmful traditional practices, such as "dry sex" for example. These and FGM have both medical and human rights implications. One approach and one NGO is perhaps not able to cover all aspects. Sida should also work with WHO to further investigate harmful practices and should lobby UNFPA and UNICEF to include programme activities in this field into their regular programmes or reserve budget lines for this activity.
- Sida should also consider broadening a more mainstreamed approach to FGM which integrates components into country programmes (as happened in Ethiopia) and into adolescent SRHR projects, as is done by AMREF in Kenya and Tanzania.

Gender violence

Gender violence, discrimination and abuse is another area that has been recognised as a serious issue by women activists in the South, and in some partner countries legislation has been passed trying to contain the problem particularly after the attention it received during the Fourth World Conference on Women. Sida's inclusion of this area in the SRHR strategy has been based on the recognition that women's powerlessness is inhibiting their rights also to make sexual and reproductive choices, and points to a truly holist understanding of SRHR. Sida has done work in the area of gender violence in Latin America with PAHO and has also addressed sexual exploitation and abuse of children/youth in the Mekong Sub-region together with ESCAP and UNICEF, an intervention that was very innovative, and one of the first of its kind.

- Given the high incidence of gender violence in Africa, which is often coupled directly or indirectly with the HIV/AIDS question (such as the rape of young women or children as a supposed cure for AIDS), and the danger of infections through forced sexual contact would fit into Sida's existing SRHR agenda in Africa.

Research cooperation

Research cooperation in the field of SRHR is another focal area of Sida's SRHR strategy and in this field Sida has initiated invaluable work, both via multilateral aid and via SAREC in both Sweden and partner countries. The stress on collaborative research to build the capacity of both Swedish researchers and researchers in the South has carried fruit. Many joint research projects and other collaborative ventures are underway.

- There is a need now to consolidate this work, and coordinate the future direction towards future needs. Throughout this report the Team stresses the need for research in the field of SRHR highlighting, in particular, the area of SWAps where it feels Sweden should take a lead, and also the field of sexual rights. Another focal area is of course the interface between HIV/AIDS and SRHR.

6.2 Global challenges ahead

As suggested throughout the report there have emerged trends which make it important to reconsider development strategies in health in general and SRH in particular. The momentum gained at the ICPD is being threatened from many angles.

HIV/AIDS

The emerging threat of the HIV/AIDS pandemic, especially in Sub/Saharan Africa, has really entered the scene as a big global development challenge. Funds are re-allocated to the management and eradication of HIV/AIDS, and new funds have been made available. As pointed out throughout the report SRHR and HIV/AIDS share some common goals, risk factors and modes of operation. To address and pinpoint the overlapping and synergetic areas in these two lines of thinking is very important, as HIV/AIDS and SRHR share behaviour change challenges and risk factors, the same imbalances of gender empowerment, and at times also the same health workers in the field setting.

- For Sida there is an important role as a development partner able and willing to see the overlap and the mutual benefits of working in these two areas in a synergetic manner. The rights paradigm was well established during the SRH negotiations, and should be brought forward to the HIV/AIDS arena. Health service resources are not likely to increase in the near future, and there is therefore a challenge in utilising existing structures to also incorporate HIV/AIDS care issues in mainstream SRHR health care delivery, rather than treating it as an add-on to overburdened health workers.

The Global Fund and other competing schemes

Funding mechanisms like the Global Fund are new in the development context. The focus of The Global Fund is on communicable diseases which pose threats to developing countries: Malaria, Tuberculosis and HIV/AIDS. The HIV part is, of course, as pointed out above overlapping with SRHR. But with a global focus on the medical treatment of HIV as a challenge for poor countries, and lacking contributions to the fund, it is not likely that countries will formulate applications that incorporate SRHR issues in this area. Since "this is where the money is" countries in need will prioritise work in areas where funding possibilities exist, and as resources are limited, areas like SRHR will loose out.

The Gag Rule and US's position

The Global GAG Rule has not only limited the resource flow to NGO's and UN agencies dealing with abortion related issues, but has contributed to a reversal of some gains in SRHR areas. While some organisations have not shifted their orientation others are in the process of doing so. Sida can play a major role both in continued funding to the agencies, such as Ipas and Mary Stopes that continue to work on the more controversial issues, but it can also play a role as a consolidating leader of countries and agencies that do not follow the GAG rule literally.

- Sida may refine its role as a non-compromising SRHR "champion", and could also be a lead agency in demonstrating and highlighting what the consequences of the Global Gag Rule are. There is scope for a stronger European lead in this, where Sida/Sweden could take a lead role. Sweden's role in EU's development aid negotiations should therefore be examined for possible fora where the issues can be raised.

The shift from thematic issues and projects to health sector reform and SWAp

Many organisations have seen the SWAp mode of development aid, and the more managerial/economic approach to health care in aid assistance as a threat to SRH. Considerable work, analysing the role of donors working in SRHR within SWAp, has been going on. Ensuring that technical issues are done properly within health care delivery and ensuring that areas are not left out in priority discussions are still important challenges for a more generalised budget support to many countries, especially since some aspects of SRHR still are controversial, or have as target groups some of the weakest population segments.

- Several activities are ongoing, and Sida should strengthen its capacity within these activities. Sida should also consider the role as a donor that takes on the task of monitoring some of the progress or lack of progress in this area.

The PSRP and Millennium Development Goals

The machinery and mechanisms that will monitor progress in these very important development strategies are there to stay. The Millennium Development Goal of reduction of maternal mortality is mainstream SRH, and the reduction of HIV/AIDS is directly linked especially through the emphasis on adolescents. It is important to develop good process indicators and investment areas, which also encompass SRHR, to achieve these goals.

The role of SRH in Poverty Reduction Strategy Papers (PRSPs) has received much less attention. PRSPs are, however, the ultimate policy and strategy foundation of many partner countries, and they outline the future direction of sector development as well as apportioning a budget to various planned activities. In many cases the PRSP has overshadowed country strategy programming of donors, in the sense that individual country strategies must remain within the framework of the PRSP. The inclusion of SRHR into PRSP processes is thus very important.

- As mentioned throughout the report, it would be desirable to integrate SRHR with the other two cross-cutting areas to ensure full coverage in all policy and planning instruments, including the PRSP.

The shift from a rights based to an economic based perspective in health

SRHR has an intermediate position in priority debates that use economic models for health care priorities, such as the Global Burden of Disease paradigm ("how much health can you get for your investment"). Some of the criticisms towards this analytical framework is that SRHR does not feature well in this system of resource priority debate. The main driving force behind SRHR, however, has been the rights approach. Because reproduction is not just a health issue, but also relates to the creation of new generations, the arguments have been that it should be safe and that it is a woman's human right to have access to health care addressing her safety in her role as reproducer. This has been an important part of health care priorities in the past decade.

- Considerable effort has been put into the debate on SRHR in health prioritisation, and it is a challenge for Sida and other strong advocates for SRHR and rights to keep that momentum in the debate. Much attention is currently devoted in the debate to central human rights issues. It might, however, be strategically more useful to center advocacy on social rights related to education, employment and general health rather than on rights related to sexuality and procreation. Work needs to be done within existing international agreements and frameworks for Human Rights regarding the interpretation of sexual rights in various contexts.

Annex 1 Terms of Reference

DESO/Health Division 2003-05-08

SRHR Group

Diarienummer: DESO- 2003-001482

Terms of Reference for the Evaluation of Sida's Work with Sexual and Reproductive Health and Rights 1994–2003

1 Background

The 3rd UN Population and Development Conference (ICPD) that took place in Cairo September 1994 is a milestone in the work for a new and broader view on issues related to population and development. The Conference resulted in a Programme of Action for the coming 20 years that brings up issues and consequences for population and development. Sida has used the Programme of Action as a basis for its activities and it was one of the main background documents for Sida's strategy on "Sexual and Reproductive Health and Rights" that was formally adopted in June 1997. The Sida Strategy identifies 8 issues for action and related issue papers have been commissioned by Sida. A number of Sexual and Reproductive Health and Rights (SRHR) specific field projects and programmes have on the same time been developed.

In the Government's Letter of Appropriation for 2003 the Government of Sweden required Sida to carry out an Evaluation of how Sida has pursued and promoted the policy inherent in the ICPD 1995, its Strategy on SRHR of 1997, and the follow up Conference Cairo +5 in 1999.

2 Purpose and Scope of the Evaluation

The Evaluation shall highlight experiences gained and lessons learnt from 1994 until today from Sida's work related to SRHR, including analyses and conclusions from the interaction between Sida and the international community. Emphasis shall be laid on the more recent years. It shall outline the main issues that should be considered in Sweden's future work in the area of SRHR.

As such, the Evaluation is expected to be an important input not only for Sida's future involvement in SRHR, but also for promoting a coherent and common agenda among other key Swedish actors such as the Foreign Office, professional bodies and institutions, and NGOs active in the area of SRHR.

3 The Evaluation

3.1 Goals of the Evaluation

The *objectives* of the evaluation are

(a) assess Sida's alignment to the ICPD agenda and the effectiveness of Sida's work related to SRHR from 1994 to date in the light of the various international agreements to which Sweden has been a signatory as well as of Sida's own strategies on SRHR.

(b) identify the strategic issues that should guide Sida's future work related to SRHR.

3.2. Issues and tasks to be covered

The evaluation shall *describe and analyse*

(i) the platform from which Sweden approached, and contributed to, the Cairo Conference in 1994

(ii) critical events and actions that have shaped the evolving SRHR agenda since 1994, at the global level as well as within Sweden

(iii) the extent to which and how Sweden has contributed to shaping international agreements and agendas within SRHR and to which extent Sweden's promotion of SRHR over time has actively considered or has otherwise been consistent with relevant global trends.

(iv) the extent to which and how Sida itself has otherwise pursued SRHR issues – globally, regionally, and bilaterally – in its overall development cooperation and policy interactions

(v) how and to what extent SRHR related issues have been reflected in the practice of Sida's development cooperation as well as with Sida's related Policies and the Swedish development objectives

(vi) the effectiveness of Sida's efforts to promote SRHR over time particularly as regards to:

- *Strategic aspects;* how work related to SRHR has been encompassed by policies and strategies that govern Sweden's development cooperation
- *Institutional aspects;* e.g. how it has influenced or strengthened the way by which SRHR issues has been incorporated in international fora and agreements
- *Organisational aspects;* like roles, functions and responsibilities – within Sida, between Sida and the Foreign Ministry, as well as between Sida HQ and the Swedish Embassies abroad
- *Operational aspects;* i.e. the way by which Sida has supported bilateral projects, regional other projects and programmes, as well as in Sida's support to bodies such as UNFPA, WHO, UNAIDS, as well as IPPF and other NGOs.

(vii) the capacity of Sida to absorb and respond to experiences gained, and transforms these into strategic initiatives at different levels

(viii) the ability of Sida to identify and deal with culturally, socially, and politically sensitive issues related to SRHR such as maternal survival, abortion, breastfeeding and adolescents issues.

The evaluation shall *identify and recommend*

(i) what issues that Sida should emphasise in the future given the 'comparative advantage' of Sida's and Sweden's experience in the field of SRHR

(ii) ways by which Sida may pursue its work on SRHR in the future

4 Methodology, Evaluation Team and Time Schedule

4.1 Methodology and approach

This is a *process* evaluation and shall involve the following:

(a) assessment and analysis of background documents with a bearing on Sida's involvement in SRHR since 1994 (the main documents along with samples of illustrative issue papers etc are given in Annex 1)

(b) interviews with relevant officials and experts at Sida incl. former officials involved in the SRHR work, the Swedish Foreign Ministry, as well as relevant technical experts within consultancy companies, institutions and organisations.

(c) visits to selected international institutions as well as projects & programmes supported by Sida. The visits shall include:

- 2–3 of the following organisations respectively:
  UN-organisations: UNFPA, WHO, UNICEF, UNAIDS
  International organisations: IPPF, IWHC, WABA, IPAS, IHAA
  Regional Networks: IPAS, ARROW, AMRN, IBFAN,
- 2–3 programmes in partner countries for example: The MR-programme (Bangladesh), FEMINA (Tanzania), Sexuality courses (IHCAR/Muhimbili, Tanzania), Straight talk (Uganda), the MAMTA-RFSU Networking Collaboration on YSRHR (India), the UMATI programme (Tanzania). While reviewing these programmes the Consultant shall also make a brief assessment of the activities, the role and importance of each the selected organisations and selected countries mentioned above.

4.2. The evaluation team

The Evaluation Team must include demonstrated experience and ability from;

a) processes of policy development and dialogue with respect to specific social and/or health development issues at global level

b) strategic analyses and evaluation of international development cooperation

c) and institutional analyses.

The Evaluation Team must have knowledge, competence, experience and ability to analyse the area of;

d) sexual and reproductive health and rights incl. HIV/AIDS and adolescents health.

It is expected that the team will comprise 3–4 experts for a total of 30 person-weeks. The team must include at least one senior member who is fluent in Swedish and familiar with Swedish development cooperation as most of the background materials are in Swedish and the summary shall be written in Swedish.

The team must reflect a gender balance.

4.3. Time schedule

The Evaluation shall be completed not later than December 15. 2003, and shall include within that time frame a presentation of the findings and recommendations at a workshop with relevant stakeholders in Stockholm.

The consulting company is fully responsible for planning, execution and follow-up of the workshop. The date of the workshop will be decided and agreed upon by Sida and the consultant.

5 Reporting

The Consultant shall comply with the following reporting schedule:

- An Inception Report to be submitted to and discussed with Sida/DESO within September 15, 2003. This shall be based on a scrutiny of relevant background material and documentation. Apart from an overview of the evolving SRHR policy and issues and identified culturally, socially and politically sensitive issues related to SRHR, it shall provide a clear work- and time-plan for the visits and interviews to be carried out, as well as a proposed structure of the full Evaluation Report.
- A draft Evaluation Report to be submitted to Sida/DESO for comments not later than November 15, 2003. Sida/DESO will coordinate possible comments from other stakeholders and provide those along with its own to the Consultant not later than December 1, 2003.
- A Final Evaluation Report to be submitted to Sida not later than December 10, 2003, and shall be presented by the Consultant at a workshop on or immediately after that date.

The evaluation report shall be written in English and should not exceed 60 pages, excluding annexes. A Swedish summary of the report not exceeding 25 pages shall be submitted simultaneously. Format and outline of the report shall follow the guidelines in *Sida Evaluation Report – a Standardised Format* (see Annex 3). The draft report shall be submitted to Sida electronically and in 10 hardcopies (air-/surface mailed or delivered) no later than November 15, 2003. Within 10 days after receiving Sida's comments on the draft report, a final version shall be submitted to Sida, again electronically and in 10 hardcopies. The evaluation report must be presented in a way that enables publication without further editing. Subject to decision by Sida, the report will be published in the series Sida Evaluations.

The evaluation assignment includes the completion of Sida Evaluations Data Work Sheet (Annex 4), including an Evaluation Abstract (final section, G) as defined and required by DAC. The completed Data Worksheet shall be submitted to Sida along with the final version of the report. Failing a completed Data Worksheet, the report cannot be processed.

Annex 2 Team members and methodology

Team members

Team leader:

Gisela Geisler	Senior Researcher, Chr. Michelsen Institute, is a senior anthropologist with extensive experience on gender relations and women's empowerment in Africa.
Berit Austveg	Senior Adviser, Norwegian Board of Health, is a senior medical specialist in the field of reproductive health.
Tone Bleie	Senior Researcher, Chr. Michelsen Institute, is a senior anthropologist with extensive experience as a researcher of gender relations.
Johanne Sundby	Associate Professor, University of Oslo, Institute of Community Medicine, is a senior medical specialist in the field of reproductive health in Scandinavia.
Heidi Skramstad	Senior Administrative Officer at Bergen University College, Faculty of Health and Social Sciences, is a social anthropologist with specialisation in gender relations and reproductive health issues.
Bawa Yamba	Associate Professor, Diakonhjemmet College, is a senior anthropologist with specialisation in medical anthropology and health issues.

General

Time constraints and the corresponding need to cover as much ground as possible reviewing the Sida's SRHR work over the last ten years informed the Team's methodology. The Team had to make choices as to focus and depth, which were not always the most satisfactory, but the best under the circumstances. The Team hopes that in this way it has managed to offer a broad snapshot of Sida involvement in the SRHR field, broad enough to enable us to formulate more general recommendations.

Time schedule

For different reasons the initial time table outlined in the ToR had to be adjusted, and resulted in a shortening of the implementation period. While the contract between the Chr. Michelsen Institute and Sida for the assignment was signed in late June 2003, a preliminary meeting with Sida staff to discuss and clarify the ToR could only be arranged for the second part of August. The Inception Report was due in mid September and was accepted at the end of September after responding to queries as to approach and focus of the evaluation raised by the Sida reference team.

Data collection thus began in October and lasted into November, when report writing had already begun. Most of the fieldtrips and visits to organisations and countries happened in October, and the results of these were consolidated during a joint meeting in Bergen in the second week of November when recommendations were discussed and report writing tasks were further allocated.

Division of tasks

The division of tasks for the data collection were divided between the team members as follows: Interviews with stakeholders in Sweden were at various times conducted by Bawa Yamba, Heidi Skramstad

and Berit Austveg. Additional interviews were conducted by phone by the above and by the rest of the team. Johanne Sundby was responsible for data on UNFPA, UNICEF, PAHO, and the World Bank as well as the International Women's Health Coalition; Berit Austveg took responsibility for WHO, UNAIDS and IBFAN and the research on Sweden's involvement in the ICPD process. Heidi Skramstad was responsible for the review of IPPF, RAINBO and the assessment of Sida's work on FGM. Bawa Yamba took responsibility for the work in Zambia, including Sida's regional HIV/AIDS team based in Lusaka and for conducting interviews with Ipas' office in Nairobi. Tone Bleie was assigned the India case study, as well as the assessment of ARROW in Kuala Lumpur, and the regional office of IBFAN in New Dehli. Gisela Geisler took the Tanzania country level study and recorded Sweden's role since the ICPD+5.

The writing of the report has been a joint effort, with team members contributing to the sections relating to their work assignments. Most team members contributed to the more general chapters, excluding Chapters 1 and 2, which were the joint effort of Berit Austveg and Gisela Geisler. The overall compilation of the report was the responsibility of the Team leader with inputs from other team members.

Methodology

This evaluation of Sida's SRHR work has been a rapidly implemented process, while the methodology used has been complex. Sida's development assistance reaches many beneficiaries, but the Team did not aim at going as far as the core target beneficiaries, namely ordinary men and women in countries. Rather, it sought to understand how Sida has prioritised its SRHR development aid by looking at the panel of organisations and issues it has supported. It has also sought to understand Sida's role as a development aid broker, lobbyist and advocate in some of the important international development debates. The Team has to a certain degree focused on current fora, debates and challenges, to be able to give Sida a forward looking evaluation.

It has not been the purpose of the evaluation to evaluate the role or function of the agencies visited. But still, it is impossible to evaluate Sida's critical choices without a focus on the achievements, obstacles and challenges that each organisation is faced with. The nature and comparative role of each agency is sometimes explained, because some readers of this evaluation may not be familiar with this. On the other hand, some of the agencies that receive Sida support or are part of the international RH family, are so large and complex that the limited time available for this evaluation has made it impossible to cover every aspect of the history with Sida or the priorities and achievements that this entailed. The Team decided to focus on a few selected activities.

Methods used have included

- Review of core documents, strategies and reports originating in Sida and Sweden. Messages and ideas that form the basis for Sida's commitment to the agenda has been critically examined and compared with international interpretations and debates.
- Visits to and interviews with core Sida staff, advisers, former staff and other Swedish SRHR stakeholders.
- Visits to and interviews with staff in international agencies that receive Sida funds. Some agencies have been exposed to more detailed scrutiny, including an analysis of central developments within the organisations themselves.
- In some organisations, especially the UN and the WB, the Team was only been able to review activities at the central level in headquarters, knowing very well that the core implementing activi-

ties of these agencies, where impact could be monitored, is at the regional or local/country level. The Team used its visits to these agencies as case studies for understanding the broader role of Sida in the development debate. Some team members had exposure to these agencies (UNFPA, UNICEF; WHO etc) in the field in other contexts, and where appropriate, this knowledge also influenced our assessment. Some of the resource persons the Team planned to meet were not available at the time of visit.

- Review of some central development reports that are produced by various agencies, where Sida may or may not have been involved (workshop reports, strategies, annual reports, policy documents etc.). This has enabled the Team to understand where SRHR is at stake at this period in time.
- At regional level the Team chose organisations that represented a selection of larger groups of networks or associations of NGOs, visiting their country offices or representatives. The visits were complemented with additional information from relevant assessments and discussions with secondary resource persons.
- The choice of country level studies was based on a decision to obtain both a snapshot of Sida's involvement in the health sector and its contributions to SRHR at country level. In order to gain as broad a view as possible in the time constraints the Team selected countries where Sida has different roles in the health sector.
- Country level activities included:
  - Review of Sida country programmes over time, including a review of changes of approach;
  - Assessment of the countries' health sector, with particular emphasis on SRHR: this included review of relevant government policies and strategies, interviews with key stakeholders in both government, the NGO sector, and in the case of Tanzania, of major donors and UN organisations working in the field;
  - Review of past and current projects funded by Sida in the field of SRHR to gain insight into the rationale for funding, the relevance of the projects for the health sector and their congruence with Sida SRHR strategy;
  - Country level experiences were supplemented by a closer study of well recorded cases, such as Sida's involvement in Bangladesh, through reports, project documents obtained from the Sida country office in Dhaka and published articles.