



DEVELOPMENT CO-OPERATION DIRECTORATE
DEVELOPMENT ASSISTANCE COMMITTEE

Working Party on Gender Equality

Reference Document

**REACHING THE GOALS IN THE S-21: GENDER EQUALITY AND HEALTH
Volume II**

(Note submitted by Sweden)

This reference document was prepared by the Swedish International Development Co-operation Agency (Sida), with Rounaq Jahan as Team Leader and Nilufar Ahmad, Juliet Hunt, Barbara Klugman, Johanna Schalkwyk and Margrethe Silberschmidt as team members. This is one of a series of three documents (Volume I - Education; Volume II - Health; Volume III - Environment), available in English only. The Synthesis of the series is available in French. It is submitted to the Working Party on Gender Equality for APPROVAL and DERESTRICTION at its 18th meeting on 8-9 February 1999.

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EXECUTIVE SUMMARY

1. *The 21st Century Strategy*, adopted by the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD) in 1996, recognises gender equality and women's empowerment as a key goal of development co-operation and sets measurable targets to reduce poverty and improve education, health and environmental sustainability. This study, commissioned by the Swedish International Development Co-operation Agency (Sida) on behalf of the DAC Working Party on Gender Equality, aims to illustrate how the DAC Member organisations are attempting to promote and mainstream a gender equality perspective in the field of sexual and reproductive rights and health. The objective of the exercise is to identify best practices, particularly in relation to practical methodologies and tools to highlight potentials and opportunities as well as to note gaps and constraints. A critical concern is to find out how the agreements reached at the International Conference on Population and Development (ICPD) and the Beijing Platform for Action (PFA) are being implemented. Findings from ten agencies and one developing country case study are included in this report.

Good Practice Principles

2. The study found that although all donor agencies accept the goal of gender equality and the need for mainstreaming a gender equality perspective in operations, there is often a gap between agency policy and practice. On the whole agencies have made more progress in producing policy and strategy documents than in actual implementation of programmes in line with ICPD and PFA. However, all agencies have taken some positive and innovative initiatives. These initiatives vary in size and impact. Some are operational and some are still at the design stage. Despite these differences, they all share common elements of good practice.

3. The good practice principles identified by this study are:

- Analyse and understand the impact of inequality between women and men on health.
- Take action to address gender inequality in access to health care and responses of the health system.
- Shift from demographic objectives (population control) to preoccupations with quality of life, and from population targets to a recognition of individuals' rights and health.
- Pay attention to women's as well as men's health needs over the life cycle and both men's and women's roles and responsibilities in relation to fertility, children's health, and in securing women's rights and health.
- Build self-esteem, confidence, and capacity of both women users of health services and health workers.
- Consult with all stakeholders including women and build partnerships with women's organisations.
- Promote gender equality in strengthening national capacity.

Enabling Factors

4. The study identifies several factors that appear to facilitate the mainstreaming of a gender equality perspective in operations. The enabling factors are:

- Redefinition of key existing concepts and tools from a gender equality perspective.
- A sexual and reproductive rights-based approach.
- Support to local initiatives involving local expertise and experience, and implementation in partnership with local organisations.
- Mandatory use of social and gender analysis.
- Consultative team approaches combining expertise from inside the agency and the partner country.
- A process of internal reflection and capacity building within donor organisations.
- Concrete steps to overcome obstacles to equal access and empower women towards equal participation.
- Democratisation of health system management.
- Supportive processes in programme/project design and implementation, such as time and flexibility, consultation and participation.
- Inter-sectoral/multi-sectoral actions to promote gender equality.

Gaps and Constraints

5. The study notes some gaps and constraints common to many of the agencies though not all of these gaps and constraints apply equally to all agencies. The gaps relate to policy, practice, performance and partnership building.

Policy: Many agencies still fall short in policy and strategy development. Only a few agencies have developed their own policies and strategies highlighting gender equality as a central concern and only a few policy and strategy documents address health and population in an integrated manner with a human rights based approach. In the absence of strong internal policy and strategy support, the mainstreaming of gender equality is dependent on the commitment of individual staff members.

Practice: Even in cases where there is an articulated policy, there is frequently a disjuncture between policy and practice. Many agencies have not developed either tools or processes to raise staff awareness and competence around ICPD and PFA agreements. Additionally, methodologies to address gender equality in new areas, such as sector programmes, are yet to be developed. Some staff are opposed to change. Policy and strategy documents, thus, generally have limited influence on operations.

Performance: Agencies are increasingly emphasizing the monitoring of results and impacts of their operations. However, performance indicators of most agencies are generally biased towards quantitative measures. Qualitative indicators of inputs, output, and outcome, particularly of gender equality are not well developed and more work is needed in this area.

Partnership: Although all agencies are emphasising partnership building and stakeholder consultation and participation, policy dialogues still tend to be limited primarily to the donors and the counterpart governments. Civil society groups in general and women's organisations in particular, are often marginal to the process of consultation and dialogue.

Priority Actions

6. To implement and particularly to achieve the DAC *21st Century Strategy* goals, concerted actions are needed on many fronts. This study recommends the following:

- **Bridge the Gap between Policy and Practice:** To bridge the gap between policy and practice the agencies need to: (1) use policy dialogue with development partners creatively to build consensus around gender issues; (2) take initiatives to empower women to participate in and monitor policies, programmes and projects; (3) support programmes and projects in response to local needs and in consultation and partnership with local organisations including women's organisations; (4) promote cutting edge work such as redefinition of concepts and tools and innovative projects; (5) facilitate the sharing of positive examples and lessons learned on addressing gender equality within agencies and with partners; (6) support capacity development of the staff of agencies and their partners; (7) support development of methodologies to address gender issues in new programming areas such as sector programmes; (8) facilitate initiatives to build partnership with men; (9) promote development of qualitative and process oriented indicators of input, output and outcome; (10) ensure adequate funding for advocacy work.
- **Review the State of Implementation of ICPD and PFA Commitments Preparatory to ICPD Plus Five:** The development co-operation agencies need to: (1) support initiatives, particularly by the national women's advocacy groups, to assess the implementation of ICPD nationally and internationally; (2) organise full-scale external reviews of development agencies' own progress in implementing the ICPD commitments; (3) use the review process to raise awareness and build competence about the gender equality issues at the local, national and international levels; (4) promote dissemination of information about good practices and lessons learnt.
- **Follow-up on OECD/DAC's 21st Century Strategy:** The DAC *21st Century Strategy* sets the broad goals and directions of future work for the member organisations. This study creates the foundation for future monitoring of progress and sharing of information amongst development co-operation organisations and their partners in the area of sexual and reproductive rights and health. Follow-up work is needed to: (1) create a mechanism for regular sharing of information about good practices in promoting gender equality in health, (2) develop a framework around gender equality and health for use in the peer review process, and (3) organise a follow-up to ICPD to assess the progress of DAC Members' implementation of ICPD agreements.

ACRONYMS AND INITIALS

AIDS	Acquired Immune Deficiency Syndrome
ARROW	Asian-Pacific Resource and Research Centre for Women
APR	Annual Programme Review
AusAID	Australian Agency for International Development
BADC	Belgian Agency for Development Co-operation
CBO	Community Based Organisation
CHW	Community Health Worker
CIDA	Canadian International Development Agency
CPR	Contraceptive Prevalence Rate
DAC	Development Assistance Committee
DANIDA	Danish Development Assistance
DFID	United Kingdom Department for International Development
FGM	Female Genital Mutilation
FP	Family Planning
FWCW	Fourth World Conference on Women
GTZ	German Agency for Technical Co-operation
HERA	Health, Empowerment, Rights, and Accountability
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
ICDDR,B	International Center for Diarrhoeal Research, Bangladesh
ICPD	International Conference on Population and Development
IWHC	International Women's Health Coalition
LFA	Logical Framework Analysis
MCH	Maternal and Child Health
NGO	Non-governmental Organisation
NZODA	New Zealand Ministry of Foreign Affairs and Trade (Development Co-operation Division)
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organisation
PHC	Primary Health Care
PFA	Platform for Action
SA	Social Assessment

Sida	Swedish International Development Cooperation Agency
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VWU	Vietnam Women's Union
WHO	World Health Organisation
WID	Women in Development
WP-GEN	DAC Working Party on Gender Equality (formerly DAC Expert Group on Women in Development)

1. INTRODUCTION

1. A common vision of progress, and an integrated set of goals and principles for a global development partnership was established by the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD) when it adopted its *21st Century Strategy* in 1996¹. The OECD DAC *Strategy* recognises gender equality and the empowerment of women" as a key goal, and underscores the importance of commitment for "increased participation including gender equality as a principle of effective development partnership. To assess progress, the *Strategy* sets out measurable goals in reducing poverty, improving education and health, and in ensuring environmental sustainability. These goals include targets to review progress toward the achievement of gender equality: elimination of gender disparity in primary and secondary education by 2005; a reduction by three-fourths in maternal mortality and two-thirds in infant and child mortality by 2015; and access through the primary health-care system to reproductive health services for all individuals of appropriate ages as soon as possible and no later than the year 2015.

2. The *Strategy* recognises that achievement of these measurable goals is integrally linked with progress towards less quantifiable goals such as effective, democratic, and accountable governance; protection of human rights; and respect for the rule of law. It emphasises that development co-operation can make a positive contribution towards realising these goals only when it adheres to sound principles of partnership: mutual commitment of partners towards shared objectives supported by adequate resources; co-ordinated assistance to locally owned strategies; strengthening capacity of government as well as civil society groups for sustainable national efforts; open dialogue amongst all stakeholders; and coherence between aid policies and other policies which impact on development.

3. The DAC *Strategy* considers the measurable and qualitative goals to be ambitious but realisable, and urges adoption of appropriate actions to meet the challenges. In view of the *Strategy's* recognition of the importance of achieving gender equality, the DAC Working Party on Gender Equality (WP-GEN) decided to carry out inventories on studies of how DAC Member organisations promote gender equality in relation to the goals established by the DAC's *Strategy* in poverty, education, environmentally sustainable development, and reproductive rights and health. The objective of these studies is to identify and illustrate best practices, particularly in relation to practical methodologies and tools, to highlight potentials and opportunities and to note gaps and constraints. The purpose of the exercise is not to evaluate donor organisation's efforts and progress but rather to focus on their positive and innovative experiences in order to learn from each other and create a common knowledge bank about good practices.

4. The *DAC Guidelines for Gender Equality and Women's Empowerment in Development Co-operation* state "Health, including sexual and reproductive health, is an essential component of human well-being. Because women are so visible in the health care system as both care-givers and clients, there is a widespread perception that gender equality and women's empowerment have been addressed. However, inequalities between women and men are evident in the health of individuals, in access to and use of health services, and in the structure of health care institutions and employment. DAC Members can assist partners to incorporate gender equality in the health sector through initiatives that support, for example:

¹ OECD/DAC, *Shaping the 21st Century: The Contribution of Development Co-operation*, A report adopted at the Thirty Fourth High Level meeting of the Development Assistance Committee, 6-7 May 1996.

- health planning and services that recognise the needs of women and girls for health care throughout the life-cycle, and not only in relation to maternity and child care;
- policies and programmes grounded in a recognition of the sexual and reproductive health and rights of women and men, and a recognition of the links between equality and the exercise of these rights;
- strategies that target men as well as women for activities related to child health, fertility regulation and safe sexual practices, and that recognise men's rights and responsibilities in these areas. (para. 46)''

5. In preparing the study on sexual and reproductive rights and health, the Working Party on Gender Equality initiated the work through written questionnaires: United Kingdom Department for International Development (DFID) circulated a questionnaire on maternal mortality, and the Swedish International Development Co-operation Agency (Sida) circulated one on sexual and reproductive rights and health. After reviewing the responses to the questionnaires, Sida decided to commission a report by a team of consultants who were asked to conduct a more in-depth search of information in agencies and in developing countries. It was agreed that the Sida team would include maternal health in its work. Annex 1 provides the Terms of Reference of the study. Ten agencies participated in it. They are: Australian Agency for International Development (AusAID), Belgian Agency for Development Co-operation (BADC), Canadian International Development Agency (CIDA), DANIDA (Danish Development Assistance), German Agency for Technical Cooperation (GTZ), Irish Aid, Development Co-operation Division of the New Zealand Ministry of Foreign Affairs and Trade (NZODA), Swedish International Development Cooperation Agency (Sida), United Kingdom Department for International Development (DFID) and the United States Agency for International Development (USAID). Bangladesh was selected as the country example to consider how donor co-ordination and efforts are functioning to support gender equality objectives.

6. The consultant team produced reports on ten agencies and one in-country study for internal use by the organisations. This report presents the overall findings of the study, particularly highlighting the various ways through which development co-operation agencies are attempting to implement and mainstream the gender equality perspective. Gaps and constraints are briefly noted and priority actions for the future are identified. The report's major focus is to identify positive experiences and opportunities in the expectation of making a constructive contribution to the ongoing work of the agencies. The report is written primarily on the basis of information provided by the agencies. No attempt has been made to independently verify the information or assess the agencies' implementation efforts. However, in analysing the data and reflecting on the agencies' experiences, the study team has used its own insight and judgement and is, therefore, responsible for the views expressed in the report.

2. IMPLEMENTATION OF GENDER EQUALITY: KEY ISSUES

7. Following the agreements reached at the International Conference on Population and Development (ICPD) in 1994 and the Platform for Action (PFA) adopted by the Fourth World Conference on Women (FWCW) in 1995, all countries and development co-operation agencies are in principle committed to the goal of gender equality and women's empowerment. But despite this international consensus, there is as yet no common understanding about the operational implications of the commitment. There are wide variations amongst development partners and within organisations in understanding *why* and *how* gender equality is related to health, particularly to sexual and reproductive health and rights, and what actions need to be taken to implement the commitments.

8. To clarify the issues and create a common understanding, this study uses an analytical framework (presented in figure 1), which is based on the ICPD and PFA agreements. The basic premise of the framework is that along with social inequality, gender inequality (that is, socially constructed inequality between men and women), is a major determinant of health status; therefore, the issue needs to be addressed in order to improve the health outcomes of the population. The framework puts forward three simple propositions:

- Gender inequality in society, manifested through disparities in education, income, workloads, and autonomy, influences the health of women and men.
- Gender inequality leads to women's unequal access to health services and their unequal treatment by the health system.
- To promote gender equality in sexual and reproductive rights and health, actions need to be taken not only in the health sector to improve women's access to health care and reorient the health system; but also in other sectors, e.g. education, employment, legal rights, and political participation, to empower women.

9. While the concept of gender equality is relatively simple and the goal is by now widely accepted, its implementation through a mainstreamed approach in development co-operation is a complex and a long-term task. Mainstreaming gender equality involves reorientation in policies, programmes, tools and approaches. The ICPD and the PFA agreements provide the broad guidelines for the needed reorientation, e.g. a shift from the population control objective to improving quality of life; from targeting women to looking at both men and women's needs, roles and responsibilities; from access through primary health care not only to maternal and child health and family planning but to a wide range of reproductive health services. Other shifts include integration of service delivery; improving quality of care; addressing women's health risks resulting from unequal gender relations; intersectoral/multi-sectoral actions to improve women's status; consultation with women and women's organisations.

10. A critical concern of this study is to find out how the ICPD and the PFA guidelines are being implemented, more particularly the extent to which policies, programmes, and approaches are being reoriented from a preoccupation with women as a target group to gender equality and women's empowerment as a goal of development co-operation. Another key concern is to note whether the agencies are considering gender equality in their partnership arrangements. The study focuses on an analysis of selected positive experiences from agencies and the developing country example to identify potentials and promising avenues as well as specific constraints. Innovative and positive initiatives are explored from a wide range of agency activities and functions including policy or strategy development, policy dialogue, sector reform, country and regional programming, planning process and tools, and programme and project implementation.

11. From the information provided by the agencies, the study team has drawn the following broad conclusions:

- All agencies accept the goal of gender equality and the need for mainstreaming a gender equality perspective in operations; but there are differences, amongst agencies and within agencies, in commitment, understanding, experience and implementation. Some agencies have developed their own policy and strategy documents in line with the ICPD and PFA agreements, others are yet to develop their own strategies. Some agencies still retain fertility reduction as a goal rather than have an indicator of high quality of life. Some agencies have taken their strategies through a broad consultative process within and outside the agencies in order to raise awareness and build consensus around the issues. Some have developed tools and methodologies. A few have started initiatives in

some of the new and emerging areas e.g., violence against women, female genital mutilation (FGM), abortion, and men's involvement and partnership.

- There is often a gap between agency policy and practice. On the whole agencies have made more progress in producing policy and strategy documents than in actual implementation of programmes in line with ICPD and PFA. The language of policy and strategy documents has changed but the content of programmes and projects have remained mostly unchanged.
- All agencies have taken some positive initiatives, but these experiences have not yet been properly analysed and disseminated. Indeed most agencies lack mechanisms for rapid analysis of their own initiatives to learn from their own experiences.

12. The agencies are grappling with a number of issues as they attempt to implement and mainstream the gender equality objective:

- **Common understanding of key concepts:** There is no common understanding of key concepts such as gender equality; gender relations; men's involvement and partnership; a human rights-based approach and mainstreaming. As in many programmes and projects women are a large proportion of the clientele of health services and are specifically identified as the target group, it is often assumed that gender equality issues are being addressed. It is not clear to many staff of agencies and their counterparts what additional dimensions emerge through a gender equality perspective or attention to gender relations or men's involvement. The impact of relations between men and women on women's exercise of sexual and reproductive rights is often not recognised. The links between sexuality and violence tend to be overlooked. Men's responsibilities for fertility and children and in securing women's rights and health, again, are generally ignored. Gender issues are addressed more often in women focused programmes and projects with a focus on service provision. How to mainstream and not compartmentalise gender issues in major programmes still remains a challenge.
- **Supportive processes:** Agencies are aware of the need for supportive processes. In their policy and strategy documents they talk about stakeholder consultation and participation, team building, networking, local and institutional ownership of initiatives and so on. But while some agencies have started to seriously invest in processes, others still do not know how to go about it and have not taken on board the fact that this requires substantial time. In addition, there are some who do not give enough priority to it in practice.
- **Tools and methodologies:** Most of the agencies have developed tools for social and gender analysis for policy/programme/project design, monitoring and evaluation. But mere availability of tools is not enough. Tools need to be used. Here agencies are facing several challenges. First, gender analysis is often not a mandatory requirement for programme/project design and implementation. Second, often the capacity to use tools both in the agencies and at the local level is limited. And finally, as agencies are moving towards new modes of programming e.g., sector programmes, results-based programmes, etc., the development of new sets of methodologies and tools which incorporate social and gender analysis have become necessary.
- **Programme design and implementation:** Programme design and implementation approaches are changing. Many agencies are moving from project to programme support and from a sectoral to intersectoral approaches. While a few agencies in some cases have been able to successfully address gender issues in sector programmes and design intersectoral interventions to create a synergistic impact, many others have not been able to identify opportunities for action.

Figure 1: Framework for understanding gender equality in sexual and reproductive rights and health

Gender inequality in society influences	Through:	Therefore, what should be addressed to promote gender equality in sexual and reproductive rights and health is:
Health of women and men	<ul style="list-style-type: none"> - Differences by gender in autonomy (higher vulnerability of women to violence, STDs, unwanted pregnancy, mortality from unsafe abortions). - Higher risk of poverty among women linked to discriminatory legislation on economic rights, discriminatory practices in the economy, education (vulnerability to poor nutrition, maternal mortality). - Cultural practices (e.g., biases against women and girls in food allocation, female genital mutilation). - Division of labour (different occupation health hazards for women and men) - Workload/length of working day of women (stress, mental health, fatigue) 	<ul style="list-style-type: none"> - Promotion of women's rights to autonomy in relation to control over sexuality, fertility, rights to decision-making in marriage and sexual practices (human rights approach). - Linkages to related policies and sectors (e.g., agriculture/food security, nutrition, water and sanitation, media, education and to gender equality policies). - Overall priority assigned to poverty reduction and improved quality of life (particularly among women). - Changes in behaviour patterns of men (on fertility decisions, reproductive/sexuality practices, violence); sexuality and life skills for men to promote increased responsibility for sexual practices, domestic work and child rearing and a decrease in violence against women.
Access to health services	<ul style="list-style-type: none"> - Lack of willingness of families (including women) to invest in health care for girls and women; lack of independent income for women. - Women's heavier workloads (less time) and women's opportunity costs in using health care services. - Social/cultural attitudes. 	<ul style="list-style-type: none"> - Lowering the cost for individuals at primary health service level. - Alternative strategies to avoid making women carry an ever-increasing role as care-givers. - Need to promote financial independence of women. - Promotion amongst women and men of positive attitudes to women's health; encouragement to women's self-confidence to challenge barriers; support to women's organisations, NGOs, CBOs. - Services structured to promote access (longer opening hour/schedules, distance in relation to availability and cost of transport, integrated services, sex of staff).
Response structure of the health system	<ul style="list-style-type: none"> - Priority biases toward single-issue vertical services (family planning, STDs, safe motherhood) targeted to specific groups of women. - Biases in resource allocation favouring e.g., tertiary hospitals rather than primary health care. - Biases in staff attitudes about appropriate roles of women and men. - Service provision that does not take account of the gender-based needs of women and men. - Unwillingness to recognise the sexuality of young . - Lack of women in decision-making. - Negative working condition for health workers. 	<ul style="list-style-type: none"> - Adequate investment in the health system at primary health care level (management, supervision, training drug supply, facilities, infrastructure and transport for emergency case). - Reorientation of services/staff toward client focus: 1) understanding the impact of gender on people (life-cycle approach beyond sexual and reproductive health for women and men, dignity, respect); ii) skills to provide integrated services (e.g., family planning, safe abortions, STDs , infertility, violence, maternal care, TB immunisation, diarrhoea, etc.); iii) appropriate working conditions for staff, including non-discrimination by sex. - Organisation of services (privacy, queuing and booking systems; the need for multidisciplinary health workers. - Services that address people through the life-cycle and recognise diversity among both women and men (i.e., broader range of services). - Capacity-building of women in the health sector for management (e.g. training, personnel policies etc.). - Targeting of both women and men for sexual and reproductive health services (to look after their own health, and health of partners, have confidence in use of health system); also link with the education system (knowledge and confidence). - Mechanisms for user inputs (both women and men), e.g. stakeholder consultations, partnership with civil society etc.

- **Resources:** Availability of adequate resources, both human and financial, is a critical issue. As agencies are facing resource constraints, there is a need to be strategic in resource allocation. In a mainstreaming approach, there is obviously a need to make all agency resources in this sector -- staff and budget -- accountable for gender equality. Some agencies, who have developed good internal processes in mainstreaming a gender equality perspective, have been more successful than others in using general staff and budget resources. However, for advocacy work on gender mainstreaming, different agencies have taken different approaches. Some agencies have successfully tapped general resources in this sector to support cutting edge work on gender equality. Some others have women-specific funds which have been useful for supporting innovative initiatives.
- **Partnership:** Proactive steps to identify opportunities to promote gender equality in supporting local ownership and building partnership is another key issue. While in some situations some agencies have felt constrained by the lack of initiatives on the part of counterpart governments, others have drawn on government's own policy statements on gender equality or women's empowerment to form a basis for co-operation. Some agencies have not engaged with local women's organisations and civil society groups in any significant way, whereas others have chosen to support them and work on sensitive issues such as female genital mutilation, abortion and violence against women.

3. POTENTIALS AND PROMISING AVENUES

13. The agencies participating in the study vary a great deal in terms of size, budget, geographical coverage and experience. For example, in 1996, USAID committed \$916 million dollars in the population and health sector and supported activities in 70 countries². On the other hand, several agencies, such as BADC, Irish Aid and NZODA are relatively small. However, size and volume are not necessarily determining factors of effective development co-operation. Given their limited resources, smaller agencies can be strategic in their support and can be just as effective as large organisations in promoting and mainstreaming gender equality.

14. This study has identified positive and innovative initiatives from all the agencies and the selected developing country example. The initiatives encompass a wide set of activities. Policy and strategy documents from several agencies, e.g. CIDA, DANIDA and Sida are highlighted as positive first steps towards implementing ICPD and PFA. Most of the agencies, e.g. AusAID, CIDA, DANIDA, Irish Aid, DFID, NZODA and Sida, have developed or are developing tools and methodologies to identify and mainstream gender issues in operations. A number of agencies e.g., BADC, DANIDA, DFID, Sida and USAID have supported research which has resulted in changing the design and implementation of operational programmes. Almost all the agencies could identify an operational project that has succeeded in promoting gender equality in an innovative way. Several agencies e.g., BADC, CIDA, DFID, NZODA, Sida and USAID highlighted special funds as a good practice to support promotional and innovative work. A number of agencies e.g. CIDA, DANIDA, DFID, Sida and Irish Aid noted their support for multilateral agencies to promote gender equality. Several agencies highlighted their support for international NGOs and networks. All agencies recognised the important role of good processes, e.g. consultation, participation, teamwork, flexibility, local and institutional ownership of initiatives and so on.

² USAID, 1997, User's guide to the Center for Population, Health, and Nutrition, Center for Population, Health and Nutrition, Bureau for Global Programs, Field Support and Research, Washington, D.C., p. 2.

15. The positive and innovative initiatives identified by the study differ in size. Some are global initiatives, others are small steps in specific countries. The initiatives also differ in impact. A few have been successful in influencing the direction of major programmes. Some are still in early stages of implementation, too early to assess. Some are in the design stages and are not yet operational. But they all share common elements of good practice. These elements are illustrated in Figure 2, and are further elaborated below with specific examples. While a few examples are discussed in this section to showcase good practice principles, others are described in Annex 2. Though each example is used to illustrate one principle, the examples generally possess multiple principles of good practice.

Figure 2 -- Seven principles of good practice

- Analyse and understand the impact of inequality between women and men on health.
- Take action to address gender inequality in access to health care and responses of the health system.
- Shift from demographic objectives (population control) to preoccupations with quality of life, and from population targets to recognition of individuals' rights and health.
- Pay attention to women's as well as men's health needs over the life cycle and both men's and women's roles and responsibilities in relation to fertility, children's health, and in securing women's rights and health.
- Build self-esteem, confidence, and capacity of both women users of health services and health workers.
- Consult with all stakeholders including women and build partnerships with women's organisations.
- Promote gender equality in strengthening national capacity.

Principle #1: Analyse and understand the impact of inequality between women and men on health

16. Initiatives which start with an appropriate understanding of gender inequality, that is the different ways in which the socio-economic and cultural aspects of being male or female affect the health risks of individuals and their access to health services and the gender-based assumptions of the health systems, are generally better able to promote and mainstream gender equality objectives. Two examples described below illustrate how gender issues can be mainstreamed when they are addressed not as marginal but as central to the identification of the problems and solutions.

17. **Women and AIDS Research Program:** Initiated in 1990 and implemented by the International Centre for Research on Women (ICRW), this USAID funded programme supported 17 descriptive and operations research projects in 13 countries in Asia, Africa and Latin America. The individual country studies and the synthesis reports from the project brought into sharp focus the central role of unequal gender relations in increasing women's vulnerability and produced important policy and programme

recommendations³. The project's findings highlighted the risk factors for ordinary heterosexual women (e.g., lack of biomedical information about their bodies, human sexuality and HIV/STDs, lack of power to demand sexually responsible behaviour from the partners; lack of knowledge about preventive behaviour and STD curative services). Women were getting infected by their husbands or partners but were hitherto ignored by HIV/AIDS prevention programmes as these programmes were focusing on certain categories of women engaging in risky behaviour e.g., commercial sex workers. The recommendations included actions for risk reduction e.g., educating girls and women about their bodies, human sexuality, HIV/AIDS, and condom use; providing individual and group consultations to share experiences and model new behaviour; access to reproductive health services integrating STD/HIV; educating boys and men about responsible sexual behaviour; support for development of technology that can be used independently by women to prevent HIV transmission; empowerment of women through education, training, and employment; strengthening of community-based women's organisations; and programmes designed through participatory research mobilising communities to question the norms of unequal balance of power in relationships. The recommendations from the project influenced redesigning of a large USAID funded project on AIDS control and prevention (AIDSCAP), and the work of other international agencies. The country studies resulted in follow up action projects.

18. **CIDA's Strategy for Health:** Adopted in 1996, CIDA's *Strategy for Health*⁴ identifies poverty as well as gender inequality and women's low status, illiteracy, and limited education as major determinants of health in the developing world. From this identification of the causal factors affecting people's health, the *Strategy* sets improvement of "women's health and reproductive health" as one of the six objectives of its assistance. Gender equality issues are also linked to other objectives: improvement of child health, decreasing malnutrition, and prevention and control of emerging pandemics. Similarly, in elaborating actions, gender equality and women's empowerment issues are addressed not only under the specific objective of improving women's health and reproductive health, but also under other objectives e.g., sustainable national health systems and improved child health. Under the specific objective of improvement of women's health and reproductive health, the *Strategy* commits CIDA support for: women's health programming throughout the life cycle in the context of family health including attention to such issues as violence and female genital mutilation; safe motherhood; women's nutrition; quality family planning services; information, education and communication on reproductive health for men, women and youth; prevention and control of STD and HIV/AIDS; and youth health.

Principle #2: Take action to address gender inequality in access to health care and responses of the health system

19. All the good practice examples identified by the study in one way or another specify actions to address gender inequality in access to health care and the responses of the health system. These initiatives recognise that barriers to women's access are created not simply by absence or limitation of services. There are other socio-economic and cultural factors that prevent access, e.g. women's heavier work load, absence of independent income, lack of willingness of families to invest in women's health etc. Similarly, these initiatives demonstrate an understanding that the response of the health system can be improved not just by adding facilities, drugs, and staff numbers, but by reorganisation and reorientation of the health system to promote access and client focus e.g., adequate investment at the PHC level, integration of

³ Rounaq Jahan, "Gender Equality in Sexual and Reproductive Rights and Health: A Case Study of USAID", Draft, January 1998.

⁴ CIDA, 1996, Strategy for Health.

services, management and communication skills for reorientation towards clients, etc. The five examples described below illustrate actions that can be taken to improve women's access to health care and responses of the health system.

20. **Recruitment of Female Field Workers in Bangladesh**⁵: This example from Bangladesh shows how gender inequality in the household and society, especially gender gaps in the access to services was addressed by the health system. In 1976, 13,500 female field workers were recruited for the first time in the Bangladesh Government's family planning programme to bring services to rural women's doorsteps. The majority of women (90 per cent), poor and illiterate, lived in rural areas, mostly within the household in the gender segregated society, and had little information or access to health and family planning services. It was realised that to increase access and availability of information and services to women in remote areas and motivate them for family planning, inter-personal communication and services provided by women workers at doorstep was necessary. Initially, the field workers worked on family planning which in the early 1980s was expanded to maternal and child health (MCH) and currently to reproductive health. The work of these female field workers, whose number has now increased to nearly 30,000, greatly contributed to the success of the country's family planning programme. As the field workers live in the communities, through inter-personal communication, they are able to break the inhibition of men and women to talk about reproductive health, especially family planning and reproductive tract infections and facilitate husband-wife communication. Furthermore, the female field workers were the first group of public sector women employees with visible presence in the rural areas and were viewed as "role models" in the communities as a paid government worker, friend of the community and earning member of the family. This had a substantial multiplier effect on increasing women's education and empowerment, and on gender equality. The field workers are trained to provide most of the essential reproductive health services. The female field workers together with their male colleagues serve 120 million people of Bangladesh by providing services in 4500 Family Welfare Centres situated in 4500 unions, and organise outreach centres such as 30,000 satellite clinics and 108,000 Immunisation Camps (6 antigens for children and three doses of tetanus vaccine for pregnant women) every year. The Contraceptive Prevalence Rate (CPR) in Bangladesh has increased from 2 per cent in 1976 to 49 per cent at present, the fertility rate has declined from 7.7 to 3.2, and the immunisation rate for pregnant women is 75 per cent and for children 85 per cent.

21. **DESAPER**⁶: This CIDA supported regional project, implemented by the Pan American Health Organisation (PAHO) illustrates the actions that can be taken to improve the responses of the health system to address high rates of maternal and infant mortality and morbidity. The regional project has been operational in eight project sites in four countries (Bolivia, Honduras, Nicaragua and Peru), since 1988. The DESAPER project's major objective is to improve primary health care, more specifically to improve reproductive, maternal, perinatal and infant health, by providing greater extension as well as better quality. Between 1991 and 1996 the project succeeded in reducing maternal mortality rate from 14 to 6 per 10,000, and infant mortality rate from 9 to 6 per 1,000. It has increased perinatal service coverage from 61 per cent to 84 per cent and early identification of problems from 21 per cent to 50 per cent. The project was successful in achieving its quantitative goals by paying attention to qualitative aspects of the programmes. A crucial strategy was effective community participation in health programming and

⁵ Nilufar Ahmad, "Gender Equality in Sexual and Reproductive Rights and Health: A Country Study—Bangladesh", Draft, January 1998.

⁶ Rounaq Jahan, "Gender Equality in Sexual and Reproductive Rights and Health: A Case Study of CIDA", Draft, January 1998.

improved co-ordination between the health system and communities. The organisation and training of local health services was improved. Similarly, community participation was enhanced through Participatory Action Research and production of participatory development tools (e.g. community game and participatory activities tool kit). In addition to perinatal service activities, the project executed over 300 micro projects to facilitate joint actions by communities and the health system. This led to creating trust and partnership and enhancing the project's sustainability. The DESAPER model has been replicated in other national projects in the four countries.

22. **Safer motherhood in Nepal⁷**: DFID's project, while in the early stages, aims to reduce the maternal mortality rate in Nepal which is among the highest in the world. DFID integrates the concern for gender equality into the overall social assessment, resulting in a broad development approach. Following in-depth assessments of economic, financial, technical, institutional, social and environmental factors, non-health service potential barriers were identified. Various difficulties in accessing district hospitals result from the terrain, lack of transport, and distance. Additional negative factors are ignorance of the childbirth process, poverty, low status of women, and the perception that women's health is not important enough to justify the time and expense of a hospital. To overcome these obstacles the project has two components: service provision and user demand. DFID aims to increase the training of hospital staff and enhance women's awareness of dangers associated with childbirth. DFID draws attention to the advantage of hospitals to alleviate the danger of childbirth, through videos and street performances throughout villages. The project also includes the establishment of an emergency transport system in communities through supporting the current most feasible methods of emergency transport and community commitment to provide the transport to take women to the hospital. Within the health service section, in addition to improvement of facilities, the major focus is on capacity building in the area of communication, management, logistics and technical training.

23. **Training of Traditional Birth Attendants and Community Health Workers in Ethiopia⁸**: Irish Aid's project, running since 1994, addresses Ethiopia's basic needs in infrastructure support for community health workers. The project has had a positive impact on women's health and has increased opportunities for gender equality. High rates of infant and maternal mortality in Ethiopia indicated not only a need to improve nutrition, but also to strengthen basic health services. Due to a lack of facilities, huge distances between them, and a lack of priority to women's health, the project focused on primary health care units, Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs). Basic facilities exist as a means of referral for CHWs and TBAs when they need a higher level of skill in the health system beyond their preventative and basic curative abilities. Both CHWs and TBAs play a large role in influencing public health. They provide an opportunity for women to be a critical source of information within the community and provide rural women's only access to health services. TBAs are always women, whereas 50 per cent of CHWs should be women according to the objectives of the project. The project is exploring means of achieving this target given the barriers to women. As a result of the project's efforts, the Ministry of Health is seeking to further institutionalise the role of CHWs and TBAs in the health system.

24. **MC-FP Extension Project, Bangladesh⁹**: A small research initiative with the potential of making a large impact was reported by a BADC supported medical researcher at the multidonor-funded

⁷ Barbara Klugman, "Gender Equality in Sexual and Reproductive Rights and Health: A Case Study of the Department for International Development, United Kingdom", Draft, January 1998.

⁸ Barbara Klugman, "Inventory on Mainstreaming Gender in Health: Irish Aid", Draft, January 1998.

International Centre for Diarrhoeal Research, Bangladesh (ICDDR,B). The research concerned the use of picture-cards by field workers in a pilot effort to assist pregnant women to understand obstetrical complications that require hospital care. Women were encouraged to keep the card and discuss it with their husbands and mothers-in-law. This simple intervention addresses a major reason for women not seeking care, e.g. lack of recognition of the problem at the outset. The picture-cards provide women with a means to make claims for health services, i.e. to communicate and validate needs for care to others in the family whose support is required to seek such care. Pilot testing yielded positive results, but the instrument is yet to be introduced in a large-scale programme. However, the Extension Project is managed jointly by the ICDDR-B and the Bangladesh Ministry of Health with the objective of seeking more effective MCH-FP service delivery through the government health system and thus the institutional links for building on positive results exist.

Principle #3: Shift from demographic to quality of life objectives and from targets to individual rights and health

25. The major paradigm shift brought about by ICPD is the shift from demographic to quality of life objectives and from targets to a human rights approach. Agencies have primarily been able to demonstrate this more through their policy and strategy documents, research support, and preparation of guidelines. Some of the agencies are also attempting to reorient the objectives and approaches of operational programmes and projects. Such changes are noticeable in the family planning programmes where explicit targets have been dropped and the concepts of "informed choice", availability of a wide range of contraceptive methods and quality of care are being introduced. Initiatives from three agencies show how this shift is being brought about in strategy documents, guidelines and operational projects.

26. **Sida's policy documents:** Two of Sida's documents, *Population, Development and Co-operation*¹⁰ and *Sexual and Reproductive Health and Rights*¹¹ illustrate the move towards quality of life objectives and a human rights approach. The first document takes a holistic and integrated approach to development. It addresses population trends as part of a matrix of dynamics including economic development, inappropriate consumption patterns, environmental depletion, migration, and sexual and reproductive rights and health, and indicates how addressing these issues fits into Sida's key development strategies, which are poverty alleviation; peace, democracy and human rights; gender equality; and sustainable development. The second document highlights the rights approach. It discusses the need for "training and continuous education of service providers and policy makers on how to respect people's sexual and reproductive rights"; and, in addition to the usual components of sexual and reproductive health it underscores the need for addressing three critical areas of gender inequality and women's ill health: abortion, female genital mutilation, and violence against women.

27. **Prevention of female genital mutilation (FGM)**¹²: DANIDA established a guideline on the prevention of FGM for use within DANIDA's programmes. It draws attention to the issue of FGM from a

⁹ Johanna Shalkwyk, "Inventory on Mainstreaming Gender Equality in Bilateral Development Cooperation Focused on Sexual and Reproductive Rights and Health, Agency Sub-Report: BADC" Draft, January 1998.

¹⁰ Sida, 1997, Position paper on Population, Development and Co-operation.

¹¹ Sida, 1997. Strategy for Development Cooperation, Sexual and Reproductive Health and Rights.

sexual and reproductive health and rights as well as a human rights perspective. The guideline promotes the abolition of FGM as part of the primary health care strategy, education and the legal systems. DANIDA's guideline emphasises that the abolition of FGM must be seen in a long-term perspective. FGM can only be eradicated if those fighting for change understand the deeply entrenched beliefs held by those who support FGM. The guideline is intended both for DANIDA staff, non-governmental organisations, consultants, international organisations, and DANIDA's partners in programme countries. Through international and local NGO workshops and seminars, DANIDA aims to influence policy makers and religious leaders to develop initiatives supporting the prevention and eradication of FGM in accordance with the Cairo and Beijing recommendations. In 1995, an international seminar on FGM was organised by DANIDA and a NGO entitled *Women and Development (KULU)* to highlight the issues surrounding FGM and possible means of prevention. DANIDA promotes the empowerment of women as a primary means of prevention of FGM, alongside support for local NGOs and the development of national efforts.

28. **Vietnam Family Planning Project¹³**: Initiated in 1993, this AusAID project is implemented by the Vietnam Women's Union (VWU) in co-operation with two NGOs: Family Planning Australia and Population and Community Development International. The project has taken an integrated approach combining community-based family planning with other health and community development activities including a micro credit facility. Its objectives are to improve quality of service; increase access to and choice of contraceptives; reduce the rate of abortion; improve maternal health and child health and nutrition; increase household income; build local community development institutions and sanitation, and develop the capacity of VWU to implement community-based integrated rural development programmes. The integrated approach and the emphasis on "informed choice" and support for provision of a wide range of contraceptives is a significant departure from previous target-oriented programmes. The project has achieved promising results in 20 communes across three provinces in Vietnam and is being replicated in other areas.

Principle #4: Pay attention to women's as well as men's health needs over the life cycle and both men's and women's roles and responsibilities in relation to fertility and children and in securing women's rights and health

29. Agencies have only recently started to turn their attention to a life-cycle approach and to address both men and women's roles and responsibilities but there is still a lack of clarity as to *why* and *how* men should be involved. Sida is supporting research and conferences on men's role. USAID has several new initiatives on male partnership including a separate sub-group in its Gender Working Group in the office of Population, Health and Nutrition. AusAID is also designing strategies for male involvement in some projects. The recently adopted Reproductive Health Strategy of the Bangladesh Government recognises the principle of the life cycle approach and the roles and responsibilities of men and women.

¹² Margrethe Silberschmidt, "Inventory on Mainstreaming Gender Equality in Bilateral Development Cooperation Focused on Reproductive Rights and Health Including Maternal Health, Agency Sub-Report: DANIDA", Draft, January 1998.

¹³ Juliet Hunt, "Report on AusAID, Mainstreaming Gender Equality in Sexual and Reproductive Rights and Health", Draft, February 1998.

30. **Male Involvement in Reproductive Health, Bangladesh¹⁴:** Since 1997, the Bangladesh Ministry of Health and Family Welfare is implementing the three innovative projects for promoting male involvement in reproductive health in partnership with NGOs, The Population Council and AVSC. USAID and CIDA fund the projects. The projects were developed using literature reviews and baseline surveys of male participation (at present 2 per cent of men participate in these projects), focus group discussions with health and family planning workers, community and religious leaders, and orientation meetings with senior government officials, NGOs and other stakeholders. The project interventions include (i) orientation of government front-line workers and service providers, as well as NGO and multi-sectoral fieldworkers; (ii) development and dissemination of information, education and communication (IEC) materials; (iii) introduction of special services for men such as "exclusive clinic hours, "husband's day" at the clinic; (iv) involvement of community and religious leaders; (v) networking with NGOs to promote men's involvement in reproductive health. Using a participatory process involving health providers, community leaders and clients, the projects have developed IEC materials on *responsible parenthood* highlighting men's roles and responsibilities in reproductive behaviour and health and welfare of their families, as well as a *service provider guide* highlighting strategies for enhanced male involvement. The initial results are encouraging as both male and female field workers are making greater efforts to involve men. Awareness among men is higher than before and use of male methods has doubled in one year.

31. Two other operational projects illustrate how after initiation of activities, the projects started paying attention to both men and women as a result of local level needs assessment. The first initiative, **Manipur and Nagaland AIDS prevention project¹⁵** is a Sida funded training of trainers' project in India. The project originally focused on men drug users. After the first year, when the idea of including women was first introduced by Sida and local consultants, there was initial resistance by the implementing NGOs' all male-staff which included ex-drug users. Their response was that this was not a problem facing women. Nevertheless the existing target group of men had sexual partners who were drug users and many women drug users were in prostitution. The dialogue raised the awareness of the NGOs and the project was redesigned to include women in the target group. To reach women drug users, women social workers and ex-drug users were employed by the NGO. Another example from a USAID project: **ReproSalud** in Peru (which is described below in paragraph 37) illustrates a reverse scenario. After starting with a focus on women, project activities were expanded to include training for men when local women themselves identified the need for raising men's awareness .

32. This survey of the agencies revealed few examples at the programme and project levels which effectively promote men's responsibilities. Despite increased interest in the role of men in relation to reproductive health post-ICPD, few agencies have yet worked out how to operationalise this issue. While the simplest response is to target men for reproductive health services, this may potentially attract resources away from women's health, without addressing the primary challenge, which is to build men's ability to take responsibility for their own reproductive behaviour, and its impact on women's health.

¹⁴ Nilufar Ahmad, "Gender Equality in Sexual and Reproductive Rights and Health: A Case Study of Bangladesh", Draft, January 1998.

¹⁵ Barbara Klugman, "Gender Equality in Sexual and Reproductive Rights and Health: A Case Study of Sida", Draft, January 1998.

Principle #5: Build self-esteem, confidence and capacity of both women users and health workers

33. Building self-esteem, confidence and capacity of both women users and health workers is a key element to creating demand for quality services as well as providing them. Though poor women constitute a large part of the health service users, they lack confidence and capacity to demand quality service. Similarly, women on the provider side are often at the lower ranks of health services, and they themselves face discrimination. As a result, they lack sensitivity towards clients. Respect for clients and each other has to be built at all levels of services. More technical training is not enough. Self-esteem, capacity and confidence can be built through a variety of ways (e.g., training, information, and linkage to support groups, etc.). Two examples described below illustrate the different ways in which capacity and confidence can be built for both users and providers.

34. **The Healthy Women Counselling Guide**¹⁶: DFID provided support to the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) for this multi-donor initiative which is developing methodologies to support local development of appropriate women's health information resources. The *Counselling Guide* was published in 1997 based on participatory research in Kenya, Sierra Leone and Nigeria, which focused on women's health needs and priorities, their health seeking behaviour, and where, how and from whom they would like to receive information. Another product which emerged from this process was a micro management tool: *Health Workers for Change: A Manual to Improve Quality of Care*¹⁷. It was developed as a training tool for health workers to relate in a more positive way to their clients including recognising women's needs. The manual was used by an NGO in South Africa with support from DFID and UNFPA to train facilitators from the Department of Health. Facilitators then used it to run Health Workers for Change workshops with staff at clinic level (including cleaners, security people and all levels of health workers) as part of a broader project: *Transformation of Reproductive Health Service Project*. The evaluation of this process noted its effectiveness both in improving the morale of health workers and building their commitment to the change process and in gathering the data needed for the situation analysis of health services. The materials produced through the *Healthy Women Counselling Guide* have promoted gender-sensitive health system interventions including addressing health worker/client relationships and gender-sensitive health promotion strategies. This is being followed up with specific guides such as a document on *Developing Radio and Illustrated Materials*.

35. **East Sepik Women and Children's Health Project in Papua New Guinea**¹⁸: Initiated in 1995, this NZODA funded project focused on training more than 300 volunteer women health workers (*Marasin Meri*) from 162 villages in three districts. Since the community volunteers are generally men, recruitment of women volunteers was an important contribution to improving women's status as they were regarded as role models. The project gave the *Marasin Meri* access to basic medicine and provided ongoing support through retraining, supervision and referral. In training, both technical issues as well as

¹⁶ WHO, 1997, Towards the Healthy Women Counselling Guide: Ideas from the Gender and Health Research Group.

¹⁷ Health Workers for Change: A Manual to Improve Quality of Care, UNDP/World Bank/WHO special programme for Research and Training in Tropical Disease and Women's Health Project, 1996.

¹⁸ Juliet Hunt, "Report on New Zealand: Mainstreaming Gender Equality in Sexual and Reproductive Rights and Health", Draft, February 1998.

strategic gender issues (e.g. issues related to women's subordinate status) are addressed. The project is focusing on women's rights and health as well as men's roles and responsibilities in areas such as violence against women and transmission of STDs. Gender equality issues have also been addressed through community based theatre. While the project sees the need for educating men, the focus is still on women and children.

Principle #6: Consult with all stakeholders including women and build partnerships with women's organisations

36. Consultation with all stakeholders is critical because it leads to a better understanding of issues and therefore a better needs identification. Consultation and dialogue make processes transparent which gives validity and credibility to help build consensus. The process itself can raise awareness both about health and about the need to address aspects of gender inequality which impact on women's health. In consulting with stakeholders, however, all categories of stakeholders need to be identified and women's representation must be ensured. Women's organisations can play an important role.

37. All agencies are moving towards using consultative processes. However, development partners need to be truly committed to the integrity of the process of consultation. Often the rules and procedures of governments both in donor organisations and in aid recipient countries work against the processes of authentic consultation, which calls for flexibility in programme/project design. Analytical tools used by agencies e.g., Social Assessment (SA) techniques or the Logical Framework Analysis(LFA), are not determining factors in promoting or inhibiting consultation. The critical factor is *who* is using it and *how*. Use of local expertise generally facilitates participation. Stakeholder participation and consultation is also easier in settings that have a strong tradition of community-based organisations, women's organisations, and expertise in participatory action research. Three examples described below show how consultation with stakeholders and partnership building with women's organisations can be done.

38. **ReproSalud project**¹⁹: This USAID funded project in Peru was launched in 1995. Implemented by Movimiento Manuela Ramos (Manuela), a feminist organisation with more than 20 years of experience, the project plans to work with at least 200 Community-Based Organisations (CBOs) in six of Peru's thirteen regions to identify and address local women's priority needs in reproductive health and rights. Through *autodiagnosticos*, a participatory qualitative research technique, the CBOs enable local women to identify, and prioritise their needs and develop activities to address these needs. As part of the initial consultative process the local women prioritised vaginal infection, complications in pregnancy and delivery, and problems related to reproductive tract infection and abortions. To address these issues, women first wanted educational activities to give information about human bodies and how to prevent these problems. They also identified the need to raise men's awareness through training. The project addresses both practical and strategic gender needs, e.g. needs arising out of women's concrete conditions and their subordination. It has income generation and advocacy components. The income generation component comprises two types of activities: credit and product development. The advocacy component has highlighted the issue of violence against women.

¹⁹ Rounaq Jahan, "Gender Equality in Sexual and Reproductive Rights and Health: A Case Study of USAID", Draft, January 1998.

39. **The Health and Population Sector Strategy (HPSS)²⁰ and Fifth Health and Population Programme (HAPP-5) in Bangladesh²¹**: Stakeholder consultation was used by the Government of Bangladesh in developing its Health and Population Sector Strategy (HPSS) in 1996 and in designing its multi-donor five year sector programme in the Fifth Health and Population Programme(HAPP-5). The HAPP-5 focuses on Primary Health Care (PHC) - which includes reproductive health, and will involve communities and stakeholders in the implementation and monitoring of the programme. The five-year (1998-2003) programme will cost nearly \$3.5 billion and serve the total population of Bangladesh. HPSS was prepared through a consultative process over a period of two years (1995-96) with inputs from users, providers, government officials, NGOs, women's organisations, the private sector and donors. To facilitate preparation of HAPP-5, the Bangladesh government constituted 17 task forces, one of them being a Community and Stakeholder Participation Task Force. The Task Force identified 34 categories of stakeholders broadly grouped into three: primary (users), secondary (providers), and external. Through local and regional level consultations (conducted nation-wide involving thousands of users, providers and other stakeholders), needs of the users, particularly women, and constraints faced by the users and providers were identified and fed into the preparation of HAPP-5. Furthermore, wide consensus on gender equality as a goal in the health system and service delivery was achieved. One of the key objectives of this participatory process was to achieve gender balance in the representation of stakeholders so that gender issues could be mainstreamed through stakeholder consultation. Poor women and women's organisations constituted a major part of stakeholders. The project will be implemented from July 1998, and as the experiences from the stakeholder consultation have been positive, the government will involve communities and women's groups in participatory implementation and monitoring of HAPP-5. By facilitating the participatory process in the design stage, women's groups have become one of the major partners in the implementation of HAPP-5.

40. **Planning Process, Project on Health Promotion and Health Insurance for Industrial Workers, Bangladesh²²**: Germany was approached by the Ministry of Labour in Bangladesh to develop a project on the health care needs of groups of industrial workers (mainly in the garment sector, and mainly women). Analytic studies and focus group discussion with the target group that were undertaken in the project preparation phase resulted in the identification of issues of reproductive health as key concerns (compared to the initial request which was mainly concerned with minor industrial accidents, and other diseases). The planning process also included collaboration with a range of government and non-government agencies involved in issues concerning workers in this sector. As a result, consensus was achieved among key government agencies, employers and other stakeholders to broaden the coverage of the project from industrial accident to include the reproductive health care for women. While the project is still at the design stage, the report on the planning process suggests the value of consultations as a means of identifying the needs of the group to be served and of building consensus about a project approach that responds to those needs.

²⁰ Government of Bangladesh, 1997, The Health and Population Sector Strategy.

²¹ Nilufar Ahmad, "Gender Equality in Sexual and Reproductive Rights and Health: A Case Study of Bangladesh", Draft, January 1998.

²² Johanna Schalkwyk, "Inventory on Mainstreaming Gender Equality in Bilateral Development Cooperation focused on Sexual and Reproductive Rights and Health, Agency Sub-Report: GTZ", Draft, January 1998.

Principle #7: Promote gender equality in strengthening national capacity

41. Capacity strengthening is needed in different places (e.g. government, NGOs, women's organisations) and at different levels (local, regional and national). Capacity needs to be developed for different kinds of activities: from policy development by national government and sector programmes to management and administration, human resources planning, service delivery, management information system, and support for authentic consultation with civil society. Capacity to refocus services to client needs and manage change at all levels is critical. There is a need to expose decision-makers at the highest level to gender equality objectives and dialogue with stakeholders. While all the projects examples reviewed, in some ways, try to strengthen national capacity, two initiatives which are described below illustrate how gender issues can be addressed in large programmes to strengthen national capacity.

42. **POLICY Project**²³: This USAID funded Project is a global initiative, which through support of different types of activities in different countries, is attempting to strengthen women's capacity to engage in policy dialogues. The Project's stated objective is to further the goals and recommendations of the ICPD through the promotion of a participatory policy process and the development and implementation of health policies responsive to clients' needs. The project has attempted to improve women's capacity to participate in the policy process, which is generally a male-dominated arena, through a variety of means, e.g. strengthening women's organisations and networks, research, training and advocacy. It has supported activities to promote women's political participation and move forward their agenda through the political process. It has supported dialogues not only on reproductive health issues but also on other issues, e.g. peace and political participation.

43. **Population and Health Consortium of Donors in Bangladesh**²⁴: Led by the World Bank, this successful example of donor co-ordination has been functioning in Bangladesh since 1976. Through successive projects the numbers of consortium members have increased and funding almost doubled. The current Fourth Population and Health Project (FPHP) has nine co-financiers e.g. AusAID, CIDA, Netherlands (DGIS), European Commission (EC), GTZ, Germany (KFW), Norway (NORAD), DFID, and Sida. The FPHP will disburse around \$780 million over its 7-year life span, with the Bangladesh Government providing about 40 per cent of the budget. The consortium functions to share information, build consensus and common policy platforms for donors, provide a mechanism for operational co-ordination, optimise comparative advantage of each donor, and streamline interactions between donors and government. Through the consortium of donors and the FPHP gender issues were institutionalised within the Bangladesh Government's health and population programmes. The project developed ten guidelines with indicators which include broadening the focus from reproductive health to all aspects of women's health; increased representation of women at all levels of the health system; gender equity in promotions; adequate accommodations for female field workers; and gender-disaggregated data. As a result of an affirmative action, employment of women in the health and population sector increased though more at the field level (at present 19 per cent of health and 37 per cent of family planning staff are women). A total of 78,000 TBAs were trained to provide services at the community level. The Ministry established a Gender Issues Office (GIO), and gender focal points in the two directorates of health and family planning to address gender concerns and to promote gender equality. A gender issues technical

²³ Rounaq Jahan, "Gender Equality in Sexual and Reproductive Rights and Health: A Case Study of USAID", Draft, January 1998.

²⁴ Nilufar Ahmad, "Gender Equality in Sexual and Reproductive Rights and Health: A Case Study of Bangladesh", Draft, January 1998.

group was formed comprising government, development partners and NGOs to monitor the progress of FPHP, and to facilitate mainstreaming of a gender equality perspective in the sector.

44. Several agencies are supporting regional and international networks to advocate women's health in particular in relation to ICPD and PFA. These initiatives e.g. Asian-Pacific Resource and Research Centre for Women (ARROW), Health, Empowerment, Rights, and Accountability (HERA), International Women's Health Coalition (IWHC), Latin American and Caribbean Women's Health Network, Women Living Under Muslim Law, draw on national experiences to inform international perspectives, they have the critical impact of building the confidence, self-esteem and competency of national NGOs in designing strategies and undertaking advocacy and programming at the national level.

4. ENABLING FACTORS

45. Several factors appear to facilitate the mainstreaming of a gender equality perspective in operations. The most important is redefinition of key existing concepts and tools. When existing concepts and tools for policy and programme development are redefined from a gender equality perspective, it facilitates mainstreaming in operations, e.g. the redefinition of such concepts as reproductive health to include family planning, maternal health, STDs, and other reproductive health needs; women's rights as human rights; and risk behaviour to include lack of knowledge and resistance of heterosexual women exposed to their partner's HIV/AIDS and STDs. Another important factor is a sexual and reproductive rights-based approach to policy/programme/project development. When women's rights are clearly recognised, the impact of unequal gender relations on health are addressed. Other enabling factors include the following:

- Support to local initiatives involving local expertise and experience, and implementation in partnership with local organisations.
- Mandatory use of social and gender analysis in policy, programme, project development, monitoring, and evaluation.
- Consultative team approaches combining expertise from inside and outside the agency, and technical as well as gender perspectives.
- A process of internal reflection and capacity building within donor organisations and their counterparts to promote gender equality.
- Proactive steps in identifying local opportunities and giving space for their development.
- Concrete steps to overcome obstacles to equal access and empower women towards equal participation.
- Democratisation of health system management, such as listening to people, accountability, and transparency.
- Inter-sectoral/multi-sectoral actions in education, employment, legal rights, and participation to address gender equality.
- Supportive processes in programme/project development and implementation such as time and flexibility, and consultation and participation.
- Adequate and flexible funding to support advocacy, innovation, and process focused activities.

5. GAPS AND CONSTRAINTS

46. As noted earlier in section two, the study found some gaps and constraints common to many of the agencies in mainstreaming a gender equality perspective into sexual and reproductive rights and health programming. These are briefly discussed below, although it should be noted that not all of these gaps and constraints apply equally to all agencies.

POLICY: Although all agencies refer to gender equality and women's empowerment in various documents, only a few agencies have come forward with policies and strategies that explicitly make gender equality a central concern in sexual and reproductive rights and health. Similarly, only a few agencies have developed their own policy/strategy documents to address health and population in an integrated manner with a strong human rights-based approach. Strategy documents of some agencies make contradictory statements, for example acknowledging on the one hand the need to reduce maternal mortality, and on the other not offering assistance for work on abortion, even though unsafe abortion is a major cause of maternal mortality/morbidity in the world. In agencies that lack strong internal policy/strategy support, there is a risk that only a few personally committed staff take the initiative to develop programmes/projects in line with the ICPD and PFA agreements. The mainstreaming of gender equality is dependent on the commitment of individual staff members.

PRACTICE: Even in cases where there is an articulated policy and strategy, there is frequently a disjuncture between policy and practice. This disjuncture arises for a variety of reasons. Many agencies have not developed either tools or processes to raise staff awareness and competence around ICPD and PFA agreements. Awareness and competence is lacking both within agencies and in partner organisations. Capacity building initiatives generally promote capacity development of health systems and tend to overlook building capacity to address gender issues. Additionally, methodologies to address gender equality in new areas of major programmes, such as sector programmes, are yet to be developed. Gender indicators are not routinely integrated in Logical Framework Analysis (LFA) and Annual Programme Review (APR), two critical tools used in programme and project design and monitoring including sector programmes. As a result, notwithstanding the agency mandates for change, it is often difficult for geographical/operations staff of agencies, who generally work under time constraints, to seek opportunities to reorient programmes and projects. Additionally, some staff are opposed to change. Policy/strategy documents, thus, may have limited influence on operations. Indeed, the innovative initiatives identified by this study by no means represent the mainstream of these agencies' operations. They are generally small-scale initiatives whose impact on the ground or on the agencies' mainstream operations is yet to be evaluated.

PERFORMANCE: Agencies are increasingly emphasizing the importance of monitoring results and the impact of their operations. This is a positive development. However, performance indicators of most agencies are generally biased towards quantitative measures. Qualitative indicators of inputs, outputs and outcome, particularly of gender equality are not well developed and more work is needed in this area. Agency staff is not rewarded for promoting gender equality objectives. Additionally, though agency documents talk about qualitative goals and factors such as consultation and participation, in reality agency rules and procedures generally are still not conducive to qualitative process-focused initiatives, which take time and need flexibility. Most agencies require predetermined inputs and outputs in programme/project design, which can inhibit authentic consultation and participation.

PARTNERSHIP: Although all agencies are emphasising partnership building and stakeholder consultation and participation, policy dialogues still tend to be limited primarily to the donors and the counterpart governments. Civil society groups in general and women's organisations in particular, are often marginal to the process of consultation and dialogue. Similarly, efforts to build partnership with men are limited.

6. PRIORITY ACTIONS

47. To achieve both the quantitative targets and qualitative objectives of the DAC *21st Century Strategy's* goals, the development partners need to take a much more proactive role. Concerted actions are needed on many fronts. Based on the agencies' own reporting of their positive experiences as well as gaps and constraints, this study recommends the following:

Bridge the Gap between Policy and Practice: The agencies have generally made progress in developing policy and strategy documents, tools and methodologies, and even some innovative operational projects but on the whole, there is a major gap between policy and practice. This is due to a variety of factors, e.g. lack of understanding and capacity; inadequacy of tools, processes, and resources; insufficient consultation with and participation by local communities and civil society groups including women's organisations; and failure to take concrete steps to reduce gender inequality and empower women. To bridge the gap between policy and practice the agencies need to:

- Use policy dialogue with development partners creatively to build consensus around the centrality of gender issues. This can be done by expanding partnership with civil society groups including women's organisations.
- Take initiatives to empower women to participate in and monitor policies, programmes and projects, including specific actions in general health programmes and projects. This can also be facilitated by providing support to women's advocacy groups and networks.
- Support development and implementation of programmes and projects in response to local needs and in consultation and partnership with local organisations including women's organisations.
- Promote cutting-edge work such as redefinition of concepts and tools and innovative projects. Smaller agencies that are not involved in major operational programmes could consider concentrating their assistance on such innovative work.
- Facilitate the sharing of positive examples and lessons learned on addressing gender equality within agencies and with partners.
- Support capacity development of the staff of agencies and their partners to use existing tools and methods. This can be done by participatory training as well as through dialogue and consultation with the experts and civil society.
- Support the development of methodologies to address gender issues in new tools that are being used to design and monitor major programmes such as sector programmes e.g., Logical Framework Analysis, Performance Review and Stakeholder Analysis and Participation.
- Facilitate initiatives to build partnership with men.
- Promote the development of qualitative and process-oriented indicators of inputs, outputs and outcome for programme design, monitoring and evaluation.
- Ensure adequate funding for innovative and advocacy work. This can be done by increasing the women-specific funds in agencies as well as by the utilisation of general funds which are earmarked for promotional work.

Review the State of Implementation of ICPD and PFA Commitments Preparatory to ICPD Plus Five: Countries and multilateral agencies are planning a series of activities to mark ICPD Plus Five. International and national women's organisations have also undertaken a number of initiatives to review the implementation of ICPD. Bilateral development co-operation agencies need to:

- Support the initiatives, particularly by the national women's advocacy groups to assess the implementation of ICPD, nationally and internationally.
- Organise full-scale evaluations of bilateral development co-operation agencies' own progress in implementing the ICPD commitments.
- Use the review process to raise awareness and build competence about the gender equality issues at the local, national and international levels.
- Promote dissemination of information about good practices and lessons learnt.

Follow up on DAC 21st Century Strategy: The *DAC 21st Century Strategy* sets the broad goals and directions of future work for the member organisations. In the area of reproductive health it has set quantitative goals for reduction of maternal mortality and increased access to reproductive health services. Gender equality is critical to achieving these goals. This study provides an analytical framework to understand gender equality in sexual and reproductive rights and health; identifies good practice principles and documents a number of positive and innovative initiatives from the work of DAC Members to illustrate these principles. However, the study also shows that the development co-operation organisations and their partners have a long way to go in mainstreaming a gender equality perspective. This study creates the foundation for future monitoring of progress and sharing of information amongst development agencies and their partners. Follow up work is needed to:

- Create a mechanism for regular sharing of information about good practices and lessons learnt in promoting gender equality in health.
- Develop a framework around gender equality and health for use in the DAC peer review process.
- Organise a follow-up to ICPD by the DAC to review DAC Members' progress in implementing the ICPD recommendations.

ANNEX 1

Selected Examples of Positive Initiatives

AusAID -- Australia

Guide to Gender and Development: a project planning and management tool

The Guide is designed to assist AusAID staff and contractors with assessment, appraisal and implementation of gender equality perspectives through the activity management cycle. The Guide includes sets of questions for project cycles and 11 sectoral areas to ensure that women's and men's needs are not overlooked in any aspect. The questions on health and population, one of the sectoral areas, cover the gender division of labour in health care, access and control of resources, decision making, benefits, project impacts and women's social status and roles as decision makers. Social and gender specific processes which determine health status are examined, including women's and men's roles and responsibilities in health promotion and care. The Guide has a gender and development approach, focusing on gender equality and gender relations, rather than focusing exclusively on women. The questions direct users of the Guide to consider both male and female needs and participation, although it does note that due to the lower status of women, promotion of gender equality requires specific attention to women's needs.

Kadavu Sub-Division Rural Health Project, Fiji: gender equality and community development

A three-year project, with a total funding of A\$7.1 million, began in July 1994 to improve both primary and secondary health care delivery systems provided by the local Kadavu hospital. The project consists of three components: community development, human resource development (targeting Ministry of Health and community members); and infrastructure, equipment and services. Villagers were encouraged to establish health committees and to have representatives on District Health Committees. Courses were provided for Village Health Workers (VHW) and Environmental Health Workers (EHW). VHW courses started out with only women participants, but by the end of the project, men were attending in almost equal numbers. Due to the chiefly system on Kadavu, women are unable to take part in public discussions. AusAID managed to incorporate the needs of women over time in a non-threatening way, by recognising traditional expectations as well as understanding the needs of women. The project's strategies for addressing gender equality issues were indirect, rather than direct. Women were trained (as VHW) prior to men (EHW), which was an effective strategy in that it noted, and made evident to the whole community, women's knowledge and potential for significant community contributions.

CIDA -- Canada

Safe Motherhood Asia: A Ten Country Consultation Workshop on Lessons Learned, Ujung Pandang, South Sulawesi, Indonesia, 1997

A Ten Country Asian consultation on safe motherhood was organised by CIDA in collaboration with UNICEF in Indonesia in 1997 to gain a better understanding of what constitutes a functional safe motherhood system. As safe motherhood is a major component of CIDA's Basic Human Needs programming priority, the workshop was organised to share lessons from what is known about what works and what does not work in safe motherhood programmes. The workshop primarily focused on examining the immediate causes of maternal mortality and came to the conclusion that the adequate capacity of the

health system, while an essential ingredient for safe motherhood, is by itself insufficient to substantially reduce the number of maternal deaths in Asia. Cultural, social and economic factors play a significant role in determining whether a women receives the care she needs. The workshop identified three major components of a functional safe motherhood system: (1) the family and community representing the demand side, (2) the health service system (facilities and personnel) representing the supply side, and (3) the agents (traditional birth attendants and trained community midwives) linking the supply side with the demand side. In small group meetings, the workshop participants were able to share experiences and draw lessons about successful and unsuccessful strategies and interventions. The final report of the workshop findings was produced in a highly readable format and widely disseminated by CIDA.

DANIDA -- Denmark

Sexual and Reproductive Health (including maternal health) Programme Support

DANIDA supports various countries in reproductive health activities. Reproductive health constitutes a considerable part of the health sector assistance in India. In Madhya Pradesh, which has one of the highest maternal mortality rates in India, DANIDA advocated an increase in the number of female staff and improvement of the status of female health workers. In Bhutan, reproductive health is supported with a focus on the prevention of STDs and AIDS, and information campaigns on family planning and mother/child health care. The five-year family life and training programme in 14 localities in Kenya (1994-99) incorporates a range of sexual and reproductive health activities. The programme consists of the following components: cultural specific strategies (specifically aimed at vulnerable groups of women and children) to improve health at the local level; culturally adapted IEC for health workers and target groups; and maternal health, prevention of STDs, including HIV/AIDS, and family planning. A number of initiatives have been taken to assist national governments in improving the education of health workers. In Uganda, DANIDA is funding efforts to extend the curricula of basic education for nurses and to give priority to midwives in order to improve maternal health. DANIDA has also insisted on equal representation of males and females from different staff categories and emphasised equal representation of men and women on national, regional, and sub-regional health boards. Upgrading female health workers' status is considered essential by DANIDA. Low status often results in lack of interest in quality of care by personnel.

DFID -- United Kingdom

Tools and Guidelines to Assist Civil Society Organisations in Monitoring Health Services

Through a project in Kenya in 1995 to monitor the quality of provision of Depo Provera from both a clinical and client's perspective, a framework for undertaking rapid monitoring of clients' perspectives through using exit interviews with clients of public and private sector services was developed. A key finding was the discrepancy between clients' and providers' perceptions of quality of care issues and appropriate client-provider communication. From this work, DFID developed an initial set of guidelines - checklists for social appraisal at project design stage for participatory design and monitoring of reproductive health programmes. Having developed this tool, DFID is now working (through contracting the Centre for Development Studies, University of Swansea) in the field in Bolivia on methods to assist NGOs in particular, to undertake analysis of the social contexts of sexual and reproductive health as a basis for design and monitoring. They are also investigating how data from this social analysis can be fed back to facilitate institutional change within health services to enable them to more effectively meet women's, men's, and young people's sexual and reproductive health needs as defined within the local context.

GTZ -- Germany**Technical Network on Reproductive Health**

The Technical Network on Reproductive Health was established by the GTZ Division for Health, Population and Nutrition in 1995 as one of several networks to facilitate the exchange of ideas and information between headquarters technical staff and field/project staff. The objective of the Technical Network is to: improve the quality and sustainability of Reproductive health Programmes; promote the efficiency of the participating projects; and reduce learning time and cost for new projects. Members of the Technical Network meet at the annual "summer workshop" of the division in Germany or other workshops or activities related to reproductive health that are funded through participating projects. The possibility for continuous exchange is also facilitated by e-mail and Internet, and several groups (not limited to GTZ projects) have been established. Six priority areas have been identified by the Technical Network as critical to the improvement of reproductive health and are being further explored by sub-groups: quality of services, adolescents, single adults, marginal groups, gender relations, and programme integration.

Irish Aid**Urban Maternity Clinics in Lusaka, Zambia**

Supported by Irish Aid since 1983, the project established a network of nine maternity clinics providing efficient, safe and convenient (close to home) maternity services for women from the poorer areas. The project built capacity to provide obstetric care services at health centres and first referral facilities. Inputs included technology, money for infrastructure, training and referral commodities--including radio communication to call ambulances. There was a significant increase in utilisation of safe services. The clinics now cover approximately two thirds of all births in Lusaka urban district. Health education and financial responsibility has been transferred from Irish Aid to the government. STD/HIV and family planning are also incorporated in the services. Irish Aid is planning replication of similar projects in rural areas.

Bangladesh Case Study**Reproductive Health Strategy**

Historically in Bangladesh, Maternal and Child Health (MCH) programme lacked a comprehensive approach. MCH services included only obstetric care provided by urban-based hospital and maternity centres. However, after the ICPD, it was realised that improving reproductive health including family planning is essential to human welfare and development. The Bangladesh Government started the process of developing a reproductive health strategy based on the ICPD and PFA agreements and the lessons learned from the country's own family planning programme. To formulate the strategy, the government organised a workshop with participation from a wide group of stakeholders e.g. government officials, NGOs, and women's organisations. The Bangladesh Government's reproductive health strategy highlights (1) user participation in the planning, implementation and monitoring of the services, (2) demand-oriented programme planning, (3) adolescent needs, (4) life cycle approach, (5) availability and access of quality service, (6) integrated health and social policies addressing human development and education of girls, (7) violence against women, and (8) enforcement of relevant laws.

ANNEX 2

Terms of Reference of the Report

Terms of reference for an inventory of mainstreaming gender equality in bilateral development co-operation focused on sexual and reproductive rights and health, including maternal health carried out by Sida for the OECD/DAC Working Party on Gender Equality

Background

The OECD/DAC's *21st Century Strategy* was adopted at a High Level Meeting in 1996. The DAC Working Party on Gender Equality agreed to carry out inventories on mainstreaming gender equality in some of the key goals established in the *21st Century Strategy* - poverty, health, education, environmentally sustainable development. Canada undertook to carry out substantive work on poverty. UK volunteered to work with health, together with Sweden. UK will focus on maternal mortality while Sweden will cover sexual and reproductive health. Sweden agreed to carry out an inventory on education. At a later stage Sweden also undertook to work on environment since Sweden was the Chair of the Working Group on Environment.

For each of the three areas - education, environment and sexual and reproductive rights and health - an initial inventory was carried out through a questionnaire distributed by the Gender Equality Group. After an initial analysis of the responses within Sida, the decision was taken to commission teams of consultants to continue the work in the different areas. One team of specialists for environment, one for sexual and reproductive rights and health and one for education. Each team will have a team leader responsible for compiling the overall report which will summarise the findings and make concrete recommendations.

The United Kingdom also carried out an initial questionnaire inventory on maternal mortality. It was agreed that the consultancy team commissioned by Sida to carry out a more in-depth study should include maternal mortality in their work.

Objective of the inventory on sexual and reproductive rights and health, including maternal health

The objective of the inventory is to document the efforts made by bilateral development co-operation agencies to mainstream gender equality perspectives in their work on sexual and reproductive rights and health, including maternal mortality - both policy development and dialogue as well as project and programme development. Best practices should be identified and illustrated, particularly in relation to practical methodologies and tools. Potentials/opportunities as well as constraints should be identified.

The main focus of the inventory is bilateral donor agencies. However, contact needs to be taken with the major multilateral actors in each area to gain access to relevant information on policies, strategies, methodologies and tools. It will be the responsibility of the team leader to ensure that there is adequate focus on multilateral agencies.

In addition to the initial work of DAC Members attention should be given to the implications for implementation of the DAC *21st Century Strategy*.

The inventory should give some attention to the manner in which the Beijing Platform for Action is utilised for operational guidance as well as the more specific international agreements made at the Cairo conference on population.

Work tasks

The work involves desk study of documents, visits to donor agencies, one in-country assessment and preparation of sub-reports and an overall report. The work will be comprised of the following steps:

- i) analysis of results of initial questionnaire and preparation of additional questionnaires for more in-depth interviews;
- ii) more in-depth interviews - by telephone or by visits to donor agencies;
- iii) one in-country study of donor efforts and co-ordination by one team member;
- iv) preparation of sub-reports on results of interviews;
- v) study of 21st century strategy and implications of the inventory for this work;
- vi) preparation of an overall report.

The teams should meet twice. The first meeting should be at the commencement of the inventory to agree on a common methodology framework and prepare "terms of reference" for the sub-reports on donor agencies and the in-country study. The second meeting should be held when all the sub-reports have been prepared. This meeting will draw out the main conclusions for the overall report and discuss the implications for the internal work of DAC Members, and the implementation of the 21st Century Strategy.

i) Analysis of initial questionnaire responses and preparation for more in-depth interviews

The team will analyse the responses to the initial questionnaire sent to donors and study the materials provided - policy and strategy documents. Additional questions will be prepared for further interviews. Additional materials will be obtained directly from donor agencies as necessary.

ii) Visits to donor agencies

A number of donor agencies should be identified for visits to obtain more in-depth knowledge and materials. The responsibility for these visits should be divided between the members of the teams. The individual team members should produce separate sub-reports on the donor agencies studied in depth. (See the attachment for the division of responsibilities). The main discussions should be held with sector specialists rather than gender specialists. That is, discussions should not be held with central gender offices but with programme officers dealing with the sexual and reproductive rights and health, including maternal health. Gender specialists will need to be consulted and kept well informed.

iii) Country level assessment

One in-country study (Bangladesh) should be carried out to assess the mainstreaming of attention to gender equality by all donors active in the sector. Ministries and NGOs should also be consulted in this study. Potentials, constraints and best practices should be identified.

iv) Preparation of sub-reports

All team members should prepare separate reports on the findings of their desk studies and interviews. These reports will not be published but will be made available to the participating organisations for internal use.

v) Study of the implication for the 21st Century Strategy

The team leader should have the main responsibility for studying the 21st Century Strategy and for leading discussion of the implications and possible recommendations.

vi) Preparation of an overall report for submission to Sida

A team meeting should assess the sub-reports and make recommendations for changes before the final versions are produced. The implications for internal DAC Member work, for the implementation of the 21st Century Strategy should be discussed. An outline for the overall report should be agreed upon. Drafts of the overall report should be submitted to all team members for comments before the draft is submitted to Sida.

List of team members and division of responsibilities.

Rounaq Jahan	Team Leader, CIDA, USAID.
Nilufar Ahmad	Bangladesh case study
Juliet Hunt	AusAID, NZODA
Barbara Klugman	DFID, Irish Aid, Sida
Johanna Schalkwyk	BADC, GTZ
Margrethe Silberschmidt	DANIDA

ANNEX 3

Selected List of Agency Documents

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