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Evaluation of DFID Development Assistance: Gender Equality and Women's Empowerment

Phase II Thematic Evaluation: Maternal Mortality

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Foreword

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PERFORMANCE AND KNOWLEDGE SHARING

DFID recognises gender equality and the empowerment of women as essential both for the elimination of world poverty and the upholding of human rights. Since 1985, we have worked to support this area, as laid out in our Strategy Paper[1].

In 2005, the international community will consider progress towards the Millennium Development Goals (MDGs). Many of the hardest-to-reach MDGs are related to gender. Two examples are the goal to reduce deaths in pregnancy and childbirth, which are still unacceptably high, and the goal to increase girls' education, which has been shown to have many positive knock-on effects including on child health and on economic growth.

2005 also marks the 10th anniversary of the Beijing Declaration and Platform for Action. World leaders will be meeting in March to consider progress towards the goals identified in Beijing.

As a contribution to this renewed effort, DFID is currently conducting an evaluation of its policies and practice on gender equality and women's empowerment. The evaluation will provide independent and systematic evidence of the effectiveness of DFID's contribution to international gender equality goals. It will draw lessons from experience to inform our future strategy.

This is one of a series of working papers produced in preparation for the main evaluation. These are rapid reviews and provide indicative evidence on eight thematic areas of DFID's work:

- Voice and Accountability;
- Maternal Mortality;
- Gender Violence;
- The Enabling Environment for Growth;
- Education;
- Conflict and Post Conflict Reconstruction;
- HIV and AIDS; and
- Migration.

Any feedback on this paper should be addressed to Jo Bosworth in Evaluation Department.

[1] Poverty Elimination and the Empowerment of Women. This is currently being reviewed and updated.

Acknowledgments

I would like to thank DFID UK and country staff who contributed to this thematic evaluation, often at very short notice. I am also grateful to Eloise Glew of Options Consultancy Services for assisting with statistical analysis, report formatting and providing administrative support. Thanks also go to the consultants working on other thematic evaluations for sharing their thoughts and ideas, in particular my colleague Rachel Grellier who I worked with closely in developing the framework for this piece of work.

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Definitions of Key Terms

Gender Equality

Women having the same rights and opportunities in life as men, including the ability to participate in the public sphere.

Women's Empowerment

A process of transforming gender relations through groups or individuals developing awareness of women's subordination and building their capacity to challenge it.

Gender Mainstreaming

A strategy to ensure that women's and men's concerns and experiences are integral to the design, implementation, monitoring and evaluation of all legislation, policies and programmes in any area and at all levels.

Twin Track Approach

DFID's strategy combining focused actions aimed at women's empowerment and gender-aware actions in the mainstream of development work.

Evaporation

When good policy intentions fail to be followed through in practice.

Invisibilization

When monitoring and evaluation procedures fail to document what is occurring 'on the ground'.

Resistance

When mechanisms are used to block gender mainstreaming based on 'political' opposition (itself embedded in unequal gender power relations) rather than on 'technocratic' procedural constraints.

Sources: Adapted from Reeves & Baden (2000); Moser et. al, (2004); DFID (2000); and Darbyshire (2002).

Executive summary

Focus of evaluation

S1 This evaluation report provides a short description of key issues in relation to maternal mortality and gender equality, a brief summary of international and DFID policy on maternal mortality reduction and associated gender issues, and comments on the extent to which key objectives of DFID's gender policy commitments are incorporated in the design, implementation and monitoring of DFID's maternal health investments.

The challenge

Every year over half a million women die as a result of complications of pregnancy, childbirth and unsafe abortion. Millions more survive but suffer ill health and chronic disability. Poor maternal health also limits the newborn's chance of survival and a mother's death can have a catastrophic impact on family livelihood, contributing to increasing poverty and poor human development. Nearly all of this burden of death and disease and up to 70% of newborn deaths could be averted through improved maternal health and care.

The high burden of maternal death and disability can be interpreted, in itself, as evidence of gross gender inequality and the low value placed on women's lives and survival. In households and communities, unequal access to resources and decision making power contribute to early marriage, poor maternal nutrition, and delays in accessing emergency obstetric care. In institutions and health systems, gender discrimination in the workplace makes it difficult to ensure adequate numbers of female doctors and midwives available to provide culturally acceptable care. At policy making and national levels, key legislation protecting women's rights (such as age of marriage, prevention of female genital mutilation (FGM), safe legal abortion) impacts on maternal health outcomes.

Relatively common and well understood obstetric complications (e.g. bleeding) lead to most (80%) maternal deaths and contribute to high levels of morbidity. All pregnant women are at risk of and about 15% will suffer a life threatening complication. Onset is frequently sudden and cannot be predicted in advance (e.g. through antenatal care). These women require immediate access to quality emergency obstetric care provided by a skilled professional (midwifery and/or medical). Reducing the number of unplanned pregnancies (e.g. increased access to family planning, increased age at marriage) would also decrease the numbers of women dying and injured; where legal ensuring access to safe comprehensive abortion care is critical to prevent death due to complications of illicit abortion.

Approach and methodology

S2 A framework, based on the Canadian International Development Agency (CIDA) Framework for Assessing Gender Equality Results, was developed for this evaluation in order to capture key elements of DFID's gender mainstreaming activities across the dimensions of decision making, rights, and access to resources. The framework also allowed for tracking of interventions across the development of a programme of work from design to monitoring and evaluation. A sample of case study interventions was then assessed against this framework, on the basis of intervention documentation backed up by email, telephone or face to face interviews with key informants.

Key findings

S3 The key findings are:

- DFID's expenditure on maternal health interventions has increased substantially since 1995, as has the level of expenditure on gender within maternal health programmes. Over two thirds (67%) of all maternal deaths take place in just 13 countries. Twelve (half of which are fragile states) of these are key countries for the 2005–8 Public Service Agreement (PSA) and most have either specific maternal or reproductive health programmes or health sector wide programmes. DFID also supports maternal health programming in some smaller countries that have very high maternal mortality ratios (e.g. Malawi). This provides opportunity to influence achievement of the maternal health Millennium Development Goal (MDG) and gender mainstreaming strategies in these challenging and globally critical settings

- DFID is unique among bilateral donors in having produced a clearly articulated strategy paper, and given significant intellectual time and energy to think through how to scale up maternal health programming using a rights based approach (that includes gender and diversity dimensions). The emerging challenge is to ensure wide dissemination of this work and to facilitate its adaptation for and incorporation in country led processes at national (e.g. poverty reduction strategies) and sector (e.g. health sector plans) levels

- the longer preparation processes and in-depth engagement with national governments and other partners inherent in new aid mechanisms such as sectoral and general budget support, is providing an opportunity for early engagement on sensitive issues such as gender discrimination. World Bank design processes, now frequently being used by DFID, provide more space to focus on such issues than traditional DFID 'project' design processes would have.

Key recommendations

S4 The main evaluation should consider a number of cross-cutting and theme-specific issues identified during the course of this study, including:

- maximising the potential to influence working processes and priorities of external development partners (EDPs). Gender mainstreaming strategies are being

marginalised as DFID country programmes harmonise with and align their policies and procedures with those of other partners. It is timely to explore alternative approaches to influencing inclusion of gender mainstreaming within national poverty reduction strategies that donors are aligning investment with

- identification of best practice emerging from gender mainstreaming within Safe Motherhood projects and programmes over the past decade, their impact on gender equality and/or empowerment, and how these strategies can be adapted for use within newer aid modalities (e.g. budget support)

- exploring the perception (on the part of advisers) that there is resistance to gender mainstreaming at a senior management level in DFID. How can this be constructively addressed to increase commitment in the future?

1 Introduction

1.1 DFID is committed to challenging and ending gender discrimination throughout its policies and programmes, and recognises that this commitment is a precondition to achieve the Millennium Development Goals (MDGs). DFID's policy is reflected in the Target Strategy Paper (TSP) 'Eliminate Gender Equality and Empower Women' (DFID 2000a), that outlines a twin track approach to gender mainstreaming through promoting **gender equality** and facilitating the **empowerment of women** (see box 1).

Box 1 DFID strategy to eliminate gender inequality and empower women

DFID launched its TSP 'Poverty Elimination and the Empowerment of Women' in September 2000. The purpose of this strategy is 'to ensure that women's empowerment and gender equality are actively pursued in the mainstream of all development activities' (p 9), through focusing on the achievement of 10 objectives.[1] The report states that 'future work will concentrate on supporting fundamental changes in policy, laws and attitudes while maintaining strategic links with work at the grass roots'. This is to be achieved through three channels: support to government, civil society and the private sector; collaboration and co-ordination with other development partners and through strengthening DFID's internal capacity.

One of the TSP's 10 objectives 'to further close gender gaps in human development, particularly education and health' and gives 'development of policies and programmes to support achievement of the International development targets (IDTs) for maternal mortality and access to reproductive health services' as an example of an action toward the objective (p 29). This illustrates how investment in reducing Maternal Mortality Rate (MMR) and increasing access to SRH services is seen, in its own right, as a means of improving gender equality and empowering women. This report explores how these aims are maximised through the way in which DFID identifies, designs, implements and monitors such investment. Equally the objectives are interdependent and the review will allow opportunity to see how other objectives are addressed through DFID's work to improve maternal health.

1.2 This report, produced by Sandra MacDonagh, Options Maternal and Newborn Health Specialist, presents the outcome of a thematic review of gender mainstreaming in DFID investments to lower maternal mortality (LMM). It is one of eight[2] thematic evaluations conducted over a 30 day period during December 2004 – February 2005. These evaluations are a part of a larger; two phase gender evaluation being conducted by DFID's Evaluation Department. A key aim of the thematic evaluations is to test methodology and propose hypotheses to inform a larger systematic evaluation.

[1] To promote equality in rights for women and men through international national policy reform; to secure greater livelihood security, access to productive assets and economic opportunities for women as well as men; to further close gender gaps in human development, particularly education and health; to promote the more equal participation of women in decision making and leadership roles at all levels; to increase women's personal security and reduce gender-based violence; to strengthen institutional mechanisms and national machineries for the advancement of women in governments and civil society; to promote equality for women under the law and non-discrimination in access to justice; to reduce gender stereotyping and bring about changes in social attitudes in favour of women; to help develop gender aware approaches to the management of the environment and the safeguarding of natural resources; to ensure that progress is made in upholding the rights of both girls and boys within a framework of the Convention of Rights of the Child.

[2] The other seven themes are: HIV/AIDS, Education; Enabling Environment, Voice and Accountability, Gender Violence, and Migration and Conflict.

1.3 The report contents follow the objectives outlined in the consultants Terms of Reference (ToRs) (available from DFID Evaluation Department). The next section describes the methodology used for this rapid review. Section three outlines the links between maternal mortality (see box 2 for a brief overview of maternal mortality), sexual and reproductive health and rights (see box 3 for a definition of Sexual and Reproductive Health and Rights (SRHR) and gender; as well as providing insight to international policy objectives for LMM. Section four, describes the evolution of DFID policy and knowledge in maternal health and its links with policy on gender equality. Section five contains three case studies of how gender mainstreaming has been approached by DFID in India, Cambodia and Nigeria. An overview of financial commitment and expenditure in maternal health since 1995 is also provided. Conclusions are drawn in section six and finally, section seven provides suggestions for the systematic evaluation.

Box 2 Maternal mortality – a brief overview

Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy (by any cause e.g. childbirth, abortion) from any cause related to or aggravated by the pregnancy or its management, but not from incidental causes (e.g. a landmine accident). Globally most maternal deaths (80%) result from one of five common obstetric complications: bleeding (25%); infection (15%); complications of unsafe abortion (13%); pregnancy-related high blood pressure (12%); and prolonged or obstructed labour (8%). All pregnant women are at risk of these common complications, and about 15% will be affected by a complication during the course of pregnancy and childbirth. Remaining deaths are due to underlying conditions that are exacerbated by the pregnancy e.g. malaria or HIV infection.

There are three major intervention points at which health services can be provided to LMM. Firstly, preventing unwanted or mistimed pregnancy e.g. through access to family planning. Secondly ensuring safe management of unwanted pregnancy through the provision of safe and accessible abortion care services. Thirdly, preventing death from a complication through ensuring access to a skilled birth attendant (a person with midwifery skills), backed up by a functioning referral system to quality emergency obstetric care (EmOC).

The services are well understood. However there has been a lack of progress in ensuring provision of equitably accessible quality evidence based service provision. Reason for this lack of progress include: inadequate international profile, insufficient commitment by leader, historic absence of clear focus and consensus around the most effective approach, a failure to prioritise maternal health in either health of development strategies, persistent gender inequality, and the broader challenge of ensuring access to functioning health services (drawn from DFID's strategy for maternal health).

Box 3 Defining sexual and reproductive health and rights (from International Conference on Population and Development (ICPD) Programme of Action)

Para 7.2: 'Reproductive health is a state of complete physical, mental and social wellbeing... in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so... It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to preproduction and sexually transmitted diseases.'

Para 7.3: '...reproductive rights embrace certain human rights that are already recognised in national law, international human rights documents... These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so and the right to attain the higher standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human right documents... As part of their commitment full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality... '

2 Methodology

2.1 In developing a framework for this review the consultant[3] reviewed the methodology used in previous gender evaluations (CIDA 2003, Ellis 2004, Braithwaite et al 2003). Drawing on this, and bearing in mind the time and resource constraints to this work, an evaluation framework was developed. This framework, presented overleaf, focuses the evaluation on identifying 'result' areas related to gender equality and empowerment (see column one: decision making, rights and access to resources and the benefits of aid), and tracks the gender mainstreaming interventions/strategies across the development of an investment/programme of work (see row 2).

2.2 In discussion with Policy Division and the Gender Study Group three countries were selected as case studies: Cambodia, India and Nigeria. Using the data sheets provided by DFID Evaluation Department (prepared by DFID Statistics Department specifically for this work), all investments with a 'P' marker for Maternal Health in Cambodia and Nigeria were identified for review. These investments are outlined in table 1 below. In India Reproductive and Child Health II (RCH-II) (no. 149555097) was the chosen case study.

Table 1 Investments, selected for review, with a 'P' Policy Information Marker System (PIMS) marker for maternal health

Country	DFID project key	Project title
Nigeria	048555048	United Nations (UN) MDG Support
Nigeria	048555037	PATHS
Nigeria	048555040	Insecticide Treated Nets
Nigeria	048680014	Pilot Project on Women's Health and Development
Cambodia	144555010	Reproductive Health/Family Planning &Sexual/Health
Cambodia	144555011	Health Sector Reform 3
Cambodia	144555016	Health Sector Support
Cambodia	144615023 & 144615024	Battambang De-mining

Using the framework as a guide; two 'instruments' were used during the evaluation:

- tracking gender mainstreaming and evidence of results through intervention documentation. Initial documentation was identified on the Performance Reporting Management System for Management (PRISM) by DFID Evaluation Dept for Cambodia and Nigeria and via the RCH-II website for India; subsequent data was suggested by and sourced from informants (appendix 3, see contents page)
- interviews (appendix 4 – see contents page) with key informants within DFID.[4] These interviews were used to explore, in more depth, the strategies used for gender mainstreaming and to identify activities, interventions and results that may not be articulated in written documentation. In addition factors that enabled or constrained gender mainstreaming were explored.

[3] This work and development of the framework was jointly undertaken by Sandra MacDonagh and Rachel Grellier Social Development Specialist, Options. The framework is also being tested in the HIV/AIDS thematic review (by Rachel).

[4] The intent was to interview a wider range of people. Due to time constraints this was not possible.

Table 2 Evaluation framework (dimensions of equality and empowerment from CIDA 2003)

		Mainstreaming			
		Identification	**Design**	**Implementation**	**Monitoring and evaluation (M&E)**
Equality & EMPOWERMENT	**Decision making:** • Capacity for public participation • Representation among decision makers • Household & individual decision making	• *Need identified?* • Is reference made to international/DFID policy/goals/targets? Are key gendered problems highlighted at this stage both in relation to the dimensions (decision taking/rights/access to resources) and to 'levels' e.g.: • At household level in relation to accessing care (decision making, access to resources) • At community/facility level in relation to provision of skilled attendance • Within the health system and policy making arena's	• *Need identified and reflected in the design?* • Has an analysis of gender dimensions, necessary to inform investment design been made? • Does the analysis and design reflect priority given to international/DFID policy/goals? • How is the interface between gender and other aspects of social exclusion/vulnerability addressed? • Are specific budget lines allocated to address gender issues? • Are other resources allocated re gender? Does the situation and risk analysis take account of key gendered problems in relation to: • Each of the dimensions (decision making, rights, access to resources) and • At different levels of programming i.e. household/community; facility; health system; policy.	• *Deeper understanding of need pursued and responded to?* • In what ways has gender mainstreaming reflected in investment/programme policy, strategy and activities? • Are some dimensions (decision making, rights, access to resources) given more priority? Why? • Are gender issues given more priority at some levels (e.g. household vs. facility)? Why? • Is manner of implementation explicitly linked to international/DFID policy/goals? • How have any resources allocated specifically for gender (financial/other) been used? • Have the approaches taken influenced other donors/strategies in country/ regional and/or international levels? • What have been the enabling and constraining factors to addressing gender dimensions of maternal mortality programming?	• *Need reflected in the M&E framework and reviews?* • Is gender 'transparent'? • Do reported results tie in with international/DFID policy/goals? • Evidence of change/ progress/ results within the dimensions of decision-making, rights and access to resources? • Evidence of change at different levels (community/household; facility, health system)? • Evidence of impact in pursuit of reducing maternal mortality? Can progress be attributed to interventions related to gender issues? • Evidence of influence on the way in which others perceive and address gender issues e.g. government, civil society, and private sector? • Evidence of linking between gender and other aspects of social exclusion/ vulnerability? • Evidence of linked impact on poverty reduction? • Evidence of increased political/high-level commitment/scaling up?
	Rights: • Legal system • Public awareness • Response to gender-specific rights violations				
	Access to resources & benefit of dev'ment • Livelihoods & productive assets • Institutional capacity • Policy & programme change				

3 Background

3.1 Maternal mortality, gender and SRHR

Box 4 Maternal Mortality and Poverty

Every year over half a million women (529,000) die as a result of complications of pregnancy, childbirth, and unsafe abortion. Millions more survive but suffer ill health and chronic disability. Poor maternal health also limits the newborn's chance of survival, and a mother's death can have a catastrophic impact on family livelihood contributing to increasing poverty and poor human development.

Globally pregnant women, regardless of economic status, face roughly an equal risk of suffering the complications that result in most maternal death and injury. However, provision of and access to the health services necessary to avert death and disability is not equitable. Consequently, nearly all (99%) maternal deaths occur in low income countries, largely in Asia (253,000) and sub-Saharan Africa (251,000). The variation in lifetime risk of maternal death[5] between poor and rich countries represents the greatest disparity of all measured human development indicators. For example women in the UK face a one in 3,800 lifetime risk of maternal death, while the risk faced by women in the world's least developed countries is more than 200 times greater at one in seventeen. Graham et al (2004) illustrated that women in the poorest quintile in Indonesia accounted for 32–4% of maternal deaths and had a risk of maternal death 3–4 times greater than women in the wealthiest quintile.

(Figures from World Health Organisation (WHO), United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) 2004)

3.1 **The high burden of maternal death and disability can be interpreted, in itself, as evidence of gross gender inequality and the low value placed on women's lives and survival**. Efforts to improve child health and address communicable disease such as malaria, HIV/AIDS and TB have dominated the global health agenda. The high death toll incurred as a result of pregnancy, abortion and childbirth has remained largely hidden. It still fails to engender high-level political commitment in many countries.

3.2 Gender inequality combined with **poverty creates a 'double deprivation'** that

- increases girls and women's exposure to unwanted pregnancy
- decreases their access to life-saving care such as skilled attendance during childbirth
- limits society's efforts to reduce the damage incurred following poor pregnancy outcomes.

These relationships are illustrated in table 3. The gender dimensions identified in the evaluation framework (table 2) can be found on the left had column and SRHR issues during the 'life cycle' stages of before, during and after pregnancy across the top row. The points raised in the table are not exhaustive but illustrate the interface between SRHR and gender that pave the path to maternal death and disability.

[5] A measure that combines the probability of becoming pregnant (fertility rate) with the probability of death during pregnancy (MMR) across a woman's reproductive years.

3.3 The same dynamics **perpetuate poor SRHR across generations**. For example the death or disability of a mother can lead to increased poverty and household vulnerability or even family breakdown creating an environment that fuels the circle of early pregnancy, gender based violence, unsafe abortion etc for the next generation.

3.4 The gender relations that impact on maternal health are **complex, dynamic in nature and vary between cultures, and over a woman's lifetime** – often influenced by the outcome of pregnancy. For example in some cultures e.g. Bangladesh, pregnancy leading to the birth of a healthy son increases a woman's status in the family and community setting (Huque et al 1999). Conversely childbirth resulting in fistulae[6] can lead to increased inequality. The social consequences of fistula for Tanzanian women include divorce and social ostracism (Bangser et al 1999). Pregnancy can be a 'spark' to the onset of gender based violence (GBV); in India GBV has been associated with up to 16% of maternal deaths (Ganatra cited in Freedman 2004).

3.5 Gender analysis of the factors that lead to maternal death needs to consider issues at different levels (community/household; facility/health system and politically/nationally), and across the dimensions presented in this report (decision making, rights and access to resources/benefits of development). It is also important to assess the impact of **other dimensions of social exclusion and vulnerability** that make some women more vulnerable than others e.g. socio-economic status, caste, age, livelihood etc.

3.6 **At community and household levels** normative female and male role expectations created through generations of gendered experience play a key role in defining maternal health. These vary between countries and ethnic groups. For example Vietnamese women may limit their own food intake during pregnancy, increasing their risk of anaemia and death in the event of a post-partum haemorrhage (Nga and Morrow 1999). In countries such as Ethiopia, female genital mutilation (FGM) carried out on girls to fulfil gendered expectations may result in life-threatening complications of childbirth years later. Unequal power in decision making and access to resources between men and women plays a key role in limiting access to life-saving services. For example absence of a male decision maker in the event of an obstetric emergency in Nigeria may mean that women die rather than reach care (Shehu 1999); in Yemen women may not be allowed to seek life-saving care in the absence of female health workers (de Regt, undated). In Tamil Nadu fear of divorce and possible destitution means that women suffering uterine prolapse feel forced to engage in painful sexual relations and face the repeated risk of unwanted pregnancy (Ravindran et al, 1999).

3.7 **Gender discrimination played within institutions** limit the health systems ability to provide quality maternal health care. Gender inequality in employment opportunity, career development, and other factors such as GBV in the workplace, salary discrimination and lack of employment flexibility for family carers make it difficult to ensure that there are adequate numbers of female midwives and doctors available to provide culturally acceptable care. Even where adequate female midwives are available they may not be empowered (or have the professional and legal right) to carry out life-saving interventions. For example

[6] Fistula is a hole that develops between the vagina and bladder and/or rectum during prolonged or obstructed labour. These holes leave girls or women leaking urine or faeces (or both) uncontrollably through the vagina.

in Turkey there are restrictions on training midwives in basic skills such as suturing, and life saving skills such as manual removal of a placenta (personal communication). This situation reflects the gendered power dynamics between predominantly female nursing/ midwifery, and traditionally predominantly male medical professions.

3.8 **At a policy making and national level** attention to gender equality and women's empowerment is also critical to addressing maternal health. Strong and equitable governance is necessary to ensure that key legislation protecting women's rights (e.g. age of marriage, prevention of FGM, safe legal abortion) is in place and implemented. A review of lessons arising from the success achieved in reducing maternal mortality in Malaysia and Sri Lanka Pathmananthan et al (2003), write that *'the governments of Malaysia and Sri Lanka consistently implemented human development programmes that reached underprivileged groups... ...women's involvement was emphasised, both implicitly and, sometime explicitly, and gender equity was a priority in both countries'*. Attention to gender equality across sectors impacts on maternal health outcomes. For example in Malawi educated women are more likely to seek skilled care at delivery (McCoy et al 2005).

Table 3 The interface between maternal health and disability, SRHR and gender

	SRHR before conception *avoiding unwanted/ unplanned pregnancy*	**SRHR during pregnancy** *ensuring health and survival through pregnancy/childbirth and access to safe abortion service for unwanted pregnancy*	**SRHR following pregnancy** *managing sequale of childbirth/abortion and preventing inter-generational aspects of poor SRHR and gender …*
Decision making • Capacity for public participation • Representation among decision makers • Household & individual decision making	• Presence and capacity of civil society to lobby/advocate • Forum for women and vulnerable groups to be heard. • Representation of women and vulnerable groups in decision making forums – health planning, M&E etc • Power within sexual relations to avoid unwanted sex, access to and use of contraception	As first three points column 1, plus • Power within sexual relations and skills to negotiate condom use to prevent STI/HIV infection during pregnancy. • Women empowered to seek appropriate care during pregnancy, childbirth and men supportive of women's needs.	As first three bullet points column 1 plus • Understanding (and challenging) the power dynamics and consequences of post-partum cultural practice e.g. where partner/husband finds alternative other sexual partners during the post-partum period
Rights • Legal system • Public awareness • Response to gender-specific rights violations	• Legal frameworks in place and enforced around minimum age of marriage; preventing genital mutilation; sexual harassment of children and women (including the workplace) • BCC programmes increase public understanding and awareness of issues around early pregnancy • Enable an environment in which sexual exploitation is not accepted and legal rights are enforced (exploitation of schoolgirls, unsafe initiation ceremonies)	• Legal frameworks in place and implemented to ensure right to safe abortion; maternity leave; dignity and confidentiality in respect to health services • Right to evidence based services including focused ANC, skilled attendants and responsive emergency obstetric care • Rights of HIV infected women to equal treatment and care including MTCT. • Programme of response following maternal death or severe injury e.g. death audits etc. • Atmosphere of 'zero tolerance' for GBV	• Mechanisms and rights to protect children & adolescents in event of mothers death e.g. removal of children esp. girls from school • Campaigns to raise awareness about the difficulty of and available treatment for common disability such as uterine prolapse, fistula and secondary infertility. • Community and policy support to prevent social exclusion due to disability such as fistula • Engender a sense of community outrage and action in response to GBV arising during early motherhood or when a woman is 'blamed' for stillbirth, neonatal death, infertility etc
Access to resources and benefit of development • Livelihoods and productive assets • Institutional capacity • Policy and programme change	• Access to contraception and family planning commodities, information and counselling • Access to SRH information, advice and counselling, especially for adolescents • Progressive gender sensitive health policy and national frameworks	• Access to, plans for and use of assets/ resources to ensure access to life-saving care during pregnancy/childbirth. • Gender dimensions of human resource management affecting the ability of skilled attendants to provide services. • Evidence-based policy for maternal health services	• Protection of women's access to assets in event of divorce due to lack of live children, sons or disability. • Attention to the need for health policy and services to address the sequale of mis-managed / unsafe childbirth and abortion.

3.2 International policy objectives to reducing maternal mortality[7]

3.9 There are international agreements pertaining to maternal mortality reduction, dating from the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1966 to the MDGs in 2000. Key guidance related to maternal health, SRHR and child health are outlined in table 4. Despite this long history, clarity and direction for maternal health programming has been slow to emerge.

3.10 During the 1950s, the training of skilled professionals particularly midwives, was a key thrust of programming. In the 1970s fears around population explosion led to a shift in focus toward family planning. Attention to health during pregnancy and childbirth was lost. From the late 1970s the ideology of primary health care dominated and 'grass-roots' approaches e.g. traditional birth attendant training was promoted.

3.11 In 1985 Rosenfield and Maine published a seminal paper arguing that the focus on maternal health had been lost. Around the same time the international women's movement was drawing attention to the unacceptably high levels of maternal mortality. In 1987 the first international conference to be dedicated to issues of maternal mortality was held in Nairobi. This initiative was supported by the World Bank, WHO and UNFPA and led to the launch of the Safe Motherhood Initiative and the formation of an Inter-Agency Group, that aimed to focus attention on and advocate for greater commitment to addressing maternal mortality.

3.12 The 1990s were critical for shaping maternal health policy understanding. The technical interventions necessary to ensure maternal survival are now understood – family planning to prevent unwanted pregnancy, safe abortion care, skilled midwifery care and access to emergency obstetric care. Lessons learnt during the 1990s led to the realisation that achievement of lower MMR was dependant on both health systems functioning and equitable access to services. Policy consensus began to emerge following the 1997 Safe Motherhood Conference in Sri Lanka, and the maternal health MDG has increased policy commitment.

3.13 Attention to the way in which gender inequality and social exclusion impact on maternal health has also grown. Key thinking around a rights based approach (RBA) to maternal health has emerged (WHO 2001, Freedman 2001), and gained increasing visibility through the Millennium Project (Freedman et al 2004). This work is drawing more closely the links between work to improve maternal health, women's rights as articulated in the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), and gender equity and women's empowerment as per the international agreements of the Beijing Platform of Action. However, new challenges have emerged; in particular the undermining of SRHR in US policy.

3.14 The challenge facing the international community and national governments is not *what* to do but *how* to programme so that there can be impact at scale. The focus today is on strengthening health systems to provide quality evidence based care, promoting equitable access to services, and on holding Governments to account through improved tools to monitor progress and application of a RBA

[7] This section draws on AbouZhar 2001, Campbell 2001.

Table 4 International Commitments for Maternal & Child Health and SRHR

Commitment	Maternal Health Policy Objective	Child Health and SRHR Policy Objective
Millennium Declaration **2000** signed by all 191 UN member states. (building on DAC/IDT's)	*Goal 5:* improve maternal health *Target:* reduce by three-quarters, between 1990 and 2015 the maternal mortality ratio *Indictors:* Maternal Mortality Ratio & Proportion of births attended by skilled health personnel	*Target:* reduce by two-thirds, between 1990 and 2015 the under-five mortality rate. No specific SRHR goal or target other than the maternal health one.
4th Conference on Women in Beijing, **1995**	International agreement to a comprehensive Platform of Action for gender equality and empowerment. Shift from WID to GAD. Emphasis placed on gender mainstreaming.	
ICPD + 5, **1999,** 179 countries approved a new plan to accelerate implementation of the ICPD Plan of Action International Conference on Population and Development (ICPD) Cairo **1994**	*Key future action no. 62:* Governments, with the increased participation of the United Nations system, civil society, including non-governmental organisations, donors and the international community should (a) recognise the linkages between high levels of maternal mortality and poverty and promote the reduction of maternal mortality and morbidity as a public health priority and reproductive rights concern; (b) ensure that the reduction of maternal morbidity and mortality is a health sector priority… *Key future action no 63iii:* ….where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that abortion is safe and accessible… *Para 8.21:* Countries should strive to effect significant reductions in maternal morbidity and mortality by the year 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. Disparities in maternal mortality within and between countries, socio-economic and ethnic groups should be narrowed.	*Key future action no 57(a):* the UN system and donors should.. support Governments in mobilising and providing sufficient resources to meet … the widest possible range of safe, effective, affordable family planning and contraceptive methods, including new and under-utilised methods. *Key future action no. 52a:* Governments should give high priority to SRH health in the broader context of health sector reform… *Key future action no 73e*: Governments…should… ensure that adolescents both in and out of school, receive.. information on prevention, education, counselling and health services to enable them to make responsible and informed choices and decisions regarding SRH … Shifted the way in which reproductive health was perceived from a primarily demography issue to a rights based issue . Renewed focus on women's reproductive health and set goals and targets on reproductive health and rights for all by 2015
Convention on Rights of the Child **1989** ratified by 192 countries	Protects those under 18 – a considerable burden of maternal mortality occurs in this age group.	Includes right to life, survival and development (article 6), sets standards for health care provision. Optional protocol on sale of children, child prostitution and child pornography added 2002, signed by 110 and ratified by 87 countries.
Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) **1979**, ratified by 175 countries by March 2004	Requires states to eliminate cultural religious and social discrimination that devalues women's health and well-being; established barriers to quality health information and services, and promotes inadequate allocation of resources for women's health care (quoted from Yamin and Maine). *Article Five* declares the need to take appropriate measures to modify cultural patterns of conduct, as well as the need for family education to recognise the social function of motherhood and the common responsibility for raising children.	*Article 12* requires steps to eliminate discrimination in health care, including access to services such as family planning *Article 16* requires steps to ensure equality in marriage and family relations…including the right to freely determine the number and spacing of children…
International Covenant on Economic, Social and Cultural Rights **1966** (ICESCR), as of June 2004 all 191 UN member states had ratified part or all of the ICESCR	*Article 12* states that special protection should be accorded to mothers during a reasonable period before and after childbirth (quoted from Yamin and Maine) *State Parties* provide data on indicators defined by WHO with respect to the proportion of pregnant women having access to trained personnel during pregnancy and the proportion attended by such personnel for delivery (Toebes quoted in Yamin and Maine)	*Article 12* specified that State Parties… recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (from Yamin and Maine)

4 Development of DFID knowledge & policy

4.1 DFID has a long history of engagement in reproductive and sexual health. However, emphasis on maternal mortality reduction has been slower to emerge. Important milestones are illustrated in box 5 below.

Box 5 Key milestones in developing maternal mortality policy in DFID

- 1997 'issues paper' on maternal mortality launched at the Safe Motherhood Technical Consultation held in Sri Lanka (DFID 1997)
- 2000 targets for maternal mortality reduction included in the PSA
- 2001 DFID position paper on abortion and maternal health (DFID 2001)
- 2002 Strong support from the Asia director for maternal health programming visible
- 2002 A multisectoral Maternal Mortality Reduction Taskforce drawn from across DFID is formed and led by the Asia Division. Papers considering maternal mortality from different perspectives including links with poverty and women's rights produced (MMRD Taskforce, 2002).
- 2002 Policy Division creates advisory post on maternal health
- 2004 DFID position paper on sexual and reproductive health and rights (DFID 2004b)
- 2004 'Reducing Maternal Deaths: Evidence and Action. A Strategy for DFID' launched (DFID 2004a) by the Secretary for State
- 2004 Africa Director sends clear message to heads of office in Africa demonstrating his support for the 'reducing maternal deaths' strategy, and intention to monitor progress in pursuit of MDG 5
- 2005 Policy Division produce 'How to reduce maternal deaths: rights and responsibilities' guidance note on applying a rights based approach to maternal mortality reduction (DFID 2005b)

4.2 DFID has now gained credibility as a leading agency in programming and thinking around maternal mortality reduction. The 'reducing maternal deaths' strategy (DFID 2004a) is highly visible within DFID – in part due to the high level political support provided by the Secretary for State. DFID's supportive stance on SRHR is particularly important given the repositioning of the US Government on these issues. DFID now fills a key policy gap in supporting open discussion and programming around issues such as safe abortion care.

4.3 Policy development in this area has been influenced both internally, by DFID health advisers and experience from projects, and by the external policy environment. Externally, the production of the White Paper on International Development in 1997 placed human development at the heart of DFID business and gave a new emphasis on poverty reduction (e.g. see DFID 2000b). This was a significant change of direction from the mid 1990s emphasis on Health Sector Reform. The adoption of the MDGs, and their translation into concrete targets for DFID through the PSAs and DDPs (see above), also helped maternal mortality reduction targets to become part of DFID's plans from 2000 onwards.

4.4 Internally, thinking on maternal mortality started with health advisers bringing in research thinking,[8] and observations of the work of other agencies into health advisers retreats and other internal debates. This was translated into programming in the late 1990s, with the launch of the DFID Nepal and Malawi Safe Motherhood Projects and other smaller but important pieces of work e.g. a review of Safe Motherhood in Kenya. Significant 'in-house' learning emerged from the Nepal and Malawi investments.

[8] For example Rosenfield and Maine 1985 and international debate on TBAs vs. EmOC

4.5 DFID also supported research around measuring maternal mortality (in particular ongoing support to the IMMPACT research programme), developing quality improvement tools (e.g. clinical audit), and treatment for key aspects of maternal health (e.g. magnesium sulphate for treating eclampsia). Over time it has become clear that

- properly functioning national health systems were a prerequisite for scaling up 'safe motherhood' projects, which would otherwise be unsustainable
- overcoming the barriers to accessing these services, particularly for poor women; would require changes beyond the health system e.g. household, legislative.

4.6 Addressing barriers to access of health services, including those that arise through discrimination against women, has been central to DFID policy and investments. However, it is difficult to draw a clear link between this and DFID's TSP on 'Gender equality and empowerment of women' (2000b). The recently-produced 'How To' note (see above, and box 6 below) builds on the TSP 'Realising Rights for Poor People' (DFID 2000c).

Box 6 Rights-based approach

DFID's strategy for reducing maternal deaths (DFID 2004x), highlights the importance of achieving women's rights in order to enable equitable progress towards the maternal health MDG. The 'how to note' (DFID 2005) provides guidance to advisers and programme managers to enable them to put a rights based approach into practice.

The rights based approach allows analytical space and provides tools to explore the underlying (rather than the immediate clinical) causes of high maternal mortality and morbidity. It enables transparent exploration of women's rights, from policy to household levels: their low status and lack of power, poor access to information and care, restricted mobility, legal and policy frameworks that undermine women's rights, and inequitable health systems that discriminate against female workers and clients etc Taking a rights based approach to initial analysis of the situation, facilitates the planning, implementation and monitoring of interventions that address the political, social, legal and economic actions necessary to achieve MDG 5, in addition to scaling up technical strategies.

DFID's TSP and the 'how to note' prioritise three rights principles to guide programming. The principles – participation, inclusion and fulfilling obligation – are familiar to many development practitioners, but used together can provide a powerful 'tool-set' to engage in a RBA.

Participation – actions to empower women to recognise and voice their claim to maternal health and to access information for decision making.

Inclusion – actions to reduce inequalities and discrimination that put specific groups of women at greater risk of maternal death.

Fulfilling Obligation – actions to strengthen the State and others with responsibility for reducing maternal deaths and fulfil a duty and strengthen accountability to women.

4.7 The coming years will provide an increasing challenge to DFID as a leading bi-lateral agency in maternal mortality reduction. There are multiple demands on the time and attention of senior management. If maternal mortality issues and RBA (including attention to gender discrimination) are to stay high on the agenda this will require:

- high-level champions within the organisation
- creative dissemination of examples of HOW maternal health can be improved through currently dominant aid modalities
- internal organisation which enables maternal mortality to be factored into all of DFID's work. The reorganisation of Policy Division into multi-disciplinary task based teams should help with this and ensure cross-disciplinary working).

Box 7 Factors enabling and limiting progress in maternal mortality policy and knowledge development

Factors enabling progress

Production of a clearly articulated strategy paper. DFID is unique among bilateral donors in this regard and having given significant intellectual time and energy to think through how to scale up maternal health programming, is well placed to influence others. The strategy which provides clear messages to enable priority setting is appreciated by country level advisors and it has been strongly supported by Regional Directors.

Strong support from the Secretary of State and SRHR as a key interest of the Under-Secretary.

Target for MMR reduction on internal management mechanism (PSA, Service Delivery Agreement (SDA}, Director's Delivery Plan(DDP)), engenders high level management commitment.

'Home-grown' examples (Nepal, Malawi) that 'something can be done' – provides a sense that integrating these lessons into health sector programmes at scale is challenging but possible.

Reorganisation of policy division to enable broader thinking e.g. the development of RBA has involved health advisers rather than being only the domain of Social development Advisers (SDAs). Also increases likelihood of attention to maternal health in a range of forums e.g. Health Metrics Network, High Level Health Forum.

Supportive stance on SRHR and provision of safe legal abortion care combined with clarity of focus on health system strengthening enables DFID to bring an important voice to the Partnership for Safe Motherhood and Newborn Health.

Factors limiting progress

Limited systems and mechanisms for collating and sharing 'best practice'. Advisers are reliant on informal sharing, adviser retreats, Output to Purpose Reviews (OPRs) and Project Completion Reports (PCR) reports, yet informants consistently reported a felt need for 'practical examples of what works'. Tightening of travel budgets is further limiting face-to-face sharing between PD and country programmes.

Perceived resistance, by senior management, to issues such as women's empowerment and human rights. There is a need to reflect equity dimensions within PSA and DDP targets in order to leverage commitment. The failure to do so to date partly reflects the lack of equity-sensitive indicators in the MDG monitoring framework.

Respondents report concern that impetus to harmonise and align policies with international partners (e.g. World Bank) means that non-headline agendas, e.g. SRHR, will be marginalised. More internal champions of these issues are required.

Language is perceived by many to act as a barrier. Complex issues e.g. RBA need to be translated into clear and compelling statements and practical examples that are accessible to and resonant with all disciplines, but that do not underestimate the complexities.

5 DFID investment and gender mainstreaming for maternal health

5.1 DFID maternal health investments 1995/6 – 2004/5

5.1 DFID uses PIMS to track the targeting of bilateral commitments and expenditure by priority policy objectives. By tracking expenditure it is hoped that the system can improve accountability, inform policy debate, monitoring and aid management, and assist project design (DFID, 2003). PIMS markers must be applied to any investment of £100,000 or more (although there are a few exceptions), and exist for both 'LMM' and 'gender discrimination'. Investments can be marked as not targeted ('0'), significant ('S') or principal ('P').

5.2 The marker system does have limitations. Discussions with advisers illustrated concern that those applying the marks lack training in or understanding of PIMS and rarely have the time to seek guidance from the PIMS 'pink book' or elsewhere. This leads to mistakes and misunderstanding in the way investments are marked. Examples were found during this review – two of the investments for the Cambodia programme marked 'P' for LMM were in fact de-mining projects. In discussion with the de-mining adviser in CHAD it was agreed that this was an error, probably arising from the difficulty in applying scores to de-mining investment, and lack of understanding about what was meant by 'maternal mortality'.

5.3 Programmes may have multiple policy makers so it is important to note that while the investments flagged should give policy priority to that area e.g. LMM it does not mean that the entire financial commitment or expenditure relates to this area. In recognition of these issues and the programming synergies between HIV/AIDS, reproductive, maternal and child health; Policy Division recently proposed and disseminated new guidance on marking and drawing the links between investments in these areas (DFID, 2005c). However, the need for quality control mechanisms around the use of PIMS remains.

5.4 Using spreadsheets (prepared for this review by DFID Statistics Department) relating to DFID financial commitment and expenditure from financial year 1995/6 to 2004/5, all investments with a 'P' or 'S' marker for LMM were identified. Table 5 illustrates the level of commitment made to maternal health since 1995 and actual expenditure for financial years 1995/6 to 1999/2000 and 2000/1 to 2004/5. Likewise commitment and expenditure, where there was a marker for both 'LMM' and 'gender discrimination' is illustrated.

5.5 It is important to note that the data sheets used for this analysis included funds channelled through direct budget support (DBS), programme partnership arrangements (PPA), and multilateral agencies. As such they are likely to over-estimate the amount spent on maternal health.[9] For example considerable funds have gone through DBS since 2000/01 (e.g. 127.5 million pounds in Uganda from 2000/1 – 2002/3). Whilst this expenditure may have a LMM PIMS marker it is estimated that not more than 5% is actually used for maternal health programming. DFID is currently working to identify ways of apportioning the amount of DBS funds spent in different priority policy areas. Even bearing in mind the limitations of the PIMS it does appear that there has been a substantial increase in expenditure on maternal health in the last five years.

[9] Recent analysis by the Research team in Policy Division found that in recent years approx. 50% of expenditure with a PIMS marker for maternal health had been channelled via DBA or PPA. It is estimated that not more than 5% of these funds are actually used for maternal health programming.

Table 5, DFID financial commitment and expenditure in maternal health, 1995/6 – 2004/5

	Commitment 1995/6 – 2004/5	Expenditure 1995/6 – 1999/2000	Expenditure 2000/1 – 2004/5
Level of DFID investment in maternal mortality globally by maternal mortality PIMS marker P or S and total T	**(P)** 511,137,364 **(S)** 2,292,271,764 **T** 2,803,409,128	**(P)** 30,566,895 **(S)** 202,209,360 **T** 232,776,255	**(P)** 168,550,140 **(S)** 1,541,301,906 **T** 1,709,852,046
Level of DFID investment globally where there is both a gender and maternal mortality PIMS marker (MM, Gender) e.g. P,P = maternal mortality 'P' and gender 'P'	**(P,P)** nil **(S,P)** 29,868,201 **(S,S)** 676,544,608 **(P,S)** 233,259,236 **T** 939,672,045	**(P,P)** nil **(S,P)** 7,339,834 **(S,S)** 54,063,290 **(P,S)**12,243,807 **T** 73,646,931	**(P,P)** nil **(S,P)**13,170,427 **(S,S)**379,286,695 **(P,S)**52,750,039 **T** 445,207,161

5.6 Just 13 countries[10] account for 67% (354,430 deaths/annum) of all maternal deaths. There was some maternal health investment in each of these countries during the last decade. However the proportion of overall DFID commitment with a PIMS marker for LMM varied from under 1% (Indonesia) to as high as 86% (Tanzania). In half of these countries there is also a gender marker applied to some proportion (18–61%) of the maternal health investment. Twelve of the thirteen are key countries for DFID's 2005–8 PSA; six of which can be defined as fragile states (DFID 2005a). Most have specific maternal or reproductive health programmes or health sector wide investments.

5.7 There are 18 countries[11] where the maternal mortality ratio (MMR) is 1000 or more per 100,000 live births. All but one (Afghanistan) of these countries are in sub-Saharan Africa, most (66%) are 'fragile states', and eight are key countries for DFID's 2005–8 PSA. DFID had made some commitment to invest in maternal health in 13 of these 18 countries since 1995; in five countries gender PIMS markers have also been applied to a part of that investment. The challenges of addressing maternal health and challenging gender discrimination in these countries, particularly those fragile states where governments can not or will not deliver basic services and protect women's rights, are enormous. DFID is well placed to take on these challenges given its commitment to achievement of the maternal health MDG and recent attention to fragile states (DFID 2005a), in addition to making many of these countries key targets for the 2005–8 PSA. Further details including the MMR, lifetime risk of maternal death, gender development index and level of commitment by DFID from 1995/96 to 2004/05, for each of these countries, can be found in appendix 2 (see contents page).

[10] India, Nigeria, Pakistan, DRC, Ethiopia, Tanzania, Afghanistan, Bangladesh, Angola, China, Kenya, Indonesia and Uganda.

[11] Sierra Leone, Afghanistan, Malawi, Angola, Niger, Tanzania, Rwanda, Mali, Somalia, Zimbabwe, Chad, CAR, Guinea Bissau, Kenya, Mozambique, Burkina Faso, Burundi and Mauritania.

5.2 Country case studies (India RCH-II, Cambodia, Nigeria)

5.8 This section provides a brief report on each of the three case studies chosen for the evaluation. Each follows the same format – a brief snapshot of country situation in relation to maternal health (the challenge); an overview of the programme and the way in which DFID is engaging partners. This is followed by comment on the level to which the investments reviewed are focused on maternal health and the process taken to date, to mainstream gender into programme identification, design, implementation, as well as monitoring and evaluation (M&E) frameworks. Factors that have enabled and limited gender mainstreaming are outlined, and finally each case study concludes with a 'tracking'of progress in gender mainstreaming using the evaluation framework presented in table 2.

5.9 All documentation provided, first by the Evaluation Department and then by the countries offices (if they felt key documents were missing) was reviewed. Documentation reviewed is listed in appendix 3. Phone interviews were held with two to three advisers in each country and discussion/issue guides can be found in appendix 4.

5.2.1 India RCH II

Box 8 India – The challenge[12]

India's basic health indicators have improved considerably over the past 50 years. However, progress in reducing child mortality has stagnated and the MMR remains high (437/100,000 live births[13]). There are an estimated 136,000 maternal deaths every year in India – over 25% of the global total. For every woman and adolescent girl who dies around 30 more will suffer ill health following complications of pregnancy, abortion and childbirth. Poor women from scheduled tribe and caste groups bear the greatest burden. The poorest 20% of Indian people have more than twice the rate of mortality and fertility than the richest 20%. Some 40% of those hospitalised fall into debt due to expenditure incurred, increasing vulnerability to and driving poverty. Gender discrimination, reflected at every level in India's society and institutions serves as a significant barrier to women accessing services. For example, absence of female doctors (especially evident in rural areas in states where the status of women is low) acts as a deterrent to women and adolescent girls, resulting in delayed care seeking. Gender inequality and other factors (e.g. poverty, caste, tribal group) that increase vulnerability are key factors in the propensity to unwanted pregnancy, poor access to and delivery of evidence-based maternal health services and sub-optimal SRH&R.

5.10 The RCH II sector support programme is led by the Government of India (GoI) Ministry of Health and Family Welfare (MoHFW). External development partners (EDPs) including WHO, UNICEF, UNFPA, European Commission (EC), United States Agency for International Development (USAID), GTZ, KFW, DFID and the World Bank have agreed in principal to move towards joint management based on the common framework of RCH II. DFID and the World Bank are pooling funds with GoI. To date DFID's financial commitment is 250 million pounds. Ultimately the GoI and EDP supported programme envelope could be up to 4.5 billion pounds, making this one of DFID's most significant investments in terms of leveraging and influencing funding. RCH II is leading in a number of key paradigm shifts in

[12] Largely drawn from RCH II documentation.
[13] Estimated by WHO, UNICEF and UNFPA in recent estimates to be 540/100,000 live births (range 430–650). Life-time risk of maternal death: 1 in 48.

health including pro-poor programming, de-centralised (State) planning and management, monitoring by poor communities, public–private partnerships and the move from project to sector programming, with performance based funding relating to the degree of focus on the poorest and most vulnerable. The paradigm shifts of RCH II have been adopted in the Rural Health Mission, recently approved by Cabinet and relating to the whole health sector.

5.11 DFID involvement in RCH II was initiated in early 2002 following discussions between the then Senior Health Adviser and MoHFW, and establishment of a task team within DFID India to take the work forward. Asia Policy Division's strong emphasis on maternal mortality reduction has driven the emphasis on safe motherhood interventions. DFID has since provided leadership and supporting World Bank lead throughout the design and appraisal process, and has ensured a focus on evidence based interventions to address maternal and newborn mortality. DFID, together with the World Bank, have influenced and led the shift from project aid to support for investment in a common sector programme.

5.12 DFID India's SDA, together with colleagues in UNFPA, the EC and World Bank, has provided technical leadership and direction to the gender mainstreaming, equity and access dimensions of RCH II design. This has not been an easy process and some resistance (from the MoHFW design team and partner EDPs) to a strong emphasis on a rights based approach and empowerment was encountered early in the design process. As a result the initial social appraisal, although thorough, took a traditional approach emphasising disadvantage and equality rather than social exclusion and empowerment. By 2003, following continued advocacy by key individuals, the emphasis on equity, access and gender was building. This was largely around the needs of 'vulnerable groups' defined in government administrative terms as Scheduled Castes, Scheduled Tribes and 'Below Poverty Line' and those in particular locations, particularly women and girls, with less focus on gender overall.

5.13 Division of work between programme partners led to DFID leading on the equity and access study whilst UNFPA took responsibility for the gender mainstreaming study. The equity and access study focused on issues of social identity, socio-economic status and geographical location, and while gender discrimination was touched upon, an in-depth analysis was left to the gender mainstreaming study. The study explored governance, institutional and service barriers to equity in addition to factors arising at the household/ community level. A comprehensive set of recommendations and ideas for mainstreaming equity within RCH II were provided. This included suggestions for ensuring that programme Observable Verifiable Indicators (OVIs) and M&E frameworks would be able to assess programme impact on improving equity in access to and utilisation of services. The gender mainstreaming study had a narrower focus looking largely at health system policy, the employment needs of female providers, and an assessment of service delivery components required for delivery of maternal health interventions. However, little attention was given to gender dimensions of decision making, rights or access to resources that impose barriers on women's access to and receipt of timely and quality care.

5.14 The appraisal of RCH II has recently been completed and the draft Project Appraisal Document (PAD) (World Bank documentation) prepared. There is limited space in the format of this document for expanding on social issues. However, within the constraints of the document format emphasis on equity is evident, including mention of the need to

redress the low utilisation of services by women. Gender inequalities are flagged within the context of a broader range of factors that lead to social exclusion and inequitable access to health services. Many of the good ideas for ensuring a focus on equity in the OVI's appear to have evaporated, although a new triangulated monitoring and evaluation framework that includes community monitoring is introduced. However, ensuring that women and particularly those from marginalised groups (rather than middle class advocates) are placed at the centre of planning and monitoring processes will be a key implementation challenge.

Box 9 India – factors enabling and limiting gender mainstreaming

Factors enabling engagement on gender discrimination and gender mainstreaming in RCH II

The presence of an SDA who was not only technically competent in issues of gender, equity and access but whose working style influenced the inclusion of these issues as the design proceeded. This input has limited although not avoided policy evaporation and invisibilisation of gender dimensions.

The framing of gender in a wider framework of vulnerability that is more politically acceptable (including within DFID) than a focus on gender alone. The broader focus is also context relevant, as in India many factors lead to social exclusion and compound gender inequalities e.g. poverty, scheduled caste and tribes.

Partnership with the World Bank has put DFID in a strong role and allowed DFID's comparative advantage in social and institutional development to be strong foci during the design process.

The use of World Bank design processes has allowed greater scope for formal engagement and dialogue with GoI and States than the DFID 'project' preparation processes allow. These processes allow a deeper level of engagement, and provide a useful vehicle to maintain momentum in addressing sensitive and often misunderstood issues such as gender equality and empowerment.

Factors limiting gender mainstreaming in RCH II

Felt apathy, from GoI, towards embracing gender mainstreaming. This is in part due to resistance to addressing the status quo e.g. at times it has been observed that some GoI actors refuse to acknowledge disparities in coverage and access. However, it is also a reflection of the steep learning curve and new skill set necessary to de-centralise and engage in cross cutting issues – such a paradigm shift takes time.

A perception (by advisers) that gender is low on the agenda with DFID senior management and that, with the move to *'ruthlessly prioritise',* emphasis on gender mainstreaming has been lost. Pragmatically it is felt that it may be best to address gender under the guise of social exclusion as this has more visibility with senior management.

Lack of space to reflect gender dimensions of programme in the World Bank documentation, resulting in invisibilisation of much of the analysis undertaken during in-depth studies to inform the programme design.

Varied capacity on the part of partner EDPs to analyse and engage in gender issues. This can result in slower progress and the promotion of more traditional approach to programming.

Table 6 India– gender mainstreaming: a summary

	MAINSTREAMING				
	India RCH II	**Identification**	**Design and preappraisal/appraisal**	**Implementation**	**M&E**
EQUALITY AND EMPOWERMENT	**Decision making:** • **Capacity for public participation** • **Representation among decision makers** • **Household & individual decision making** **Rights:** • **Legal system** • **Public awareness** • **Response to gender-specific rights violations** **Access to resources & benefits of development:** • **Livelihoods & productive assets** • **Institutional capacity** • **Policy & programme change**	*Gender flagged early, though remained largely 'hidden' in a broader range of equity issues.* Gender mainstreaming, together with equity & access, beneficiary needs assessment and demand/supply nexus identified as gaps in RCH I. Gaps identified in donor/GoI group discussions rather than through a review of RCH I. These key gaps flagged as priorities for RCH II at an early stage. DFID has led on placing gender on the design of this programme, although the DFID TSP has limited visibility and was not a key document in informing RCH II. Maternal Health Strategy Paper has influenced DFID India team to address areas not envisaged in RCH II (particularly advocacy). GoI policies/national documents state a commitment to gender equity and to ICPD that the identification draws on.	*Increasingly (over time) gender sensitive design process in a gender resistant context.* Analysis of gender made through consultancies on 'mainstreaming equity and access', 'social assessment in 5 States' and 'mainstreaming gender, suggestions and options for States'. State understanding and capacity to incorporate gender mainstreaming (GM) built through a series of cluster workshops, including session/presentation on GM and E&A. Focus on 'vulnerable groups' e.g. scheduled caste, the poor, geographically marginalised etc Gender & women's equality addressed as a dimension of vulnerability. GM report focused on gender aspects of the health system e.g. equality & safety of female personnel. E&A report provides framework for mainstreaming E&A, including gender throughout the programme (including M&E). Rights dimension least visible in available documentation, although the renewed focus in RCH II on evidence based interventions will enable the right to safe and appropriate care to be achieved.	*Implementation not yet started* Key challenge is enabling and building the capacity and commitment of GoI to move from the very strong centralist and supply driven agenda to one that is de-centralised and equity focused. Significant institutional change is required and inevitably resistance to such change can be expected. It is recognised that translating policy statements into equity in practice will require tenacity and persistence in championing equity, and the design and use of bureaucratic incentives to shift the focus of the programme. DFID's high level of awareness of this challenge will help. The SDA is leaving so continuity is more difficult. However, informal communication between the outgoing and incoming SDA is ongoing.	*Many ideas for equity sensitive M&E presented* in the equity and access study including: • a high level equity health watch forum or commission with GoI and civil society representatives, formed to monitor equity and health vulnerability trends – potentially functioning as a national watchdog. • a list of potential equity sensitive indicators • nationally agreed social and gender equity indicators should be factored into the next round of the National Family Health Survey and RCH Rapid Household Survey, as well as State and lover level Human Development Reports. Many of these ideas have become invisible in the PAD – probably more due to documents format than intent. A triangulated approach to M&E that includes methods to bring the voices of marginalised women to the monitoring process, has been designed and will be tested.

5.2.2 Cambodia case study

Investments reviewed (all with a 'P' PIMS marker for maternal health) and level of financial commitment

144555010	Reproductive Health/Family Planning & Sexual Health	£1,870,000
144555011	Health Sector Reform 3 (HSR-3)	£3,641,000
144555016	Health Sector Support Programme	£15,400,000
144615023/024	Battambang De-mining[14]	£321,680

Box 10 Cambodia – the challenge[15]

After the genocidal Pol Pot regime and decades of civil war, Cambodia entered a period of stability in the late 1990s. During this period the country lost nearly an entire generation of health professionals and the health system infrastructure was destroyed. Since then the Royal Government of Cambodia (RGC) has embarked on the long and challenging process of rebuilding infrastructure and systems. Civil society is weak – particularly in relation to advocacy on issues of equity. Cambodian society and institutions are strongly masculine, GBV is commonplace and women have little control over the factors that affect their SRHR. Every year around 2,100 women and adolescent girls die (18% of all reproductive age deaths in women), and up to 80,000 are injured due to complications of pregnancy, abortion and childbirth. Complications of unsafe abortion are thought to contribute to up to 29% of maternal deaths. The abortion law, passed in 1997 has not yet led to widespread availability of safe and comprehensive abortion care. The cost of services and transport are major barriers to access. Out of pocket costs are high and 45% of people borrow money for health emergencies; such expenditure exacerbates vulnerability to poverty.

5.15 DFID Cambodia in partnership with RGC has, since the early 1990s, been engaged in rebuilding the foundations of the Ministry of Health (MoH), and National Health System. This has been the main focus of the three phase HSR programme from 1992 – 2002. In HSR-3 (no. 144555011) emphasis was placed on re-establishing basic services that are accessible to and can be utilised by the poor. HSR-3 also began to lay the ground for the health Sector Wide Management Programme (SWIM). The current Health System Strengthening Programme (HSSP) (no 144555061) was initiated in 2002. Together with key partners – the World Bank and Asian Development Bank (ADB) – DFID is co-financing support to this programme through the SWIM. The last few years have been dominated by the considerable time and effort required to establish understanding, commitment and partnership for sector wide management.

5.16 Emphasis on maternal health has been relatively slow to emerge. Although the HSR programmes focused on establishing service delivery, maternal health was not explicitly targeted, and the HSR-3 logical framework had no observable verifiable indicators (OVIs) that relate to health during pregnancy or childbirth.[16] Over the same time period DFID did

[14] The de-mining projects (nos. 144615023 and 144615024) appear to have been marked 'P' for maternal health in error, whilst valuable initiatives did not contribute to reducing maternal mortality. See also footnote 9.
[15] References: WHO, UNICEF and UNFPA 2004; Policy Project; DFID Cambodia CSP & discussion with DFID Cambodia team. MMR 450/100,000 live births (range 260 – 620). Life time risk of maternal death 1 in 36.
[16] Although during this period the HSR programmes supported the development of core packages of health services at health centre and referral hospital level. These have a significant reproductive health element.

engage in project funding that included safe motherhood interventions. The Urban Health Project Component of HSR-3 had considerable success in designing and piloting an equity fund that enabled slum dwelling women to access safe delivery and emergency obstetric care. Lessons drawn from this work are informing the scaling up of equity funds under the HSSP. DFID also provided support to the National Reproductive Health Programme through UNFPA to a Marie Stopes International managed reproductive, family planning and sexual health project (investment no: 144555010). Output four of this project, 'safe motherhood services in selected pilot areas improved and women given information about them' had a 'poor' performance rating on project completion; although there was 'satisfactory' progress in improving access to birth spacing and family planning services.

5.17 In summary, DFID investment in maternal health in Cambodia has been limited, (until the HSSP) and the number of 'P' PIMS markers allocated for maternal health are probably an over-estimate of the investment in this area. More recently DFID has been actively engaged in ensuring that maternal health interventions are mainstreamed through supply side work supported under HSSP. This is well reflected in the logical framework. In addition, DFID has been developing and intends to fund a programme component that begins to explore and address demand side issues (to date not a feature of programming). This will include attention to enabling implementation of safe comprehensive abortion care, access to long term family planning methods and scaling up access to equity funds, particularly for poor women requiring assistance to access skilled care during delivery or emergency obstetric care. The renewed emphasis on maternal health is a reflection of the burden of disease, the focus in the DFID Asia DDP on maternal health and DFIDs comparative advantage in engaging in issues such as abortion care (where many other donors e.g. UNFPA are reluctant to tread since the United States has taken an anti-abortion stance).

5.18 None of the health sector investments reviewed have engaged at any significant level on gender equality or women's empowerment. Although the word 'gender' appears in HSSP documentation there has, to date, been no evidence of gender mainstreaming. Programming has been largely gender blind, or at best gender neutral. DFID Cambodia, reflecting on this, feels that this is largely due to the Cambodia's development context – in the last decade the government has focused on rebuilding and re-initiating delivery of health services. The rebuilding of a civil society with the freedom and confidence for groups to advocate on gender, (or other equity issues) has been slow. Government and donors have focused on the relationship between poverty and health outcomes. More recently emphasis has been placed on developing a sector wide programme, and gender concerns been marginalised in the effort required to get the basic nuts and bolts of joint working in place. There has been no gender analysis of access to or delivery of health care, but monitoring indicators will be disaggregated by sex where appropriate. Nevertheless, government and donor engagement with civil society is increasing in relation to issues of rights and equity – the opportunity for a more systematic approach to gender and maternal mortality is arising.

Box 11 Cambodia – factors enabling and constraining gender mainstreaming

Opportunities emerging to enable more engagement on gender issues

An SDA will join the DFID Cambodia team in 2005, enabling more regular and consistent engagement on dimensions of social exclusion and access to health services including gender.

The Ministry of Women's Affairs is beginning to have the capacity to engage in other sectors and has recently established a technical working group on gender. This group has not looked at health issues as yet, but the opportunity to do so is there.

Other donors are developing their own capacity for gender analysis (particularly the United Nations and World Bank), and this is building a 'coalition' on gender advocacy.

DFID's emerging work in 'demand side' maternal health issues including scaling up of the equity fund and providing analytical support to develop rights based approaches, will provide a platform from which to engage in factors that limit access to evidence based services including gender discrimination.

F*actors limiting gender mainstreaming to date*

Cambodia's development context; particularly the focus on building basic infrastructure and health systems after the civil war. In a context where no clear voices were advocating for equity concerns (either from donors or civil society) gender has not been given priority.

Recently focus has been on promoting joint working – issues that cut across programmatic boundaries (often geographical and sector) are more difficult to address. Where partner external development partners (EDPs) lack the social analytical skills and capacities, issues such as gender are likely to disappear.

There is a lack of skills and intellectual understanding of gender discrimination and its impact on women's empowerment and health within the MoH. This has resulted in a resistance to engage on any dimensions of equity with the exception of poverty which appears to be more acceptable.

There have not been any forums in which to raise gender discrimination (particularly given that SDA support for DFID Cambodia is from a distance, covered by the Bangkok office). In addition there is a lack of space to fully reflect gender dimensions in World Bank and ADB documentation.

Table 7, Cambodia – a summary of gender mainstreaming

		MAINSTREAMING			
	Cambodia	**Identification**	**Design and pre-appraisal/appraisal**	**Implementation**	**M&E**
EQUALITY AND EMPOWERMENT	**Decision taking** • **Capacity for public participation** • **Representation among decision makers** • **Household and individual decision making**	**HSR-3:** maternal health & SRHR not flagged on Project Concept Note (PCN). Issue of identifying a skill mix that can ensure gender equity and access to services by poor people, addressed throughout project cycle raised. Nil on gender, women or maternal health on initial draft log-frame. **Reproductive, family planning and sexual health project:** no PCN available. **HSSP:** Gender equity not mentioned on PCN. Some flagging of maternal health issues – mention of emergency obstetric care and contraceptive prevalence. Emphasis on improving health service access by poor and on joint working.	**HSR-3:** equity concerns in relation to poverty informed programme design. The programme documentation does raise, briefly the need to build capacity to monitor and evaluate the impact of HSR on gender issues. **Reproductive, family planning and sexual health project** does not appear to have been informed by an understanding of gender dimensions of access to or delivery of health services. Focused on strengthening delivery of services that are key to maternal health and reducing maternal death (family planning and emergency obstetric care). **HSSP:** gender flagged (briefly) in a number of places in programme documents (ADB and World Bank format). At times when gender is described it appears to be more focused on women and targeting women and girls, than addressing issues of gender equity and women's empowerment. Nil mention of gender or demand/access issues in the summary report on safe motherhood. These issues are probably addressed in more recent DFID documentation for the Safe Motherhood Component – these documents not reviewed in this evaluation.	Strategies to address gender discrimination and empower women do not appear to have been implemented in any of these programmes. This impression – emerging from documentation was confirmed through discussions with DFID Cambodia.	Gender not highlighted on the M&E framework of any of these programmes – OVI's do not reflect a need for breakdown of data by sex, socio-economic group etc. Maternal health requirements visible in a range of OVI's on **HSSP** log-frame, although UN process indicators for maternal health are not reflected.
	Rights • **Legal system** • **Public awareness** • **Response to gender-specific rights violations**				
	Access to resources and benefits of development • **Livelihoods and productive assets** • **Institutional capacity** • **Policy and programme change**				

5.2.3 Nigeria case study (focus on PATHS[17])

Investments reviewed (all with a 'P' PIMS marker for maternal health) and level of financial commitment:

048555048	UN MDG Support	£100, 000,000
048555037	Partnerships for Transforming Health Systems (PATHS)	£39,000,000
048555040	Insecticide Treated Nets Programme (ITNP)	£2,131,094
048680014	Pilot Project on Women's Health and Development	£171,755

Box 12 Nigeria – the challenge (drawing on programme documentation)

In Nigeria, home to 20% of the population of sub-Saharan Africa; 70% of people live in extreme poverty (less than one dollar per day). Forty years of military rule and widespread corruption have undermined service provision and left deep rooted obstacles to reform. In 2003, Nigeria successfully held its second consecutive election consolidating the transition to civilian rule. Under the current, reform minded, government progress in developing and momentum towards implementing the poverty focused National and State Economic Empowerment and Development Strategies, has provided hope for the future. However with basic health indicators among the worst in Africa and a rapidly rising HIV prevalence, the challenges faced are enormous.

Every year there are an estimated 37,000 maternal deaths in Nigeria. Nationally MMR is estimated by the UN to be 800/100,000 live births. However, there are wide regional variations and in Kano State MMR has been estimated to be as high as 2420/100,000 live births. Women living in the conservative North, where Shari'ah law is enforced (and often misinterpreted), face the highest burden with a one in 15 lifetime risk of maternal death. In these areas exposure to early and repeated pregnancy is commonplace and access to safe abortion and family planning severely restricted. Delays in reaching care begin in the home with cultural barriers, and the tradition of purdah restricting many women's mobility. For those who are able to travel to seek care, lack of transport and/or inability to pay for transport and services cost countless lives. Even if women reach a health facility she may receive sub-standard care and experience treatment which shows disregard for her needs. Gender discrimination is institutionalised at every level of Nigerian society and within institutions.

5.19 DFID Nigeria has a large portfolio in health, and is focused on enabling the current Government of Nigeria (GoN) to scale up appropriate health sector inputs in pursuit of the MDGs and achievement of the National and State Economic Empowerment and Development Strategies (N/SEEDS). Current support includes:

- the UN MDG Support Programme (no. 048555048) is being designed, and will provide support to UN agencies to scale up and harmonise activities that enhance progress toward MDGs and N/SEEDs targets
- the ITNP (no. 048555040), which was implemented by Futures Group Europe and worked on both demand and supply side action to increase use of insecticide treated nets (particularly by young children and pregnant women). Development of the next phase of support of ITNP is in progress and will continue to focus on reducing mortality and morbidity from malaria in pregnancy.

[17] Due to a very busy time within the DFID Nigeria office while this evaluation was taking place, it was agreed, with DFID Nigeria that documentation for all programmes would be reviewed, but that interviews would take place only with the company managing implementation of PATHS.

- PATHS (no. 048555037, the focus of this review) was designed in 2001 and launched in mid 2002. Toward the end of 2003 a joint inception review (JIR) of progress to date on PATHS and other DFID investments was undertaken. PATHS was adapted to align more closely with DFID priorities and direction informed by the MDGs, the Africa DDP, the new DFID Country Assistance Plan, the findings of the Nigeria Drivers of Change paper and GoN's N/SEEDS. The management of PATHS is contracted to a consortium led by HLSP. Reviews are undertaken twice annually by Oxford Policy Management.

5.20 afe motherhood has been a key priority of PATHS and studies on provision of emergency obstetric care and health seeking behaviour in pregnancy were undertaken early in the programme. This focus was reinforced by the JIR. The overall programme purpose is to improve the delivery and use of effective, replicable, pro-poor health service for the management of common health problems in selected states (currently Enugu, Ekiti, Jigawa, Benue and Kano). A key challenge faced by PATHS is to strike a balance between the need for immediate results or 'quick wins', and addressing the deep rooted systemic problems that obstruct quality service provision and equitable access to the health system. This is achieved through attention to four thematic areas: a) increasing quality and sustainability of services necessary for achievement of the health MDGs, b) sustainable access to quality essential drugs, c) strengthen GoN's stewardship role, and d) stimulate demand for and accountability of priority health services. Attention to maternal health is integrated through these themes and within work at both Federal and State level, although the type of initiative varies between states. For example considerable progress in developing strategy for both demand and supply sides of maternal health has been achieved in Jigawa whilst in Ekiti the attention, to date, has largely been on service delivery issues.

5.21 Gender and rights are visible on the PATHS agenda. For example, one output is specifically rights focused: 'consumers of health services aware of their entitlement to good quality, affordable health care...' Use of the 'three delays framework' to analyse barriers to accessing and receiving quality emergency obstetric care, has enabled a focus on rights and gender issues at household and facility levels. These issues were presented and discussed with a wide group of stakeholders and decision makers at a Safe Motherhood Round Table consultation in mid 2004. In addition PATHS recently produced a short paper on experience to date in mainstreaming gender and rights (in preparation for the 2004 OPR). A social development roundtable facilitated by PATHS Social Development Technical Advisory team in late 2003 also focused on entry points for integrating a gender focus into programme activities.

5.22 Actual progress in tackling gender discrimination is slow. In part this is due to the country context. Given the dysfunctional nature of the health system in Nigeria, most effort is placed on basic steps and similar to the experience in Cambodia, gender mainstreaming comes second place to these. Compounding this data availability is poor; so many indicators cannot be disaggregated.[18] There has not yet been an OPR focused on demand side or gender issues (although this is planned), there is no full time SDA expertise on the in-country PATHS team and no specific budget for social development-related activity. In short, although the PATHS programme is aware of gender issues, a combination of factors mean that addressing gender

[18] Nevertheless, most monitoring indicators used by PATHS are gender disaggregated, at DFID Nigeria's request, and DFID has also required that PATHS's support for the National HMIS insists on gender-disaggregation of all data when feasible and relevant.

issues is opportunistic rather than mainstreamed. That said progress is being made for example, the strong links and support by PATHS to the Ministry of Social Affairs and Women's Development who are strong advocates of gender empowerment.

Box 13 Nigeria – factors enabling and constraining gender mainstreaming

Opportunities emerging to enable more engagement on gender issues

In Jigawa State links with and support to strengthen the capacity of the Ministry of Social Affairs and Women's Development is enabling a voice for gender empowerment (for example by challenging the acceptance of domestic violence against women) from within FGoN.

In some states the PATHS team have a strong background and skills in social development and have drawn on and utilised extensively social development technical advisory support provided by PATHS Programme Technical Advisers. This has led (in these areas) to a stronger focus on 'demand' side issues and a greater awareness of the impact of gender inequality on maternal health outcomes.

A recent state health planning process in Jigawa resulted in the establishment of a Health Equity Task Force which has a remit to lead a process of consultation over, and produce a state level gender, health equity and participation policy. This will provide an important policy level framework and reference point for ongoing work to mainstream gender issues into safe motherhood programming.

There is a new opportunity for enhanced cross fertilization between sectors, especially as DFID Nigeria's new Girls' Education Project (joint with UNICEF) gets going in northern Nigeria, with an emphasis on empowering women and girls to achieve improved health (as well as educational) outcomes for their families and communities. This will build on the successful Expanded Life Planning Education Project, completed in 2003.

Factors limiting gender mainstreaming to date

The cultural context limits/slows engagement on gender issues. For example in some States (e.g. North) the limited vitality of women's organisations and civil society combined with cultural barriers to women's empowerment created by Sharia law and Purdah create challenges for addressing gender discrimination, and locally appropriate levers of change must be identified. In other states the weakness of the civil society sector means that a major driving force for change on gender and rights issues is absent.

Within the health system engaging on human resource issues appears to be a very contentious issue in itself never mind gender dimensions of human resource management.

Lack of clarity and understanding/skills on gender mainstreaming across programme teams and absence of gender mainstreaming strategy (with the exception of the Access to Justice Programme) has been recognised (through the JIR) as a constraint by DFID. Ideas such as having mandatory gender training for DFID and management agency teams have been flagged.

The lack of a full-time in-country Social Development Adviser means that follow-up to ensure that social development related issues remain on state level agendas can be difficult. Receptivity to these issues, and thus time invested in influencing local agendas varies significantly within the PATHS in-country team.

Table 8 Summary of gender mainstreaming in Nigeria

		MAINSTREAMING			
	Nigeria	**Identification**	**Design and preappraisal/appraisal**	**Implementation**	**M&E**
EQUALITY AND EMPOWERMENT	**Decision taking** • **Capacity for public participation** • **Representation among decision makers** • **Household & individual decision making** **Rights** • **Legal system** • **Public awareness** • **Response to gender-specific rights violations** **Access to resources and benefits of development** • **Livelihoods and productive assets** • **Institutional capacity** • **Policy and programme change**	**PATHS** – no gender equality marker on project header sheet. No PCN available for review.	**PATHS –** focus on pro-poor development articulated and gender analysis of poverty and health provided in the social analysis, and summarised in the main body of the project memorandum. Social appraisal rights focused, although initial indicators do not take this further.	**PATHS** – where possible attention to gender and rights issues articulated including in demand side assessments of safe motherhood in Jigawa state, at the safe motherhood roundtable, in preparation of a paper on gender mainstreaming and rights. However, progress more opportunistic than mainstreamed (see main text). No overall gender strategy in place.	**PATHS** – monitoring framework has limited ability to capture gender dimensions and data availability, this means that intended desegregation of existing indicators constrained. Each OPR follows a theme. An OPR focusing on demand side issues is planned but has not yet taken place, as both DFID Nigeria and PATHS recognise that this is an area that takes longer to bear fruit.
		UN MDG SUPPORT– gender issues not explicit in identification data. No gender equality maker on project header sheet.	**UN MDG SUPPORT –** design documentation not yet available.	**UN MDG SUPPORT**– not yet being implemented	**UN MDG SUPPORT –** not applicable, programme at identification stage.
		ITNP – no explicit mention of gender issues in identification level documentation.	**ITNP –**pregnant women and young children articulated as main beneficiary target group. Social appraisal explored issues of women's access to the benefits of the programme (only summary seen during review).	**ITNP** – insufficient documentation reviewed to comment. No gender strategy apparent.	**ITNP** – resource constraints limited ability to monitor the % of pregnant women and young children using bed-nets although secondary data indicates success in this area; otherwise no specific attention to gender within OPR/PCR reviewed.
		Pilot Project on Women's Health and Development (PPWHD)– gender discrimination marker not applied on project header sheet.	**Pilot Project on Women's Health and Development (PPWHD)**– no documentation on PRISM for review	**Pilot Project on Women's Health and Development (PPWHD)** – insufficient documentation available for review	**Pilot Project on Women's Health and Development (PPWHD)**– no log-frame/ monitoring framework available. No mention of gender in PCR (though formatting made this difficult to read).

6 Conclusions: outcome, impact and DFID contribution

6.1 This review cannot provide concrete evidence of outcomes or impact on maternal mortality reduction as a result of DFID investment. Much less can the contribution of gender mainstreaming strategies to DFID programming for maternal mortality reduction be firmly determined. Changes in MMR[19] are notoriously difficult to assess (particularly over the time span of any one programme of work), and can rarely be attributed directly to the investment of any one donor or to any one strategy (e.g. gender mainstreaming). Global experience in using the 'UN process indicators' (see UNICEF, UNFPA, WHO, 1997) to assess equity dimensions of availability and access to key maternal health services is lacking. Increased focus on developing, testing and disseminating practical methods and tools that enable assessment of equity in maternal health programming is required. DFID is contributing to this need (see box 14).

Box 14 Examples of DFID contribution to improving ability to monitor equity in maternal mortality reduction

DFID is part-funding the research programme IMMPACT which will providing rigorous evidence of the effectiveness and cost-effectiveness of safe motherhood intervention strategies and their implications for equity and sustainability (http://www.abdn.ac.uk/immpact/about/index.htm).

DFID India have developed and are testing (in RCH-II) a 'triangulated approach' to monitoring and evaluation that includes attention to equity dimensions of access to and utilisation of maternal health services (see 5.2.1).

the DFID funded Nepal Safer Motherhood Project adapted and tested use of the Swansea/ Options Peer Ethnographic Evaluation and Research tool (PEER), to ensure that the voices of marginalised women are heard within monitoring processes. This has maintained focus on equity dimensions and informed future programme direction. Under the new DFID funded investment 'Support to the National Safe Motherhood Programme' use of these methods will be scaled up (http://www.options.co.uk/te-peer-unit.htm).

6.2 The review can however provide some insights into the factors that are shaping the level to which DFID is mainstreaming gender.

6.3 **Firstly, the country context is critical**. DFID works in close partnership to support national governments in their development objectives. These objectives are necessarily informed by a hierarchy of need. Urgency to tackle gender inequality and therefore emphasis on gender mainstreaming strategies depends on the stage at which the country's health system is at. A good example is DFID work in Cambodia. Over the last decade all investment and effort has focused on rebuilding the infrastructure and basic functioning of the health system. It is only now that these 'foundations' are in place that the gender dimensions of health seeking behaviour, service delivery and utilisation and institutions are appearing on

[19] For information on the challenges in measuring changes in MMR see appendix 13 'Measuring and monitoring changes in maternal mortality' by Sandra MacDonagh in 'Maternal Mortality – time for a multisector approach to a neglected MDG' (MMRD Taskforce 2002). For examples of where MMR has been lowered and analysis of key programme strategies that led to this see 'Briefing paper for DFID maternal mortality task force' Sandra MacDonagh, Feb 2002.

DFID's agenda. There would be value in exploring the potential and means of putting gender mainstreaming on the agenda early in such settings – this may be particularly important for work in fragile states.

6.4 **Secondly, advisors reported that gender is still considered the domain of SDA's rather than a 'mainstream' issue** of concern across all disciplines. The gender equality and women's empowerment TSP has little visibility and 'gender', and RBA language is considered to be alienating, and the TSP is not seen to provide practical advice that enables advisers in different disciplines to identify how they can mainstream gender in their work. Useful guides that would demystify such issues such as DFID's gender manual (Derbyshire 2002) are not widely disseminated or recognised. A move toward multi-disciplinary team working appears to be overcoming some of these constraints. However, there is a need to develop clear and practical strategies that apply to and resonate with different disciplines if gender is truly to be a mainstream issue. This challenge is being taken up by those working on the guidance for applying a RBA for reducing maternal mortality.

6.5 **Thirdly, the way in which DFID 'does business' influences the level of attention apportioned to gender mainstreaming**. DFID's approach to development has altered radically over the last few years. The days of discrete projects where DFID had a high level of control over inputs, approaches and M&E frameworks has gone. The focus today is on promoting sustainable development through harmonised working arrangements with other EDPs, and expenditure is increasingly via budget support. The organisation is more externally focused. In theory this allows DFID greater influence and the potential to progressively work toward inclusion of gender issues in national poverty reduction strategies. In practice it seems that efforts to ensure harmonisation and alignment of policies mean that there is a narrowing of DFID engagement. Hard won focus on gender equality and women's empowerment seems to be evaporating in the face of competing policy priority. However, the upstream nature of DFID's engagement does provide opportunity to influence cross-sector engagement on RBA and to enable development of national gender strategies. It may be that as new ways of working mature marginalised agendas such issues gain momentum again. For example one programme (RCH II) reported that the World Bank design processes used by DFID increased the opportunity for engagement on issues such as gender discrimination. However, this cannot be taken for granted and certainly at this point of time it would appear that DFID is not living up to the policy priority outlined in the gender equality and women's empowerment TSP.

6.6 **Finally, although there is evidence that 'senior management'[20] commitment has led to increased focus on maternal health the same cannot be said for gender mainstreaming.** Nearly everyone interviewed during this review reported a sense of resistance to 'gender' from DFID 'senior management'. Without high level support gender mainstreaming will never become a reality. If DFID is ready to have a corporate commitment to gender mainstreaming/RBA then this needs to be reflected in PSA, SDA and DDP monitoring frameworks and be visible in all programme OVIs and terms of reference.

[20] In discussions with Evaluation Department and the Gender Study Group it was agreed that 'senior management' is most likely to refer to policy level directors/director generals but, may in some contexts refer to department heads.

6.7 There can be little argument that high levels of maternal mortality and disability are fuelled by multiple dimensions of inequity, including poverty, gender discrimination and other factors that lead to exclusion such as ethnicity, age etc. Gender discrimination at the highest political levels and within legislative, governance and health systems conspires to create laws and services that increase women's risk of unwanted pregnancy, and limit the availability of and their access to life-saving services. The 'how to' note on applying RBA for maternal health that Policy Division has been working on, provides a potentially excellent tool to ensure that these issues are considered within and beyond DFID's work in health system strengthening for maternal mortality reduction. Taking this work forward will require high level support within DFID.

6.8 Future focus on sharing 'best practice' on mainstreaming a RBA that includes attention to multiple dimensions of inequity, including gender discrimination will be important. However, there is a challenge in balancing the brevity of information required to track the policy focus of bi-lateral expenditure (e.g. PIMS markers and header sheets), and to monitor progress (e.g. OPR/PCR), and the type of information needed to enable country programmes to share best practice and maximise learning.

7 Suggestions for the systematic review

7.1 Areas for consideration in the systematic review

7.1 This section contains a number of cross-cutting and theme specific issues that have been highlighted during the course of this review, but that would benefit from deeper investigation and thought in the forthcoming systematic evaluation.

7.1.1 Cross-cutting issues

There are a number of cross-cutting issues:

- despite increased potential to influence working processes and priorities of other EDPs; it would appear that attention to gender discrimination and gender mainstreaming strategies are being marginalised, as DFID country programmes harmonise with and align their policies and procedures with those partner EDPs. To what extent is this perception true or merely a factor of the earlier stages of a harmonisation process? How can new 'ways of working' be harnessed (often using other partners e.g. the World Bank's processes and documentation) to maximise attention to gender? If processes used by the World Bank enable deeper engagement on issues such as gender discrimination, what lessons can be learnt to improve DFID's own programme identification and design procedures?

- The PIMS and core information from PRISM i.e. PCNs, project header sheets, project memorandums (often without appendixes), OPRs and PCRs do not contain sufficient information to assess, at any depth, the strategies and approaches used during a programme that led to successful or failed achievement of outputs, purpose and goals. How can the brevity of information necessary to enable rapid collation of parliamentary submissions, track bilateral expenditure by policy priority, produce monitoring reports that are useful to senior management etc, be combined with the need for increased sharing and dissemination of practical ways to mainstream gender?

- Is the felt resistance to gender mainstreaming from DFID's senior level management really present? If so what interventions and mechanisms are necessary to engender a shift from resistance to commitment? If not how can this commitment be articulated and 'assured' within the rest of the organisation?

7.1.2 Thematic (maternal mortality) issues

There are also a number of thematic issues:

- what lessons of 'best practice' emerging from gender mainstreaming strategies have been used in Safe Motherhood projects and programmes over the last decade (DFID and non-DFID)? What impact have these strategies had on gender equality and/or empowerment? How can successful strategies be adapted for use within newer aid modalities e.g. programmatic, DBS and Sector Wide Approaches (SWAps)?

- RBA is emerging as the dominant framework to address equity issues in maternal health programming. What checks need to be in place to ensure that gender equality and empowerment are retained as key elements during the implementation of a

RBA? What do country programmes and advisers need to enable them to embrace and use RBA in their work?

7.2 Comments on methodology and quality of data

7.2.1 The evaluation framework

7.2 Overall the framework developed for this evaluation was a satisfactory, flexible and practical tool. The framework appeared to be well received by interview respondents. Certainly it was useful as a tool for tracking gender across the life of an investment from identification to M&E; enabling identification of points where policy evaporation or invisibilisation were occurring. For example in RCH II excellent ideas for monitoring and evaluation were presented in the design documents but seem to have disappeared in the draft M&E framework.

7.3 The utility of the framework in investigating, in any depth, attention to the three dimensions (decision making; rights and access to resources and benefits of development) was limited. This was in part due to the rapid nature of this evaluation. However it is also because documentation (e.g. project concept notes, project memorandum) do not have space for this level of detail on any one issue and even where gender was explored different dimensions were not. In addition this was not the framework used by DFID advisors to guide their thinking (it was drawn from a CIDA model); so it was difficult to relate the dimensions used in the framework to work on the ground.

7.4 For this reason and also given the many comments on the confusing use of language and plethora of frameworks available, it would be pertinent to review the evaluation framework against current DFID conceptual frameworks and strategy documents, in particular the new RBA 'how to' note for maternal mortality reduction – using the framework of participation, inclusion and fulfilling obligation/accountability. It is also important that the evaluation framework is presented in conjunction with a narrative report. This is necessary to avoid the framework becoming a rigid tool.

7.5 Overall the framework was useful. With adaptation based on the experience of testing it within this and the HIV/AIDS evaluation; it could be a valuable tool for the larger systematic evaluation.

7.22 Quality of information available

7.6 The quality of written documentation varies. Generally, the majority of the documents, held on PRISM give little explicit evidence of gender mainstreaming. This is not to say that it is not occurring, more that the pressure of incorporating and reporting on a wide range of activities and priorities means that choices, assumptions and trade-offs are made when deciding what to include in a report.

7.7 Other, more detailed, documentation e.g. consultant reports, appendixes of project reports etc contain more information on programme strategies. However, these do not appear to be available from PRISM and the relatively short time span of country adviser postings mean that institutional memory of such reports is short. These circumstances mean that collection of key documentation for a review such as this is rather ad-hoc. It may be useful to allow more time to identify and track documents in the systematic review.

7.2.3 Timing

7.8 The process of agreeing case studies, sourcing and receiving documentation, and contacting and arranging interviews with country staff has taken much longer than envisaged. This is in part due to the timing over the Christmas and New Year period, but is also a reflection of the very high work loads of DFID advisers and the long lead-in time required to ring-fence their time for activities such as this. It is suggested that this is taken into account in preparations and timing for the systematic evaluation.

References

AbouZahr C (2001) *Cautious champions: International agency efforts to get safe motherhood onto the agenda.* In (Eds: De Brouwere V, Van Lerberghe W) Safe Motherhood Strategies: a Review of the Evidence, Studies in Health Services Organisation and Policy, 17) 387–414

Bangser M, Gumodoka B, Berege Z (1999) A comprehensive approach to vesico-vaginal fistula: a project in Mwanzan, Tanzania. In (Berer M, Ravindran TKS) Safe Motherhood Initiatives: critical issues, Reproductive Health Matters 157–65.

Braithwaite M, Haile J, Vouhe C, Walker J, Van Esbroeck B, Hijazi W, Moussa A, Sobritchea C, Urioste D, Steinmeyer M (2003). *Thematic evaluation of the integration of gender in EC development co-operation with third countries.*

Campbell OMR (2001) *What are maternal health policies in developing countries and who drives them? A review of the last half-century.* In (Eds: De Brouwere V, Van Lerberghe W) Safe Motherhood Strategies: a Review of the Evidence, Studies in Health Services Organisation and Policy, 17) 415–48.

CIDA (2003) *Framework for assessing gender equality results.* Work in progress, Gender Equality Division. June.

Derbyshire H (2002) *Gender Manual: A Practical Guide for Development Policy Makers and Practitioners*, London, DFID

De Regt (undated) *Pioneers or pawns? Women health workers and the politics of development in Yemen*, published PHd thesis.

DFID (1997) *Time for Action, reducing the dangers of pregnancy in poor societies.*

DFID (2000a) *Poverty Elimination and the Empowerment of Women: Strategies for Achieving the International Development Targets*, London, DFID

DFID (2000b) *Better health for poor people, strategies for achieving the international development targets.* Target Strategy Paper.

DFID (2000c) *Realising rights for poor people.* Target Strategy Paper

DFID (2001) *Abortion and maternal health*

DFID (2002) PSA and SDA 2003 – 2006, version 16th July 2002, 1020

DFID (2003) *Project Header Sheet Guidance incorporating Input Sector Codes and Policy Information Marker System.* Statistical Reporting and Support Group.

DFID (2004a) *Reducing maternal deaths: evidence and action.* A strategy for DFID.

DFID (2004b) *Sexual and reproductive health and rights.* A position paper.

DFID (2005a) *Why we need to work more effectively in fragile states.* Jan.

DFID (2005b) *How to reduce maternal deaths: rights and responsibilities DRAFT FEB.*

DFID (2005c) Memo re: Monitoring the AIDS Spending Targets – New PIMS Guidance. 12 Jan 2005.

Ellis (2004) *Evaluating the Australian overseas aid programme – a third generation of evaluation?* Draft submitted to Canberra Bulletin of Public Administration. April.

Freedman L, Wirth M, Waldman R, Chowdhury M, Rosenfield A (2004) *Millennium project task force 4 child health and maternal health, interim report.*

Freedman LP (2001) *Using human rights in maternal mortality programmes: from analysis to strategy.* International Journal of Obstetrics and Gynaecology, 75: 51–60.

Graham WJ, Fitzmaurice AE, Bell JS, Cairns JA (2004) The familial technique for linking maternal death with poverty. The Lancet 363, 23–7.

Huque SA, Leppard M, Mavalankar D, Akhter HH, Chowdhur TA (1999) Safe Motherhood Programmes in Bangladesh. In (Berer M, Ravindran TKS) Safe Motherhood Initiatives: critical issues, Reproductive Health Matters 53–61.

McCoy D, Ashwood-Smith H, Ratsma E, Kemp J, Rowson M (2005) *Going from bad to worse: Malawi's maternal mortality. An analysis of the clinical, health systems and underlying reasons, with recommendations for national and international stakeholders.* Commissioned by Task Force 4 of the UN Millennium Project.

MMRD Taskforce (2002) *Maternal mortality – time for a multisector approach to a neglected MDG.* Prepared by Sandra MacDonagh for Options/DFID.

Moser C, M'Chaju-Liwewe O, Moser A, Ngwira N, (2004) *DFID Malawi Gender Audit: Evaporated, Invisibilised or Resisted?*, London, DFID

Nga DTN, Morrow M (1999) Nutrition in pregnancy in rural Vietnam: poverty, self-sacrifice and fear of obstructed labour. In (Berer M, Ravindran TKS) Safe Motherhood Initiatives: critical issues, Reproductive Health Matters 137–46

Pathmanathan I, Liljestrand J, Martins JM, Rajapaksa LC, Lissner C, de Silva A, Selvaraju S, Singh PJ (2003) Investing in maternal health: learning from Malaysia and Sri Lanka. The World Bank, Human Development Network Health, Nutrition and Population Series.

Policy Project. Maternal and Neonatal Program Effort Index. Cambodia. Sourced from www 25/01/05 on www.dec.org/pdf_docs/PNACR871.pdf

Ravindran TKS, Savitri R, Bhavani A (1999) Women's experiences of utero-vaginal prolapse: a qualitative study from Tamil Nadu, India. In (Berer M, Ravindran TKS) Safe Motherhood Initiatives: critical issues, Reproductive Health Matters 166–72.

Reeves H, Baden S (2000) *Gender and Development: Concepts and Definitions*, Brighton, BRIDGE

Rosenfield A, Maine D (1985) *Maternal mortality – a neglected tragedy: where is the M in MCH?* The Lancet 2: 83–5.

Sehu D (1999) Community participation and mobilisation in the prevention of maternal mortality in Kebbi, North-western Nigeria. In (Berer M, Ravindran TKS) Safe Motherhood Initiatives: critical issues, Reproductive Health Matters 21 – 226.

UNICEF, WHO, UNFPA (1997) *Guidelines for monitoring the availability and use of obstetric services.*

WHO, UNICEF and UNFPA (2004) *Maternal mortality estimates in 2000: estimates developed by WHO, UNICEF and UNFPA.*

WHO (2001) *Advancing safe motherhood through human rights.*

Yamin AE, Maine DP (1999) Maternal mortality as a human rights issue: measuring compliance with international treaty obligations. Human Rights Quarterly, Vol. 21 563–607.

Abbreviations

ACPP	Africa Conflict Prevention Pool
ADB	Asian Development Bank
BRAC	Bangladesh Rural Advancement Committee
BRIDGE	Gender and Development Information Service, IDS
CAP	Country Assistance Plan
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CHAD	Conflict and Humanitarian Affairs Department
CIDA	Canadian International Development Agency
CPCS	Community-Based Policing and Community Safety Programme
CPPs	Conflict Prevention Pools
CSO	Civil Society Organisation
CSP	Country Strategy Paper
CSR	Corporate Social Responsibility
DAC	Development Assistance Committee, OECD
DAC-GENDERNET	Development Assistance Committee – Gender and Development Network
DBS	Direct Budget Support
DDP	Directors Delivery Plan
DDR	Disarmament, Demobilisation and Reintegration
DEVAW	Declaration on the Elimination of Violence against Women
DPKO	Department of Peacekeeping Operations
DRC	Democratic Republic of Congo
DTI	Department of Trade and Industry
DV	Domestic Violence
EC	European Commission
EDP	External Development Partner
EE	Enabling Environment
EFA	Education for All
EMAD	Europe, Middle East and Americas Division
EmOC	Emergency Obstetric Care
EU	European Union
FCO	Foreign and Commonwealth Office
FDI	Foreign Direct Investment
FGM	Female Genital Mutilation
GBIs	Gender Budget Initiatives
GBV	Gender Based Violence
GCPP	Global Conflict Prevention Pool
GE	Gender Equality
GoB/ I / N / P / SA /U	Government of Bangladesh / India / Nicaragua / Nigeria / Pakistan / Peru / South Africa / Uganda
GTZ	German Aid Agency: Gesellschaft fur Technische Zusammenarbeit
HSR	Health Sector Reform
ICEE	Investment, Competition & Enabling Environment Team, DFID
ICPD	International Conference on Population and Development
IDB	Inter-American Development Bank and Fund

IDPs	Internally Displaced Persons
IDS	Institute of Development Studies, University of Sussex
IDT	International Development Targets
INGO	International Non-Governmental Organisation
ISP	Institutional Strategy Paper
JICA	Japan International Co-operation Agency
JRM	Joint Review Mission
KFOR	Kosovo Force
LMM	Lower Maternal Mortality
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MOD	Ministry of Defence
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Development and Cooperation
OPR	Output to Purpose Review
OVI	Objectively Verifiable Indicator
PAD	Project Appraisal Document (World Bank)
PCN	Project Concept Note
PCR	Project Completion Report
PCRU	Post Conflict Reconstruction Unit
PEAP	Poverty Eradication Action Plan
PfA	Platform for Action
PIMS	Policy Information Marker System
PPA	Participatory Poverty Assessment
PRISM	Performance Reporting Information System Management
PRS(P)	Poverty Reduction Strategy (Paper)
PSA	Public Service Agreement
PSD	Private Sector Development
RBA	Rights Based Approach
RCH	Reproductive and Child Health
RGC	Royal Government of Cambodia
SAAW	Social Audit of Abuse against Women
SDA	Social Development Adviser or Service Delivery Agreement
SDD	Social Development Department
SED	Small Enterprise Development
SG	Secretary General, United Nations
SIDA	Swedish International Development Co-operation Agency
SME	Small and Medium Enterprise Development
SRHR	Sexual and Reproductive Health and Rights
SSAJ	Safety, Security and Access to Justice
SWAp	Sector Wide Approach
ToRs	Terms of Reference
TRC	Truth and Reconciliation Commission
TRCB	Trade Related Capacity Building
TSP	Target Strategy Paper
UAF	Urgent Action Fund
UN	United Nations

UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNGEI	United Nations Girls' Education Initiative
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organisation
UNIFEM	United Nations Development Fund for Women
UNMIK	United Nations Peacekeeping Mission in Kosovo
UPE	Universal Primary Education
USAID	United States Agency for International Development
VAW	Violence Against Women
WHO	World Health Organisation
WID	Women in Development
WTO	World Trade Organisation

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