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Management response

Evaluation of Sida's work with sexual and reproductive health and rights
1994-2003

Background

The government's spending authorisation for 2003 commissioned Sida to evaluate its work on sexual and reproductive health and rights (SRHR). The points of departure for the evaluation were Sida's strategy for sexual and reproductive health and rights, the action plans for the UN's 1994 International Conference on Population and Development (ICPD) in Cairo and its follow-up 1999 conference, ICPD+5.

The health division formulated a project description for the evaluation and invited several consultancies to submit tenders. This evaluation process was considered to be so extensive that it required a tendering procedure, carried out together with a consultant and Sida's procurement and evaluation divisions. However, one of the consultancies had been closely involved in Sida's work with SRHR and could not be considered sufficiently independent. The two consultancies that remained at the end of the first round each presented a technical proposal. The Health Division's SRHR group found none of the consulting firms to be ideal, but considered Chr. Michelsen Institute (CMI) in Bergen to be the better qualified of the two, on condition that it added an SRHR expert to the team.

Implementation of the evaluation

The Project Description covers eight areas, all of which are included in the evaluation to a greater or lesser extent. However, even in the final report the focus is on description, not analysis; rather than providing analytical insight, the final report repeats information such as methods used, as well as organisations and countries visited. The consultants interviewed a large number of partners, though health division personnel were not interviewed; the information that would have been obtained during these interviews most probably would have facilitated the consultants' work and straightened out several misunderstandings. Health division employees feel that CMI therefore did not use the available opportunities to acquire already gathered information. Although the team leader and an employee held an initial meeting, clearly this was not enough. Moreover, because of lack of time, a planned seminar at which the consultant's recommendations were to be discussed with the involved departments and organisations in Sweden was never held either.

Certain observations and conclusions have a gender perspective, while such a perspective is missing in many other cases. Indeed, the gender perspective does not permeate the report but comes in *ad hoc*. Although the project description does not specify a clear requirement for a gender-based analysis, the health division assumed that Sida's goals and its action programme promoting gender equality served as an obvious basic premise in the evaluation, since this perspective permeates the SRHR strategy. In addition, one

strong reason for awarding CMI this project was because the team leader is an expert on gender issues.

The consulting team carried out the evaluation during autumn 2003 and Sida received the final report on 30 January 2004, at which time it was delivered to the Ministry of Foreign Affairs. This was one month later than originally scheduled for the project. The delay was mainly because the final report had to be revised on two occasions by the consultant since it did not fulfil the requirements specified in the project description.

The tender included a requirement for the team to engage a senior person who is accomplished in written and spoken Swedish. There were multiple reasons for this requirement, including familiarity with the Swedish bureaucracy, the fact that many documents were written in Swedish, and that the project also required an extensive summary in Swedish to be submitted to the Ministry of Foreign Affairs at the same time as the evaluation report. The consultant did not use the Swedish consultant for this purpose; instead, CMI hired an outside consultant and delivered the summary in January 2004. The quality of this summary was so poor that Sida could not approve it. Nor was the second, revised version acceptable; it was also disorganised, contained countless repetitions and used cumbersome language. CMI then hired another external consultant, which did not particularly improve the quality. Finally, Sida agreed to take back that portion of the project and deducted the equivalent cost from CMI's budget after consultation with Sida's legal department. Sida hired a consultant who organised the report and clarified the language.

Conclusions

The evaluation is consistently positive towards Sweden and Sida's SRHR contributions. Among the general conclusions: Sida has played a vital role in supporting SRHR, and evaluators attribute great weight to the 1997 SRHR strategy, which laid the foundation for both a gender equality and a rights perspective. Thanks to this strategy, men have been involved, which is viewed as a major and significant accomplishment.

Sweden's broad *political* support has opened the door to bring up taboo subjects both internationally and in bilateral co-operation, especially with reference to the sexuality of young people and the right to safe abortion. *Financial* support has been of great significance; Sweden is perceived as a generous and reliable donor that recognises the value of long-term support. International organisations in particular stress the importance of non-earmarked contributions. According to the evaluators, Sida's *institutional* and *technical* support to organisations and research institutions has also meant much for developments within SRHR.

The only weakness that the evaluation notes is the lack of integration of SRHR and HIV/AIDS contributions at the policy and implementation level, as well as the integration of SRHR in SWAps and PRSPs.

Recommendations

The evaluators formulated a few general recommendations. The point of departure is that the SRHR area faces major risks for setbacks, and Sida should help to stop such a development. The risks identified in the evaluation are

(a) support to HIV/AIDS will increase at the expense of SRHR (much because of "the global gag rule"). As a result less attention will be paid to areas such as maternity care, maternal mortality and abortion issues.

Considering these risks, the report recommends that Sida once again stress SRHR more than what is the case in the current health policy from 2002, focus more intensely on maternal health and more strategically than previously, and increase support for midwifery training and "baby friendly hospitals". Sida should give priority to support for safe abortions; current forms of contributions need to be reviewed. Moreover, the report recommends co-ordination of SRHR and HIV/AIDS strategies.

(b) "Sector wide approaches" (SWAp) need to become more common. If governments make SRHR a lower priority, then civil society must accept greater responsibility, especially for controversial SRHR activities. NGOs in Sida's partner countries do not have adequate resources.

To stop negative developments the report recommends that Sida assume a leadership role and include SRHR in both SWAp and PRSP. At the same time Sida should continue to support NGOs.

(c) "Poverty Reduction Strategy Papers" (PRSPs) are becoming more important strategy documents than country strategies for donors *and* they pay relatively little attention to SRHR.

The report therefore recommends that Sida take the lead to influence PRSP processes to include SRHR, while integrating these contributions in other policies, and even become part of the actions taken within other areas.

(d) access to contraceptives and other services is being pushed into the background, while advisory services and information are in the spotlight. According to the report, this risk is particularly great in relation to contributions involving young people.

To stop such a development Sida should support services, such as distribution of contraceptives, more than what is currently the case. Another important task for Sida is to help to improve co-ordination among different types of contributions involving young people.

These general recommendations are supplemented by some thirty specific proposals. These proposals cover changes within Sida as well as changed relationships to partners. Examples of proposals for change within Sida are to revise Sida's current SRHR strategy, to become more visible in the general health policy "Health is Wealth" and to strengthen co-ordination between SRHR and HIV/AIDS activities.

The specific proposals also include an appeal for Sida to support certain urgent areas which in the future are expected to receive less support than they have received so far. These areas include midwifery training, "baby friendly hospitals", abortion, female genital mutilation, violence against women and adolescent health initiatives carried out within the World Bank.

In addition, the evaluation recommends that Sida devote more attention to female genital mutilation (FGM) and broaden current support to even include “dry sex”, another harmful custom. Sida should also consider supporting prevention of infertility and increasing its support to projects to counteract violence against women. Experiences from Latin America and the Mekong region could be helpful in SRHR contributions in Africa.

Sida's position

Sida feels that the evaluation generally presents a true and fair view of the work with SRHR during the past decade, but in many cases the recommendations are difficult to implement because they are

- obvious or already stated in the spending authorisation
- ongoing activities already exist
- not relevant based on the Health division's SRHR strategy, which for natural reasons cannot focus on all important aspects of SRHR but must give priority to certain areas for different reasons, e.g. because Sweden has special expertise in certain areas, so called comparative advantages, or because the area is overly sensitive for other countries to work in, but possible for Sida because of the broad political support in Sweden.

Actions and follow up of recommendations

Sida has already implemented activities to address many of the recommendation, while others are not relevant.
Please refer to the list at the end of this document presenting all 30 specific recommendations with Sida's response to the actions.

While the health division is already well aware of the general recommendations and risks that the evaluation points out, it is well worth highlighting them and in various ways continuing to work actively on:

- the risk that support to SRHR could become less than previously because of the increased focus on and major initiatives addressing HIV/AIDS projects
- the fact that SRHR is given low priority within SWAp discussions
- the importance of the PRSP process focusing on SRHR issues much more than what has been done to date

Distribution of the report

The current report will be used in seminars and workshops. The evaluation shows that Sweden has long been a forerunner in the field of sexual and reproductive health and rights. It is therefore important to present the report in various fora to achieve a greater distribution.

Usefulness of the evaluation - general

One purpose of the evaluation was to contribute to the policy for the work with SRHR that the government spending authorisation commissioned Sida to carry out, at the same time that it helps to achieve change in Sida's SRHR strategy. The health division intends

to produce a draft for SRHR policy between autumn 2004 and early spring 2005, including initiatives such as seminars and workshops that use the evaluation as a starting point. Sida and the Ministry of Foreign Affairs have formed the SRHR Network, which meets regularly, in response to the increased Swedish involvement in SRHR issues. This network will address the evaluation as a special issue. Conclusions and recommendations will be discussed and considered in the work with policy and updating of the strategy. For those reasons mentioned above, however, the evaluation probably will not have the same influence as planned. Also, in many cases it is much too vague. It provides too little guidance for choice of paths, levels, methods or partners.

Administrative lessons

The evaluation has been a great drain on resources for the Health Division. Far more time has been devoted to the evaluation than expected, largely because the evaluation team did not completely and fully satisfy the requirements stipulated in the project description. One weakness that the health division noted was that the team did not work as a team in the full sense of the word; rather, the team leader acted more as an editor for contributions submitted by team members. Consequently, team members did not have a comprehensive view of the entire evaluation. The team then accepted other assignments and was not available to work on the final formulation of the evaluation. It was difficult to foresee that this was how it would be from the consultant's work plan.

A more general question is whether this problem is inherent to the actual format of procurement of consultants through the tendering procedure, which Sida is required to follow. However, the Nordic countries are small and the number of experts in SRHR (as in other specialised fields) is limited. An optimal team would therefore often consist of people from diverse backgrounds: consultancies, research environments or similar institutions. Such temporary mixed teams would probably lead to higher quality and be less resource-intensive for the health division. It is therefore worth discussing the feasibility of such a development.

List of the evaluation's recommendations and Sida's response to actions.

Recommendation	**Sida's response**
Sida should consider promptly updating its SRHR strategy to focus on global change and highlight neglected areas. An update is especially important since Sida's new health policy (2002) only takes up two of seven original areas that should be given special attention.	**Agree. This work was already planned; the evaluation was expected to make contributions and suggestions for this work. Since then, the 2004 spending authorisation also commissioned Sida to submit a contribution for Swedish SRHR policy by 30 April 2005.**
It is important for Sida to continue to use the full terminology “sexual and reproductive health and rights (SRHR)” and encourage other organisations to do the same. Sida should also support other organisations, such as WHO, so that they fulfil the definition of sexual health, and also support further development of the concept reproductive rights as a component of human rights.	**Agree. Sida and Sweden belong to organisations and countries that have consistently used this expression since ICPD, nor are there plans to change this. SRHR is also gaining acceptance as an expression internationally.**

Sida should continue to pursue long-term co-operation with important expert SRHR departments in Sweden and maintain close contact with Swedish NGOs within the field of SRHR, and consider how these could benefit from budget support for SRHR.	**The health division collaborates well with several Swedish departments and organizations which, in addition to its regular contacts, the health division also visits to get to know the personnel and get an idea of the institution's expertise.** **Previously several Swedish inst. and org. received budget support with the purpose of building up international expertise, which has now been accomplished. Resuming this type of support is therefore not relevant at this time. However, Sida still provides budget support to several international organisations for their activities.**
The success of the projects addressing young people's SRHR in Zambia and India (Kafue, MAMTA) suggests a successful collaboration between RFSU and local partners. Continued support is recommended for co-operative projects based on this model.	**Agree. Success was achieved because both local organisations, RFSU and Sida, devoted considerable human resources.**
Some regional networks for capacity building have established institutional structures that have proved to be both stable and well coordinated. Sida should consider whether and how to emulate these good experiences. AMRN, which has a rolling chairmanship among member countries south of the Sahara, is an example of a successful network that has established responsible people and offices in member countries and this model should be copied.	**Agree. The model serves as a well functioning system; both Sida and partner KI encouraged its formation. This method should be held up within the health division as an example that can be used in more areas. Using another successful method, "Institutional network co-operation/Core Group model", Sida has supported the development of a midwifery training programme in Zambia. This model is now being applied to plan such a programme in Nicaragua and India.**
Sida has consistently encouraged and even initiated regional organisations and networks that often received budget support. But such support should not prevent Sida from also giving advice and advocating such organisations in general.	**Agree. Sida participates in dialogue at annual reviews and evaluations in policy issues that are high-priority for Sida.**
Sida can support international NGOs such as IPPF at policy level and by advocating an approach to SRHR based on rights. Support should also include a solid contribution to counter the economic consequences of current trends.	**In response to such consequences, especially from the Gag rule, support to IPPF increased by SEK 15m to SEK 85m per year during 2004. The level of support is specified in the spending authorisation to Sida. In addition, Sida supports an assistant bilateral expert position in IPPF's regional agency in Nairobi; a major duty will be to work with HIV/AIDS in the region. Sida participates in dialogue on important policy issues, such as application of a rights perspective, in annual reviews and evaluations.**
Sida should be as open as possible in relation to contribution levels to various organisations. Rapid changes can damage NGOs devoted to controversial issues and which in the current political climate cannot rely on getting contributions from other donors. Sida should be reliable in this regard.	**Sida endeavours to work with a long-term approach through its allocation of global and regional programme funds. However, these funds are steered by both the Ministry of Foreign Affairs in the spending authorisation and through an internal priority-setting process within Sida.**

Global development trends can threaten ICPD's action plan. It is therefore important to associate SRHR with new development themes.	**Agree. It is important that those who work with the separate issues combine them with an all-round perspective for SRHR and its given position in PRSPs and SWAps.**
HIV/AIDS In a time of intensified support to HIV/AIDS, Sida should assume a leading position to identify and develop areas with opportunities for mutual benefit between HIV/AIDS and a comprehensive SRHR effort. The Swedish/Norwegian HIV/AIDS team in Lusaka could work as a starting point for both theory and practice.	**Agree. Sida created an internal AIDS project which produced sector-specific guidelines, including for the health field, in which SRHR has a prominent role. Sida has mostly worked with SRHR issues within the framework of support that has gone to HIV/AIDS. In the dialogue on the global and country level, Sida has always pursued SRHR issues in an HIV/AIDS context.**
Sida should spearhead an effort to formulate a model that combines HIV/AIDS, gender equality, poverty and SRHR in PRSR processes. The UN system has initiatives that can be supported and with which Sida can collaborate.	**Agree. Sida works with DAC and collaborates with the World Bank on PRSP.**
The relationship between the PRSP process and work with SRHR can appropriately be followed up with the World Bank by focusing on an analysis of the correlation between SRHR and poverty based on *Demographic and Health Surveys* (DHS).	**The health division has an ongoing programme for policy co-operation with the World Bank to introduce SRHR issues, especially with a focus on young people in the PRSP process.**
Sida supports the organisations' pilot project as part of an effort to acquire good experience, which often combines research with building up local knowledge. This integrated model, exemplified by AMREF and RAINBO, is worth cultivating and copying, particularly to achieve results regarding HIV/AIDS, gender equality, poverty and SRHR, including female genital mutilation.	**Agree. Collaboration with AMREF and RAINBO continues. But Sida also supports other organisations' pilot projects that combine research with building up knowledge locally, such as support to Arrow, IPAS, AMRN, and the MAMTA-RFSU network.**
Health Sector reform and SWAp As a leader in both health sector reform and SRHR, it is important for Sida to take the initiative on discussions about SRHR within SWAp, while other aid donors take care of other urgent areas. To achieve this Sida's personnel has to be very familiar with the SWAp process and know the partner country well, but high staff turnover makes this difficult.	**Sida hopes that expanding the number of national programme officers will bridge the gap left when rotating personnel stationed abroad. Alternating work in the field and at Sida-S does not cause the expertise to disappear.** **Personnel stationed abroad receive training and support from the health division regarding SWAp and SRHR issues. Sweden participates in SWAp in Bangladesh, Uganda and Zambia, and it plans to participate in the formation of a SWAp process via UNFPA in India. In some of these countries Sweden also has bilateral co-operation within SRHR.**
Sida should be present in those courses on reproductive health and health sector reforms provided by the World Bank Institute. The	**Discussions are in progress between Sida and the World Bank Institution about these**

purpose of these courses is to build up capacity in people in different countries so that they can successfully negotiate in SRHR-related issues in SWAp contexts, and ensure that SRHR is not neglected in policy-making and priority-setting at meetings among donors and governments or in strategic negotiations.	**courses; the health division has participated in these discussions.** **Other methods through which Sida supports this process include the NGOs IPAS and IWHC, which both actively work with lobbying for SRHR in SWAp processes, especially the abortion issue. In addition, Sweden provides extensive support to UNFPA, which actively works to achieve integration of SRHR in SWAps and PRSPs at the country level.**
There is an acute need to include UNFPA's technical expertise in the SWAp process. Sweden has recommended that UNFPA be given a leading assignment to advocate SRHR. Sida should clarify how it sees UNFPA's relationship to SWAp and its mandate. It is essential to have a strategy that releases UNFPA from the rules on joint financing within SWAp but at the same time provides UNFPA with the opportunity to make itself heard "at the SWAp table".	**The point of departure for the Swedish collaboration with UNFPA is presented in the Swedish strategy for UNFPA.**
Efforts to correct SWAp must not be permitted to draw attention away from the continued need to provide care, especially in fields that are so important for Sida such as SRHR. Consequently the following applies: Sida should particularly consider that implementation of health sector reforms almost always counters good maternal health. Since improved maternal health is a UN millennium goal and a priority for Sida, temporary separate support to maternal health should be considered during a transition phase in the health sector reforms. Perhaps it could be implemented by suitable UN bodies, through special programmes or as multilateral support at the country level.	**In any situation, Sida supports contributions that aim to achieve millennium goals. Sweden has bilateral contributions within SRHR in those countries where Sweden supports a SWAp (according to comments above). In some countries the bilateral SRHR contributions serve as necessary pilot project/models paradigms to develop methodologies for how contributions can be implemented and serve as models for how to combat issues such as maternal mortality within the framework for SWAp. SRHR is a dialogue issue for Sweden in the process of developing a SWAp.**
In such cases in which the government's healthcare in specific regions is known to be weak and dependent on certain NGOs, support to these organisations should continue and only be phased out gradually.	**Agree. This is done in countries such as Bangladesh and India.**
Sida should ponder the difficulties that NGOs face when they advocate rights, monitor governments' performance or provide care that is not in line with cultural and social norms. These organisations may find it impossible to receive government support to continue with their activities. Sida should seriously consider establishing alternative mechanisms to support organisations in such cases.	**Sida provides extensive support to several regionally active NGOs with the purpose of strengthening the impact of work in particularly sensitive issues.**

Sida should develop a plan for how to appropriately support and maintain capacity in volunteer organisations within SRHR during the ongoing health sector reform.	**Even in this case, Bangladesh is one such example in which Sweden intervened and gave support to NGOs in order for them to be able to continue their operation until such time as its activities are fully included in regular operations, financed by the government budget.**
UN millennium goals The relationships between the millennium goals and the field of SRHR must be continuously reviewed and mutual positive effects identified and distributed. Sida is well positioned to assume a leading role.	**The health division continuously monitors the relationships between the millennium development goals and SRHR within different fora.**
SRHR In the case of special areas within SRHR that are at risk of being neglected in the future, the evaluation group recommends: Increased support to participation of midwives within maternity care could be considered as a priority in Sweden's strategy for collaboration with UN organisations that feel limited in other more controversial SRHR areas	**Agree. Sida is currently recruiting a senior midwife to the Making Pregnancy Safer initiative at WHO. A midwife/ assistant expert was recruited to WHO/SEARO in New Delhi in April 2004. Recruitment of 3 midwives/ junior assistant experts to UNFPA is in progress for placement in field offices in Mozambique, Bolivia and Bangladesh.**
Promoting and supporting breastfeeding is central for infant survival. *The Baby Friendly Hospital Initiative* and activities within *The Safe Motherhood Initiative* are important in this regard. To date women have dominated the global movement to protect and promote breastfeeding. Sweden has long supported gender equality in general and breastfeeding issues in particular. Closer co-operation is recommended between IBFAN and Sweden.	**Agree. Sida has an ongoing five-year contract with the IBFAN-Gifa, IBFAN-Africa, IBFAN Asia & Pacifism and WABA networks for contributions that promote, protect, and support breastfeeding. This support includes increased involvement of fathers in legislated maternal protection, their children's development, their partners' SR health and engaging more men in the work that these breastfeeding networks pursue. Sida also provides technical support to breastfeeding networks through Uppsala Univ./IMCH.**
Abortion is an issue that is constantly under threat. Especially in the current climate toward abortion, Sweden must maintain its traditional defense for the fulfilment of agreements from international conferences, and also place the issue in an ethical context and a rights perspective.	**We share this view and in addition support Sida's efforts to introduce new abortion techniques and increase the role and authorities of the midwife in abortion care. Such efforts will help make it possible for abortion care to be provided in regions where this has otherwise not been possible.**
The organisation Ipas is a leader in the work with quality issues within abortion and post-abortion care. Sida should recapture its leading role in promoting controversial aspects of SRHR, such as access to safe abortion and good post-abortion care. Sida should be proactive in this work and in	**Sida supports a large number of contributions that are related to abortion care in various ways, including IPAS. This is possible because of broad political support to promote safe abortion, making Sweden one of few countries that can accomplish this.**

supporting such organisations.	
Based on its positive experiences during the time before the UN's population conference in Cairo, Sida should once again try to create alliances among donors, women's health advocates and other players who have embraced abortion issues today, particularly in the hostile political environment exemplified by the *Global Gag Rule.*	**A number of alliances were created and are still active. The evaluation limits its attention to the Gag Rule as a threat, but other conservative forces also constitute strong threats to women's sexual and reproductive rights.**
Female genital mutilation continues to be a great challenge for both wellness and in a rights perspective, but Sida has not adequately addressed this issue. Sida should give priority to work against this and other harmful customs. Sida should counter sexual mutilation by supporting organisations such as RAINBO, which built up a solid case as well as technical and organisational capacity. Sida should consider taking in other organisations in this field. Yet another challenge is working with WHO and other organisations to integrate female genital mutilation in regular programmes.	**Rainbo has received support from Sida since it began in 1994; Sida was one of the first subsidy providers. Two other organisations also receive support, Tostan and Amanitare. WHO has already included female genital mutilation in its regular programme, as has UNFPA; both receive support from Sida.**
Many of Sida's projects on the country level consist of information, education and communication, as well as behaviour modification with the purpose of changing attitudes and behaviours in young people. The HIV/AIDS pandemic has attracted multiple donors. Sida should therefore consider entering areas related to young people and SRHR that are still controversial and weak. Examples include rights perspective and young men's attitudes and behaviours.	**Sida supports YMEP, which works with boys and young men. A regional project is under development. Another example is the MAMTA-RFSU network co-operation in India, which works with SRHR in young people; sex and relationship issues, youth clinics within regular health care centres, basic and vocational training to combat youth unemployment, and other measures.**
Sida should offer technical support to relevant organisations within fields that are well-developed in Sweden but missing elsewhere. Gaining expertise in young people's SRHR within the World Bank is one example that could provide results.	**Since 2003 Sida has supported a World Bank project within the policy area in order to ensure that young people's needs for SRHR are included and highlighted in PRSP work. In addition to SRHR, the project works with other important areas for young people, such as education.**
Within the area of young people's SRHR, Sida should pay more attention to the need for services, promote integration between what is said and actual service, and also focus more on concrete measures to involve men in projects.	**DESO has established young people as a main target group for its operation. The health division works actively at involving men in several SRHR contributions by integrating this in different contributions globally, regionally and on the country level. However, it takes time before this type of integration effort translates into concrete results.**
Gender-related violence is a serious problem in	**Sida participates in dialogue in which it always maintains the importance of combating**

most of Africa and has been recognised as an important factor in the HIV/AIDS-pandemic. An expansion of Sida's contributions in this segment especially in Southern Africa would be appropriate.	**gender-related violence. Sida has been involved in formulating brochures and studies that clarify the financial consequences of gender-related violence in terms costs to society, as well as the social trauma associated with this violence. This field requires an innovative approach within different organisations and authorities, including within Sida.**