THE MUSKOKA INITIATIVE: CANADA'S COMMITMENTS ON MATERNAL, NEWBORN, AND CHILD HEALTH AND SEXUAL AND REPRODUCTIVE HEALTH

By Alessandra Bergeron
#6029601
Submitted to Professor Rebecca Tiessen
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University of Ottawa

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ADRA	Adventist Development and Relief Agency Canada
AMREF Canada	African Medical and Research Foundation Canada
BWSS	Battered Women Support Services
CCFC	Christian Children's Fund of Canada
CCISD	Center for International Cooperation in Health and Development
CFPs	Call for Proposals
CHF	Children's Health Fund
CIDP	Canadian International Development Platform
EA	Executing Agency
FAO	Food and Agriculture Organization of the United Nations
GAC	Global Affairs Canada
GAD	Gender and Development
GII	Gender Inequality Index
GNI	Gross National Income
HDI	Human Development Index
MNCH	Maternal, Newborn and Child Health
NPSIA	Norman Patterson School of International Affairs
PMTCT	Preventing Mother to Child Transmission
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organization
PWS&D	Presbyterian World Service & Development
RFPs	Request for Proposals
SRH	Sexual and Reproductive Health
SDG	Sustainable Development Goal
SDH	Social Determinant of Health
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHRC	United Nations High Commission for Refugees
UNICEF	United Nations Children's Emergency Fund
UNOPS	UN Office for Project Services
USAID	United States Agency for International
WB	World Bank
WHO	World Health Organization
WID	Women in Development
WUSC	World University Service of Canada

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INTRODUCTION

Currently, approximately 830 women die each day from preventable causes related to pregnancy and childbirth (WHO, 2015). The maternal mortality ratio is approximately twenty times higher in developing countries than in developed countries (WHO, 2015). These statistics highlight extremely inequitable circumstances in which women in developing countries live. These circumstances further limit women's access to timely and quality health services.

In June 2010, Prime Minister Stephen Harper announced the Muskoka Initiative (hereafter, the Initiative) at the G7 Summit to mobilize international interest around maternal, newborn and child health (MNCH). The conference highlighted the accomplishments as well as the shortcomings of state governments and the international community to reduce maternal mortality and the mortality of children under age five in developing countries around the world[1], the two major objectives of the Millennium Development Goals (MDGS). The announcement of the Initiative is deemed an act of leadership on the part of the former Conservative Government of Canada regarding its commitments to MNCH. Many projects have been put in place through this Initiative to improve this cause. The projects were deliberately created to carry out the Initiative platform. The process by which these projects have been implemented is through a call for proposals. All 88 projects of the Initiative were designed specifically by the donor/client, Global Affairs Canada (GAC) for the purpose of this MNCH Initiative. GAC designed each project and also established a budget for each one. It then released a call for proposals inviting Executing Agencies (NGOs, Universities, Government Ministries, private firms, and world organizations) to submit a proposal explaining how they would be the best candidate to execute the project

[1] This refers to developing countries in general. Specific targeted countries of the Muskoka Initiative are presented in Chapter 1 below.

within the stated budget. Funding is provided by GAC.

While many projects have been put in place, there are still gaps in the way these projects address important development components such as gender equality and the empowerment of women.

The purpose of this research project is to analyze Canada's commitments to MNCH, specifically in relation to sexual and reproductive health (SRH). The analysis of Canada`s MNCH and SRH commitments concerns the types of projects that are funded by GAC – formerly the Department of Foreign Affairs, Trade, and Development - through the Initiative. To fulfill the purpose of this research project, I examine the 88 project profiles of the Initiative (available on the Government of Canada's website) which are funded by GAC and executed between 2010 and 2019. I also conduct a thorough review of development and feminist scholarly debates, feminist approaches in development, and Canada's broader commitments to gender equality.

The purpose of the projects analyzed in this research study is to improve the SRH of women and girls in the global South. At a quick glance, it would appear that the Initiative encompasses all the crucial aspects necessary to improve MNCH in a comprehensive way. However, after a preliminary analysis of the project profiles, it appears that there are gaps in the implementation of project activities, especially when they relate to SRH. In my initial reading of the Initiative projects, I found that more than half of the projects implement services and resources in regard to SRH. This is surprising since there is a substantial amount of critical literature suggesting that Canada`s MNCH programs fail to include elements of SRH such as abortions and they only minimally address these needs (Berthiaume, 2010; Auld & Michael, 2010; Tiessen, 2014). Based on these previous considerations, the research question guiding my review of government funded

commitments is: To what extent do the project profiles funded under the Muskoka Initiative consider the contribution of the SRH of women and girls in the Global South[2]?

This is a qualitative research project because my main purpose is to determine how the projects are responding to the commitments of the Initiative. My intention is not to quantify the results. Therefore, I use a suitable method of qualitative analysis - content analysis - in the reviewing process of the project profiles of the Initiative. According to Krippendorff (2013), "text analysis examines data, printed matter, […], or texts in order to understand what they mean to people, what they enable or prevent, and what the information conveyed by them does" (Krippendorff, 2013: 2). Using this methodology allows me to categorize MNCH projects based on their primary focus along particular thematic areas concentrating on references to SRH. It also permits me to examine the nature and implications of the language employed in references to SRH, women`s empowerment, women's rights and opportunities, and gender equality and gender violence. Preliminary analysis of the Initiative projects indicates that the former Harper government made good strides in its commitment to MNCH. However, this progress is limited by the reasons examined in this study, specifically by the failure to adopt a holistic approach that ensures gender equality and sustainable community development.

[2] The term "Global South" refers to developing countries which are located primarily in the Southern Hemisphere (UNDP, 2007).

CHAPTER 1: BACKGROUND/HISTORY: COMMITMENTS OF THE HARPER GOVERNMENT

The Harper government showed good initiative in its commitments to improving MNCH and gender equality around the world. The announcement of the Muskoka Initiative in 2010 was an important first set of commitments to maternal and newborn health initiated by the Canadian government. The Initiative grew out of a stated commitment by several countries collaborating on a United Nations (UN) initiative to address Millennium Development Goal (MDG) 5 on Maternal Health. Building on the strides made by this important UN committee, Canada also sought to advance this particular issue as a core priority in Canadian development assistance.

Canada's stated objective of the Initiative is to reduce maternal mortality and mortality in children under five years of age by improving nutrition, reducing the burden of disease, and strengthening health systems in ten specific developing countries: Afghanistan, Bangladesh, Ethiopia, Haiti, Mali, Malawi, Mozambique, Nigeria, South Sudan, and Tanzania (Government of Canada, 2016). The target countries of the Initiative all have common characteristics in terms of high levels of poverty and a low human development index (HDI). As indicated by the United Nations Development Programme (UNDP), these countries are categorized as having low human development which is characterized by lower (compared to other countries) life expectancy at birth, lower expected years of schooling, and lower gross national income (GNI) per capita (UNDP, ND). When the targeted countries' HDI is adjusted for gender (which is a major barrier for human development), they also score very low (UNDP, ND). The Gender Inequality Index (GII) measures countries on their maternal mortality ratio, their adolescent birth rate, the share of seats of men and women in parliament, population with at least some secondary education, and the labor participation rate (UNDP, ND). In terms of poverty, 30 to 80 percent of the population

in these countries live below the poverty line[3]. On another note, though the prevalence of HIV/AIDS varies by individual country, countries targeted by the Initiative such as Ethiopia, Malawi, Mozambique, Nigeria, and Tanzania, have the highest HIV and AIDS rates in the world (Avert, 2016). For example, "in 2013, an estimated 24.7 million people [in Sub-Saharan Africa] were living with HIV, accounting for 71% of the global total. In the same year, there were an estimated 1.5 million new HIV infections and 1.1 million AIDS-related deaths" (Avert, 2016). Lastly, in relation to gender violence, a Canadian based organization named Battered Women Support Services (BWSS) states that "women and girls are still being forced into marriages against their will, particularly in Asia, the Middle East and sub-Saharan Africa [and] over 60 million girls worldwide [are] married before the age of 18 primarily in South Asia (31.3 million) and sub-Saharan Africa (14.1 million)" (BWSS, 2016). Though these conditions can exist for people in developed and developing countries, they can serve as an explanation for higher rates of maternal mortality and children under the age of 5 mortality since it could make accessing health services more difficult.

The projects put in place under the Initiative are based on the Chair's Summary from the 2010 Halifax meeting of G7 - formerly G8 - development Ministers (Government of Canada, 2014). At the time of the announcement, the Harper government highlighted several elements that the Initiative and its projects would focus on. These included: prenatal care, attended childbirth, postpartum care, SRH care and services (including voluntary family planning), health education, treatment and prevention of diseases (including infectious diseases), prevention of mother-to-child transmission of HIV, immunization, basic nutrition, safe drinking water, and sanitation (Government of Canada, 2014).

[3] Afghanistan (36%); Bangladesh (32%); Ethiopia (39%); Haiti (80%); Mali (36%); Malawi (53%); Mozambique (52%); Nigeria (70%); South Sudan (51%); Tanzania (36%) (Indexmundi, 2014).

Since the announcement of the Initiative in 2010, the former Harper government invested approximately $6.35 million dollars towards MNCH efforts (Government of Canada, 2015). At the *Saving Every Women, Every Child: Within Arm's Reach Summit* in May 2014, Canada invested an additional $3.5 billion dollars, over twice as much as originally committed (Government of Canada, 2015). This investment would extend the Initiative until the year 2020 (Government of Canada, 2015). The additional investment also provides support to several non-profit organizations and initiatives such as: Gavi, the Vaccine Alliance, the Global Financing Facility in Support of Every Woman Every Child, the Micronutrient Initiative, the Eliminate Maternal and Neonatal Tetanus Initiative, and the Innovating for Maternal and Child Health Program, which are all committed to improving the health of mothers, newborns, and children in developing countries (Government of Canada, 2015). In relation to gender equality, the Harper government showed its commitment in three ways. First, it launched the Action Plan for the Implementation of United Nations (UN) Security Resolutions on Women, Peace and Security in 2010 which helps women and children in conflict and post-conflict situations (Government of Canada, 2015). Second, gender equality is one of three crosscutting themes of Canada's programs (Government of Canada, 2015). Lastly, gender equality is central in the formulation of Canadian foreign policy (Government of Canada, 2015).

Knowing the commitments made by the Harper government, one might expect to see projects in the Initiative that apply the stated priorities of the former government. However, after a careful reading of the Initiative projects, it appears that the pattern and approach of the projects to SRH may not be taking into account and contributing to important development issues such as the promotion of women`s empowerment and gender equality. Even though some projects provide resources and education on SRH for women in developing countries, they do not create

an environment that protects basic human rights. These basic human rights include the right to equality and dignity and the right to life, liberty, and security (United Nations, ND). They relate to SRH because women and children should be able to live with a certain standard of health, specifically a standard of SRH to allow them to accomplish day to day activities. Furthermore, the projects of the Initiative do not create mechanisms to protect women from gender violence or offer them opportunities to improve their health and to empower them (at all levels) in their communities. As will be discussed throughout this study, the analysis and findings of the project profiles points to the former Harper government having its own agenda about which issues need attention in the targeted countries. My research shows that the beneficiaries of the projects were not consulted to know what the true barriers are for accessing SRH resources. This point is especially important when we consider that one of the pillars of the Government of Canada's foreign and domestic policy is mainstreaming of the gender perspective, gender equality and the advancement of women's rights internationally.

CHAPTER 2: CONCEPTUAL AND THEORETICAL FRAMEWORK

2.1 Conceptual Framework

This study involves categorizing MNCH projects based on their primary focus along particular thematic areas. References to SRH are the main focus of this analysis; therefore, any references to SRH are carefully reviewed. The projects that reference this area are judiciously analyzed to see what kinds of activities are being put in place and which are not. To facilitate the understanding of the projects and to guide my analysis, recurring concepts are identified in each project profile. It is imperative to be familiar with what the most significant concepts mean, what they consist of and how they are related to one another. The concepts selected for this research project include: i) maternal, newborn, and child health, ii) sexual and reproductive health, iii) gender equality, iv) women's empowerment, v) women's rights, and vi) gender violence. A brief explanation of each concept is presented below.

Maternal, newborn, and child health refers to "health for girls of reproductive age, improving the health and nutrition of mothers to-be, and providing quality reproductive health services including ante- and post-natal care" (USAID, ND). In the targeted countries of the Initiative, maternal mortality is due to "obstetric causes" (USAID, ND). According to UNICEF, "eighty percent of maternal deaths are caused by direct obstetric causes such as hemorrhage, infection, hypertension disorders of pregnancy and complications of unsafe abortion" (UNICEF, 2012). Many women and girls in these developing countries do not receive timely and quality services to address these complications which consequently put their lives and those of their newborns in danger. In the end, the outcomes include mental and physical disabilities and/or death for women, newborns, and children under five years of age.

Sexual and reproductive health deals with the "physical, mental and social well-being in all

matters relating to the reproductive system [and whether one has a] safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so" (UNFPA, ND). To have good SRH, women in particular require "effective, affordable and acceptable contraception method[s]" (UNFPA, ND). They must also be "informed and empowered to protect themselves" (UNFPA, ND) from situations that could cause obstetric complications as mentioned. Again, both essential conditions to good SRH are seldom present for the women in the targeted countries of the Initiative. The reasons why are explained below.

Gender equality is a distinct feature of international development and it is now Goal 5 of the Sustainable Development Goals (SDGs). This concept refers to men and women having equal opportunities regardless of their gender. Equal opportunities are important in various contexts such as education, the workplace, representation in political and economic decision-making, and healthcare (UN, ND). In relation to MNCH and SRH, gender equality calls for women having the opportunity to seek healthcare and to make important decisions in regard to their own bodies. Gender inequality is very prominent in many developed and developing countries which limits the ability of women and girls to make decisions as simple as going to a maternal clinic which could improve their SRH. The value of women and girls, what they deserve and what they are entitled to is very different from the experience of men. However, important decisions in regard to health care and family planning require the input of both men and women, rather than one party alone. The role that men play in the household is crucial for women to have support and to feel empowered.

The concept of **women's empowerment** refers to "increasing and improving the social, economic, political and legal strength of the women, to ensure equal-right to women, and to make them confident enough to claim their rights" (Team Work, 2015). Women must feel

empowered and need not be afraid or embarrassed to ask for assistance when it comes to the improvement of their SRH. In many developing countries, and also in developed countries, there are instances where gender equality is not recognized and women are repressed and ignored when they seek reproductive health prevention methods or treatments. This, in turn, could contribute to higher mortality rates for women and children under five years of age. Women's empowerment is a crucial component for development projects that address SRH to succeed. It is only when women are able to

> "freely live their life with a sense of self-worth, respect and dignity, make their own choices and decisions, have equal rights to participate in social, religious and public activities, have equal social status in the society, have equal rights for social and economic justice, determine financial and economic choices, get equal opportunity for education, get equal employment opportunity without any gender bias, get safe and comfortable working environment[s]" (Team Work, 2015),

that the international community will see an improvement in MNCH.

Women's rights go hand in hand with the concepts discussed above. Although the push for women's rights as human rights has achieved important milestones, there are still women in both developed and developing countries who have their rights repressed every day due to their gender. This has a direct impact on their access to education on SRH and their ability to make informed and free decisions in relation to their bodies and to feel safe (Human Rights Watch, 2014).

Regarding **gender violence**, the United-Nations Population Fund (UNFPA) considers that "violence against women and girls is one of the most prevalent human rights violations in the world" (UNFPA, ND). Again, this occurs in both developed and developing countries. However, women and girls in developing countries are more at risk due to circumstances such as higher levels of poverty. Violence against women takes away their rights to control their body. In the present research project, it is important to note that violence can lead to "sexual and

reproductive health consequences, including forced and unwanted pregnancies, unsafe abortions, traumatic fistula, sexually transmitted infections including HIV, and even death" (UNFPA, ND). Maternal mortality is higher in developing countries because many women do not always have the right to "the enjoyment of the highest standard of physical and mental health; access to healthcare services; [or] the right to determine the number, timing, and spacing of children" (Amnesty International USA, ND).

Though these concepts may not appear verbatim in my analysis of the Initiative project profiles, they help in keeping the research design on track. Understanding what these concepts mean and especially how they relate to each other is a very important stepping stone to identifying and making important findings, analyzing those findings, elaborating conclusions and formulating recommendations.

2.2 Theoretical Framework

Several theoretical frameworks emerge from the document review and scholarly literature examined. These frameworks can be summarized as: Charity Framework, Liberal Feminism, Women in Development (WID), and Gender and Development (GAD). Below, I present a synthesis of the main frameworks used in the documentation reviewed.

The Initiative is characterized by the **Charity Framework** which signifies using money to solve a problem. This framework is problematic since it simply "fill[s] the gaps of the needs of the receivers or so-called 'beneficiaries.'" (Katsui, 2009: 11). In other words, it resolves the immediate problem taking place by providing 'aid' but does not consider the factors causing those problems or the "fundamental structure" (Katsui, 2009: 11) rooted in a community that needs to be altered to see change and get the desired result. Observing the Initiative through the Charity framework, one can conclude that the Harper government did commit billions of dollars

towards the Initiative and SRH projects. One must be critical, however, and ask: how will donating money for training and health facilities contribute to the improvement of MNCH and SRH of women and girls in those developing countries? Most importantly, how does the Charity framework change the problems which act as barriers to the intended objective of the Initiative and are more deeply rooted in communities?

The second development framework used in the Initiative projects is the **Liberal Feminist Framework**. This framework is based on the notion that it is important for men and women to be equal in status, and therefore, barriers to women's rights and opportunities need to be removed (Gillis, ND). Most of the barriers come from legislation, which is what liberal feminists try to amend. Again, this framework has been criticized for having very individualistic assumptions and not looking into deeper systemic causes of societal problems that put women in a disadvantaged position (Gillis, ND). Through this framework, the Harper government mainly targeted women, apart from 12 projects that include male participation. In these 12 projects, it is intended that men will adopt personal behaviors to reduce the transmission of diseases and support the health of women and children in their community. One project goes as far as recognizing that men can play a vital role in raising awareness of MNCH issues. However, the small number of projects that include male participation is insufficient, and the focus of the framework is not appropriate to modify societal perceptions and customs about gender equality and women's empowerment. With this framework, women issues are still addressed on an individual, not an integrated level.

The **Women in Development (WID) Framework** is an extension of the Liberal Feminist framework since it also focuses on women as a separate group. It also ignores the unequal power relations between men and women in a society and how gender inequalities create disadvantages

and repress rights and opportunities for women (World Bank, ND). WID focuses on the fact that women are targeted as the main subjects of development projects and their issues are addressed separately, instead of involving all members of society. As a result, gender inequalities are not addressed by women and men together. Also, the important role of male participation in finding solutions to the unequal distribution of power between women and men is not really taken into account in this framework (World Bank, ND). Therefore, it is fair to say that these frameworks do not contribute to the improvement of MNCH and SRH in developing countries. This is the reason why my preference is for the GAD framework, which is presented below.

The **Gender and Development (GAD) Framework** is a fourth framework I have identified in my review of documents. From my perspective, I consider that this framework is better suited to guide development projects connected to the Initiative, especially to emphasize the contribution to the improvement of SRH of women and girls. This framework is not solely focused on *women* or *women's projects* but on gender and unequal power relations (FAO, 2003: 5-6). It addresses how men and women interact in social, political and economic spheres and allows for the analysis of any inequalities that could restrict the rights and opportunities of women in those settings. In the end, it is essential that both men and women have a say in the policies and processes of their communities. I think this is the most appropriate way to involve women and men solving gender inequalities existing in developing and developed countries as well. The GAD framework intends to make this possible by identifying the reasons why barriers to gender equality and the ability of both sexes to be empowered may co-exist at the same level (FAO, 2003: 5-6).

Besides the conceptual and theoretical frameworks presented above, I think it would be useful to include here some additional considerations that would provide a context for the

analysis and interpretation of results as well as the conclusions and recommendations formulated. These considerations will also contribute to a better understanding by the reader (scholar or researcher) of the analysis and interpretation of results presented in Chapter 5 (findings presented, their connection with the scholarly debates, and the identification of themes stemming from the findings).

Too often, Western researchers and people from the general public think of women and children living in developing countries as people who need to be rescued and who cannot change certain social or economic conditions they live in without the help from people in 'developed' countries. Further, Western researchers think that they know what is 'best' for people who live in developing countries. This is what Chandra Mohanty was trying to explain in *Under Western Eyes* when she wrote that Western researchers "falsely universali[ze] methodologies that serve the narrow self-interest of Western feminism" (Mohanty, 2003: 501). There are two issues with this way of thinking.

First, this type of naïve thinking characterizes women "as a singular group on the basis of shared oppression" (Mohanty, 1988: 337) and labels them as "Third World Women" (Mohanty, 1988: 337). That is, women living in different social, economic and political environments in developing countries are seen as all having the same problems and deficiencies because they live in countries that have lower human and economic development. Women in developing countries are therefore labelled as "powerless, exploited, [and] sexually harassed" (Mohanty, 1988: 338) whereas women in developed countries are considered to be living in conditions opposite to this. Mohanty (1988) writes that there is too often a "universalization" (343) of women, where there is such a big "interest in and commitment to improving the lives of women in "developing" countries" (343).

This generalization of women living in developing countries leads us to the second issue. That is, conditions of poverty, lower income, gender inequality, gender violence, and poor SRH also exist for people in developed countries. For example, in Canada, "1 in 7 (or 4.9 million) people […] live in poverty" (Canada Without Poverty, 2016). Further, "1 in 10 Canadians cannot afford to fill their medical prescriptions [even though] Canada is the only industrialized country with a universal healthcare system but without a national pharmacare policy" (Canada Without Poverty, 2016). A McMaster University study found a "21-year difference in life expectancy between the poorest and wealthiest residents of Hamilton, Ontario" (Canada Without Poverty, 2016). In a 2015 UN Human Rights report, it was stated that there are "persisting inequalities between women and men in Canada, including the "high level of the pay gap and its disproportionate effect on low-income women, visible minority women, and indigenous women" (Canadian Women's Foundation, ND). In relation to gender violence, "every six days, a woman in Canada is killed by her intimate partner [and] out of the 83 police-reported intimate partner homicides in 2014, 67 of the victims—over 80%—were women" (Canadian Women's Foundation, ND). Lastly, approximately "75,500 Canadians were living with HIV at the end of 2014 [which is] and increase of 6,700 people (9.7%) since 2011" (Challacombe, 2016). These statistics show that even the most developed and wealthiest countries have people living in less than positive conditions and who face barriers to exist with a certain standard of living. Thus, throughout this study, it is important not to generalize and victimize the people (especially women) living in the targeted countries of the Initiative. It is also crucial to remember that the conditions they face are universal and could be faced by a person living in a developed or developing country. As Mohanty (2003) puts it, we "must be attentive to the micropolitics of context, subjectivity, and struggle, as well as to the macropolitics of global economic and

political systems and processes" (501). My study is important and relevant to know to what extent the Initiative is contributing to the SRH of women and girls in the Global South. It is equally important to, as Mohanty (2003) states, "demystify capitalism as a system of debilitating sexism and racism and envision anticapitalist resistance" (514).

CHAPTER 3: REVIEW OF LITERATURE

The work of many scholars (Tiessen, 2014; Tiessen, 2015; Tiessen, 2016; Percival, 2015; Berthiaume, 2010; Auld & MacDonald, 2014; Sethna & Doull, 2012; Huish & Spiegel, 2012; Carrier & Tiessen, 2015; Brodie & Bakker, 2008; Swiss, 2012) can be used to critique the Initiative and the Government of Canada for not following a GAD approach in the implementation of the projects. The Initiative is also critiqued for declaring the importance of gender equality in development programs for MNCH but not following through (Tiessen, 2015: 16). These scholars are all in agreement of the need for a comprehensive approach to improve maternal and child health in developed and developing countries, one that identifies, considers and changes the root causes of gender inequality in those communities.

Valerie Percival, a scholar with the Canadian International Development Platform (CIDP), writes that MNCH programs must acknowledge the discrimination and exploitation of women that compromise their rights and ability to decide when to seek healthcare, and the ability to choose when and with whom they will bear children (Percival, 2015). Also, women must be safe from sexual exploitation and violence (Percival, 2015). Rebecca Tiessen, a Professor at the University of Ottawa from the School of International Development and Global Studies, argues that governments, scholars, and Executing Agencies (EA) need a broader understanding of health challenges that are a result of societal and gender inequality issues and that create barriers for women to access health services (Tiessen, 2014). These include: "lack of resources, permission from men to use funds for maternal health care and gendered institutional practices that lead to negative experiences in clinics" (Tiessen, 2014). In "'Walking Wombs': Making Sense of the Muskoka Initiative and the Emphasis on Motherhood in Canadian Foreign Policy" (Tiessen, 2015), Tiessen cites many scholars who have raised very valid critiques and that support her

perspective on maternal and child health initiatives. Lee Berthiaume (2010) states that the Initiative projects need to "address gender inequalities that limit sexual and reproductive health options" (Tiessen 2015: 2). Alison Auld and Michael MacDonald (2014) provide the example of abortion (Tiessen, 2015:2), which relates to the ability of a woman to have control and rights over her body. Sethna & Doull (2012) take the issue of abortion and state that there are *extralegal implications* (p.465-469) to be considered in the case of abortion, and that there is a lack of access and especially choice for women in order to take advantage of SRH resources (p.465-469). This is due to factors such as cost of travel to medical facilities, geographic disparities, lack of referrals, and accommodation (Sethna & Doull, 2012: 465-469). Barriers like these must be addressed and broken down before women can have access to the services that will improve their health. Steven Lewis declares that the projects of the Initiative "avoid the root causes of maternal and child death" (Lewis as cited in Berthiaume, 2010: NP) which is gender inequality (Berthiaume, 2010). Huish and Spiegel (2012) indicate that the projects fail "to adequately address the social determinants of health (including gender equality, education, work opportunities and family planning) that lead to maternal and child mortality" (Tiessen, 2016:3). Carrier & Tiessen (2013) state that the Initiative is a form of "hypocritical internationalism" (Carrier & Tiessen, 2015: 189) where "those who have the most to lose from the Muskoka Initiative – namely the 68,000 women who die each year [...] - are silenced in the policy process" (Carrier & Tiessen, 2015: 191-192) because underlying challenges, namely gender inequality, is not addressed in development programs.

The projects of the Initiative are criticized for following a Charity approach (as well as Liberal and WID approach) (Tiessen, 2015: 17) rather than a GAD approach since there is an omission of gender and inequality issues. Brodie and Bakker (2008) argue that the government

of Canada's foreign policy has seen a "progressive disappearance of the gendered subject both in discourse and practice" (Tiessen, 2015: 17). Also, Swiss (2012) argues that the "instrumentalization of gender equality [has been] used as a tool for generating support for international objectives or for staged or overt demonstration of international leadership" (Tiessen, 2015: 18). Thus, even though it appears that the Government of Canada is making a major effort to include projects for SRH, it is not targeting the underlying societal factors that will ensure the success and sustainability of those projects. This is a main concern that is absolutely necessary to address if there is to be serious interest in solving gender inequality and improving SRH. Otherwise, the commitments stipulated in the Initiative will never be achieved and the financial commitments will be a waste of taxpayers' money and a reason for disappointment.

The scholarly literature specific to MNCH highlights the core theoretical debates relating to development programming on maternal health and are the basis for further research and analysis in this research project. I return to these particular debates in my analysis section (Chapter 5) where I present my findings, discuss the connection between the findings and the debates and identify themes stemming from the findings.

CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY

4.1 Research Design

The research design selected for this study is of a qualitative nature. I use qualitative content analysis of the Initiative project profiles that are available on the Government of Canada's website. Qualitative content analysis is a "type of systematic analysis that identifies and notes through the presence of certain words, phrases, or concepts within text, speech, and/or other media" (The World Bank, 2009: 378). Further, qualitative content analysis "identifies and summarizes the messages hidden in the data" (The World Bank, 2009: 378). The researcher creates a "coding system" (Babbie, 1999: 286) in order to understand and make sense of these messages and finds that "words and phrases mentioned most often are those reflecting important concerns" (The World Bank, 2009: 379). This allows the researcher to identify categories of the frequencies and see if there is a relationship between them and the research question and research framework (The World Bank, 2009: 379).

In this research, qualitative content analysis was employed to examine the nature and implications of the language employed in reference to women, SRH, women`s empowerment, women's rights and opportunities, gender equality, gender violence, and other important language. Prior to the initial analysis of the project profiles, there was some speculation as to what types of patterns would emerge from the data. It is not until several project profiles were read, that clear patterns in the data began to identify themselves. Through inductive analysis at the beginning, I identified patterns of analysis. The advantage of using inductive analysis at this stage was that it allowed me to identify patterns as they emerged out of the data instead of deciding prior to data collection and analysis what these might be (Patton, M., 1987, p.15). After identifying the categories, themes, and concepts, they were used to guide additional readings of

the project profiles. The categories from the initial analysis are in no way definitive. However, they helped guide further reading, especially since each project profile needed to be read more than once to determine whether or not and to what extent they were related to the MNCH and SRH of women and girls in developing countries.

Qualitative content analysis has strengths and weaknesses. In terms of strengths, this type of analysis shows the underlying relationship between two variables within the data (The World Bank, 2009: 381). In this case, the variables are the Harper government and women and girls in developing countries. The relationship is shown by how the projects profiles address MNCH and SRH and whether or not that is consistent with the commitments of the Harper government. Also, qualitative content analysis "is an unobtrusive means of analyzing interactions" (The World Bank, 2009: 381). The researcher does not have to conduct interviews or field investigations. On the other hand, qualitative content analysis can be very time-consuming since many careful readings of the text are required (The World Bank, 2009: 381). Second, it is subject to error when trying to derive a particular meaning from different words and to find relationships among those words (The World Bank, 2009: 381). The researcher could mistakenly draw a relationship or interpret a word or group of words to mean something that it does not. Lastly, the coding categories created do not provide tools for interpretation (Kohlbacher, 2006). For this reason, it is very important that preliminary research be conducted to know the literature on the topic and have a sound conceptual and theoretical framework upon which to base the analysis and interpretation of results. These strengths and weaknesses are applicable in the current research project and they were taken into consideration when doing analysis of the Initiative project profiles. In conducting the content analysis, great care was taken to minimize the potential problems associated with this research method by examining the key points presented

in the documents within the broader context.

4.2 Methodology for the Analysis of the Project Profiles

Before presenting the steps followed for the analysis of the project profiles, it is necessary to explain what a profile is. I believe that this will help to better understand how I conducted the analysis of the project profiles.

A project profile is an electronic tool on the Government of Canada's International Development Project Browser. It is used to present information about each project funded by GAC under the Muskoka Initative. Each project profile has six sections (Appendix A):

a) *Basic Information*: This sections includes the project number, the maximum funding contribution by GAC (former CIDA), the Executing Agency (EA), the status of the project (Operational, Closed, Terminating), the start and end dates, and the country or region the project is being implemented in.

b) *Description*: This section can include the aim (or purpose) of the project, its components, the services and activities being provided, and who the beneficiaries of the projects are. However, not every profile includes all of this information.

c) *Sectors*: This section specifies the health sub-sectors that the project is addressing and the percentage of assistance to each sub-sector.

d) *Results*: This section specifies the expected results and the progress achieved at a certain date and results achieved. However, not every profile includes this type of information.

e) *Related Information*: This section includes links to articles, videos, and reports that have been shared to the public on the project.

f) *Transparency*: This section includes other contracts, grants, and contributions related to the project.

The methodology used to conduct the analysis of the project profiles consisted of the following stages: a) a preliminary analysis of some project profiles aiming at identifying potential patterns; b) a more systematic first analysis of each project profile; c) a second analysis to confirm the number of projects related to SRH; and d) an in-depth analysis of the project profiles. Each of these stages is presented below.

4.2.1 Preliminary Analysis

Before creating any category or coding system , I read 15 (out of 88) project profiles. My supervisor suggested that this would be a sufficient number of projects profiles to read in order to see how they were written and what kinds of patterns I might find. I began to notice patterns in the way the descriptions in the project profiles referred to the subjects of the projects: women, children, newborns, men - and also patterns in the components of the projects and what they intended to carry out. Moving forward, formulating guiding points for in-depth analysis was the challenge. My supervisor suggested different ways to code (categorize) the content in the project profiles, such as themes identified in the website material for Canada's commitments to MNCH, exclusive focus on children (general wellbeing, micronutrient, vaccines, etc), exclusive focus on women, exclusive (or near exclusive) focus on mothers, attention to men's roles, attention to SRH, and others. As I began reading the project profiles, more specific categories began to emerge.

4.2.2 First Analysis

After an initial reading of the project profiles, I conducted the first analysis of them. This consisted of a deeper and systematic review of each profile and identification of additional

categories that were emerging. Each of the 88 projects was numbered from 1 to 88 to be able to reference them more easily during subsequent analysis. A spreadsheet was created with all the selected categories (See Appendix B) and I classified the projects according to their purpose(s), planned activities or main focus specified in the profiles. There were activities[4] in each project profile that fell under more than one category. The categories identified are as follows: a) focus on children, b) focus on women, c) focus on mothers, d) focus on men, e) SRH, f) infrastructure, g) human resources, h) newborns, i) nutrition, j) private sector, k) reducing disease, l) accountability, m) government capacity, n) equity, o) comprehensive approach, p) awareness, and q) other. The main purpose of the first analysis was to identify codes (categories) and then to conclude how many projects are related to SRH. After the first analysis was conducted, it was concluded that 42 out of 88 project profiles include activities in relation to SRH.

4.2.3 Second Analysis

The second analysis was used to confirm the number of projects that relate to SRH in the Initiative. It was also used to add information to the first spreadsheet created (Appendix B) and verify information. Throughout the analysis, the project profiles were divided into two piles. One pile consisted of the project profiles that had activities relating to SRH and the other of the project profiles did not. After the second analysis, I concluded that 61 out of 88 projects include activities relating to SRH. The number of projects analyzed increased because I decided to analyze the 'Expected Results' and 'Progress and Results Achieved' sections that some of the profiles included. Though not all profiles had this information, I decided to analyze it since it could provide interesting findings to discuss afterwards.

[4] Activities are anything being carried out by the project, previously stated in the workplan and work breakdown structure submitted in the proposal to GAC by the Executing Agency during the call for proposals.

4.2.4 In-depth Analysis

The in-depth analysis was the final stage of the analysis of the project profiles. By this stage, the spreadsheet was completed and only the projects including activities relating to SRH were analysed. This was done by using the conceptual and theoretical framework discussed in Chapter 2. The in-depth analysis paid close attention to any references to SRH but especially focused on identifying (or not) patterns attributed to gender equality, women's empowerment, women's rights and opportunities, and reducing gender violence. Also, analysis was conducted with the GAD framework in mind and how and if it is utilized in addition to the other frameworks outlined above. The in-depth analysis allowed me to note results as well as prepare the interpretation of the results.

I created a list of guiding points, presented below, to help me analyze the profiles. These points were created as a tool to do an accurate and thorough in-depth analysis. These points were put into a second table (Appendix C). This table was important to pull relevant information from the projects profiles that I could use to write my findings. Based on the sections of the profiles, I prepared the following guide to assess each project:

1. Project description, activities or results that relate to SRH.
2. Reference to contribution and barriers to gender equality.
3. Mention of contribution to women's empowerment.
4. Indication of contribution to women's rights and opportunities.
5. Mention of contribution to reduce gender violence.
6. Executing Agency (EA) - Partner of the project; pattern or trend.
7. Mention of the possibility that both sexes be empowered and coexist on the same level.
8. Reference to social determinants of health (including access to health services, gender equality, education, work opportunities and family planning) that lead to maternal and child mortality.
9. Mention of newborns.
10. Reference to awareness of SRH

Any statements related to a particular guiding point were quoted directly and placed into the spreadsheet. If a statement related to more than one guiding point, then it was put in those

columns. If a statement specifically related to points 2-10, then it was put in those columns. If a statement was related to SRH but not specifically to points 2-10, then it was put under point 1.

4.3 Some Limitations of the Research

One limitation of this research is that the analysis carried out is based on the information provided in the project profiles without going beyond this step. From the inception of this research project, and according to my approved project proposal, the main idea was to take the 88 project profiles available on the government of Canada's website and analyze them. If the purpose and information provided in the project profiles were not clear, I still had to take the information at face value to perform the analysis.

Another limitation is the quality and precision of the information provided in the project profiles. During the analysis, I observed that the project profiles are not always well written. The description of the project can be very vague and can use ambiguous language. Moreover, the activities outlined for the projects are not always consistent with the project's stated purpose, the expected results or the information provided on the progress achieved.

Finally, a third limitation is related to the achieved results. Not all project profiles include information with regard to achieved results, which reduces the possibility of verifying them.

Considering that 88 project profiles were analyzed in the preliminary stage, followed by 61 in the third in-depth analysis, there was a lot of information to organize. I categorized the themes and patterns from the project profiles the way I thought made the most sense and the way I thought would make it easier to formulate findings. Using qualitative content analysis could be subjective, and another researcher might have coded the project profiles differently, coming up with different results. To reduce the potential for bias, I took specific precautions prior to coding my data by clearly establishing the concepts that I was looking for (Chapter 2: Conceptual

Framework) and thoroughly reviewing the findings I formulated. Throughout, I also kept in mind my research question.

It should be acknowledged that a couple of findings discussed in Chapter 5 could be taken on their own for further research and analysis but this is not something that can be done in the context of this study.

CHAPTER 5: ANALYSIS AND INTERPRETATION OF RESULTS

The results of the analysis and interpretation of the results are organized below around ten findings (Subsection 5.1.). Each finding is presented in the order of guiding points enumerated in Chapter 4 (subsection 4.2.4) that were used in the restructured table (Appendix C) to do the final in-depth analysis.

5.1 Presentation of the Findings

Finding #1: The language used in the Muskoka Initiative project profiles emphasizes pregnancy and motherhood rather than women as persons[5].

The purpose of the projects analyzed in this research study is to improve the SRH of women and girls in the global South. As stated above, good SRH means "physical, mental and social well-being in all matters relating to the reproductive system [and whether one has a] safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so" (UNFPA, ND). What is important to take into account from this definition, is that women have the right to choose *not* to get pregnant and to enjoy a safe sex life. Also, a woman has the right to seek and use SRH services as a *woman* on her own terms and to avoid negative outcomes such as unwanted pregnancies. The language used in the project profiles, however, reduces women to child-carriers that can only seek services when they are pregnant and whose only responsibility is to keep the unborn child in good health.

Over three quarters of the 61 projects relating to SRH in the Initiative refer to the women they are helping as "pregnant women" (Government of Canada, 2016: A034732-001) or "mothers" (Government of Canada, 2016: M013426-002). Also, the words "child" (Government of Canada, 2016: D000402-001) and "newborn" (Government of Canada, 2016: D000402-001)

[5] That is, a person who has their own specific needs, separate from the health needs of a child or newborn.

are often included in these descriptions, making it seem that we cannot have one without the other. In "Walking Wombs': Making Sense of the Muskoka Initiative and the Emphasis on Motherhood in Canadian Foreign Policy", Tiessen states that "the exclusive focus on mothers obscures other aspects of women's identities and essentializes all women in relation to their biology" (Tiessen, 2015: 11). Further, she states that this type of language negates the important role that men have played in the gender constructs of developing societies and the role that they must play to build towards gender equality and helping to empower women to improve their SRH (Tiessen, 2015: 11). Women are not "walking wombs" (Tiessen, 2015: 11). They have rights and they must be seen as equals in their ability to make important decisions that affect their health not only for newborns, but for themselves as well.

Moreover, in the project profiles, women are often referred to as *women of childbearing age* (Government of Canada, 2016: A035488-001). This type of language is very ambiguous because it is difficult to know, in the countries of the Initiative, what childbearing age is. In the targeted countries of the Initiative, gender dynamics, the perception of women and their rights, and the high prevalence of gender violence cause could girls to sometimes become sexually active at a very young age (as could girls in developed countries). It is therefore difficult to determine the demographic of girls and women who need access to SRH services. A MNCH initiative must target all girls and all women, regardless of their age. The language used in the project profiles needs to be more specific to include any girl or woman that could be negatively affected by the social, political, and economic context in their country.

Finding #2: Only 36% (22 out of 61) of the project profiles related to SRH include explicit references about gender equality.

The Initiative has been heavily criticized in regard to matters of gender equality because it does not include means (techniques or strategies) to identify when there is gender inequality and its causes. Gender equality, or "equality between women and men" (Tiessen, 2015: 16) has always been a central theme of Canadian foreign policy because "without identifying gender inequality, we cannot know why women are unable to access maternal health services in the first place or how decisions around maternal health care are made" (Tiessen, 2015: 16). This is especially important in the targeted countries of the Initiative in which women are perceived much differently from men in the social, economic, and political spheres. Considering that gender equality is a central element of Canadian foreign policy, however, it is very surprising to see that only one-third of projects relating to SRH includes issues dealing with gender equality.

Though the inclusion of gender equality is minimal, when it is included, it is expressed in a way that could make the reader believe that it is a primary focus of the project, which is not necessarily the case. For example, the project profiles include statements such as providing or creating "gender sensitive and gender responsive services and policy" (Government of Canada, 2016: D000164-001/A035518-001) and "coordinating gender sensitive policy at the community level" (Government of Canada, 2016: A035263-001). These statements make it appear as though gender equality is an issue that is being taken into account at every stage of implementation of the project and that it is regarded as a top priority. However, these statements often appear only once or twice in the project profiles and they appear out of place. Gender equality is almost never the focus of the project and it is almost never considered a means to an end that will improve SRH.

Furthermore, the language used in the profiles (or the proposals submitted for funding) might persuade the reader, a government official for example, who will determine whether or not the

project will get funding, to believe in certain outcomes of the projects. It might lead the reader to believe that both men and women are being provided with the knowledge and education of the causes of poor SRH, what it is, and the barriers for women and girls to having good health. The government official will believe this because the description of the project is exaggerated to receive funding. For example, some project profiles include statements about services that both men and women have access to and where both are involved in activities to improve SRH. Activities include training on SRH (Government of Canada, 2016: A034732-001), working together in the promotion of methods to improve poor SRH[6] (Government of Canada, 2016: S065383-001), attending awareness sessions (Government of Canada, 2016: S065365-001), and becoming peer educators and ambassadors on the importance of the issue (Government of Canada, 2016: S065364-001). Some projects even single men out on the acquisition of knowledge of SRH, which can appear like a big accomplishment towards the stated objective of the project. Several project profiles state that the objective is to "improve the ability of men to recognize, prevent, and respond" (Government of Canada, 2016: A035254-00) to the signs and symptoms of poor SRH and that they intend to create "male champions to raise awareness about potential health issues" (Government of Canada, 2016: A035254-001). Men need to become involved in improving SRH for women and girls. Also, gender dynamics need to be identified and studied before development projects such as these are put into place to see what kind of barriers women are facing when trying to access SRH services. Gender equality is not a factor that is consistent within the projects and it is very much omitted from the language of the profiles.

[6] Poor SRH can include conditions such as reproductive disabilities or bad health (IPPF, 2015: 6).

One characteristic that was noted about the language referring to gender equality in the project profiles is that it was mostly gender neutral. That is, most of the time, it is difficult for the reader to know whether the activities involve only women, only men, or both genders. This is shown when the project profiles state that they would provide training on safe motherhood, child health, and gender equality, but without targeting a specific group. This is also demonstrated in project profiles stating that they intend to "provide information of gender barriers" (Government of Canada, 2016: A034616-001), but they do not state to whom this information will be provided. The target population needs to be identified more specifically to allow the reader to see that the project will benefit the groups of people that are supposed to be the beneficiaries. In addition, for the projects to have long lasting results it would be necessary to involve all concerned players - including women, girls, men, boys, government officials, and community members - which could prove to be very difficult. All concerned players must also participate in the identification of the root causes of the problem, especially at the preliminary stage. Studies and reports show that a lack of gender equality is one of the biggest causes of poor SRH in the targeted countries since it strips women of their autonomy to make important decisions about their health and it limits their access to SRH services (IPPF, 2015: 9). The projects implemented under the Initiative have minimal regard for these consequences. They are not consistent with the foreign policy commitments stated by the Harper government, which specify that "gender equality results are systematically and explicitly integrated across all international development programs" (Government of Canada, 2016).

Finding #3: Women's empowerment efforts in developing countries targeted by the Muskoka Initiative are insufficient to encourage women to seek SRH care services[7].

[7] Only 11 projects of the projects that relate to SRH mention aspects related to women empowerment.

Finding #3 is discussed under three separate headings, which are: a) Empowerment in the community and household, b) Safe spaces and sharing empowerment experiences, and c) Support for contraception methods.

a) Empowerment in the community and household

It is important to highlight what the Initiative is doing well in relation to women's empowerment in developing communities. For instance, several project profiles include activities and outcomes like the following:

i. Adolescent girls and boys empowering youth and holding education sessions on issues relating to health, nutrition, hygiene, early marriage, family planning and pregnancy (Government of Canada, 2016: S065336-001);

ii. Addressing "social factors that prevent women from using [SRH] services" (Government of Canada, 2016: S065365-001);

iii. Empowering community members, especially women, "to demand the health services they require, to make choices that support good health, and to get involved in managing local health care services" (Government of Canada, 2016: A035253-001);

iv. Improving the knowledge of household heads and women on health and nutritional good practices (Government of Canada, 2016: A035102-001); and

v. Educating communities on the empowerment of women (Government of Canada, 2016: S065386-001/A035207-002).

The activities and outcomes listed above are a good indication of women's empowerment by encouraging women and girls in the targeted countries to make important decisions about their bodies and health (even though women and girls in developed countries may also face the same barriers). Women and girls can also be encouraged to stand up to adversary opinions and perceptions from other women, their families, their doctors, and their spouses. It is important to inspire every actor within a community to do their part to contribute to enabling a safe and empowering environment for women and girls. Sadly, the Initiative only minimally addresses

women's empowerment as a necessary element that can lead to the improvement of SRH.

In regard to women making financial decisions about their health, this could prove to be difficult due to the perception of women and their rights in the targeted countries of the Initiative and the financial situation of the household. Several projects aim to increase the level of confidence of women regarding consulting their partners on SRH issues. Ultimately, the ability to access SRH services will depend on the financial situation of the families in the target communities of the Initiative, who unfortunately have higher levels of poverty that communities in developed countries (as discussed in Chapter 1).

b) Safe spaces and sharing empowerment experiences

The existence of safe spaces and the act of sharing empowerment experiences could be a good way to contribute to women's empowerment. The United Nations High Commission for Refugees (UNHCR) defines a safe space as: "any kind of space, formal or informal, where groups or individuals can feel physically and emotionally safe [;…] the absence of trauma, excessive stress, violence (or fear of violence) or abuse [;and] a place where individuals can build social networks, express, and entertain themselves (UNHCR, 2014: 1). Thus, in these spaces, women and girls feel safe and empowered to share intimate and sensitive experiences that could have a negative impact on them. A woman or girl can speak in confidence and know that their experience will remain confidential. These are also places where women and girls feel included, valued, and respected.

The *Maternal and Child HIV/AIDS Health Care and Promotion Project* provided HIV-positive women with a safe space to share their experiences through Women's Empowerment Groups held every two weeks (Government of Canada, 2016: S065382-001). Providing safe

spaces for women to share their experiences is a very important element for empowering women. Talking about difficult experiences with other people, especially women who have gone through the same experience, helps to increase confidence, feel empowered, and take appropriate measures to change and improve negative situations. Hearing that other women have had the same experiences shows them that they are not alone and that they should not feel scared or ashamed to make important decisions in regard to their health and bodies. As illustrated by the project profiles, women do not have the opportunity to participate in empowerment groups and get a sense of safe spaces and security. These spaces should be created and should be more common and easily accessible for women and girls who have trouble getting help for SRH issues.

c) Support for contraception methods

Only three projects related to SRH indicate support for contraception methods to control and prevent unwanted pregnancies. The *High-Impact Intervention for Maternal, Newborn and Child Health Project*, funded by the United Nations Development Program (UNDP), states that in Mozambique, "the total number of acceptors of new modern contraception methods has almost doubled from 122,817 users in 2011 to 231,627 in 2013" (Government of Canada, 2016: A035264-001). The *Accelerating the Reduction of Maternal and Newborn Mortality Project*, funded by United Nations International Children's Emergency Fund (UNICEF), also indicates that "more than one million couples were provided with protection against unwanted pregnancies that contributed to averting over two hundred thousand pregnancies and over 1,000 pregnant women from dying during childbirth" (Government of Canada, 2016: A034616-001). In the same project, "additional funds of US$11 million [were mobilized] to procure contraceptive commodities" (Government of Canada, 2016: A034616-001). Lastly, the *Community-Led Health*

in Bangladesh Project specifies that "2,846 (81%) of eligible couples between the ages of 15 and 49 are using contraception" (Government of Canada, 2016: S065336-001). These three statements on their own are a very good sign of empowering women to make decisions about their bodies. However, even if abortion is available and legal in targeted countries, women must feel empowered to make the choice to use and take advantage of these methods. Barriers are the social, economic and political dynamic of men and women and also *extralegal conditions*, such as lack of referrals that limit women's access to contraceptive and abortion services (Sethna & Doull, 2012: 465-469). When analyzing the Initiative it must be emphasized that there is a difference between the non-acceptance of contraception or other birth control methods and the identification and reduction of the barriers for access to these methods. Birth control methods may not even be available from doctors in certain targeted communities and countries, but the point is that women should have the opportunity to *control* whether or not they get pregnant or carry the fetus to term. If a woman does not wish to become pregnant, she should not risk an unwanted pregnancy. According to UN Women, "it is estimated that 35 percent of women worldwide have experienced either physical and/or sexual intimate partner violence or sexual violence by a non-partner at some point in their lives" (UN Women, 2016). Further, a Canadian based organization named Batterred Women Support Services (BWSS) state that "women and girls are still being forced into marriages against their will, particularly in Asia, the Middle East and sub-Saharan Africa [and] over 60 million girls worldwide [are] married before the age of 18 primarily in South Asia (31.3 million) and sub-Saharan Africa (14.1 million)" (BWSS, 2016). Lastly, BWSS states that "women who are beaten by their partners are 48 per cent more likely to be infected with HIV/AIDS" (BWSS, 2016). These statistics warrant the establishment of methods, such as contraception, to minimize unwanted pregnancies and also have mechanisms

and resources in place that women and girls can access if they find themselves in an unfavorable health situation.

Finding #4: The projects profiles relating to SRH in the Muskoka Initiative only superficially show signs of contributing to women's rights and increasing opportunities.

Curiously, only 11 projects (18%) related to SRH deal with women's rights and increasing opportunities for them. Following a GAD framework, it is essential for development projects to look at the ways men and women interact in different contexts and how these conditions could restrict women's rights and opportunities. In this research project, it is important to analyze how the Initiative projects are contributing to women's rights and opportunities to improve SRH. In the projects analyzed, more women are intended to or are giving birth in health facilities, are using SRH care services, and have access to qualified doctors who are trained in emergency obstetric and newborn care and neonatal care. The project profiles show good progress since women and girls should have options to attend health care appointments and inquire about health care services that will improve their SRH.

In a moral sense, women and girls have the right to access family planning methods such as contraceptives, or at least to consult other family planning methods. However, this may prove to be difficult because of several factors (that will be discussed below as social determinants of health) such as geographical location or cost. As discussed in Finding #3, the ability to have access to family planning methods, such as contraception, is a clear indication of women being in charge and having a say regarding what happens to their bodies. Despite this, the project profiles analyzed do not stress the importance of women having more opportunities such as access to family planning methods and identifying barriers that restrict their ability to use them.

Finding #5: There is virtually no consideration for gender violence in the projects relating to SRH for women and girls in the global South.

Astoundingly, only one project relating to SRH mentions gender violence. This is extremely surprising considering the countries in which the Initiative projects are being executed and knowing that gender violence, namely violence against women, "is one of the most prevalent human rights violations in the world" (UNFPA, ND). According to the World Health Organization (WHO), "1 in 3 (35%) of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime" (WHO, 2016). The prevalence of violence is much higher in countries where there are attitudes of acceptance of violence and gender inequality (WHO, 2016). A WHO study conducted in 2005 indicated that among women aged 15-49,

> "(1) 71% of [women] in Ethiopia reported physical and/or sexual violence by an intimate partner in their lifetime; (2) between 0.3–11.5% […] reported sexual violence by someone other than a partner since the age of 15 years; [and] (3) the first sexual experience for many women was reported as forced – 17% of women in rural Tanzania, 24% […] and 30% in rural Bangladesh" (WHO, 2016).

Knowing these facts and being familiar with the social, economic and political context of men and women in the targeted countries of the Initiative, it is unacceptable that only one project briefly includes a reference to support women victims of gender violence.

The only project mentioning gender violence is the *Support to Maternal and Newborn Health in the Administrative District of Ituri*[8] *Project*, which states that one of its activities is "assistance to women who are victims of violence" (Government of Canada, 2016: S065370-001). Assistance for women after having gone through violent experiences is a crucial service that must be included when designing projects that will improve SRH for women and girls in the

[8] Ituri is located in the Democratic Republic of Congo.

global South. The environments in these developing countries are already very conducive to the negation of gender equality, women's empowerment and women's rights, which ultimately leads to gender violence. Moreover, especially in the targeted countries of the Initiative (as discussed Chapter 1), gender violence leads to a higher prevalence of transmission of HIV which can be transmitted from mother to child, causing higher rates of maternal and child mortality and unwanted pregnancies resulting from rape. Considering that gender violence is a root cause of maternal, child and newborn death, support for and protection from gender violence is an element that must be more commonly present in the Initiative according to the GAD framework for development. The Initiative, however, does not seem to consider this cause to be important.

Finding #6: Additional research on certain Executing Agencies (EA) reveals that there are conflicts of interest between their organizational mandate and the nature of some projects they are executing.

At the beginning of the analysis of the project profiles, I wanted to see what types of EAs were contracted by GAC to carry out the projects. This analysis, along with additional research, revealed that there could exist some conflicts of interest between the organizational mandate of an EA and the projects it is implementing. That is, that there are discrepancies in the type of involvement that some EAs have in the Initiative and the type of involvement they have had, with the same development issues, on other projects or programs. To verify this hypothesis, one EA – the United Nations Population Fund (UNFPA) - was selected as is explained below. An entire research paper could be written analyzing each EA to compare its mission and mandate with its involvement in MNCH and SRH in the Initiative and other development initiatives where they participate. I believe this is a task that goes beyond the limits and purpose of my study.

The UNFPA was chosen based on its level of participation as an EA to implement projects

relating to SRH of the Initiative. Table 1 (Appendix D) shows that the UNFPA is a partner in 6 projects, the most out of the 61 agencies funding projects relating to SRH. The UNFPA states that poor SRH is one of the leading causes of death for women in developing countries (UNFPA, 2016). Their mandate is to "deliv[er] a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled" (UNFPA, 2016). Furthermore, the objective of the UNFPA is to create opportunities for women to have more "possibilities […] to lead healthy and productive lives" (UNFPA, 2016), to be empowered, to be protected from violence and harmful practices and to "exercise their basic human rights, including those that relate to the most intimate and fundamental aspects of life" (UNFPA, 2016).

Evidently, the profile of the UNFPA is consistent with the commitments of the Government of Canada to improve MNCH and SRH. However, there are many scholars who are very critical of the UNFPA for the types of programs that they support. Steven Mosher is the President of the Population Research Institute, a non-profit research group which works to "expose the myth of overpopulation [and to] expose human rights abuses committed in population control programs" (Population Research Institute, 2016). He criticizes the UNFPA by saying they use "soporific propaganda" (Mosher, 2011) and cause human rights abuses by encouraging forced abortion and forced sterilization (Mosher, 2011). Mosher uses the UNFPA's connection to China's one-child policy and states that "hundreds of millions of poor women (and men) have had their fundamental rights – i.e., to control their own reproductive systems and to determine the number and spacing of their children – grossly violated" (Mosher, 2011) by this policy. Since the UNFPA is the EA of six projects relating to SRH that should be looking to promote women's empowerment and women's rights, these denunciations do not resonate very well and are also inconsistent with the stated commitments of the Government of Canada on MNCH.

The Initiative is already heavily criticized for not executing gender-focused development projects and for only superficially addressing the issue of SRH in the targeted countries. It looks very bad on the part of any government, which launches an MNCH Initiative but does not ensure that all of its projects are being executed from a gender and development lens, and where crucial aspects such as gender equality, women's empowerment, women's rights and reducing gender violence are not central concerns. The UNFPA is a one of the biggest EA organizations in the Initiative and it is highly regarded internationally. Further research, however, could show that other EA organizations have many criticisms against them that would not be in line with their own mandates, the stated purpose and commitment of the Initiative, and the commitments of the Government of Canada on SRH and MNCH in general.

Finding #7: The project profiles[9] of the Muskoka Initiative do not stress the need for men and women to coexist on the same level to be able to change gender dynamics and empower both genders.

This finding not only refers to women being empowered, but also to men coexisting with women at the same time - not necessarily in the same way - to engage in activities that will improve SRH for women and girls. The Initiative achieves this through: a) Providing obstetric and neonatal training to both men and women together; b) Promoting behaviors that can reduce barriers to access SRH services; c) Stimulating shared decision-making (on MNCH) at the household level as well as encouraging male involvement in decisions relating to SRH.

a) Providing obstetric and neonatal training to both men and women together

One project profile in particular states that both men and women will be able to access training in "basic obstetric ultrasound, maternity and deliveries, focused prenatal care, basic emergency obstetrics, prevention of mother to child transmission of HIV, neonatal resuscitation,

[9] 11 out of 61 projects (18%).

[and] service-excellence and customer care" (Government of Canada, 2016: A035252-001). Another project profile declares that midwife training will be equally accessible to men and women and will be "aligned with the expectations and needs in obstetric and neonatal care and in family planning, taking into consideration the rights of women and girls" (Government of Canada, 2016: A034732-001). These activities are extremely important to a GAD framework of development since it takes into account different power dynamics between genders and puts men and women on the same level by being able to get the same medical training. A person should not receive different instructions and training because of his or her gender. Despite individuals learning at their own pace, both need to learn together. Barriers to both men and women receiving the same type of education and training could be that not everyone has access to or can afford training and education. In the end, however, the projects would benefit from not only having women trained and aware of the barriers to improving SRH, but also men. Men and women carry with them different experiences, opinions, perspectives and abilities that can contribute to improve SRH. Women should not be isolated, and the issue of poor SRH should not be seen as only a women's problem. In any part of the world, women are vital members of their community, and they and all other members should be aware and trained on the issues they are facing.

a) Promoting behaviors that can reduce barriers to access SRH services

It is a challenge in the countries targeted by the Initiative for both men and women to adopt behaviors that will improve the SRH of women and girls. This is because men and women in these countries, in comparison to Western countries, sometimes have different perceptions of women's roles in social, economic and political contexts and how they are able to engage and act in these contexts. In several project profiles, men and women participate together in activities to

promote proper nutrition, for example (Government of Canada, 2016: A035288-001), or to increase their ability to adopt behaviors that reduce the transmission and incidence of diseases (Government of Canada, 2016: S065383-001). Another project "promotes the use of quality health, nutrition and family planning services, […] improved health, nutrition and family planning behaviors of caregivers and family members" (Government of Canada, 2016: S065350-001), and educates families about healthy behaviors (Government of Canada, 2016: S065350-001). These tasks are extremely important but we have to take into account that behaviors and perceptions will not change overnight. Gender dynamics and the way men and women perceive each other is carried over from generation to generation. Though it is difficult to do in any part of the world, men and women must realize that they can work together and use each other's resources and experiences to improve health conditions. To this effect, the current social, economic, and political conditions and how men and women relate to each other must first be identified without assuming what these conditions (and interactions) are. The best way to do this is to consult the men and women living in the targeted countries of the Initiative as they ultimately will be impacted by the hopefully positive changes that these projects will bring.

Awareness sessions are a common activity in the project profiles and will be discussed in Finding #10. Nonetheless, it is important to mention here that this is an excellent technique to promote changes in behaviors and perceptions in men and women to improve, together, SRH for women and girls in the global South. UN Women state that "training for gender equality is a transformative process that aims to provide knowledge, techniques and tools to develop skills and changes in attitudes and behaviors" (UN Women, ND). Further, UN Women firmly believe that training and awareness sessions require "political will and commitment of all parties in order to create inclusive societies that recognize the need to promote gender equality" (UN Women).

Several projects mention the use of awareness and information sessions to changing behaviors and perceptions of men and women. For instance, in the progress and results achieved sections of some project profiles, it is indicated that:

i. "1,864 (67%) of targeted households are now aware of the benefits of natal, antenatal and postnatal care" (Government of Canada, 2016: S065336-001) which indicates a change in behavior;

ii. "244 men were trained to raise the awareness of other men on the importance of maternal health" (Government of Canada, 2016: S065365-001) which means it is intended that they use their knowledge to change behaviors or perceptions; and

iii. "3,796 men participated in information sessions on women's health issues, and 48% of these men are now able to report at least two issues related to women's health" (Government of Canada, 2016: S065349-001) which clearly indicates a change in behavior.

Knowing the results and outcomes above, it is fair to conclude that awareness and information sessions for both men and women are extremely important as techniques or means to promote changes in behaviors and perceptions in projects related to MNCH and SRH. Both men and women need to be aware of the issues that are affecting members in their community. It is imperative that both genders become informed and involved.

b) Stimulating shared decision-making [on maternal, newborn and child health] at the household level as well as encouraging male involvement in decisions relating to SRH.

Women and girls must feel empowered to make important decisions relating to their bodies on their own without third party influences. Nevertheless, shared decision-making is just as important because others may have valuable insights and suggestions that one may not think about when trying to make difficult and stressful decisions, especially when it comes to health. These decisions can have a big impact on the bodies and health of women and girls as well as the health of their newborns and children.

Even though these projects are primarily targeted at women and girls in the South, men can play a significant role in conjunction with women. For example, the *Community-Led Health in Bangladesh Project* places "special emphasis on the role that men can play in helping to improve the health of women and children" (Government of Canada, 2016: S065336-001). The key goal is to not isolate women and girls by making it seem as if poor SRH is only their problem. Women and girls are part of a community of people, and therefore the issue of poor SRH is the concern of the entire community. Therefore, the design of the Initiative projects should contribute to helping women and girls make positive and educated decisions. As illustrated in some of the project profiles, men are taking the appropriate steps to receive training and to become informed on the issues of SRH for women and girls. One project profile in particular includes activities such as "promoting shared decision-making on maternal, newborn and child health at the household level" (Government of Canada, 2016: S065363-001). The project profile also indicates that "475 discussion groups on maternal newborn and child health which encouraged male involvement, family communication and shared decision-making were held with 3,288 pregnant women, 6,899 lactating women, 5,138 husbands, and 4,275 mothers-in-law" (Government of Canada, 2016: S065363-001). Activities and progress like this is what the international community should be seeing in more projects from the Initiative.

Finding #8: The majority of projects[10] related to SRH identify a factor or social determinant of health that could act as a barrier against women and girls in the Global South to improve their SRH.

According to the WHO, the social determinants of health (SDHs) are "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (WHO, 2016). These conditions have an impact on people's

[10] 52 out of 61 (85%).

health and, depending on the policies in place in a particular country; they can impact each person very differently. In *Social Determinants of Health: The Canadian Facts*, 14 social determinants of health are identified[11]. As shown in this research project, SDHs can even affect people within the same country very differently. For example, in Canada, 15% of children are living in poverty and therefore early childhood development conditions and education will most likely be different for them compared to children who are not living in poverty (Mikkonen & Raphael, 2010). In contrast, the poverty level for children and the general population in the targeted countries of the Initiative is much higher (as exemplified in Chapter 1). We can then conclude that SDHs affect women and girls in Western countries much differently than women and girls in the South.

The Initiative project profiles that reference SRH focus on three specific SDHs that scholars judge are not properly addressed in the projects and that could lead to maternal and child mortality if not properly addressed (Tiessen, 2016: 3, Huish and Spiegel, 2012). These include a) Education and training of women, girls and other people involved in SRH care services, b) Accessing health care services and referrals, and c) Family planning. These factors are discussed below.

a) Education and training of women, girls, and other people involved in SRH care services

Education and training is the primary SDH mentioned in the project profiles of the Initiative and projects related to SRH. Individuals targeted for education and training include: men and women midwives, nurses, birth attendants, doctors, government health care workers

[11] The 14 social determinants of health are: income and Income Distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety network, health services, aboriginal status, gender, race, and disability (Mikkonen & Raphael, 2010).

(Government of Canada, 2016: S065372-001), students, and volunteers. They are trained and mentored on several topics[12]

i. SRH, birthing practices, antenatal, postnatal and newborn care (Government of Canada, 2016: S065363-001);
ii. Maternal death reviews (Government of Canada, 2016: A035251-001);
iii. Diagnosis and treatment of HIV/AIDS (Government of Canada, 2016: S065387-001);
iv. Screening newborns for acute malnutrition (Government of Canada, 2016: A035102-002);
v. Emergency obstetric care and midwifery skills (Government of Canada, 2016: A035518-001); and
vi. Providing counselling and growth monitoring targeted at pregnant women (Government of Canada, 2016: A035243-001).

Another main component of these projects is: a) Developing midwifery programs and curricula in training institutes in the targeted countries at the Bachelor, Graduate, and Post Graduate level (Government of Canada, 2016: S065358-001); b) Updating training materials on obstetric and neonatal care (Government of Canada, 2016: S065370-001); and c) Providing scholarships to doctors and clinical officers for further education in obstetrics and gynecology (Government of Canada, 2016: A035358-001).

Education is a very important SDH because it results in two positive outcomes. First, "people with higher education tend to be healthier than those with lower educational attainment" (Mikkonen & Raphael, 2010: 15) because higher education generally leads to better jobs, higher income, and more opportunities to access health care services (Mikkonen & Raphael, 2010: 15). Second, "education increases overall literacy and understanding of how one can promote one's own health through individual action" (Mikkonen & Raphael, 2010: 15). These outcomes are extremely important in the targeted communities and countries of the Initiative due to the knowledge that they will obtain on SRH. The projects also provide education to thousands of

[12] The project profiles do not indicate who is training and mentoring these individuals. These individuals would most likely be consultants who are employees of the Executing Agencies (EAs) or consultants employed through the Executing Agencies who will work on a contract as independent consultants.

people that would not have otherwise received this opportunity. This knowledge has a big impact on the lives of women, children and newborns that will be receiving these services since they will now know what SRH is, the causes of poor health, the barriers to achieving good health and how to treat specific medical situations. In addition, creating programs at the University level allows community members to access and develop their knowledge and contribute to the improvement of SRH. Not everyone has the privilege to receive education like this so it is a very positive opportunity that the Initiative is giving to the people in the targeted countries. However, it is important to always keep in mind that income and poverty are significant SDHs. A person can receive an endless amount of training about SRH but without the income and resources to put that knowledge into practice, the training will be ineffective. GAC and the EAs implementing the projects in the targeted countries must acknowledge that women and girls may already be aware of their health issues, but that there are other barriers, such as a lack of steady income, which keeps them from accessing solutions to improving their SRH.

While training and education on SRH is very important, it is also important to wonder whether training that is medically focused ensures the improvement of important concepts such as gender equality, women's empowerment, and women's rights and opportunities, or if other types of training have to be provided. These concepts will not be identified and reinforced if training is only done from a medical perspective and not from a social and developmental perspective. Again, it must be stressed that the high levels of poverty and low human development conditions may create barriers for some women and girls to make use of the knowledge and training received on health conditions. EAs cannot ignore the impact that poverty has and that sometimes education and training may not be enough.

b) Accessing health care services and referrals

Even though training and education are very prominent activities of the SRH projects, they are not useful if women and girls cannot access the health care services they need. This is why education, access, and income go hand in hand. Access to SRH care services for women, pregnant women and newborns is also an objective and desired outcome in the majority of the projects relating to SRH. These objectives include access for all women, especially women who have low incomes and who live in underserved areas (Government of Canada, 2016: A035252-001). Moreover, access to SRH care services means to obtain different kinds of services such as:

i) Quality gender-sensitive services (Government of Canada, 2016: D000164-001);
ii) Delivering in higher quality health care institutions (Government of Canada, 2016: D000472-001);
iii) Qualified midwives (Government of Canada, 2016: A035518-001);
iv) Mobile phone networks (Government of Canada, 2016: D000472-001);
v) Transportation to health care facilities (Government of Canada, 2016: A035262-001);
vi) Malnutrition services, including nutritious food (Government of Canada, 2016: A035263-001);
vii) At least one antenatal care visit to a health provider (Government of Canada, 2016: A035218-001);
viii) Pre-natal consultations (Government of Canada, 2016: A035264-001);
ix) Post-natal care (Government of Canada, 2016: S065349-001);
x) Emergency obstetric care, regular access to sexual and reproductive care (Government of Canada, 2016: S065349-001);
xi) Finances to pay for health services (Government of Canada, 2016: A035251-001);
xii) Home visits to provide pre-natal and post-natal care and care for newborns and young children (Government of Canada, 2016: A035254-001);
xiii) 24-hour comprehensive emergency obstetrical and neonatal care services (Government of Canada, 2016: A035244-002); and
xiv) Therapy to prevent mother-to-child transmission (PMTCT) of HIV/AIDS (55); and shorter waiting time (Government of Canada, 2016: A034782-008).

The access to SRH services such as the ones above is increased by strengthening and even establishing a referral system in many of the targeted countries (Government of Canada, 2016: D000164-001). Many projects attempt to create “community linkages” (Government of Canada, 2016: D000472-001) by providing emergency transportation (Government of Canada, 2016:

D000472-001) for women who require emergency care that cannot be provided at home. This ensures that women who live in isolated and remote areas and who are poor can also access health care services when they need it the most.

Improving the referral system in the target countries is an extremely positive finding of the project profiles, but again, one has to take into account that access and referrals cannot be obtained by all women and girls. Sometimes there are societal factors, gender dynamic and equality issues that come into play that do not allow them to make the *choice* to access these services. These factors must be identified first before access to health care services can make a difference. This is the flaw in many of the Initiative projects and why many scholars criticize the projects.

c) Family Planning

According to the WHO, family planning "allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births" (WHO, 2016). As discussed above, a popular (but not always accessible) method of family planning is contraception. Contraceptives, and other methods of family planning, allow women to be empowered, and enable them to control if and when they become pregnant, and what happens to their bodies. Regrettably, family planning is not a focus in the SRH projects of the Initiative. Only 10 projects make reference to family planning (including those that reference the acceptance of "new modern contraception methods" (Government of Canada, 2016: A035264-001)). This includes the use of adopting family planning behaviors for caregivers and family members and educating families about healthy behaviors around family planning (Government of Canada, 2016: S065350-001).

Interestingly, attendance at family planning education sessions and clinics has increased and almost doubled as indicated in progress reports of some project profiles (Government of Canada, 2016: A035207-002/ A035206-001). Despite these activities and progress achieved, it does not appear that family planning is a primary concern in the design of these projects. This is not surprising since the Harper government did not fund particular family planning methods, such as abortion, as part of this MNCH Initiative (Berthiaume, 2010; Auld & Michael, 2010; Tiessen, 2014). Although an entire report could be written to criticize this decision, it must be reiterated that the Initiative was created to "address the significant gaps that exist in maternal, newborn, and child health in developing countries" (Poirier, 2014: 1). The Harper government did not fund abortion as part of the Initiative because there were "enough other worthy initiatives to support" (Poirier, 2014: 1). A scholar from the Norman Pattern School of International Affairs (NPSIA) at Carleton University states that this is unethical (Poirier, 2014: 1). In addition to citing arguments from several ethics theories, she states, "on the basis that less women dying from unsafe abortions is a positive, ethical goal, an ethical maternal health initiative must include funding for abortion" (Poirier, 2014: 11), especially an Initiative announced by a State calling itself a leader of global MNCH efforts.

Due to the lack of funding for family planning methods, thousands of women die every year from unsafe abortion (Berthiaume, 2010; Auld & Michael, 2010; Tiessen, 2014). If the Harper government wanted to reduce maternal mortality, then it could have made it a point to fund abortion and contraception. Women should be able to access SRH care and family planning services at any point in time, not only when they are pregnant or have contracted a sexually transmitted disease. Since many of the countries targeted by the Initiative still have a wide gap in gender equality (discussed in Chapter 1) and since gender violence (discussed in Finding #4)

is so prominent, women need a way to protect themselves from carrying an unwanted pregnancy to term. They should be able to take all necessary precautions to make sure they stay healthy and safe.

Finding #9: Newborns are considered an afterthought compared to women when it comes to improving newborn health.

Even if 45 out of 61 (74%) projects refer to newborns, there is only minimal concern for their health within the projects relating to SRH. Moreover, the importance of newborn health is regarded as secondary to the health of women and mothers. De Graft-Johnson *et al*., (2006) state that "mothers, newborns, and children are inseparably linked in life and in health care needs [, but that] in the past maternal and child health policy and programs tended to address the mother and child separately, resulting in gaps in care which especially affect newborn babies" (p.23). Today, there is a continuum of care that is taken into account when providing health care to newborns. This continuum acts as a timeline for when newborns should receive care and what type of care is involved (de Graft-Johnson *et al*., 2006: 24). As stated in the *World Health Report 2005,* "the critical challenge for maternal, newborn, and child health is not in procuring expensive equipment and technology, but in setting up the health care system with continuity of care during pregnancy, skilled care at birth, and care given to the mother and newborn at home" (de Graft-Johnson *et al.*, 2006: 25). In this way, it is important to identify the exact needs of newborns before procuring additional medical equipment (de Graft-Johnson *et al.*, 2006: 25).

After the analysis of the project profiles, it is clear that there is a very specific way the Government of Canada refers to newborns and to determine what needs to be done to improve their health. It directly links the mother and newborn together. However, referring to newborns in this manner may cause the specific priorities of newborn health to be ignored or valued less

than the health of the mother. In many project profiles, newborns are only mentioned because we are dealing with projects under a MNCH initiative. In other project profiles, the only time newborns are mentioned is when the purpose of the project is stated specifically. For example, several project profiles read:

i. "aims to improve the health and nutritional status of mothers, newborns, and children under five" (Government of Canada, 2016: S065377-001);
ii. "aims to improve maternal, newborn, and adolescent child health" (Government of Canada, 2016: S065336-001);
iii. "aims to improve health of mothers and newborns" (Government of Canada, 2016: S065368-001);
iv. "aims to improve maternal, newborn, and child health services" (Government of Canada, 2016: A034616-001).

Moreover, some projects only say: "This project is part of Canada's Maternal, Newborn and Child Health Commitment" (Government of Canada, 2016: A034732-001). This type of language puts newborns under the umbrella of mothers' health. It does not highlight the importance of providing newborns very specific types of care. Evidently, because of their age, there are important considerations and precautions that must be taken into account when providing health care for them.

On the other hand, some project profiles expand upon newborn health:

i. Prenatal care and post-natal services;
ii. Safe deliveries;
iii. Care for high risk pregnancies;
iv. Ensuring safe childbirth;
v. Improving delivery facilities and equipment;
vi. Minimizing the transmission of mother to child HIV/AIDS;
vii. Basic obstetric ultrasound;
viii. Neonatal resuscitation;
ix. Growth monitoring; and
x. Reducing deficiencies that affect safe childbirth and development.

Here newborns are directly targeted because of their specific medical needs. Moreover, they are prioritized as requiring a service at a specific time and place. For example, several projects explicitly state that they will provide unique services for the interests of newborns, like the following:

i. Availability of emergency newborn care (Government of Canada, 2016: A035362-001);
ii. Increase in the number of babies delivered by a midwife (Government of Canada, 2016: A035358-001);
iii. Increase in the number of women delivering their babies (Government of Canada, 2016: S065347-001);
iv. Conducting home visits for post-natal and newborn care (Government of Canada, 2016: A035254-001); and
v. Implementing initiatives to antenatal, postpartum, and care at birth (Government of Canada, 2016: A034616-001).

These statements show that certain projects were designed with the causes of early newborn mortality in mind and that they go beyond stating that reducing newborn mortality is an objective of the project. The statements also show that there is a recognition that newborn care must be addressed in a timely manner for the newborn to survive. This is not to say that women and children are less important than newborns, but the needs of newborns must be addressed with the same importance as those of women and children since they are all directly linked. The language used in the project profiles is very ambiguous and leaves the reader to think that the health issues of all parties are being given equal priority, when this is clearly not the case.

Finding #10: The analysis of the project profiles shows the insufficiency of systematic activities and strategies aiming at raising awareness of women, men, and the community regarding SRH.

It is important for women, men and the community to be aware and have knowledge of SRH. Each party will use the knowledge and information acquired in a different way. This is the main reason why a) awareness for women, b) awareness for men, and c) awareness for community

members is discussed in separate subsections below.

Coming from a GAD perspective, the first step to resolving an issue is to identify it. Yet, only 17 project profiles relating to SRH make any specific reference to awareness of SRH.

Raising awareness about SRH issues in the targeted countries of the Initiative is extremely important for a variety of reasons. Awareness seminars and campaigns help communities identify that they are facing a problem that needs to be resolved. Several projects in the Initiative intend to or have already conducted activities or seminars to advertise that sexually transmitted diseases, HIV/AIDS and mother-to-child transmission of HIV, are one of the primary causes of maternal, child, and newborn mortality (Government of Canada, 2016: S065382-001/A035372-001) in targeted countries. Furthermore, thousands of households are now aware that proper natal, antenatal and postnatal care can help reduce maternal, child and newborn mortality (Government of Canada, 2016: S065386-001) and also that there are gender barriers that limit these actors to accessing SRH services (Government of Canada, 2016: A034616-001).

a) Awareness for Women

Many women and girls in the targeted countries of the Initiative may not even realize why they are getting sick and may not know about the high rates of maternal and child mortality. Thousands of women, pregnant women and girls do not have general nutrition education (Government of Canada, 2016: A035231-001), nor do they realize the importance of antenatal care (Government of Canada, 2016: S065365-001). Acquiring knowledge on these issues is extremely beneficial for them. Women must be able to access information about the factors that are putting their health and the health of their children and newborns at risk in both developed and developing countries.

Several of the project profiles I analyzed indicate that they will provide training and education on issues such as "nutrition, immunization, reproductive health, and family planning" (Government of Canada, 2016: S065365-001) to improve the SRH of women, children and newborns. Nonetheless, it is unfortunate that most of the projects related to SRH do not state that they will conduct awareness and education sessions. In the project profiles that do include awareness activities, positive results have been achieved. For instance, in the *Increased Maternal and Child Health Access Project*, "83% of the 20,929 mothers who participated in workshops on maternal and child health are now able to report at least two known danger signs during pregnancy" (Government of Canada, 2016: S065349-001). If women were aware of the signs and could detect when their health is deteriorating, they would be more willing to ask questions and seek help to improve their condition. Regrettably, they do not receive this opportunity from many projects.

b) Awareness for Men

It is equally important for men to be aware of the dangers of poor SRH for women and girls. In the targeted countries of the Initiative, due to gender inequalities, men have a significant impact on whether or not women can actually access SRH services and make decisions to seek help and use methods to prevent poor or unwanted outcomes (UNICEF, 2006). In half a dozen projects in the Initiative relating to SRH, men were given information or were made aware of SRH and MNCH. In the *Community-Led Health in Bangladesh Project*, for instance, "4,175 men were given information about maternal, newborn and child health during 69,811 home visits for postnatal and newborn care; and 290 female and 354 male peer educators and male motivators were trained to carry out awareness raising and mobilization activities" (Government of Canada, 2016: A035254-001). In another project, awareness for men encouraged "male involvement,

family consideration and shared decision making" (Government of Canada, 2016: S065372-001). These activities are extremely important to promote and improve gender inequalities and gender dynamics, but also to empower women and ensure that their rights and opportunities are not negated. Again, it is often because of the male head of the household that women cannot access SRH care services. For example, men may refuse access to household resources needed for proper medical attention or deny women access to transportation to attend health facilities, However, when a woman's spouse is supportive and believes in her cause, the outcomes can be much more positive for women and children.

An interesting point is that in some projects, men are "trained to raise awareness of other men on the importance of maternal health" (Government of Canada, 2016: S065365-001). In addition, men in general became ambassadors with women to raise awareness on the importance of good SRH for women and girls (Government of Canada, 2016: S065364-001). Despite these activities, awareness for men is not as common in the projects relating to SRH as one would hope to see. Helping women be aware, as well as men, is one of the first steps to improving this situation. Women cannot improve their SRH if men do not support them or are not even aware that a problem exists. To ensure these projects are as comprehensive as possible, it is necessary to increase the awareness strategies and activities addressed to all members of a community, especially those that can have a more important impact in their community.

c) Awareness for the community

The project profiles analyzed have important references to community awareness and community building around SRH. As discussed above, this is especially important in a GAD development framework to ensure that development projects are not targeting women alone, but that their interests are considered as part of the larger community. Again, SRH issues affect

every person in the community, regardless of their gender.

Many project profiles make references to "local committees" (Government of Canada, 2016: S065361-001), "community groups" (Government of Canada, 2016: S065372-001), and "community engagement activities" (Government of Canada, 2016: S065372-001) carrying out education campaigns. These projects make it appear as though they are achieving the purpose of involving all community members in efforts to raise awareness about SRH. However, it is difficult to know whether both men and women, or how many of them, will be targeted and receive education and training. This is because when words like *community* or *community members* are used, it is not clear whether these initiatives include both men and women, or whether they are solely targeting women in the community. If it is the latter, this isolates women in their cause. In the end, each man and woman within a community must have the opportunity to choose to become informed on the causes of SRH. Some projects organize mass media campaigns (Government of Canada, 2016: A035254-001), community theatre groups (Government of Canada, 2016: A035254-001), and radio broadcasts on SRH to reach as many community members as possible (Government of Canada, 2016: S065364-001). These are ways to spread awareness of SRH issues throughout the community.

5.2 Connection Between Findings and the Scholarly Debates

Before conducting the in-depth analysis of the Initiative project profiles it was important to do a thorough literature review to know about the scholarly debates surrounding the topic. Several core arguments surrounding the Initiative point to limitations in terms of promoting gender equality (Tiessen, 2014; Tiessen, 2015; Tiessen, 2016; Percival, 2015; Berthiaume, 2010; Auld & MacDonald, 2014; Sethna & Doull, 2012; Huish & Spiegel, 2012; Carrier & Tiessen, 2015; Brodie & Bakker, 2008; Swiss, 2012). The in-depth analysis and formulation of findings

presented here reinforce many interesting links between the findings identified and the scholarly debates. These links are discussed below using the four theoretical frameworks presented in Chapter 2, mainly the GAD framework. The purpose of this section is to determine how each finding from Chapter 5 relates to the frameworks and debates.

The findings clearly show that the GAD development framework is not present in the project profiles. As shown in Finding #2, for example, there are minimal references to gender inequality or any of the root causes of gender inequality and unequal power relations in different social environments (Tiessen, 2015). Tiessen (2015) noted that gender equality is stated as a primary concern of foreign Canadian policy but that it may only be included in foreign policy discourse to suggest that Canada is an international leader on the matter. Clearly, issues of gender equality are missing from the project profiles. It is evident that gender inequality is a common problem globally and that it is exacerbated by poverty in the targeted countries of the Initiative. Knowing this, it is difficult to understand how this concept can be omitted from the project profiles, but unfortunately this is the case.

The GAD development framework is also supposed to identify barriers (Tiessen, 2014) in addition to those rooted in gender inequality that make it difficult for women to access SRH resources and to be empowered to make important decisions that will improve their health. Findings # 3, 4, and 5 show that women's empowerment, women rights and opportunities and the protection of women from violence is not a primary concern, nor have these concepts been identified as issues that need to be resolved for women's SRH to improve. Percival (2015) declares that these root problems, like poverty, are the biggest barriers that stop women from making health and financial decisions to improve their SRH and becoming informed and accessing health services. It is evident that women are robbed of important opportunities in the

targeted countries of the Initiative. Percival (2015) states that this reality is unacceptable and that underlying societal issues, especially sexual exploitation and gender violence (as discussed in Chapter 5), must be identified as a very serious problem. The first step to rectifying the issues discussed in Findings # 3, 4, 5 and the issues raised by scholars such as Tiessen (2014) and Percival (2015) is for women to feel that they have the support from their communities and to be able to talk about the barriers to improving SRH and share their experiences (as discussed in Finding #3). Regrettably, as exemplified (or not) by the projects, women do not have many opportunities to do so.

The Charity, WID and Liberal Feminist development frameworks are the ones that are most often used as background development frameworks in the Initiative project profiles. No scholar can downplay the considerable amount of money that the Harper government committed to the Initiative. However, this development aid is not being directed to activities that promise sustainable and ground breaking changes and results. After analyzing the project profiles, there is no doubt that the Initiative follows the Charity framework as stated by Tiessen, 2015 (17). Millions of dollars are being invested in activities that may not even guarantee short term results because the barriers for access and referrals for women are not being addressed, let alone identified.

The WID and Liberal Feminist development framework is often portrayed in the project profiles by isolating women in their problems and barely recognizing the role that men and the community can play in improving SRH for women, newborns and children. It is imperative that we recognize that women are part of a larger community and that poor SRH is not only their problem. Each member of the society as well as institutions and organized groups can and should play a role in improving SRH. According to Tiessen (2014), the first step to recognizing

this is understanding what the problem is. She says that by not playing a part in the solution, men and community members are leaving women not only to solve the problems on their own but live with it on their own as well. The WID framework does not recognize the influential role and position that men hold. As explained in the analysis of Finding #7, however, it is not only women who have to change their behavior. Changing behaviors must be promoted for all members of the community, so that they can all be included and encouraged to find solutions and establish mechanisms to improve access to SRH services.

As stated at the beginning of this study, the analysis and findings of the project profiles points to the former Harper government having its own agenda about which issues need attention in the targeted countries. My research underscored that the beneficiaries of the Initiative projects were not consulted. Here there appears to be a certain deficit of needs assessment of the situation of the beneficiaries. As stated by Sethna & Doull (2012), many women and children in Canada and elsewhere would probably tell us that they are not able to afford medication or even transportation to medical clinics to take advantage of the equipment being procured or the training being delivered to nurses and doctors. None of these commodities, that is, equipment and training of nurses and doctors, matter if women and the SDH have a big impact on women and girls for accessing SRH services and resources. The most commonly mentioned SDHs in the project profiles analyzed were education, referrals and family planning. Each of these SDHs affects women and girls differently depending on their own situation. This means that each beneficiary will need a different amount and level of help to take advantage of SRH services. Again, as stated by Tiessen (2014), we need to be aware and informed about these differences and the extent to which different people can be affected by particular circumstances. Finding #10 shows that there is an attempt to educate and raise awareness in communities about the

barriers for women and girls to have good SRH, but it is not a main concern in most of the project profiles. Identifying barriers, however, is a crucial part of the GAD development framework. This important component of the GAD framework is clearly overlooked by foreign policy and EAs of the projects.

Lastly, one of the biggest links between the findings and the scholarly debates is that the targets of the projects – i.e. women, newborns, and children – are not consulted about what they believe are the biggest barriers to accessing SRH services and what activities are necessary from the projects being implemented in their communities (Carrier & Tiessen, 2015). As discussed by Tiessen (2015) and echoed in Finding #1, poor SRH is considered only a women's problem and their role as valuable members of a community is downplayed when they are referred to as *walking wombs* and *child carriers*. The language employed when referring to women turns them into victims and vulnerable people that need to be saved. Thus, this language creates the "Third World Woman" (Mohanty, 1988: 333) which Mohanty (1988) describes as "women [who] are characterized as a singular group on the basis of shared oppression" (338). The result of this type of language is that it paints women "as an always-already constituted group, one which has been labelled powerless, exploited, sexually harassed, etc" (Mohanty, 1988: 338). However, there are specific reasons such as high levels of poverty that make it difficult for women to access SRH services.

Instead of labelling women and girls as victims who do not have a voice, planning and assessments need to include them. After all, they would know best what they need since they are the ones most greatly affected by the factors, such as gender inequality, that worsens their SRH. This point can be stressed even more so for newborns, whose specific health concerns are not considered a priority along with the other objects of the projects (ie. women and children). As

discussed in Finding #9, newborns have equally as much to lose in regard to their health. Even though newborns cannot be directly consulted, as Carrier & Tiessen (2015) stress, they are directly linked to women. Under an MNCH Initiative, it is critical that equal consideration be given for all stated stakeholders without making the needs of one party (women and children) more of a priority and disregarding the needs of another (newborns).

Finding #6 was not mentioned by scholars in the literature review, however it appeared and was identified in my in-depth analysis as an important finding. The reason for its importance is that research on Canadian efforts toward MNCH and the Initiative would greatly benefit from an analysis of each EA to compare their missions and mandates with their involvement on MNCH and SRH in the Initiative and other development initiatives where they participate. This research would be a benefit for future calls for proposals (CFPs) and requests for proposals (RFPs) for the donor agency (client) to know the mandate and areas of focus of the firm or organization answering a call or submitting a proposal for a project. At the same time, it would allow the donor agency to know or at least be aware of potential conflicts of interest of an organization or firm submitting a proposal for funding between its mandate and the nature of some projects they are executing or have implemented.

5.3 Identification of Themes Stemming from the Findings

The in-depth analysis of the project profiles led to the 10 specific findings presented in Chapter 5 of this research. Further analysis of the findings indicates that there are apparent links among some of them. These links and the need to present the findings in a more integrated way led us to re-examine them thoroughly. Finally, based on the nature and content of the findings and the analysis section connecting them with the scholarly debates, four main themes clearly

emerge from the research presented in this report. These themes are identified and discussed below.

Three themes are directly related to the topics treated in this research; the fourth is more related to an administrative matter.

1. **Women and newborns have different health needs, however women are not treated as their own persons and newborns are treated as an afterthought. The reason why they are valued differently is because the same level of attention is not paid to both groups even though both women and newborns are targeted by the same MNCH Initiative.**

Findings #1 and #9 are linked because both discuss the specific, yet different, health needs of of women and newborns. On the one hand, it is clear that the language used in the project profiles reduces women to child-carriers who should seek medical attention only for the benefit of the newborn. It does not recognize that pregnant women and girls can have poor SRH. On the other hand, despite women being referred to as child carriers and walking wombs in the project profiles, it does not appear as though the health of newborns is as much of a priority, or that there are as many activities designed in the projects to address their unique health needs.

2. **Foundational development concepts to improve SRH, such as gender equality, women's empowerment, women's rights and opportunities, and gender violence as well as the need of coexistence of men and women for changing gender dynamics and empowering both genders are not addressed the way they should have been in the project profiles. At the same time, poverty in the targeted countries is not always considered.**

Finding #2, 3, 4, 5, and 7 are all connected to each other because in each of them there is a discussion of root/crucial development elements such as gender equality, women's empowerment, women's rights and opportunities, and gender violence that are clearly omitted from the project profiles. Further, the severity of the status of these development elements is

heightened because the targeted countries have been identified on the low human development index and because there is such a high prevalence of poverty. For this reason, these development elements need to be identified and addressed in the targeted communities as a first step of the planning process of a project. The project profile analysis demonstrates that there is a lack of systematic and previous needs assessments as a base for planning the activities to be implemented in the context of the projects. The previous elements mentioned are crucial for the improvement of SRH for women and girls in developing countries and neglecting to identify and recognize them contributes to the degeneration of SRH.

First, the analysis of the project profiles shows that gender equality is almost never the focus of the projects and it is almost never considered as a means to an end that will improve MNCH and SRH. Consequently, they are not consistent with the foreign policy commitments made by the former Harper government, which specify that "gender equality results are systematically and explicitly integrated across all international development programs" (Government of Canada, 2016).

Second, considering the low levels of income and high levels of poverty, women and girls might not be able to afford SRH services. It is insufficient to build maternal facilities and provide training to thousands of doctors and midwives on SRH services if women and girls cannot afford the services offered. Training is also insufficient if empowerment activities are limited in scope and do not encourage women to use the services available. Moreover, it is unacceptable that the projects do not provide sources of support such as empowerment groups and safe spaces, and even, what it is also very important, financial support to access SRH services.

Third, either in their purpose, activities, or results, the project profiles analyzed do not stress the importance of women having more opportunities such as access to family planning methods and identifying barriers that restrict their ability to use them.

Fourth, considering that gender violence is a root cause of maternal, child, and newborn death, it is inexcusable that only one project briefly includes a reference to support women victims of gender violence.

Lastly, it is essential that both genders be aware, educated, and trained about SRH together to promote changes in behaviors and perceptions on this issue. Both genders receiving the same kind of training and having access to awareness and education sessions could contribute to reducing gender barriers for accessing SRH services. Regardless of the fact that the Initiative was announced by a member of the G7 governmental political forum, the Harper government publicly proclaimed itself as a leader of MNCH interests for women and girls around the world. Therefore, it is intolerable that projects designed under the Harper government's supervision do not promote actions and activities that will improve SRH and reduce maternal mortality and mortality for children under the age of 5, which are development goals for developed and developing countries.

3. **The analysis of project profiles indicates the presence of factors or social determinants of health that act as barriers for women and girls for improving their SRH. The same analysis also shows the insufficiency of systematic strategies aiming at raising awareness of women, men, and the community regarding SRH. Ultimately, the stakeholders of the projects are not aware of the factors that are acting as barriers for improving their SRH which leads to strategies to sensitize them not being put in place.**

Findings #8 and #10 are linked because both discuss how the projects executed do not implement systematic mechanisms allowing the stakeholders of the Initiative (women, girls, children, and men) to identify the issues that contribute to poor SRH. Training that is medically

focused may not necessarily identify and improve important social development concepts such as gender equality, women's empowerment, and women's rights and opportunities. These social development concepts have a big impact on medical referrals and access to SRH services, since women and girls in the South face additional barriers such as lower income, higher poverty rates, and higher rates of sexually transmitted diseases. It is deplorable that an MNCH initiative does not attribute as much importance to identifying and overcoming these additional barriers to accessing family planning methods and SRH services. Considering the unique benefits of SRH awareness sessions for women, men, and the entire community, it is extremely surprising that they are not the focus of more projects of the Initiative.

4. **Evidence identified in the review of literature indicates that there are conflicts of interest between the organizational mandates of some EAs, the mandate of the Muskoka Initiative, or the commitments of the Government of Canada on MNCH and SRH and the projects these EAs are implementing.**

Though Finding #6 is a theme on its own, it is a very interesting point to take into account. Some organizations, such as the UNFPA, have evidence-based criticisms against them because they support initiatives that are not coherent with either their organizational mandates, the mandate of the Initiative, and/or the foreign policy commitments of the Government of Canada on MNCH and SRH.

CONCLUSIONS AND RECOMMENDATIONS FOR EACH THEME

Building on the four main themes identified above, a series of conclusions and recommendations for each is provided below.

A. CONCLUSIONS

1. Both women and newborns, who are supposed to be the beneficiaries of the Initiative, are not receiving the attention they are owed through a maternal, newborn, and child health (MNCH) Initiative. The language used in the project profiles reduces a woman to a child-carrier who should seek medical attention only when she is pregnant, and does not speak to her SRH in general. It does not recognize that women and girls can have poor SRH in general. Moreover, it does not appear as though the health of newborns is as much of a priority or that there are as many project activities designed to address their unique health needs.

2. The projects funded by the Government of Canada are not responding to the real needs of the intended beneficiaries (women, newborns, children, and men) of the Initiative. Further, the projects have not been designed to address the relevant development issues deeply rooted in the developing communities. For this reason, women and girls are robbed of important rights and opportunities that could improve their SRH. The limited or lack of relevance of these concepts indicates that the projects being implemented are not consistent with the foreign policy commitments stated by the Government of Canada. These commitments specify that gender equality -- closely associated with the other foundational concepts identified in theme #2 -- is systematically and explicitly integrated across all international development programs.

3. The project profiles do not emphasize the need to improve SRH and thus, they are not contributing effectively to the goal of the Initiative. When there is low awareness of SRH issues and the barriers for improving poor SRH among the beneficiaries, this puts limitations on their ability to make changes. It is shocking that an MNCH initiative does not attribute as much importance to identifying and overcoming different gender inequality issues in particular communities, for example, and barriers to accessing family planning methods, such as geographic location and transportation issues, awareness and education, and poverty. Considering the unique benefits of SRH awareness sessions for women, men, and the entire community, it is extremely surprising that they are not the focus of more projects of the Initiative.

4. Each Executing Agency (EA) participating in the Initiative has a different organizational mandate or mission and, as such, supports certain aspects of the Initiative but not others. Some EAs emphasize, in the proposals submitted for approval, the aspects they support and are part of the Initiative and the commitments of the Government of Canada on MNCH and SRH. At the same time, they avoid discussing aspects that they do not support. In this way, they maximize the chances of being funded by GAC and become part of the Initiative without really sharing and promoting all the commitments of the Government to MNCH and SRH throughout the Initiative.

B. RECOMMENDATIONS

1. Projects aimed at improving maternal as well as newborn health must include specific health care activities for each group. It is important that this be an essential requirement to be fulfilled by the projects submitted for approval by the EAs since the health of women and newborns are always linked, even if their needs are different. Newborn health

cannot be considered secondary since their well-being is dependent on health services they receive in utero and when they are born. Moreover, there needs to be more control and due diligence applied in the project selection stage. It is crucial that the team within GAC responsible for selecting these projects review and improve the criteria of project selection taking into consideration the main goals of the Initiative and the needs and priorities of the beneficiaries. Further research is needed on the identification of specific health needs of women and newborns in the targeted countries of the Initiative.

2. The EAs planning to submit a project need to conduct a thorough assessment of the situation in the targeted communities in relation to these foundational developments concepts as a first step of the planning process. This would be a good basis for the activities to be implemented. In addition, at the proposal stage of projects, the team responsible for evaluating the projects submitted must pay greater attention to the coherence and consistency of the needs assessments results with the project purpose, activities, and expected results as well as the foreign policy commitments of the Canadian government related to SRH.

3. Considering the low level of awareness of SRH issues and the barriers for improving poor SRH, it is imperative that the EAs responsible for the implementation of the projects include more systematic actions, strategies, and campaigns to sensitize the people concerned – women, men, and community members - in relation to the barriers that are limiting the possibilities of improving their SRH. To this respect, the EAs should actively promote the participation of locally-based women's organizations, which would be

extremely valuable allowing, at the same time, to make good use of local expertise. Their participation would help to resolve their own problems ensuring this way the sustainability of the development initiatives. Further project development and implementation would benefit from forming partnerships with locally-based women's organizations to provide them with technical assistance and improve their capacity to better participate in raising awareness in the community. This type of action-research would help improve the capacities of people who know the context of the communities and who could already be working in the targeted areas with the beneficiaries. This could be done through a model of action-research that will involve the locally-based women's organizations and help them to improve their capacities to assist women and men in raising awareness related to the barriers that are limiting them from improving their SRH. This type of research would identify gaps in knowledge and resources that could be taught or supplied to locally based organizations.

4. Further research is required to analyze the missions and mandates of each EA to compare them with the mandate of the Initiative and the commitments of the Government of Canada on MNCH and SRH. Carrying out a project such as this one would help to verify to what extent EAs playing a part in a MNCH initiative really support root development concepts such as gender equality, women's empowerment, women's rights and opportunities, and reducing gender violence. Furthermore, field-based research and interviews with program implementers would shed light on some of the strategies employed by staff members to address some of the issues noted above. Text-based analyses provide some insights into the commitments and strategies employed. However,

they may not offer a fully comprehensive description of the nature of programming that takes place in the communities. For example, some "insider activists" may employ gender equality strategies in ways that are not adequately reported in the project summaries. Therefore, future research could build on the textual analysis provided here to complement the information with context-specific data collection.

As a closing remark, I would like to reiterate that this study offers important findings about the ways that the Initiative does or does not address women's rights, gender equality and community needs. Several positive and encouraging signs can be found from analysing the data presented in the study such as: a) inciting the adoption of different family planning methods, b) inspiring women to make important decisions about their bodies and health, c) giving confidence to women to share their experiences through women's groups, d) assisting women in accessing SRH care services, e) providing medical training to women, men and community members, f) promoting shared decision-making in the household and community level, and g) raising awareness about the SRH health needs of women and girls in the targeted communities and the barriers to improving poor SRH. Nonetheless, important gaps in programming remain and greater attention to the criticisms identified in the findings presented here and the broader literature on this subject is necessary for improving MNCH (and SRH) programming. Moving beyond charitable approaches and women in development (WID) strategies is imperative. It is especially important to avoid thinking about women in *developing countries* only as women who are powerless, as women who do not "have choices or the freedom to act" (Mohanty, 1988: 344) and as women whose needs are predetermined because of the country in which they live. A woman in a developed country could be living under similar conditions. Being conscious of this connection, in addition to adopting a gender equality lens, can facilitate a more sophisticated

analysis and comprehensive approach of maternal and newborn health needs, rights and opportunities.

APPENDICES

APPENDIX A: SAMPLE OF PROJECT PROFILE FORMAT

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Sectors | Results | Related Information | Transparency

Basic Information

Project Number:
S065372-001

Maximum CIDA Contribution:
$19,335,120

Executing Agency — Partner:
Plan International Canada

Status:
Closed

Start — End:
2011-11-25 — 2015-09-30

Country/Region

Bangladesh: 23.52%
Mali: 22.06%
Zimbabwe: 20.59%
Ghana: 19.12%
Ethiopia: 14.71%

Description

This project aims to improve maternal, neonatal and child health (MNCH) in underserved populations of 26 districts and sub-districts of Ghana, Mali, Ethiopia, Bangladesh and Zimbabwe. Reaching over 1.85 million people, including families and community health workers, the project uses a community-based approach and works to improve the quality of community outreach and MNCH services while encouraging health-seeking behaviours, and improved health care management.

Activities include: training government health workers on basic obstetric and neonatal care, safe deliveries, and management of childhood illnesses; training health facility managers to strengthen quality control; equipping 63 health facilities and 30 maternity wards; conducting home visits for postnatal care; and helping communities address traditional cultural views impeding the use of health services. Plan Canada is working with the Society of Obstetricians and Gynaecologists of Canada, UNICEF and ministries of health, to implement this project.

This project is part of Canada's Maternal, Newborn and Child Health commitment.

Sectors

Improving health
Health education (012261): 40%
Basic health care (012220): 24%
Health personnel development (012281): 20%
Basic health infrastructure (012230): 16%

Results

Expected Results

This is a new feature, part of CIDA's efforts towards increasing transparency. Information will only be available for projects approved after October 15, 2011. For other projects, information on expected results is usually included in the description.

Progress and Results Achieved

Results achieved as of September 2013 include: (i) developing a monitoring and evaluation framework with an online database system that aggregates data in real time to help develop better targeted, more effective maternal, newborn and child health programming; and (ii) developing a common understanding of the links between gender equality and better maternal, newborn and child health results. For example:

In Bangladesh, (i) 26 family welfare clinics that had not functioned for the past 15-20 years were rehabilitated and equipped; (ii) 148 community health committees were rehabilitated and played a key role in the re-establishment of functioning health facilities; and (iii) 93 birth attendants were trained and are improving women access to quality services.

In Zimbabwe, (i) the technical and managerial capacity of Health Care Committees was improved; (ii) community and religious leaders were trained in maternal, newborn and child health; (iii) village health worker groups were trained and in turn trained 150 care groups; (iv) five waiting mothers' homes were built, including a Kangaroo Care Ward, which is a model for the country and is already contributing to reducing newborn mortality; and (v) health centres were rehabilitated.

In Mali, over 3,300 community groups attended maternal, newborn and child health and gender equality sessions.

In Ghana, community health committee members and health workers were trained in Basic Emergency Obstetric and Newborn Care, preventing mother to child transmission of HIV, safe motherhood, child health and gender equality.

In Ethiopia, specialized training was provided to health workers, Health Development Army, government officers from district administration and staff from health offices, women and children's affairs, health posts and health centres.

These results are contributing to reducing mortality among mothers, newborns and children in underserved populations by scaling up integrated health interventions and by increasing people's awareness of, and access to, health services.

Related Information

- See the video and story on how a song can save a life: Singing loud and proud for mothers and babies in Zimbabwe

Transparency

Contracts, Grants and Contributions

Recipient Name	Date	Type
Plan International Canada	2011-11-25	Contribution

APPENDIX B: FIRST ANALYSIS SPREADSHEET

PROJECT #	FOCUS ON CHILDREN	FOCUS ON WOMEN	FOCUS ON MOTHERS	FOCUS ON MEN	SEXUAL/ REPRO HEALTH	INFRASTRUCTURE	HUMAN RESOURCES	NEWBORNS	NUTRITION	PRIVATE SECTOR	REDUCE DISEASE	ACCOUNTABILITY	GOV CAPACITY	EQUITY	COMPREHENSIVE APPROACH	AWARENESS	OTHER
D000402-001	Children	Girls		Boys			Training local government registration agents	NEWBORNS		Partnership w key mobile service providers		Birth registration system, innovative technology, real-time monitoring of birth registrations,	Gov to finalize Birth and Death Registration law; coordinating inter-ministerial committee on civil registration and vital stats			Awareness campaigns for new system in each region	
D000145-002	Children <5	Women (pregnant & breastfeeding)					Training health workers (detect/treat severe acute malnutrition)		Malnutrition, nutritious food		Vitamin A supps; de-worming;						*Treating SEVERELY malnourished children
D000164-001		Women (pregnant)	Maternal		Standard operating practices; emergencies		Enhance skills of management teams; recruit, staff, train	NEWBORNS						POOR pregnant women; GENDER SENSITIVE services			
D000472-001		Women (pregnant)	Maternal				Training; hospitals of excellence; support;supervision; referrals; improve skills	NEWBORNS		Mobile Phone Network; Transfer vehicles; local/emergency transport; bicycle ambulance							

M013426-002	Children		Mothers						SUN; undernutrition; food security; nutritious food;				Increase it; for efficiency & sustainability; overall coordination & technical expertise				
D000052-001	Children <5		Mothers		Promote breastfeeding		Staffing; equipping; training; supervise	NEWBORNS	Nutrition		Vaccinations; micronutrients; malaria, diarrhea, pneumonia, insecticide treated anti malaria bed nets, water-borne diseases, safe drinking water, household latrines,			Remote communities; mobile clinics; community volunteers; mobile health teams;			
A035457-001	Children <5						Educate caregivers/ health workers		Oral rehydration salts, zinc for diarrhea	Encourage investment;				Low cost treatments, better supply, better distribution; hard to reach areas			
M013757-001	Children								Direct nutrition interventions		Fortified foods; Supplements	Document lessons to inform nutrition related policy; use behavior change comm programs to promote good feeding practices;			Combined w existing outreach programs in health sector		

D000058-001	Children <5	Girls		Boys			Technical assistance & training		Malnutrition (early detection,community screening,treatment,referrals)		Therapeutic foods		Support measures that can be taken in short run to improve capacity of MOH				
A035567-002	Children	Women	ESPECIALLY ffor mothers		Ultra sound equipment, child delivery tables,stethoscope	Building, repairing, equipping (solar vaccine refrigerators, thermometers)				Ambulances							
A035564-001	Children	Girls		Boys		Latrines, hand washing stations, urinals, hygiene kits, wells, water supply networks					Safe water, sanitation, hygiene					Community led awareness and eduction campaigns	
A035518-001		Women			Safe deliveries, prenatal care, volunteer midwives, mentoring midwifery & nursing students												

M013707-001	Children	Women			Promote good breastfeeding practices				Training in home-based agricultural production, educating on nutrition, raising awareness of behavior change			Monitor impact of activities on child growth & nutritional status and # of women adopting good practices in the home					
A035372-001		Women			Family health house, delivery room, examination room; referral system, for high risk pregnancies, delivery and recovery care, safe childbirth, mobile health teams, midwife training	Diagnostic & medical equipment	Training	NEWBORNS		Telecommunication and transport services,							
A035261-001	Children		Mothers					NEWBORNS					Improve management capacity of Provincial Directorate for long term efficiency/sustainability				
A035496-001	Children<5	Girls		Boys							Vaccination campaign; mass distribution of bed nets						

A035 243-003	Childr en	Women		Men			Training					Nutrition Surveillance System (NSS); Health Monitoring Information System (HMIS)		Drough t and conflict affecte d areas; vulnera bility to nutritio n emerge ncies.			
A035 262-001		Women (pregna nt)			Inc births in health care facilities; incentives (offset transport and other costs) to seek care during pregnancy and childbirth; to receive pre-natal, safe delivery & post natal care.	More facilities	More workers	NEWB ORNS									
A035 243-001	Childr en<5	Women (pregna nt)	Materna l		Implement/ evaluate maternal, neonatal,ch ild health strategies and programs, train midwives/n urses on nutrition	More equipment in health facilities	Training (nutrition counselling & growth monitoring)		Identifying prevelance of underweight; rehab drinking water sources; promoting diverse diets; techniques to better preserve food							Public Awaren ess Program s	

A035243-002	Children	Women	Mothers				Training family health action groups, community health committees, religious and community leaders		MN supplements/feeding practices/monitoring growth/manage acute malnutrition/			HMIS; Management practices;monitoring;evaluation						
A035360-001	Children	Women	Maternal		Prenatal care; Delivering with support of skilled birth attendant; emergency obstetrics care.	Est facilities/clincs/formal hospitals;			Basic health and nutrition		Vaccines (malaria)		Make systems stronger for eventual take over for providing quality primary health care/oversee/supervise					

PROJECT #	FOCUS ON CHILDREN	FOCUS ON WOMEN	FOCUS ON MOTHERS	FOCUS ON MEN	SEXUAL/REPRO HEALTH	INFRA/SUPPLIES	HUMAN RESOURCES	NEWBORNS	NUTRITION	PRIVATE SECTOR	REDUCING DISEASE	ACCOUNTABILITY	GOV CAPACITY	EQUITY	COMP APPROACH	AWARENESS	OTHER
A035485-001	Children<5										Vaccines (Polio)				Work w political, traditional and religious leaders	Health Education	
A035102-003	Children<5	Woemn (pregnant & nursing)							Procure/distribute food products; treat acute malnutrition/			Stakeholders to prevent, detect, treat malnutrition & plan, manage, monitor,evaluate programs					

A035488-001	Children					Refrigerators in community health centers (vaccine storage); medical equipment			Detection;treatment, prevention of acute malnutrition		Immunization;vaccines;essential drugs; timely supply	Est mechanism for active detection/treatment				Promotion of adequate nutrition	
A034732-001		Women; Girls; Pregnant Women			Basic obstetric, neonatal care; family planning; prevention and testing of HIV/AIDS & STIs; services for victims of sexual violence; training professional midwives	Reconstruction of NSM and maternity clincs	Training health and management personnel										
S065804-001	Children		Maternal					NEWBORNS							Increase effectiveness of partner orgs; promote knowledge sharing, identify strategies to enhance collaboration, joint reporting/processes, etc.....See Description		

A035362-001			Mothers					NEWBORNS				Plan, conduct, report two national surveys: causes of death among women of chilbearing age & need for emergency obstetric and newborn care	Helps MOH and National Bureau of Stats to plan/manage surveys and needs assessments & to analyze and apply the data collected				
M013596-002	Children	Women							Scaling-up Nutrition				Strengthen ability to combat disease	Most disadvantaged			
M013596-001	Children	Women							Nutrition			Track changes by building on national health information systems		Most disadvantaged			
A035263-001	Children	Women	Pregnant/Lactating						Malnutrition; Anaemia; Stunting								
A035358-001		Women	Mothers		Midwifery program; high quality midwife services	Improve training facilities; equipment	Training health workers & nurses	NEWBORNS					MOH to manage & regulate education of midwives				
M013603-002	Children	Women										See Description					

S0653 70-001	Childre n	Wom en	Maternal		Prevent mother to child transmissio n of HIV; proper care for HIV/AIDS; update training materials on obstetric and neonatal care, family planning;	Rehab of maternity hospitals; supplies and medicines										Educating/inf orming: on preventing spread of sexually transmitted diseases/HIV AIDS and mother to child transmission of HIV	Assis t wom en victi m of viole nce;

PROJ ECT #	FOCUS ON CHILD REN	FOCUS ON WOMEN	FOCUS ON MOTH ERS	FOC US ON ME N	SEXUAL/R EPRO HEALTH	INFRA/SUP PLIES	HUMAN RESOURC ES	NEWBO RNS	NUTRIT ION	PRIV ATE SECT OR	REDU CE DISEA SE	ACCOUNTA BILITY	GOV CAPAC ITY	EQUIT Y	COMP APPRO ACH	AWARENESS	OTHER
S0653 74-001	Childre n	Women(preg nant)	Mother s		Training repro health		Improve knowledge/ skills of health staff (doctors, nurses,mid wives)	NEWBO RNS	Nutritiou s food			Mangement of health and nutrition services					
S0653 81-001	Childre n	Women (pregnant, reproductive age, postpartum)					Training health care providers; /transfering knowledge/ local consultatio ns		Critical Nutrition packages					Vulnera ble Populati on		Community education and mobilization	THEIR FAMILIE S?

A035242-001						Installation of security grilles for labs in KU; Digging of a well at TTC; Security wall at TSS;											Two commemorative plaques
S065383-001	Children	Women	Pregnant and lactating mothers;	Men	Access to repro health services	New clinics			Nutritious food; Supplements (malaria, anaemia, acute resp infections, intestinal parasites infections, diarrhea)						Local actors: Integrates agricultura, nutritional and clinical activities		Men (to adopt behaviors to reduce transmission of disease)
A035288-001		Women (pregnant/lactating)	Girls	Boys					Stunting and malnutrition						Address behavior change in areas of feeding practices, agricultural production, water, sanitation, hygiene		

A035264-001	Children		Maternal				Training	NEWBORNS				Policy, planning, budgeting, monitoring, evaluation; teachnical assistance to Prov Directorate of Health				Social Mobilization to increase knowledge and demand for quality health care/infant feeding and hygiene practices	
A035252-001	Children	Women (of child bearing age, pregnant)	Mothers		Skilled birth attendants; training midwives	Basic equipment/supplies	Training public & private workers	NEWBORNS		Affordable services				Underserved; lower-income; poorer communities;		Health education(health,hygiene,nutrition)	
S065358-001	Children		Maternal		Strengthen midwifery & pediatric nursing programs			NEWBORNS					Educational capacity; enable environment for policy dev/deisgn and lanuch courses in neonatology and paediatrics; BSc Midwifery program; controbuting to national health policy and planning				
S065350-001	Children <5	Women (of reproductive age)			Family planning		Training community health workers	NEWBORNS					Training local MOH partners			Educate Families	FAMILY? CAREGIVER?

S065353-001	Children <5	Women (pregnant)	Maternal		Training for midwives		Training birth attendants, nurses, doctors, primary health care providers, paramedics	NEWBORNS				Improve diagnostics and early intervention of childhood infections & strengthen health systems					
S065386-001	Children<5	Women (of reproductive age)	Mothers			Eight health facilities	Training local village support groups		Improve nutrition; distribute micronutrients (fe, folic acid)		Promote vaccination, appropriate care during illness and better household sanitation and hygiene			Empower* ; underserved		Nutritional awareness sessions	

PROJECT #	FOCUS ON CHILDREN	FOCUS ON WOMEN	FOCUS ON MOTHERS	FOCUS ON MEN	SEXUAL/REPRO HEALTH	INFRA/SUPPLIES	HUMAN RESOURCES	NEWBORNS	NUTRITION	PRIVATE SECTOR	REDUCING DISEASE	ACCOUNTABILITY	GOV CAPACITY	EQUITY	COMP APPROACH	AWARENESS	OTHER
S065377-001	Children<5	Women (pregnant/lactating)					Training health workers	NEWBORNS	Promote better nutrition		disease reduction; malaria,diarhea,pneumonia, mother to child transmission of HIV/AIDS		Training MOH workers			Community education programs (nutrition, child feeding, disease prevention)	
S065346-001	Children, children<5	Women (pregnant)				Upgrade Equipment	Training community and health centre workers	NEWBORNS			Encourage early treatment for acute illness	Analyzing project's results and sharing the Bushenyi model through the media and meetings with government planners					
S065382-001	Child		Maternal		Safe brestfeeding practices, prevnt mother to child transmission of HIV; providing care for those affected		Training health workers									Promoting safe breastfeeding	
S065336-001	Child, Adolescent	Women	Maternal	Men		Constructing, equipping, operating clinics		NEWBORNS				Facilitating community-led improvements in accountability of healthcare providers				Community Awarenes s Campaigns	

S0653 51-001	Childre n<5		Mother s					NEWBO RNS			Childhood illness (malaria, diarrhea,pneumoni a)				Commun ity based approach : communi ty based health and first aid training; radio braodcas ts on illness symptom s and treatment ; establish ment or reinforce ment of village health committe es to support volunteer s and communi ty health workers and liaise with various decision makers		
S0653 48-001	Childre n	Women	Mother s				Training women/com munity health workers on feeding practices/foo d diversity/nut rition to improve back yard and gardens**				Improved hygiene			Vulnera ble; develop income generati ng activitie s for women **			

A035231-001	Children		Mothers		Improve access to quality repro health, basic emergency obstetrics and newborn care services		Equip facilities with health providers and nutrition coordinators					Electronic stock management systems that enable them to monitor their supply of essential medicines, vaccines, contraceptives, etc - & to forecast future requirements		Gender responsive			
S065387-001		Women (pregnant)			comprehensive health care; reduce nutritional deficiencies that affect safe childbirth and development; training of midwives and health workers on emergency obstetric and newborn care/diagnosis and treatment of HIV/AIDS, malaria, tuberculosis, waterborne disease; training nurses on safe and clean childbirth	Provide ambulance and lab equipment					Training nurses and midwives on malaria, tuberculosis, and waterborne diseases			Nomadic communities	Community-based approach		

S0653 65-001	Childre n	Women (of repro age/pregnant)		Wom ens' spous e	Antenatal care; training women on reproductive health/famil y planning	Est and upgrading delivery rooms and basis health units	Training nurses and health workers	NEWBO RNS; Training midwives	Training women on nutrition					social factors that prevent women from using these services		Communi ty health education sessions; Training women on immuniza tion	
M013 354-002										Public-private partners hip, internati onal financin g institutio n, attracts and disburse s addition al resource s; governm ent, civil society, private sector, affected commun ities;							People in countrie s implem ent their own program s based on their prioritie s which are verified *
S0653 47-001	Childre n	Women			Training on obstetric care; Est neonatal care units;	Distributing medical equipment	Training health workers and and birth attendants on safe, clean delivery;	NEWBO RNS	Training on nutrition and improve d child feeding practices					Remote and underser ved districs	Cummun ity based approach	Education on sanitation and hygiene and malaria and preventio n	Training mothers on home-based manage ment of commo n childho od illnesses

PROJECT #	FOCUS ON CHILDREN	FOCUS ON WOMEN	FOCUS ON MOTHERS	FOCUS ON MEN	SEXUAL/REPRO HEALTH	INFRAS/SUPPLIES	HUMAN RESOURCES	NEWBORNS	NUTRITION	PRIVATE SECTOR	REDUCING DISEASE	ACCOUNTABILITY	GOV CAPACITY	EQUITY	COMP APPROACH	AWARENESS	OTHER
S065364-001	Chilren	Women (pregnant, breastfeeding)	Mother		Prevention of mother-to-child HIV transmission; Est program with comprehensive monitoring plan for prevention of it;	Specialized health center for HIV+ pregnant and breasfeeding women	Training female beneficiaries in health, hygiene and nutrition, training home care workers									Broadcasting radio announcements concerning mother-to-hild HIV transmission	
S065349-001	Children <5	Women	Mother		Regular access to basic prenatal and postnatal care & basic health care & attendants	Est health centers	Training of attendants	NEWBORNS							Community-based approach		
S065355-001	Infants	Woem (pregnant)	Mothers (priority)		During pregnancy and childbirth, neonatal care; Est prenatal and neonatal home visit system; neonatal care kits;	Local clinics supplied with rapid malaria test kits	Training community-based volunteers/ local health professionals				Malaria control program; provide mosquitto nets for residents;			Marginalized villages		Malaria control workshops	

A035251-001		Women, adolescent girls	Mothers (esp)				Improve knowledge and skill of health workers;	NEWBORNS		Enhance women's ability to pay for health services		Improve district level health management teams to plan, budget, manage, monitor, and evaluate health services provided in their districts	Improve community health management	Reduce barriers that prevent women in rural areas from getting access to health services; in rural areas	Community-based	Training volunteers to provide education and information to women and their households	HOUSEHOLDS?
S065361-001	Children	Women			Training workers in obstetric care, child health and nutrition		Improve skills of medical staff and community health workers;		Reduce malnutrition			Improve skills of gov health management; improve procedures and communication across all levels of community health facilities		Increase coverage	Community-based	Help local committees carry out nutrition education campaigns	
S065368-001			Mothers		To provide obstetric care; Trained to identify referral patients, provide emergency surgical & obstetrical care, conduct C-sections, training midwives		Training non-physician health professionals (clinical officers, assistant medical officers, admin officers	NEWBORNS;									

S06533 1-001	Child		Materna l				WET Centers (training, leadership, tech consulting, education resources, networking services)	NEWBO RNS							Catalyzes : gov agencies, NGOs, communi ty groups		
S06537 2-001	Child		Materna l, neonatal		Training basic obstetric and neonatal care, safe deliveries, management of childhood illness; equip facilities with maternity wards; conduct home visits for postnatal care		Families and community health workers; training facility managers to improve quality control							Underser ved; address traditiona l cultural views impeding use of health services	Commun ity-based approach		
S06532 8-001	Children <5	Women (pregnant & lactating)	Mother		Basic HC services to reduce HIV/AIDS; training birth attendants;	Mobile clinics; equipment & medicine; contruct latrines	Training workers & community groups	NEWBO RNS	Prevent and treat		Basic HC services to redice malaria;				Commun ity-based	Vaccinatio n & de-worming campaigns	

S065363-001	Children	Women	Mothers	Husband	Training in antenatal, postnatal and newborn care and safe pregnancy;		Training health workers and community health groups		Training in nutrition		Promote immunization and raising awareness of how to prevent and treat malaria, respiratory infections and diarrhea			Access to and use			Promote shared decision making on MNCH at the household level
A035253-001	Children	Women	Mothers	Men	Family planning skills	Refurbishing and equipping health centers and district hospitals	Training health workers and community health groups w focus on GENDER EQUALITY	NEWBORNS					Training for local gov officials to help them better manage and prioritize health services	Empower: community members but especially women to demand the health services they require, to make choices; that support good health and to get involved in managing local health care services; GENDER EQUALITY training in relation to public health issues		Community engagement activities to help local communities become more aware of issues relating to health of the subjects and gender equity	FAMILY;Promote learning home based life saving skills; Involving men in supporting the health of women and children in their community

PROJECT #	FOCUS ON CHILDREN	FOCUS ON WOMEN	FOCUS ON MOTHERS	FOCUS ON MEN	SEXUAL/REPRO HEALTH	INFRA/SUPPLIES	HUMAN RESOURCES	NEWBORNS	NUTRITION	PRIVATE SECTOR	REDUCING DISEASE	ACCOUNTABILITY	GOV CAPACITY	EQUITY	COMP APP	AWARENESS	OTHER
S065337-001	Children		Mothers				Training volunteer health workers, birth attendants, informal health service providers		Nutrition education	Improve partnerships between communities/ health facilities	Malaria prevention education			Marginalized	Community-based	Community education to promote household behaviors	
A035254-001	Young children	Women (of childbearing age)	Mothers	Men	Home visits for prenatal/postnatal care and care for newborns and young children		Training for health care workers in emergency care for pregnant women, new mothers, newborn babies	NEWBORNS						In remote areas		Organize community events, mass media campaigns, training community theatre groups, selecting peer youth educators	*Ability of men and women to recognize, prevent, respond to MNCH issues; Male champions to raise awareness about potential health issues; emphasis on role that men can play

M013402-001			Maternal					NEWBORNS					UN mechanism of health agencies to assist high burden countries in accelerating the implementation of commitments already made to UN SGGSWCH				
A035102-001	Infant, Children <5	Women							Procurement and distribution of food products				Strengthen capacity of community health care SH in terms of prevention, detection, care, planning, monitoring, evaluation, management of nutrition programs diagnose malnutrition at an early stage in all forms of under 2, handle cases of moderate acute malnutrition				ALSO: improve household heads and women's knowledge of health and nutritional good pratices

A034908-001		Women (pregnant)	Maternal		Emergency obstetric care, prevention of mother-to-child transmission of HIV/AIDS); set up a system to reduce time it take for women in labour to get to a health centre			Neonatal		Direct financial support for: new resources to upgrade orbuild new health units, ensuring key services are available (See repro health box) + transportation and qualified personnel							Improve referral and evacuation plan incl. Transport of pregnant women from villages to community health centers
A034616-001	Child		Maternal		Procurement and distribution of resuscitation devices, HIV testing kits, communication equipment, reproductive health supplies		Training (enhance the skills) health workers, midwives, doctors	NEWBORNS									
A035244-001	Children	Women	Maternal		Est 24hr emergency obstetrical and neonatal care services	Provide facilities with drugs, supplies, equipment, for 24hr services	Training of hospital personnel in obstetrical and neonatal care	NEWBORNS						increase access			

M013403-001	Children	Women (pregnant)	Maternal		Improve antenatal care, care at birth, postpartum and newborn care			NEWBORNS	Integrate micronutrients: therapeutic zinc, oral rehydration therapy, vitamin A, ready to use therapeutic foods, iron, folic acid,								
A034782-008	Child		Maternal		National strategy for combatting HIV/AIDS					Health care financing; partnerships (gov and development partners)		Central support systems (infrastructure, health management, information systems, drug supplies, transport, communication and info tech); HR issues;					
M013404-001	Children									Increase predictability of global financing and improve sustainability of national financing for immunization; shape vaccine markets	Increase access to immunization, uptake of new and underused vaccines		Strengthen capacity of integrated health systems to deliver immunization				

PROJECT #	FOCUS ON CHILDREN	FOCUS ON WOMEN	FOCUS ON MOTHERS	FOCUS ON MEN	SEXUAL/REPRO HEALTH	INFRA/SUPPLIES	HUMAN RESOURCES	NEWBORNS	NUTRITION	PRIVATE SECTOR	REDUCING DISEASE	ACCOUNTABILITY	GOV CAPACITY	EQUITY	COMP APPROACH	AWARENESS	OTHER
A033033-007	Children		Maternal, Mothers									To build effective, transparent, and accountable country systems, reinforce mutual accountability	increase coordination among donors, foster greater policy dialogue between CIDA, gov and partners in order to reinforce efforts for effective, focused aid and long term development results.				
A035171-001	Children <5	Women (pregnant, lactating)				Clean water sources, separate toilets, hand-washing facilities	Training community health workers on screeningand treatment; training on breastfeeding,		Nutrition and health: clean water, sanitation, comm-based nutrition		Regular provision of Vitamin A, Fe supplements, de worming tablets					Nutrition counselling for caregivers	
A035190-001			Mothers				Training to improve skills of doctors, nurses and other community based health personnel	NEWBORNS					Tech assistance and support to improve local level planning by gov; support coordination on between non gov orgs and gov to develop better services	Poor and marginalized populations		Training for mothers on harmful practices and need to use and demand better services	

A034921-002	Children	Women Pregnant women	Maternity	Men	Construction of 30-bed maternity ward/waiting home for pregnant women; specialized training in maternal, neonatal and child health issues	Construction of 200-bed provincial hospital/paediatric ward; Design, construction, equipping of new hospital;	Training hospital management/equipment usage and maintenance;										*Improve access to and quality of specialzed health services for children, women and men in Artibonite Department
A035207-001	Children <5	Women			Basic emergency obstetric and neonatal care; C-section and blood transfusions	Rehabilitation of 9 maternity clinics/7 health centers; repairing infrastructure; installing equipment	Staff training		vitamin A distribution, growth monitoring, oral rehydration therapy, deworming,		Routine vaccinations; Water & sanitation (cholera)			Remote rural areas			
A035207-002	Children <5	Women			Basic obstetric and neonatal care; caesarean sections and blood transfusion	Rehabilitation of 9 maternity clinics/7 health centers; repairing infrastructure; install equipment	Staff training		Vitamin A distribution, growth monitoring, rehydration therapy, deworming		Routine vaccinations, water and sanitation initiatives (cholera)			Remote rural areas			

S065339-001	Children		Maternal				Training: Disability workers, community health workers, policy makers, community members						Policy advice and coordination			Raise awareness among community members about the importance of using such services;	MNC & DISABILITY services
M013426-001	Children	Women	Mothers						Coherent food and nutrition assistance			EVIDENCE BASED nutrition intervention program guidance accessed by global health practitioners and applied to nutrition programs	Build gov and national capacity				EVIDENCE BASED*
A035206-001	Children <5	Women (pregnant)			Medical exams, consultations, hospital fees, medical lab tests, med prescriptions, medicines			NEWBORNS						and other vulnerable groups		Health promotion, prevention and curative treatment	and other vulnerable groups
A035465-001	Children <5	Women (illeterate)					Training community-based volunteers				Malaria, pneumonia, diarrhea			Remote areas	Community-based		*ILLITERATE WOMEN
A035218-001	Children	Women										Manage, monitor, evaluate the national health system	SHARP support to Afghan MoPH; communication and coordination between central MoPH and provincial health offices	Rural areas			

A035232-001	Children <5										Measles vaccine; dose of Vitamin A; deworing medicine						

APPENDIX C: IN-DEPTH ANALYSIS SPREADSHEET

Project #	Project Name	1. Description, activities, or results related to sexual and reproductive health. Poorly phrased, vague, not specific			2. Reference to contribution and barriers to gender equality.	3. Mention of contribution to women's empowerment.	4. Indication of contribution to women's rights and opportunities.	5. Mention of contribution to reduce gender violence.	6. Executing Agency - Partner of the project; pattern or trend.	7. Mention of the possibility that both sexes be empowered and coexist on the same level.	8. Reference to social determinants of health (including acces to health services, gender equality, education, work opportunities and family planning) that lead to maternal and child mortality.	9. Mention of newborns.	10. Raising Awareness
		DESCRIPTION	ACTIVITIES	RESULTS									
D000145-002	Support to Child Survival		Activity (3): "treating severely malnourished children and pregnant and breastfeeding women"		None	None	None	None	Micronutrient Initiative	None	None	None	
D000164-001	Making Motherhood Safe	"benefit more than 500,000 pregnant women and their newborns by improving the quality of care they receive"		"improved procedures, systems, and support services at the Maternity and Newborn Hospital"	Activities: "to provide quality gender sensitive maternal and newborn services in emergency situations" (cont)	None	None	None	Comprehensive Community-Based Rehabilitation in Tanzania	None	"Recruiting, staffing, and training health care workers for a new specialized Maternity and Newborn Hospital" // "improved acces to quality gender-sensitive maternal and newborn health services" // "improved referral system" // Description: "improve access to quality health services or poor pregnant women and their newborns" (desc)	All	

D00047 2-001	Maternity Centres of Excellence (MCE)	"improve the quality and timeliness of maternal and newborn health services and reduce illness and death for at least 10,000 pregnant women and newborns"	None		None	None	"increased number of women delivering in higher quality health care institutions"	None	Jhpiego	None	"increased number of health workers trained in critical interventions to reduce facility-specific maternal and neonatal mortality rates" // "increased number of women delivering in higher quality health care institutions" (results)// "improve access to quality care for mothers and newborns by creating three Centers of MNCH" // "enhance referral and community linkages" // "supporting communities and facilities to provide emergency transport" // "establishing mobile phone networks" (facilitating access)	All	
A03551 8-001	Deploying Midwives to South Sudan	"reduce maternal and newborn deaths" // "midwives facilitate about 100,000 safe deliveries, provide at least 200,000 women with prenatal care"		"161,185 pregnant women received prenatal care and more than 33,858 safe delieries were conducted" //	"strenghthened capacity of graduate midwives, midwifery stuednts and health workers to delivery gender-responsive reproductive health and midwifery services"	None	"increasing women's access to qualified midwives"	None	UNFPA	None	"increasing women's access to qualified midwives" // "increased use of quality midwifery services and care by pregnant women" // "increased delivery of maternal and newborn health services" // "increased availability of midwifery and reproductive	#1 Description	

											health services for women and girls" // "4,992 health workers, including midwifery and nursing students, were trained on sexual and reproductive health, emergency obstetric care, and midwifery skills" (results) // "increased capacity of midwives and health workers to delivery emerg obstetric care to women" (results) // "mentor more than 400 midwifery and nursing students" (desc)		
A035372-001	Family Health Houses			"decreased maternal and neonatal mortality and morbidity" // "community and family action, practices, and values that improve women's reproductive health"	None	None	None	None	UNFPA	None	"project also establishes a referral system for women and babies who require emergency care, women with high risk pregnancies, and women who require delivery and recovery care beyond the basic care provided at the family health houses" // "Each house has a delivery room and an examination room in which a trained community midwife can safely work" (desc) // "training midwives and equiping each family health	None	

											house with the diagnostic and medical equipment required to ensure safe childbirth" (acts) //		
A035262-001	Support to the Increasing Demand for Childbirth Health Services	Improve the health of women and newborns" //		increased use of apropriate health care services by womenduring pregnancy and childbirth as well as for thie newborns //	improved quality of gender sensitivity of MNCH services at public health facilities //	None	increase the nummber of women giving birth in health care facilities and the number of pregnant women using health services //	None	Gov of UK - DFID - Department for International Development	None	Offsets transportation and other costs, to provide incentives to encourage pregnant women to seek health care attention during pregnancy and childbirth as well as for newborns // aims to help 100,000 women receive pre-natal care, safe delivery, and post natal care services (desc) //	#1, 8	
A035243-001	Maternal and Under-5 Nutrition and Child Health				"increased equitable and gender-sensitive health services for mothers, newborns and children under five"	None	None	None	World Vision Canada	None	"(5) training health facility staff in proven approaches to nutrition counselling and growth monitoring targeted at pregnant women" (acts) //	#2	

A03536 0-001	Health Pooled Fund	Deliver life-saving basic health care, with an emphasis on maternal, neonatal and child health //	providing over 120,000 women with prenatal care and protection from malaria // ensuring that over 60,000 pregnant women deliver their babies with the support of a skilled birth attendant // supporting 15 county hospitals with emergency obstetrics care		None	None	None	None	Gov of UK - DFID - Department for International Development	None	None	None	
A03510 2-003	Community-Based Nutritional Health in Souththern Mali - II	improving the nutritional status of children under the age of five and of pregnant and nursing women // handling cases of moderate acute malnutrition that are detected among pregnant and nursing women //			None	None	None	None	WFP	None	community health volunteers and women's groups trained to screen newborns for acute malnutrition (results) //	#1	
A03548 8-001	Basic Health Care and Nutrition for Mothers and Children (SESAME)			health centres located in communities targeted by this project have built capacity to fight deadly childhood diseases and to meet basic obstetric needs // UNICEF provided…1,091,209 women of childbearing age with a vaccine against tetanus - this language should not be used, who are these girls? women? MNCH means targeting all girls not just women.	None	None	None	None	UNICEF	None	None	None	

A03473 2-001	Health Services for Women in Haiti	rebuilding of the National School of Midwifery and the construction of a maternity clinic // offer some 230,000 women and girls who were victims of the earthquake, including 25,000 pregnant women, greater access to neonatal and obstetric preventive and emergency services.	build a National School of Midwifery to train qualified midwives // build and equip a maternity clinic with an emphasis on emergency neonatal and obstetric care //	use of obstetric/neonatal care in Haiti has increased for populations served by the maternity clinic built	Haitian midwives receive quality training, equally accessible to women and men, aligned with the expectations/needs in obstetric/neonatal care and in family planning, taking into consideration the rights of women and girls;	None	Haitian midwives receive quality training, equally accessible to women and men, aligned with the expectations/needs in obstetric/neonatal care and in family planning, taking into consideration the rights of women and girls;	and services for victims of sexual violence //	UNOPS - UN Office for Project Services	Haitian midwives receive quality training, equally accessible to women and men, aligned with the expectations/needs in obstetric/neonatal care and in family planning, taking into consideration the rights of women and girls;	offer services such as emergency neonatal and obstetric care, family planning services, services for preventing and screening HIV/AIDS and sexually transmitted infections (desc) //	None	

A035362-001	Maternal Mortality Survey and Emergency Obstetric and Newborn Care Needs Assessment	reduce the number of mothers and newborns who die in South Sudan // With reliable and accurate information about deaths linked to pregnancy and childbirth and the need for emergency obstetric and newborn care, the government and donors can better target their efforts to save the lives of women and newborns // helps the national and state-level Ministries of Health develop five-year plans for making emergency obstetric and newborn care more available //	It includes planning, conducting, and reporting on two national surveys: a survey of the causes of death among women of childbearing age and an assessment of the need for emergency obstetric and newborn care.	The first assessment on Emergency Obstetrics and Newborn Care (EmONC) needs in South Sudan was planned and conducted with over 400 facilities offering maternal health services in both the public and private sector (including not-for-profit organizations) participating	None	None	None	None	UNFPA	None	(2) the locations of these facilities to determine equitable distribution; (3) the extent to which pregnant women, including those with major obstetric complications, are accessing these facilities for delivery; (4) whether enough critical services (for example, caesarean deliveries and blood transfusion) are being provided;	and (5) whether there is emergency newborn care available and the quality of the care is adequate.	
A035263-001	Multisectoral Support to Nutrition Activities and Policies	the project supports Malawi's national efforts to prevent anaemia in pregnant and lactating women // brings the SUN Movement to districts, communities and households, reaching 3.3 million women of reproductive age // NO INFO ON THE AGE		More than 20,000 babies are expected to be born in the hands of a midwife or midwifery student over the course of the project //	coordination of gender-sensitive nutrition policy and programs at central, district and community level	None	None	None	World Bank	None	improved access and utilization of prevention and treatment of malnutrition services in children and anaemia in pregnant and lactating women (including adolescent girls) // developing a midwifery program at these training institutes, improving the training facilities, obtaining the equipment required, and improving the ability of the faculty members and administrative staff at the training institutes to teach and manage the	None	

											new midwifery program (acts) //		
A035358-001	Training Midwives in South Sudan				None	None	increased number of pregnant women attended by a qualified midwife or other health care professional with midwifery competencies, including emergency obstetric and newborn care; enhanced enabling environment that ensures increased availability, accessibility, and utilzation of quality skilled maternity care, including obstetrical and neonatal care services for pregnant women.	None	UNFPA	None	aims to reduce the number of mothers and newborn babies who die in South Sudan by providing women with GREATER ACCESS to high-quality midwifery services // 3) scholarships have been provided to 31 doctors and clinical officers for further education in obstetrics and gynecology, including emergency care and anesthesia // (4) a national program for the bachelor's degree in emergency obstetrics care was developed at the University of	#4	

											Juba (results).		
S065370-001	Support to Maternal and Newborn Health in the Administrative District of Ituri	prevention of mother-to-child transmission of HIV and the provision of proper care for HIV/AIDS-affected children // project reaches 48,444 pregnant women, 230 health care workers, and 3,400 newborns with HIV-positive mothers			None	None	None	assistance to women who are victims of violence //	Oxfam-Quebec	None	family planning // updating training materials on obstetric and neonatal care (acts) //	None	raising activities on preventing the spread of sexually transmitted diseases and HIV/AIDSer care for HIV/AIDS-affected children, and mother-to-child transmission of HIV //
S065374-001	Improving Maternal and Child Health in Burkina Faso				None	None	None	None	WUSC - World University Service of Canada	None	Reaching 80,000 newborns and 125,000 pregnant women and mothers, the project is designed to train 200 doctors, nurses, and	Yes	None

											midwives in reproductive health (desc) //		
S065381-001	Meeting Critical Health Care and Nutritional Needs in Kenya	Reaching 3,000 pregnant women and their families, the project is focused on improving pregnant women' critical nutrition status; improving the quality of health services for pregnant women and infants; and transferring knowledge on program design and implementation //	providing a critical nutrition package for women of reproductive age, pregnant and post-partum women and infants //		None	None	None	None	University of Manitoba	None	None	None	None
S065383-001	Maternal and Child Health Enhancement Program in South Sudan				increasing the ability of women, men and children to adopt behaviour that reduces the transmission and incidence of these diseases - write as separete, targeted separately? Is that clear? Suppose that together? Or separate? Depends on the wording	None	None	None	CHF	increasing the ability of women, men and children to adopt behaviour that reduces the transmission and incidence of these diseases	improving access to nutritious food for infants, children, and pregnant and lactating mothers // (2) increase women's access to reproductive health services by setting up new and strengthening existing local health clinics (acts) //	None	None
A035288-001	Maziko: Nutrition Foundations or Women and Children	This project (Maziko) aims to benefit more than 236,000 women, with a focus on pregnant and lactating women and girls and boys in two districts where stunting and malnutrition are widespread //			25,000 women and men participated in activities to promote proper nutrition	None	None	None	CARE Canada	25,000 women and men participated in activities to promote proper nutrition	(1) 3,000 staff and volunteers at the national, district and community levels were trained to deliver optimal nutrition services for pregnant and lactating women and children under five, including monitoring and promoting growth and nutrition (results) //	None	None

A03526 4-001	High-Impact Intervention for MNCH				None	the total number of acceptors of new modern contraceptio n methods has almost doubled from 122,817 users in 2011 to 231,627 in 2013;	the total number of acceptors of new modern contraception methods has almost doubled from 122,817 users in 2011 to 231,627 in 2013;	None	UNDP	None	the total number of acceptors of new modern contraception methods has almost doubled from 122,817 users in 2011 to 231,627 in 2013; // (6) five ambulances have been procured and are helping with the referral of patients // increase in the availability, demand and quality of preventive and curative services for adolescents, mothers and future mothers, pregnant women, newborns, and children // (1) the percentage of pregnant women who receive an insecticide-treated bed net during pre-natal consultation for prevention of malaria rose from 70% in 2010 to 97% by the end of 2013 (results) //	None	None

A035252-001	Joining Hands - Improving Maternal, Newborn and Child Health in Tanzania	The project helps women of childbearing age maintain better health // The project is expected to help approximately 700,000 people, including women of childbearing age, pregnant women, newborns, and children //			(3) 810 female and 171 male health workers were trained in basic obstetric ultrasound, maternity and deliveries, focused prenatal care, basic emergency obstetrics, prevention of mother to child transmission of HIV, neonatal resuscitation, service excellence and customer care;	None	None	None	Aga Khan Foundation Canada	(3) 810 female and 171 male health workers were trained in basic obstetric ultrasound, maternity and deliveries, focused prenatal care, basic emergency obstetrics, prevention of mother to child transmission of HIV, neonatal resuscitation, service excellence and customer care;	training public and private health care workers and midwives // strengthening patient referral systems // improved use of maternal, newborn, and child health services by women of childbearing age, newborns, and children under five, particularly lower income and poor women and children, at primary health care and referral facilities in underserved target areas; //	(5) 3,245 children under the age of one received newborn services such as preventing hypothermia, initiating exclusive breastfeeding, and umbilical cord care;	None
S065358-001	Maternal, Newborn and Child Health in Rwanda	project focuses on strengthening midwifery and paediatric nursing programs //			None	None	None	None	Western University	None	launching advanced courses in neonatology and paediatrics, including a Bachelor of Science Degree (BSc) Midwifery Program (acts) // (i) validating the midwifery program // (ii) providing training to expert trainers in the Continuing Professional Development program in obstetrics, pediatrics, obstetrical anesthesia, maternal mental health, and essential interventions and services; // (iv) developing a curriculum for	None	None

											an advanced postgraduate diploma in specialty advanced pediatrics and neonatology and a Bachelor of Science Degree in Midwifery; (results) //		
S065350-001	Improving Community Health	improve the health and nutrition of newborns, children under five, and women of reproductive age //			None	None	None	None	Save the Children Canada	promotes the use of quality health, nutrition and family planning services, and improved health, nutrition and family planning behaviours of caregivers and family members // provide family planning services; and educating families about healthy behaviours //	promotes the use of quality health, nutrition and family planning services, and improved health, nutrition and family planning behaviours of caregivers and family members // provide family planning services; and educating families about healthy behaviours //	Yes	None
S065353-001	Interrupting Pathways to Sepsis	the project works with communities, *midwives*, and hospital care providers to improve diagnostics and early intervention of childhood infections, and strengthen health systems // benefiting 18,400 pregnant women and their newborns //			None	None	None	None	UBC/University-Industry Liaison Office	None	(v) developing a referral and transport system // provides training for 60 midwives and birth attendants (desc) // (iii) training 32 hospital-based midwives and nurses in the early detection of sepsis and in emergency obstetrical care (results) //	Yes	None

S065386-001	Securing the Lives of Mothers and Infants			(1) eight waiting and delivery rooms were constructed and 13 health centres were equipped to provide essential mother and child health services // // (7) the level of satisfaction among pregnant women and mothers regarding the availability of skilled professionals for their deliveries at health centres increased from 50.4% to 78.7%, which is above the target of 70% //	6) mothers' levels of confidence regarding consulting their partners on reproductive health and childhood illness issues increased from 69.6% to 90.2%, which is above the target of 90.0% //	empowering communities by improving the health care practices of mothers and <u>women of reproductive age</u> // 6) mothers' levels of confidence regarding consulting their partners on reproductive health and childhood illness issues increased from 69.6% to 90.2%, which is above the target of 90.0% //	None	None	ADRA - Adventist Development and Relief Agency Canada	(3) 23,935 people, including more than 10,000 men, attended awareness raising sessions on how to prevent illnesses impacting mothers and children under five // 6) mothers' levels of confidence regarding consulting their partners on reproductive health and childhood illness issues increased from 69.6% to 90.2%, which is above the target of 90.0%	(2) 53 midwives and 160 traditional birth attendants were trained on safe birthing practices, including referring pregnant women to health centres when needed // training local village health support groups (acts) // (4) health centers staff, including midwives and traditional birth attendants having increased their ability to administer appropriate maternal care has increased to 88.5%, which is above the target of 50.0%; // (5) live births attended by skilled health personnel increased from 46% at the beginning of the project to 70.7%, which is above the target of 55.0%; (results) //	None	(3) 23,935 people, including more than 10,000 men, attended awareness raising sessions on how to prevent illnesses impacting mothers and children under five //

S065377-001	Supporting Systems to Achieve Improved Nutrition, Maternal, Newborn, and Child Health	with a focus on malaria, diarrhea, pneumonia, and mother-to-child transmission of HIV/AIDS // The project is expected to reach around 18,000 pregnant and lactating women and 159,000 children under five //		(4) quality of prenatal care improved by providing 66% of pregnant women with two doses of malaria preventive therapy, and 97% pregnant women with HIV counselling and screening //	None	None	None	None	World Vision Canada	None	(3) ability of 426 front-line health workers improved to manage pregnancy (results)	Yes	None
S065346-001	Healthy Child Uganda	aims to improve the health and survival rates of pregnant women, newborns //			enhanced institutional environment to support sustainable, equitable and gender sensitive maternal health services //	None	increased use of skilled birth attendants among expectant mothers; increased use of improved referral system for emergency birthing situations //	NOne	University of Calgary		enhanced institutional environment to support sustainable, equitable and gender sensitive maternal health services // improve access for approximately 340,000 people, including 40,000 pregnant women //	Yes	None
S065382-001	Maternal and Child HIV/AIDS Health Care and Promotion				None	(9) HIV-positive women were given a safe space to share their experiences through Women's Empowerment Groups held every two weeks;	None	None	IDRF - International Development and Relief Foundation	None	None	Yes	(10) quarterly community meetings were held and 30 community leaders were trained to raise awareness and improve understanding of HIV/AIDS in the community, including understanding maternal, newborn and child health in the context of HIV/AIDS.

S065336-001	Community-Led Health in Bangladesh				(7) 1,864 (67%) of targeted households are now aware of the benefits of natal, antenatal and postnatal care	(6) 2,846 (81%) of eligible couples between the ages of 15 and 49 are using contraception	(6) 2,846 (81%) of eligible couples between the ages of 15 and 49 are using contraception	Nope	HOPE International Development Agency	(5) 28 adolescent girls and boys groups are now working to empower 602 youth and have held a total of 721 health education sessions on issues such as health, nutrition, hygiene, early marriage, family planning and pregnancy // (7) 1,864 (67%) of targeted households are now aware of the benefits of natal, antenatal and postnatal care	(1) 6,418 women and girls (100% of those living in the target areas) are now able to access health care when travel is involved // (6) 2,846 (81%) of eligible couples between the ages of 15 and 49 are using contraception // (4) 721 women have received antenatal care by skilled health personnel. (results) //	Yes	(7) 1,864 (67%) of targeted households are now aware of the benefits of natal, antenatal and postnatal care
A035231-001	Improving Maternal, Newborn, and Child Health and Nutrition - One UN Program	It helps to establish comprehensive emergency obstetric and newborn care services in all six district health facilities in Zanzibar //			project includes improving policies and practices that promote maternal and newborn health and nutrition in a gender-responsive manner, in order to improve access to quality reproductive health, child health, and nutrition services for women and children //	None	None	None	UNDP	None	bring basic emergency obstetric and newborn care services and integrated management of newborn and childhood illness to 70% of health centers in underserved districts //	Yes	9,800 pregnant and lactating women received food and general nutrition education in 40 health facilities across three rural districts
S065387-001	Improving Maternal, Newborn and Child Health in Pastoralist and Semi-Pastoralist Communities				None	None	None	None	AMREF Canada - African Medical and Research Foundation Canada	None	increase the number of pregnant women accessing health services // training midwives and health workers on emergency obstetric and newborn care, and the diagnosis and treatment of HIV/AIDS (acts) //	Yes	None

S065365-001	Maternal, Neonatal and Child Health				(3) 98% of women were allowed by their spouse to access maternal health care services (an increase of 27% since the beginning of the project) // (2) 244 men were trained to raise the awareness of other men on the importance of maternal health // (3) 6,457 people, including 2,129 men, attended information sessions to raise awareness of maternal and child health; (4) 85% of women and 76% of men in these villages improved their knowledge of sexual and reproductive health; (5) 74% of women in the project area now have the support of their spouse to seek maternal care (an increase of 49% since the beginning of the project in 2011) //	strengthening the use, quality, and availability of health services for women, newborns, and children and addressing social factors that prevent women from using these services // (3) 98% of women were allowed by their spouse to access maternal health care services (an increase of 27% since the beginning of the project) //	strengthening the use, quality, and availability of health services for women, newborns, and children and addressing social factors that prevent women from using these services.	None	PWS&D - Presbyterian World Service & Development	strengthening the use, quality, and availability of health services for women, newborns, and children and addressing social factors that prevent women from using these services / (2) 244 men were trained to raise the awareness of other men on the importance of maternal health // (3) 6,457 people, including 2,129 men, attended information sessions to raise awareness of maternal and child health; (4) 85% of women and 76% of men in these villages improved their knowledge of sexual and reproductive health; (5) 74% of women in the project area now have the support of their spouse to seek maternal care (an increase of 49% since the beginning of the project in 2011) //	providing training for women in nutrition, immunization, reproductive health, and family planning; conducting community health education sessions; establishing and upgrading delivery rooms and basic health units; and training midwives, nurses, and health workers // (1) attendance of 2,983 women of reproductive age to education sessions on safe family planning methods // (4) access for 749 women to four antenatal visits (an increase of 62% since the beginning of the project) // (9) community-managed bicycle ambulances provided to 32 villages to ensure that pregnant women who require emergency care could be transported to health facilities // strengthening the use, quality, and availability of health services for women, newborns, and children and addressing	Yes	expected to reach up to 17,000 children through access to improved health care services, up to 6,000 pregnant women through antenatal care, as well as up to 3,000 of their spouses, and 19,000 women of reproductive age through training, community outreach and education // providing training for women in nutrition, immunization, reproductive health, and family planning; conducting community health education sessions; establishing and upgrading delivery rooms and basic health units; and training midwives, nurses, and health workers // (1) attendance of 2,983 women of reproductive age to education sessions on safe family planning methods // (2) 244 men were trained to raise the awareness of other men on the

											social factors that prevent women from using these services // expected to reach up to 17,000 children through access to improved health care services, up to 6,000 pregnant women through antenatal care, as well as up to 3,000 of their spouses, and 19,000 women of reproductive age through training, community outreach, and education (desc) // providing training for women in nutrition, immunization, reproductive health, and family planning; conducting community health education sessions; establishing and upgrading delivery rooms and basic health units; and training midwives, nurses, and health workers. (acts) // (5) screening of 6,573 pregnant women for malnutrition and training about the importance of a balanced diet for good health //		importance of maternal health //

											neonatal mortality rate also went from 60 per 1,000 live births in 2011 to 12 at the end of the project // (7) 8% increase of ante-natal care coverage since 2011; (8) 18% increase in the number of births attended by a skilled health worker (results)		
M013354-002	Global Fund to Fight AIDS, Tuberculosis and Malaria			2.5 million HIV-positive pregnant women receiving antiretroviral drugs to prevent HIV transmission to their infants //	None	None	None	None	Global Fund to Fight AIDS, Tuberculosis & Malaria	None	None	None	None

S065347-001	Improving Maternal and Child Health: Partnership and Action for Community Transformation		emergency obstetric care; establishing neonatal care units //	(v) protecting 14,151 pregnant women, 38,055 children under five, and 25,752 other family members from malaria //	(i) increased use of quality gender-sensitive maternal, newborn and child health services by women and children (girls and boys) // (ii) increased practice of appropriate gender-sensitive, home-based management of childhood illness and prevention of common diseases among parents (mothers/fathers) //	None	None	None	CCFC - Christian Children's Fund of Canada	None	(iii) increasing the number of women delivering their babies in health institutions//	Yes	None
S065364-001	Integrated Prevention of Mother-to-Child Transmission of HIV (PMCT) in Burundi)	focuses on ensuring effective health services for HIV-positive pregnant and breastfeeding women //	establishing a program with a comprehensive monitoring plan for the prevention of mother-to-child HIV transmission //	Improve health services for HIV positive pregnant and breastfeeding women; increase the number of secure pregnancies for HIV positive pregnant women //	60 women and men ambassadors have been trained and have made 2,578 awareness activities about the importance of PMCT to 38,778 people in rural area //	none	none	none	L'AMIE	None	Reaching more than 150 HIV-positive pregnant or breastfeeding women (desc) // a multidisciplinary team of seven health specialists, nutritionists and social workers and trained on the program for "Integrated Prevention of Mother-to-Child HIV Transmission" (PMCT) has been set up (results) //	None	awareness of the importance of avoiding transmission of HIV from mothers to their children // broadcasting radio announcements concerning mother-to-child HIV transmission // 60 women and men ambassadors have been trained and have made 2,578 awareness activities about the importance of PMCT to 38,778 people in rural area // 123 radio and 31 TV shorts to make known the program and to promote the prevention of mother to child HIV transmission to the

													population have been broadcasted on the main channels of the country //
S065349-001	Increased Maternal and Child Health Access	aims to improve health among mothers, newborns and children under the age of five in 130 Bangladeshi villages //		As a result, 586,504 consultations, including those of 302,927 women of reproductive health and 174,656 children of age under five, were done at the village-level maternal and child health centres //	(5) 3,796 men participated in information sessions on women's health issues, and 48% of these men are now able to report at least two issues related to women's health //	None	None	None	Primate's World Relief andDevelopment Fund	(5) 3,796 men participated in information sessions on women's health issues, and 48% of these men are now able to report at least two issues related to women's health //	63,000 women and mothers, and 94,500 children under five are expected to have, for the first time, regular access to basic prenatal and postnatal care, basic health care, and trained birth attendants // (3) 664 traditional birth attendants who are active in their respective communities were trained and have referred 1,652 pregnant women (representing	Yes	(4) 83% of the 20,929 mothers who participated in workshops on maternal and child health are now able to report at least two known danger signs during pregnancy // (5) 3,796 men participated in information sessions on women's health issues, and 48% of these men are now able to report at least two issues related to women's health //

											20% of pregnant women in the project area) to hospital // 63,000 women and mothers, and 94,500 children under five are expected to have, for the first time, regular access to basic prenatal and postnatal care, basic health care, and trained birth attendants (desc) //		
S065355-001	The Leyaata ("Rescue Us") Project to Reduce Maternal, Infant and Child Mortality	the project addresses care during pregnancy and childbirth, neonatal care, and malaria control as critical health concerns in these communities //	Key project components include establishing a prenatal and neonatal home visit system for pregnant women and infants, and launching a malaria control program that prioritizes mothers and infants // distributing neonatal care kits //	(1) distributing more than 50 neonatal care kits to community-based surveillance volunteers;		None	None	None	Ghana Rural Integrated Development	None	(3) training 25 local health professionals to support the community-based surveillance volunteers' referral system // (2) training 51 community-based volunteers to conduct two antenatal and three neonatal visits in the first week of a baby's life (results)	Yes	None
A035251-001	Improving Maternal and Reproductive Health in Six Districts of Rural Tanzania			improved quality of maternal and reproductive health services at government health facilities in the target districts // strengthened management and accountability for maternal and reproductive health services in Tabora region //	(1) 85 female and 43 male health workers were trained in Basic Emergency Obstetric Care and communication skills; (2) 43 female and 24 male health workers were trained in maternal death reviews //	None	None	None	CARE Canada	None	(1) 85 female and 43 male health workers were trained in Basic Emergency Obstetric Care and communication skills; (2) 43 female and 24 male health workers were trained in maternal death reviews // enhances women's ability to pay for health services // increased utilization of	Yes	None

											maternal and reproductive health services by women and adolescent girls in the target communities (results)		
S065361-001	Mother Care and Child Survival in Underserved Regions of Mali, Mozambique and Pakistan				None	None	None	None	Aga Khan Foundation Canada	None	training health care providers in obstetric care, and child health and nutrition; improving procedures and communication across all levels of community health facilities // (ii) 1,567 community health workers trained to identify nutrition problems in pregnant and lactating women and in children under five years of age (acts nd results)	Yes	and helping local committees to carry out nutrition education campaigns for mothers and children //

S065368-001	Safer Obstetrics in Rural Tanzania	// (ii) provide emergency obstetrical care; and (iii) conduct caesarean sections //			None	None	None	None	Canadian Network for International Surgery	None	(i) identify patients who require referral // (i) delivering 72 courses on essential surgical skills, fundamental interventions, referral, safe transfer, and surgical operative obstetrics to 1,498 participants // goal of the project is to improve the health of mothers and newborns by assisting Tanzania's Ministry of Health in training 1,300 non-physician health professionals to improve their ability to provide quality obstetrical care // (ii) provide emergency obstetrical care; and (iii) conduct caesarean sections // 40 obstetrics professionals and 96 midwives are expected to have increased skills in emergency surgical and obstetrical care contributing directly to reducing illness and death in mothers and newborns in rural Tanzania (description) // (i) delivering 72 courses on essential	Yes	None

											surgical skills, fundamental interventions, referral, safe transfer, and surgical operative obstetrics to 1,498 participants // contributing to improving the ability health care workers to provide better obstetrical and maternal health care, including safer care for all women, including those suffering from obstetrical and other maternal health-related disorder (results)		

S065372-001	Women and their Children's Health (WATCH)	This project aims to improve maternal, neonatal and child health (MNCH) in underserved populations of 26 districts and sub-districts of Ghana, Mali, Ethiopia, Bangladesh and Zimbabwe //			(ii) developing a common understanding of the links between gender equality and better maternal, newborn and child health results // In Mali, over 3,300 community groups attended maternal, newborn and child health and gender equality sessions // In Ghana, community health committee members and health workers were trained in Basic Emergency Obstetric and Newborn Care, preventing mother to child transmission of HIV, safe motherhood, child health and gender equality //	None	None	None	Plan International Canada	None	This project aims to improve maternal, neonatal and child health (MNCH) in underserved populations of 26 districts and sub-districts of Ghana, Mali, Ethiopia, Bangladesh and Zimbabwe // training government health workers on basic obstetric and neonatal care, safe deliveries (results) //	Yes	In Mali, over 3,300 community groups attended maternal, newborn and child health and gender equality sessions //
S065328-001	Improving Maternal and Child Health Conditions in Haiti	Approximately 12,000 families are expected to benefit from this project including over 1,600 pregnant and lactating women //		(v) distributing vitamin A to 1,137 children under one, 5,534 children under five, and 865 mothers, as well as a dose of iron to 3,484 pregnant women //	None	None	None	None	International Child Care Canada	None	(iv) setting up 96 prenatal and family planning clinics at Grande-Rivière Hospital and 96 prenatal clinics at the Bahon health centre // (iii) improve access to basic primary health care services to reduce the number of women and children dying of common diseases such as malaria and HIV/AIDS (desc) // (iii) implementing ongoing training	Yes	(vi) implementing 200 educational sessions on the importance of good nutrition, eight community-based educational sessions on immunization and child growth, and five training sessions for nurses and nursing assistants on family planning counselling and methods, prenatal and postpartum

											sessions on obstetrical work and the partogram (a diagram used to monitor labour) for nurses and nursing assistants (results)		care //
S065363-001	Pakur Mother and Child Survival Project				(iii) promoting shared decision-making on maternal, newborn and child health at the household level // (3) 475 discussion groups on maternal newborn and child health which encouraged male involvement, family communication and shared decision making were held with 3,288 pregnant women, 6,899 lactating women, 5,138 husbands and 4,275 mothers in-law //	None	None	None	HealthBridge Foundation of Canada	(iii) promoting shared decision-making on maternal, newborn and child health at the household level // project expects to reach over 1,100 health workers and 600 village health and sanitation committees, as well as over 280,000 women of reproductive age and their husbands and more than 56,000 pregnant women // (3) 475 discussion groups on maternal newborn and child health which encouraged male involvement, family communication and shared decision making were held with 3,288 pregnant women, 6,899 lactating women, 5,138 husbands and 4,275 mothers in-law //	(i) training community health workers and families in antenatal, postnatal and newborn care, nutrition, and safe pregnancy and delivery practices (acts) // (2) 2,465 community health workers were trained to provide nutritional counselling, growth monitoring, prenatal check-ups, safe pregnancy and delivery, postnatal and newborn care and infectious disease prevention and treatment (results)	Yes	(3) 475 discussion groups on maternal newborn and child health which encouraged male involvement, family communication and shared decision making were held with 3,288 pregnant women, 6,899 lactating women, 5,138 husbands and 4,275 mothers in-law //

A035252-001	Accelerating Efforts to Improve Maternal and Child Health in the Simiyu Region	expected to directly help 108,000 pregnant women, 20,000 infants, and 114,000 children under five and indirectly help another 400,000 women and their families //			providing training for health workers with a focus on gender equality and public health issues // supports community engagement activities that help local communities become more aware of issues relating to the health of women and children and to gender equality //	designed to strengthen existing health systems and to empower community members, especially women, to demand the health services they require, to make choices that support good health, and to get involved in managing local health care services	designed to strengthen existing health systems and to empower community members, especially women, to demand the health services they require, to make choices that support good health, and to get involved in managing local health care services	None	African Medical and Research Foundation (Tanzania)		project provides community health workers with essential tools for treating women and children and training in home-based life-saving skills, birth planning, the treatment of childhood illnesses, and involving men in supporting the health of women and children in their community	Yes	supports community engagement activities that help local communities become more aware of issues relating to the health of women and children and to gender equality //
S065337-001	Community-Based Maternal, Newborn and Child Health				None	None	None	None	World Renew	None	aims to improve the health of the most marginalized mothers .. // 106 informal service providers have been trained to reduce harmful practices and to increase appropriate referrals for mothers and newborns //	Yes	In Bangladesh, 53 female community health volunteers and 53 female traditional birth attendants have been trained on maternal and newborn care and are doing home visits to pregnant women to educate them on eating nutritious foods, going for antenatal care visits, making birth preparedness plans and watching for danger signs that indicate a need to go to the health facility // monthly home visits to 9,600 households that have a pregnant woman and/or children under age two and are delivering

													messages about malaria prevention and treatment and proper nutrition for pregnant and lactating women and children under two //

A03525 4-001	Community-Based Maternal, Newborn and Child Health Services	project is expected to benefit 309,000 women of childbearing age and over 306,000 children under five //			designed to improve the ability of men and women in these communities to recognize, prevent, and respond to maternal and child health issues // organizing community events and mass media campaigns, training community theatre groups, and selecting peer youth educators and male champions to raise awareness about potential health issues // The project places special emphasis on the role that men can play in helping to improve the health of women and children // (1) 158 female and 92 male health care providers were trained on basic emergency obstetric and neonatal care, sex and age disaggregated data collection, documentation and gender analysis and reporting // (4) 4,175 men were given information about maternal, newborn and child health during 69,811 home visits for postnatal and newborn care; and (5) 290 female and 354 male peer educators/male	None	None	None	Plan International Canada	designed to improve the ability of men and women in these communities to recognize, prevent, and respond to maternal and child health issues // The project places special emphasis on the role that men can play in helping to improve the health of women and children	provide women with greater access to good-quality, reliable health services // conducting home visits to provide pre-natal and post-natal care and care for newborns and young children; and equipping community health workers to provide services in remote areas and to refer patients to health centres where necessary // Designed to "provides training for health care workers in emergency care for pregnant women, new mothers, and newborn babies" (description)	Yes	organizing community events and mass media campaigns, training community theatre groups, and selecting peer youth educators and male champions to raise awareness about potential health issues // (4) 4,175 men were given information about maternal, newborn and child health during 69,811 home visits for postnatal and newborn care; and (5) 290 female and 354 male peer educators/male motivators were trained to carry out awareness raising and mobilization activities //

					motivators were trained to carry out awareness raising and mobilization activities //								

M013402-001	The H4+ Initiative to Accelerate Support for Maternal and Newborn Health	the Joint United Nations Programme on HIV/AIDS, the World Bank, and UN Women) to assist high-burden countries in accelerating the implementation of commitments already made to the UN Secretary General's Global Strategy for Women's and Children's Health		in Burkina Faso, emergency obstetrics equipment and drugs were provided to 45 health facilities //	None	None	None	None	UNFPA	None	None	Yes	None
A035102-001	Community-Based Nutritional Health in Southern Mali - I	aims to reduce infant mortality in three districts of the Kayes region by improving the nutritional status of children under the age of five and pregnant and nursing women, and reducing the malnutrition rate // handle cases of moderate acute malnutrition detected among pregnant and nursing women and children aged 6-59 months //		(2) reduced malnutrition in pregnant and nursing women in the regions of Kayes, Koulikoro, Segou, Sikasso and the district of Bamako //	improve household heads and women's knowledge of health and nutritional good practices in the areas covered	improve household heads and women's knowledge of health and nutritional good practices in the areas covered	None	None	WFP	None	designed to strengthen the capacity of community and healthcare stakeholders in terms of prevention, detection, care, planning …//	No	None
A034908-001	Maternal Evacuation in District of Kayes	aims to contribute to reducing maternal and neonatal mortality in four districts of the Kayes region // supports the Government of Mali with the implementation of its Health and Social Development Plan (PRODESS), specifically to improve Maternal and Neonatal Health //	aims to make new resources available for upgrading or building new health units, ensuring key services are available (e.g. emergency obstetric care, prevention of mother-to-child transmission of HIV/AIDS) //		None	None	None	None	Government of Mali - Ministry of the Economy and Finances	None	designed to complete the integrated community-level health system thereby strengthening the referral and evacuation plan, including the transport of pregnant women from villages to community health centres //	No	None

A03461 6-001	Accelerating the Reduction of Maternal and Newborn Mortality	supports the procurement and distribution of equipment such as newborn resuscitation devices, HIV testing kits, communication equipment, and reproductive health supplies to cover 60% of the annual requirements of these states //		(1) helping to reach over four million pregnant women with essential maternal health services //	designed to strengthen the delivery of maternal, newborn and child health services through evidence-based, gender-responsive interventions // (3) providing information on the gender barriers to maternal, newborn and child health services to about 3.5 million women and men //	More than one million couples were provided with protection against unwanted pregnancies that contributed to averting over two hundred thousand pregnancies and over 1,000 pregnant women from dying during childbirth // c(4) mobilizing additional funds of US$11 million to procure contraceptive commodities	More than one million couples were provided with protection against unwanted pregnancies that contributed to averting over two hundred thousand pregnancies and over 1,000 pregnant women from dying during childbirth // (4) mobilizing additional funds of US$11 million to procure contraceptive commodities //	None	UNICEF	None	(4) mobilizing additional funds of US$11 million to procure contraceptive commodities // provides technical and financial support to enhance the skills of health workers - midwives, doctors and Community Health Extension Workers - through updating training guidelines under the Midwifery Services Schemes, the Community Health Extension Workers Program and doctors serving in the Nigeria Youth Service Corps (desc) // (1) training 248 nurse-midwives and community resource people to provide skilled pre- and post-natal care to about 100,000 pregnant women and their newborns // (3) training 60 health care providers and 30 people living with HIV to provide prevention of mother-to-child transmission of HIV services to an estimated 3,000 HIV-exposed	Yes	(3) providing information on the gender barriers to maternal, newborn and child health services to about 3.5 million women and men //

											infants (results) // (2) reaching over three million caregivers with training on the prevention of leading diseases affecting mothers and children (sleeping inside insecticide treated bed nets, using oral rehydration solutions to treat diarrhea, completing immunizations, hand washing, antenatal care and preventing mother-to-child transmission of HIV) (results) //		
A035244-001	Emergency Obstetrics in South Sudan				None	None	None	None	WHO	None	aims to establish 24-hour comprehensive emergency obstetrical and neonatal care services in hospitals in Southern Sudan. It is designed to improve women's access to care to reduce maternal and newborn mortality and morbidity // An estimated 210 hospital personnel are being trained in all aspects of obstetrical and neonatal care services, including clinical and training guidelines (description) //	Yes	None

M01340 3-001	Essential Health and Nutrition Services for Maternal, Newborn and Child Health	to deliver iron and folic acid to avoid anaemia at term among pregnant women // MI also aims to implement initiatives to improve antenatal care, care at birth, and postpartum and newborn care //			None	None	None	None	Micronutrient Initiative	None	None	Yes	None
A03478 2-008	Strenghthening Tanzania's Health System for Maternal, Newborn and Child Health	implementing the national strategy for combating HIV/AIDS //			Nne	None	None	None	Government of Tanzania - Ministry of Finance	None	(3) the number of HIV positive pregnant mothers who were provided with therapy to prevent mother-to-child transmission (PMTCT) of HIV/AIDS increased from 70,944 in 2008 to 86,875 in 2011, an increase of 22% // (4) the ratio of nurse-midwives per population of 10,000 rose from 2.6 in 2004/2005 to 4.9 in 2012 // - results	Yes	None
A03303 3-007	Support to Prosaude to Achieve Millenium Development Goals 4 and 5			expansion or rehabilitation of 250 maternity rooms at health centres //	None	None	None	None	Government of Mozambique - Ministry of Health	None	(vi) the percentage of women giving birth in a health facility increased from 55% in 2009 to 63.8% in 2012; // 11% increase in the number of women receiving at least two doses of preventive malaria treatment during prenatal visits and antiretroviral medication distributed to 38,057 children and	No	None

											94,151 pregnant women (expected) (results) // (i) the number of HIV positive adults receiving antiretroviral therapy increased from 156,688 (106,892 women) in 2009 to 297,801 (190,686 women) by the end of 2012 // (v) the percentage of health facilities with a maternity waiting home for pregnant women increased from 40.8% in 2009 to 50% in 2012; (results) //		
A03517 1-001	Improved Food Security for Mothers and Children	This project aims to improve the nutritional and health status of 3 million children under-five and pregnant and lactating women //			None	None	None	None	UNICEF	None	None	No	None

A03519 0-001	Joint Government of Bangladesh-UN Maternal and Neonatal Health Projects	project seeks to increase the quality and quantity of health services for mothers and newborns by supporting the Joint Government of Bangladesh-UN Maternal and Neonatal Health Initiative //			None	The project targets current challenges such as inconsistent quality of services and the fact that mothers, for a variety of reasons, hesitate to use such services even when they do exist // (1) providing training and information for mothers about harmful health practices and the need to use and demand better services //	The project targets current challenges such as inconsistent quality of services and the fact that mothers, for a variety of reasons, hesitate to use such services even when they do exist // (1) providing training and information for mothers about harmful health practices and the need to use and demand better services	None	UNFPA	None	The project targets current challenges such as inconsistent quality of services and the fact that mothers, for a variety of reasons, hesitate to use such services even when they do exist // takes place at the local level in districts and communities and focuses on poor and marginalized populations // (3) the number of women delivering in institutional facilities rose from 24% in 2012 to 29% in 2013 in four districts // (7) the numbers of prenatal visits increased from 204,547 visits of pregnant women in 2012 to 239,497 visits in 2013 // (4) 3,809 community health volunteers received five days of training and another 10,523 received refresher training on prenatal, post-natal and essential newborn care and counselling // (6) waiting times to receive maternal and newborn health services were reduced,	Yes	(5) 20 health service user forums to discuss health service delivery were put in place with 15 to 20 health service users each (at least 40% of whom are women) //

											and 47.5% of clients now receive care within 15 minutes of arriving at a health facility (both from results) //		
A03492 1-002	Construction of the Artibonite Provincial Hospital in Gonaives - II	This component supports the construction of a 30-bed maternity ward, a 35-bed paediatric ward, and a waiting home for pregnant women close to delivery //		the design, construction and equipping of the new hospital includes a 30-bed maternity ward (including neonatology and obstetric/gynaecolo gic services) // a waiting home for pregnant women close to delivery //	The Gonaïves hospital initiative aims to improve access to and the quality of specialized health services for children, women, and men //	None	None	None	UNOPS - UN Office for Project Services		includes initial institutional support such as training in hospital management, hospital equipment usage, and maintenance, as well as specialized training in maternal, neonatal, and child health issues (activities)// The Gonaïves hospital initiative aims to improve access to and the quality of specialized health services for children, women, and men //	No	None
A03520 7-001	Integrated Management of Maternal and Child Health in Artibonite (1)	It supports the rehabilitation of nine maternity clinics and seven community health centres // Five of the maternity clinics offer basic emergency obstetric and neonatal care. // The other four offer a higher level of			None	2. Increase community mobilization around the fight against maternal and child mortality in particular, but also for hygiene,	None	None	CCISD - Center for International Cooperation in Health and Development	None	improve coordination and referrals between community and province-wide service providers // • The number of deliveries at obstetrics and	Yes	None

		care, including caesarean sections and blood transfusions. //				water, sanitation and the empowerment of women. //					neonatal care institutions supported by the project have increased by 20.3%; // • The percentage for the use of modern family planning methods increased from 11% at the database to 19.72% in September 2014,or form 20,869 users to 39 964; //		
A035207-002	Integrated Management of Maternal and Child Health in Artibonite (2)	It supports the rehabilitation of nine maternity clinics and seven community health centres // Five of the maternity clinics offer basic emergency obstetric and neonatal care. // The other four offer a higher level of care, including caesarean sections and blood transfusions			None	2. Increase community mobilization around the fight against maternal and child mortality in particular, but also for hygiene, water, sanitation and the empowerment of women. //	None	None	CCISD - Center for International Cooperation in Health and Development	None	improve coordination and referrals between community and province-wide service providers // • The number of deliveries at obstetrics and neonatal care institutions supported by the project have increased by 20.3%; // • The percentage for the use of modern family planning methods increased from 11% at the database to 19.72% in September 2014,or form 20,869 users to 39 964; //	Yes	None
A035206-001	Increased Access to Basic Health Services			(1) free care provided to more than 70,000 pregnant women // (4) the majority of institutions have achieved and even surpassed the pre-established targets for obstetric and pediatric care at 103% and 118%; //	None	None	None	None	PAHO - Pan American Health Organization	None	The aim of the project is to increase access to health services for pregnant women, children 0-5 years old and other vulnerable groups. (description) //	Yes - 40	None

A03521 8-001	Strengthening Health Activities for the Rural Poor								World Bank		Between 2009 and 2013, the total number of pregnant women receiving at least one antenatal care visit to a health provider increased from 32.3% to 54%. //		None

APPENDIX D: NUMBER OF TIMES EACH EXECUTING AGENCY/PARTNER IS CONTRIBUTING TO A PROJECT

UNFPA	6
UNICEF	3
Micronutrient Initiative	2
Government of the United Kingdom - DFID	2
World Vision	2
WFP XX	2
CARE Canada	2
UNDP	2
Aga Khan Foundation	2
PLAN International Canada	2
CCISD	2
UNOPS	2
World Bank	2
Jhpiego	1
Oxfam Quebec	1
WUSC	1
University of Manitoba	1
CHF	1
Western University	1
Save the Children Canada	1
UBC/University-Industry Liaison Office	1
ADRA	1
University of Calgary	1
IDRF	1
HOPE International Development Agency	1
AMREF Canada	1
PWS&D	1
Global Fund to Fight AIDS, Tuberculosis & Malaria	1
CCFC	1
L'AMIE	1

Primate's World Relief and Development Fund	1
Ghana Rural Integrated Development	1
Canadian Network for International Surgery	1
International Child Care Canada	1
African Medical and Research Foundation (Tanzania)	1
World Renew	1
Government of Mali - Ministry of the Economy and Finances	1
WHO	1
Government of Tanzania - Ministry of Finance	1
Government of Mozambique - Ministry of Health	1
PAHO	1
Comprehensive Community-Based Rehabilitation in Tanzania	1
HealthBridge Foundation of Canada	1
TOTAL	61

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