PROGRAMMING GUIDE

PROMOTING GENDER EQUALITY IN SEXUAL, REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH

UN WOMEN

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ACRONYMS AND ABBREVIATIONS

CCBRT	Comprehensive Community-Based Rehabilitation in Tanzania
CCT	Conditional cash transfer
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CSE	Comprehensive sex education
CRVS	Civil Registration and Vital Statistics
DHS	Demographic and Health Surveys
EWEC	Every Woman Every Child
FGM/C	Female genital mutilation/cutting
GBV	Gender-based violence
GINA	Gender Informed Nutrition and Agriculture (Alliance)
GREAT	Gender Roles, Equality, and Transformations (Project)
ICW	International Community of Women Living with HIV/AIDS
IPV	Intimate partner violence
MDGs	Millennium Development Goals
MDSR	Maternal Death Surveillance and Response (systems)
MHM	Menstrual hygiene management
NGO	Non-governmental organization
MSD	Multi-stakeholder dialogue
OHCHR	Office of the United Nations High Commissioner for Human Rights
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SRMNCAH	Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health
SDGs	Sustainable Development Goals
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UPR	Universal Periodic Review
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

TABLE OF CONTENTS

ACKNOWLEDGEMENTS 4

ACRONYMS AND ABBREVIATIONS 5

INTRODUCTION 7

Context 7

About the programming guide 9

Intended use and audience 10

PART ONE: UNDERSTANDING HOW GENDER INEQUALITY INFLUENCES WOMEN'S HEALTH 11

1. GENDER AS A DETERMINANT OF SEXUAL, REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH 12

1.1 The influence of sex versus gender on sexual, reproductive, maternal, newborn, child and adolescent health outcomes 12

1.2 Gender as a power relation and driver of inequality in health 15

2. HOW GENDER INEQUALITY AFFECTS THE WAY HEALTH SERVICES ARE PLANNED, DELIVERED AND EXPERIENCED 16

3. GENDER EQUALITY, WOMEN'S RIGHTS AND THE RIGHT TO HEALTH 19

3.1 Ensuring the empowerment of women 20

PART TWO: HOW TO APPLY A STRONGER FOCUS ON GENDER EQUALITY AND WOMEN'S EMPOWERMENT 21

4. STRENGTHENING GENDER EQUALITY IN SEXUAL, REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH: A FRAMEWORK FOR ACTION 22

4.1 Rationale for the framework for action 22

4.2 The framework for action explained 22

4.3 The framework for action in practice: Programmatic case studies 34

5. MULTISECTOR ACTION TO ADDRESS GENDER INEQUALITY AS A DETERMINANT OF SEXUAL, REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH 51

5.1 The essential role of non-health sector interventions 51

5.2 Strengthening collaboration between the health and non-health sectors 52

5.3 What's working? Programmatic case studies across sectors and geographies 53

6. INSIGHTS AND ACTION FOR FUTURE PROGRAMMING 64

6.1 Characteristics of programmes that improve both gender equality and sexual, reproductive, maternal, newborn, child and adolescent health outcomes 64

6.2 Checklists to guide the practical application of the framework for action 66

ANNEXES 74

Annex 1. Glossary 74

Annex 2. International human rights mechanisms and instruments relevant to women's, children's and adolescents' health 77

Annex 3. Illustrative gender indicators for sexual, reproductive, maternal, newborn, child and adolescent health programming 84

Annex 4. Related programming guidance 86

ENDNOTES 88

REFERENCES 94

INTRODUCTION

Context

In 2010, the United Nations Secretary-General launched the Global Strategy for Women's, Children's and Adolescents' Health (2010-2015) to accelerate progress to meet Millennium Development Goals (MDGs) 4 (Reduce child mortality) and 5 (Improve maternal health). This led to the launch of the '*Every Woman Every Child*' movement (EWEC) to put the Global Strategy into action. Support to country leadership and action on the Strategy was provided by the H4+ partnership, which later expanded to become the H6 partnership, including the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO) and the World Bank.

The past few decades have seen vast improvements in the health of women, adolescents and children. Between 1990 and 2015, the maternal mortality ratio declined by 45 per cent and the under-five mortality rate was more than halved, dropping from 90 to 43 deaths per 1,000 live births.[1] Yet, despite the impressive progress, the gains have been uneven, with variations in health services and outcomes within and across countries. In 2015, more than 303,000 women died from preventable causes related to pregnancy and childbirth with 99 per cent of all maternal deaths occurring in developing countries.[2] Adolescent and young girls face a higher risk of complications and death as a result of pregnancy than older women, with the risk of maternal mortality highest for adolescent girls under 15 years old.[3] The need for modern contraceptives remains unacceptably high, as an estimated 214 million women of reproductive age in developing regions have an unmet need for modern contraception.[4] According to the World Health Organization (WHO), 5.46 million children under the age of 5 died in 2017. Most deaths were in low-income countries: the under-five mortality rate was nearly 14 times higher in low-income countries (69 deaths per 1,000 live births) compared to high-income countries (5 deaths per 1,000 live births).[5]

In the transition to the Sustainable Development Goals (SDGs), the UN Secretary-General launched the updated Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) to complete the unfinished work of the Millennium Development Goals (see **Box 1** for Global Strategy targets). Support to country leadership and action on the Strategy continues to be provided by the H6 partnership (**Box 2**).

Broader and more ambitious than its predecessor, the revised Global Strategy includes an expanded focus on adolescents and those living in humanitarian and fragile settings. It also emphasizes the importance of tackling the underlying determinants of SRMNCAH, including gender equality. The strategy highlights how discrimination against women has negative consequences on women's health throughout their life course as well as on the health of their families.[6]

The life course approach to SRMNCAH recognizes gender as a key determinant of women's health and well-being and focuses on the fact that women's health needs differ according to their life stages. Promoting a life-course approach to women's health also acknowledges that sex and gender combine with social and environmental determinants of health to influence how health risks and benefits accumulate through life. In this way, gender inequality is explicitly recognized as an important determinant of health outcomes, with women and girls often at a societal disadvantage. Women, children and adolescents facing discrimination based on their sex, gender identity, gender expression or sexual orientation have unequal access to, and uptake of, health services and resources.

BOX 1

Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)

The Global Strategy provides a road map for ending preventable deaths of women, children and adolescents by 2030 and helping them achieve their potential for, and rights to, health and well-being in all settings. The Global Strategy has three objectives: survive (end preventable deaths), thrive (ensure health and well-being), and transform (expand enabling environments). These objectives are aligned with 17 targets within nine of the Sustainable Development Goals (SDGs), including: SDG 3 on health; SDG 5 on gender equality and the empowerment of women and girls; and other SDGs related to the political, social, economic and environmental determinants of health and sustainable development. Commitment to gender equality and women's empowerment is both a goal and a condition for achieving the SDGs.

SURVIVE
End preventable deaths

- Reduce global maternal mortality to less than 70 per 100,000 live births (SDG 3.1)
- Reduce newborn mortality to at least as low as 12 per 1,000 live births in every country (SDG 3.2)
- Reduce under-five mortality to at least as low as 25 per 1,000 live births in every country (SDG 3.2)
- End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases (SDG 3.3)
- Reduce by one third premature mortality from non-communicable diseases and promote mental health and well-being (SDG 3.4)

THRIVE
Ensure health and well-being

- End all forms of malnutrition and address the nutritional needs of children, adolescent girls, and pregnant and lactating women (SDG 2.2)
- Ensure universal access to sexual and reproductive health care services (including for family planning) and rights (SDG 3.7 and 5.6)
- Ensure that all girls and boys have access to good-quality early childhood development (SDG 4.2)
- Substantially reduce pollution-related deaths and illnesses (SDG 3.9)
- Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines (SDG 3.8)

TRANSFORM
Expand enabling environments

- Eradicate extreme poverty (SDG 1.1)
- Ensure that all girls and boys complete primary and secondary education (SDG 4.1)
- Eliminate all harmful practices, discrimination and violence against women and girls (SDG 5.2 and 5.3)
- Achieve universal access to safe and affordable drinking water and to sanitation and hygiene (SDG 6.1. and 6.2)
- Enhance scientific research, upgrade technological capabilities and encourage innovation (SDG 8.2)
- Provide legal identity for all, including birth registration (SDG 16.9 and 17.19)
- Enhance the global partnership for sustainable development (SDG 17.16)

Sources: Every Woman Every Child (2015). The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). Geneva: WHO. Available at: http://www.who.int/life-course/partners/global-strategy/en/

BOX 2

The H6 Partnership

The H6 partnership leverages the full strengths of UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank to support high-burden countries to improve the survival, health and well-being of every woman, newborn, child and adolescent. It serves as the technical arm of the Every Woman Every Child movement by providing coordinated technical support to countries to implement the actions and recommendations of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) and achieve related SDG targets, including SDG 3 on health and SDG 5 on gender equality and the empowerment of women and girls.

The partnership's efforts focus on providing countries with technical support, capacity strengthening and policy advice; data and strategic information to reveal gaps, show returns on investments and prioritize responses; and support to leverage investments and convene stakeholders across women's, adolescents' and children's health efforts.

Both the Global Strategy and the SDGs also emphasize the need for partnerships and multisectoral action. Removing discrimination in health-care settings – and ensuring that women and adolescent and young girls are aware of their rights and able to demand stigma-free and discrimination-free services – is fundamental to upholding human rights to the highest attainable standard of health, as protected by international law. At the same time, approximately 50 per cent of the gains made in the health of women, children and adolescents result from investments outside of the health sector,[7] particularly through efforts in education, nutrition, water and sanitation, technology and the environment.[8] These multisectoral efforts to address determinants of health are particularly important for reducing inequalities and creating healthier environments.[9] They include action within various single sectors (e.g. health, education, water and sanitation, environment and nutrition) as well as joint action across and between sectors (e.g., between health and education sectors, environment and water and sanitation sectors). By addressing determinants of health – including gender inequality – in this way, interventions beyond the health sector should be considered as core to national strategies on women's, children's and adolescents' health.

About the programming guide

Given the impact of gender inequality on the sexual and reproductive health of women and girls and the health of women and their children, it is imperative that policymakers, health professionals and community organizations have practical guidance and tools on how to understand the influence of gender on SRMNCAH and how to effectively integrate gender equality into programming. This guide responds to a perceived gap in such guidance.

Purpose

This guide serves as an important resource to complement and build on existing guidance and tools to strengthen gender equality to improve health outcomes for women, children and adolescents. It is designed to help users:

- Understand how and why gender inequality is a key determinant of SRMNCAH;
- Learn about types of interventions to address gender inequalities as a root cause of poor SRMNCAH outcomes by providing examples of evidence-based interventions;
- Identify actions to support human-rights-based and gender-responsive interventions to improve gender equality and SRMNCAH outcomes for women, children and adolescents.

This guide was developed to increase awareness of the influence of gender inequalities on women's health and provide ideas for addressing them in the context of SRMNCAH. It focuses on gender as a determinant of health and examines how unequal gender norms, attitudes and practices can affect women's health-related behaviours and the realization of their rights. It proposes that demand for health services is determined at the individual level, but also by household members, social networks, communities and broader social and structural policies and norms.[10]

Methodology

The conceptual framing for promoting gender equality in SRMNCAH was developed after a literature review of programmes, approaches and policy documents. It is grounded in existing conceptual frameworks, specifically the Social Ecological Model (see **Annex 1**) for health interventions, and is aligned with the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). It draws on inputs from expert group consultations, including a virtual consultation at the global level as well as consultations during the H6 partner intercountry meetings in Cameroon, Kenya and Burkina Faso (2015-2016). The guidance has benefited from country consultations in 2017 in Ethiopia, Kenya, Sierra Leone and Liberia to inform the finalization of the framework and programming guidance.

Intended use and audience

The intended audience for this programming guide includes:

- Policymakers, programme managers and professionals from the health sector that influence health service-delivery and SRMNCAH outcomes;
- Policymakers, programme managers and professionals from other sectors, such as gender, planning and education, whose activities contribute to the achievement of SRMNCAH outcomes;
- National and international non-governmental organizations and community-based organizations;
- Women's networks and organizations advocating for gender equality and sexual and reproductive health and rights; and
- United Nations agencies and programmes providing support to countries to implement the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

1

UNDERSTANDING HOW GENDER INEQUALITY INFLUENCES WOMEN'S HEALTH

1. GENDER AS A DETERMINANT OF SEXUAL, REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH

1.1 The influence of sex versus gender on sexual, reproductive, maternal, newborn, child and adolescent health outcomes

Sex and gender both influence health. Sex refers to the biological and physiological distinctions between males and females, such as reproductive organs, chromosomes and hormones. Gender, by contrast, emphasizes the socially constructed roles, behaviours and attributes that a given society considers appropriate for males and females, which in turn affects how people live, work and relate to each other at all levels, including in relation to their health.[11]

Some health conditions are determined primarily by biological sex differences. Others are the result of how societies socialize women and men into gender roles supported by norms about masculinity and femininity and power relations that accord privileges to men, but which adversely affect the health of both women and men.[12] However, many health conditions reflect a combination of biological sex differences and gendered social determinants. For example, pregnant women are at greater biological risk than men of severe malaria in most endemic areas. At the same time, studies on activities that increase human vector contact reveal that the ways that women and men spend their time during peak mosquito biting periods may place them at differential risk of contracting malaria.[13]

In the context of SRMNCAH, sex-based biological factors interact with inequalities based on gender, age, income, race, disability, ethnicity, class and environmental factors in shaping women's, children's and adolescents' exposure to health risks, experiences of ill health, access to health services and health outcomes. For example, South Asian studies have documented an increased risk of neonatal mortality among girls, despite their early biological survival advantage.[14] Existing literature has pointed to gender preference and differential care-seeking behaviours to explain this inversion of risk. Reports of sex imbalances in countries, such as Census data from India, for example, show an imbalance in sex ratios among children. Such disparities almost always reflect a preference for sons.[15] Women and girls' biological characteristics combined with gender inequality increase their vulnerability to sexually transmitted infections (STIs) and HIV. Among adolescents, girls are more vulnerable than boys to STIs and HIV due to a biological disadvantage that makes possible abrasion and tearing of the immature reproductive tract more likely, particularly during their first sexual

encounter. The same applies for adult women, who are at a greater physiological risk of contracting HIV than men because of the biological disadvantage of females' reproductive anatomy. However, the vulnerability of women and girls to HIV cannot be explained by biology alone. Studies also show that manifestations of gender inequality, such as gender-based violence (GBV) and harmful gender norms place women at higher risk for HIV infection (see **Box 3**). Gender norms and attitudes in many societies encourage men to engage in sexual activity and multiple concurrent sexual partners, while women are expected to be monogamous and sexually passive.

BOX 3

Violence against women and girls and poor SRMNCAH outcomes

Violence against women is one of the most extreme and harmful manifestations of gender inequality, a grave violation of human rights, and it significantly influences women and girls' ill health. Violence against women and girls hinders access to SRMNCAH information and services, limits the ability of women and adolescent girls to exercise their sexual and reproductive health and rights (SRHR), and leads to poor SRMNCAH outcomes. Some of the most tangible signs of violence against women and girls – including intimate partner violence (IPV); sexual violence and harmful practices such as female genital mutilation or cutting (FGM/C); and child, early and forced marriage – manifest themselves not only in poor SRMNCAH outcomes, but also poor gender equality and wider development outcomes.[16] Worldwide, addressing violence against women and girls has been identified as an important priority for improving the health of women, children and adolescents. The Global Strategy for Women's, Children's and Adolescents Health (2016-2030) reaffirms that violence and harmful practices are not just a critical health issue but a human rights and developmental issue that cannot be ignored.

A worldwide problem

- An estimated 35 per cent 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.[17]
- Around 120 million girls worldwide (slightly more than 1 in 10) have experienced forced intercourse or other forced sexual acts at some point in their lives.[18]
- At least 200 million women and girls alive today in 30 countries have undergone FGM/C.[19]
- Globally, 21 per cent of young women (aged 20-24) today were married as children and approximately 650 million women and girls alive today were married before age 18.[20]

Impact on women's and adolescents' sexual and reproductive health and rights

- Violence or fear of violence may prevent women from seeking health care. In one study, women who had experienced IPV were more than twice as likely to have foregone medical care compared to women who had not experienced IPV.[21]
- Forms of violence, such as FGM/C and child, early and forced marriage are serious human rights violations affecting children's, adolescents' and women's rights to health. These forms of violence are also associated with poor sexual and reproductive health outcomes for adolescent girls, women and their children.

BOX 3 (CONTINUED)

Violence against women and girls and poor SRMNCAH outcomes

- Women who experienced FGM/C face long- and short-term health risks such as chronic infections, menstrual problems, increased risk of HIV infection and complications around their sexual health.[22]

- Globally, complications during pregnancy and childbirth are the leading causes of death among adolescent girls (aged 15-19).[23]

Impact on access to and use of family planning

- Numerous studies have found that women may fear using contraception or condoms because of their partner's potentially violent reaction.[24]

- Violence limits women's access to family planning, which can potentially decrease maternal mortality by an estimated 20 to 35 per cent by reducing women's exposure to pregnancy-related health risks.[25]

- Often women subjected to IPV are not able to choose when to have sex, to insist on contraception, or to effectively and consistently use contraception.[26]

Impact on the ability to protect against STIs, including HIV

- In some regions, women who have been physically or sexually abused are 1.5 times more likely to acquire HIV, compared to women who have not experienced IPV. Large-scale studies have also found violence to increase the risk of STIs.[27]

Impact on maternal and newborn health

- IPV in pregnancy increases the likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight babies.[28]

- Adolescent girls are more likely to face obstetric fistulas due to childbearing before the pelvis is fully developed.[29]

Impact on child health

- IPV is associated with higher rates of infant and child mortality and morbidity (e.g. diarrhoeal disease, malnutrition). For example, maternal exposure to IPV has been shown to substantially increase a child's risk of stunting.[30]

- Children exposed to violence are more likely to perpetrate violence later in life.[31]

- Almost half of all girls (aged 15-19) worldwide (around 126 million) think a husband is sometimes justified in hitting or beating his wife.[32]

These examples demonstrate that even in health (where the physical body is central), biology is not destiny.[33] Sex and society, nature and nurture, genetics and environment interact in complex ways to determine SRMNCAH outcomes. Achieving gender equality in health means that – irrespective of biological sex – women and men across their life course have the same equal opportunities to realize their full rights and potential to be healthy, contribute to healthy development and benefit from the results.

1.2 Gender as a power relation and driver of inequality in health

SRMNCAH outcomes are influenced by the conditions in which we are born, grow, live, work and age, and the distribution of power, money and resources that affect these conditions. These are referred to as the social determinants of health.[34] These determinants influence the health of women, children and adolescents, who often experience discrimination and unequal access to resources and realization of their rights. These factors cause inequities in health, affecting access and coverage of essential health interventions and directly affecting the health of women, children and adolescents within and between countries.

Gender relations are about social relations between and among men and women. They can determine hierarchies between groups based on norms and can contribute to unequal power relations. Gender relations of power constitute the root causes of gender inequality and are among the most influential of the social determinants of health.[35] They operate across many dimensions of life and determine whether people's needs are acknowledged, whether they have voice or control over their lives and health, and whether they can realize their rights.[36] As a power relation, gender influences: vulnerability to ill health, household decision-making and health-seeking behaviour, access to and utilization of health services, the design and use of health products and technology (e.g., SRMNCAH commodities), the nature of the health labour force, the implications of health financing, what data is collected and how it is managed, and how health policies and programmes are developed and implemented.[37]

Manifestations of gender inequality (such as differential access to education and health services, forced and early child marriage, unequal labour market participation and remuneration, and violence against women and children) are major contributors to maternal and child mortality.[38] Despite global improvements in maternal and newborn health, gender inequalities continue to influence SRMNCAH outcomes in several ways. For example, worldwide, as many as one in four women experience physical or sexual violence during pregnancy.[39] Violence against women during pregnancy has a range of adverse health outcomes for women and children, including miscarriage, depression and delay in prenatal care.[40]

Conversely, there are numerous pathways by which greater gender equality can lead to improvements in health and quality of life for women and their families. Women with greater agency are more likely to have fewer children, more likely to access health services and have control over health resources, and less likely to suffer domestic violence.[41] Their children are more likely to survive, receive better childcare at home and receive health care when they need it.[42] Improved health outcomes for women and adolescent girls can also help to strengthen their own agency and empowerment. Healthy women and girls are more able to actively participate in society and take collective action to advance their own interests, such as demanding rights-based, gender-responsive health services. Enabling environments for gender equality are also linked to positive health and broader societal outcomes.[43]

2. HOW GENDER INEQUALITY AFFECTS THE WAY HEALTH SERVICES ARE PLANNED, DELIVERED AND EXPERIENCED

Within the health sector, SRMNCAH outcomes are influenced by both the supply of health information and services as well as the demand for the services.[44] Supply-side SRMNCAH interventions generally focus on WHO health system building blocks[45] to improve the availability, accessibility and quality of SRMNCAH services. Demand-side interventions aim to increase healthy behaviours and appropriate care-seeking by providing information to individuals and groups, through community mobilization and through the use of financial incentives.[46]

Gender equality influences both the supply of, and the demand for, SRMNCAH information and services. As described in **Figure 1**, supply-side interventions aim to ensure acceptable SRMNCAH services are available and accessible to women and girls, while demand-side interventions increase women's and girls' access to knowledge and their capacity to demand and use such services. Yet, policies and programmes that influence SRMNCAH often fail to take gender into account. When gender is considered, it is often reduced to focusing on women only or not going beyond sex disaggregation of data. Both of these approaches ignore the socially constructed power relations and gender norms that exist between and among men, women, transgender people and other gender identities which can lead to vastly different health needs, experiences and outcomes.[47] Health policies, programmes and systems may even exacerbate these inequalities because of the manner in which these health systems are conceptualized, implemented and delivered.[48] This is because health systems are not gender-neutral: they reflect gender norms and, as such, can reinforce gender inequalities and discrimination. For example, this can be manifested through gender-based discrimination and abuse, provision of differential quality of care to women and men, gender-bias in health policies and planning, and discriminatory workplace environments.

Gender inequality also affects demand for and utilization of SRMNCAH information and services. For example, in sub-Saharan Africa, research has shown that gender inequality plays a role in fertility behaviour, affecting demand generation for family planning commodities and services.[49] Couples in this region tend to differ in their fertility aspirations, with men showing desire for larger families (higher

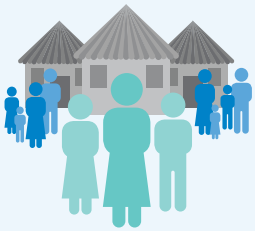
FIGURE 1

Addressing demand and supply-side factors for women's access to SRMNCAH

Demand

Individuals and communities have access to knowledge and capacity to seek services and ensure health-related rights.

Supporting women's demand for health services addresses **women's bodily autonomy and integrity at various points at which a woman needs information, services, and opportunities** to act upon choices over her lifespan.

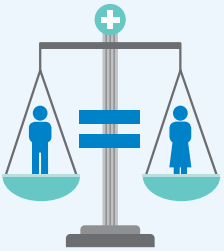


Women's demand for health services is determined not only by individual attributes such as knowledge and skills, but also by **relationships with household members, social networks, communities, and broader social and structural policies and norms.**

Supply

Delivering quality health services that are available, accessible and acceptable to individuals and communities served.

Removing user fees for maternal health care, especially for deliveries, can both stimulate demand and lead to increased uptake of essential services.



Removing discrimination in health-care settings, and ensuring women and adolescent girls are aware of their rights and able to demand stigma and discrimination-free services is therefore fundamental to upholding their human rights.

fertility). Empowering women across sub-Saharan Africa to participate in decision-making at the interpersonal and household level is therefore crucial in order to achieve lower fertility and, as a result, improve maternal health.[50] This is supported by studies investigating the relationship between women's empowerment and fertility indicators, which found increasing women's agency had a positive association with lower fertility, longer birth intervals and lower rates of unintended pregnancy.[51] This and other research continues to show that taking action to empower women and girls to demand and realize their rights is one of the most direct and potent ways to reduce health inequities overall, ensure effective use of health resources and improve SRMNCAH outcomes.[52]

Strengthening demand-side factors (see **Box 4**) supports women to be fully informed of their rights and empowered to seek out appropriate, discrimination-free, quality SRMNCAH services. It is therefore critical to address the underlying barriers that prevent women from demanding and realizing their right to health. This includes tackling challenges such as women's and girls' lack of knowledge and rights education, economic constraints, and lack of autonomy or decision-making. These gender-related factors affect the ability of women and girls to act on their own behalf and protect their health, including through autonomy in decision-making, control over income and assets, and living free of violence and discrimination.

BOX 4

What is demand?

Demand refers to the willingness and ability of men and women, including adolescent girls and boys, to use SRMNCAH information, services and commodities and/or to adopt healthy behaviours.

Structural issues, particularly gender inequality and poverty, influence many of the **demand-side** barriers to SRMNCAH services.

Demand generation focuses on improving awareness of SRMNCAH services and the rights of women, children and adolescents so that individuals – especially women and adolescent girls – can make an informed choice about accessing and using these services.

3. GENDER EQUALITY, WOMEN'S RIGHTS AND THE RIGHT TO HEALTH

Through pathways such as those described in the previous section, gender inequality prevents women and girls from demanding and realizing their right to health, a key human right (**Box 5**). Human rights are held by all persons, regardless of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[53] All persons are equally entitled to human rights without discrimination. These rights are all interrelated, interdependent and indivisible.[54] The right to health is closely related to and dependent upon the realization of other human rights, including the full realization of women's rights. In this way, gender equality is a precursor to realizing the right to health.[55]

BOX 5

The right to health

"[The right to health is] an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information..."

– Committee on Economic, Social and Cultural Rights, General Comment No. 14

The right to health includes both freedoms and entitlements:

- **Freedoms** include the right to control one's health and body (e.g. sexual and reproductive rights) and to be free from interference (e.g. free from non-consensual medical treatment).
- **Entitlements** include the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health.

The right to health includes four interrelated elements:

- **Availability:** Health-care facilities, goods and services are well-functioning and adequately available.
- **Accessibility:** Health-care facilities, goods and services are accessible to all, encompassing the following dimensions – non-discrimination, physical, economic (affordability) and information accessibility.
- **Acceptability:** Health-care facilities, goods and services are respectful, culturally appropriate, gender-responsive and they honour confidentiality.
- **Quality:** Health-care facilities, goods and services are appropriate and of good quality.

Source: WHO (2017). "Human Rights and Health Fact Sheet No. 323." Available at: http://www.who.int/mediacentre/factsheets/fs323/en/

The right to health includes the right to timely and appropriate health care. Elimination of all forms of discrimination – including discrimination based on sex, gender identity, gender expression and sexual orientation – is at the core of a human rights-based approach.[56] SRMNCAH service-delivery must be free of stigma and discrimination and uphold a patient's right to autonomy, privacy, informed consent and choice.[57] There is increasing evidence that systematic application of human rights standards and principles, including gender equality, contributes to improving health outcomes.[58] **Annex 4** suggests some resources on human rights-based approaches to SRMNCAH.

The right to health also includes addressing underlying determinants that contribute to health outcomes. Realizing human rights in the context of SRMNCAH implies recognizing and addressing the underlying causes of women's and men's human rights violations, challenging structural constraints to the equal rights and choices of women and girls when it comes to their health, and putting in place appropriate policy and programmatic responses in line with human rights principles. A human-rights-based approach to gender equality also calls for the participation of marginalized, disempowered and discriminated-against groups of women and girls, and men and boys, including adolescents, in decisions that affect their livelihoods and overall sustainable development, and for their engagement in monitoring their equal enjoyment of societal benefits derived from development.[59]

Critical to women's right to sexual and reproductive health (SRH) is the extent to which laws and policies support availability, accessibility, acceptability and quality. Women's, children's and adolescents' health are recognized as fundamental human rights in several international treaties (**Annex 2**). In addition to these, governments have also signed onto agreements from major UN conferences, such as the International Conference on Population and Development Programme of Action and the Beijing Declaration and Platform of Action. Holding governments accountable to these international human rights standards remains a vital strategy to reduce inequalities and underlying factors that cause poor gender equality and SRMNCAH outcomes for women, children and adolescents. Through periodic reporting, UN treaty-monitoring bodies hold governments to account by publishing their concerns and recommendations, including in relation to sexual and reproductive health and rights. The creation of the Universal Periodic Review (UPR) in 2006, the first international human rights mechanism to address all countries and all human rights, has also emerged as an important human rights accountability mechanism for the right to health and gender equality.

3.1 Ensuring the empowerment of women

Empowered women exercise their human rights and their right to health. Women's empowerment is also key to achieving gender equality and improving SRMNCAH outcomes. Empowerment is defined as "the expansion in people's [women's] ability to make strategic life choices in a context where this ability was previously denied to them".[60] It is a social process that enables women to gain control over their lives. It is a way to address unequal power relations and aspects of gender-based discrimination. It also aims to increase individual or group capacities.

Evidence shows that by engaging women as agents of change and increasing their awareness and knowledge of their SRMNCAH rights, women are more likely to claim these rights.[61] Women with greater agency are more likely to have fewer children, more likely to access health services and have control over health resources, and less likely to suffer domestic violence.[62] Their children are more likely to survive, receive better childcare at home and receive health care when they need it.[63] Improved health outcomes for women and adolescent girls can also help to strengthen their own agency and empowerment. Healthy women and girls are more able to actively participate in society and take collective action to advance their own interests, such as demanding rights-based, gender-responsive health services.

A rights-based approach to SRMNCAH programming that puts women's empowerment at the forefront can translate into more effective interventions for improving the health of women, children and adolescents.

2

HOW TO APPLY A STRONGER FOCUS ON GENDER EQUALITY AND WOMEN'S EMPOWERMENT

4. STRENGTHENING GENDER EQUALITY IN SEXUAL, REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH: A FRAMEWORK FOR ACTION

4.1 Rationale for the framework for action

A framework for action is an analytical tool for framing and understanding the role of gender inequality in affecting the sexual and reproductive health of women and girls and the health outcomes of women and their children. It is not a new framework but builds on and combines existing models in order to outline an approach to strengthen gender equality through SRMNCAH programming. The framework is intended to support SRMNCAH programming and interventions within and beyond the health sector.

4.2 The framework for action explained

The framework has four key steps (see **Figure 2**):

Step 1. Use the Social Ecological Model to understand the multiple levels of a social system and the interactions between individuals and their environment within this system.

Step 2. Apply a 'gender lens' to the Social Ecological Model to: i) understand how gender and gender inequality plays a role in SRMNCAH at different levels; and ii) identify barriers that prevent women and adolescent girls from demanding and realizing their rights to SRMNCAH information and services.

Step 3. Fully integrate gender analysis and gender equality considerations into planning and programming to reduce barriers and improve access to and use of SRMNCAH information and services.

Step 4. Promote action on empowering women and girls to demand and realize their rights to services to improve their health and well-being.

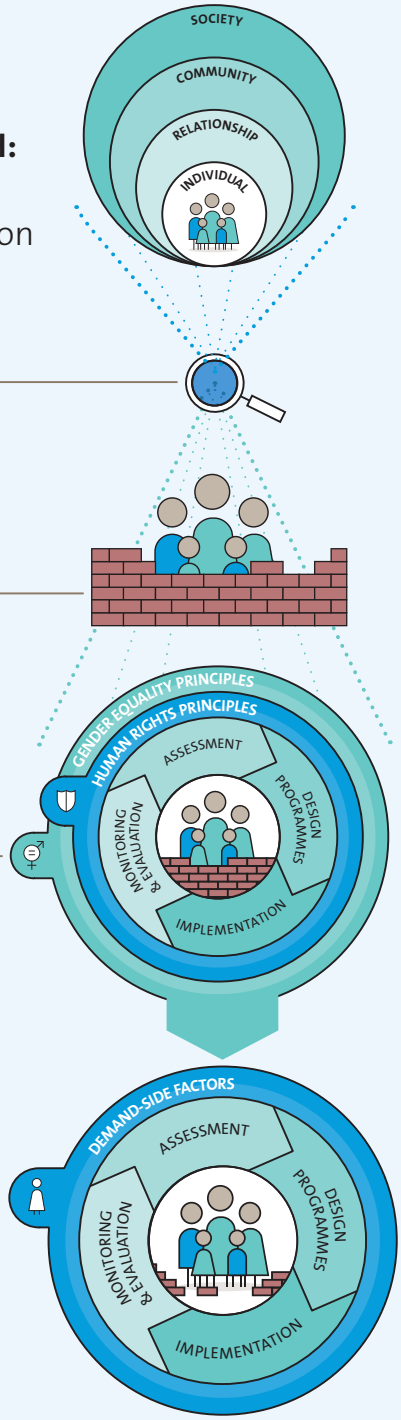
Step 1. Use the Social Ecological Model to understand the multiple levels of a social system and the interactions between individuals and their environment within this system.

The Social Ecological Model is a widely accepted conceptual framework for understanding health behaviour

FIGURE 2

Strengthening gender equality in SRMNCAH: A framework for action

Addressing gender inequalities to improve SRMNCAH: UN Women's framework for action



1

Using the Social Ecological Model to understand the multiple levels of a social system and the interactions between individuals and their environment within this system.

2

Applying a 'gender lens' to the Social Ecological Model (SEM) to:
(i) understand how gender and gender inequality plays a role in SRMNCAH at different levels;
(ii) identify barriers that are preventing women and adolescent girls from demanding and realizing their rights to SRMNCAH information and services.

3

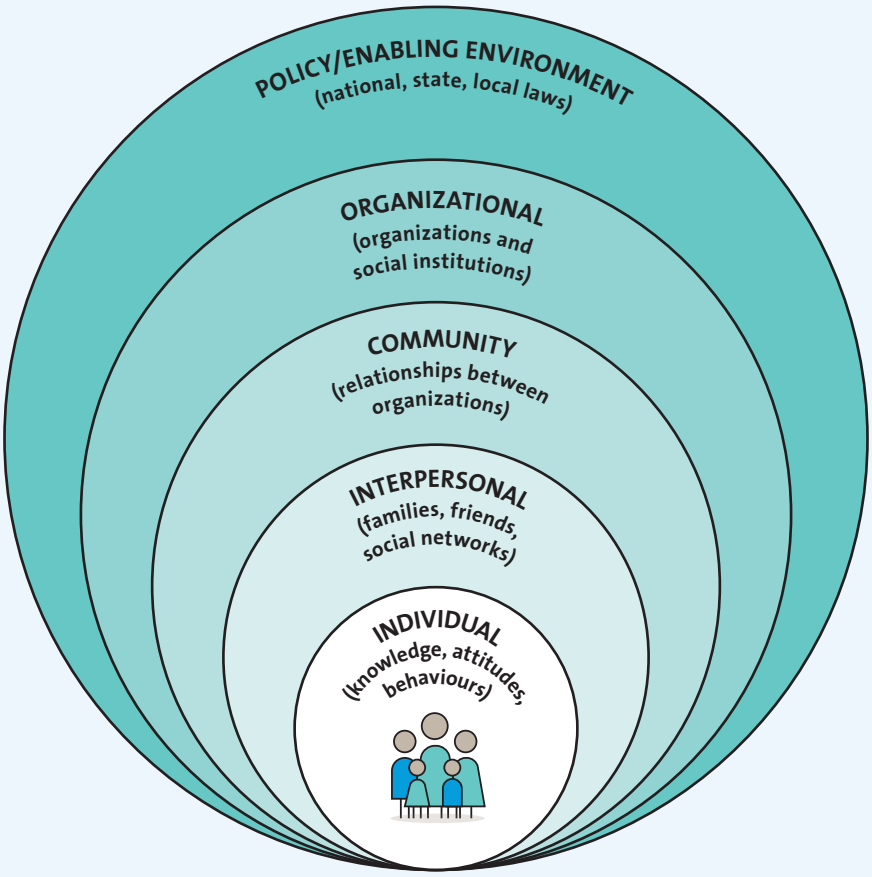
Fully integrating gender analysis and gender equality considerations into planning and programming to reduce barriers and improve access to SRMNCAH information and services.

4

Ensuring greater programmatic attention on empowering women and adolescent girls to seek services (demand generation) and claim their health-related rights.

FIGURE 3

The Social Ecological Model for health interventions



and multilevel interventions of change.[64] As SRMNCAH outcomes are influenced by factors other than health care alone, the Social Ecological Model is a useful way to conceptualize the intersecting spheres where key factors associated with SRMNCAH come into play (see **Figure 3**). Using this approach also helps to explain why efforts to improve determinants of health – such as gender – require action within and beyond the health sector in order to accelerate progress on SRMNCAH.

The Social Ecological Model recognizes that there are multiple determinants of any health condition, particularly SRMNCAH.[65] Women, children and adolescents are embedded within networks, communities and systems. In addition to engaging the individual woman, child or adolescent, it is also important to address the multiple determinants of SRMNCAH that lie in the wider environment in which they live and interact with others. This wider environment includes the different levels of the system in which the woman, child or adolescent live, such as the relations with members of the household, community and society.

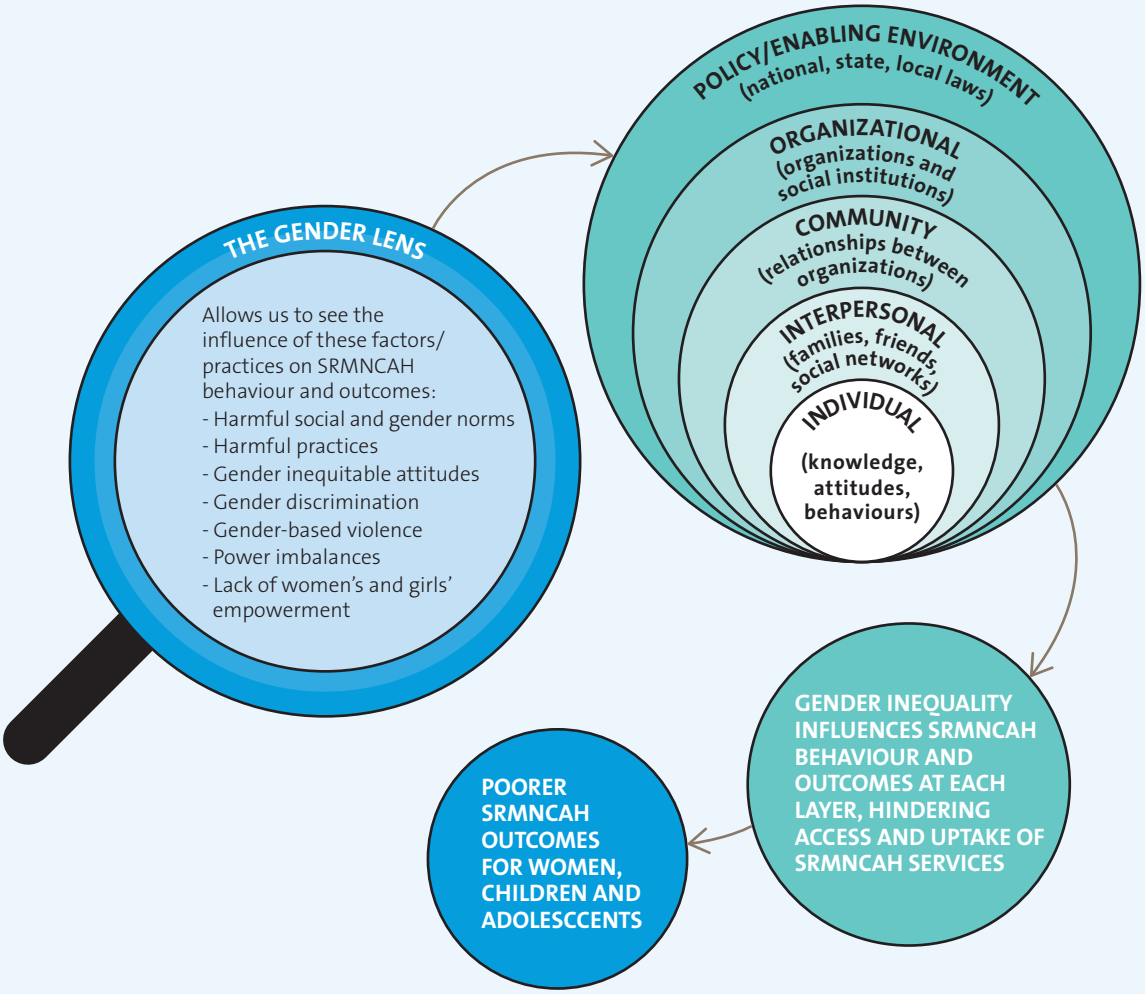
Step 2. Apply a gender lens to understand how gender inequality plays a role in sexual, reproductive, maternal, newborn, child and adolescent health at different levels and identify barriers that are preventing women and girls from demanding and realizing their rights.

The second step in the framework is the application of a gender lens to the Social Ecological Model (**Figure 4**).

Conducting gender analysis is an essential step to examining how gender inequality affects health and well-being. Specifically, gender analysis will identify underlying factors and how they influence health behaviour, services and outcomes. These underlying causes include discriminatory attitudes, social norms and unequal power relations between men and women. However, gender not only influences individual behaviour and interpersonal relationships but also has an impact at the organizational, community and policy levels. When applied to the Social Ecological

FIGURE 4

Applying a gender lens to the Social Ecological Model



Model, a gender lens helps us see how gender influences SRMNCAH outcomes for women and girls throughout their lives.

Diverse types of evidence are needed in order to understand how gender inequality plays a role in SRMNCAH. Gender analysis must be informed by data or information gathered from research, surveillance and monitoring activities and involve consultations from various groups and individuals, both men and women. The limited disaggregated data available may sometimes mean that there is a need to look for information where evidence may not be available. Using the Social Ecological Model, gender analysis becomes a valuable tool for identifying barriers to SRMNCAH information, services and commodities and which of these are influenced by gender inequality. In order to identify barriers, gender analysis uses a set of key and critical questions. The process of critical questioning is crucial, as one good question can lead to another, uncovering further the root causes of gender inequality.

Examples of questions for gender analysis that could be considered at each level of the Social Ecological Model are provided in **Table 1**. Guidance is also provided by **Checklist #1: Tips for identifying gender-related barriers to sexual, reproductive, maternal, newborn, child and adolescent health**.

Figure 5 suggests some barriers that a gender analysis of SRMNCAH might identify at the different levels of the Social Ecological Model.

FIGURE 5

Examples of gender barriers to SRMNCAH at different levels of the Social Ecological Model

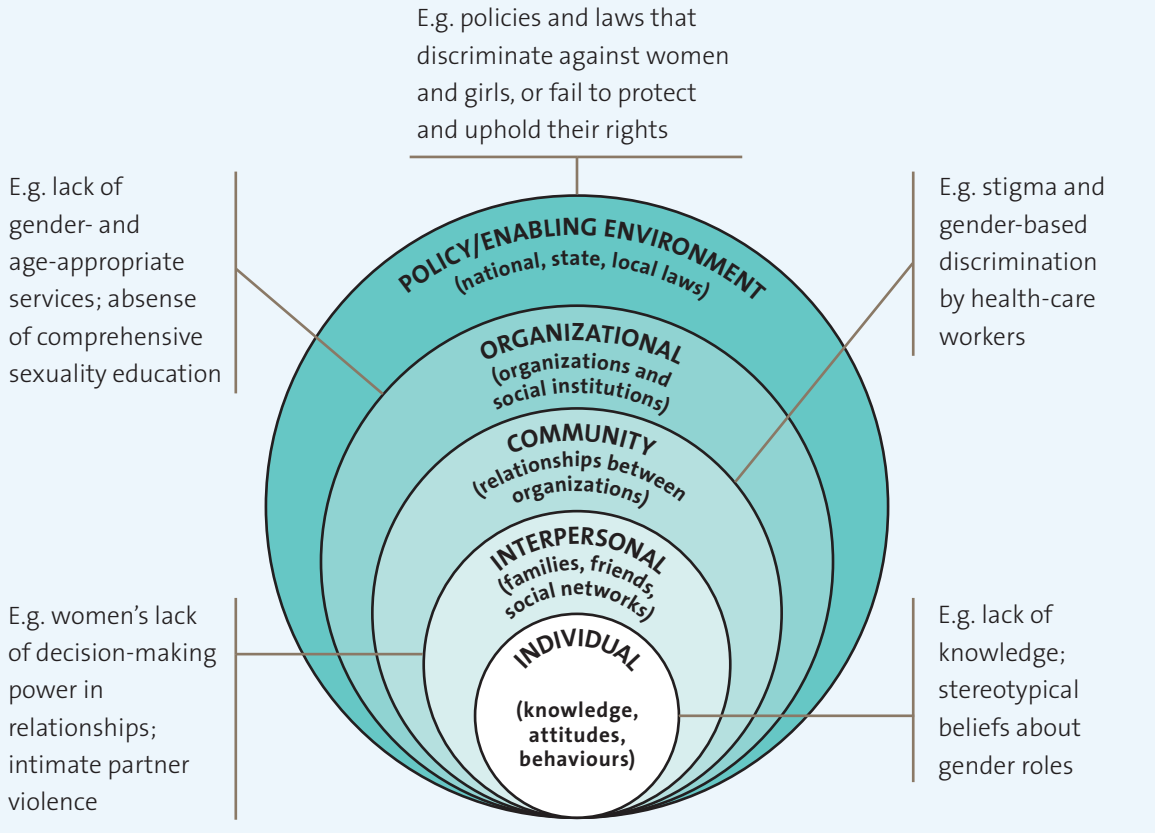


TABLE 1

Illustrative analysis at all levels of the Social Ecological Model of how gender influences the ability of women and girls to demand and realize their rights to SRMNCAH information and services

Level of the Social Ecological Model	Description (in the context of health)	Questions for consideration	Illustrative gender-related barriers	How these barriers limit the ability of women and girls to demand and realize their rights to SRMNCAH information and services
INDIVIDUAL	Characteristics of a person, such as knowledge, attitudes, behaviour and skills that influence how gender is negotiated by the individual. These characteristics, in turn, affect their health needs, experiences and outcomes and may also interact with other social markers such as age, education, ethnicity, (dis)ability, etc.	• Where SRMNCAH services are readily available, why aren't more women and adolescent girls accessing and using them? • What individual-level factors might be affecting the ability of women and adolescent girls to access/use available SRMNCAH services?	Skills (reading, writing), attitudes, stigma (including self-stigma) and discrimination, embarrassment, beliefs (gender and cultural beliefs about reproductive health), knowledge (past negative experiences in health-care settings), poverty, educational level, etc.	• A lack of knowledge about sexual and reproductive health; lack of knowledge about gender and women's rights; acceptance of social norms that justify the inferior status of women and girls; and a lack of resources to access SRH services.
INTER-PERSONAL	Examines close relationships that may lead to or exacerbate gender inequalities in health. Harmful gender norms and unequal power relations between an individual and their intimate partner/spouse, family members and social circle/peers can influence their health-seeking behaviour and contribute to their range of experience.	• What is the relative influence of various networks on SRMNCAH issues? • How can we increase male involvement in maternal, newborn and child health-care programmes? • What factors at the interpersonal level might be making it difficult for women and men to engage in issues related to SRMNCAH?	Partner (attitudes, beliefs and knowledge about SRH services); friends (misinformation or disapproval from peers); family (family structure, disapproval from kin)	• Gender norms and social constraints may stipulate that women and girls should remain modest and chaste about sexual matters, limiting access to information and services. • Young, unmarried women in some settings may be labelled as promiscuous if they seek information or related services. • A family environment may not be supportive of accessing SRMNCAH information or services. • Peer pressure may prevent young women and men from seeking health information. • Relationships may limit discussion about sexuality and reproductive health. • Norms and beliefs may hold that family planning/child health is a woman's responsibility.

TABLE 1 (CONTINUED)

Illustrative analysis at all levels of the Social Ecological Model of how gender influences the ability of women and girls to demand and realize their rights to SRMNCAH information and services

Level of the Social Ecological Model	Description (in the context of health)	Questions for consideration	Illustrative gender-related barriers	How these barriers limit the ability of women and girls to demand and realize their rights to SRMNCAH information and services
ORGANIZATIONAL/ COMMUNITY	Explores organizational /institutional and community settings – such as schools, workplaces, health-care institutions and neighbourhoods in which social relationships occur. Seeks to identify characteristics of these settings that increase gender inequalities in health (e.g. values and beliefs of the community or a health worker, perceived social norms/expected roles).	• Do health service-providers treat women and men, girls and boys equally in SRMNCAH service-delivery? • What challenges do local communities and schools face in providing a more supportive environment for reproductive health services, including menstrual hygiene management?	Inconvenient service hours, geographical inaccessibility of services, inadequate counselling from health workers, lack of privacy, disapproval, stigma or discrimination from health workers, established norms and values in the community (rigid gender roles, disapproval, stigma or discrimination from community members).	• Adolescent girls may be unable to access information if it is not offered with sufficient privacy and confidentiality, fearing that the information will reach family who may disapprove. • Adolescent girls may fear negative attitudes and rude behaviour from disapproving health workers. • Health-care workers may discriminate against women and girls, particularly those who are poor or from marginalized groups.
POLICY/ ENABLING ENVIRONMENT	Looks at broad societal, political and economic factors – such as public policy, laws and allocation of resources – in which gender inequalities are either progressively transformed or replicated in ways that impact inequities in health services and health outcomes.	• Does the legal and policy environment support the provision of SRMNCAH information and services to both men and women, including adolescent girls and boys? • Are there any laws or policies that make it difficult for specific populations (such as unmarried women or adolescent girls and boys) to access sexual and reproductive health information and services?	National laws and policies that directly or indirectly affect SRMNCAH (including national policies relating to women, children and adolescents, and to the allocation of resources). Public information and dissemination (conflicting information from the State and from social institutions, such as: media, schools, civil society, religious institutions, etc.)	• Laws may set a minimum age for marriage that is too low, putting adolescent girls at risk. • Child marriage is closely linked to early childbearing, with consequences that can be fatal. Limited access to reproductive health information and services for both unmarried and married adolescents contributes to these harms. • Child marriage also deprives girls of life opportunities.

Table partially adapted from: Chimphamba Gombachika, B. and others (2012). "A Social Ecological Approach to Exploring Barriers to Accessing Sexual and Reproductive Health Services among Couples Living with HIV in Southern Malawi," *ISRN Public Health*, Article ID 825459. Available at: https://www.hindawi.com/journals/isrn/2012/825459/cta/

Step 3. Fully integrate gender analysis and gender equality considerations into planning and programming to reduce barriers and improve access to and use of sexual, reproductive, maternal, newborn, child and adolescent health information and services.

Applying a gender lens to the Social Ecological Model can help a programme planner or implementer identify and understand how they can effectively contribute to strengthening gender equality through SRMNCAH programming, whether on one level or multiple levels of the model, in turn affecting how SRMNCAH information and services are demanded, delivered and experienced. Fully integrating this type of gender analysis throughout the programming cycle is an important step to making programmes more responsive to the health-related needs of women, children and adolescents. This constitutes the third step in the framework for action.

By integrating gender analysis alongside human-rights-based approaches at every stage of the programming cycle (design, development, implementation, and monitoring and evaluation), programmes that affect women's, children's and adolescents' health will be better able to identify and address barriers that impede progress on SRMNCAH. Depending on the type of programme and context, areas of intervention might be concentrated at one or several levels of the Social Ecological Model.

An assessment tool to determine the extent to which gender equality is considered in a programme's design, implementation and scale-up is included as **Checklist #2: Tool for gender-responsive SRMNCAH programming**. **Table 2** highlights an approach for programme planners and implementers to ensure gender is addressed throughout their programming cycle.

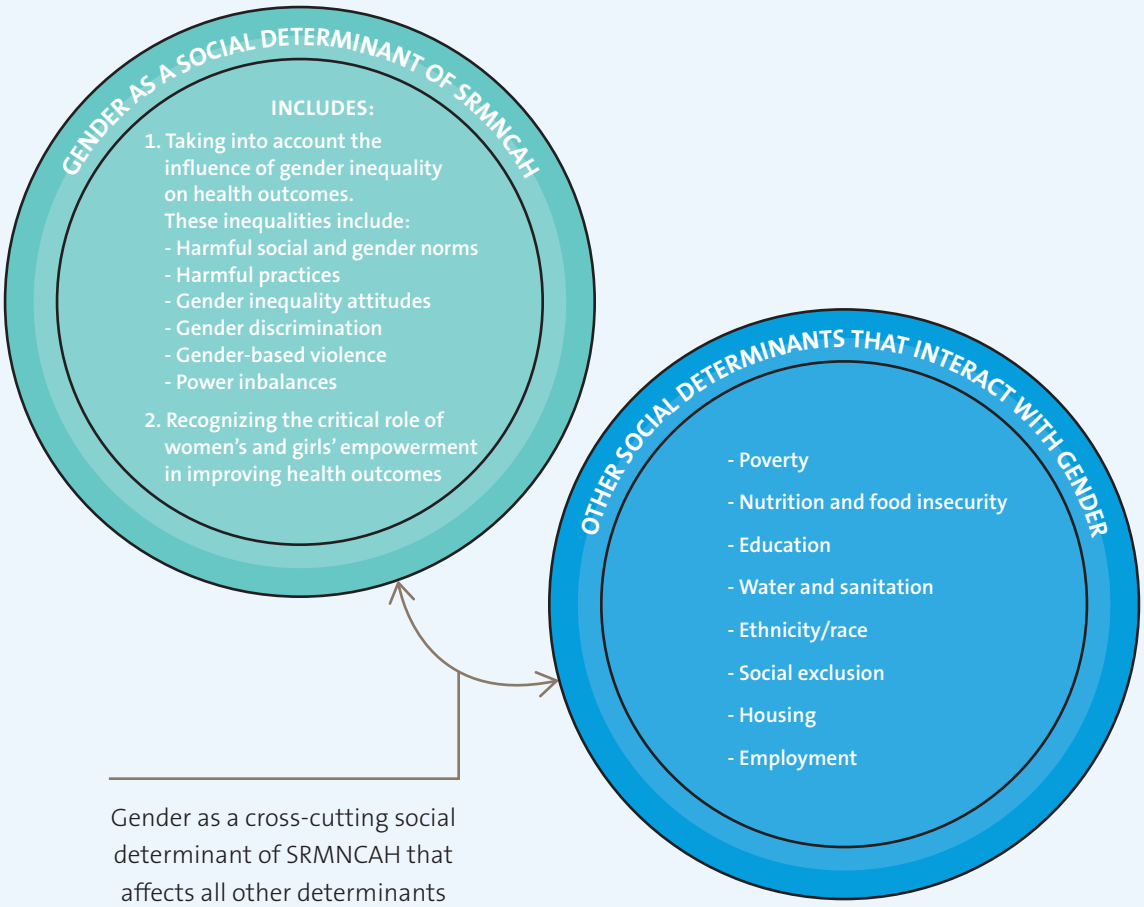
TABLE 2

Illustrative example of how to address gender during the stages of the programming cycle

Stage of programming cycle	How to integrate gender equality considerations into SRMNCAH
DESIGN AND DEVELOPMENT	• Integrate gender considerations into the design and development of SRMNCAH programme and policy support activities by conducting gender analysis that examines how gender influences SRMNCAH on all five levels of the Social Ecological Model. • Identify strategies to reduce barriers that undermine the sexual and reproductive health of women and girls and the health outcomes of women and their children, as well as strategies to increase women's empowerment. • Identify specific interventions across different sectors (health, education, energy, women's empowerment and gender equality, finance, justice, agriculture, etc.) that contribute to gender equality and women's empowerment, supporting the achievement of SRMNCAH outcomes. • Use baseline data including sex-disaggregated data on specific gender issues to identify gender equality objectives and establish feasible gender equality targets.
IMPLEMENTATION	• Ensure gender remains a focus during implementation by reviewing monitoring data to assess differential impacts on women and men, girls and boys and the impact on gender equality, adjusting programme implementation as needed.
MONITORING AND EVALUATION (M&E)	• Ensure the monitoring and evaluation plan effectively measures the programme's influence on gender equality. See **Checklist #2: Tool for gender-responsive SRMNCAH programming** for further guidance. **Annex 3** provides illustrative gender indicators for SRMNCAH programming. • Evaluate whether the programme reduced the health gaps between women and men, girls and boys, and increased gender equality.

FIGURE 6

Gender inequality as a cross-cutting determinant of SRMNCAH



Recognizing gender inequality as a cross-cutting determinant of health and identifying different pathways through which these inequalities impact SRMNCAH are critical components when planning and implementing programmes that affect the health of women, children and adolescents (**Figure 6**). It also involves non-health sector interventions (such as those within education, water and sanitation, and energy and environment sectors) since programmes beyond the health sector make important contributions to reducing gender inequalities and improving SRMNCAH outcomes for women, children and adolescents. The framework for action recognizes these contributions and advocates for stronger collaboration between the health and other sectors to deliver joint or "co-benefits" for SRMNCAH. This is supported by research showing that greater collaboration across sectors maximizes health benefits for women, children and adolescents while also supporting their empowerment and realization of their rights.[66] When planning and delivering SRMNCAH services, ensure that gender is addressed as a cross-cutting social determinant of SRMNCAH, which affects all other determinants.

Step 4. Promote action on empowering women and girls to demand and realize their rights to services to improve their health and well-being.

The framework for action supports a women's empowerment approach. The framework recognizes that personal relationships, social networks, communities and society affect a person's decisions and behaviours. When it comes to accessing and using SRMNCAH information and services, the Social Ecological Model shows how demand for SRMNCAH services is determined not only by individual attributes, such as knowledge and attitudes, but also by household members and peers, community support, access to resources, and broader social and structural policies and norms.

Too often, these demand-side factors – and the role of gender inequality in influencing demand – are overlooked in programmes that affect the health of women, children and adolescents. Greater attention is given to supply-side factors of SRMNCAH, such as skilled human resources, infrastructure and availability of essential commodities, with less attention paid to whether information and services, once made available, are able to be used. Even where information and services are available, gender inequality has a major impact on whether these can be accessed and used.

The fourth and final step in the framework for action calls for greater programmatic attention on:

- the engagement of women in decision-making as agents of change and ensuring this at each level of the Social Ecological Model; and
- ensuring that women have knowledge and information regarding the services available, and that they have the right to demand these services.

By engaging women as agents of change and increasing their awareness and knowledge of their SRMNCAH rights, as well as enhancing their capacities to know and advocate for those rights, women are more likely to demand and claim their rights. **Box 6** describes how empowered women are demanding SRMNCAH

BOX 6

Amplifying women's voices on what they want

With the knowledge that health care is more effective when it is informed by the people it is meant for, the White Ribbon Alliance and partners launched the *What Women Want* campaign in April 2018 to hear directly from women and girls worldwide about how they define quality maternal and reproductive health care and their top needs. It aims to expand the movement for quality health care for women and girls, helping governments, health professionals and civil society organizations to understand what is most important to women and girls.

With a target of reaching 1 million women and girls, one year later, an unprecedented 1,187,738 women had responded from 114 countries. While responses are still being analysed, preliminary findings indicate that women want to be treated with dignity and respect by health providers, they want clean facilities and privacy. Women and girls also want comprehensive information and services that are provided without judgement, no matter their economic status, religion or age. A consistent theme across countries and continents is that women simply want to be heard.

After the final results are reported, national dialogues will engage cross-sector stakeholders to fully explore responses from the women and girls in their own countries and devise advocacy agendas that will respond directly to their demands.

Sources: "What Women Want: Demands for Quality Healthcare for Women and Girls." Available at: https://www.whatwomenwant.org/. Preliminary findings provided by the What Women Want campaign.

TABLE 3

Strategies to empower women at each level of the Social Ecological Model

Level of the Social Ecological Model	How women's empowerment influences SRMNCAH	Strategies to empower women
INDIVIDUAL	Women and girls have the ability to expand their sexual and reproductive health choices and achieve basic needs and rights.	• Increase women's and girls' access to SRMNCAH information and skills. • Increase awareness of women and girls about gender. • Ensure women and girls have a legal identity and increase their knowledge of laws.
INTERPERSONAL	Women and girls have equal and positive social relationships with men and boys in their families, as well as in their peer and social networks, allowing them to protect their own health and that of their families.	• Shift gender norms to support women's decision-making authority, freedom of movement, etc. • Increase equitable access and control over household and public resources.
ORGANIZATIONAL/ COMMUNITY	Women and girls are empowered to engage with community and organizational structures to advocate for their own sexual and reproductive health needs and the needs of their families.	• Provide leadership training for women and girls. • Increase participation of women and girls in civil society. • Increase access of women and girls to education and economic opportunities.
POLICY/ENABLING ENVIRONMENT	Women and girls are empowered to advocate for legal and policymaking structures that support their sexual and reproductive health choices.	• Increase participation of women and girls in legal and policymaking structures. • Increase participation of women and girls in gender-responsive budgeting. • Advocate for laws and policies that support women's rights.

services that meet their needs through the *What Women Want* campaign.

Achieving this requires identifying opportunities and actions within programmes to empower women and adolescent girls to make informed choices, seek services and fully exercise their rights. These actions and interventions can take place at one or several levels of the Social Ecological Model, within programmes that directly (e.g. antenatal, delivery and post-natal care services) or indirectly (e.g. clean water initiatives) affect the health of women, children and adolescents. Women leaders and gender champions should also be enlisted to promote engagement and demand rights. **Table 3** offers examples of actions to empower women at various levels of the Social Ecological Model.

Women can be powerful agents of change when placed in leadership positions in SRMNCAH programmes and other programmes that directly affect their own lives. Women's leadership is crucial not only from a rights perspective but also because of the impact of women's leadership on health outcomes. For example, studies in India have found that women politicians were more likely to invest in public health infrastructure, and higher shares of women in parliament were associated with increased use of antenatal care, increased early breastfeeding, lower numbers of home deliveries, and increased child immunizations.[67] In the United States, women lawmakers are more likely than men to sponsor bills related to education, health care and children's issues.[68]

However, fewer women reach health leadership positions, despite women being the overwhelming majority of home caregivers and front-line health workers. Women in the health workforce are paid less, are less likely to be promoted, and are often discriminated against. An analysis of 32 countries found that in 2010 women contributed USD $3 trillion to global health care, but nearly half of that was unpaid.[69] Regardless of the number of women in the health workforce, they are poorly represented in leadership roles.[70] In 2015, only 27 per cent of Ministers of Health were women.[71] Only a quarter of State delegations to the 68th World Health Assembly in 2015 had a chief delegate who was a woman.[72]

Positive change requires change at all levels of the Social Ecological Model. Individual beliefs and attitudes about women's leadership must be changed. Support should be provided by increasing access to training and leadership positions, human resource policies that support women in all of their roles and throughout their life course, gender-responsive policies, labour market policies, recognition of women's unpaid contributions to health-care and caregiver support policies, and the elimination of discrimination in compensation.[73]

Increasing demand depends on the collaboration of male partners, households, communities and societies, including parents/guardians and family members, community leaders, health-workers, media and policymakers. It requires multilevel, multisectoral collaboration on building demand for SRMNCAH services in ways that take gender inequalities into account and increase women's and girls' empowerment to seek out and use these services. Men and boys are important allies in efforts to improve women's SRMNCAH.

Men and boys are often inadequately addressed or entirely absent from SRMNCAH interventions; yet they are vital for shifting gender norms towards gender equality, as well as for increasing the demand for and utilization of SRMNCAH commodities and services. Evidence shows that men who are well-informed about their sexual and reproductive health are more likely to make better health choices for themselves, their partners, and their families than men who lack this knowledge.[74] Studies have shown that male involvement in SRMNCAH improves maternal and child health outcomes, including shortened labour time and fewer low-birth-weight infants in low-income families. Principles for engaging men in SRMNCAH identified by UNFPA and EngenderHealth are described in **Box 7**.

BOX 7

Principles for engaging men

The following set of principles are meant to serve as examples when involving men in SRMNCAH. A similar set of principles can be developed to guide organizations and individuals in their work with engaging men to ensure a rights-based and gender-responsive approach to SRMNCAH:

- View men as clients of sexual and reproductive health services with a right to the highest attainable standard of health, aside from their role in supporting the health of their partner or family;
- View men as part of the solution and work to increase their sense of ownership of new initiatives that promote gender equality and women's empowerment;
- Question rigid gender norms and promote more equitable behaviour among staff and clients;
- Ensure that funding efforts to involve men do not detract from ongoing and planned work with women and girls;

BOX 7 (CONTINUED)

Principles for engaging men

- Assure women the choice as to whether to include their partners in reproductive and sexual health counselling, service-delivery and treatment. Staff must be trained to counsel couples and recognize possible controlling or violent behaviour by a partner;
- GBV, including physical violence and sexual harassment, can never be tolerated. It must be recognized in programming (at the very least through referral relationships);
- Ensure that the SRHR of everyone are respected, irrespective of sexual orientation and gender identity;
- Ensure that rights-based community values and experiences are respected;
- Involve men from a positive perspective, understanding that they can play a positive role in their partner's health and in their own SRH;
- Encourage relationships between men and women based on mutual trust, respect, ownership of decisions and their outcomes, shared benefits and equal opportunities; and
- Ensure that positive changes that can result from involving men are extended to women.

Sources: United Nations Population Fund and Engender Health (2017). Engaging Men in Sexual and Reproductive Health and Rights, Including Family Planning: Why Using a Gender Lens Matters. New York: UNFPA; World Health Organization (2015). WHO Recommendations on Health Promotion Interventions for Maternal and Newborn Health. Geneva: WHO.

Beyond specific health interventions, men and boys are instrumental to shifting gender norms towards gender equality. Engaging men as agents of change in SRMNCAH includes the promotion of gender-equitable fatherhood, advocacy against discriminatory laws and policies, and changing attitudes and behaviours that are a cause and consequence of sexual and GBV and women's inequality.[75] For example, the HeForShe[76] solidarity movement – which UN Women launched in 2014 – offers a systematic approach and targeted platform where a global audience can engage and become change agents working to achieve gender equality. The movement aims to encourage all genders to take action against negative stereotypes and behaviours.

4.3 The framework for action in practice: Programmatic case studies

The following case studies illustrate how a gender lens has been used in SRMNCAH programming to strengthen gender equality. The examples are varied in geography, scope and the way they utilize a gender-based approach, yet all of them provide strong illustrations of how an intervention can support improvements in gender equality and health and promote the realization of rights for women, children and adolescents.

Case study 1. SASA! A gender-transformative, community mobilization approach for preventing violence against women and HIV

THE ISSUE

Global and regional estimates published by WHO show that one in three women worldwide have experienced either physical or sexual violence in their lifetimes. Gender-based violence (GBV) is one of the most extreme and harmful manifestations of gender inequality. GBV hinders access to RMNCAH information, commodities and services; limits the ability of women and adolescents to exercise their sexual and reproductive health and rights; and leads to poor RMNCAH outcomes. Women and girls are disproportionately affected by GBV, but young men and boys are also affected and their reporting rates are lower. Violence, in addition to being a human rights violation, is also associated with poor maternal health outcomes, lower rates of modern contraception and less autonomy in SRH decision-making. In addition, there are negative outcomes for children with a parent who has experienced GBV. Evidence from research and programmatic experience shows that violence against women can be prevented through interventions that target the key driver of violence – unequal gender power relations. In Uganda, 2011 data from the capital and largest city, Kampala, showed that 45 per cent of ever-married women aged 15 to 49 reported lifetime experience of physical and/or sexual violence by their current or most recent partner and 9.5 per cent are living with HIV.[77]

The programme intervention SASA! means "now!" in Kiswahili. This comprehensive approach combines tools and a systematic process for community mobilization to prevent violence against women and HIV. SASA! was developed by Raising Voices (a non-governmental organization in Uganda) and was first implemented in Kampala by the Center for Domestic Violence Prevention, a local civil society organization. The duration of the original SASA! programme in Uganda was from 2007 to 2012.

AIM

To change community attitudes, norms and behaviours that result in gender inequality, violence and increased HIV vulnerability for women.

LEVEL OF INTERVENTION (SOCIAL ECOLOGICAL MODEL)

Individual, interpersonal, community, organizational, policy

APPROACH

SASA! works to mobilize communities by changing community attitudes, norms and behaviours that result in gender inequality, violence and increased HIV vulnerability for women. The central focus of the intervention is to promote a critical analysis and discussions of power and inequality of power. In Uganda, training for the community was provided using *SASA! An Activist Kit for Preventing Violence against Women and HIV*. Staff from the Center for Domestic Violence Prevention trained 400 activists in Kampala to implement SASA!. Surveys of 1,583 community members spanning the ages of 18 to 49 were taken at the start of the programme; four years later, 2,532 surveys were taken at the end of the programme.[78] Changes were assessed for violence and HIV-related outcomes. Communities learned how to respond to women's experiences with violence and how to hold men accountable. Partner communication increased and communities experienced a reduced social acceptance of violence and gender inequality. The programme made a deliberate effort to focus on power dynamics, as all people experience feeling powerful and powerless in certain circumstances. This allowed participants to tap into their own experiences on both ends of power dynamics, whereas when only gender inequality was discussed, men may have felt excluded.

CROSS-SECTORAL COLLABORATION

Community activists are trained on issues of violence, power and rights, along with staff from other sectors – including police and health services. SASA! works at all levels on national policies and media, with police and health-providers, among friends, relatives and neighbours, and with individual men, women and youth. SASA! fosters knowledge of violence as a problem, as well as public debate, discussion and personal reflection. As part of a multisectoral response, SASA! has also successfully reduced physical violence by school staff against primary students in Uganda using *SASA!'s Good School Toolkit*.[79]

LEARNINGS, OUTCOMES AND IMPACT

A multisectoral response can prevent violence, with significant outcomes in both violence reduction and HIV-related outcomes. A pair-matched cluster-randomized controlled trial, conducted in eight communities (four intervention, four control) in Kampala found that SASA! was significantly associated with: lower social acceptance of IPV among women and men; significantly greater acceptance by both men and women that a woman can refuse sex; 52 per cent lower past-year experience of physical IPV among women; and lower levels during the past year of sexual IPV among women.[80] Women experiencing violence in intervention communities were more likely to receive supportive community responses. Moreover, reported past-year sexual concurrency (overlapping sexual relationships) by men was significantly lower in the intervention group compared to control communities. Both reduced sexual concurrency by men, in addition to the increase in women's ability to refuse sex, are critical to preventing HIV acquisition and transmission.

SCALE-UP/REPLICATION OPPORTUNITIES

SASA! is currently being implemented by 60 organizations in 20 countries including: Botswana, Burundi, Ethiopia, Kenya, Malawi, Rwanda, South Sudan, Tanzania, Zambia, Iraq, Pakistan, Mongolia, Haiti, Honduras, and Uruguay, in addition to Uganda. Various types of adaptations are occurring through translation, cultural adaptations, issue-specific adaptations (e.g. FGM), group-specific adaptations (e.g. faith-based communities), and the integration of activities instead of full-scale implementation.[81] However, more work is needed globally to ensure scale-up. A public-health-approach response to prevention of violence against women is important and SASA! is an example of how this can be done effectively.

Case study 2. A review of evaluation studies: Addressing gender and power in comprehensive sexuality and HIV education

THE ISSUE

Young people are at an elevated risk of unintended pregnancies, STIs and HIV, and further disparities exist for young women. Globally, pregnancy and childbirth are the second leading cause of death among girls 15 to 19 years of age.[82] Adolescent pregnancies lead to higher rates of maternal deaths and morbidity and overall poor RMNCAH outcomes. In 2017, there were an estimated 2.4 million adolescent girls and young women living with HIV, constituting 60 per cent of all young people living with HIV.[83] Data from 2014 suggests that only 20 per cent of adolescent girls and 29 per cent of adolescent boys have comprehensive knowledge of HIV.[84] Young women are particularly vulnerable to the multiple risks that result from the power imbalance of inequitable gender norms, including early sexual initiation, coerced sex and early marriage.

Comprehensive sex education (CSE) programmes are an effective way to reach a large number of young people. CSE,

as defined by the United Nations Educational, Scientific and Cultural Organization (UNESCO), entails assessing the reproductive health needs and behaviours of young people on specific health goals, the risks and protective factors affecting health-related behaviours, and activities that change these risks and protective factors. CSE involves designing activities that are sensitive to community values (consistent with available resources), piloting programmes, obtaining ongoing feedback, focusing on clear goals, and addressing situations that may lead to unwanted or unprotected intercourse. The underlying focus of CSE is on knowledge, values, norms, attitudes and skills through employing participatory teaching methods; providing scientifically accurate information about the risks of unprotected sexual intercourse and the effectiveness of protection methods; addressing perceptions of risk; addressing personal values and norms; and addressing peer norms, skills and self-efficacy. Despite the fears of some community leaders and parents that sex education will encourage young people to engage in sex, evidence indicates that sex education can delay sexual debut and can increase condom or contraceptive use by sexually active adolescents. Evidence on sex education suggests that CSE given to young people before they initiate sex can have positive outcomes on their ability to negotiate safe and consensual sexual activity.

AIM

To assess whether CSE programmes that include a focus on gender and power relations are more effective than programmes without this focus in improving SRH outcomes for adolescents.

LEVEL OF EVALUATION (SOCIAL ECOLOGICAL MODEL)

Individual, organizational/community, enabling environment

APPROACH

Various electronic databases were used to search for studies that included behaviour-change interventions to prevent unintended pregnancy, STIs or HIV that were: group and curriculum-based for adolescents 19 or younger, were published between 1990 and 2012, had rigorous evaluation designs, and measured the effect of the intervention on health outcomes (e.g. acquired STIs or HIV, pregnancy or childbearing). The evaluation considered any mode of curriculum-based sexuality education, delivered in schools, clinics, community settings, multiple settings and a Marine recruit training base. Of the selected 22 studies,[85] seven covered females and the remaining 15 included females and males. In terms of location, 14 were in the United States, six were in low- or middle-income countries, and two were in in high-income countries other than the United States. Sample sizes ranged from 148 participants to more than 9,000.

RESULTS

The review of the selected studies on CSE found that the inclusion of gender and power had a significant effect on programme outcomes. Of the 22 curricula examined, 10 included attention to issues of gender and power and 12 did not. Among the 10 programmes that addressed gender and power, eight (80 per cent) led to significant decreases in one of the health outcomes related to adolescent pregnancy, childbearing or acquisition of HIV or STIs. By contrast, among the 12 CSE programmes that did not address gender and power, only two (17 per cent) significantly reduced rates of pregnancy or STIs. Of the 22 studies, 15 were randomized controlled trials (the strongest possible evidence) and seven were longitudinal cohort studies with controls (also strong evidence); among the randomized controlled trials, eight out of nine (89 per cent) that addressed gender or power had a beneficial effect.

LEARNINGS AND OUTCOMES

The findings of this evaluation align with existing evidence that links gender, power and GBV with HIV and SRH outcomes. To address adolescents' sexual behaviour and health, contextual factors and norms need to be addressed. A CSE programme with a strong gender lens that takes into account power dynamics between males and females allows for young adults to understand the root causes of gender inequality and poor SRH outcomes. Using a gendered approach encompasses understanding gender norms and

attitudes, agency, power in relationships, critical thinking skills, IPV, advocacy and civic participation, school environments, safety and more. CSE rooted in a gender framework incorporates the non-judgmental teaching on SRH to adolescents and leads to empowered young adults that have equal, respectful, non-violent relationships and a strong understanding and ability to access their SRHR. Using participatory, interactive approaches can lead young people to fully embody and apply equal behaviours to their own lives and relationships. Using CSE as an empowering mechanism may result in young people applying healthy behaviours and attitudes to their sexual and reproductive lives, which can carry on into their adulthood.

FUTURE IMPLICATIONS

This review identified four key qualities of a gender and power CSE programme that may lead to positive SRH outcomes as well as an improved understanding of gender inequalities that affect SRH. The common characteristics that emerged from gender-responsive CSE studies that led to positive outcomes include:

- **Attention to gender or power in relationships:** This includes providing teachers with content to explore gender stereotypes and power inequalities in relationships, including handling subtle and non-subtle sexual harassment.
- **Critical thinking of how gender norms or power manifest and operate:** This is context-specific but may involve analysing females in media, harmful practices such as early marriage, power disparities in relationships due to economic or age gaps, or the differences in how males and females express their sexuality because of gender stereotypes.
- **Fostering personal reflection:** When participants can reflect on how gender and power relate to their lives, sexual relationships and health, they can better understand systematic and structural barriers to one's SRHR. This includes discussing relationships, sexual coercion, intimate partner violence (IPV), gender norms and more.
- **Valuing oneself and recognizing one's own power:** Acknowledging the power to change one's self, relationships or community is a recurring theme in the successful studies. Many of the programmes focused on young women's power, agency and self-respect. Intersectionalities, including ethnic and racial pride, were also included.

Case study 3. Gender Roles, Equality and Transformations (GREAT) Project: Promoting gender-equitable attitudes and behaviours among adolescents in Uganda

THE ISSUE

Adolescents form one-third of the world's youth population. The age group of 10-19 years[86] is a time of life where it is highly effective to change gender norms. Community beliefs about ideal roles for women and men affect the well-being of girls and boys as they grow into adults. These beliefs may cause adolescents to stop going to school, marry and have children early, miss opportunities to earn a good living, and make decisions that harm their health and the well-being of their families. Many have unmet SRH needs, educational and vocational needs, and experience high exposure to cycles of poverty and violence, leading to poor health and social outcomes. Evidence suggests that gender norms directly influence health-related behaviours, particularly in the key transitional period of adolescence as gender norms and identities begin to coalesce. Adolescence represents an opportunity to lay the groundwork for positive SRH through strengthened social networks. Conditions in the post-conflict setting of

northern Uganda – increased GBV, disrupted social and human services, erosion of cultural traditions, and heightened economic and physical insecurity – may contribute to the adoption and reinforcement of inequitable gender norms, unhealthy behaviours and sexualization of vulnerable youth who lack exposure to positive role models and appropriate conflict-resolution skills and psychological support.

The programme intervention, known as the GREAT Project is funded by the United States Agency for International Development (USAID) and carried out by the Institute of Reproductive Health at Georgetown University in partnership with Pathfinder International, Save the Children, Concerned Parents Association, and the Straight Talk Foundation. The duration of the project spanned from 2010 to 2017. The GREAT Project provided an interactive mixed-media approach to individuals, schools and communities to improve gender equality among adolescents.

AIM

To promote gender-equitable attitudes and behaviours among adolescents (ages 10-19) and their communities with the goal of reducing GBV and improving SRH outcomes in post-conflict communities in northern Uganda.

LEVEL OF INTERVENTION (SOCIAL ECOLOGICAL MODEL)

Individual, interpersonal, community, organizational

APPROACH

The GREAT intervention package promotes reflection, dialogue and action on inequitable gender norms, SRH and GBV. It includes several components in its implementation: a serial radio drama to catalyse discussion and reflection on gender equality, SRH and GBV; a toolkit with flipbooks and community engagement games for young adolescent boys and girls; a Community Action Cycle to encourage community leaders to strengthen their capacity and promote change; training for Village Health Teams to improve access to and quality of youth-friendly SRH services; and implementations of the programme in classrooms through school clubs. Additionally, the project recognizes those who demonstrate commitment to gender-equitable behaviours in the community.

CROSS-SECTORAL COLLABORATION

The intervention involved various collaborations across sectors, including communities, health clinics, media and schools. Community leaders and mobilizers engaged in collective dialogue and action to foster change and improve social norms and attitudes towards gender, reproductive health and violence. Village Health Teams were trained to meet the needs of adolescents, reduce stigma of SRH service-delivery, and provide more gender-sensitive services to community members. Support was also provided to health-care facility staff to deliver stigma-free care. A local serial radio drama was broadcast across implementation areas to discuss decisions around relationships, sexuality, violence, alcohol, sharing of resources and responsibilities, and parenting. Radio discussion guides were provided for small groups of adolescents to relate the radio drama to their own lives. Other activities and games were also provided to adolescents in community settings and schools to understand puberty, sexual health and gender norms, and promote gender-equitable behaviours.

LEARNINGS, OUTCOMES AND IMPACT

Using gender-transformative practices to teach young adolescents about their SRHR can lead to a positive passageway to adulthood, healthy behaviours, gender-equitable lives free of violence and unintended pregnancy. It also fosters positive community engagement among members at all life stages. The project's endline survey showed improvements among adolescents exposed to the intervention: 48 per cent of older adolescents (14-19 years) exposed to the GREAT Project believed men and women are equal, compared to 37 per cent in the non-exposed group; 10 per cent more newly married and parenting respondents were using family planning as a result of the intervention; and 9 per cent fewer older adolescents and 4 per cent fewer newly married/parenting individuals believed a woman should tolerate violence to keep a family together.[87] GREAT led to notable

improvements in the attitudes and behaviours of those involved in the project, particularly towards gender norms, family planning and GBV.

SCALE-UP/REPLICATION OPPORTUNITIES

As the project was designed with scale in mind, the model highlights the need for multisectoral linkages to catalyse widespread, sustainable movements to challenge harmful gender norms and support positive health outcomes at individual and community levels. In 2015, the GREAT Project was scaled to two new districts in northern Uganda and expanded in current intervention districts, with additional trainings of Village Health Trainers. Partners Pathfinder International and Save the Children have introduced the GREAT model worldwide, particularly in francophone West Africa and Mozambique. The Institute of Reproductive Health has adapted the GREAT curriculum in Rwanda. A GREAT Project scalable toolkit and Community Action Cycle Implementation Plan are also available for the global audience on the Institute of Reproductive Health website.

Case study 4. Malawi Parliament adopts constitutional amendment to end child marriage

THE ISSUE

Child marriage is a harmful practice that disproportionately affects girls and is rooted in the perpetuation of gender inequalities. More than 650 million women in the world today were married as children; more than one in three married before the age of 15.[88] Girls married before the age of 18 are less likely to continue their education, more likely to experience violence, less able to negotiate contraception use, and face increased complications in pregnancy and childbirth. Early marriage is often rooted in discriminatory practices, such as dowry, strategic economic survival of families, the encouragement of premature childbearing, and disproportionate investments in boys' educations and futures. Females in the poorest quintile are 2.5 times more likely to marry during childhood than those in the wealthiest quintile.[89]

Malawi has one of the world's highest rates of child marriage, with one in two girls married before they reach the age of 18. Teen pregnancies contribute up to 30 per cent of maternal deaths in the country. Child marriage in Malawi has poor outcomes for girls' educational status, as less than half the girls in Malawi (45 per cent) remain in school past 8th grade.[90] In Malawi, nearly two-thirds of women with no formal education were child brides compared to 5 per cent of women who had attended secondary school or higher.[91]

AIM

To raise awareness on the harmful effects of child marriage and lobby for legislative change to ban child marriages in Malawi.

LEVEL OF INTERVENTION (SOCIAL ECOLOGICAL MODEL)

Community, policy

APPROACH

Through consistent advocacy efforts, UN Women Malawi has played a critical role in lobbying to increase the legal age of marriage and working with traditional leaders to understand the harmful effects of child marriage and annul existing customary marriages. Civil marriages can be ended under civil law, but customary marriages are regulated by cultural practices and traditional leaders. UN Women worked

with its partners to raise awareness on child marriage and advocate for legislative change. In April 2015, Senior Chief Inkosi Theresa Kachindamoto supported this initiative and annulled 330 customary marriages in the Central Region of Malawi to encourage young boys and girls to continue their schooling and have a healthy childhood. Although she was faced with resistance from community leaders, especially in unions with a dowry involved, she continued campaigning in communities, with members of the Village Development Committee, faith-based leaders and NGOs to support ending and annulling child marriages. During this time, the Malawian Parliament passed and enacted the Marriage, Divorce and Family Relations Act, raising the minimum age of marriage without parental consent to 18 years.[92] Chief Kachindamoto had also previously suspended village heads that consented to child marriages, but the 2015 Act allowed all Chiefs to regulate suspensions under this law. UN Women and partners supported traditional leaders and the Ministry of Gender, Children and Social Welfare to ensure the 2015 law was understood and implemented, and to move forward in achieving gender equality for adolescent girls and young women.

In February 2017, the Parliament made a monumental decision to ban child marriage in the country's Constitution.[93] The Parliament unanimously voted for a constitutional amendment raising the minimum age of marriage for girls and boys to 18 years. Doing so removed a legal loophole in the 2015 Marriage, Divorce and Family Relations Act, allowing parents to provide consent for their child's marriage between the ages of 15 to 18. During this time, UN Women provided support to the constitutional review process, carried out key consultations for the amendment, and mobilized other UN agencies and civil society to work with the Ministry of Justice and Constitutional Affairs and Women and Law in Southern Africa to ensure the engagement of all stakeholders. Going forward, UN Women will continue to partner with civil society to change harmful, gender-based practices and ensure effective implementation of the law. They will also support the Ministry of Gender and Justice to harmonize this new amendment with other discriminatory legislations against women and girls.

CROSS-SECTORAL COLLABORATION

In order for this law and constitutional amendment to be adopted, various actors came into play to influence, encourage and help lawmakers and traditional leaders understand the importance of ending child marriage. Taking steps towards ending child marriage in Malawi required traditional leaders and chiefs, UN agencies, civil society organizations, youth-driven campaigns, ministries of Gender and Justice and Constitutional Affairs, law agencies and more. The collaboration and activism from a diverse group of stakeholders – from the grass-roots level to the parliamentary level – contributed to the success of the constitutional amendment.

LEARNINGS, OUTCOMES AND IMPACT

The impact of passing this law and constitutional amendment will have far-reaching benefits for married girls and boys in Malawi today, those culturally of age to be married, and for the many generations of youth to come. Enacting and enforcing these laws, with the community-based advocacy of district chiefs and traditional leaders, will allow young women and girls to look forward to their education, livelihood opportunities and good health. Preventing child marriage allows young women and girls to thrive, reducing their risk of early pregnancy, childbirth complications, IPV, or exposure to HIV and STIs. When young women and girls can grow to their full potential, they can make informed decisions around their sexual health, claim their reproductive rights, and invest in a more positive future.

SCALE-UP/REPLICATION OPPORTUNITIES

The monumental efforts of Malawi to outlaw child marriage set an example for other regions, countries and communities to fully understand the many harms that exist in reinforcing such gender discriminatory practices. It is a strong example for others to see how to help community leaders and local and national government understand the importance of ending child marriage and embody practices to contribute to a more equal and prosperous society.

Case study 5. Engendering the inter-agency response to the Zika epidemic in Brazil

THE ISSUE

As new global epidemics emerge, women are often placed at the centre of impact – especially when it is related to sexual health. HIV, Ebola and Zika viruses are similar in nature as they have led to the perpetuation of gender stereotypes. Women are often responsible for containing disease transmission, preventing infection and caring for ill family and community members. This burden exacerbates during emergency responses, when health systems are dysfunctional. In early 2015, the Zika virus spread from Brazil to 72 countries and territories causing a global epidemic until November 2016. The virus especially impacted the Americas and the Caribbean. Zika is a mosquito-borne disease that can also be sexually transmitted from a male to his sex partners. Aside from typical, flu-like symptoms, Zika can cause Guillain-Barré syndrome, which damages a person's nervous system. Zika virus infection during pregnancy can also cause microcephaly in the fetus – a congenital malformation resulting in a smaller than normal head size for an infant. Microcephaly can lead to other birth defects and neurological conditions.

Brazil was disproportionately affected by the Zika virus epidemic. Between 2015 and May 2017, the Pan American Health Organization (PAHO) suspected 223,230 cases and confirmed 133,527 cases. There have also been 2,698 confirmed cases of congenital syndrome associated with the virus. Although the Zika virus is no longer considered an epidemic, it left many lessons to learn about setting up adequate, gendered emergency health responses during crisis situations. The fear of Zika, similar to Ebola and HIV, drove many people away from testing and medical attention and, therefore, perpetuated transmission. Addressing the Zika epidemic required strong information campaigns, peer education and access to care. During this epidemic, women and girls faced additional burdens of the virus. Zika thrives in conditions of inequality and dysfunctional health systems, bringing additional burdens of care to women. A 2016 study revealed that 57 per cent of women surveyed avoided or attempted to avoid pregnancy due to the Zika epidemic. Fearing pregnancy is not the solution, instead, it is critical to provide information and education on how Zika can be sexually transmitted and the ways to prevent or address infection. A focus on pillars of prevention, strengthening health systems, and ensuring national strategies and plans to address the sexual and reproductive needs of women and girls can lead to improved responses during emergencies and epidemics involving STIs.

AIM

To engender the Zika response and bring women's human rights into policies, programmes and investments to ensure women's voices, needs and demands are at the centre of the response of governments.

LEVEL OF INTERVENTION (SOCIAL ECOLOGICAL MODEL)

Community, enabling environment

APPROACH

UN Women's role in Brazil's Zika response was multifaceted and targeted communication efforts and research around women's rights in the response to the virus. The most prominent activity was the "Situation, Advocacy and Mobilization Room for Women's Rights, including Sexual and Reproductive Health Rights, in the Context of the Zika Virus Epidemic." The Brazilian Situation Room is a coordination space convened by UN Women, the United Nations Population Fund (UNFPA) and PAHO/WHO, which has the regular participation of 45 organizations representing Brazil's diversity. It is a space to identify ongoing strategies and share information about how challenges are being met in confronting epidemics spread by the 'yellow fever mosquito', such as Dengue, Yellow Fever, Chikungunya and Zika. These diseases particularly affect poorer, Afro-Brazilian women living in situations of economic, social and environmental vulnerability. In 2016, UN Women, UNFPA and PAHO/WHO also developed a communication strategy in partnership with the Secretariat of Women's Policies and the Brazilian Public Media Company. It

involved the production of radio programmes underscoring the health and rights of women, TV programmes focused on the voices of women, and dissemination materials for women and health professionals distributed throughout states and municipalities. In the research realm, UN Women supported a consortium of 10 women's organizations in Brazil to implement participatory, action-oriented research with women in communities most affected by Zika. These community dialogues supported dissemination of information on prevention as well as on social services such as access to health care. The research process focused on enabling women to engage in advocacy activities with their local authorities. During the Zika epidemic in Brazil, and broadly in Latin America and the Caribbean, UN Women played a vital role in ensuring women's voices, needs and demands were at the centre of the response of governments and society. This includes a wide range of policies and investments to prevent infection, plan for women's reproductive lives, investments in water and sanitation, and comprehensive SRH services. Treatment, support and rehabilitation services for children with Congenital Malformations Syndrome were also provided.

CROSS-SECTORAL COLLABORATION

UN Women's participation in Brazil's Zika response was in partnership with many agencies, including UNFPA, PAHO/WHO, government departments such as the Special Secretariat of Policies for Women and the Ministry of Women, Racial Equality and Human Rights, as well as civil society organizations and women's health experts.

LEARNINGS, OUTCOMES AND IMPACT

Government and academic institutions have acknowledged the Situation Room as an important body. The Situation Room created opportunities to emphasize the importance of developing policies, research and other initiatives to guarantee that women's voices are heard, their needs are met, and all their rights are guaranteed. These policymakers have recognized the role of women and their organizations to ensure a comprehensive response to the epidemic. Through this intervention, targeted messages and communications materials disseminated through various channels along with the multisectoral coordination platforms helped spread information and awareness among pregnant women, women of reproductive age, men and health professionals.

FUTURE IMPLICATIONS

During an epidemic, it is imperative to focus on the larger picture of prevention, treatment, care and support. Working with governments, civil society, women's organizations and human rights groups is important to bring strong pillars of prevention and treatment as well as ensure national strategies address the needs of women and girls.

Collecting sex-disaggregated data can also help improve understanding of women's vulnerabilities to such epidemics, including barriers they face due to unequal social norms, legal frameworks, and laws that may inhibit their ability to access services. It is essential to integrate SRH into these responses and engender the approach to addressing epidemics.

Case study 6. Integrating gender equality in civil registration and vital statistics in Thailand

THE ISSUE

Civil registration and vital statistics (CRVS) refers to the registration and legal record-keeping of vital events, such as births, deaths, causes of death, adoptions, marriages and divorces of a population. Well-functioning civil registration systems create records of events and provide individuals with necessary documentation to secure recognition of identities

and family relationships and ensure their rights as citizens. Identity documentation also provides access to essential services, including health and education. It facilitates voter registration, allowing an individual to exercise electoral rights and ensures rights to inheritance, access to bank accounts and loans, and more. Civil registration also provides the basis of a country's vital statistics system. Vital statistics refer to the quantitative data concerning a population.

Civil registration and identification are especially important in societies where women are restricted from exercising citizen rights or are denied access to essential services and entitlements. CRVS systems need to function in a manner that serves the needs of all individuals and collects data that reflect the vital events of all – including women and girls. Women face unique barriers to accessing CRVS systems and identification documents, including distance, cost and regulations that place demands on women that are not required for men. Gender inequality within CRVS systems is directly related to the lack of access to legal identity documents, resources and services and, importantly, a significant gender data gap. Identity documentation expands economic opportunities by allowing women to acquire, claim, transfer and dispose of physical and financial assets independently. It also increases women's independent access to services and entitlements, and expands women's voting and political rights and opportunities. More importantly, it is a basic vehicle to increase women's voice and agency and their ability to both contribute to and benefit from development.

Currently, there are approximately 27 countries that have discriminatory laws that affect women's ability to register for their own identification documents or transfer citizenship to their children.[94] As universal birth registration is mandatory in international human rights law, boys and girls are registered about equally. Women in many countries are disadvantaged, however, due to not being able to register their children without the father's signature. Such legislations discriminate against the agency and autonomy of women in the household. Efforts are required to integrate the needs and contexts of women and girls at the individual and public health level. To ensure women and girls have equal access to and use of CRVS systems, it is necessary to address gender-related barriers at the individual, community and institutional levels in line with processes linked to CRVS systems.

AIM

To ensure all children born in Thailand are registered at birth, regardless of their parents' ethnic or legal status, and work towards integrating birth registration as a hospital-based practice.

LEVEL OF INTERVENTION (SOCIAL ECOLOGICAL MODEL)

Individual, interpersonal, enabling environment

APPROACH

Data from Thailand's National Statistical Office shows that nearly all children under the age of 5 are registered at birth. Yet, the survey also found that the number of children registered at birth is lower among mothers with low education. Additionally, the birth registration rate for children born in non-Thai households is only 79.2 per cent, although the Civil Registration Act states that any child born in Thailand regardless of their parents' legal status has the right to be registered and obtain a birth certificate.[95] UNICEF worked with the Department of Provincial Administration of the Ministry of Interior to develop an online birth registration programme that links information to a newborn child in a hospital to the civil registration system. When linked, the registrar can instantly track families that have not come to record their child's birth or obtain a birth certificate.

CROSS-SECTORAL COLLABORATION

Setting up the computer registration programme involved close collaboration and support from government agencies. UNICEF worked directly with the Bureau of Registration Administration in the Department of Provincial Administration, Ministry of Interior to develop this programme. The training of staff in all public hospitals on using the new system and monitoring progress was conducted by the National Health Security Office. Working with government systems allowed UNICEF to reach several hundred hospitals with the online birth registration programme and work towards achieving larger outreach.

LEARNINGS, OUTCOMES AND IMPACT

Setting up the computer birth registration programme in public hospitals creates accessibility for mothers who face barriers to registration due to lower literacy, poverty, ethnicity or migration status. Ensuring registration allows a child to access subsidized health care, social welfare services, ability to travel, as well as future education and employment opportunities. It also alleviates the increased vulnerability of exploitation or trafficking they may face due to their undocumented legal status. According to the most recently reported results, 620 hospitals across the country are using the birth registration programme.[96]

SCALE-UP/REPLICATION OPPORTUNITIES

The Bureau of Registration Administration develops and maintains the birth registration project and is currently working with UNICEF to expand the registration system to 900 hospitals nationwide. The end goal is to register every child born in Thailand at birth, regardless of their parents' ethnic or legal status.

Case study 7. Preventing and responding to sexual and gender-based violence in displaced settings of Kenya

THE ISSUE

Sexual and GBV is a fundamental violation of human rights. Individuals in humanitarian settings face complex vulnerabilities and an increased risk of sexual and GBV due to a collapse of family and community systems, limited access to resources, insufficient security and inadequate housing.[97] An increase of IPV also occurs in settings of displacement. Women and girls who are forced migrants experience a disproportionate amount of sexual and GBV compared to men and boys, often attributed to the increased social, economic and cultural strains men face in refugee settings. Women and girls who experience sexual and GBV are at risk of STIs, HIV, unintended pregnancy, unsafe abortion, trauma to the reproductive system, post-traumatic stress disorder, depression, social stigma and rejection from family or community. Experiencing violence in displaced settings can exacerbate these outcomes, with limited access to physical and psychological care services.

Kenya has a long history of integrating refugees, mostly from Somalia, Sudan and Ethiopia. The Dadaab refugee camp is a cluster of sub-camps near the Somalian border. Most of the residents originate from Somalia, with a small proportion from Ethiopia. In August 2012, 6,000 new arrivals from Somalia increased the camp's population to 474,000. In the Kakuma refugee camp located in the northwest region of Kenya, approximately 13,000 new refugees were registered – mostly from South Sudan – raising the population to more than 101,000. By August 2012, the total number of registered refugees and asylum-seekers in Kenya were more than 630,000.[98] In the southern part of the country, 664,000 Kenyan citizens were displaced due to post-election violence after the 2007 presidential election results, which caused inter-ethnic violence. There are still many Kenyans and refugees displaced today, with low security and service-delivery in camps. The incidence of sexual and GBV in displaced areas is difficult to measure but largely underreported. The Human Rights Center at the University of California Berkeley School of Law, along with the United Nations High Commissioner for Refugees (UNHCR) conducted a one-year study in 2012 to understand the needs of refugees, migrants and internally displaced persons who experience sexual and GBV and come up with multisectoral approaches to facilitate access to shelter and critical services.

AIM

To generate evidence to inform donors, policymakers and international and local actors about relevant models, priority challenges and promising practices to address sexual and GBV in settings of refugees, migrants and internally displaced persons.

LEVEL OF INTERVENTION (SOCIAL ECOLOGICAL MODEL)

Individual, organizational, policy

APPROACH

The Human Rights Center conducted in-depth, semi-structured interviews with survivors in four refugee camps across the country. Key informants from the Government, community-based organizations, NGOs and UN agencies also provided additional contextual information.

CROSS-SECTORAL COLLABORATION

This research was conducted with inputs from various actors in the refugee and displacement camps including staff, residents and survivors of sexual and GBV, community-based organizations and NGOs, government officials and UN agencies.

LEARNINGS AND OUTCOMES

The findings discovered a diversity of shelter models, several of which serve refugee and internally displaced survivors of sexual and GBV. To strengthen the response to sexual and GBV in shelters in Kenya, a multisectoral and collaborative effort is required. There is a need for increasing and diversifying shelter options of sexual and GBV survivors, protecting marginalized groups, mapping and monitoring of programmes, enhancing staff training, developing clear referral networks, and fostering decision-making and agency of survivors while ensuring their safety.

SCALE-UP/REPLICATION OPPORTUNITIES

This study is part of a larger series of four country-case studies in Colombia, Haiti, Thailand and Kenya. A comparative report allows for a more global understanding of how sexual and GBV is being addressed for displaced persons.[99] This large-scaled study informs various stakeholders involved in the protection of these populations of the need to understand, monitor and address sexual and GBV in displaced and refugee settings.

Case study 8. Namibia's Supreme Court upholds the rights of women living with HIV

THE ISSUE

Women living with HIV often face stigma and exclusion, aggravated by their lack of rights. A review of the effects of discrimination on women living with HIV revealed painful consequences, such as social rejection, denial, violence within the family and community, and ill-treatment by health-care providers. Women living with HIV are especially vulnerable to SRHR violations. When accessing health-care services, women living with HIV have faced forced and coerced sterilization, refusal of services, hostile attitudes when planning to have children, stigmatizing behaviour by health-care providers, breaches of confidentiality and testing for HIV without informed consent. When women's rights and agency are denied, their ability to protect themselves is limited.

In 2009, a report by the International Community of Women Living with HIV/AIDS (ICW) focused on women in Namibia who had experienced forced and coerced

sterilization due to their HIV status. This practice violated rights guaranteed under the Namibian Constitution and various international laws and human rights obligations. Of the 230 women living with HIV that participated in ICW's research, 40 reported facing coerced or forced sterilization.[100] The key findings from the research were that women who were sterilized had been pressured, sterilized against their will, or sterilized without proper consent. They reported sensing a direct link between their HIV status and encouragement by health providers to be sterilized. Women who faced coerced sterilization were not provided with information on the procedure or its effects, consequences or associated risks. In some cases, women were asked to sign a tubal ligation form to access other reproductive health services such as abortion, caesarean section or childbirth. Some women were also asked to sign forms for tubal ligation without being told the implications of the procedure or being given other options of family planning. Compromises in confidentiality also occurred, for example, when women with HIV were asked to identify themselves and wait in a separate area or non-medical hospital staff provided medical translations during consultations. This report stressed the need to address unwanted sterilization of women living with HIV from a systemic and legal realm.

AIM

To support women living with HIV in seeking legal retribution for sterilization performed by government health providers without full, informed consent.

LEVEL OF INTERVENTION (SOCIAL ECOLOGICAL MODEL)

Individual, interpersonal, enabling environment

APPROACH

ICW, civil society and key legal partners supported three women living with HIV to seek legal redress after undergoing sterilization without informed consent. In November 2012, these three women sued the Namibian Government as their coerced sterilization violated their Constitutional rights to physical integrity and to found a family. In addition, the women asserted that they were sterilized due to their HIV status, violating their right to be free from discrimination. In November 2014[101], the High Court of Namibia ruled that all three women were sterilized without their informed consent and against the law. The Government appealed the High Court's decision because the women had signed consent forms and their claim of not being provided adequate information was not considered relevant. However, when the case reached the Supreme Court, the Government's argument was rejected and it upheld the High Court's decision that the women's constitutional rights were violated. The Supreme Court stated the importance of a woman understanding the nature, risks, consequences and alternatives of sterilization beyond providing written consent. They stressed that consent for sterilization cannot be given when women are in labour or in pain, as such high-stress moments limit their decision-making abilities. The High Court and Supreme Court's judgement set a precedent to ensure that women's human rights are not being violated due to their HIV status.

CROSS-SECTORAL COLLABORATION

Supporting these women stemmed from a larger movement in Namibia to guarantee the rights of women living with HIV. ICW, the Southern Africa Litigation Center, UNAIDS, media campaigns, multiple civil society groups and key partners worked together to advocate for the women affected and ensure their voices were heard.

LEARNING AND OUTCOME

The support of key advocacy groups such as ICW, civil society and key legal partners gave the plea of these three women living with HIV much-needed visibility. After two years of persistence, the case was won in November 2014 in the nation's Supreme Court. This single victory is a step in the right direction for governments to fully investigate claims of coerced and forced sterilization and other forms of discrimination of women living with HIV. Engendering their approach and understanding how the barriers that women face lead to ill-treatment will hold health-care providers more accountable for quality, equitable and informed SRH care.

Case study 9. Empowering women and girls with disabilities in Senegal to manage their menstrual hygiene

THE ISSUE

Formative research conducted in Niger, Cameroon and Senegal for the Joint Programme on Gender, Hygiene and Sanitation found large gaps in girls' knowledge of menstruation. Many of them were also missing school due to the lack of available sanitation facilities. In all three regions, girls were unprepared for their first period. More than one third of girls interviewed in the Louga region of Senegal said they miss school due to lack of water, soap, hand-washing facilities and hygienic toilets.[102] In addition to cultural taboos around menstruation and the lack of adequate infrastructure, women and girls with disabilities face an additional burden in accessing education on their health, including menstruation, and experience poor access to adequate health-care services. This includes difficulty accessing medical facilities and inadequate medical equipment or staff training to address their needs. In the Louga region, women and girls with motor disabilities reported small facilities and narrow doorways preventing access to use public restrooms. Visually impaired women found it difficult to know when they have their period. Women with disabilities reported not being able to manage their menstruation discreetly and on their own, often relying on female relatives for support. Women and girls living in remote areas without water or permanent toilets faced additional complications, especially when menstruating.

The Joint Programme on Gender, Hygiene and Sanitation is designed and implemented by the Water Supply and Sanitation Collaborative Council and UN Women in West and Central Africa, specifically in Niger, Cameroon and Senegal. The pilot programme duration was from 2014 to 2017. One component of the Joint Programme is working with women and girls with disabilities in Senegal to educate them on menstrual hygiene management (MHM) and their rights.

AIM

To support governments in placing measures to significantly improve access to and enjoyment of sanitation and hygiene services by women and girls, including those with disabilities.

LEVEL OF INTERVENTION (SOCIAL ECOLOGICAL MODEL)

Individual, community

APPROACH

The Joint Programme on Gender, Hygiene and Sanitation collaborated with the Gender-Equitable Local Development Programme by conducting workshops and information sessions for women with disabilities in Louga, Senegal. These sessions inform women of laws (e.g., Senegal's social orientation law of 2010) and institutional systems to integrate people with disabilities and empower them to manage their menstrual hygiene. The menstrual hygiene workshops focused on how to use and maintain sanitary materials and how to dispose of menstrual waste in an environmentally-friendly way. Many women participated in the International Day of Persons with Disabilities 2014 march, coinciding with the 16 Days of Activism against GBV campaign, to improve the conditions of people with disabilities.

CROSS-SECTORAL COLLABORATION

The workshops, information sessions and advocacy events were conducted by the Joint Programme on Gender, Hygiene and Sanitation in partnership with the Gender-Equitable Local Development programme. The overarching strategy of the Joint Programme is to work at multiple levels to ensure women and girls' rights to water and sanitation. This includes working to increase budgets for water, sanitation and hygiene (WASH) at the local and central levels, promoting evidence-based policies, partnering with government institutions and non-WASH actors, strengthening existing systems and filling knowledge gaps. The programme closely collaborates with the education, health and environment sectors.

LEARNINGS AND OUTCOMES

As of 2015, 213 women with disabilities from 58 districts of Senegal participated in the International Day of Persons with Disabilities; 59 women benefited from the MHM information sessions. As a result of these sessions, schools in Louga

committed to purchasing sanitary pads for their medical kits, which are available to female secondary school students.

SCALE-UP/REPLICATION OPPORTUNITIES

Women and girls with disabilities are often left further behind due to gender inequalities. They face additional barriers in accessing education, employment and health services. Supporting women and girls with disabilities in understanding their rights, their menstrual health and overall SRH can allow them to prosper and advocate for their civil liberties.

Case study 10. Addressing gender inequalities in maternal death surveillance and response systems of Africa

THE ISSUE

Africa remains a region where women face challenges in pregnancy, as 1 in 39 face risk of death due to pregnancy- or childbirth-related complications. As of 2015, 550 of the 830 maternal deaths occurring every day were in sub-Saharan Africa. Although infrastructural and provider-focused interventions improve the quality of health services, there are many social factors that inhibit women's access to maternal care. Gender inequality has many implications on women's access to and uptake of maternal health services related to decision-making, education, access to resources, violence and more. A study of 31 countries (21 in Africa) found that women's educational, economic and empowerment status are positively associated with the use of maternal health services. Understanding systemic, gender-related barriers and issues that lead to women's maternal morbidity or mortality is critical to improving maternal health. One approach used to investigate and respond to maternal death is a maternal death audit, or an in-depth review of maternal deaths to understand the underlying factors and circumstances contributing to each death. When used correctly, the maternal death audit can improve the quality of care available to pregnant women and improve health systems to reduce the prevalence of maternal mortality.

AIM

To identify gaps related to gender inequality analysis and GBV in maternal death audits (or maternal death surveillance and response (MDSR) systems in Africa), and develop a gender-mainstreaming framework to address these gaps.

LEVEL OF INTERVENTION

Policy

APPROACH

The purpose of this research was to understand the way MDSR systems track gender inequalities and make recommendations on how to improve the tracking of gender-related contributors to maternal deaths. In order to provide a balanced regional representation of Africa, five countries were selected – Chad, Ethiopia, Nigeria, South Africa and Tunisia. Overall, 73 in-depth interviews were conducted across the five countries from key informants, such as representatives from the local health department, a MDSR project coordinator, a community health-care worker, women's group leaders, health-care providers, community representatives and more.

CROSS-SECTORAL COLLABORATION

The African Union Commission partnered with UN Women to conduct this study in a collaborative effort with many government agencies, UN agencies, local health department representatives, NGOs, community leaders and partners working on MDSR. This process also included inputs from the Ministry of Health in all five countries, the Society for

Gynaecology and Obstetrics in each study country, WHO and UNFPA. This study was funded by the Government of France under the Muskoka Initiative.

LEARNINGS AND OUTCOME

The study found that several aspects exacerbated gender inequality and contributed to maternal mortality, including a woman's lack of decision-making power, GBV, adolescent pregnancy, poverty and other socioeconomic factors, cultural factors, health infrastructures, governance, as well as conflict and civil unrest. Respondents shared that patriarchal norms significantly inhibit women's ability to make decisions about when and how to seek services, even during pregnancy-related complications. In Chad, Nigeria and Ethiopia, respondents shared that harmful traditional practices, such as early marriage and FGM, can contribute to maternal morbidity and mortality. The stigma and shame associated with adolescent pregnancy lead to hidden pregnancies and the lack of adequate antenatal care in all five countries. Many respondents struggled to pay for transportation to health facilities, particularly women in rural areas. Low literacy and education were also identified as a contributor to morbidity and mortality. In Nigeria, Chad, Ethiopia and South Africa, the use of traditional healers and birth attendants were a main reason why women facing pregnancy-related complications did not access medical care. Poor governance and policies left girls vulnerable to early marriage in Chad, and respondents in Nigeria indicated that the misuse of funds allocated for maternal health led to ill-equipped health facilities. The study also found that MDSR systems in all five countries do not specifically incorporate the tracking of gender inequality or GBV as a contributor to maternal mortality. Many members of MDSR committees were not informed of the importance of including a gender perspective in maternal audit systems.

RECOMMENDATIONS

The findings from the study informed a framework to support the measurement of and response to gender inequality in MDSR systems in Africa. The four key dimensions and actions to ensure gender-responsive MDSR systems are:

1. **Advocacy:** Target advocacy at the international, regional and national levels to address gender inequality in the maternal health agenda, encourage governments to engender and strengthen maternal health audit systems, and ensure government bodies and stakeholders are responsive to the findings of gender-related contributors of maternal death.

2. **Adapting MDSR guidance documents to be more gender-focused:** Ensure that existing guidelines better track gender-related factors known to contribute to maternal morbidity and mortality.

3. **Strengthening MDSR systems:** Address and improve existing technical, human and financial resources to institutionalize and implement functional MDSR systems, with a stronger emphasis on gender.

4. **Providing gender training to MDSR committees:** Improve the committee members' understanding of gender concepts, provide gender-focused training to health workers and others carrying out maternal death audits, and ensure a gender specialist provides insights on how to ask relevant questions to collect useful data.

SCALE UP/REPLICATION

The result of the study demonstrates the importance of applying a gender lens to programmes that directly and indirectly impact the health and well-being of women and adolescent girls. The governments in this study demonstrated strong political will to respond to consequences of gender inequalities which affect maternal morbidity and mortality. The study further established the importance of mainstreaming gender into MDSR systems. The findings and recommendations of the study provide the necessary basis to replicate such studies elsewhere and mainstream gender into maternal death surveillance and response systems.

5. MULTISECTOR ACTION TO ADDRESS GENDER INEQUALITY AS A DETERMINANT OF SEXUAL, REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH

5.1 The essential role of non-health sector interventions

Many of the determinants of SRMNCAH are outside the health sector. Cross-sector action – such as increasing women's political and economic participation and mitigating and adapting to climate change – has also been shown to contribute significantly to health outcomes (see **Box 8**).[103] For example, India finally eradicated polio by working with other sectors to target the causes of diarrhoeal disease in children (lack of clean water, sanitation, etc.), which was reducing the efficacy of polio vaccinations.[104] Conversely, a lack of attention to the impact that policies and interventions beyond the health sector have on women, children and adolescents can undermine efforts to improve SRMNCAH outcomes. In Lao People's Democratic Republic, agricultural practices have generated barriers to exclusive breastfeeding practices as mothers return to their farming roles as early as six weeks after childbirth, leaving the newborn child with caregivers who report hand-feeding the infant steamed rice, risking adverse nutritional outcomes, contamination and disease.[105]

BOX 8

Challenges of multisector collaboration

Although multisectoral efforts related to the determinants of health can have broad impact, implementation faces several barriers. Firstly, many efforts have been half-hearted, attempting marginal collaboration at best, without truly recognizing the impact of other sectors on health. Secondly, evaluations of multisectoral interventions have been scattered and limited, often drawing on modelling exercises. The resulting lack of evidence hinders investment in multisectoral work.

The greatest benefits come from efforts that address structural forces and social and gender norms that affect all of society, as well as ensuring that single sectors do their core business well.

Source: Rasanathan K and others (2015). "Ensuring multisectoral action on the determinants of reproductive, maternal, newborn, child, and adolescent health in the post-2015 era," *BMJ*, 351 doi: https://doi.org/10.1136/bmj.h4213

Policies and interventions outside the health sector also have the ability to challenge or reinforce gender inequalities that hinder access to and uptake of SRMNCAH services. For women and girls, the policy decisions made and programmes implemented in a range of sectors and settings can empower or constrain their access to SRMNCAH information, services and commodities, with a corresponding impact on SRMNCAH and gender equality outcomes.

Education-sector strategies offer a good example of cross-sectoral leveraging on gender equality and SRMNCAH. Education is significantly associated with both health and gender equality outcomes. Women's level of education has an impact on a variety of factors, such as fertility rates, childbearing age and modern contraceptive use.[106] Better female education is associated with lower infant mortality rates and improved performance on other SRMNCAH indicators.[107] Whether it is providing adolescent girls and boys with access to SRH information through CSE or improving menstrual hygiene facilities in schools, education sector strategies have a critical role in increasing demand for, access to and uptake of SRMNCAH services, as well as upholding women's and children's human rights.

5.2 Strengthening collaboration between the health and non-health sectors

To date, governance, financing and joint monitoring of action across or between sectors to achieve SRMNCAH targets has proved difficult in practice. The view that the health sector bears sole responsibility and accountability for the health of women, children and adolescents has hindered greater collaboration between sectors. It has also made it more difficult to address the determinants of SRMNCAH – including gender inequality – through multisectoral action and programmes. The SDGs and Global Strategy make clear that this must no longer be the case. SRMNCAH programming can learn from the response to the HIV epidemic. Multisectoral programming has been a mainstay of the HIV response for decades, providing numerous examples of rights-based collaboration between health and other sectors to address the social determinants of health, including gender inequality, that play a role in HIV transmission and the ability of people with HIV to seek treatment, care and support.[108]

A key feature of global and national HIV responses has been the use of the multi-stakeholder dialogue (MSD).[109] An MSD is a structured, interactive process that brings relevant partners together to promote mutual understanding and create shared courses of action.[110] MSD processes can be used to strengthen collaboration and action between the health and non-health sectors and encourage multisectoral efforts to address social determinants of SRMNCAH, including gender inequality. MSDs supporting women's and children's health are already occurring in many countries. Recent examples include the national implementation analyses supported by the Reproductive, Maternal and Newborn Health Alliance and conducted in six Asia-Pacific countries, as well as multi-stakeholder efforts to shape the health budget allocation in Uganda.

Lessons from conducting MSDs on women's, children's and adolescents' health have noted the challenges of engaging other sectors.[111] One national convener of a multisectoral dialogue on women's and children's health observed: "It was very difficult to get non-health sector involvement. You have to use your connections, personal relationships. I would recommend getting the highest level in the health ministries to issue the invitations to the other actors".[112] Leadership and commitment at all levels are essential to strengthening collaboration between sectors. One strategy for engaging partners is including items from sectors other than health on the agenda. In Peru, for example, multisectoral dialogues on SRMNCAH included a child nutrition review with participants from health and other sectors,[113] providing a relatively rare opportunity for cross-sectoral discussion on health-related topics and encouraging a stronger focus on the social determinants of health. Linking dialogues on SRMNCAH to ongoing national planning and policy cycles can also

make it more likely that partners beyond the health sector will value and engage with discussions on SRMNCAH. While MSDs represent an important first step in promoting dialogue between health and other sectors on the social determinants of SRMNCAH, it needs to be followed up with action.

Given the lack of a strong evidence-base or specific guidance on the work and governance of different types of multisectoral action, a useful starting point is to look for examples of what's working well. UN Women, working with its other H6 partners, has therefore compiled a series of case studies to highlight the types of action that can be implemented and linked across sectors to address gender inequality as a determinant of SRMNCAH, even in low-income, high-burden settings. **Annex 4** provides additional resources on multisectoral approaches to SRMNCAH.

5.3 What's working? Programmatic case studies across sectors and geographies

The following case studies offer examples of contributions that non-health sector interventions are making to transform unequal power relations, overcome gender inequalities and improve SRMNCAH outcomes. These case studies demonstrate how the incorporation of gender-responsive strategies in non-health sector programmes and interventions can drive cross-sectoral efforts to improve SRMNCAH and empower women and adolescents to realize their sexual and reproductive health rights.

Case study 11. Strengthening the provision of comprehensive sex education in schools in Zambia and empowering adolescents to adopt healthy sexual and reproductive behaviour

THE ISSUE

Comprehensive Sex Education (CSE) not only plays an important role in preventing negative SRH outcomes, but also offers a platform to discuss gender issues and human rights and to promote respectful, non-violent relationships. The Global Education Monitoring Report found that gender-responsive and life-skills-based HIV and sexuality education was only covered in the national curriculum by 15 per cent of 78 countries analysed.[114] When CSE programmes focus on gender and power relations, they are much more likely to show positive effects in reducing STIs and unintended pregnancies than programmes ignoring gender and power. When young women and adolescent girls have access to comprehensive, age-appropriate sexuality education before becoming sexually active, they are more likely to make informed decisions about their sexuality and approach relationships with more self-confidence. CSE is also known to increase young girls' condom use, increase voluntary HIV testing among young women and reduce adolescent pregnancy, especially when linked with non-school-based, youth-friendly health services provided in a stigma-free environment.

As of 2016, Zambia has the largest population of young people in its history, with 46 per cent younger than 15 years and 52.5 per cent younger than 18 years.[115] During their school years, teachers and sexual health specialists have an ideal opportunity to reach students with correct and appropriate health education information. The onset of adolescence brings not only physical change but also vulnerabilities to human rights abuses, particularly in the areas of sexuality, marriage and childbearing.

A programme intervention "Strengthening Comprehensive Sexuality Education for Young People in School Settings

in Zambia" is a national project implemented by the Government of Zambia and UNESCO, with support from the Swedish International Development Cooperation Agency. The project duration spanned from 2013 to 2018.

AIM

To increase access to high-quality, gender- and age-appropriate sexuality education and services for young people (aged 10-24), including those living with HIV and with disabilities, in order to achieve better sexual and reproductive health outcomes for adolescents and young men and women.

LEVEL OF INTERVENTION (SOCIAL ECOLOGICAL MODEL)

Community/organizational, policy

APPROACH

National efforts to scale up CSE used the International Technical Guidance on Sexuality Education, developed by UNESCO in partnership with UNFPA, UNICEF, WHO and UNAIDS. The Technical Guidance supports a rights-based approach with a strong focus on gender equality, participatory learning and youth advocacy. It recognizes and promotes human rights and gender equality, and explicitly uses an empowerment approach.

In 2014, Zambia revised its curriculum, integrating CSE that was gender transformative, evidence-based, and age and culturally appropriate. The curriculum was then rolled out in Grades 5 to 12 in all government schools across the country. However, teaching gender-transformative and rights-based sexuality education in schools takes more than rolling out a revised curriculum. Changes are required at multiple levels. Teachers need training and ongoing support – from pre-service training to the classroom. The project integrated CSE into pre-service training for primary teachers and in-service teachers were trained in effective delivery of gender-transformative, rights-based CSE at the classroom level. This was supported by the development of rights-based and gender-sensitive teaching and learning materials for all grades.

"I saw the need to get more involved in teaching comprehensive sexuality education because of the way our society hides information on sexuality. I remember growing up and being told that if you sit next to a boy at school you would conceive. I don't want the current generation to go through what we went through." —*Agather Shindende, a teacher at Kabulonga Primary School, Lusaka, Zambia*

CROSS-SECTORAL COLLABORATION

Given the project's scale and scope, the engagement of multiple sectors – including Ministries of Education, Health, Youth, Sport and Child Development, as well as NGOs and other partners – was essential to ensuring the implementation of CSE was owned across sectors. Strong cooperation across sectors also facilitated the sustainability and evolution of this project, including the development of Zambia's out-of-school CSE framework to ensure adolescents and young people who are not in school also have access to rights-based and gender-responsive SRH information.

LEARNINGS AND OUTCOMES

Cross-sectoral collaboration between the ministries of Health and Education – in partnership with UNFPA, UNESCO and NGOs working on education, health, youth engagement, GBV, women's empowerment and gender equality – facilitated the delivery of quality age-appropriate SRH information and health services for adolescents and young people in supported project sites. In some areas, the Millennium Development Goals Initiative used CSE training manuals for both health and education staff to create stronger linkages between the sectors. Additionally, some schools host visits from Ministry of Health staff to discuss SRH education and services with students. Further systematic linkages between school-based CSE and health-facility based SRH services are being explored. The 2016 progress report reveals that the Eastern province will receive funding from the UK Department for International Development to train peer educators to work in youth-friendly corners in clinics. These peer educators will support demand creation in schools and increase awareness of available health services in the area. This project will also continue to collaborate

with UNFPA to pilot a referral system between schools and SRH services in selected western and north-western provinces. If effective, this model can be integrated into future nation-wide trainings. Building ownership at both the national and sub-national level also proved essential to the implementation process. For example, Provincial Standards Officers were trained to monitor the quality and delivery of CSE at the school level. In 2015, the Sexuality Education and Review Tool was used to evaluate the CSE programme. The programme scored high, nearly 90 per cent, for its objectives, coverage of effective behaviour, programme model and stakeholder analysis. In regard to the programme content, knowledge scored 81 per cent, feelings 85 per cent, life skills 67 per cent, human rights 55 per cent, gender 78 per cent, and social norms 68 per cent. As of 2015, 100 per cent of targeted schools reported integrating CSE in their curriculums. More than 1.35 million learners from grades 5 to 12 have been reached with CSE, making up 77 per cent of the overall project target; 243 master trainers and 38,521 in-service teachers have been trained to deliver CSE in classrooms. By the end of 2016, the project is expected to link 12,000 young people to SRH services.[116]

SCALE UP/REPLICATION OPPORTUNITIES

Zambia is one of the first countries in the region to initiate such a comprehensive nation-wide scale-up of CSE programmes. In 2016, the country's in-school CSE curriculum was complemented by the launch of the out-of-school CSE framework. This built on the earlier national CSE project and was characterized once again by strong cross-sectoral collaboration between the Ministry of Youth, Sport and Child Development, Ministry of Health and Ministry of General Education, with support from UNFPA and UNESCO. The out-of-school framework aims to ensure comprehensive, rights-based, gender-sensitive CSE is provided to adolescents and young people who are not in school, recognizing that they are often excluded from social and health interventions that are delivered within the formal education systems and may not have access to accurate information about their SRH, negatively impacting their transition into adulthood.

"Among the topics that I have learned, gender stands out as the most interesting one. I like gender because it teaches us to be equal. Boys and girls can do the same things – mathematics, science, home economics and technical drawing. I have learned that we must respect each other and that household chores have to be done by girls and boys." —*Harriet Lilanda, age 13, student at Twalumba Primary School in Lusaka, Zambia*

Case study 12. Creating an enabling environment for water, sanitation and hygiene in Bangladesh and empowering adolescent girls to demand services

THE ISSUE

The effective management of menstruation is both a WASH issue and a fundamental part of reproductive health. However, menstrual hygiene – a cross-cutting theme with a significant impact on the health and well-being of women and girls – has often been an overlooked issue in both SRH and WASH programmes. Poor hygiene management can cause infection and jeopardize women's and girls' SRH. The lack of adequate facilities for the management of menstrual hygiene also raises issues for an individual's right to privacy, human dignity, gender equality and non-discrimination. Most sanitation programmes do not consider women's and girls' needs to manage menstruation. Latrine design usually does not address the specific needs of women and girls, and where hygiene promotion programmes exist, many exclude the issue of menstrual hygiene, focusing instead largely on hand-washing practices. Social stigma and norms around

menstruation – and often male-dominated WASH decision-making – also mean that the social and physical needs of women and girls in relation to menstrual hygiene often go unmet. In Bangladesh, MHM remains a serious challenge, especially in schools. According to the Bangladesh National Hygiene Baseline Survey, there is 1 toilet for every 187 students, and 40 per cent of surveyed girls reported missing school during menstruation for an average of three days a month.[117] Knowledge on MHM is low, with more than 85 per cent of female respondents reporting using old pieces of cloth for menstrual protection.[118] Both lack of awareness and social taboos are significant factors contributing to health complications in young girls when they reach puberty.

The Ritu Programme intervention in Bangladesh was implemented by the NGO Simavi, with support from the Embassy of the Kingdom of the Netherlands and in partnership with a Bangladeshi media and communication agency, RedOrange and The Netherlands Organisation for Applied Scientific Research (TNO), an independent research institute. The programme runs from 2015 to 2019.

AIM

To improve menstrual hygiene and related well-being of girls, aged 11 to 13 years, in selected districts of Bangladesh.

LEVEL OF INTERVENTION (SOCIAL ECOLOGICAL MODEL)

individual, community/organizational, enabling environment

APPROACH

The Ritu Programme integrates a SRHR approach into WASH interventions, including gender equality interventions that focus on raising awareness and addressing taboos and harmful gender norms. The cornerstone of the Ritu Programme is a shift in the current school culture and the community, breaking the taboos around menstruation. Through an empowerment approach, school-going girls in Grades 6 to 8 are supported to understand the changes to their bodies as part of a wider focus on gender equality, with an emphasis on self-esteem and challenging self-stigma around menstruation. The programme also aims to create an enabling environment for girls and women to demand these services from the government, private sector and NGOs. This includes working with decision-makers at multiple levels to emphasize the importance of arranging separate toilets for women and adolescent girls at all educational institutions, health centres, workplaces and public places.

CROSS-SECTORAL COLLABORATION

To date, much of the leadership and activities on MHM, both in and out of schools, has been through the WASH sector. Yet, education plays a critical role in promoting girls' reproductive health and rights. Evidence shows that educated girls are more likely to delay first sex, have fewer sexual partners, use contraception and are less likely to become infected with HIV. They are also more likely to have their children vaccinated and attend school and have healthier families. Both the human rights argument and the need to improve MHM for health and educational reasons provide strong rationales for engagement from multiple sectors. Consequently, the Ritu Programme focuses on ensuring greater cross-sectoral collaboration between the WASH and education sectors, so teachers have the necessary materials and facts and are prepared to teach these subjects. Beyond the public sector, the programme works with private-sector manufacturers and distributors to ensure girls in Bangladesh have access to affordable and environmentally friendly sanitary napkins.

LEARNINGS AND OUTCOMES

The Ritu Programme shows that WASH policy and programming present opportunities to go beyond the consideration of the practical needs of women and girls to affect more transformative WASH interventions, which can positively impact unequal power relations and improve both gender equality and SRMNCAH outcomes. This is not only positive for gender equality but also critical for an equitable, inclusive and rights-based approach to WASH and SRMNCAH. Initial findings from the Ritu Programme highlight the importance of cross-sectoral collaboration between the health and education sectors in addressing gender inequality as a key determinant of reproductive and adolescent health. Mid-term findings indicate that gender-transformative

interventions are more effective when implemented at both the individual level (e.g. improving girls' self-confidence and empowering them to demand adequate facilities for MHM) and community level (e.g. addressing taboos and harmful gender norms within the community around menstruation). While it is too early for an impact evaluation to have been undertaken, early findings from the Ritu Programme provide valuable insights regarding the effect of gender transformative interventions aimed at reducing menstrual-related bullying, improving girls' self-confidence and empowering them to demand adequate facilities for MHM. At a time when there is a paucity of experimental evidence available to demonstrate the effectiveness of MHM interventions for health and schooling, the Ritu Programme will make an important contribution to the evidence base.

SCALE UP/REPLICATION OPPORTUNITIES

Scaling up gender-transformative MHM programmes can contribute to better WASH, health and gender equality outcomes, especially for adolescent girls. This opportunity is already being capitalized on in other parts of South Asia (India) and East Africa (Ethiopia, Kenya, Tanzania, Uganda) where SRHR is being integrated into WASH programmes using an empowerment approach that encourages girls to make informed decisions about their reproductive health. At a time when there are competing resource priorities in the health and education spheres, these initiatives demonstrate that it is possible to integrate MHM into existing programming in ways that reduce gender inequalities as a determinant of SRMNCAH and empower girls to demand and access services.

Case study 13. Transforming gender roles in agricultural production and improving nutritional outcomes among children under five in Mozambique, Nigeria and Uganda

THE ISSUE

With malnutrition estimated to be an underlying cause of 45 per cent of child deaths worldwide and anaemia contributing to 20 per cent of maternal mortality, investing in programmes that address household food and nutrition security is fundamental to improving SRMNCAH outcomes. While many agricultural development interventions have increased food production, these have not necessarily led to improvements in the nutritional status of women and children. Research shows that the amount of food produced and available in a farming household does not implicitly relate to food quality, nutritional value or diversity of household members' diets. There is also a strong correlation between gender inequality and food and nutrition insecurity, with gender relations determining roles and responsibilities in the household and decisions about allocating resources or adopting technologies in farming systems. Unequal power relations mean that household resources – particularly food – are allocated according to the priorities of the most powerful household member, in most cases a male. Women's own food security and nutrition needs, and often those of their daughters, are being neglected at the household level, where discriminatory social and cultural norms prevail, contributing to adverse health outcomes. Cross-sectoral planning between the health and agriculture sectors can ensure the positive impact of agricultural policies on health and vice versa, contributing to improved nutrition security for women, children and adolescents and, consequently, better SRMNCAH outcomes. However, an integrated approach linking agricultural production and human nutrition must also address the adverse impact of gender inequality on nutrition and health outcomes. This is supported by research showing changes in the distribution of inputs and/or control over resources between men and women farmers can significantly increase productivity, food and nutrition security, and improve health and education outcomes.

The Gender Informed Nutrition and Agriculture (GINA) Alliance Project was piloted in Uganda, Mozambique and Nigeria, funded by USAID. The duration of the project was

18 months in Mozambique and Nigeria and 24 months in Uganda, between October 2005 and September 2007.

AIM

To improve nutritional outcomes among children under 5 years of age, using a gender lens.

LEVEL OF INTERVENTION (SOCIAL ECOLOGICAL MODEL)

Individual, community, enabling environment

APPROACH

The programme employed a gender-focused, community-based approach to improving household food and nutrition security in Mozambique, Nigeria and Uganda, with an emphasis on the nutritional status of children under the age of 5. The programme operated at both the national (policy development) and community (implementation of integrated community-based activities) level. GINA supported efforts to formulate and implement cross-sectoral policies that address hunger, food insecurity, malnutrition and gender inequality as a determinant of poor nutritional outcomes among children. As well as positioning nutrition in the national development policy frameworks of Mozambique, Nigeria and Uganda, the programme had a strong focus on cross-sectoral collaboration. GINA included multidimensional components, such as women's empowerment through knowledge and skills trainings to improve their capacity while at the same time increasing their access to resources, income and decision-making roles in their households and communities. There were also efforts to involve women in leadership and attempts to ensure men's participation in programme activities. The formation of community groups was also important to ensuring community engagement of men and women in programme activities. Each country had individual objectives, and individual communities applied a gender-sensitive lens to address community-specific challenges in improving household food and nutrition security.

CROSS-SECTORAL COLLABORATION

At the national and subnational level, representatives of the Ministry of Agriculture and Rural Development were engaged alongside those from the Ministry of Health. In Mozambique, cross-sectoral collaboration also involved the Ministry of Education, and in Nigeria, the Federated Planning Committee was represented on the multidisciplinary advisory committees set up at the national and local level to support programme coordination and implementation. Across the three countries, these committees also included research institutions and NGOs and community-based organizations working on agriculture, nutrition, food security and women's empowerment issues.

LEARNINGS AND OUTCOMES

Through an analysis of qualitative interviews and archival data, Lewis demonstrated the importance of the gender dimension to the success of the GINA programme.[119] These community-based projects were shown to reduce the number of underweight children as well as increase the availability, knowledge and consumption of nutritious food items. They were also shown to improve women's status, transform gender roles in agricultural production and processing, and increase women's power in financial decision-making. GINA's focus on reducing gender inequalities and transforming gender roles led to an upgrading in the status of women and recognition of them as producers and processors of food. As a result, women's control over their assets, as well as the size of their assets, increased in the programme sites. During the period from the programme baseline to follow-up evaluation, GINA projects were able to reduce the inadequate weight-for-age of 3,000 children under 5 years of age. Overall, the nutritional status improved for children in programme target areas across the three countries, with a 56.5 per cent reduction in severely and moderately underweight children.

SCALE UP/REPLICATION OPPORTUNITIES

As a result of the successful pilot, USAID scaled up the GINA model through a USD $15 million Nutrition Collaborative Research Support Programme and Nutrition Innovation Laboratory. This research is specifically designed to build the evidence base to demonstrate how gender-sensitive agricultural interventions implemented and co-located with health activities may lead to improvements in the nutritional status of women and children at scale.

Case study 14. Ensuring conditional cash transfer programming in Brazil transforms gender inequalities

THE ISSUE

There is increasing evidence that conditional cash transfer (CCT) programmes generally improve child health outcomes and uptake of services for pregnant women and children as well as increase school enrolment for girls. One of the first and largest CCT programmes in the world is Brazil's Bolsa Família Programme. Established in 2003, this nationwide CCT programme reaches nearly a quarter of the country's population, and 93 per cent of its beneficiaries are women. It aims to eliminate extreme poverty and increase access to services among the country's most vulnerable populations. The conditionalities of the programme, which include ensuring up-to-date vaccinations, regular school attendance, and annual medical check-ups, are all child-centred. By overwhelmingly enrolling female participants, the Bolsa Família Programme also aims to give women greater control of family resources and reinforces their rights and responsibilities as full citizens, given the programme's requirements to visit public offices and manage legal documentation. While the programme is aimed at – and has seen gains in – empowering women directly, the extent to which it reduces gender inequalities as a key determinant of health is less clear. There are concerns that CCT programmes are reinforcing rather than transforming gender divisions of responsibility and care. By reinforcing women's roles as holding the primary responsibility for their children's school and health needs, CCTs are not only removing responsibility from men but may also be placing an undue burden on women and perhaps exposing them to backlash from family and community members. Results from the International Men and Gender Equality Survey identified a link between women's increased income and participation in CCT programmes with an increase in experiences of violence. In research sites in Latin America, there were reports of increased domestic violence due to a backlash from husbands as transfers were handed to their wives, eroding men's self-esteem as providers for the household. These findings suggest that if social protection policies and programmes are designed and implemented without using a gender lens, these interventions can reinforce harmful gender norms, increase the time poverty of women and even result in GBV. In doing so, CCT programmes risk unintended gendered impacts and undermining progress toward better RMNCAH outcomes.

The Bolsa Família Companion Programme, was a three-year research-action project (2013-2015) implemented by Brazil-based international NGO Promundo in both urban and rural communities in the states of Rio de Janeiro and Pernambuco, funded by UN Women's Fund for Gender Equality.

AIM

To address and prevent the perpetuation of harmful gender norms and potential escalation of violence in the context of Brazil's CCT programme, Bolsa Família.

LEVEL OF INTERVENTION (SOCIAL ECOLOGICAL MODEL)

Interpersonal, community/organizational, policy

APPROACH

The project used a multipronged approach directed at the interpersonal, community/organization and policy levels. At the household and interpersonal level, the project proactively engaged men that benefitted from CCTs to support the economic empowerment of their female partners by encouraging them to critically reflect on their female partners' empowerment, participation and decision-making, and re-joining/joining the labour market. At the community level, the project's focus on group education encouraged men and women to critically reflect on shared decision-making and power dynamics within their relationships in order to increase the gender-equitable impact of the Bolsa Família Programme. These efforts were complemented through awareness-raising and capacity-building of professionals and community leaders who work with beneficiaries of the CCT programme, including training public-sector staff to

discuss gender equality and the importance of sharing care work when administering Bolsa Família grants. Using micro-level qualitative and quantitative research, the programme also sought to make macro-level policy recommendations to the Brazilian Federal Government and international community on the benefits of gender-transformative CCT programming and implementation.

CROSS-SECTORAL COLLABORATION

Promundo's approach is that multilevel collaboration across sectors is essential to making CCT programmes more gender-transformative. In project design and implementation, Promundo engaged government (unions, local government agencies, social assistance departments), civil society (Instituto Papai, Themis, Aldeia da Criança Alegre, Reciclação, Casarão dos Prazeres, Criola), social workers, health professionals and women's advocates, together with male and female beneficiaries of the Bolsa Família Programme. Partners received training on gender transformative programming in the context of the Bolsa Familia Programme through workbooks, information materials, and various outreach campaigns and activities.

LEARNINGS, OUTCOMES AND IMPACT

Results from the first two years of the project, which focused on direct interventions with beneficiaries of the Bolsa Família Programme, found that introducing complementary interventions and encouraging women's social and economic empowerment through equitable, non-violent attitudes and behaviours can minimize unintended, harmful gendered impacts of CCTs. It also showed that addressing gender inequality through social protection could be achieved at low cost, using simple design modifications together with investment in capacity-building for implementation at the community level.

A key lesson from the Bolsa Família Companion Programme was the importance of multilevel collaboration. If all partners – including government policymakers and implementers, civil society, women activists and donors – can work multisectorally and be more proactive in addressing institutional power dynamics and blockages, CCT programmes can be more effective and transformative in tackling gender inequalities. In particular, strengthening women's agency, voice and participation in social protection design and delivery can enhance the State's responsiveness to women's needs, as well as accountability for gender equality. The programme reflected an innovative and self-reflective approach to understanding and advocating for women's economic empowerment, leading to many discussions about gendered power-relations with men and boys, women, health professionals, the community, social workers and local government.

Another key lesson learned was that applying a gender lens to CCT programmes is not an optional add-on but must be an integral part of social protection policy and programming if it is to maximize gains in women's empowerment, including SRMNCAH. At the beginning of the Bolsa Família Companion Programme, 75 per cent of male participants said that men's responsibilities include childcare; by the end, 100 per cent said that this is the case. At the beginning of the programme, 36 per cent of male participants said that taking care of the home, taking care of the kids, and cooking for the family are a woman's main responsibilities; by the end, this number had dropped to 22 per cent. Of male participants, 13 per cent agreed that women should have no say in family spending; by the end, only 8 per cent agreed with this statement. In Nova Friburgo, a municipality of Rio de Janeiro, there was a 16 point decrease in the belief that contraception was the responsibility of the woman (baseline: 20 per cent to endline: 4 per cent). Women's perceptions of their roles in family relationships also changed, as shown by qualitative surveys conducted before and after the programme. At the beginning of the programme, women revealed a certain resignation around taking care of the household and children. By the end of the programme, women had gained a deeper understanding of the importance of equally sharing the care work and of their right to greater emotional and financial independence. The encouragement of women's social and economic empowerment through the programme led to an increase in families who qualified for the CCT programme, impacting 800 couples (400 in Rio de Janeiro, 400 in Pernambuco). Women's participation in advocacy for their economic development also increased in project sites, affecting more than 40,000 female beneficiaries.

SCALE UP/REPLICATION OPPORTUNITIES

Promundo and partners stress the importance of sustaining this programme to have a long-term impact and are confident that this programming can be a model and can be scaled up to other states in Brazil and countries in Latin America with similar programmes. The support of local and national level governments and securing funding from non-governmental sources, such as private trusts, can be ways to ensure the continuation and expansion of the Bolsa Familia Companion Programme.

"We are convinced that this successful experience can be replicated at a larger scale in other states, and even in other countries, with similar cash transfer programmes." —*Vanessa Fonseca, Instituto Promundo Programme Coordinator*

Case study 15. Using mobile phone technology to increase access to fistula repair in Tanzania and support women's empowerment

THE ISSUE

Estimates show that every 2 seconds, a woman is seriously injured or disabled while giving birth. The development of obstetric fistula is directly linked to one of the major causes of maternal mortality: obstructed labour. Obstetric fistula – a hole in the birth canal – is caused by complications in childbirth and poor maternal health care. In Tanzania, approximately 20,000 women live with the condition and an estimated 3,700 new cases of obstetric fistula occur every year, but only about 1,000 get treated. A study conducted in Tanzania between 2008 and 2010 with 151 fistula patients found that when deciding where to give birth, almost all women had wanted to give birth in a health facility, but the eventual decision was left to only 7 per cent of the women.[120] The husband or mother-in-law had the final say in approximately 60 per cent of cases, and most chose home births. Unequal power relations and entrenched social norms mean that women have limited decision-making power and access to resources, which can create additional delays in seeking emergency obstetric care and increase their risk of developing a fistula.

Gender inequality also intersects with rural poverty, preventing women in remote areas from accessing emergency obstetric services during childbirth. A major obstacle in accessing fistula repair services has been identified as the high cost of transportation to health facilities, particularly for those living in remote areas. The 2001 Tanzania Fistula Survey found that many women with fistula must travel more than 500 km to reach one of the major centres for repair surgery, with some travelling as far as 1,000 km.

Other gender-related barriers include the relative dearth of information about treatment options (many women and girls living with fistula are not aware that treatment is available) and the cost of repair. This often leaves fistula treatment beyond the physical and financial reach of most women living with the condition. As well as physical effects such as incontinence, women often experience psychological trauma, social stigma and isolation. In the analysis of the lived experiences from women affected by obstetric fistula, four themes emerged: loss of body control, loss of social role as a woman, loss of integration in social life, and loss of dignity and self-worth. Because so few people understand the causes, consequences and treatment of obstetric fistula, it tends to be surrounded by stigma and taboo. Consequently, many women try to hide their condition, or are marginalized by the community, which further reduces opportunities to access information and services to treat the condition.

The TransportMYpatient initiative was implemented by Comprehensive Community Based Rehabilitation in Tanzania (CCBRT). The pilot phase (2009-2010) was funded with support from the Vodafone Foundation and UNFPA.

AIM

To harness the potential of mobile banking to reduce access barriers to fistula repair services for women.

LEVEL OF INTERVENTION (SOCIAL ECOLOGICAL MODEL)

Individual, interpersonal, community/ organizational

APPROACH

M-Pesa, a service provided by Vodacom, is the biggest mobile money service in Tanzania, with 7 million subscribers. Vodacom is also the market telecom leader in the country, with 38 per cent of the national SMS traffic exchanged via its network.[121] The TransportMYpatient initiative makes innovative use of Vodafone's mobile banking system M-Pesa—M for 'mobile' and Pesa for 'money' in Swahili—to cover travel and accommodation costs to CCBRT's affiliate hospital in Dar es Salaam for free repair surgery. Using community-based mobilization, the programme creates links between women living with fistula to volunteer ambassadors, local M-Pesa agents, and transport providers. Money is sent via SMS to ambassadors, who may be former patients, health workers, or staff of NGOs, who identify and refer women suffering from fistula for treatment. The ambassadors retrieve the money at the local Vodacom M-Pesa agent and buy bus tickets for the patients. When the patient arrives at the hospital, the ambassador receives a small incentive, again via M-Pesa.

At the organizational level, the TransportMyPatient initiative works hand-in-hand with the hospital to provide age- and gender-sensitive health care. This includes sensitizing health-care workers on gender-related stigma, discrimination and violence experienced by women with fistula and training them to provide medical and psychosocial services without stigmatizing female patients. Following the pilot phase, the programme expanded its focus on empowerment at the individual level, working to increase the self-esteem and self-confidence of women on their path to recovery.

A single text message changed the course of Ruth's life. She had lived with fistula for 28 years and was ostracized by her community because of the condition. As Ruth was unable to afford the journey to the hospital, her ambassador triggered CCBRT's TransportMyPatient initiative. CCBRT sent the money for Ruth's bus ticket to the ambassador's mobile phone via M-Pesa. After getting a text message from CCBRT, the ambassador redeemed the text for cash and bought Ruth a bus ticket to Dar es Salaam. After her surgery, Ruth participated in group and individual counselling sessions and received health education, family planning advice and physiotherapy to increase her self-confidence and reintegration into her community.

CROSS-SECTORAL COLLABORATION

The partnership between telecom-provider Vodacom and its mobile banking service (M-Pesa) with the health sector illustrates the power of cross-sector collaboration to improve RMNCAH outcomes. This can be supported through multilevel partnership that includes institutional health-care workers, the volunteer ambassador network, local M-Pesa agents and bus transportation companies.

LEARNINGS AND OUTCOMES

Using a combination of mobile banking, public information, community-based mobilization, free treatment, travel and gender-sensitive counselling, the CCBRT has improved the health outcomes of many women living with fistula in Tanzania. In 2012, the CCBRT introduced holistic care into its fistula service with a focus on more gender-transformative activities that promote the status of women and attempt to address unequal power relations between women and others in the community. Focusing on individual-level interventions, it includes elements of

health education, including: family planning, nutrition and HIV prevention; gender-sensitive counselling; occupational therapy; singing and life skills, so that they can exercise more control over their own lives and participate on equal terms with others in their community. The number of women able to access fistula surgery increased by 65 per cent during the pilot phase, with the number of fistula operations carried out in 2010 more than doubling compared with 2009. In 2010, 268 fistula surgeries were performed at the CCBRT hospital, of which 129 were on women who travelled on transport paid for through M-Pesa via referrals from 54 ambassadors.[122] During 2011, 166 women with obstetric fistula came to CCBRT from almost all regions in Tanzania via the TransportMYPatient scheme, representing a 29 per cent increase compared with 2010 and accounting for 49 per cent of total repairs. The total number of fistula repairs continued to increase, with 144 CCBRT ambassadors spread across all regions in Tanzania in 2012.

SCALE UP/REPLICATION OPPORTUNITIES

Within the first 12 months of implementation, the ambassadors' network expanded to all regions of the country. Since the pilot phase in 2009-2010, the number of women accessing treatment has grown steadily, reaching 920 women in 2015. From 2012 to 2015, CCBRT and its satellite facilities carried out more than 65 per cent of all fistula surgeries reported in Tanzania. With continued funding from the Vodafone Foundation and additional support from organizations including USAID/President's Emergency Plan For AIDS Relief, Fistula Foundation and Johnson & Johnson, CCBRT's fistula programme has grown to become one of the biggest worldwide. The TransportMYPatient initiative is not alone in its efforts to increase women's access to life-saving health care using mobile phones. The Freedom from Fistula Foundation in Kenya is using mobile funds and community education to provide free fistula repair surgeries and the Aberdeen Women's Centre in Sierra Leone has launched a toll-free hotline to provide information and care options to women living with fistula.

6. INSIGHTS AND ACTION FOR FUTURE PROGRAMMING

6.1 Characteristics of programmes that improve both gender equality and sexual, reproductive, maternal, newborn, child and adolescent health outcomes

The collection of case studies in previous chapters identifies approaches and examples of programmes that address gender inequality within the health sector and in collaboration with non-health sectors, to improve SRMNCAH outcomes. Many of them illustrate how the framework for action can be applied: by conducting gender analysis of how factors on multiple levels influence the sexual and reproductive health of women and girls and the health of women and their children; identifying barriers that are preventing women and girls from demanding and realizing their rights to SRMNCAH information and services; reducing these barriers through programmes that address supply and/or demand, and often collaborate across sectors; and by empowering women and girls. The case studies also suggest several key characteristics of programmes that effectively achieve both gender equality and SRMNCAH outcomes. These are described below.

Integrating gender across the programming lifecycle

Gender equality is influenced by each of the levels of a social system and by the interactions between individuals and the environment. Analysis of how gender influences SRMNCAH behaviour on the five levels of the Social Ecological Model helps identify entry points for programmes to strengthen gender equality to improve SRMNCAH outcomes. As highlighted by many of the case studies, the best results are achieved by addressing multiple levels of the Model simultaneously, so change in one area is reinforced by changes in another. For example, programmes may integrate interventions into the supply of SRMNCAH services or into demand generation and community engagement, or they may focus on the health sector or collaborate more broadly across sectors.

In addition to the initial gender analysis that applies a gender lens to the different levels of the Social Ecological Model, gender considerations must remain a focus throughout programme implementation, monitoring and evaluation. Programmes that define specific gender equality objectives, accompanied by measurable targets and with sufficient budget allocations, have a clear mandate to effectively implement interventions to strengthen gender equality. Gender equality is not merely the means to achieve better SRMNCAH outcomes, but a goal to be achieved through better health.[123] Sex-disaggregated data and data on specific gender issues – collected using both quantitative and qualitative methods – should be used to monitor progress and modify activities to increase impact. Evaluations should measure the programme's impact on both SRMNCAH outcomes and gender equality.

Strengthening gender equality through both supply- and demand-side sexual, reproductive, maternal, newborn, child and adolescent health interventions

Interventions to strengthen gender equality must be incorporated into both the supply of SRMNCAH services and within efforts to generate demand and engage communities. Supply and demand are complementary: without demand, supply is irrelevant, and without supply, the demand remains unmet. Addressing gender-related barriers through supply-side interventions is critical to ensure that SRMNCAH information and services are available, accessible and acceptable to women and girls and to support them in realizing their rights to sexual and reproductive health. Interventions can target any of the levels of the Social Ecological Model, for example by improving health policies, strengthening health service-delivery, improving interpersonal provider-patient communication and shifting provider attitudes. At the same time, gender influences women's and girls' demand for SRMNCAH information and services, interacting with other determinants that influence SRMNCAH (e.g. poverty, education and employment). Interventions can support demand by shifting gender norms related to SRMNCAH through individual and peer-level training and support, community mobilization, strengthening organizational and political resources to support women and girls (e.g. laws on domestic violence and shelters for people experiencing IPV).

Multisector action for increased impact

The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) calls for government leadership to "identify key structural forces that affect health and drive disparities, including gender-related structural and institutional biases [and] enact broad-ranging cross-sector policies to advance shared goals and address challenges that lone sectors cannot resolve".[124] Yet, working across sectors for health continues to prove challenging, especially in settings with a high SRMNCAH burden. Even when the rationale is accepted by policymakers, efforts to drive collaboration across sectors on determinants of health – including gender equality – have often been stalled at the implementation phase.[125]

The Social Ecological Model can also be used to guide multisector action by helping identify complementary interventions that address the gender-related barriers on the individual, interpersonal, community, organizational and policy levels. Because gender interacts with other determinants of health, interventions beyond the health sector must be considered as core to strategies on women's, children's and adolescents' health.[126] As seen in the case studies on collaboration between health and non-health sectors, gender inequality undermines all areas of development.

Supporting women and girls to realize their right to health

Applying a human rights and gender-based approach includes strengthening the capacity of women and girls to defend and demand their rights, raising awareness of gender equality and human rights among local communities, and advocating for policy or legislative change that supports equitable social systems, as seen in the case of Malawi, which outlawed child marriage.

Programmes should promote not only women's right to health, but also the right to reproductive self-determination and bodily integrity. For example, the gender, hygiene and sanitation programme in Senegal on women and girls with disabilities went beyond increasing individual capacities that would allow them to better understand their menstrual health to creating opportunities to advocate for their civil liberties, thus strengthening the participation and empowerment of women and girls.

Empowerment strengthens individual women's capacities and builds positive social relationships in order to expand their capacity to make free choices, alter unequal structures and realize rights. It is a dynamic process, with the individuals themselves being significant actors in the process of change.[127] The empowerment

of women and girls concerns their gaining power and control over their own lives. It involves awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources, and actions to transform the structures and institutions that reinforce and perpetuate gender discrimination and inequality. This implies that to be empowered, people must not only have an enabling environment that conditions choices (structure) and equal access to resources and opportunities to participate in decision-making about their own health (relations), but they must also have equal aspirations and capabilities (agency) to use these rights, resources and opportunities to make strategic choices and decisions (such as is provided when a woman can decide if, when and how many children to have).[128] To be effective, programmes that aim to improve SRMNCAH outcomes must engage women and girls as agents of change.

However, in addressing the determinants of SRMNCAH – especially gender inequality – their contributions are seldom fully harnessed. Women and adolescent girls are often unable to voice their specific needs or requirements even though a policy, programme or service may be affecting women and men or girls and boys differently. A lack of voice in policymaking and service-delivery limits the potential for women and adolescent girls to be agents of change in transforming gender inequalities in SRMNCAH.

The Global Strategy calls for a world where women, children and adolescents are able to fully participate in shaping sustainable and prosperous societies. In the context of SRMNCAH, engagement by civil society – including women's and child rights organizations, youth organizations and gender equality advocates – is necessary for effective action by governments and international organizations, and for holding them to account. Women and their organizations play a crucial role in bringing about gender equality and their own empowerment. An essential part of ensuring human rights accountability and the engagement of women and adolescents is building the capacity of women's rights organizations and movements to utilize national and international human rights mechanisms to claim their health and health-related rights.

Investments in women's leadership are critical not only from a rights perspective but also for achieving better SRMNCAH. Leaders direct resources to the issues that are most relevant to their lives – for many women, that includes the health and education of their families and communities.

6.2 Checklists to guide the practical application of the framework for action

Based on the shared understanding of the characteristics of programmes that support both gender equality and SRMNCAH outcomes, a series of programming checklists were developed to support the incorporation of key programming elements into SRMNCAH-related interventions. The assessment tools and programming checklists build on and adapt a number of existing tools. The overall purpose of the checklists is to help programme managers and implementers determine how to better integrate gender into SRMNCAH programming. The checklists are included as a separate handout.

Checklist #1: Tips for identifying gender-related barriers to sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH)

This checklist uses the Social Ecological Model approach to analyse gender-related barriers that may undermine the SRMNCAH of women and girls. Using this tool, programme designers can garner a deeper understanding of gender inequalities in SRMNCAH and use the findings to design interventions that strengthen gender equality and empower women. Understanding the SRMNCAH-related issue and its context – for example whether this SRMNCAH-related issue is specific to the health sector (e.g., antenatal care) or involves several sectors (e.g., issues such MHM or CSE) – the programme is then designed to address gender inequalities (including any gender-related barriers to information and services) that are impeding

progress towards improved SRMNCAH outcomes for women, children and adolescents.

Checklist #2: Tool for gender-responsive sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) programming

Checklist #2 is a set of questions that can help determine the extent to which gender inequality is considered in the programme design and implementation stage. Using this tool, programmes can be tailored to fit the nuanced needs of their audiences and to address gender inequalities at different levels (as per the Social Ecological Model approach) in order to improve SRMNCAH outcomes for women and adolescent girls and for women and their children. As with all rapid-assessment tools, further analysis will be required to determine which level of the gender integration spectrum (levels in the Social Ecological Model approach) applies to the programme.

TIPS FOR IDENTIFYING GENDER-RELATED BARRIERS TO SEXUAL, REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH

Using the Social Ecological Model as a framework, this tool allows programme designers to reflect on ways in which gender inequalities impact sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) and use the findings to design interventions that strengthen gender equality and empower women.

	Comments/Notes
INDIVIDUAL LEVEL: KNOWLEDGE, ATTITUDES AND BEHAVIOURS	
Do women and girls have knowledge of sexual and reproductive health and their rights to them?	
Are women and girls able to make decisions about their sexual and reproductive health and realize their rights?	
Are women and girls able to negotiate safer sex and/or their own fertility? If not, what factors restrict them from doing so?	
Can women and girls decide to seek SRMNCAH services by themselves? If not, what factors restrict them from doing so?	
Do women have control over resources they can use towards their own health-seeking behaviours? If not, what factors restrict them from doing so?	
Do women and girls feel safe in their communities? Do they face any restrictions in their mobility?	
How do women and girls perceive their own gender roles?	
How do women and girls perceive their reproductive, economic and political roles?	
INTERPERSONAL LEVEL: FAMILIES, FRIENDS, SOCIAL NETWORKS	
Are women and girls' health-seeking abilities and behaviours influenced by their spouse/partner, family and friends? How?	
Are there factors that facilitate the ability of women and girls to seek health-care services for themselves and/or their family? If so, what are they?	
What are women and girls' roles in the household?	
Are there harmful practices perpetuated by household members against women and girls? If so, what types of practices are they?	
How much do household members influence the decision-making power of women? Do women hold decision-making power in relationships, and around what decisions?	
How is gender-based violence perceived at the interpersonal level?	
COMMUNITY LEVEL: RELATIONSHIPS BETWEEN ORGANIZATIONS	
Are women and girls free to participate in formal or informal groups or associations in their communities?	

	Comments/Notes
Do women and girls engage in community dialogues and discussions related to their health?	
What roles do women and girls play in allocating community resources in order to facilitate access to health care?	
Are there social factors that constrain the ability of women and girls to seek SRMNCAH services?	
Do women and girls face restrictions or require authorization to access health care?	
Do health-care workers respect the rights of women and adolescent girls when they are accessing SRMNCAH services?	
Do women and girls face discrimination when seeking health-care services? What are some of the discriminatory attitudes and practices facing women and girls in health-care settings?	
ORGANIZATIONAL LEVEL: ORGANIZATIONS AND SOCIAL INSTITUTIONS	
What are some social norms related to the status of women and girls that are linked with age, ethnicity, social, economic and marital status?	
What are some structural barriers restricting women from accessing SRMNCAH services?	
Do women face barriers in pursuing a career in the medical field?	
Are both male and female health providers supported equally?	
Can adolescent girls use SRMNCAH services without the permission of a family member?	
Do women and girls who have faced gender-based violence have access to confidential services (e.g. one-stop centres)?	
How is the delivery of care organized to meet the differing needs of women and girls, including those most marginalized (e.g. women and girls living with HIV, women and girls with disabilities, indigenous women and girls)?	
POLICY/ENABLING ENVIRONMENT LEVEL: NATIONAL, STATE, LOCAL LAWS	
Is there political will and commitment to gender equality in the context of health, including through commitments to global mandates (e.g. CEDAW)?	
Do women and girls have access to legal identification and civil registration?	
Are there any laws and policies that hinder or prevent women and girls from accessing health services?	
How do health policies and resource allocations support gender equality at different levels of the health system?	
Are the constitutional and legislative frameworks conducive to advancing gender equality?	
To what extent do women and girls feel they can influence health-care policies?	
Is there a presence of a critical mass of women in decision-making positions in political, public and private sectors?	
Are there well-developed and adequately financed civil society organizations that can advance gender equality, including in the SRMNCAH response?	
What factors facilitate or hinder an enabling environment for women's participation in decision-making in SRMNCAH?	

TOOL FOR GENDER-RESPONSIVE SEXUAL, REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH PROGRAMMING

This checklist is an assessment tool to determine the extent to which gender equality is considered in a programme's design, implementation and scale-up. Using this tool, programmes can improve how they address the gender inequalities that undermine the sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) outcomes of women and girls. As this tool captures multiple phases of programming, it can be used continuously or only for relevant sections. As with all tools, further contextualization will be required to fully integrate and sustain gender-responsive measures into programming.

Instructions

To use this checklist, respond to all criteria in each phase of Programme Design and Development. If your programme meets the criteria, check yes or 'Y'. If it does not meet the criteria, check no or 'N'. If it partially meets the criteria, check partially or 'P'. For any additional comments, clarifications or notes, use the 'Comments' section.

Phase	Criteria	Y	N	P	Comments/ Notes
SECTION 1: PROGRAMME DESIGN AND DEVELOPMENT					
NEEDS ASSESSMENT	Does the assessment use data and research which is disaggregated by sex and age?				
	Does it include existing knowledge on gender norms, roles and relations, particularly in relation to SRMNCAH?				
	Does the assessment review international commitments and obligations such as the Sustainable Development Goals, Beijing Platform for Action, CEDAW, ICPD Programme of Action and relevant human rights treaties?				
	Does it include an assessment of national or district health-sector policies and do they prioritize the SRMNCAH needs of women and girls?				
	Does it identify existing mechanisms, processes and partners focused on addressing gender equality in the provision of health services?				
SCOPE AND APPROACH	Was the programme approach developed taking into consideration how gender roles, access to and control over resources and power relations inform access to SRMNCAH services?				
	Does the scope of the programme include commitments to improving SRMNCAH for women and girls?				
	Do the scope and approach articulate key gender issues and how they affect SRMNCAH?				
	Were women and girls involved in the design phase and did it take into their account their concerns, experiences and demands?				
	Does the approach identify the specific needs of women and girls, boys and men, including those from marginalized groups (e.g. minority groups, those living in rural areas, persons with disabilities)?				

Phase	Criteria	Y	N	P	Comments/ Notes
THEORY OF CHANGE	Was a situation analysis conducted to contextualize gender inequalities in health for the programme setting?				
	Do the programme inputs include activities to ensure women and girls' demand for SRMNCAH?				
	Were any programme activities specifically designed to meet the needs of women and girls in terms of SRMNCAH?				
	Was gender equality considered as a social determinant of health?				
	Do the short- and long-term effects of this programme consider how it will impact women and girls?				
PROGRAMME DESIGN	Was a scoping exercise conducted to understand the status of women and girls' rights and access to SRMNCAH in the programme implementation area?				
	Did the development of the programme design involve women and girls, including those most left behind in the SRMNCAH response?				
	Does the programme design provide solutions to remove barriers women and girls face in accessing and utilizing SRMNCAH services?				
	Does the programme design include activities to ensure women and girls' can voice their SRMNCAH demands in decision-making platforms?				
	Was gender equality integrated throughout each phase of the programme design?				
BUDGET	Has the entire budget been reviewed using a gender perspective, ensuring allocations have been made to ensure women's and girls' needs are met in SRMNCAH?				
	Do the gender equality commitments in the programme design align with adequate funding allocations?				
	Are there specific budget functions that promote gender equality?				
	Are there strategies developed to mobilize/sustain resources for gender equality-related SRMNCAH activities?				
	Are there allocations for stakeholder consultation and involvement, including engaging with community members, civil society, political and traditional leaders and government bodies to advocate for gender equality in the SRMNCAH response?				

Phase	Criteria	Y	N	P	Comments/ Notes
SECTION 2: PROGRAMME IMPLEMENTATION					
STAKEHOLDERS	Does the programme include routine, relevant gender trainings for all staff?				
	Does the recruitment of project staff consider the importance of gender parity?				
	Are women and girls regularly providing inputs to programme implementation processes?				
	Does the programme ensure it is accessible and inclusive towards women and girls, including those often marginalized (e.g. women with disabilities, women living with HIV, indigenous women)?				
	Has the programme been discussed with all stakeholders to ensure it identifies the needs of the specific community it is reaching, particularly women and girls?				
IMPLEMENTATION	In programming, are the health consequences of gender inequality considered and addressed?				
	Are the links between harmful gender norms (e.g. gender-based violence, inability to negotiate condom use, restrictions on mobility to attend health services, financial restrictions to attend health services, lack of health education) and SRMNCAH outcomes considered?				
	Are the principles of gender equality and non-discrimination integrated throughout the programme?				
	Does the programme address underlying factors of poor SRMNCAH, such as gender inequality, harmful practices and violations of basic human rights?				
	Does the programming include activities around rights-based education on SRMNCAH?				
MONITORING AND EVALUATION (M&E)	Does the programme collect and report on sex-disaggregated data?				
	Are participatory and qualitative methods used to capture nuanced gender issues in SRMNCAH?				
	Does the data collection include gender equality markers and indicators, preferably those that are widely recognized/validated?				
	Is gender equality considered throughout the entire M&E process – baseline, mid-line, endline?				
	Does the M&E capture norms and behaviour changes around SRMNCAH?				

Phase	Criteria	Y	N	P	Comments/ Notes
SECTION 3: PROGRAMME SCALE-UP AND NEXT STEPS					
DISSEMINATION OF RESULTS	When M&E analysis was conducted, was it reported using sex-disaggregated data?				
	Were any differences in programming outcomes between men and women explained?				
	Were gender issues captured in M&E processes and reported on?				
	Do the results consider the extent to which the intervention contributed to strengthening the capacity of health systems, communities or the target area to ensure SRMNCAH responds to women and girls' needs?				
	Do the results capture any improvements in women's access to and participation in SRMNCAH services? If there were not any improvements, can the results explain why?				
ADVOCACY	Can this programme be used as an example to advocate for women and girls' meaningful participation in SRMNCAH processes?				
	Can the aspects of this programme, which meaningfully engaged women and girls, link to other improved outcomes (e.g. increased empowerment and agency, economic empowerment, or improved quality of SRMNCAH services)?				
	Can programme staff advocate for the importance of using a gender-responsive approach to SRMNCAH programming?				
	Can the programme results and learnings be used to advocate for the importance of gender equality in health programming to donors, government officials and civil society organizations?				
	Are the participants of the programme, particularly women and girls, able to demand their right to SRMNCAH in decision-making platforms (e.g. in communities, local political spaces, national agendas)?				
SCALE-UP AND INTEGRATION	In any future uptake of the programme, is gender equality considered?				
	Are any gaps in addressing gender equality in SRMNCAH addressed when discussing the scale-up and future of the programme?				
	Can this programme be linked to broader gender equality programmes (e.g. those that address gender-based violence, economic empowerment, education)?				
	Can this programme be adapted for implementation in national-level settings or other countries?				
	Are women and girls active participants and stakeholders in the next phase of this programming?				

ANNEXES

Annex 1. Glossary

Agency

Agency means that empowerment cannot be given to people or done to people but comes from processes where people empower themselves. Agency is people creating their own momentum, gaining their own skills, and advocating for their own changes. Agency is defined as "the ability to define one's goals and act upon them".

Empowerment

The empowerment of women and girls concerns their gaining power and control over their own lives. It involves awareness-raising, building self-confidence, expanding choices, increasing access to and control over resources, and transforming the structures and institutions that reinforce and perpetuate gender discrimination and inequality. Empowerment is therefore defined as "the expansion in people's [women's] ability to make strategic life choices in a context where this ability was previously denied to them".

Gender

Refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed.

Gender analysis

Gender analysis is a critical examination of how differences in gender roles, activities, needs, opportunities and rights/entitlements affect men, women, girls and boys in certain situations or contexts. Gender analysis examines the relationships between females and males and their access to and control of resources and the constraints they face relative to each other. A gender analysis should be integrated into all sector assessments or situational analyses to ensure that gender-based injustices and inequalities are not exacerbated by interventions, and that where possible, greater equality and justice in gender relations are promoted.

Gender equality

Refers to equal chances or opportunities for groups of women and men to access and control social, economic and political resources, including protection under the law (such as health services, education and voting rights). It is also known as equality of opportunity, or formal equality. Gender equality is often used interchangeably with gender equity, but the two refer to different, complementary strategies that are needed to reduce gender-based health inequities.

Gender equality in health

Women and men have equal conditions to realize their full rights and potential to be healthy, contribute to health development and benefit from the results. Achieving gender equality will require specific measures designed to support groups of people with limited access to such goods and resources.

Gender equity

Refers to fair treatment of women and men according to their respective needs, preferences and interests. This may include equal treatment or treatment that is different but is considered equivalent in terms of rights, benefits, obligations and opportunities.

Gender equity in health

Refers to a process of being fair to women and men with the objective of reducing unjust and avoidable inequality between women and men in health status, access to health services and their contributions to the health workforce.

Gender mainstreaming

The process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is not a goal or objective on its own. It is a strategy for implementing greater equality for women and girls in relation to men and boys. It is making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally, and so that inequality is not perpetuated.

Gender norms

Are the accepted attributes and characteristics of male- and female-gendered identity at a particular point in time for a specific society or community. They are the standards and expectations to which gender identity generally conforms, within a range that defines a particular society, culture and community at that point in time. Gender norms are ideas about how men and women should be and act. Internalized early in life, gender norms can establish a life cycle of gender socialization and stereotyping.

Gender-responsive

An approach that recognizes the distinct roles and contributions of different people based on their gender takes these differences into account and attempts to ensure that women and girls equitably benefit from the intervention.

Gender-specific

Refers to any programme or tailored approach that is specific for either women or men. Gender-specific programmes may be justified when analysis shows that one gender has been historically disadvantaged socially, politically and/or economically.

Gender-transformative

A response that seeks to change existing structures, institutions and gender relations into ones based on gender equality. Gender-transformative programmes not only recognize and address gender differences but also create the conditions whereby women and men can examine the damaging aspects of gender norms and experiment with new behaviours to create more equitable roles and relationships.

Health equity

The absence of unfair, avoidable or preventable differences in health among populations or groups defined socially, economically, demographically or geographically.

Human rights

Are commonly understood as being those rights that are inherent to the human being. The concept of human rights acknowledges that every single human is entitled to enjoy his or her human rights without distinction as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Human rights are legally guaranteed by human rights law, protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity. They are expressed in treaties, customary international law, bodies of principles and other sources of law. Human rights law places an obligation on States to act in a particular way and prohibits States from

engaging in specified activities. All human rights and instruments that concern them apply equally to men and women. In addition, CEDAW has specified and complemented some of them from the perspective of women's rights.

Reproductive rights

Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.

Sex

The different biological and physiological characteristics of males and females, such as reproductive organs, chromosomes, hormones, etc.

Sexual and reproductive health and rights (SRHR)

Taken together, SRHR can be understood as the right for all, whether young or old, women, men or transgender, straight, gay, lesbian or bisexual, HIV positive or negative, to make choices regarding their own sexuality and reproduction, providing they respect the rights of others to bodily integrity. This definition also includes the right to access information and services needed to support these choices and optimize health.

Social Ecological Model (SEM)

SEM is a theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviours, and for identifying behavioural and organizational leverage points and intermediaries for health promotion within organizations. There are five nested, hierarchical levels of the SEM: individual, interpersonal, community, organizational and policy/enabling environment.

Sources: Kabeer, N. (1999); Kabeer, N. (2005); Office of the Special Adviser on Gender Issues and the Advancement of Women (2001); United Nations Children's Fund (n.d.). "Social Ecological Model"; United Nations Children's Fund, UNFPA, UNDP, UN Women (n.d.). Gender Equality, UN Coherence and You; United Nations Educational, Scientific and Cultural Organization (2009). *Gender in Education Network in Asia-Pacific;* World Health Organization (2011). *Gender Mainstreaming for Health Managers: A Practical Approach.*

Annex 2. International human rights mechanisms and instruments relevant to women's, children's and adolescents' health

International human rights mechanism/ instrument	Monitoring body/ mechanism	Relevance for addressing the determinants of SRMNCAH, including gender inequality	Opportunities for civil society to ensure human rights accountability and the engagement of women/ children/ adolescents	Additional resources
UNIVERSAL PERIODIC REVIEW (UPR)	The UPR is a state-driven monitoring mechanism, under the auspices of the Human Rights Council.	The UPR is one of the most important international procedures for addressing human rights violations. Currently, the UPR makes more health-related recommendations than most treaty-body mechanisms. The UPR provides a critical entry point to sharpen the focus on pressing health issues that face women, children and adolescents within a country and to identify concrete actions to address and further promote the fulfilment of their right to health.	While the UPR is an intergovernmental process, a number of opportunities for contribution are available to non-governmental stakeholders. Opportunities for civil society engagement at different stages of the UPR process are outlined at http://nhri.ohchr.org/EN/IHRS/UPR/Documents/RoadMap_en_16.09.09.pdf	OHCHR (2014). *Universal Periodic Review. A Practical Guide for Civil Society. Revised Edition.* Geneva: OHCHR. Available at http://www.ohchr.org/EN/HRBodies/UPR/Documents/PracticalGuideCivilSociety.pdf; CONECTAS (2009). *Roadmap for Civil Society Engagement with the UPR*. Brazil: CONECTAS. Available at: https://nhri.ohchr.org/EN/IHRS/UPR/Documents/RoadMap_en_16.09.09.pdf

International human rights mechanism/ instrument	Monitoring body/ mechanism	Relevance for addressing the determinants of SRMNCAH, including gender inequality	Opportunities for civil society to ensure human rights accountability and the engagement of women/ children/ adolescents	Additional resources
INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS	Committee on Economic, Social and Cultural Rights	The International Covenant on Economic, Social and Cultural Rights is widely considered as the central instrument of protection for the right to health. It recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." The Committee on Economic, Social and Cultural Rights has clearly indicated that women's right to health includes their sexual and reproductive health. This means that States have obligations to respect, protect and fulfil rights related to women's sexual and reproductive health.	NGOs and community-based organizations can provide information in the form of alternative (shadow) reports, briefings or submissions to the Committee on Economic, Social and Cultural Rights.	Global Initiative for Economic, Social & Cultural Rights (GI-ESCR) and the International Network for Economic, Social and Cultural Rights (ESCR-Net) (2016). *The International Covenant on Economic, Social & Cultural Rights at 50: The Significance from a Women's Rights Perspective*. Australia: GI-ESCR. Available at https://static1.squarespace.com/static/5a6e0958f6576ebde0e78c18/t/5ab3db6af950b7622d6c1737/1521736562722/The_ICESCR_at_50_en.pdf; World Health Organization (n.d.). *Health & Human Rights Factsheet: International Covenant on Economic, Social and Cultural Rights*. Geneva: WHO. Available at http://www.who.int/hhr/Economic_social_cultural.pdf.

International human rights mechanism/ instrument	Monitoring body/ mechanism	Relevance for addressing the determinants of SRMNCAH, including gender inequality	Opportunities for civil society to ensure human rights accountability and the engagement of women/ children/ adolescents	Additional resources
INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS	Human Rights Committee	The International Covenant on Civil and Political Rights does not contain a specific provision safeguarding the right to health; however, several rights incorporated in the Covenant are directly or indirectly linked to a person's enjoyment of his or her right to health. Those provisions include: the right to not be subjected to torture or to cruel, inhumane or degrading treatment or punishment (Article 7); the right to not be subjected without free consent to medical or scientific experimentation (Article 7); and the right to not be held in slavery or servitude or to be required to perform forced or compulsory labour (Article 8).	NGOs and community-based organizations can provide information in the form of alternative (shadow) reports, briefings or submissions to the Human Rights Committee.	World Health Organization (n.d.). *Health & Human Rights Factsheet: International Covenant on Economic, Social and Cultural Rights.* Geneva: WHO. Available at http://www.who.int/hhr/Economic_social_cultural.pdf. United Nations (1966). International Covenant on Civil and Political Rights. https://treaties.un.org/doc/publication/unts/volume%20999/volume-999-i-14668-english.pdf

International human rights mechanism/ instrument	Monitoring body/ mechanism	Relevance for addressing the determinants of SRMNCAH, including gender inequality	Opportunities for civil society to ensure human rights accountability and the engagement of women/ children/ adolescents	Additional resources
CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW)	Committee on the Elimination of All Forms of Discrimination against Women	CEDAW specifically addresses the rights of women and girls, including the full realization of their health and health-related rights. Article 12 establishes State Parties' obligation to adopt adequate measures to guarantee women access to health and medical care, with no discrimination whatsoever, including access to family-planning services. It also establishes the commitment to guarantee adequate maternal and child health care. Article 16 guarantees women the right to decide on the number and spacing of children. The right of access to specific educational information and advice on family planning is guaranteed under Article 10. Article 14 specifies the right of women in rural areas to have access to adequate health-care facilities, including information, counselling and services in family planning. Many other provisions have an implicit or indirect bearing on women's and adolescent girls' rights in relation to health, some of which are detailed in the General Recommendations of the CEDAW Committee (on FGM, sexual violence, HIV and reproduction).	NGOs and community-based organizations can provide information in the form of alternative (shadow) reports, briefings or submissions to the Committee on the Elimination of All Forms of Discrimination against Women.	International Women's Rights Action Watch (2008). *Producing Shadow Reports to the CEDAW Committee: A Procedural Guide*. Minneapolis: IWRAW. Available at: http://hrlibrary.umn.edu/iwraw/proceduralguide-08.html World Health Organization (2007). *Women's Health and Human Rights: Monitoring the Implementation of CEDAW*. Geneva: WHO. Available at: http://apps.who.int/iris/bitstream/10665/43606/1/9789241595100_eng.pdf WHO (n.d.) *Health & Human Rights Factsheet: Convention on the Elimination of All Forms of Discrimination against Women*. Geneva: WHO. Available at http://www.who.int/hhr/CEDAW.pdf.

International human rights mechanism/ instrument	Monitoring body/ mechanism	Relevance for addressing the determinants of SRMNCAH, including gender inequality	Opportunities for civil society to ensure human rights accountability and the engagement of women/ children/ adolescents	Additional resources
CONVENTION ON THE RIGHTS OF THE CHILD	Committee on the Rights of the Child	The Convention on the Rights of the Child guarantees every child's right to health. Articles 23 and 24 recognize the right to health for all children and identify several steps for its realization, such as: diminishing infant and child mortality; combating disease and malnutrition; ensuring appropriate pre- and post-natal care for mothers; and abolishing traditional practices prejudicial to the health of children. The fulfilment of a child's right to health is linked to the protection and implementation of other provisions in the Convention, including States parties' obligation to protect the child from: all forms of physical and mental abuse while in the care of parents or legal guardians (Article 19); economic exploitation and performing work that is likely to be hazardous to a child's health (Article 32); sexual abuse and exploitation, abduction, trafficking and sale of children (Articles 34–36). It also guarantees the child the right to: privacy and confidentiality (Article 16); a standard of living adequate for the child's physical and mental development (Article 27); and the right to education (Articles 28–29).	NGOs and community-based organizations can provide information in the form of alternative (shadow) reports, briefings or submissions to the Committee on the Rights of the Child.	Child Rights Connect (2014). *The Reporting Cycle of the Committee on the Rights of the Child: A Guide for NGOs and NHRIs*. Geneva: Child Rights Connect. Available at: http://www.childrightsconnect.org/wp-content/uploads/2015/07/EN_GuidetoCRCReportingCycle_ChildRightsConnect_2014.pdf; World Health Organization (n.d.) *Health & Human Rights Factsheet: Convention on the Rights of the Child.* Geneva: WHO. Available at: http://www.who.int/hhr/CRC.pdf

International human rights mechanism/ instrument	Monitoring body/ mechanism	Relevance for addressing the determinants of SRMNCAH, including gender inequality	Opportunities for civil society to ensure human rights accountability and the engagement of women/ children/ adolescents	Additional resources
CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT	Committee against Torture	While the Convention does not include specific health provisions, it addresses certain forms of abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment. These can include specific reproductive rights violations, including abuse in health-care settings, coercive sterilization, denial of medical care (such as access to safe, legal abortion and post-abortion care), mistreatment and violence in detention and other custodial settings, and FGM.	NGOs and community-based organizations can provide information in the form of alternative (shadow) reports, briefings or submissions to the Committee Against Torture.	Center for Reproductive Rights. (2010). *Reproductive Rights Violations as Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: A Critical Human Rights Analysis*. New York: Center for Reproductive Rights. Available at: https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/TCIDT.pdf; World Health Organization (n.d.) *Health & Human Rights Factsheet: Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. Geneva: WHO. Available at: http://www.who.int/hhr/Convention_torture.pdf?ua=1
CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES	Committee on the Rights of Persons with Disabilities	The Convention on the Rights of Persons with Disabilities protects the rights of all persons – including women, children and adolescents – with disabilities. The Convention contains detailed sexual and reproductive rights protections and prohibitions of torture or cruel, inhumane or degrading treatment in Articles 15, 23 and 25.	NGOs and community-based organizations can provide information in the form of alternative (shadow) reports, briefings or submissions to the Committee on the Rights of Persons with Disabilities.	UNICEF (2013). *Children and Young People with Disabilities. Fact Sheet*. New York: UNICEF. Available at: https://www.unicef.org/disabilities/files/Factsheet_A5__Web_REVISED.pdf; de Silva de Alwis, R. (2010). *The Intersections of the CEDAW and Convention on the Rights of Persons with Disabilities: Putting Women's Rights and Disability Rights into Action in Four Asian Countries*. Wellesley: Wellesley Centers for Women. Available at: https://files.eric.ed.gov/fulltext/ED511408.pdf

International human rights mechanism/ instrument	Monitoring body/ mechanism	Relevance for addressing the determinants of SRMNCAH, including gender inequality	Opportunities for civil society to ensure human rights accountability and the engagement of women/ children/ adolescents	Additional resources
INTERNATIONAL CONVENTION ON THE PROTECTION OF THE RIGHTS OF ALL MIGRANT WORKERS AND MEMBERS OF THEIR FAMILIES	Committee on Migrant Workers	Article 28 of the Convention recognizes the right of all migrant workers and their family members, including children and adolescents, to receive emergency medical care, independent of their administrative status of stay.	NGOs and community-based organizations can provide information in the form of alternative (shadow) reports, briefings or submissions to the Committee on Migrant Workers	UNDP (2015). *The Right to Health: Right to Health for Low-Skilled Labour Migrants in ASEAN Countries, Bangkok*. New York: UNDP. Available at: http://www.asia-pacific.undp.org/content/dam/rbap/docs/Research%20&%20Publications/hiv_aids/rbap-hhd-2015-the-right-to-health.pdf; United Nations Children's Fund (2011). *The Rights of Children, Youth and Women in the Context of Migration. Social and Economic Policy Working Paper.* New York: UNICEF. Available at: http://www.globalmigrationgroup.org/system/files/uploads/gmg-topics/human-rights/The-Rights-of-Children-Youth-and-Women-in-the-Context-of-Migration.pdf

Annex 3. Illustrative gender indicators for sexual, reproductive, maternal, newborn, child and adolescent health programming

This annex provides examples of gender-related indicators for SRMNCAH interventions along the five levels of the Social Ecological Model. Some of the indicators are current SDG indicators and some have been suggested by other sources. They can be used within and beyond the health sector to measure the success of addressing gender inequality as a key determinant of SRMNCAH.

TABLE 1
Illustrative gender-sensitive indicators

Indicator	Indicator source
Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	SDG indicator 5.6.1
Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	SDG indicator 5.2.1
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence	SDG indicator 5.2.2
Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18	SDG indicator 5.3.1
Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age	SDG indicator 5.3.2
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex	SDG indicator 5.1.1
Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education	SDG indicator 5.6.2
• Women's status and empowerment:[129] • Secondary or higher education • Employed in the last 12 months • First married by exact age (15, 18) • Women's participation in household decisions • Women's opinions on whether a woman can refuse sex to her husband • Hurdles faced by women in accessing health care for themselves	Demographic and Health Surveys (DHS)

TABLE 1 (CONTINUED)

Illustrative gender-sensitive indicators

Indicator	Indicator source
• Domestic violence: [130] • Women's attitudes toward wife-beating by husbands • Physical, sexual or emotional violence committed by husband/partner in last 12 months	DHS Domestic Violence Module
• Female genital cutting:[131] • Women circumcised	DHS Female Genital Cutting Module
Gender-sensitivity in the [health] service-delivery environment, including:[132] • Availability of services to adolescents, single women, widows, LGBTIQ groups; • Absence of requirements that clients have permission of husband or mother-in-law (for married women) or parents (for adolescents); • Percentage of providers in the health facility who are female; • Non-stigmatizing attitudes towards clients (e.g., unmarried female clients with sexually transmitted infections, sex workers, adolescents); • Number of referrals to other programmes that empower women (e.g., related to literacy, income-generation, micro-credit, domestic violence); • Percentage of facilities that, with the permission of the female client, encourage men to visit/attend (to accompany partner, obtain information or obtain services); • Equal treatment (e.g., waiting time, courtesy, privacy, information given) for male and female clients; • Percentage of family planning service-providers trained to detect, discuss and refer clients to services that handle sexual and gender-based violence.	Menu of indicators suggested by MEASURE Evaluation
• Women and girls' status and empowerment, including:[133] • Age at first marriage • Law requires free and full consent of parties to a marriage	MEASURE Evaluation

Annex 4. Related programming guidance

Human rights-based approaches to sexual, reproductive, maternal, newborn, child and adolescent health

Office of the High Commissioner for Human Rights (2012). *Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality.* UN Doc. A/ HRC/21/22. Available at: http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf

Office of the High Commissioner for Human Rights (2014). *Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce and Eliminate Preventable Mortality and Morbidity of Children Under 5 Years of Age.* UN Doc. A/ HRC/27/31. Available at: http://www.ohchr.org/EN/Issues/Children/TechnicalGuidance/Pages/TechnicalGuidanceIndex.aspx

Office of the High Commissioner for Human Rights (2015). *Information Series on Sexual and Reproductive Health and Rights*. Geneva: OHCHR. Available at: http://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx

Office of the High Commissioner for Human Rights (2015). *Summary Reflection Guides on a Human Rights-Based Approach To Health. Application to Sexual and Reproductive Health, Maternal Health and Under-5 Child Health.* Geneva: OHCHR. Available at: http://www.ohchr.org/EN/Issues/Women/WRGS/Pages/MaternalAndChildHealth.aspx

World Health Organization, Office of the High Commissioner for Human Rights, and Swedish International Development Agency (2011). *Human Rights and Gender Equality in Health Sector Strategies. How to Assess Policy Coherence*. Geneva: OHCHR. Available at: http://www.ohchr.org/Documents/Publications/HRandGenderEqualityinHealthSectorStrategies.pdf

Multisectoral approaches to sexual, reproductive, maternal, newborn, child and adolescent health

World Health Organization Partnership for Maternal, Newborn and Child Health (2011). *Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health.* Geneva: WHO. Available at: http://www.who.int/pmnch/topics/part_publications/essential_interventions_18_01_2012.pdf?ua=1

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UN Women supports UN Member States as they set global standards for achieving gender equality, and works with governments and civil society to design laws, policies, programmes and services needed to ensure that the standards are effectively implemented and truly benefit women and girls worldwide. It works globally to make the vision of the Sustainable Development Goals a reality for women and girls and stands behind women's equal participation in all aspects of life, focusing on four strategic priorities: women lead, participate in and benefit equally from governance systems; women have income security, decent work and economic autonomy; all women and girls live a life free from all forms of violence; women and girls contribute to and have greater influence in building sustainable peace and resilience, and benefit equally from the prevention of natural disasters and conflicts and humanitarian action. UN Women also coordinates and promotes the UN system's work in advancing gender equality.

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