

PROMOTING GENDER EQUALITY IN COMMUNITY MNCH/SRH EDUCATION: GUIDE FOR CAPACITY BUILDING OF COMMUNITY HEALTH WORKERS¹

OBJECTIVES OF THIS GUIDE

This Guide defines minimum themes and suggested exercises for all capacity building of front-line community health workers (CHWs) in countries implementing MNCH/SRHR project: 1) building CHWs' commitment to and understanding of gender equality (GE) and the interplay of gender-related barriers and issues with social determinants that all contribute to low maternal, newborn and child health (MNCH) outcomes; and for 2) supporting them to feel comfortable and able to promote gender equality in their MNCH/SRH education and promotion work with women, men, girls and boys in the communities they serve.

Why: Prevailing gender-discrimination, unfair gender norms, roles and practices are among the major determinants of low MNCH/SRH outcomes. For example, due to gender and age-based inequalities, complications from pregnancy and childbirth are the second leading cause of death for adolescent girls aged 15 to 19 years.² These gender inequalities put women and girls at a lower socio-economic status; devalue men and boys' roles in sharing responsibility for MNCH/SRH and support gender unresponsive health care systems.

For this reason, it is critical to recognize that health promotion cannot be isolated from gender-based barriers that undermine women and girls' abilities to make informed and timely choices about their health and of their children. A central strategy for tackling key gender-related barriers and issues is to build male and female community members' gender awareness, commitment and actions towards promoting gender equality and MNCH and sexual reproductive health (SRH). As trusted and trained health education promoters, CHWs and volunteers play key roles in this regard as frontline responders in health care systems. They work directly with men, women, adolescent girls and boys to increase MNCH/SRH knowledge; and to promote positive health-seeking behaviours among all community members.³ By integrating gender equality considerations into their information and education interventions, they can help reduce household and community gender-related barriers facing women and girls in accessing and utilizing health services.

¹ This guide has been developed by drawing from several sources. The main ones are: Save the Children (2014). *Improving Nutrition for Mothers, Newborns and Children in Afghanistan: a Facilitator's Guide: Gender Training for Community Health Workers in Afghanistan*. Ottawa: DFATD, PATH (2007). *Community Health Workers' Manual*. Nairobi, Kenya: APHIA II/USAID, and PAHO (2013). *Integration of Gender and Human Rights in HIV and Sexual and Reproductive Health Services: Training for Health Care Providers: Facilitators' Manual*. Washington, D.C: PAHO.

² WHO (2014).

³ CHWs are named differently across project countries but may be male or female (i.e. in Haiti, they are mostly male); come from the communities for which they serve; are part of the health care system; receive standard government training and offer a package of services (i.e. home visits, WASH, treatment of common ailments, health education, nutrition/surveillance, MNCH, family planning activities and so on).

Many countries have gender and health sector policies that recognize gender-related barriers to equitable health at household and community levels and commit to addressing these injustices in one form or another. In community level health education, however, CHWs, who may be male or female, generally are not systematically trained or capacitated on understanding how to apply a gender lens to their routine work. This guide serves to help the MNCH/SRHR projects work with government partners to create a cadre of gender-aware CHWs able to promote gender equality for improved MNCH/SRH outcomes.

Depending on the country, CHWs will play key roles in facilitating group education on gender equality and thereby contribute to the creation of an environment that leads to change: in the way women's and girls' rights and roles are perceived; the opportunities and treatment they receive; their agency and decision-making capacity and to fostering an internal change movement based on healthier, more gender equitable dynamics among women, men and boys and girls.

Purpose: This guide is meant to inform supplementary CHW/supervisors' "gender in MNCH/SRH" training material development and training that should complement standard government CHW curriculum and training on MNCH/SRH. The themes are based on the minimum knowledge and skills CHWs must know in order to apply gender responsive approaches to their roles and responsibilities.

For whom: It has been developed for: 1) all Plan International country offices implementing MNCH/SRH projects; and 2) For project partners to consult during implementation of project demand side activities and use as resource material for training their staff working on MNCH/SRHR projects; 3) For project staff and partners for training facilitators of the CHWs GE training; 4) For Ministry of Health staff involved in developing such CHW GE training material in collaboration with project staff; and 5) For any consultants hired to review social behavior change and communication (SBCC) material to be used by CHWs in their community education work.

It provides:

- Essential themes and skills-building that all capacity building activities of CHWs must cover in order to enable CHWs and their supervisors to effectively integrate gender considerations across all their individual, household, and community awareness raising and basic health care activities from household visits to individual and couple consultations to facilitating dialogue groups⁴; and
- Guidance on how to facilitate group education and dialogue groups in gender and socially inclusive ways with different male and female groups.

Key themes covered are:

- Key gender concepts and terms;
- The intersection of gender inequality with the social determinants of health and common gender-related issues and barriers women and girls and their male partners face in accessing and utilizing health care so as to sensitize CHWs of the gender dimensions that can affect care-seeking and treatment compliance; and
- Simple and practical approaches CHWs can explore and apply in their individual consultations and house visits, and in facilitating good discussions to make their health education and basic health interventions more gender-responsive.

Note for the Plan International CO staff, particularly the Gender and Health staff:

⁴ Select supervisors from the second level of health care services who are specifically responsible for supervising a certain number of CHWs in their health catchment area should be part of the gender equality CHW training. They must be able to support CHWs they are responsible on addressing gender barriers and identifying the most effective gender responses in their group education and household level visits and consultations.

With regards to gender-transformative projects: These projects have gender transformative strategies, tailored to each country's socio-cultural specificities that will address the condition and position of women and girls. At the demand side, two key gender transformative strategies are to increase women and girls' empowerment in the private and public domains by building their social and financial capital and knowledge and capabilities for MNCH/SRH decision-making. To create an enabling environment for good MNCH/SRHR outcomes and gender equality, men and adolescent boys will be engaged to become active partners of change, using MNCH/SRHR as the entry point and incrementally expanding to broader GE promotion based on international human rights standards. Awareness-raising on the prevention of gender-based violence (GBV), and harmful traditional practices (HTPs), i.e. child early and forced marriage (CEFM) and female genital mutilation/cutting (FGM/C) are included (see Annex 4).

For each of these projects an indicator at the Immediate Outcome level will measure the level of gender equality knowledge of WRA, their male partners, and of adolescent girls and boys in MNCH/SRH. It is recognized that *unless* women and girls are empowered, and unless an enabling socio-cultural environment is created for them to take MNCH/SRH decisions, utilization of services and MNCH/SRH outcomes will remain low. Neglecting gender inequality may even lead to reinforcing existing inequalities that do harm to women and girls' health and wellbeing and that of their children.

CHWs have been identified as the first responders in the health care systems that will build the awareness of women, men, girls and boys on gender equality for better MNCH/SRH. In partnership with the Ministries of Health and Gender/Women, projects will support capacity building of CHWs and volunteers to promote both improved MNCH/SRH and greater gender sensitivity and gender awareness-raising across multiple groups, i.e. women of reproductive age (WRA), adolescent girls (both married and unmarried and in and out of school), male partners of WRA, adolescent boys and older generations of women and men (both religious and traditional leaders and influencers) and the general population.

It must be emphasized that:

- All themes presented in this Guide should be covered in all capacity building of CHWs in order to ensure a high level of consistency across projects and countries;
- Development of gender CHW training will be based on collaboration with the Ministries of Health and Gender with the aim of building government buy in and longer-term systematic adoption of such capacity building of CHWs in gender equality in MNCH/SRH; and
- Training sessions should be designed based on existing national CHW training and competency-based criteria and adapted based on the country-specific context.

Please note that this guide focuses on the essential content and themes for supplementary training of CHWs on building gender responsiveness in their roles and responsibilities in MNCH/SRH. Additional guidance will delve more specifically on early marriage and GBV prevention and engagement of men (See Annex 3 and guidance documents on male engagement).

BEFORE GETTING STARTED

TIPS FOR TRAINING DESIGN

- As a first step, carry out a pre-orientation consultation with select CHWs and supervisors to determine their learning needs regarding gender equality, gender issues in MNCH and their role.
 - Identify/assign a highly skilled staff member with expertise in developing and facilitating training in GE/MNCH/SRH and SBCC. If not no one has this capacity, it is strongly recommended to hire an external consultant with this required expertise to ensure quality and rigor.
 - Draft the training modules with learning sessions, exercises, tools and aids based on existing national government CHW curriculums and training programs and any other relevant national and global good practice resources.
- Design both a facilitator's guide for both the trainers of the training and for CHWs. Note that many of the essential content and suggested exercises in this guide can be used by the CHWs in their own GE/health education of male and female community members and groups. For this reason, it is recommended that job-aids on key GE/MNCH/SRH and rights themes be developed to help CHWs to better understand the GE themes covered in the training and then for them to use in their own community education and consultations. For example, job aids should be developed on key GE/MNCH/SRH messaging.
- Pre-test all training sessions and modules on a select group of CHWs.
- Revise the workshop and manual, if required.
- Roll-out the orientation.

TIPS FOR FACILITATION OF CHW TRAINING ON GENDER EQUALITY

Recognizing that gender is a complex concept to learn and apply, it is recommended that all CHW training:

- Take a **participatory adult learning approach** to encourage problem-oriented learning through deep reflection on self and society and sharing and exchange. Participants are then better able to translate their personal knowledge and experiences into general conclusions and turn them into proposals for change. An examination of the deeply embedded role of gender stereotypes and norms are at the heart of this methodology.
- **Be highly interactive.** Learning aides such as pictures, graphics, videos etc. are best employed for reducing lecture type sessions. Furthermore interactive exercises such as role play, timelines, case studies, drawing, mapping etc. are recommended. All conceptual sessions are better illustrated through extended locally relevant examples linking the poor MNCH outcomes to underlying gender issues to encourage embedding of these new and complex concepts.

One suggested learning approach is **the three Ps**: presentation, practice and performance.

- **Presentation:** Key concepts and approaches are presented to the participants in interactive ways such as by asking participants if they can define the concept or have an example to share first.
- **Practice:** Participants actively engage with the concepts they are learning through individual or group activities.
- **Performance:** Participants reflect on the new concepts and take action to apply them in their day-to-day work, with continuous supervision. At the end of the training, a suggested exercise is for supervisors and CHWs to develop their own action plans of how they are going to integrate

their new gender equality knowledge and skills into their routine work and how their supervisors can hold them to account.

Five key principles to creating an environment that is optimal for learning are:

- 1) **Openness:** An open space is provided where all participants have the opportunity to share their thoughts and experiences without fear of judgment. To create this space, as facilitators we must be respectful of and appreciative for all ideas that are shared, even when they are different from our own;
- 2) **Participation:** Opportunities for active participation are provided for all participants so that they have opportunities to engage with the concepts and build an understanding of how to translate what they are learning into action;
- 3) **Reflection:** Time and space for reflection is provided for all participants to process the information being shared and determine what it means to them and their work (i.e. check ins after sessions or before and after a day's workshop to ask participants to share what they found most interesting, challenging or relevant to their work);
- 4) **Empowerment:** Participants should receive continuous support and encouragement to share and reflect on their learning. Facilitators can support participants in building their confidence by using positive language, celebrating their learning, encouraging their creativity, recognizing their challenges and supporting them in finding solutions; and
- 5) **Confidentiality:** whereby all participants commit to keep whatever is shared in the group. These five principles can be part of the capacity building of CHWs to become good facilitators of dialogue groups.

These facilitation approaches and principles for CHW training in GE can equally be used by CHWs to inform their facilitation of community dialogue groups.

RECOMMENDED TRAINING STRUCTURE

A basic one to two day gender training of CHWs can at least cover basic gender concepts; gender related determinants of health; introduce the application of gender aware to gender transformative responses based on prioritizing key gender access barriers relevant to the situation and some key tips on how to facilitate dialogue groups with men, women and adolescent girls and boys on GE in MNCH/SRH. If these themes cannot be covered, job-aids on gender equality awareness-raising in MNCH/SRH should be given out to the participants at the end of the training as pertinent to the CHWs' community health education promotion and basic health care given. The selection of exact content, facilitation approaches, exercises and tools provided should be adapted based on the country's national CHW curriculum training and any relevant national gender equality training material. Additional alternative exercises can be explored depending on how much time has been allocated.

THEME 1: UNDERSTANDING GENDER AND GENDER EQUALITY

Tips

- Engage participants in questioning their own personal and societal values.
- Only share gender definitions after participants explore their own understanding first

The Difference between Sex and Gender

Sex refers to the biological differences between women and men. These are universal and timeless. E.g. only women across time and around the world bear children and breastfeed.

Gender refers to the social interpretations and values given to being a woman, man, boy or girl. More specifically, it refers to the way behaviours and identities are determined through the process of socialization. The roles and expectations of women and men are usually unequal in terms of power, agency and control over decision-making, assets and freedom of action. They are specific to every culture and change over time.

Sex	Gender
Biological	Socially constructed
Universal	Culturally Specific
Born with	Learned
Cannot be changed or difficult to change	Changes over time

Note: Suggested exercise for the above is the “Wordstorm” or free-listing of words describing men and women for training CHWs in GE.

Woman	Man

Questions:

- What words describe a woman; what words describe a man? Write them in the table categories.
- Which words purely represent the sex difference between men and women?
- What are the similarities and differences amongst words that describe women? What about for men?
- Which words can describe both men and women?

After a full discussion, summarize by sharing a clear definition of gender and of sex. If the training is more than two days, other key concepts to cover would be gender equity and gender equality.

Gender Socialization and its Effects

Socially constructed gender norms and values affect all of us all the time - from the time we are born, across our life cycles. Messages of the social difference between boys/men, girls/women are communicated to us by institutions that are closest to us – family, community, school, religious institutions and continue to be communicated to us through society and its institutions. Some of these messages we do not even question. These are socially sanctioned by what we value in our society. We learn these norms by observing how others act, and listening to what our parents, friends, and community tell us who we should be. These values and norms may be formally sanctioned in laws and formal institutions like government and informally valued and practiced through our local cultural beliefs and practices.

Note: Suggested exercises for the above for training CHWs. Select one of these exercises:

1. Personal reflection in pairs

When was the first time you realized you were a boy or girl?

- What was the message that led to this realization?
- Who communicated it to you?
- Where was the message communicated?
- How did you feel?
- What impact can this have on the everyday life of a boy? And a girl?
- What impact does it have on the everyday life of a woman? What about for a man?

2. **Values-deliberation** to question personal and societal values

Instructions: Ensure enough space for all participants to form a line by standing side by side in front of you. Ask them to step back from the line. Explain that you are going to read out some statements. Point to the imaginary line stating that one end of the line represents “agree” and the opposite end, “disagree.” Participants must decide for themselves whether they agree or disagree and place themselves on the scale where they agree to disagree. Some may end up in between somewhere. After reading all the statements, ask participants: “what did you learn in doing this exercise?” Ask participants that are on different points of the line.

The Statements (select 5-10 from the list):

- The most important thing a woman can do is have babies.
- A woman should be a virgin when she gets married.
- It is OK for a man to have sex outside marriage, if his wife does not know.
- Women should not talk openly about sex or issues related to sexual health.
- A women’s most important role is to take care of her husband and child.
- Men and boys should not try to show their feelings, especially feelings of vulnerability
- Men are the strong sex because the bible/Koran says that is the way it should be.
- Men are responsible as the head of the house for making decisions on their children’s education and how his wife spends her time.
- Women should listen to their husbands and not criticize or challenge them.
- Women are naturally better at taking care of babies and children.
- Women and girls are naturally more emotional than men and boys.
- Little girls are gentle, boys are tough.
- By caring for the baby for nine months, mothers have a closer natural link with the baby.
- Women have long hair men have short hair.
- Women should have no experience in relationships when they marry and men need to be experienced when they get married.
- Intensive involvement of men in child rearing will help children to become more balanced.
- Men are freer to go around and therefore are more qualified to lead.
- Men are the heads of families.

3. **Illustrate with an example (can do exercise 1 and 2 and then illustrate with such a case study)**

Instructions: Explain that a common gender norm in many countries is the expectation that “good girls” do not engage in sexual activity and that any girl who has engaged in sexual activity before marriage must be a “bad girl.” What impact might this gender norm have on girls and women? What about on men and boys? Please share any examples of the consequences. Emphasize that the intention is not to judge or advocate one way or another for a woman’s free choice to remain a virgin till marriage or not.

If not raised mention:

- Girls may not want to ask questions about sexual health, leading to possible health consequence
- Girls may be pressured to marry early to ensure her virginity and reputation at the time of marriage. Early marriage, before a girl is emotionally and physically ready, can result in a range of mental and physical problems. It also often leads to girls dropping out of school. It is also a contributing factor to adolescent girls giving birth before they are physically and emotionally ready.
- Girls and women who are sexually abused or raped may not seek or receive the full range of assistance, including medical care, counseling, support and legal protection they need.

If the first exercise (#1) was selected, skip this question. If #2 was chosen; suggest ending the discussion on the difference between gender and sex with: “How have gender norms affected your choices, decisions and actions? How? And what were the consequences? What was the impact? Facilitate a discussion.

The Effects of Gender Socialization

Gender influences a person and social groups' status in three different ways:

- **Self and group identity** based on the socially defined roles that are ascribed to what women and girls/men and boys should be. These gender norms influence women and or girls' self-esteem as much as how women and men and girls and boys understand the opposite sex and the kinds of relationships they have with one another.
- Who has **access to and control over opportunities and resources** and
- Ability and opportunities to influence **decision making**.

Why is understanding gender and gender norms important? Gender norms can greatly limit women and men's opportunities and choices and even be harmful.

While social constructions of gender vary from place to place, inequalities between boys, girls, women and men occur everywhere as a result of them.

- Boys and girls **learn different skills** that give them different advantages over the other.
- Boys and girls **receive different opportunities and treatment** that give them different advantages over the other.
- Boys and girls grow up believing their **capabilities are different and develop behaviours** to conform, giving them different advantages over the other.
- Boys and girls as they grow end up taking **different roles and responsibilities** giving them different advantages over the other.

The effects of gender on women (and girls) by and large around the world are grave, placing women and girls at a disadvantage relative to men and boys:

- Women commonly have less decision making power (in the community and household).
- Women commonly do not have equal control over household resources.
- Woman commonly face strong access barriers to information and resources.

What are some gender norms that may have negative health consequences? How can limiting someone's opportunities, choices, and decisions affect their health?

Note: Suggested exercise for CHWs is “Changing gender norms.” Ask the participants to complete the following statements:

“In my community, men/boys are supposed to...”

“In my community, women/girls are supposed to...”

“It may not happen now, but I expect one day women will....”

“It may not happen now, but I expect one day men will...”

What is the possible impact and consequences of each statement? What if we switched around the words “men” and “women”? Do they sound strange? How would men feel if they were expected by society to allow women to make decisions, for example? What if men were responsible for taking care of children in the home?

Closing remark: It is critical to remember that gender is not fixed and:

- Can change over time, place and even will vary between individuals because of different life experiences and by varying family, community, regional and national political and or economic circumstances.
- Varies by a person’s geographic location, ethnicity, age, religion, wealth status and so on. Gender roles and norms will be different for a woman in an urban city as opposed to a woman living in a rural area as much as the gender roles of an older woman will be different than for an adolescent girl.

It is important to recognize that some gender norms within a society may not necessarily lead to harmful inequalities, such as when gender norms are flexible and women and men, girls and boys, have the opportunity to make their own choices. If children observe equality among their role models, within their families and in their communities, they are likely to adopt such values and practices.

For achieve gender equality, everyone must be involved, not just women and girls, but men and boys also. By engaging women and men, boys and girls, everyone will benefit from gender equality, because everyone will have the opportunity to identify and address their needs. We, ourselves, do not need to follow the roles that our community thinks are acceptable for women and men. We can choose different ones and role-model alternatives.

THEME 2: GENDER RELATED DETERMINANTS OF MNCH/SRH

Influence of gender on MNCH/SRH outcomes

Tip: Start with the Story of Kabila (below and in Annex 1) to engage CHWs in exploring what are the key gender related barriers and issues at individual, household and health facility levels first. The detailed list of barriers can be presented in a Power point and included in the CHW GE training workbook and should be reviewed after participants first identify key barriers.

Note: To introduce the topic, ask questions to engage participants in thinking about what gender has to do with MNCH?

- If a woman cannot leave her home by herself, how can she access MNCH related information and care?
- If by custom, a woman is always the last person to eat, how can she get adequate nutrition for herself and her baby?
- If a woman is blamed for giving birth to girls, how can she care and support her girls?
- If going to a health clinic undermines a man’s self-esteem, how can he support his expectant wife and children?

Gender norms also influence the health status of women and men, and girls and boys. Prevailing gender inequality and related barriers at the household, community and health facility level are key determinants

of MNCH/SRH. While the impact of gender issues varies by degree and nature within each country's socio-cultural context, **three clusters of gender issues and barriers** are consistently pervasive that have direct bearing on poor MNCH/SRH access, utilization and outcomes.

Common GE barriers on the demand side

1. Girl/woman related barriers due to existing gender norms and values:

Low status and low agency of women and girls *contributing to:*

- Disproportionate burden of domestic care work on women and girls
- High rates of child marriage and early child bearing
- Restrictions on autonomy, mobility and decision-making at the household level to seek MNCH information and services independently
- Lack of access to and control over financial resources
- High rates of gender-based violence (GBV)⁵
- Low educational status, low knowledge of MNCH and ability to access MNCH information

2. Household/broader community level barriers

Prevailing patriarchal norms and attitudes resulting in lack of/low male support for MNCH

- MNCH viewed as solely a women's concern thereby distancing or excluding men from taking up responsibility in caregiving in the household
- Low knowledge of men and boys about MNCH risks and issues [but Men are often the main decision-makers in families and communities and control decisions regarding pregnancies, place of birth and birth spacing]
- Low participation in birth preparedness planning
- Low participation and support to women and girls over the MNCH continuum of care

Household/broader community level barriers

Influence of cultural taboos, norms and practices with gender norm underpinnings

- Son preference
- Dietary restrictions
- Hard labour good for easy delivery
- Not seeking care alone due to "evil spirits" taking over
- Rigid gender norms and stereotypes, i.e. women/girls should stay near the home

Influence of social values-social invisibility

- Exclusion from community level participation in decision-making bodies-community health committees
- Low value accorded to women's representation and voice in community structures
- Isolation of adolescent married/unmarried pregnant girls

⁵ *Gender-based violence* is the general term used to capture violence that occurs as a result of socially constructed expectations and norms associated with each gender, along with the unequal power relationships between the two genders, within the context of a specific society. Generally, due to women and girls' lower status in society, violence affects women and girls disproportionately due to their 'gender.' GBV are acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.

3. Supply side of health care service delivery

Key gender-responsiveness gaps in health service provision

- Fragmentation of services
- Inappropriate/culturally insensitive staffing such as male health service providers for maternal health
- Lack of adequate privacy often resulting in client indignity (especially adolescent girls)
- Client-provider-interaction - attitudes and behaviours of health service providers (especially towards adolescents)
- Exclusion of men, thereby distancing them from active participation in MNCH
- MNCH facility infrastructure and facilities often not mindful of men's needs
- No designated latrines and washrooms for women Certain service protocols requiring male consent/presence, thus undermining women's health-seeking autonomy
- Low representation of women/girls in health decision-making/governance resulting in inappropriate services
- National MNCH data by and large disaggregated by sex and age. HOWEVER, low capacity to analyze the data with a gender lens, resulting in assumption based planning and the invisibility of adolescent girls
- Women form large proportions of the health workforce. HOWEVER, women's representation in policy-making forums is low, resulting in, low voice representation and thereby gender-blind policy
- Low inter-ministerial coordination (health and gender/women's development) despite MNCH being high priority in most national women's policies/plans
- Low representation and participation of women in local/community level health committees, resulting in inability of women to hold duty-bearers accountable

Note: Suggested exercise for the above for training CHWs and then of male and female community members.

Full group exercise: unpacking gender-related barriers- Kabula's story... (See Annex 1 for the full exercise and story)

Kabula is a 17 year old mother of one daughter, now 5 months pregnant with another child...

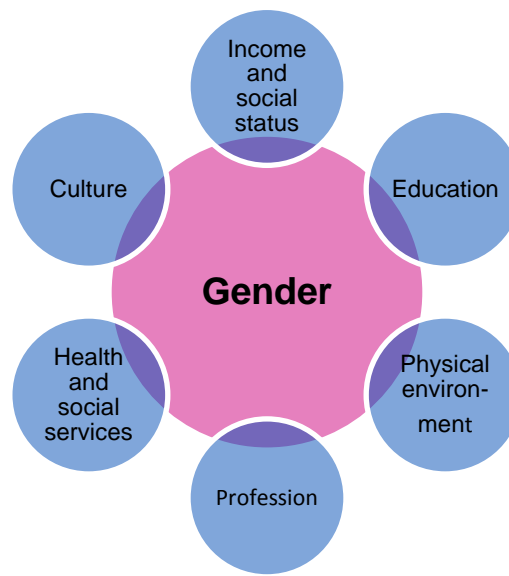
What are key issues Kabula will face in accessing and utilizing MNCH/SRH services?
Why does Kabula face these issues?

Note: Another possible exercise is the "Power Walk" (See Annex 2) to explore how gender interplays with other social barriers to make certain individuals and groups more marginalized.

One group of people who are commonly discriminated against is women. This is sometimes called gender based discrimination. The opportunities and resources available to women and the ability of women to be involved in decision making is limited. Women are excluded from most positions of power. This exclusion is not based on the ability of the person. In most cases, women are excluded simply because they are women. In traditional societies there are very different roles for men and women. In most cases, customary law and practices give positions of power, authority and decision making to men. This exclusion from community decision-making is a form of discrimination.

Intersection of gender and the social determinants of health

The social determinants of health refer to the conditions in which people are born, grow, live, work and age, as well as the health systems that are put in place. These are decisive factors influencing people's health. Gender has a bearing on each of the social determinants.



Education: an individual's education level influences their ability to read and understand health information. Gender norms often accord lower priority to girls' education, resulting in lower educational status of women and girls relative to boys and men, thereby limiting their ability to read and understand health/MN(C)H/SRH information.

Income and social status: an individual's access to and control over resources influences their ability to purchase nutritious food and seek health care. Due to gender norms women have fewer employment opportunities, are financially dependent on men/family members, have little independent access to financial resources or decision-making over the usage of income in households, thereby reducing their financial capacity to access health/MN(C)H/SRH care.

Physical environment: an individual's living conditions and work patterns influences whether they are exposed to certain pathogens, such as malaria. Gender-related roles and responsibilities relating to women's role increases their exposure to water-borne diseases due to household water sourcing, pollutants related to poor stoves due to cooking and exposure to sanitation related diseases due to their cleaning and child and elder care, thereby contributing to increased MN(C)H/SRH risks.

Profession/work: an individual's working conditions will influence what they are exposed to, such as chemicals. Due to gender related values, women tend to be employed in precarious unregulated work or work as unpaid agricultural workers in rural areas. The tasks performed by them are invariably low technology based involving hard labour, such as manual weeding, seeding, cutting etc., thereby exposing them to higher risks of contaminants and poor posture related health/MN(C)H/SRH risks.

Culture: cultural and harmful traditional practices and norms such as female genital mutilation and cutting (FGM/C), early marriage, or son preference, or dietary restrictions during pregnancy, or breastfeeding

related restrictions etc. invariably affect women and girls more negatively relative to men and boys, thereby increasing MN(C)H/SRH risks and complications.

Health and social services: an individual's ability to access health and social services (such as health insurance) influences their health. Gender norms often restrict women's mobility, requiring permission from male partners or family members, restricting travelling far if services are at a distance, women's lower financial independences leaves them incapable of paying transportation charges, women's household workload and care work often leaves little time for them to access services, thereby compromising their ability to access social or health/MN(C)H/SRH services.

Note: Suggested exercise for the above for training CHWs:

Small group work: divide participants in three equal groups giving them two Social Determinants of Health each; ask participants to brainstorm how gender-related barriers, issues and norms influence the Social Determinants.

Groups report back in plenary.

Based on Kabula's story, it is clear that gender acts as a cross-cutting determinant of health through its influence on each person's access to and control over opportunities and resources, as well as their opportunity to influence decision making.

THEME 3: GENDER RESPONSIVENESS IN COMMUNITY HEALTH EDUCATION AND PROMOTION

What are the International and National Gender Policy Commitments relating to health?

Key points to cover:

- Explain that all girls, boys, women and men have "rights" and define the key concepts of "right holders" and "duty bearers."
- The rights to health (including MNCH/SRH) and gender equality are fundamental rights for all girls and boys, women and men. This fact is stated in International Law, onto which all countries implementing projects (name the specific country in question) and therefore, responsible for.
- The right to appropriate, accessible and timely health services is clearly defined in International Law, i.e. the United Nations Covenant on Economic, Social and Cultural Rights (CESCR). It clearly states that all services should be based on principles of non-discrimination regardless of sex, age, ethnicity, class and so on.
- The right to equality is clearly defined in the United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The Convention requires that States who have signed onto the law represent the principle of equality for women and men in their national constitution and laws. The Government signed this Convention on _____ and ratified the Convention on _____.
- Sexual and reproductive health and rights are human rights and fundamental freedoms at the core of human dignity. They have their legal basis in a number of international human rights instruments including the Convention on the Rights of the Child (CRC), CEDAW, Convention on the Rights of Persons with Disabilities (CRPD) and The Optional Protocol to the Convention of the Rights of the Child on the sale of children, child prostitution and pornography. They include the right to choose whether, when and with whom to engage in sexual activity; to choose whether, when and with whom to have children; and to access information, opportunities and means that enable these decisions, free from violence, coercion, subjugation and discrimination.

Almost all countries implementing have committed to ensuring equality of opportunity for women, men, girls and boys, in health services. In x country, the following policies exist.

Countries implementing the project should add relevant content as applicable.

As shown, rights to health and gender equality are inter-linked. Gender and other social disparities in society are major barriers to realizing the right to health because of their impact on equitable access to health-care services and consequent impact on avoidable morbidity, mortality and well-being.

Promoting gender equality in health is thus a major component of promoting the right to health of all people. With this in mind, a key approach to addressing gender inequalities is integrating consideration of gender equality in health policies and services in order to identify and address barriers to health that are based on gender-based discrimination and injustices that deny women and girls and men and boys their rights to health.

Concluding remark: This integration of gender equality must happen at all levels of health services from within health care facilities and in community health work. Community health workers have a very important role to play within this.

PRACTICAL TOOLS FOR UNDERSTANDING WHERE WE ARE AT AND WHAT WE SHOULD STRIVE FOR...

Plan International strives for all its programs to be gender aware and as much as possible gender transformative. To help conceptualize this notion, imagine a gender continuum along which all projects and services fall, ranging from gender blind to gender transformative.

Using a traffic light imagery, imagine projects and services including community health activities that are gender aware to gender transformative fall in the 'green light' to continue doing what we're doing. When projects, and services fall in the red area- think of this as our 'red light,' indicating that we need to stop and re-assess how we are approaching our work, in order to ensure positive outcomes for girls, boys and women and men in the communities we serve, and to uphold a 'do no harm' principle.

There are four 'categories' to assess degree of quality of gender equality integration:

- **Gender Unaware:** *Gender unaware programs and services do not recognize gender issues, and tend to aggravate gender inequalities.*
- **Gender Neutral:** *Gender neutral programs and services recognize gender issues but don't do anything about them, and so tend to reinforce gender inequalities.*
- **Gender Aware:** *Gender aware programs and services seek to improve the daily condition of women and girls by addressing practical gender issues such as improving women and girls' access to MNCH services. These activities try to reduce barriers based on existing role expectations of women. They do not try to transform gender relations such as engaging men in MNCH.*
- **Gender Transformative:** *There is an explicit intention to transform unequal gender power relations and the root causes of inequality. The focus goes beyond improving the condition of women and girls and seeks to improve their social position (how they are valued in society) as well as the full realization of their rights. Thus, it involves improving women and girls' access to MNCH services by*

addressing gender norms that devalue men and boys' sharing of responsibility and partnership in gender equality and MNCH promotion.

Note: Suggested scenarios to introduce how CHWs can integrate gender awareness and responsiveness (transformative approaches) into their work.

Scenario #1: Some women may not be able to visit your CHW site because gender norms in her community prevent her from travelling alone. However, by accounting for this norm and adjusting when and where you conduct consultations with them, she may be able to access and benefit from your services. It is also an opportunity to invite her male partner along.

Scenario #2: In some households, men may be the primary decision makers when it comes to spending household income and thus women may face challenges in paying for medicines or traveling to a health centre for a referral. However, by raising awareness in communities and targeting men and boys, as well as women and girls, to build understanding around gender equality and the importance of women having equal access to funds to seek health care, she and her children may have greater access to your services and those at health facilities, thus enhancing the impact of community health education work. CHWs can sit down with the husband separately or with the wife to explain how joint decision making and pooling of resources can improve household wellbeing and help ensure a healthy baby is born.

Are these scenarios, gender aware or gender transformative?

Note: Suggested exercise is to brainstorm on: "Can you think of activities that you/CHWs in your region do that fall in one of these categories?" Once participants have shared at least one example of each category; ask them "If as a CHW, you were asked to truly find ways to address gender barriers and to support greater gender equality in community work on MNCH/SRH education and promotion, what activities would you suggest?" "What other role could CHWs play?" List all ideas on a flipchart.

WAYS TO INTEGRATE GENDER EQUALITY CONSIDERATIONS IN CHW'S WORK:

- **Striving to be gender aware at the least and gender transformative where possible.**
- Consider how gender-related barriers and issues may cause vulnerability, risk and disadvantage for women, adolescent girls, men and adolescent boys, particularly **paying attention to the most vulnerable and marginalized**. These barriers can affect their capacity to seek health care services in MNCH/SRH and their opportunities to access them, including information.
- **Adhere to a 'do no harm' principle to ensure that any gender related barriers are taken into account.**
- **Be sensitive to the particular barriers women and girls face; and helping them to overcome these barriers.**
- Consider the differences between and among women, adolescent girls, men and adolescent boys. They are not all the same.
- Ensure that the way you provide consultations and facilitate community dialogues and information sessions take into account the different needs, priorities and concerns of women and adolescent girls and men and adolescent boys.
- Recognize the influence men have over the lives of women and children in families and communities
- Recognize the influence of other socially respected male and female leaders such as religious leaders or certain traditional female influencers (i.e. mother in laws).
- **Engage men as productive and supportive partners in MNCH/SRH care.**
- Engage socially recognized and respected male and female leaders as productive and supportive partners in promoting gender equality and MNCH/SRH care.
- Challenge prevailing discriminatory attitudes, behaviours and assumptions
- Act as a good role model-lead by example.

- Influence and inform male/female clients on gender equality and gender issues in MNCH.
- **Empower men/boys and women/girls to bring about change for equality.**
- Act as an advocate for change in the larger community context.
- Actively listen to women/girls and men/boys and remain non-judgmental. At the same time, clearly communicate that gender discrimination and any form of violence or HTP is a human rights violation.

How?

One key strategy is that you clearly communicate key gender equality messages in community MNCH/SRH and rights education.

Note: Suggested exercise is to divide up the CHWs into small working groups to brainstorm on possible gender equality messaging in MNCH/SRH that CHWs should advocate for in their work. Divide them up into two thematic groups: 1) Messaging for women and girls' empowerment; 2) Messaging for encouraging men and adolescent boys to become equal partners and supporters of women/girls in MNCH/SRH.

Groups then share in plenary. After discussion, review and cross-check with list below.

POSSIBLE GE/MNCH/SRH MESSAGING (ADAPT ACCORDING TO LOCAL CONTEXT)

- Key message: Gender-based discrimination, injustice, unfair treatment, and loss of opportunities to advance in life just because one is born a female violate the fundamental and universal right to equality between women/girls and men/boys. And that families and societies are more productive and prosperous when they reap the full potential and talents of all. The emphasis being that gender equality is not a 'women's concern' but the responsibility of all in society, as all benefit from it.
- Women and girls face additional gender based barriers, i.e. lack of access and control of financial resources and may be constrained in their mobility by dominant gender norms and this contributes to delays in accessing timely appropriate MNCH services for themselves and their children.
- There is an **inextricable connection between the wellbeing of mothers and their children**, where healthy and empowered women and mothers are essential if we are to realize the rights of women and children to health and equality for positive MNCH outcomes.
- Equal responsibility of women and men in family health/MNCH (ensuring the stereotype of MNCH being a "woman's issue" is addressed). Men's role in and contribution to family health and well-being
- Support gender equality and value the rights of women and children.

COMMUNICATION STRATEGIES FOR ENGAGING MEN AND BOYS IN MNCH/ASRH

Why is male engagement important in MNCH/SRH outcomes?

- Increases pre and post natal care and usage of skilled birth attendants at birth
- Contributes to less physical and emotional distress during labour and delivery
- It increases breastfeeding
- It increases child development outcomes
- Increases household income with increased women's economic participation and increases health and well-being of families
- And finally it improves the health and well-being of men themselves: more productive at work; less substance abuse and more satisfaction and happiness.

Good practices:

- Use appropriate messaging (See Promundo guidance).
- Home visits to men and women to discuss gender issues in a private space, in confidentiality and with more time to discuss *thoroughly*.
- Reaching men where they gather.
- Deliver messages through existing leaders or institutions; men are more likely to follow advice of respected or senior community members, i.e. religious leaders or socially respected elders.
- Use edutainment and entertainment to develop catchy and original stories that also match with men's actual lived experiences.
- Use multiple channels to deliver message; men may be open to receiving health information at a range of forums.
- Messages more acceptable when sensitive to socio-cultural norms and taboos.
- Raise taboo issues gradually - after community sensitization on MNCH.
- Adopt a gender-synchronized approach that includes complementary strategies or activities with men and women.
- Understand male engagement as a broad concept rather than specific actions taken by men.
- Rather than promoting a single model, consider how couples might be supported to decide together how men can best engage in MNCH.
- Ask men/boys themselves what their needs are.
- Consider men's work schedules and other obstacles.
- Prepare men for the challenges of upcoming parenthood and engage them early
- Encourage men to share an equal burden with the mother by learning caregiving skills and taking on more of the domestic work in the home
- Encourage the father to learn about the different stages of the pregnancy and be present for prenatal care visits. This can positively influence a father's attendance and participation in follow-up visits
- Prenatal, pregnancy and postpartum care issues are not only about the health of the mother and the child. Advise the father to look after his own mental health and take physical exercise, thereby creating an overall healthy environment for the development of his child.
- Share the risks associated with unhealthy behaviors such as alcohol and drug use, and physical and psychological violence. Advise the father about the negative effects on the health of the mother and child.
- Promote attitudes of mutual support, collaboration and dialogue between mother and father that allow them to better address the anxieties and concerns often generated during pregnancy.

- Address the father's questions and concerns regarding pregnancy and its impact on the couple's sex life.
- Discuss contraceptive use to plan for or prevent future pregnancies.
- Teach both mother and father how to act promptly and adequately in cases of emergency, know what merits a visit to a health care facility, how to access services, etc.
- Engage men: ask questions on their roles and concerns in MNCH/SRH
- Ask them if they support their wives in family planning, birth preparedness, delivery and post natal care. Ask: what do you do? What could you do?

Use messaging like:

- Emphasize that men are equally capable of all child care tasks and responsibilities, except, of course, breastfeeding.
- Benefits of male engagement in MNCH to men themselves and their families.
- Barriers (women and men) to family planning.
- Men's support during pregnancy, delivery and post-natal,; **i.e. encouraging their husbands and male relatives to support women.**
- Encouraging the husband to accompany his wife or partner or female relative to a health facility.
- Encouraging men to support their wives to rest; Helping their wives/female relatives with housework.
- Supporting and encouraging their wives to practice exclusive breastfeeding for first six months.
- Helping take care of children.
- Encouraging men to decide with their female partners the best birth-planning.
- Arranging transportation for the female partner/relative to get to a health clinic.
- Supporting women's decision making.
- Buying medicine.
- Encouraging men to be champions of gender equality.
- Encouraging men to value equality, respect and dignity of all people for collective benefit, i.e. for peaceful households.
- Be active caregivers and nurturers: when planning to have a child, during pregnancy, during labor and delivery and after the child is born.
- Should assume equal and joint responsibility of domestic chores and in the development of a happy, healthy and caring relationship with their partner.

FOR WORKING WITH ADOLESCENT GIRLS AND BOYS

Good practices:

- Go to where they spend time
- Provide informational material using a language, format and comprehension level appropriate to adolescent girls and boys.
- Avoid mixing groups of girls and boys when speaking about sensitive topics; only bring them together when they are ready for such dialogue.
- As part of working with young women and men/adolescent girls and boys, ensure that they are involved in the development of the SBCC material.
- Ensure gatekeepers, parents and older generations and community leaders are involved as well in the design of health education and communication strategies and materials to avoid any resistance and build community buy in.
- Ensure privacy, confidentiality, non-discrimination and non-judgmental attitudes.
- Suspend any gender and or age biases.
- Adolescent girls and boys are heterogeneous groups. It is strongly recommended not to organize discussion groups with married adolescent and unmarried adolescent girls

- It is recommended never to mix married and unmarried adolescent girls in one dialogue group. Adolescent girls should be segregated by civil status for good reason: their issues and barriers are not the same given their social status and they are not to be conflated under one monolith of “adolescent girls”.
- It is also important that the mix is not such that it inhibits one individual versus another. For example in close knit communities there may be extended relations living in one area, making it difficult to speak openly. In such cases, it is advised that the sphere is widened to invite group participants that are not related in order to ensure that participants are able to freely share their personal views and experiences.
- Female facilitator works the girls groups
- Male facilitator works the boys groups.
- Male facilitators should never facilitate girls groups
- Develop messaging on gender that is based on their interests – the hook

COMMUNICATION SKILLS FOR WORKING WITH YOUNG MARRIED WOMEN AND FIRST TIME PARENTS (FTPS)

- Young married women and first-time parents face a unique set of challenges to living healthy sexual and reproductive lives which are different to those faced by unmarried adolescents or older married women.
- Kabula’s story illustrates many of the unique barriers young married women/adolescent girls to healthy SRHR and MNCH: They often suffer social isolation, burden of household responsibilities and limitations on their mobility; often have limited supportive social networks or access to health information and services; very low decision making power and access and control to resources; and this makes it very hard for them to influence when to have a child, child spacing, general family planning and decisions on their health and that of their children.
- Their husbands, co-wives, community and family elders, in-laws, and religious leaders have most of the decision-making power (or influence) related to sexual and reproductive health (SRH) and they also often decide how resources within the household are used.
- Unequal power dynamics and gender inequalities place young married women and first-time mothers at particular risk of gender-based violence, gender-based household maltreatment, pressure to bear children before they are ready and prevention of pregnancy spacing.

Result: Many young in-union or married women become parents during their youth and young mothers have closely spaced pregnancies, compromising their health and that of their newborns. Significant evidence posits that both mother and baby are healthier if at least 24 months passes between pregnancies.

What can CHW’s do?

- Demonstrate appropriate, nonjudgmental, and comprehensive counseling for young married women and FTPs regarding their reproductive health.
- Identify the key influencers of young married women and FTPs’ on reproductive health decision-making and
- Develop gender responses to increase acceptance of young married women’s and adolescent girls and their male partners to family planning among key influencers (e.g., husbands, mothers-in-law, and others) on young married women’s and FTPs’ reproductive health.

TIPS FOR FACILITATING COMMUNITY SEX SEGREGATED DIALOGUE GROUPS

- Gender equality is a sensitive subject. Create an atmosphere of respect for all views and one of self-reflection. Not all men are opposed to gender equality and not all women are champions of gender equality by virtue of their sex. Gender is socially constructed and thereby behaviours, attitudes and values are learned.
- Encourage men (and women) to share, question and analyse their own behaviours, attitudes and experiences so they can unlearn/deconstruct behaviours and values. This is especially important

when engaging men. While it is extremely important to inform women of their rights and gender equality, it is critical to simultaneously work with men to create an enabling environment for the empowerment of women.

- It is important to respectfully challenge and resolve views/statements that may be offensive or sexist by offering an alternate view in keeping with Plan's values by thanking the participant for their view, seeking an alternative view and backing the alternative opposing view with national laws and evidence. E.g. *"I believe she deserved to be beaten by her husband. She was disrespectful. I don't blame him for breaking her arm and ribs."* Respond by asking other participants if they agree, if no response is given, provide the response that any kind of violence against women is unacceptable. Refer to national legislation regarding GBV, domestic violence etc. and provide data/evidence to show the harm caused by GBV.
- Depending on context and cultural appropriateness, it may be necessary to have sex-separated spaces to discuss issues, so men and women are open to discuss the themes. However, while sex-segregated spaces are recommended, it is also important to move gradually towards a gender-synchronized approach by having more couple/mixed-sex sessions on the same topics. In all cases, it is key to check with women and men to determine their level of comfort in single-sex or mixed-sex groups and ways to promote couple involvement where possible.

Facilitating group discussions

- Locate a venue that is conducive to discussion, i.e. private, comfortable and safe.
- Choose regular meeting times in consultation with your target group to ensure all can participate.
- For dialogue groups or discussions, avoid giving health education talks but rather work with the group to generate discussion and questions about topics
- Be non-judgmental – do not judge any participant because of their actions and beliefs. Try to question and suspend your own judgments.
- Actively make women, men, and adolescent girls and boys feel comfortable and accepted in order to foster a group dynamic that allows for exploring sensitive issues and looking at them differently.
- Practice active listening – listen, do not interrupt, do not judge a person, withhold your own judgments.
- Do not be passive or indifferent.
- Encourage the speaker; use your body language to show you are interested and listening.
- Ask questions – make sure you understand and try summarizing what the person said.
- Provide effective feedback to help the other person. Generally, feedback is given in private.
- Keep tone calm and cool – do not get upset.
- Be specific.
- Use positive body language.
- Retain confidentiality.
- Encourage all participants to use "I statements" – "I believe" "I feel"
- Use participatory learning techniques such as:
 - Brainstorming – accept every idea without judging; aim for quantity not quality; do not interrupt the brainstorming process
 - Group exercise
 - Quizzes
 - Role plays – are a powerful technique for exploring personal experiences, feelings, beliefs in a safe and effective way.
 - Timelines of a fictional key player or of a social group, the community etc; for exploring changes over time and what causes the changes
 - Experience sharing

- Be assertive but not aggressive
- Relate to others in a collaborative way

During home visits

- Ensure privacy and confidentiality. This includes both visual privacy and auditory privacy.
- Respect the woman's/adolescent girls' dignity
- Treat all clients with respect irrespective of her social or economic position or age or marital status.
- Respect the client's culture and value systems even if you don't agree with them
- Carry out a two-way conversation without being judgemental or coercive
- Do not underestimate a client's knowledge or assume she is ignorant. Acknowledge her knowledge-base and build on that with counselling
- Probe about any issues related to gender roles and norms (such as access to and control over resources and decision-making) that could impede optimal utilization of MNCH services
- Encourage the mother to share all information with the father and involve him in the process including birth preparedness planning.
- However, if the father takes over the conversation and answers questions for the mother, ensure that you encourage the woman to speak for herself.

During referral to a higher level facility

Making a referral mechanism gender-responsive requires understanding the need of privacy and dignity of a pregnant/postpartum woman while being transported and arranging for timely, appropriate, adequate and safe transportation to take her and an accompanying attendant, freely chosen by her from the community to the primary or higher levels of health care. This also includes:

- The necessary information regarding the referral links are communicated to the woman and her partner.
- The transportation is appropriate (i.e. there is comfortable and safe space for the woman and her partner/accompanying person), accessible and affordable (meaning that if government transport/ambulance is not available providing access to community-based system of organizing transport).

GENDER APPROACHES DURING CONSULTATIONS

One important first step is to identify gender considerations to take into account while conducting consultations with women of child bearing age, of adolescent girls and their babies and of male partners and relatives that should be involved.

Practical Questions for CHWs to consider in consultations

- 1. Consider gender barriers and develop a gender response to address the barrier.**
 - Be mindful of how you visit households by first **identifying the gender access barriers for different groups of women (i.e. married versus single women, women in polygamous households etc.), adolescents girls (married/unmarried, in school or out of school, etc.), men (husbands versus male relatives, etc.) and adolescent boys (young fathers, etc.) and even differences between older more experienced parents and new and young male and female parents, caregivers and their babies and so on, may experience in seeking MNCH/SRH services.**
- 2. Aim for developing both gender aware and gender transformative responses:**
 - Each gender response may consist of gender sensitive and gender transformative approaches.

- Gender sensitive refers to when the different needs, abilities and opportunities of boys and girls and men and women are identified, considered and accounted for.
- Gender transformative or gender responsive refers to when we utilize a gender aware approach and go one step further to promote gender equality. We also work with key stakeholders to identify, address and transform the root causes of gender inequality for women and men, girls and boys and thus the entire community to promote social change for gender equality and good health.

How?

In following this two-step approach, it is useful to think of a consultation as a process that includes three phases:

- **Pre-consultation** – Prior to the female or male client arriving at the CHW site or a CHW visiting a home.
- **Consultation** – While the female or male client is at the CHW site or in a home visit.
- **Post-consultation** – After the female or male client departs from the CHW site or in a home visit.

In the pre-consultation phase:

- Consider: **how does gender influence** the ability of a young adolescent unmarried girl to access health services at a CHW site?
- **Prioritize the numerous barriers** based on those that have the greatest impact on limiting access to and benefit from health and services.
- In reviewing the role of a CHW, review the list of prioritized barriers and **determine which ones CHWs have the greatest ability to influence** considering whether it is the client coming to the CHW site or the CHW conducting a home visit.
- **Identify a gender response that is gender aware and gender transformative** by identifying how the barrier could be addressed by changing the ideas, behaviours or actions of women, men, girls and boys in the community; and determine the most appropriate gender equality promoting actions that can be carried out in your CHW activities; and
- **Identify any risks** that might be associated with the gender responses and determine how they may be mitigated.

By applying these steps, CHWs can both identify the most critical gender barriers and related responses to apply in the consultation process to address and better support the adolescent girl.

Note: Suggested exercise is to go back to Kabula's story (Annex 1).

During the pre-consultation phase

What were the barriers Kabula faced to accessing health care services before the project began? Ask participants until all ideas are shared.

Possible responses are: physical: heavy burden of domestic chores; social: unable to make a decision without her husband's permission; and cognitive: lacked access to information.

What are the possible gender responses to reducing these barriers that a CHW could initiate? (Review by one barrier at a time as illustrated below).

Gender Response(s): To reduce each possible barrier, as a CHW;

Barrier: women and adolescent girls' heavy work burden

- Sensitize male and female community leaders and community members, particularly engaging men and adolescent boys on the importance of sharing responsibilities for household chores to reduce the burden on pregnant women, pointing to the health risks and needs of pregnant women for healthy pregnancies and deliveries. The sensitization process may include formal or informal, group or

individual sessions with community leaders and members to discuss the barrier presented to pregnant women and adolescent girls.

- Conduct a household visit to Kabula's home and try to discuss with the husband separately the importance of the husband's support and then go back again to discuss with the husband and wife together but focus on other MNCH issues before suggesting again the importance of the husband's support.

Barrier: married women and adolescent girls' low decision making power/agency in MNCH

- Can sensitize male and female community leaders and community members on the importance of maternal and child health, as well as the importance of equitable opportunity to influence decisions at the household level.
- Conduct additional home visits to sensitize household members, especially male head of households, on the importance of MNCH and the importance of equitable decision making for common benefit to all including success of the husband as a father and household head.
- Conduct group or individual sessions within the community or home to support women in feeling confident about advocating for their health needs and rights to health, as well as those of their children. It may be helpful to provide supporting documents that explain the importance of equitable decision making for the health of the entire household.

Barrier: women and adolescent girls' low education and limited mobility

- When informing women, adolescent girls and men and boys about danger signs of pregnancy and child birth, communicate health information more clearly and according to the audience's literacy level and local language. This may mean that you must use simpler language, use pictures and possibly bring in a trusted translator.
- Use role plays, imagery and interactive theatre and videos

During the consultation phase, what are the possible responses or actions or behaviour changes the CHW can provide?

Sample Barrier – Gender norms may dictate the way in which men and women can interact, may limit the opportunity of WRA to receive health services from a male healthcare provider.

Ask for participants to share any experiences with this obstacle?

Gender Response(s): To reduce this barrier, as a CHW;

- May decide to raise this barrier to the local health committee, respecting the confidentiality of the beneficiaries, to seek their support in addressing the barrier.
- Invite a trusted male or female community member, such as a religious leader or elder of the community, to attend the consultation with the WRA or adolescent girl. This way, the female client may feel more comfortable in receiving services for themselves and their children.
- On a regular basis, rather than hosting consultations inside the site building, host consultations in an open space that is visible to others but also respects confidentiality.

In the post-consultation phase, the gender based barriers are similar to those already mentioned during the pre-consultation and consultation phase; however, in this phase explore how at times there are intersecting barriers.

Multiple Gender Access Barrier: Kabula faced multiple gender related barriers based on low decision making power and limited access to financial resources.

Gender Response(s): To address one or both barriers, as a CHW;

- Sensitize male and female community leaders and community members on the importance of equal access to family resources and/or equal decision making power for the realization of equal rights to good health for women and children.
- To further increase the effectiveness of the sensitization through addressing the root causes of poor access, identify female and male community leaders who can themselves advocate for gender equality within the beneficiary communities.
- Make special efforts to engage grandmothers in information and awareness raising sessions. As a CHW, you may consider hosting special sessions for grandmothers to ensure that they have access to critical health information, and to promote their acting as advocates for the equal health of women and children in their family's household and their other circles of influence.

Closing remarks: More specifically, if we do not correctly identify and address gender barriers to health services we risk reinforcing health inequalities, as well as delivering services which cannot be accessed by those most in need.

If a barrier is too big to address alone, it is best to contact a supervisor immediately to determine the best course of action.

APPLYING A GENDER EQUALITY LENS TO SOCIAL BEHAVIOUR CHANGE COMMUNICATION (SBCC)

SBCC is when we use forms of communication to promote healthy behaviours and practices to improve MNCH/SRH outcomes.

Ask participants what kinds of behaviour change communication work they include in their work?

CHW use diverse forms of communication – one on one sessions, community sessions, radio messages, theatre for development, and printed materials – to promote healthy behaviours and practices that promote positive health seeking behaviours and practices such as child spacing, birth preparedness, doing 4 anti-natal visits; giving birth in a health facility with a skilled birth attendant and prevention of illnesses such as diarrhea, pneumonia, and malaria.

Add examples:

- One-on-one counselling with caregivers during consultations or home visits on exclusive breastfeeding.
- Group education sessions with WRA and separately with adolescent girls on health.
- Group education sessions and or discussions with men and boys around topics of caring fatherhood, parenting education, positive role modeling, and gender equality. Male engagement is critical to full support and care necessary for the wellbeing of mothers and girls and boys.

As a first step: identify gender based barriers to learning and benefiting from behaviour change communication messages, and to select which gender approaches to employ, gender access barriers based on physical, social and cognitive barriers should be asked.

Note: Suggested exercise is to use examples (scenarios) to explore gender barriers and responses (see Annex 3).

EXAMPLE 1

Gender Access Barrier: For female caregivers, one gender based barrier that is common among women is that they do not have equal control over household resources for uses such as transportation costs to attend a session.

Ask participants if they have observed this obstacle and to share their observations.

Gender Response(s): To reduce these barriers experienced by women and adolescent girls, CHW may;

- Host sessions at various locations within a catchment area to reduce the physical distance one must travel to attend.
- Schedule sessions before or after planned community events so that women and or adolescent girls who are already at the event do not need to travel again to attend the session.
- Host one-on-one sessions at the homes of women who are unable to attend community level sessions.
- Promote health education sessions being delivered via radio and drama groups.

EXAMPLE 2:

Gender barrier: Women & men may not have time to attend discussions on the use of family planning services.

Ask participants if they have observed this obstacle and what they have observed.

Gender Response(s): To reduce these barriers, as a CHW,

- Host several sessions for the same purpose across different days and times to ensure women/adolescents girls and men/adolescent boys are able to attend.
- Schedule sessions before or after planned community events so that women, men, and adolescent girls and boys who are already at the event do not need to travel again to attend the session.
- Organize sex and age segregated groups to maintain safe and welcoming spaces for each group

EXAMPLE 3:

Gender barrier: The ability of male and female caregivers to access behaviour change communication sessions that focus on culturally sensitive topics, such as family planning.

Ask participants if they have experienced this and what they have observed?

Gender Response(s): To reduce these barriers for women/men/adolescent girls/boys, CHW may;

- Create gender-safe spaces by providing sessions on culturally sensitive topics on a one-to-one basis rather than in groups.
- Provide these forms of sessions with men and women and adolescent girls and boys in age and sex disaggregated groups so that all are more comfortable to talk about sensitive topics.
- Organize community awareness sessions with community leaders and community members, both women and men, to address taboos related to family planning.
- Identify respected female and male community leaders who can support in the sensitization of community members on the importance of family planning and the need to break the taboo.

Note: Suggested additional scenarios for CHW participants to practice in groups of 2 to 3 are found in Annex 3.

Closing remark: It is important to recognize that not all gender barriers are visible and easy to see. Thus it is good practice to:

- Routinely ask female and male clients in home visits and in CHW-site consultations questions about their experiences in accessing health services.
- Ask questions about their experience in accessing health services and if they confirm experiencing a barrier you may ask them how you can support them in addressing the barrier.
- Remember that the first priority is to do no harm and if you respond simply based on assumptions, you may inadvertently increase the barrier.

Guidance on simple steps you can take as a community health worker to be more gender-responsive in your consultations with women, men, adolescent girls and boys and in your facilitation of information sessions, group education and social mobilization.

ANNEX 1: KABULA'S STORY – AN EXPERIENTIAL GROUP EXERCISE

The experience of married adolescent girls and young women is illustrated in the Story of Kabula. This story is an experiential exercise that can be used in the CHW training workshop and then by the CHW for mixed groups of women, men, girls and boys in a community setting to raise awareness and commitment to gender equality and adolescent/girls' rights to appropriate MNCH knowledge and services for positive maternal, newborn and child health.

Opening

Kabula (Give a local name) is a 17 year old girl. She lives in a village named _____. Kabula has a much higher chance of dying in childbirth as someone in their twenties and her child is much more likely to die in childbirth than women of any other reproductive age group. If a mother dies at childbirth, the child is 10 times more likely to die. Kabula like most rural women will likely give birth at home with neighbours and no skilled birth attendants and if there are complications, she is likely to lose her life or that of her child. She has not received more than one antenatal care visit and will likely not receive a postnatal care visit. She cannot get to the nearest health facility because it's too far to walk and she is burdened by household chores. Like many other women, her husband makes decisions on whether she receives health care or not. These are everyday realities faced by women in rural _____ (name the implementing country)."

Instructions

1. Ensure a large enough space for all participants to stand in two concentric circles. Come to the session with blank paper, marker and a big roll of wool or string.
2. Ask for a volunteer to be a fictional girl from a village in your country. Ask her to sit in the chair and to hold the ball of wool.
3. Ask everyone to stand around the girl. You may have one inner circle around Kabula and another larger one outside of the smaller one. Explain that everyone is a part of Kabula's story.
4. Ask all the participants to imagine that they are in a rural area. You will narrate parts of her story, statement by statement, and they will have to explain why the girl is in that particular situation. You will help them by reformulating the questions behind the statement.
5. Explain to the group that every time a gender issue or barrier is identified with the statement, Kabula has to pass a ball of wool to the person holding the type of gender issue identified and then they wrap it around themselves and give the ball back to her and she has to wrap it around herself before the next statement is read aloud. Another facilitator will have a pen and small sticky notes and will write the barrier identified by each participant who must keep that paper with them until the end of the exercise.

Read the first statement of the opening: "Kabula has a much higher chance of dying in childbirth as someone in their twenties and her child is much more likely to die in childbirth. If a mother dies at childbirth, the child is 10 times more likely to die."

Ask the question: "Why is Kabula and her child likely to die?"

The participants will respond.

For each response given by a participant (one by one), write on the piece of paper, give it to the participant who gave the response then Kabula has to pass the ball of wool to the person holding the type of gender issue identified and then they wrap it around themselves and give the ball back to her and she has to wrap it around herself before the next statement is read aloud.

Go to the second statement: “Kabula like most rural women will likely give birth at home with neighbours and no skilled birth attendants and if there are complications, she is likely to lose her life or that of her child.”

You reformulate: “why is Kabula likely to die giving birth at home?”

Participants respond.

You continue to wrap Kabula with each answer. If the same factor has already identified, you don’t need to wrap again.

Continue to read: “She has not received more than one antenatal care visit and will likely not receive a postnatal care visit.”

Reformulation: Why did she get only one antenatal care?

Participants respond.

Continue once participants have no more gender barriers to suggest. “She cannot get to the nearest health facility because it’s too far to walk and she is burdened by household chores.”

Why couldn’t she get to the nearest health facility? Participants respond.

“Like another 40% of women, their husbands make decisions on whether they receive health care or not.”

Read: “Why should their husbands make decisions on whether they receive health care or not?”

Once participants have finished suggesting “why.” Conclude with the statement: “These are everyday realities faced by women in rural x country.”

At the end of the opening text, Kabula will be entirely wrapped.

When all the statements are read aloud ask people the following questions:

- What do you see/observe?
- To Kabula: how do you feel?
- What are the implications for our project?
- How is the project addressing/dealing with this situation?

Kabula’s story is quite common. Within the story, many different factors (barriers) influenced her health seeking behavior including her ability and opportunities to seek and access health services. Many factors (determinants) are related to gender. With greater access to information, financial resources and services, the story of Kabula and her children’s health could be very different.

Closing = you read this part at the end of the role play – to show how more gender responsive services, including the CHWs’, can change Kabula’s story.

“We have spoken a lot about Kabula, a 16 year old girl from a village in one of the rural areas. She was the example of how gender barriers and constraints affect young girls currently in country x. I would like us now to picture Kabula’s life in 4 years.”

“Kabula is now 20 years old, still living in x area and is pregnant again. During her pregnancy, she has been to the local health facility for her antenatal check-ups, and has also been visited by her local CHW. In one visit, the CHW gave her information on the importance of registering her child when they are born to ensure that they are counted and will be able to access their rights. During her last antenatal visit at

the health facility, Kabula had high blood pressure and was identified as a high risk for complications during delivery. She discusses this with her husband, and understanding the potential risk, they are aware that Kabula needs to go to the health facility early during labour to assess the situation, and so save money for this trip. When Kabula goes into labour, they immediately go to the local health facility, where it is clear to the nurse that Kabula needs further medical attention for the delivery. Immediately the nurse contacts the district's ambulance, and Kabula is taken to the regional hospital. Upon arrival, Kabula is taken into surgery where an emergency cesarean-section is performed. Kabula delivers a healthy baby..Kibuka.. After returning to her village, Kabula and her husband are visited by the CHW for a follow up visit who discusses the baby's health and feeding practices. Kabula's son will grow up with his parents, and as Kabula was healthy during her pregnancy, the baby already has a head start at good nutrition throughout his life!"

In comparing the two versions of Kabula's story, what is it that makes them different?

Access to health information: The CHW came to Kabula's house knowing that Kabula as a young married woman does not have the freedom to leave the house when she wants. She is also overburdened with household chores. The CHW's gender sensitivity to Kabula's situation helped ensure that Kabula was still able to access information.

Opportunity to influence decision making: In the first story, Kabula did not have the opportunity to influence the decision to take her son to the CHW site because her husband had greater decision making power; however in the second story Kabula had the opportunity to make the decision. Her husband was also informed about the potential risks and he supported her to make a joint decision for herself and their children. This meant that in the second story Kabula was able to overcome this critical barrier.

Access and control over resources: In the first story, Kabula had to ask her husband to be able to visit a health facility and so did not have equal access and control over the household resources; however in the second story Kabula and her husband were both aware and concerned of the risk of complications in child birth and need for Kabula to go to the hospital promptly. They had saved money together. Thus, gender was a factor in the sense that the husband and wife shifted their understanding that birth preparedness should be a concern of the husband and the wife and that the husband should support his wife emotionally, intellectually and financially.

ANNEX 2: THE POWER WALK FOR UNDERSTANDING THE INTER-LINKAGES AMONG GENDER AND OTHER SOCIAL DETERMINANTS OF HEALTH

Note: Suggested exercise is the “Power Walk.” This exercise is a recreation of how gender issues and barriers interplay with other social disparities in action. The role play provides participants with a real sense of the person behind the inequity. The debriefing following the exercise allows participants to reflect on the types of disparities that exist and how they influence the life experiences of individuals.

This activity is preferably carried out in an open and fairly wide space to allow for movement.

Step 1: Make cards for each character using the roles provided below, or by making up diverse characters using the local context.

Step 2: Write cards with questions for observers: What did they notice as people took steps forward or remained still? After disclosure of characters, where were the male characters and where were the female characters? Why do they think some characters are empowered and why? Why are others not?

Step 3: Identify two or three observers, provide them with these questions, and place them in strategic places where they have a good overview of the participants. They will be asked to share their observations at the end of the activity.

Step 4: Instruct all other participants to start off in a straight line as if they are about to begin a race, reflecting the Universal Declaration of Human Rights, which states that “All are born free and equal in dignity and rights.”

Step 5: Randomly pass cards with the characters to the participants.

Step 6: Read out the statements provided below. With each statement, the participants who feel that the statement responds to their character take one step forward. Participants who feel that the statement partially responds to their character take a small step forward. Participants who feel that the statement does not respond to their character remain in the same place.

Step 7: After the last statement has been read, participants remain in their position and reveal their character.

Step 8: Lead a discussion on the outcomes of the Power Walk: Select a couple of characters from the front section to describe their experience, and what it felt like to be in those positions. These are the high-level persons and decision-makers in the community.

Then, select a couple of characters from the middle section to share their experience. Usually these are community organizers, professionals and CHWs. When it comes to health services, we would like these persons to be able to say yes more often to the Power Walk statements. Ask participants what strategies they think could help to do this.

- Select a couple of characters from the back section to share their experience, and what it felt like to be in those positions. Ask how they felt as they watched others moving forward. If no one else points it out, mention that the people at the back are usually the direct beneficiaries of the programs and policies we are involved in, and usually the most difficult to reach. These are the women and men whose health we are supposed to promote and protect—why are they at the back?

- Ask what the Power Walk tells us about the way in which we should develop health programs and policies, and what the different people need in order to participate effectively. How can the front group better respond to the different situations to improve health programming and policies?
- Conclude by highlighting the following key points:
 - Sex, age, ethnicity, sexual orientation, and place of residence are all important determinants of health. When they interact with gender norms, they often reduce the ability of characters (both women and men) to take a step forward in the Power Walk—or to safeguard their own health.
 - It is not only the existence of health services that ensures proper and effective access and use. Who you are and the conditions of your life make a difference in how you interact with the health system and how the health system treats you.
 - Furthermore, certain conditions of your life may mean that you have less social support for coping with disease and illness or less power to control decisions over your own body.
 - These are all aspects that are uncovered when we pay attention to gender.

(Modified from: *Gender Mainstreaming in Health: A Practical Guide*. PAHO, Washington, D.C.)

Characters:

- | | |
|--|--|
| ○ Orphan girl (10 years old) | ○ Man suffering from a mental health disorder |
| ○ Poor rural grandmother looking after 4 grandchildren | ○ Primary school teacher Nurse |
| ○ Orphan boy (10 years old) | ○ 20-year-old female survivor of rape |
| ○ Poor rural indigenous woman (18–24 years old) | ○ Pharmacist |
| ○ Male sex worker | ○ 20-year-old male survivor of rape |
| ○ Poor rural indigenous man (24–44 years old) | ○ 15-year-old rural pregnant girl, married to a man 45 years old |
| ○ Female sex worker Illiterate woman (50 years old) | ○ Professional gay man (24–44 years old) |
| ○ Minister of Health Illiterate man (50 years old) | ○ HIV-positive woman |
| ○ Director of health Professional man with 1 child | ○ Divorced woman with children |
| ○ Female community health worker | ○ Visually impaired young woman |
| ○ Professional woman with 1 child | ○ Divorced man with children |
| ○ Male community health worker | ○ Visually impaired young man |
| ○ Teenage boy (14–16 years old) | ○ Professional lesbian woman (24–44 years old) |
| ○ Female journalist for a local newspaper | ○ Transgender woman |
| ○ Teenage girl (14–16 years old) | ○ Professional gay man living with HIV |
| ○ Male journalist for a local newspaper | ○ Transgender man |
| | ○ 25-year-old alcoholic man |
| | ○ 14-year-old pregnant girl |
| | ○ 25-year-old alcoholic woman |
| | ○ 16-year-old boy with symptoms of an STI |

Read out the following statements and explain the instructions as defined above.

1. I know where to find the nearest health facility.
2. I feel respected by local health care workers.
3. I have a say in the way health services are organized and delivered in my community.
4. I can consult health services when and if I need to.
5. I have access to family resources if I need to pay for health care.
6. I can talk openly to local health care workers about my health problems.
7. I can talk openly to my family about my health problems.
8. Health programs in my area understand what my life is about.
9. I understand how to take medication given to me by my doctor.

10. I am allowed to be treated by a health care worker of the opposite sex.
11. I get to meet government officials.
12. I can read and understand the health information posters at the health facility.
13. If I get sick, I know I will be able to find the medicines I need.
14. I have access to micro-credit or other forms of borrowing money.
15. 15 My opinion is important within my own ethnic or tribal group.
16. I have access to clean and safe drinking water.
17. I eat at least two full meals a day.
18. I can buy condoms.
19. I can negotiate condom use with my sexual partner(s).
20. I can refuse sex with my partner or spouse if I want.
21. I went to secondary school or I expect to go to secondary school.
22. I can pay for treatment in a private hospital if necessary.
23. My opinion is respected/is considered important by municipal or district health officials where I live.
24. I am not in danger of being sexually harassed or abused.
- 25.** I do not feel judged by health care workers.

ANNEX 3: ADDITIONAL SCENARIOS AND ROLE PLAYS FOR CHWS TO PRACTICE IDENTIFYING GENDER BARRIERS AND GENDER RESPONSES

Note: It is recommended that scenarios be developed based on the context-specific gender related barriers and issues in the communities in which the CHWs work.

Scenario #1: During a home visit, the CHW started to discuss family planning with the head of the household and his wife. However, as soon as the CHW started to discuss contraceptive methods, the husband asked the CHW to leave by saying that he and his wife were not interested. However, during the conversation his wife seemed interested but did not speak up when the CHW was asked to go.

Questions: What is the gender barrier in the scenario? What is your response?

Sample Gender Response: At a later date, with a community leader or another couple who support family planning, return to the house of the couple. At the house, facilitate a discussion with the husband about the importance of family planning for the health of his wife and children. In the long term, organize education sessions on family planning with women and men separately in the community to ensure that they are informed on the importance of family planning, and have the opportunity to ask questions and learn in a comfortable setting.

Scenario #2: One evening, a CHW organized an educational talk with the community leaders to discuss the importance of women and men both participating in decisions together related to child spacing, family planning, birth preparedness and parenting. The male community leaders at the meeting said that men are too busy to participate in all these discussions. Their role is to provide money to pay for the wife to go to a clinic.

Questions: What is the gender barrier in the scenario? What is your response?

Note: Suggested role play for learning how to engage husbands during a home visit

Ask for 4 volunteers to play two couples. Role-play the following two situations.

Characters: a wife and husband

Scenario 1: The “unsupportive husband” does not help his wife even though she is six months pregnant. He thinks she can still do the same amount of work; does not need extra food or nutrition and that it is too expensive to go to the clinic to pay for exams. The wife is just returning from a day selling vegetables in the market. The husband is just returning from working in the fields. What will be their interactions?

Scenario 2: The “supportive husband” helps his wife so that she does not have to work so hard; he helps make sure that she rests; gives her money to go buy food; contributes to an extra fund to save for the birth of their child; accompanies her to prenatal consultations and regularly discusses with her the birth plan. It is morning. They have sent the kids to school. The wife is going out to sell vegetables in the market and the husband is going to the fields.

- Ask the unsupportive couple to act out their situation.
- After ask participants if this happens in the communities they work?
- As a CHW, what kinds of gender responses could they use to change the situation for the unsupportive husband?

ANNEX 4: PREVENTION OF EARLY MARRIAGE AND GBV

This brief overview of what should be covered in CHW training on GBV and early marriage prevention are the essential content. Additional training material will be needed specifically on these themes for CHWs that will be working with women/adolescent girls and men/adolescent boys groups.

Violence is the intentional use of physical force, whether threatened or actual, against oneself, another person, or against a group or community, that results in, or could result in, injury, death, psychological harm, poor development, or deprivation (WHO, 2002). Explain that being exposed to violence can encourage the use of violence, consciously and unconsciously. But this cycle of violence can be stopped as in the case of gender-based discrimination. Violence has many different faces, including GBV. In order to recognize what acts are perceived or experienced as violence, we need to understand the different forms of violence that can occur between partners: psychological, economic, physical, and sexual.

Interpersonal violence: are acts of violence that occur between family members, and in particular by men's use of violence against female partners, spouses or wives. One of the most common forms of interpersonal violence is gender-based violence (GBV).

Gender-based violence is the general term used to capture violence that occurs as a result of socially constructed expectations and norms associated with each gender, along with the unequal power relationships between the two genders, within the context of a specific society. Generally, due to women and girls' lower status in society, violence affects women and girls disproportionately due to their 'gender.' GBV are acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. They involve the abuse of power over another person.

Child marriage is when a child is married before age 18. It has negative consequences for girls including limiting her education, increasing girls' risk of violence, abuse, and HIV infection; and often leads to early pregnancy as well. Globally, pregnancy and childbirth are the second leading cause of death for girls aged 15 to 19.

Key content

- Explain that GBV and early marriage are human rights violations that harm women/adolescent girls disproportionately and are linked to gender-based discrimination and inequality.
- Present international human rights laws that prohibit all forms of Harmful Traditional Practices (HTPs) like the Convention on the Elimination of All Forms of Discrimination against Women against GBV and early marriage (before the legal age of 18 years of age). Key human rights agreements are the Universal Declaration of Human Rights, Convention on Consent to Marriage, Minimum Age for Marriage, and Registration of Marriage and Convention on the Rights of the Child. Present national constitution, gender laws and policies promoting gender equality and regarding gender-based violence (GBV) and early marriage in the country.
- Discuss empowerment of women and girls and national and local means of redress/justice and institutional supports available.

In applying a gender aware to gender transformative approach and response to community health education, CHWs can play a key role in sensitizing men/boys and women/girls on GBV, perpetration of interpersonal violence, and forms of GBV in the family including Harmful Traditional Practices (HTPs). It is recommended to introduce these issues to women/girls and men/boys in age and sex segregated groups due to the sensitive nature of these topics (See Promundo guidelines).

- Key discussions and exercises should cover:
 - What is perceived by men/boys and women/girls as violent behavior?

- What cultural ideas and beliefs encourage violence?
- How can a non-violent relationship improve the relationship between women and men, boys and girls and parents with children and in relation to healthy couple relationships and MNCH/SRH?
- Discuss the differences among power over, power within, power to and power with to promote adoption of more positive harmonious relationships.

For men: focus on how new insights into gender equality and GBV can improve his own life, family life and support wife/partner in having a better and safer pregnancy, delivery and better future for their child.

Additional content:

- Present practical legal knowledge, including information on the country's laws and policies related to gender equality, gender-based violence (GBV), early marriage and if relevant, female genital mutilation (FGM).
- Build participants awareness on the roots of violence, calling particular attention to gender-based violence.
- Build awareness on the root causes of early and forced child marriage, calling particular attention to the links with early pregnancy, low education and decision making power and contributing to inter-generational cycles of poverty and deprivation for women, men and girls and boys (Suggested exercise: use the problem tree analysis and frame the discussion using the ecological framework (see below)).
- Discuss different types of violence (from the state, to community to interpersonal) and raise awareness about various levels and forms of violence in the society in question, to encourage reflection on participants' own experiences with violence.
- Share country and regional data on trends in GBV, early marriage, and FGM (if relevant) and discuss the root causes of each of these HTPs.
- Discuss various signs which may indicate violence being inflicted on women and children.
- Discuss reasons why abused women are reluctant to seek help and stay in abusive relationships and possible role of CHWs and or female and male community members.
- End with how to integrate the new legal knowledge into your life, especially in connection to promoting positive respectful gender relationships among women, men and girls and boys in MNCH care.

A good practice in exploring these culturally sensitive issues is to bring men and women and adolescent girls and boys together after they are aware of what GBV is and are comfortable exploring their own behaviours and perspectives on the issue.

Note: Suggested exercise is to ask participants to recall an experience that involved violence, abuse or powerlessness and to talk about it in a small group.

Ensure participants feel comfortable to do this.

Questions:

- Can you describe the situation, how did you feel at the time?*
- How did you react; what was the reaction of the people around you?*
- Which reactions were helpful and which ones unhelpful?*
- How did you deal with this experience later?*

Note: Another suggested exercise is the “problem tree analysis” accompanied by a presentation of the “ecological framework/Venn diagram” to explore causes of early marriage and or gender-based violence and their effects on poor MNCH for adolescent girls and their children This exercise can be used in GE training for CHWs and as a tool to share with them to use in their own community awareness-raising. Draw a tree with roots and branches on a flipchart. The problem, early marriage or GBV, are at the level

of the trunk. Using the tree analysis, explore with participants the causes of the problem, referring to them as the roots of the tree. Once all ideas have been noted in the roots, the effects of the causes on women and adolescent girls' lives are explored and represented by the branches. The interplay of the various factors and levels of impact can easily be understood within an ecological framework, where a girl's life impacts and is impacted upon by factors that operate at various levels. You can share the framework to guide participants' suggestions of the causes and effects. The five levels are: 1. Child; 2. Family; 3. Community; 4. Institutions; and 5. Policies. See Figure for what to share with participants. Once the causes and effects have been discussed, participants can then be encouraged to explore realistic solutions, again looking at what needs to happen at each level for the prevention of early marriage of GBV.

