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Demand Generation for Reproductive, Maternal, Newborn and Child Health Commodities

ADDRESSING THE ROLE OF GENDER IN THE DEMAND FOR RMNCH COMMODITIES: A PROGRAMMING GUIDE

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Acronyms

ANC	Antenatal Care
CSW	Commercial Sex Worker
EC	Emergency Contraception
EE	Entertainment Education
EWEC	Every Woman Every Child
FC	Female Condom
FGM/C	Female Genital Mutilation/Circumcision
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
ICT	Information Communication Technology
IPC	Interpersonal Communication
M&E	Monitoring and Evaluation
MDG	Milennium Development Goals
ORS	Oral Rehydration Salts
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SBCC	Social and Behavior Change Communication
SEM	Social Ecological Model
SMS	Short Message Service
UN	United Nations
UNCoLSC	UN Commission on Life-Saving Commodities for Women's and Children's Health

About this Guide

What is this guide?

This guide is a resource for increasing demand for the 13 reproductive, maternal, newborn, and child health (RMNCH) commodities identified as underutilized by the UN Commission on Life-Saving Commodities (UNCoLSC) for Women's and Children's Health. This guide provides information and practical tools to help program managers determine how gender norms and roles may limit demand for these commodities, and how to address these norms and roles to ultimately increase the demand for and utilization of these commodities.

The guide serves as an important resource to supplement the *Demand Generation Implementation Kit for Underutilized Commodities in RMNCH* (HC3, 2013), available at http://sbccimplementationkits.org/demandrmnch/, which is designed to support the development of country-specific communication strategies to increase demand for the 13 commodities.

Who should use this guide?

This guide is intended for program managers, planners and other professionals involved in the design, implementation or evaluation of demand generation programs that work to improve the demand for and utilization of RMNCH commodities and services.

Why should I use this guide?

The guide can help you examine gender dynamics influencing the demand for RMNCH commodities and explore how to address them in demand generation programs. This process can make health messages more effective, stimulate awareness of the need for equity in gender roles and improve equitable behaviors with respect to RMNCH. For additional resources on broad-based issues of gender equity or structural and policy domains that limit supply and access to services, see Part 7 at the end of the guide.

The information and tools provided in this guide can be used throughout the different steps of the project cycle of any program seeking to improve RMNCH health through increasing the demand of RMNCH commodities.

First, an overall introduction to the 13 commodities is provided, followed by relevant gender and demand generation concepts and their definitions, two key frameworks used to guide RMNCH program design and analysis. Later, there is a guide to integrating gender into different programmatic steps, including checklists that can be used as analytical tools in the program design and implementation process. And lastly, additional resources that further explore issues and concepts covered in this guide are listed.

Due to limited information about the specific role of gender dynamics in generating demand for some of the 13 underutilized commodities, the guide highlights the key gender dimensions of demand within RMNCH care and services. Where possible, the guide uses the 13 commodities to further examine these dimensions.

13 Underutilized Commodities for RMNCH

In 2010, the United Nations (UN) Secretary-General's Global Strategy for Women's and Children's Health (the Strategy) highlighted the impact that a lack of access to life-saving commodities has on the health of women and children around the world.

The Strategy called on the global community to save 16 million lives by 2015 through increasing access to and appropriate use of essential medicines, medical devices and health supplies that effectively address leading avoidable causes of death during pregnancy, childbirth and childhood. In 2012, under the Every Woman Every Child (EWEC) movement and in support of the Global Strategy and the Millennium Development Goals (MDGs) 4 and 5, the UN Commission on Life-Saving Commodities for Women's and Children's Health (the Commission) was formed to catalyze and accelerate reduction in mortality rates of both women and children.

The Commission identified 13 overlooked life-saving commodities across the RMNCH 'continuum of care' (see Figure 1) that, if more widely accessed and properly used, could save the lives of more than six million[1] women and children. For additional background information on the Commission, please visit http://www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities.

[1]For assumptions used to estimate lives saved see UNCoLSC Commissioner's Report Annex (http://www.everywomaneverychild.org/images/UN_Commission_Report_September_2012_Final.pdf)

Figure 1: 13 Lifesaving Commodities

Reproductive Health		
 **Female Condoms**	 **Contraceptive Implants**	 **Emergency Contraception**
Prevent HIV and unintended pregnancy: A female condom (FC) is a plastic pouch made of polyurethane that covers the cervix, vagina and part of the external genitals. FCs provide dual protection by preventing STI infection, including HIV, and unintended pregnancies.	**Prevent unintended pregnancy:** Contraceptive implants are small, thin, flexible plastic rods inserted into a woman's arm that release a progestin hormone into the body. These safe, highly effective, and quickly reversible contraceptives prevent pregnancy for three to five years.	**Prevent unintended pregnancy:** The emergency contraceptive pill is the most widely available emergency contraceptive in developing countries. It is optimally taken in one dose of 1.5mg as soon as possible after sexual activity. An alternative product of 0.75mg is also widely available.
Maternal Health		
 **Oxytocin**	 **Misoprostol**	 **Magnesium Sulfate**
Post-partum hemorrhage: WHO recommends oxytocin as the uterotonic of choice for prevention and management of postpartum hemorrhage.	**Post-partum hemorrhage:** In settings where skilled birth attendants are not present and oxytocin is unavailable, misoprostol (600 micrograms orally) is recommended.	**Eclampsia and severe pre-eclampsia:** WHO recommends MgSO4 as the most effective treatment for women with eclampsia and severe pre-eclampsia.
Child Health		
 **Amoxicillin**	 **Oral Rehydration Salts**	 **Zinc**
Pneumonia: Amoxicillin is an antibiotic that is used to treat pneumonia in children under five. Amoxicillin is prepared in 250mg scored, dispersible tablet (DT) in a blister pack of 10 DTs.	**Diarrhea:** Oral rehydration salts (ORS) is a glucose-electrolyte solution given orally to prevent dehydration from diarrhea. ORS is packaged in sachets of powder to be diluted in 200 ml, 500 ml or 1 liter of fluid, prepared to an appropriate flavor.	**Diarrhea:** Replenishment with zinc can reduce the duration and severity of diarrheal episodes. Zinc is prepared either in 20mg scored, taste masked, dispersible tablets or oral solutions at concentration of 10mg/5ml.
Newborn Health			
 **Injectable Antibiotics**	 **Antenatal Corticosteroids**	 **Chlorhexidine**	 **Resuscitation Device**
Prevent newborn sepsis: WHO recommends benzlypenicillin and gentamicin, in separate injections, as first-line therapy for presumptive treatment in newborns at risk of bacterial infection.	**Prevent pre-term RDS:** Antenatal corticosteroids are given to pregnant women who are at risk of preterm delivery to prevent respiratory distress syndrome in babies born in pre-term labor.	**Prevent umbilical cord infection:** Chlorhexidine digluconate is a low-cost antiseptic for care of the umbilical cord stump that is effective against neonatal infections.	**Treat asphyxia:** Birth asphyxia, or the failure of a newborn to start breathing after birth, can be treated with resuscitation devices.

An Overview of Demand Generation

Demand generation increases awareness of and demand for health products or services among a particular intended audience through social and behavior change communication (SBCC) and social marketing techniques.

Demand generation can occur in three ways:

- ***Creating new users:*** convincing members of the intended audience to adopt new behaviors, products or services;
- ***Increasing demand among existing users:*** convincing current users to increase or sustain the practice of the promoted behavior and/or to increase or sustain the use of promoted products and services; and
- ***Taking market share from competing behaviors*** (e.g., convincing caregivers to seek health care immediately, instead of not seeking care until their health situation has severely deteriorated or has been compromised) and products or services (e.g., convincing caregivers to use oral rehydration solution [ORS] and zinc instead of other anti-diarrheal medicines).

Demand generation programs, when well designed and implemented, can help countries reach the goal of increased utilization of the commodities by:

- Creating informed and voluntary demand for health commodities and services;
- Helping health care providers and clients interact with each other in an effective manner;
- Shifting social and cultural norms that can influence individual and collective behavior related to commodity uptake; and/or
- Encouraging correct and appropriate use of commodities by individuals and service providers alike.

In order to be most effective, demand generation efforts should be matched with efforts to improve logistics and expand services, increase access to commodities, and train and equip providers in order to meet increased demand for products and/or services. Without these simultaneous improvements, the intended audience may become discouraged and demand could then decrease. Therefore, it is highly advised to coordinate and collaborate with appropriate partners when forming demand generation communication strategies and programs.

Who are the audiences of demand generation?

Reducing maternal and child morbidity and mortality through increased demand for and use of RMNCH commodities depends on the collaboration of households, communities and societies, including mothers, fathers and other family members, community and facility-based health workers, leaders and policy makers. Some of the commodities are more provider-focused in terms of demand and utilization, but all depend on the care-seeking behaviors of women and families (see Figure 2).

Provider-focused	Provider and End-user
☐ Oxytocin	☐ Female condoms
☐ Magnesium sulfate	☐ Implants
☐ Injectable antibiotics	☐ Emergency contraception
☐ Antenatal corticosteroids	☐ Misoprostol
☐ Resuscitation equipment	☐ Chlorhexidine
☐ Amoxicillin	☐ ORS
	☐ Zinc

Figure 2: Audiences of Demand Generation

Key Concepts

Key Concepts and Definitions in Demand Generation

Social and Behavior Change Communication (SBCC): SBCC promotes and facilitates behavior change and supports broader social change for the purpose of improving health outcomes. SBCC is guided by a comprehensive ecological theory that incorporates change at both the individual level and at the family, community, environmental and structural levels. A strategic SBCC approach follows a systematic process to analyze a problem in order to define key barriers and motivators to change, then to design and implement a comprehensive set of interventions to support and encourage positive behaviors. A communication strategy provides the guiding design for SBCC campaigns and interventions, ensuring communication objectives are set, intended audiences are identified and consistent messages are determined for all materials and activities.

Social Marketing: Social marketing seeks to develop and integrate marketing concepts—product, price, place and promotion—with other approaches to influence behaviors that benefit individuals and communities for the greater social good (Lefebvre, 2013).

Channels and approaches:

- ***Advocacy:*** Advocacy processes operate at the political, social and individual levels, and work to mobilize resources and political and social commitment for social and/or policy change. Advocacy aims to create an enabling environment to encourage equitable resource allocation and to remove barriers to policy implementation.
- ***Community Mobilization:*** Community mobilization is a capacity-building process through which individuals, groups or organizations design, conduct and evaluate activities on a participatory and sustained basis. Successful community mobilization works to solve problems at the community level by increasing the ability of communities to successfully identify and address its needs.
- ***Entertainment Education (EE):*** EE is a research-based communication process or strategy of deliberately designing and implementing entertaining educational programs that capture audience attention in order to increase knowledge about a social issue, create favorable attitudes, shift social norms and change behavior.
- ***Information and Communication Technologies (ICTs):*** ICTs refer to electronic and digital technologies that enable communication and promote the interactive exchange of information. ICTs are a type of media, which include mobile and smart phones, short message service (SMS) and social media such as Facebook and Twitter.
- ***Interpersonal Communication (IPC):*** IPC is based on one-to-one communication, including, for example, parent-child communication, peer-to-peer communication, counselor-client communication or communication with a community or religious leader.
- ***Mass and Traditional Media:*** Mass media reaches audiences through radio, television and newspaper formats. Traditional media is usually implemented within community settings and includes drama, puppet shows, music and dance. Media campaigns that follow the principles of effective campaign design and are well executed can have a significant effect on health knowledge, beliefs, attitudes and behaviors.

Key Concepts and Definitions in Gender

Female empowerment is achieved when women and girls acquire the power to act freely, exercise their rights and fulfill their potential as full and equal members of society. While empowerment often comes from within and individuals empower themselves, cultures, societies and institutions create conditions that facilitate or undermine the possibilities for empowerment (USAID, 2012a).

Gender is used to refer to a set of roles, responsibilities, rights, expectations and obligations that are socially and/or culturally associated with being male or female. Gender also includes the power relations between and among women and men, and girls and boys. Gender is based on widely shared beliefs and norms within a society or culture about male and female characteristics and capacities. Gender similarities and differences will vary within and between societies and can change over time. Gender is different from 'sex,' which refers to how people are classified biologically as male or female. At birth, infants are assigned a sex based on a group of characteristics such as chromosomes, hormones, internal reproductive organs and genitalia (USAID, 2012a).

Gender norms are based on widely shared beliefs and norms within a society or culture about male and female characteristics and capacities. From the time a person is born, he or she is taught ways of being that are defined by how society believes women or men should behave.

Gender equality is a state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities and resources. Genuine equality means more than equality in numbers or laws; it means expanded freedoms and improved overall quality of life for all people (PRB, n.d.; USAID, 2012a).

Gender equity is the process of being fair to women and men, and girls and boys. To ensure gender equity, action must be taken to compensate for engrained economic, social and political disadvantages that prevent women and men, and girls and boys from operating on a level playing field (PRB, n.d.).

Gender-based violence (GBV) is violence that is directed at individuals based on their biological sex, gender identity or perceived adherence to culturally defined expectations of what it means to be a woman or man, girl or boy. Whether occurring in public or private, GBV includes physical, sexual and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation. GBV can occur throughout an individual's life, from infancy to old age, and can affect women, men, girls, boys or people in other sexual categories. Specific types of GBV include, but are not limited to, female infanticide; early and forced marriage and "honor" killings; female genital cutting/mutilation; child sexual abuse and exploitation; human trafficking; sexual coercion, harassment and abuse; neglect; domestic and intimate partner violence; economic deprivation; and elder abuse (USAID, 2012b).

Gender integration involves identifying and then addressing gender inequalities during strategy and project design, implementation and monitoring and evaluation. Since the roles and power relations between men and women affect how an activity is implemented, it is essential that project managers address these issues on an ongoing basis (USAID, 2012a).

Gender transformation attempts to achieve gender equality and female empowerment and promote positive and sustainable change by: 1) fostering critical examination of inequalities and gender roles, norms and dynamics; 2) recognizing and strengthening positive norms that support equality and an enabling environment; 3) highlighting the relative position of women, girls and marginalized groups, and transforming the underlying social structures, policies and broadly held social norms that perpetuate gender inequalities.

Useful Frameworks for Gender Programming in RMNCH

Key Frameworks

To guide program design and achieve intended program outcomes, program managers and implementers can use various gender analysis and behavior change frameworks and models to generate greater demand for RMNCH services and commodities. Two key frameworks/models are presented and utilized in this guide:

1. The Gender Equality Continuum (GEC) Framework
2. The Social Ecological Model (SEM)

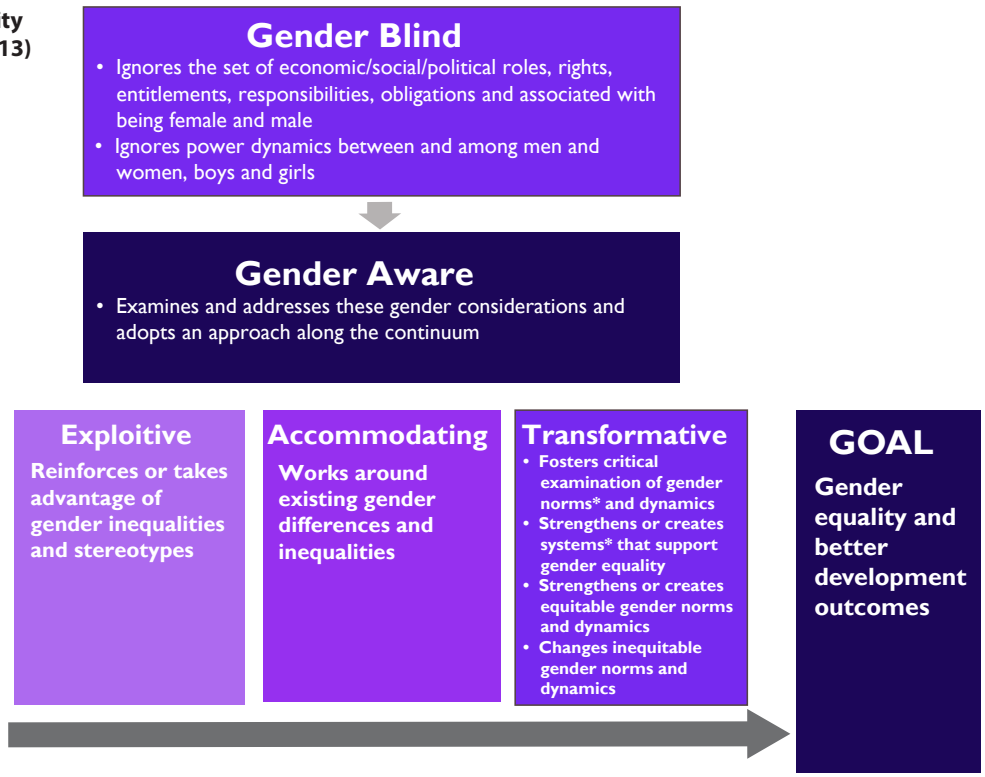
1 Gender Equality Continuum

The GEC (see Figure 3) can be used as a planning framework or as a diagnostic tool. As a planning framework, it can be used to determine how to design and plan interventions that move along the continuum toward transformative gender programming. As a diagnostic tool, it can be used to assess if, and how well, interventions are currently identifying, examining and addressing gender considerations, and to determine how to move along the continuum toward more transformative gender programming. This framework is applied in Checklist 3, which guides users to examine the gender approach of their RMNCH demand generation programs.

The continuum shows a process of analysis that begins with determining whether interventions are ***gender blind*** or ***gender aware***. **Gender blind** policies and programs ignore gender considerations. They are designed without any analysis of the culturally defined set of economic, social and political roles, responsibilities, rights, entitlements, obligations and power relations associated with being female and male, or the dynamics between and among women and men, girls and boys. Any impact on gender dynamics under these types of programs is generally unintended and accidental and may be positive or negative.

On the other hand, **gender aware** policies and programs examine and address the set of economic, social and political roles, responsibilities, rights, entitlements, obligations and power relations associated with being female and male, and the dynamics between and among women and men, and girls and boys. RMNCH interventions should *always*

Figure 3: Gender Equality Conntinuum (IGWG, 2013)



* Norms encompass attitudes and practices
* A system consists of a set of interacting structures, practices and relations
Adapted from Interagency Gender Working Group. Gender Integrated Continuum. http://www.igwg.org/igwg_media/Training/FG_GendrIntegrContinuum.pdf

aim to, at minimum, be "gender aware" and to move toward transformative gender programming. Program managers of "gender blind" programs should revisit the design, planning and implementation processes of their programs to move toward gender awareness.

The process then considers whether gender aware interventions are *exploitative, accommodating* or *transformative*.

Exploitative Gender Programming: These policies and programs intentionally or unintentionally reinforce or take advantage of gender inequalities and stereotypes in pursuit of project outcomes. This approach is harmful and can undermine program objectives in the long run.

Example: To improve male involvement in family planning, a program used messages that relied on sports images and metaphors that encouraged winning, being in control of one's life and making decisions. Impact evaluation showed that men interpreted the messages as promoting the notion that men alone should make family planning decisions. These messages unintentionally undermined the objectives of shared decision making, improved couple communication and men as supportive partners (PRB, 2009).

Accommodating Gender Programming: Policies and programs that acknowledge, but work around gender differences and inequalities to achieve project objectives. Although this approach may result in short-term benefits and realization of outcomes, it does not attempt to reduce gender inequality or address the gender norms that contribute to the differences and inequalities.

Example: While trying to improve safer sex among commercial sex workers (CSW), a program had brothel owners demand 100 percent condom use in their brothels. Although the program helped increase condom use among CSWs and their clients, the power dynamics of negotiation between CSWs and their clients were not challenged (PRB, 2009).

Transformative Gender Programming: Policies and programs that seek to transform gender relations to promote equality and achieve program objectives. This approach attempts to promote gender equality by: 1) fostering critical examination of inequalities and gender roles, norms and dynamics; 2) recognizing and strengthening positive norms that support equality and an enabling environment; 3) highlighting the relative position of women, girls and marginalized groups, and transforming the underlying social structures, policies and broadly held social norms that perpetuate gender inequalities.

Example: While trying to encourage a community to abandon the practice of female genital mutilation/cutting (FGM/C), a program engaged women, men, girls, boys and community leaders to examine the existing gender norms and beliefs leading to the practice of FGM/C. Challenging these norms helped the community identify a healthy and empowering coming of age ritual for young girls to replace FGM/C (PRB, 2009).

The Gender Equality Continuum emphasizes two key principles important for program implementation:

1. Programs must never be gender exploitative. While some interventions may be or contain elements that are (intentionally or unintentionally) exploitative, the aim should always be to move them toward transformative approaches.
2. Programs should ultimately work toward transforming gender roles, norms and dynamics for positive and sustainable change.

2 The Social Ecological Model

Behaviors related to demand for care and treatment take place within a complex web of social and cultural influences. The SEM is a useful model to understand the multi-faceted aspects of demand for life-saving commodities. This model recognizes that social networks, communities and society affect a person's decisions and behaviors. For example, demand for RMNCH services is determined not only by individual attributes such as knowledge and attitudes, but also by household members and peers, community support, access to resources, and broader social and structural policies and norms (see

Figure 4). SBCC programs must work across all levels to ensure sustained normative and social change. This model can be used to explore the gender-related determinants of health behavior and inform the design of demand generation programs so that gender norms within each level of the model are considered in implementation.

Individual Level: This level focuses on the behavior, intentions, knowledge, attitudes, beliefs, values, self-efficacy skills and personal norms about a particular behavior (e.g., a woman's knowledge and attitudes about using female condoms; a mother or father's perceptions about who should be involved in caring for a sick child).

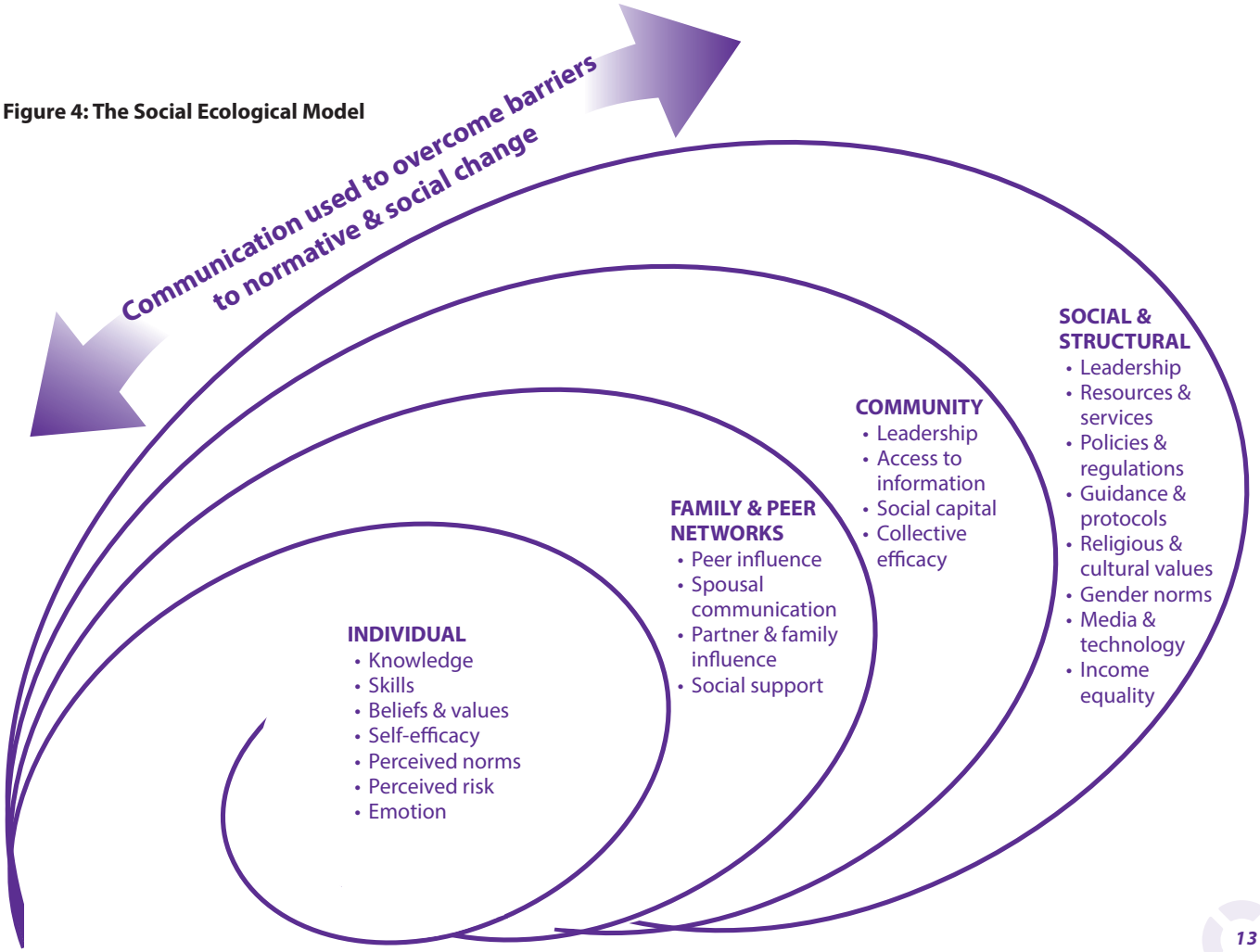
Family and Peer Network: This level includes the formal and informal social systems influencing an individual. They include partner and family relationships, peer influence and work groups (e.g., peer support for contraceptive implants; opinions of mothers-in law about men participating in antenatal care [AC]).

Community/Services: This level examines the impact of shared community norms and beliefs, local leadership, access to information, resources, health services and relationships among local institutions (formal or informal) that operate on and for individuals (e.g., community leaders promoting use of services, or health providers' attitudes and opinions about counseling men on family planning).

Society: This level includes laws, policies, infrastructure, government leadership, resource allocation and societal religious, cultural and gender norms and values.

By analyzing how gender-related determinants of behavior operate at each SEM level, program managers can understand how gender dynamics influence individual and social behavior change. As shown in Checklists 1 through 4, by conducting this analysis at each step of the project cycle of demand generation programs, programs can gain improved understanding of context and subsequently will be better placed to fit their audiences' needs and achieve improved RMNCH outcomes.

Figure 4: The Social Ecological Model



Gender and Situational Analysis

Prior to designing and implementing a program to increase utilization of underutilized commodities, programs should conduct a situational analysis to identify the gender-related social determinants that impact demand for RMNCH commodities and services.

As outlined in Checklist 1 (page 16), key aspects of such an analysis include:

- Gathering information on social, cultural and economic factors regarding gender norms, practices and power relations between women and men to understand how access to health services may be compromised for women and their children.
- Analyzing local cultural and gender norms that govern sexuality, sexual behavior, fertility, family planning, pregnancy, women's health, motherhood and fatherhood, and raising and caring for girls and boys in the project community.
- Considering the unequal power dynamics of decision making, access to information and control over resources between women and men.
- Taking into account any biases that may result from unequal power relations among different community groups or members due to issues beyond gender such as age, ethnicity or other differences.
- Identifying the location and quality of services and how accessible they are to women and men.

Social and behavioral determinants can include, but are not limited to, gender roles, partner communication, gender-based violence, access to and control over resources, women's empowerment and male engagement in RMNCH.

Some illustrative examples of gender-related determinants of demand at each level of the SEM include:

Individual

- *Attitudes:* A higher value placed on male children over female children can impact care and treatment-seeking behaviors (e.g., reserving ORS or zinc for the treatment of diarrhea in boys before girls in the same household, or reserving limited food resources for male over female children).
- *Knowledge:* Men's lack of participation in pre- and post-natal consultations means that they do not benefit from information provided by service providers.
- *Self-efficacy:* Young adolescent girls may lack the self-efficacy to act on the knowledge they have about avoiding unplanned pregnancies, negotiating safer sex with partners or purchasing contraceptives.

Family and Peer Networks

- *Partner communication:* Inequitable gender norms may hamper communication between partners. For example, couples may find it difficult to discuss issues related to sexuality and contraception because men may perceive this as "women's business" or women may fear they will be perceived as "loose" if they are the ones who begin the discussion about condoms. Poor communication may lead women and men to have misperceptions about their partner's attitudes toward family planning or MNCH care.
- *Household decision making:* Gender norms that grant men most of the decision-making power in households often means that family planning decisions and care seeking for RMNCH depend on male approval.
- *Power dynamics:* Dynamics within the household can either facilitate or prevent women from accessing resources that they may need for their own or their children's health (e.g., mothers-in-law may exercise greater authority over household resources than their daughters-in-law, or women's limited power in the household restricts their ability to negotiate for contraceptive use and safer sex).

- *Access to and control of resources:* Women's role within the household may limit access to and control of resources, such as money to spend on treatment, transport or mobile phone use.
- *Gender-based violence:* Women may encounter physical, sexual and psychological violence as barriers to seeking RMNCH services. Studies have shown that there is a correlation between the incidence of domestic violence and child growth, supporting the position that violence experienced by mothers limits their ability to secure newborn and child health services (Ackerson & Subramanian, 2008).

Community/Services

- *Access to community resources:* Women and men may have unequal access to community resources. For example, women may have limited access to community sources of information and not know about RMNCH services available. Similarly, men may not have such information and may see services as unnecessary and limit their partners' access to and use of these services.
- *Community perceptions and norms:* Women of reproductive age who want to purchase female condoms or emergency contraception at community-based outlets may encounter negative, judgmental reactions from service providers, pharmacists or other community members. These reactions may stem from communal norms that regard women who seek contraception as "loose" or immoral. Adolescent girls may face even more negative reactions, which can weaken their self-efficacy to access and use contraception.
- *Service provision:* Health care providers may not be trained on how attitudes around gender affect uptake of RMNCH services. For example, untrained providers may use judgmental attitudes during family planning counseling or neglect counseling confidentiality requirements. Services may not reach fathers and husbands, or encourage their participation in MNCH care. Additionally, women and girls may avoid RMNCH services located in or near unsafe areas in order to avoid the risk of violence on these routes.

Society and Structural

- *Social roles:* Expected social roles of women that prioritize mothering roles, and roles of men that tie social status to producing offspring, may limit demand for family planning. Similarly, men may be discouraged from being involved in pregnancy, delivery and child care—subjects that society may deem as "women's issues."
- *Policies and laws:* Laws that govern responses to gender-based violence may not be implemented in ways that actually provide protection for women. Poor implementation of these laws in communities can strengthen norms that support violence against women. This, in turn, may contribute to the increased use of violence as a way to deal with conflict during discussions about family planning or MNCH care.

Putting Analysis to Work

The tools below follow planning processes for programs that utilize different behavior change strategies to generate demand for services or commodities. References to the SEM are incorporated within the tools to emphasize the importance of the model during situation analysis, design and implementation. For additional information on these planning processes, see the Demand Generation Implementation Kit for Underutilized Commodities in RMNCH (HC3, 2013), available at http://sbccimplementationkits.org/demandrmnch/, and additional resources provided at the end.

Checklist 1: Including Gender in Situation Analysis

When to use this checklist:

During the design of formative research methodology and during the synthesis and analysis of formative research data that will inform program design.

How to use this checklist:

Use the following questions as a guide to ensure that you have taken gender into consideration when analyzing the context of the RMNCH issue(s) that your program will tackle. Make sure to pay particular attention to how your answers address the issue at each level of the SEM.

Question	Suggested Action Points
Understand the Problem *(What is the main problem you are working to address?)*	
1. What are women's and men's roles and responsibilities related to the health problem(s) that the commodity(s) addresses?	- Identify women's and men's roles and responsibilities and existing social, cultural and gender norms related to the health problem(s) that the commodity(s) addresses.
2. How are men, women, boys and girls affected differently by the health problem?	- Identify how males and females of relevant ages are affected differently by the health problem.
3. What are the barriers* and facilitators* at each SEM level that adolescent girls, women, their partners and couples encounter in performing their roles related to using the commodity(s)? * (E.g., self-confidence, mobility, financial resources, role in making decisions, access to services, perceived social norms, providers' judgmental attitudes, inequitable policies)	- Conduct formative research with target audiences. In addition to any formative quantitative and qualitative studies, analyze secondary data available in existing resources. - List these barriers and facilitators at each level of the SEM. - Examine their impact on the demand for RMNCH care, services and/or commodities. - Design interventions and activities that will address barriers that play the largest role in preventing women, adolescent girls and men from using and accessing the commodity(s). - Utilize facilitators in your interventions, activities and messaging to help affect positive change in behavior.
4. What are the existing support systems, services or commodity marketing initiatives at each SEM level that can help with the RMNCH issue?	- Conduct community-mapping activities to gain information about safe spaces for women and for men, support systems, services, marketing spaces, relevant initiatives, etc. - Make sure you understand the impact of these initiatives on women and men, both individually and collectively. - If relevant, collaborate with these initiatives and link your interventions and activities to these services. - Before you link with these initiatives and services, examine their approach to gender using Checklist 3. - Help strengthen existing spaces that are more equitable and enable women to express agency for accessing RMNCH care and services.

Question	Suggested Action Points
5. How will the program target women or men to yield the best results in achieving behavior change?	- Determine if the program should target women and men together or separately. - Determine what channels are most appropriate to reach men and to reach women (including sub-populations such as young women and men). - Determine the approach the program will use based on women's and/or men's needs.
6. Will targeting men or women reinforce inequitable gender norms and stereotypes?	- If yes, revisit your targeting approach and revise to ensure it does not reinforce inequitable norms. You can use Checklist 3 as a guide to help your analysis.
Understand Your Audience *(What are the social, cultural, psychological, economic and geographic factors that influence health behavior?)*	
7. What are the differences and similarities in women's and men's knowledge, attitudes and practices about the life-saving commodity(s)?	- Identify and refer back to these differences and similarities throughout your analysis and program design.
8. At what stage are women and men in the community in carrying out the intended behavior?	- Answer the following separately for women and men: are women/men intending to change behaviors? Thinking about changing behaviors? Maintaining desired behaviors? - Identify the barriers that women and men face in each of the above stages of behavior change. - Identify the facilitators that may have helped women and men adopt the health behavior.
9. Who influences women and men in their decisions and actions about the specific health concern?	- Use this information to understand how you can utilize influencers to develop a supportive environment for women and men to practice the healthier behavior(s).
10. Does your program need to focus on transforming gender norms in order to be successful?	*Your program may need to address specific gender norms or larger gender dynamics to be successful.* Examine your program's overall objectives, barriers to demand, and the results of your analysis above to determine this.
Understand Communication Capacity (*What are the gender dynamics of media and information access?)*	
11. What are the communication channels that women and men use to access health information?	- Use this information to understand the quality and effectiveness of existing communication channels and identify the best channels and methods to reach women and men with messaging.
12. Who controls access to communication sources (i.e., who selects the stations or programs to listen to or watch)?	- Use this information to determine the extent of women and men's control over access to information.

Gender and Program Design and Implementation

After the initial step of understanding the problem and its context, the program is then designed to increase demand for RMNCH services and commodities. Designing a program to increase demand of the underutilized commodities includes:

- Identifying a vision that the program will work to achieve
- Segmenting the target audience, including primary and secondary audiences
- Establishing communication and behavior change objectives
- Positioning the program to present a clear benefit
- Outlining key message points to convey in all materials and activities for each target audience;
- Selecting appropriate intervention domains and activities
- Selecting indicators and putting a monitoring and evaluation system in place

For more details on the design process, see the Demand Generation Implementation Kit for Underutilized Commodities in RMNCH (HC3, 2013), available at http://sbccimplementationkits.org/demandrmnch/. Using the SEM can help ensure that gender-related behavioral determinants identified in the situation analysis are translated into design of appropriate interventions and activities.

Important Considerations Regarding Service Delivery

When implementing activities at the facility level, programmers may want to consider some of the following approaches to address gender-related barriers and facilitators for demand of services and commodities:

- Streamlining services so that health service visits are not overly burdensome on time.
- Consulting women, men and communities in order to identify the appropriate times to offer services, including times that couples can come together.
- Setting up mechanisms that help male and female clients deal with gender-based violence and other harmful practices that impede the demand and uptake of RMNCH health services.

Training for RMNCH service delivery personnel (including facility-based and community-based health workers) may include opportunities to build skills in:

- Exploring personal beliefs and values about gender norms related to RMNCH
- Refraining from imposing those beliefs on clients
- Supporting clients to utilize communication, negotiation and decision-making skills
- Responding to reported incidents of GBV, using counseling and/or referral services
- Reaching men about RMNCH without reinforcing negative gender norms
- Respecting confidentiality regarding a woman's use of a family-planning method
- Counseling women and their partners about men's supportive role in RMNCH
- Ensuring that women and their partners both receive information about RMNCH health issues and available services

Checklist 2 on page 19 serves as a tool for program managers to take gender into consideration while designing interventions and activities that will generate demand. Checklist 3 is a tool that program managers can use to analyze the extent to which gender is considered in program design and implementation. Checklist 2 can therefore be used during the actual design and development of your program. Checklist 3 can be used as a tool to analyze the gender approach you have selected in your design AND while you implement your program. Using these two tools, program managers can tailor programs to fit the nuanced needs of their audiences and address gender inequities at different societal levels that hinder demand for RMNCH commodities.

Checklist 2: Integrating Gender into Program Design and Implementation

(adapted from Center for Communication Programs, 2003)

When to use this tool:

While designing new programs or replanning for existing programs.

How to use this tool:

Use the questions as a guide to gather information or examine the gender implications of different aspects of your program at each step of program design and implementation.

Question	Action Point
Audiences	
1. Who are your primary audience(s) and reasons for selecting them?	- Make sure you have considered gender-related barriers for each audience.
2. Who are your secondary audience(s)?* *Secondary audiences are generally influencers of the primary audience.	- Make sure you have considered gender-related barriers and influencing factors of each audience. - Make sure you look at the barriers and factors at each level of the SEM
3. What will affect participation of women and men (access, control, facilitators, gender roles, etc.) in your intervention?	- Identify any barriers to participation at each level of the SEM and how to overcome them. - Identify facilitators of participation and how to strengthen or emphasize them.
Behavioral and Communication Objectives	
4. Do your program's behavioral and communication objectives need to be different for women and men?	- Make sure your objectives address the needs of women and men and do not reinforce inequitable norms and stereotypes.
5. How have you incorporated gender-focused objectives in your program and communication objectives?	- Use the information discovered in the situation analysis to determine your gender-focused objectives. - Make sure your objectives address the gender issue that is the biggest barrier to adopting behaviors.
Positioning the Benefits	
6. What benefits do the promoted services, commodities or practices have for women and men?	- Pay particular attention to both the similarities and differences.
7. Identify how women and men perceive these benefits as beneficial to them and their families. * For example: Keeping your pregnant wife healthy will help ensure you have a healthy baby.	- Position benefits so that women and their partners see the individual benefits.* Do not reinforce inequitable stereotypes when positioning.

Question	Action Point
Message and Materials Design	
8. How have you addressed gender issues in message concepts and material design?	- Make sure the materials address the gender-related barriers to behavior change for women and men.
9. Do messages and design concepts reinforce negative gender stereotypes or inequitable gender norms?	- Make sure message content and creative considerations (tone, color, branding, illustrations, pictures, language) do not reinforce negative gender stereotypes and norms.
10. Do messages and materials include positive and realistic female and male role models who act in ways that challenge restrictive roles and norms?	- Revise or incorporate realistic and relevant role models in messages and materials if they are missing from materials.
11. Have messages and design concepts been pretested with women and men separately?	- Pretest messages and the design concepts with women and with men. - Include open-ended questions that explore the relevancy and appropriateness of concepts and content.
12. Have pretesting results addressing gender issues been incorporated into revisions of materials?	- Incorporate results of the pretesting into revision of the materials.
Interventions and Activities	
13. Are the selected activities appropriate for both women and men?	- Be aware of and sensitive to the needs, beliefs and values of both women and men when selecting activities. - If activities do not address barriers and factors at the different SEM levels, consider revisiting your design or identify opportunities for partnership to address the barriers that are outside your program's mandate. - Select channels that take age, culture, timing, access, weather, seasons, migration patterns and the literacy and technology levels of women and men into consideration.
14. Do activities address the different aspects of gender barriers and influencing factors in the SEM?	
15. How have you tailored your marketing mix (product, price, place and promotion) to the concerns and needs of both women and men?	
16. Are the communication channels selected appropriate for and accessible to women and men?	
Program Management	
17. How have women's and men's active participation been included in program implementation?	- Include women's and men's active participation (separately or jointly) in program implementation as appropriate and when necessary.
18. How has program management ensured that staff and stakeholders understand gender issues as it relates to demand?	- Ensure staff are trained in gender issues as they pertain to the RMNCH and demand generation. - Ensure that stakeholders are oriented on the gender issues affecting the different program elements and how addressing gender will help achieve optimal program outcomes.

Checklist 3: Using the Gender Equality Continuum to Assess Integration of Gender in Programming

When to use this tool:

During initial program design for new programs or re-planning for existing programs. It can also be used at the evaluation stage to understand how gender aspects of the program may have influenced results.

How to use this tool:

Use the questions to determine whether the program is gender exploitative, gender blind, gender aware, gender accommodating or gender transformative, and to determine how to move a program along the continuum toward more transformative gender programming.

Questions	Yes	No
1. Does the program employ existing rigid gender norms and imbalances to achieve RMNCH health program objectives and outcomes? For example, does the program: • Require husband's permission for long-acting methods? • Support the notion that it is acceptable for men to have multiple partners? • Keep decision-making power in households in the hands of mothers-in-law?		
If the answer to question 1 is yes, STOP! Your program may be gender exploitative. Your program may be doing harm by reinforcing gender inequities and stereotypes. Reevaluate your development and health objectives!		
2. Did the program consider gender during prior analysis of the health issue in the project community? In other words, did the program analyze the impact of the culturally defined set of economic, social and political roles, responsibilities, rights, entitlements, obligations and power relations associated with being female and male, and the dynamics between and among women and men, girls and boys?		
If the answer to question 2 is no, your program may be gender blind. Review and reconsider how you should consider gender in your program.		
3. Did the program's formative research include a gender analysis (e.g., considered the roles of status differences between women and men, gender norms, gender roles, responsibilities and time-use patterns, policies and institutional practices)?		
4. Did the program design consciously address gender constraints and opportunities affecting uptake of RMNCH services and commodities?		
5. Did the program plan gender-focused objectives (e.g., increase gender equitable attitudes among women and among men; increase joint decision making)?		
6. Has the program examined and addressed gender-related outcomes during design and implementation?		
If the answer is yes to any of these four questions, your program may be gender aware. You are on the right track! Go to the next set of questions to further analyze the extent to which your program considers gender.		
7. Does the program acknowledge the role of gender norms and inequities in uptake of RMNCH services?		

Questions	Yes	No
8. Does the program try to adjust to and compensate for these norms and inequities (e.g., offer services in locations or hours more convenient to women)?		
9. Does the program try to limit harmful impact on gender relations, but does not seek to change underlying structures and norms that perpetuate inequities?		
If the answer is yes to all of these questions, your program can be said to be gender accommodating. The program is supporting a gradual shift toward challenging rigid gender norms and inequities. Continue to answer the next set of questions.		
10. Does the program proactively examine, question and change unequal gender norms and power imbalances in order to improve demand for RMNCH services and commodities?		
11. Do program approaches encourage critical awareness among women and men of the gender roles and norms affecting RMNCH issues in their community?		
12. Do program approaches promote the position and empowerment of women with respect to norms that affect uptake of RMNCH services and commodities?		
13. Do program approaches challenge allocation of roles and the distribution of resources between women and men in the program community?		
14. Do program approaches work to change unequal power relationships between women and other people in their community such as service providers and community leaders?		
If the answer is yes to these any of these five questions, your program (or certain elements of your program) can be said to be gender transformative. The program clearly engages women and men to change health and gender equality objectives.		

Gender and Monitoring and Evaluation

Considering gender while monitoring and evaluating programs ensures that gender will be addressed and measured as a component of program inputs, outputs and outcomes. For RMNCH demand generation programs, considering gender in monitoring and evaluation (M&E) helps program managers understand how women's and men's knowledge, attitudes and behaviors regarding life-saving commodities have changed as a result of the program.

Gender-related information provides evidence to demonstrate program progress and impact. Program managers can use this data as evidence to mobilize women, men, families and communities to address inequitable norms and behaviors and to increase allocation of resources for women's and children's health. The collection of sex-disaggregated data is essential to develop gender-informed perspectives.

Programs should also identify and use gender-sensitive and gender-focused indicators for monitoring the success of interventions. Indicators can measure processes and impact during program implementation and evaluation phases. Below are a few examples of gender-sensitive and gender-focused indicators that can be used to measure the success of demand generation interventions for RMNCH commodities.

Illustrative Indicators*

Individual

- Percent of women and men aged 15–49 who know of at least one source of information and/or services for [commodity].
- Percent of men present who accompany their partner to a [family planning/MNCH care] visit.
- Percent of men who are present at the health facility during birth of their last child.
- Percent of girls and boys who received home-based care for diarrhea using ORS and zinc.

Family/Peer Networks

- Percent of female and male household members reached with interventions communicating information about how to respond to RMNCH emergency care needs.
- Percent of women and their partners who report improved communication about women's needs during pregnancy and antenatal and newborn care.
- Proportion of women reporting experiencing violence while discussing RMNCH needs in the household.

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Community/Services

- Proportion of community leaders aware of women's medical needs during pregnancy.
- Percentage of providers who successfully complete gender-sensitive training on RMNCH commodities.
- Percentage of providers who report more equitable attitudes about adolescent girls' uptake of emergency contraception (EC) and female condom (FC).
- Percent of facilities providing antenatal and postnatal services that are male-friendly.**

Society

- Absence of policies that require clients to have permission of husband or mother-in-law (for married women) or parents (for adolescents) in order to access services.
- Number of referrals to other programs that empower women (e.g., related to literacy, income generation, microcredit, domestic violence prevention).

* Sources: Yinger et al, 2002; Bertrand & Tsui, 1995; MEASURE Evaluation PRH, n.d.

**(Male-friendly services are defined here as services that have hours convenient to men, encourage men to visit/attend with the permission of the female client, have staff receptive to men in clinic and have visible and available communication materials targeted to men.)

Checklist 4: Is Gender Integrated into Monitoring and Evaluation?

When to use this tool:

During M&E design, planning, data collection and dissemination of results.

How to use this tool:

Use the answers to help guide development of an M&E framework, qualitative and quantitative instruments, and dissemination mechanisms. Also use the tool to identify gaps in M&E design and to guide integration of findings into program re-planning.

Evaluation	
Designing Evaluation and Choosing M&E Methods	
1.	Have you chosen the most appropriate M&E methods to get information from women and men about how the program affects/affected them?
2.	Is the M&E team knowledgeable and skilled in gender-sensitive data collection activities? (e.g., collect data from women and men separately for each indicator; collect data at the best time of the day for reaching women and men) (See additional sources in Part 7)
3.	How are your data collection methods tailored to the realities of women and men? (e.g., convenient times to hold interviews)
4.	How do process and outcome indicators reflect the behavior change intended for women and for men?
5.	What questions have you included in your instruments to help uncover unintended consequences for women and men?
Disseminating and Utilizing Results	
1.	How will you disseminate the results to women and men in the project community in a way that is culturally relevant, but does not reinforce gender stereotypes? (e.g., dissemination to women's and men's groups, community-leader meetings, at health-worker trainings, etc.)
2.	Have opportunities been provided to help women and men understand how the findings can improve their health and well-being and address harmful gender norms? (e.g., presentations to community leaders, participatory workshops with women and men, etc.)
3.	How will stakeholders and the project community use the findings to advocate for changes in health programs so that the needs of women and men are addressed? (e.g., advocacy with influential community members, policy makers, etc.)

Additional Resources

Demand Generation

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