

Promoting Gender Equality through UNICEF-Supported Programming in Young Child Survival and Development

Operational Guidance



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ABOUT THIS DOCUMENT

This guidance document aims to orient UNICEF programme staff on how to apply gender analysis to programming in Young Child Survival and Development (YCSD) overall, as well as to sectoral areas of intervention. This document focuses specifically on issues relevant to YCSD. It is to be read in connection with *Promoting Gender Equality: An Equity-Focused Approach to Programming (Operational Guidance Overview)*, which reviews key concepts and definitions related to gender equality and provides a conceptual framework for operationalizing UNICEF's gender policy within the programming cycle.

WHY GENDER MATTERS TO YOUNG CHILD SURVIVAL AND DEVELOPMENT



UNICEF/NYHQ2008-0297/Susan Markisz

UNICEF's role in YCSD extends across a range of actions that support the achievement of targets in the Millennium Development Goals relating to health; nutrition; water, sanitation and hygiene (WASH); and early childhood

development. This section reviews basic concepts as they apply to YCSD in a brief introduction and also explores why gender matters to YCSD.

INTRODUCTION

As mentioned earlier, the overarching document to the YCSD guidance *Promoting Gender Equality: An Equity-Focused Approach to Programming (Operational Guidance Overview)*, details the definitions, concepts and frameworks relevant to mainstreaming gender analysis into UNICEF's programming. This guidance supplements this introductory text by framing the discussion around the following questions:

- What is gender and how does it relate to other forms of social inequality?
- What is the relationship between gender equality and equity?
- Is focusing on women the same as working on gender?

What is gender and how does it relate to other forms of social inequality?

Sex is biologically determined, while gender – the social meaning of being masculine or feminine – is defined by the social context in which a person lives and can be, like any other social category, fluid. As a social category, gender refers to the social roles of men and women, and boys and girls, as well as the relations among them, in a given society at a specific time and place.

Gender relations, like other social relations, are simultaneously relations of cooperation, connection and mutual support, as well as of conflict, separation and competition, and of difference and inequality.¹ Gender, along with others forms of social hierarchy (such as class, race, etc.), determines who does what, who has what, who decides and who is valued for what. Power relations are therefore central to how gender influences the social norms, decision-making, division of labour and access to resources that justify, define and maintain gender equality or inequality. Gender, like other power relations, determines whether children's needs are acknowledged, including that of their caregivers, whether they have a voice or a modicum of control over their lives, and whether they can realize their rights.²

While the focus of gender analysis tends to be on girls and women, gender inequality is also harmful to boys and men, despite the many tangible benefits it gives them through resources, power, authority and control. These benefits to boys and men do not come without a cost to themselves, often translated into risky and unhealthy behaviours and reduced longevity. For example, boys in particular are more at risk of road traffic injuries and may be subject to harsher punishment than girls, or to worse forms of child labour.

As important as gender relations are in influencing the interactions between women and men, they are not the only social forces that determine inequality between girls, boys, women and men. Social class and geographic location are likely to be the most powerful social stratifiers determining outcomes for YCSD. While certain forms of social inequity may be more powerful than others in determining outcomes, it is critical to recognize their interactions and to understand that even if discrimination is not easily recognizable or tangibly measured, it remains unjust.

What is the relationship between gender equality and equity?

In development studies, feminist analysts have used the concept of gender *equality* as the foundation for notions of gender justice or *equity*. This is based on the presumption that, to the extent that inequalities between women and men are the product of social power relations, they are likely to be inherently biased and unfair. The relationship between equality and equity is less clear-cut in certain areas of YCSD because differences can be due to biological characteristics and not necessarily socially determined (e.g., maternal anaemia, malaria in pregnancy, neonatal survival or adolescent girls' menstruation).

As a result, some differences between girls and boys, or women and men, do not signal social inequality, and in certain circumstances equality can actually be an indicator of gender injustice because it may indicate that biological needs or abilities are not adequately recognized.³

For example, providing a man and a pregnant woman with *equal* food rations of identical nutritional composition during an emergency situation could be *inequitable* given the greater nutritional needs of pregnant women. Both boys and girls need immunization, but

¹ March, Candida, Ines Smyth and Maitrayee Mukhopadhyay, 'A Guide to Gender-Analysis Frameworks', Oxfam Publishing, London, March 1999.

² Sen, Gita, Asha George and Pirooska Östlin, 'Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it exists and how we can change it', final report to the World Health Organization Commission on Social Determinants of Health by Women and Gender Equity Knowledge Network, September 2007.

³ Ibid.

pregnant women may be prioritized for tetanus coverage. Both boys and girls need water and sanitation facilities, but adolescent girls are more likely to miss school due to a lack of such facilities when menstruating.

Thus gender equity in YCSD must stand directly on the foundation of absence of bias. Not being able to draw on a simple universal principle such as equality necessitates an even more careful interrogation of where bias is present and how it works. It is critical to underscore

that while biological differences can create different needs for women and men, and girls and boys, these differences do not naturally lead to or justify unequal social status or rights.⁴ Where no plausible biological reason exists for different outcomes, social discrimination should be considered a prime suspect for different and inequitable outcomes. Equity in the latter case will require policies that encourage equal outcomes, including differential treatment to overcome historical discrimination.⁵

Is focusing on women the same as working on gender?

Depending on its design and implementation, a programme that supports women without taking into consideration how power relations influence the outcome could maintain gender inequality rather than reverse it. An effort is gender-blind, even when girls or women are its target group, if it fails to account for questions of power, discrimination or bias. For instance, if a nutrition effort approaches women only as mothers and views them as an instrumental conduit for service delivery to children, the project may reinforce social norms that confine women to the domestic sphere and that let men off the hook when it comes to caring for children. It is important to keep in mind that girls and women should benefit from the

development process – they are not free labour to be deployed in support of the process.

While in many instances taking a gender perspective does entail targeted interventions to promote women’s empowerment and protect girls’ rights, promoting equality for girls and women is not effective if the boys and men they live with at home and in the larger society are left out of the equation. An analysis of who the gatekeepers are that dominate in decision-making for YCSD needs to be undertaken, and the actors, whether boys, men or more powerful women (older, married, richer, etc.), need to be engaged as allies for addressing the power relations that underpin gender equality.

WHY GENDER MATTERS TO YCSD

A gender analysis that reviews **the character of social norms, processes of decision-making, the division of labour and differences in access to resources between girls, women, boys and men** is critical to understanding YCSD profiles. It determines **exposure to risks, programme responses and outcomes** at the household, community, service delivery system and policy levels.

The following section will explore why gender matters to YCSD by focusing on three critical topics that will form the organizing principle for the remainder of this document:

- Gender equity
- Gender vulnerability
- Addressing gender in programming

Gender equity

Gender equity is about responding appropriately to differences in exposure to risks, programme responses and outcomes to ensure gender equality:

- *Differences in risks that are due to specific needs must be addressed.* For instance,

social norms and water and sanitation facilities in schools must be provided to ensure the attendance of adolescent girls when they are menstruating, and women’s nutritional needs must be addressed to ensure healthy pregnancy outcomes.

- *Differences in programme responses should affirm gender equality.* Women's voices and participation in planning processes that determine water and sanitation facilities and community health and nutrition programmes must be ensured, as they are the primary stakeholders of such programmes. In addition, early childhood development programmes should include both men and women role models.
- *Differences in outcomes should be monitored to ensure that they do not reflect social inequality.* For example, it is necessary to address sub-national differences in child immunization by gender due to beliefs that immunization programmes may harm male children.

Gender discrimination may be a factor in terms of possible differences in YCSDD outcomes, as well as in the *process* through which outcomes are achieved. Gender inequalities between women and men may have negative effects on the dynamics of care provision affecting the survival and development of girls and boys alike. For example, in many countries there is not much difference between boys and girls

in terms of immunization rates at the national level. Nonetheless, one may find that among the non-immunized, mothers are less likely to be educated and have less autonomy to take children to clinics when outreach services fail.

Similarly, while there is no evidence of disparity in prevalence of undernutrition between girls and boys at national, regional or global levels, significant association between low maternal literacy and education levels and poor nutrition status of young children has been found, and the low status of women is considered to be one of the primary determinants of undernutrition across the life cycle. Thus, addressing gender inequalities should make health and nutrition programmes more effective overall and improve the nutrition prospects for both girls and boys, as well as for women.

In another example, evidence shows that although women have the most responsibility for gathering water from designated points of access, they are poorly represented and have little voice in decisions regarding the location of water points and their accessibility. Improving the voice of women in water management decisions provides an opportunity to reduce the workload of women and girls.

Gender vulnerability

Addressing gender vulnerability means responding to differences in social determinants. This involves questions of power and authority (decision-making), social norms (who is valued for what), division of labour and access to and control over resources. Examples include the following:

Decision-making and social norms

- When household decision-making is more egalitarian, children's needs are more adequately met.⁶ **Women's ability to assert agency and negotiate power**

relations at the household level has the most direct impact on children's well-being. Factors underlying women's agency in the household include control of income and assets, age at marriage and level of education. **Greater control of income by women** has been shown to reduce child mortality rates and to improve child nutrition indicators, even when the household's total income is taken into account.⁷ A study in Andhra Pradesh, India showed that a woman with greater autonomy (indicated by access to money and freedom to decide when to go to the

⁴ For example, during the official Beijing Platform for Action of the Fourth World Conference on Women in September 1995, conservative governments argued in favour of the language of gender *equity*, but were unwilling to accept gender *equality*. Their argument was premised on their belief that their laws, which enshrine differences in women's and men's rights to property and inheritance, are eminently 'fair' or 'just', since they flow from 'natural' differences rooted in maternity and hence in roles and abilities.

⁵ Sen, Gita, Asha George and Pirooska Östlin, 'Engendering International Health: The challenge of equity', MIT Press, Cambridge, Massachusetts, 2002.

⁶ United Nations Children's Fund, *The State of the World's Children 2007: Women and children – The double dividend of gender equality*, UNICEF, New York, 2007, p. 25.

⁷ Ibid.

market) was significantly less likely to have a stunted child than peers who had less autonomy.⁸

- Men typically enjoy financially beneficial and authoritative roles, while **women are often relegated to subservient and menial roles** when managing services and resources. For example, in Mali, management of wells was entrusted to male community leaders without consulting women in the planning of the new resource or its continued management. Women, on the other hand, were assigned cleaning tasks. The systems and equipment set-ups were impractical for women, although they were the ones primarily responsible for collecting water from the well. As a result, at peak times, women dismantled the equipment and went back to their old ways of collecting water.⁹
- In societies in which a woman's social value is largely determined by her ability to produce children for the family or for the larger social group, **high fertility patterns** and **high-risk pregnancies** are common. These types of pregnancies, which are too early or too late, too frequent or too many, adversely impact the survival of a woman's offspring, as well as her own health.

Division of labour

- To varying degrees determined by socio-economic context and rural vs. urban residence, **water is at the core of women's traditional responsibilities**: collecting and storing water, caring for children, cooking, cleaning and maintaining hygiene and sanitation. These tasks often represent a whole day of work. Providing access to safe water close to the home cannot only dramatically improve

children's survival and health but can also reduce women's and girls' workloads, freeing up time for other activities such as education, health care and paid work, all of which contribute to gender equality. Women who have more time available have been shown to spend it caring more for their children, such as by feeding and playing with them.¹⁰

- **Domestic chores and care of the young, the elderly and the sick keep girls out of school and women out of the paid labour force**, thus affecting their autonomy, health and livelihoods. For a woman, taking a day off to care for her sick child could mean not only the loss of a day's wages, but also the risk of losing that job.¹¹ It is often girls and families from the poorest households who are charged with caring responsibilities, and they seldom receive support, let alone adequate economic compensation.
- **Understanding the role that men can and do play in the care of their children is key to improving YCSD prospects.** While it is logical to target YCSD advocacy and programming/interventions towards those who are most vulnerable (and do the lion's share of hands-on child care in societies the world over) – girls and women – and to neglect the roles that boys and men play in different social contexts, doing so can make interventions less effective and sustainable. For example, in Mexico a study showed that when both men and women appeared in materials to promote sanitation and oral rehydration, none surveyed thought that it was unusual or silly for men to play a role in these areas; however, when the materials showed only women, 63 per cent of mothers and 70 per cent of fathers thought that it was a mother's role only to perform these duties.¹² Heightening

⁸ Shroff, Monal, et al., 'Maternal Autonomy is Inversely Related to Child Stunting in Andhra Pradesh, India', *Maternal and Child Nutrition*, vol. 5, no. 1, 1 January 2009, pp. 64–74.

⁹ Swiss Agency for Development and Cooperation, 'Gender & Water: Mainstreaming gender equality in water, hygiene and sanitation interventions', SDC/Federal Department of Foreign Affairs, 2005.

¹⁰ Dr. Malavika Chauhan, Sir Ratan Tata Trust, Mumbai, 'Case Study of Women in Central Himalaya'.

¹¹ United Nations Development Programme, *En Route to Equality: A gender review of national MDG reports 2005*, UNDP, New York, 2005.

¹² Program for the Introduction and Adaptation of Contraceptive Technology, 'Mexico: Fathers and children', *Salubritas*, vol. 6, no. 2, 1982, p. 1.

the role of men and older boys as caregivers and nurturers increases the chances that men in positions of political, economic and social power will better understand and prioritize the needs of children.

Access to resources

- **The low status of girls and women across the life cycle can have long-terms effects on their development.** For example, in maternal health and nutrition, it can contribute to pregnancy outcomes such as lower infant birth weight, as well as child survival and development outcomes such as the quality of infant care and nutrition. Poor health and nutrition status, particularly anaemia and malnutrition among vulnerable women, is compounded during pregnancy by overwork, undernutrition, chronic ailments and harmful cultural practices.¹³ Nutrition supplementation during pregnancy does not correct the causes of the problem, although it may correct the manifestation or prevent it from worsening.
- **Significant disparity in child nutritional status exists in terms of mothers' education and literacy.** A number of studies and analyses have found a significant association between low maternal literacy and the poor nutrition status of young children. An analysis of survey data from 17 developing countries, for example, confirms a positive association between maternal education and nutritional status in children 3–23 months old, although a large part of these associations is the result of education's strong link to household economics.¹⁴ Similar disparities related to women's education have been observed in terms of health outcomes.

ADDRESSING GENDER IN PROGRAMMING

UNICEF-supported programmes involve families, communities, service delivery, policy and emergency contexts. Gender concerns regarding the character of social norms, processes of decision-making, the division of labour and differences in access to resources

manifest themselves across these various levels or spheres of intervention. Each of these spheres plays a critical role in fostering behaviour change and enabling environments for advancing, rather than obstructing, gender equality.

Families

Traditional planning tends to consider the household as being the basic unit of resource allocation. A gendered approach to planning underscores, *first*, the heterogeneity of family structures and the growing presence of female-headed households; *second*, the unequal control over resources and decision-

making power among adult household members; *third*, the patterns of distribution of labour (paid and unpaid) between men and women, as well as between boys and girls;¹⁵ and *fourth*, the fact that the family is not always internally harmonious and often fails in its protective role.

¹³United Nations Development Programme, *En Route to Equality: A gender review of national MDG reports 2005*, UNDP, New York, 2005.

¹⁴Cleland, John G., and Jeroen K. van Ginneken, 'Maternal Education and Child Survival in Developing Countries: The search for pathways of influence', *Social Science and Medicine*, vol. 27, no. 12, 1988, pp. 1357–1368.

¹⁵Moser, Caroline O.N., *Gender planning and development: Theory, practice, and training*, Routledge, New York, 1993.

Factors to consider include:

- During periods of drought, **girls may be required to leave school to support their families** by seeking water. Girls can also be pulled out of school when households have no one to turn to in terms of home care for the young, sick and disabled. Promoting the importance of all children to participate in school for the entire school year and reducing the burden on young girls to complete their domestic duties through more egalitarian family roles can help girls to attend school.
- **Unequal access to resources within the household can manifest itself among children.** Boys tend to be more privileged than girls when it comes to medical care and the distribution of food (particularly proteins) in times of scarcity, even when mothers are allocating these resources.
- **Women who are encouraged to promote hygienic, health-supporting behaviours and good nutrition practices are better able to improve the lives of children.** Mothers supported to be strong advocates of healthy behaviours and good practices within their families can influence others in the community to adopt such behaviours and practices. Moreover, children who are influenced during the formative years are more likely to teach their own children healthy habits.

An idealistic vision of the community as being a homogenous group with shared values and norms, a collective personality and a willingness to work together to resolve problems must be put aside. There is a need to take into account economic and social differences and interests within communities.

World Health Organization

- **Greater (and eventually equal) involvement of men in child care and household tasks**, as well as in addressing gender discrimination and inequalities, is critical to establishing a supportive environment for YCSD.¹⁶ Young

Communication strategies and messages must take gender into account

Many of the sub-components of YCSD emphasize behaviour change, which typically depends on positive social change. Examples include breastfeeding and complementary feeding, care-seeking practices for common childhood illnesses, home treatment, hand washing, sanitation and other hygiene practices, injury prevention, early stimulation, social-emotional support and the like. Many of these behaviours and practices have a gender dimension. It is therefore crucial that the communication strategies and materials produced are designed to reach and appeal to women and girls, as well as men and boys, and that their development is based on sound evidence.

children need to receive loving care from both men and women; and mothers' and fathers' roles are important, supportive and complementary throughout the development of the child.

- **Poor women typically bear the burden of domestic and care work**, but this work, ubiquitous though it is, can be invisible to policymakers and planners. Although it is not counted in most statistics, without this 'care economy', the productive economy, including service delivery, could not function.¹⁷
- Those promoting YCSD technologies and practices sometimes pay inadequate attention to the **demands they make on girls and women in the context of their existing burdens.** Practices that may, if improperly implemented, burden women include exclusive breastfeeding and complementary feeding, immunization, water purification and home treatment for oral rehydration and malnutrition. These

¹⁶United Nations Children's Fund, *The State of the World's Children 2009*, UNICEF, New York 2009.

¹⁷For information about the care economy, see the United Nations Research Institute for Social Development project, 'Political and Social Economy of Care.'

practices require considerable time, energy and knowledge, as well as changes in social norms. The successful application of these practices in ways that do not overburden women requires, first and foremost, greater participation by other household members, as well as community services and labour-saving technologies.

Communities

Understanding community dynamics and gender-equity issues is critical if vulnerable members of the community are to be heard. The community environment strongly influences gender norms, roles and responsibilities. It offers opportunities for:

- **Changing social norms and behaviour:** Community-level interventions offer opportunities for raising awareness of social norms related to gender and for building support for changing those norms that impede YCSD. (Refer to 'Promoting Gender Equality through UNICEF-Supported Programming in Child Protection: Operational Guidance' for more about social norms that support or impede YCSD.)
- **Supporting service delivery:** Community-level interventions create opportunities for people to mobilize demand services, including water supply and sanitation, health and nutrition care, early childhood development, transport and credit, which will allow them to better care for their children. Consultation processes that enable the voicing of community perspectives, including the perspectives of girls and boys, and women and men, are essential for services to be responsive to community needs. For example, making sure that women are considered in the design of water and sanitation infrastructure, such as elevated water supply platforms and toilets that can accommodate mothers, including those who are pregnant or who carry children, as well as children themselves, ensures the dignity of women and allows them to provide for their families more efficiently.

- **Time constraints are a particularly important factor to contend with among poor women** – especially rural women – who, as several studies in Latin America and elsewhere¹⁸ have demonstrated, already work longer hours than men. Yet many planners still view women's time as endlessly elastic.

- **Promoting local ownership and management:** Community involvement in monitoring and auditing local services is central to ensuring that service delivery remains accountable to community needs. Without further impoverishing time-constrained poor communities, some elements of service delivery may also be financed and managed by communities themselves. Ensuring the participation and perspectives of girls and boys, and women and men, in all of these processes is essential.

For example, given that the primary responsibility for accessing water supply, sanitation and hygiene falls disproportionately on women and children, as well as the impact of poor quality and managed water and sanitation services, women's active involvement in the design of infrastructure and management is imperative. Involving women in the decision-making processes of designing and managing WASH projects, *without increasing their workloads*, addresses women's practical needs and strategic interests, namely, the right to safe water and the right to participate in the community decisions that affect their well-being and that of their families. Evidence from community water and sanitation projects show that projects designed and run with the full participation of women are more sustainable and effective than those that ignore women.¹⁹

¹⁸ United Nations Development Programme, *Human Development Report 1995, 1997, 1998, 1999*, UNDP, New York, 1995, and Oxford University Press, 1997, 1997, 1998, 1999; Organización Panamericana de la Salud (CEPAL), 'La Economía Invisible y las Desigualdades de Género: La importancia de medir y valorar el trabajo no remunerado', CEPAL, Washington, D.C.; CEPAL, 'Objetivos de Desarrollo del Milenio: Informe 2006 – Una mirada a la igualdad entre los sexos y la autonomía de la mujer en América Latina y el Caribe' ('A look at gender equality and women's autonomy in Latin America and the Caribbean'), CEPAL, Santiago, Chile, 2008.

¹⁹ Task Force on Education and Gender Equality, *Taking Action: Achieving gender equality and empowering women*, UN Millennium Project, New York, January 2005, p. 69.

Service delivery

All types of service delivery are vulnerable to bias in their recognition of user needs, design in responding to users, or utilization by users. Typically, outreach services such as immunization are more equitable, as they are planned on a population basis and actively search for beneficiaries. Services that rely on users to seek them out tend to favour those who already are entitled, empowered or enabled with resources to access them.

Service delivery can perpetuate gender inequality when planners and implementers fail to:

Recognize bias in monitoring or assessing service delivery needs because sex-disaggregation of child survival, growth and development indicators and service statistics are incomplete or infrequent; reliable information on conditions that affect girls and women particularly is lacking; and gender-based violence is not recognized as a YCSD issue.

Respond to biases that arise in the focus of service delivery because public messages regarding child survival, growth and development, as well as child-care practices and adolescent and adult reproductive behaviours do not target both men and women. Such a response is also necessary because men are excluded from programmes related to family planning, child maternal health, and sexual and reproductive health.

Respond to biases that arise in defining access to service delivery that result from restrictions on access to and confidentiality of reproductive health services used by adolescent girls, as well as inadequate access to sanitation

services by those girls who are menstruating. Inequitable financing systems place a heavier financial burden on women because women use primary health services for themselves and their children more frequently than men do.²⁰

Respond to biases that arise in the production and management of service delivery. These biases can arise when sex imbalances in the service delivery personnel preclude the rapport required for certain types of services, whether agricultural extension work, health promotion regarding breastfeeding or intimate clinical procedures; when service delivery professionals lack training and sensitization on gender issues; when volunteer work is primarily undertaken by girls and women with little appreciation for their time constraints and rights to development, and little recognition or support for their contributions; and when representation of women in decision-making positions is scant and inconsistent.

To support gender equality, service delivery must:

- Acknowledge that power relations mitigate the recognition of needs and influence of those least able to secure YCSD, resulting in certain issues and groups being neglected, silenced, stigmatized or devalued;
- Be accountable to ensure that providers and services do no harm through systems that track inequity and support redress; and
- Be proactive in supporting primary health care and in addressing the broader determinants of YCSD.

Policies that support enabling environments

Policies that fail to recognize and address differences between girls, boys, women and men in terms of needs, responsibilities, access to resources and power over decision-making can perpetuate, exacerbate or create gender inequality and limit programme effectiveness.

For instance:

- Health-sector reform policies related to cost reduction and efficiency frequently hide profound gender biases because they involve cost transfers from the paid

²⁰ Gomez, E., 'Guía para el Análisis y el Monitoreo de la Equidad de Género en las Políticas de Salud', Organización Panamericana de la Salud, Washington, D.C., 2008.

economy to the care economy based on women's unpaid work.

- The introduction of user fees affects women disproportionately, because women tend to be primary users for themselves and for children, but have less access to and control over income, security and social resources in comparison to men.

Enabling environments for effective YCSD also require integrated national planning processes, as several critical elements for advancing gender equality lie outside YCSD sectors per se. These potentially transformative approaches require inter-sectoral policy and action, community mobilization and support to social movements. Inter-sectoral actions that support gender equality and thus create an enabling environment for YCSD include:

- Supporting women's education;
- Services that address and prevent gender-based violence;
- Ensuring legal mechanisms for universal access to services;
- Legislative measures to support working women during pregnancy, including leave for mothers and fathers;
- Revisions in legal codes to enable women to register for pensions, land records, inheritance, etc.
- Revisions in the requirements for bank accounts and credit so that women can save their incomes securely and access finance.

Emergency, recovery and disaster risk reduction contexts

Emergencies, both natural and those arising from political strife or conflict, have major consequences on the survival and development of children in the affected populations. Children and women are particularly vulnerable to a lack of access to water and sanitation and an absence of services that protect health, nutrition and early child development and prevent illness, malnutrition and violence.

The emergency field handbook for UNICEF staff clearly states that "*gender sensitivity must be built into all programme activities in all sectors.*"²¹ The assessment and implementation of YCSD-related programmes must take specific account of the social and economic roles of girls, boys, women and men and the extent to which these have been changed or are in the process of changing as a result of the emergency. Wherever possible, programmes should be designed to reduce disparities in access to resources, opportunities, knowledge and information.

When developing and planning within a disaster risk reduction and/or recovery context, the potential issues for girls and women, and the impact on gender roles during an emergency should be considered. For example, having prior knowledge of where water supplies are safe, accessible and sustainable within conflict-prone countries may provide valuable information in the planning and positioning of camps such that women do not have to travel extended distances beyond the safety of the camp to gather water for their families. Identifying the risk to women and children from external factors such as climate change is also essential.

The Inter-Agency Standing Committee's (IASC) gender handbook from 2006, *Women, Girls, Boys and Men: Different needs, equal opportunities*, outlines key gender issues in the areas of WASH, health, nutrition and early childhood development in emergency situations and interventions.

²¹ Inter-Agency Standing Committee, 'Women, Girls, Boys and Men: Different needs – Equal opportunities', IASC, New York, December 2006.

ENTRY POINTS FOR GENDER ANALYSIS AND PROGRAMMING IN YCSD SECTORS



UNICEF/NYHQ2004-0174/Roger LeMoynne

This section identifies concrete entry points and provides guidance for gender analysis and programming in the four sectoral areas of YCSD: health, nutrition, WASH and early childhood development.

Each sectoral area will include:

- A narrative introduction that outlines the key gender inequalities that currently exist in the sector, as well as the key gender issues to consider.
- A table that provides practical, sector-specific guidance on how to integrate gender into the programme cycle at the following points: assessment, analysis, design and implementation of actions (programmes), and evaluation.²²

The sections to follow include:

- Health (maternal and newborn health, immunization, managing common children's infectious diseases, malaria prevention);
- Nutrition (infant and young child feeding (IYCF) and maternal nutrition, acute malnutrition, micronutrients);
- WASH (integrated as part of a holistic WASH programming approach); and
- Early childhood development.

²² Generic tips applicable to all UNICEF-supported programmes can be found in *Promoting Gender Equality: An Equity-Focused Approach to Programming (Operational Guidance Overview)*, specifically Section D: 'Entry points for promoting gender equality in/through UNICEF-supported programmes'.

HEALTH

This section describes gender issues outlined in the introduction (gender equity, gender vulnerability and gender programming) by highlighting illustrative examples from several

technical areas of health programming: 1) maternal and newborn health; 2) immunization; 3) management of common children's infectious diseases; and 4) malaria prevention.

Maternal and newborn health

Gender equity: Responding to outcomes that are unjust

Some of the largest inequities in public health are found in maternal and newborn health, as documented in access to skilled birth attendance.²³ This is because **social determinants** play a powerful role in determining women's agency and effective access to quality services related to maternal and newborn health.

Women in general – but especially those marginalized by illiteracy, minority status or poverty – are often not aware of their rights or are unable to exercise them. For example, unmarried pregnant women, as well as those forced into prostitution or from other marginalized groups, face considerable **stigma** and thus may not be able to seek health-care services. **Social norms** can restrict access to information and support biased norms and unfair decision-making regarding sexuality and marriage, including the ability to use family planning. **The division of labour** within households may be such that once a woman becomes pregnant, she may have too many responsibilities that are unsupported and thus may not have time to prioritize her own health, well-being or status.

If services are available, women often lack the decision-making power, financial resources and/or the empowerment to challenge harmful, stigmatizing or discriminatory norms, which prevents them from obtaining the full range of quality sexual and reproductive health and rights, including maternal health, to which they are entitled. Ensuring that the full range of quality services is available can improve

the status of women and strengthen equality between both men and women.²⁴

Some groups of women may be particularly vulnerable. For example, **adolescent girls** are more vulnerable to traditional harmful practices, such as child marriage and female genital mutilation/cutting. They may marry early and get pregnant at a young age, due to social pressures, lack of awareness and lack of access to appropriate services. Once pregnant, they may have their schooling opportunities curtailed, thus jeopardizing their longer-term economic and social well-being. It often happens that adolescents marry older males and have a junior role in the family hierarchy, and therefore they may not be able to negotiate access to family planning or health care more broadly. As a result of these social determinants and biological vulnerability, adolescent girls 15–20 years old are twice as likely, and adolescent girls younger than 15 years old are five times as likely, to die during pregnancy or childbirth as women in their twenties.²⁵ They are also more likely to have a low birthweight baby.

Utilization of quality services for girls and women may not be possible, due to determinants that are linked to their status in society (e.g., access to resources or decision-making power). If and when girls and women do access services, they may experience poor quality of, and even degrading, treatment. They may not feel able, however, to claim their entitlements to respectful and good quality health care, including care that addresses neglected women's health issues that have important maternal and newborn implications, such as anaemia, post-natal care and domestic violence (including against pregnant women).

²³The White Ribbon Alliance for Safe Motherhood, 'Atlas of Birth', White Ribbon Alliance, 7 July 2009.

²⁴Department for International Development, 'Choices for Women: Planned pregnancies, safe births and healthy newborns – The UK's framework for results for improving reproductive, maternal and newborn health in the developing world', UKAID, December 2010.

²⁵United Nations Department of Education and Social Affairs, *The World's Women*, United Nations, New York, 1990.

“If we can fix things for mothers – and we can – we can fix so many other things that are wrong in the world. Women are at the heart of every family, every nation. It’s mostly mothers who make sure children are loved, fed, vaccinated and educated. You just can’t build healthy, peaceful, prosperous societies without making life better for girls and women.”

- Sarah Brown, White Ribbon Alliance

Studies in several countries have shown that partner abuse can actually increase during pregnancy; this has enormous implications not only for the mother but for children. In India, domestic violence towards mothers during pregnancy doubled the risk of child death during the perinatal and neonatal periods.²⁷

Involving men in maternal and newborn care can support gender equality. For example, a child is well served when both the mother and the father are involved in the caretaking, nurturing and support of their children. The Men in Maternity programme in India targets low-income urban couples to encourage men’s participation in family planning. An evaluation showed “significantly higher” husband involvement “during antenatal consultation...family planning consultation.... post-partum visits...and presence during labour and delivery.”²⁸ In 2009, Chile passed a law institutionalizing the Childhood Social Protection System, Chile Crece Contigo [Chile Grows with You]. This includes measures to increase the participation of fathers in child care, pregnancy and birth.²⁹

Immunization

While there is no evidence suggesting a significant difference in the coverage of routine immunization between boys and girls at the global level, such differences have been reported at the sub-national level in

Understanding the source of vaccine refusal is critical

In Pakistan, a polio campaign specifically targeted men, as they were thought to be the main decision makers and the force behind most cases of vaccine refusal. Subsequent research showed that while men were the main decision makers in most areas, women were the main decision makers in health-care-seeking and immunization and were behind most refusals. Changes in communication strategies and messages specifically targeting mothers and mothers-in-law showed significant success in improving coverage and decreasing refusals in a relatively short time. This highlights the importance of local research to understand gendered patterns of communication and decision-making rather than making universal assumptions.

some countries.³⁰ Further analysis regarding gender issues in immunization goes beyond differences in coverage and involves the manner in which immunization services are delivered. Addressing these gendered dimensions of service delivery can increase coverage of immunization for all marginalized children, whether male or female. (See, for example, the *Box* on sources of vaccine refusal.)

Differences in coverage by gender may interact with other social stratifiers and inequities. In Bangladesh, Ethiopia, Nigeria and the United Republic of Tanzania, and less so in Cambodia and Yemen, coverage gaps against girls in immunization is worse among poorer groups. Girls are less often reached with follow-up services than boys. In the wealthiest quintiles

²⁷ Saifuddin Ahmed, Michael A. Koenig, and Rob Stephenson *Effects of domestic violence on perinatal and early-childhood mortality: Evidence from North India* American Journal of public health v. 96, no 8 pp. 1423-1428 2006

²⁸ Leila Caleb Varkey, Anurag Mishra, Anjana Das, Emma Ottolenghi, Dale Huntington, Susan Adamchak, M.E. Khan Frederick Homan *Involving Men in Maternity Care in India* Population Council New Delhi, India 2004

²⁹ Barker, Gary, et al., ‘What Men Have to Do with It: Men and gender equality policy project’, International Center for Research on Women/Instituto Promudo, 2010.

³⁰ World Health Organization, *Weekly Epidemiological Record*, no. 1–2, 2011, vol. 86, no. 1.

for some of these countries, however, the bias often reverses, and the proportion of boys not immunized is greater than that of girls. For example, in Bangladesh, the ratio of girls to boys not immunized changes from 0.5 (bias against girls) in the poorest quintile to 1.6 (bias against boys) in the wealthiest quintile. In Ethiopia, a similar change occurs for full immunization coverage, from a 0.4 ratio against girls in the poorest quintile to a 1.2 ratio, biased against boys, in the wealthiest quintile. In some contexts (e.g., in India) gender inequalities cut across all class groups.³¹

Studies on decision-making in households concerning health care show that although women often have more responsibility for decisions regarding the health care of children, they are usually less knowledgeable about vaccinations and other health issues than men.

Managing common childhood infectious diseases

In most countries, there are no apparent differences in access to community case management for girls and boys, although in India, there is some evidence that boys are taken sooner to private clinics than girls are.³² Gender issues arise when one considers how the responsibility for caring for sick children is shared and whether that responsibility is supported by corresponding decision-making authority and access to resources. In Ghana, it was found that treatment-seeking behaviour for children was influenced by norms of decision-making power and 'ownership' of children; access to and control over resources to pay for treatment; norms of responsibility for payment; marital status; household living arrangements; and the quality of relationships between mothers, fathers and elders.³³

Another study in Ghana found that women who lacked either short- or long-term economic

support from male relatives, or disagreed with their husbands or family elders about appropriate treatment-seeking options, faced difficulties in accessing health care for children with malaria.³⁴ This illustrates the significant influence of women's access to resources and decision-making power on treatment-seeking behaviour for children with febrile illnesses, as well as the importance of approaching malaria management in the community or household from a gender perspective.

Similar results were found in Kenya, where disputes concerning perceived cause and appropriate therapy of convulsions highlighted the importance of age, gender and relationship to household head in intrahousehold relations and treatment decision-making. Although mothers' treatment-seeking preferences are often circumscribed by these relations, a number of strategies can be drawn upon to circumvent inappropriate decisions.³⁵

Women may be expected to undertake preventive, guided management and follow-up of children's health in the home, without any consideration for their other household or income-earning tasks. In this regard, women's time tends to be seen as elastic.

Public campaigns tend to target men as decision makers, although women do the lion's share of child care. A good example of changing the social norms concerning men's roles for child care is demonstrated by the following example from Canada. Boys for Babies was a school-based programme in Toronto run by parents. Ten-year old boys were taken to a childcare centre and taught to hold and feed babies and to talk about how it is beneficial when men look after children. At first, the boys opposed this, but by their second visit, they were referring to "my baby."³⁶

³¹ Gwatkin, Davidson R., '10 Best Resources on...Health Equity', *Health Policy and Planning*, vol. 22, no. 5, 2007, pp. 348–351.

³² Ganatra, B. and S. Hivre, 'Male Bias in Health Care Utilization for Under-Fives in a Rural Community in Western India', *World Health Organization Bulletin*, vol. 72, no. 1, 1994, pp. 101–104.

³³ Tolhurst, R., et al., 'He Will Ask Why the Child Gets Sick so Often: The gendered dynamics of intra-household bargaining over healthcare for children with fever in the Volta Region of Ghana', *Social Science & Medicine*, 2008.

³⁴ Tolhurst, R., and F. K. Nyonator, 'Looking within the Household: Gender roles and responses to malaria in Ghana', *Transactions of the Royal Society of Tropical Medicine and Hygiene*, April 2006, vol. 100, no. 4, pp. 321–326.

³⁵ Molyneux, C. S., et al., 'Intra-Household Relations and Treatment Decision-Making for Childhood Illness: A Kenyan case study', *Journal of Biosocial Science*, vol. 34, no. 1, January 2002, pp. 109–131.

³⁶ Kaufman, Michael, 'The AIM Framework: Addressing and involving men and boys to promote gender equality and end gender discrimination and violence', United Nations Children's Fund, New York, 31 March 2003, p. 28.

Malaria prevention

Those at highest risk biologically of malaria are infants and young children (from 6 months to 5 years old), pregnant women, non-immune people (such as travellers, labourers and populations moving from low-transmission to high-transmission areas) and people living with HIV and AIDS. The rate of malaria infection is higher in pregnant women because of their decreased immunity. Infection rates are highest in first and second pregnancies and lower in later pregnancies. Pregnant women with malaria have an increased risk of miscarriage, stillbirth, premature delivery and low birthweight infants. Malaria is one of the leading causes of anaemia in pregnant women. Despite the dangerous impact of malaria on pregnant women and their infants, it is estimated that less than 5 per cent of pregnant women have access to effective interventions. Women co-infected with both HIV and malaria are at increased risk of severe anaemia and adverse birth outcomes.

Gender norms and values that influence the division of labour, leisure patterns and sleeping

arrangements may lead to different patterns of exposure to mosquitoes for men and women. The acceptability and use of insecticide-treated mosquito nets can be linked to gender norms and culturally accepted sleeping patterns. In some instances, young children sleep with their mother and are therefore protected by her net if she has one. Alternatively, if a household only has one net, priority may be given to the male head of the household, as he is often considered the primary breadwinner.

In other contexts, men have little access to nets if they sleep outdoors. Men are also vulnerable to contracting malaria through occupational exposure (for example, working outside in fields or working at night). Women may also be vulnerable to malaria and to ill health in general, due to their lower social status: higher incidence of poverty, poorer nutrition, lower level of formal education, less access to financial resources and gendered divisions of labour that leave women with less time to take care of their own health.

HEALTH AND GENDER ASSESSMENT, ANALYSIS AND PROGRAMMING TIPS

ASSESSMENT

- What are the health outcomes of interest and can they be disaggregated by sex and other social markers? Are there significant differences?

For example: sub-national sex differences in immunization, differences in maternal health outcomes by marginalized groups of women, e.g., unmarried adolescents.

- Are there differences in coverage of interventions or access to quality services by sex and other social markers?

For example: differences in access to malaria diagnosis and treatment if it is only available in facilities that are harder for women to access or lack of continuity of maternal-care services by marginalized women, e.g., women who are HIV-positive.

- Are there differences by sex and other social markers in participation, decision-making and planning of interventions at the family, community, service delivery and policy levels?

For example: Is there a lack of involvement of women in immunization communication campaigns or, at the other extreme, exclusion of men from messages about caring for a sick child?

HEALTH AND GENDER ASSESSMENT, ANALYSIS AND PROGRAMMING TIPS

... CONTINUED

ANALYSIS

- Are there biological risks or needs specific to sex that need to be addressed?

For example: Women have higher risks of developing malaria and therefore developing anaemia during pregnancy and are at risk of maternal morbidity and mortality; other examples are that younger adolescents are more at risk of HIV and poor maternal health outcomes than older adolescents and women.

- Are there differences in social risks and responsibilities specific to gender that need to be addressed?

Questions to consider include: What is the nature of decision-making?, What are the social norms? What is the division in labour?, and How are resources allocated and access to services determined?

- Are there other barriers for effectively practicing interventions or accessing quality services that are linked to gender?

For example: who decides family size and use of contraception; quality and integration of family planning with other reproductive health services and accessibility by adolescent girls; work burdens and domestic violence during pregnancy; and permission and resources from men and elders in the family to access health-care services.

ACTION

- Can the intervention function better by addressing gender issues?

For example: Can it be better to focus on marginalized groups (e.g., adolescent girls, women from minority groups)?; Can communication strategies address gaps in awareness and norms by women and men?; Can community mobilization address gender inequalities behind low coverage (e.g., women not able to travel to health-care facilities on their own)?; Can service delivery modes be more responsive to gender issues (e.g., better support for women who are more likely to default the continuum of maternal health services)?

- Can the intervention area ensure that female agency and empowerment is supported and male responsibility encouraged?

For example: Are women's views included in quality improvement efforts and are men's roles in families addressed in communication messages?

- What are the capacity gaps for supporting gender-sensitive programming?

MONITORING AND EVALUATION:

- What are the indicators for marking progress related to gender issues in the intervention area of interest?

For example: the intervention outcomes or outputs, levels of participation and resources allocated.

- What are the methods of data collection and resources required to collect the information for such indicators?
- How will this information be disseminated to ensure further discussion and action to improve gender equality in the intervention area of interest?

NUTRITION

Introduction and global situation

This section describes key observed gender disparities and critical gender issues in nutrition and includes programming tips for the assessment, analysis, action and monitoring and evaluation phases of the programme cycle. It focuses on IYCF and maternal nutrition, acute malnutrition and micronutrients.

The direct causes of undernutrition include a combination of a lack of quality food, frequent attacks of infectious disease and deficient care. Nutritional deficiencies are particularly harmful while a woman is pregnant and during a child's first two years of life. During this period, undernutrition poses a significant threat to mothers and to children's survival, growth and development, which in turn negatively affects children's ability to learn in school and to work and prosper as adults.

A wide variety of underlying factors also contribute to maternal and child nutrition, such as poor-quality public health systems, society's ability to deal with poverty, food insecurity for disadvantaged groups, the capacities of social justice and welfare systems, and the effectiveness of broader economic and social policies. Low levels of maternal education and women's social status are among the underlying factors that need to be taken into consideration and addressed – along with poverty and various other dimensions of inequity – in order to reduce undernutrition in a sustained manner. This message can be used as an entry point for reaching men:

“Your children and the children of our community will be healthier and stronger when the women in our community have more education and a higher status.”

An analysis of nutrition outcome indicators at the global level reveals negligible differences between boys and girls less than 5 years old.

Similarly, programme coverage data that are disaggregated by sex – for example, vitamin A supplementation – reveal no significant differences on the basis of gender.

But further disaggregation of data from some countries indicates there may be differences in the feeding and care of girls compared with boys. Data in some countries point to the possible effects, such as Bangladeshi boys being significantly taller relative to their age than girls.³⁷ In sub-Saharan Africa, on the other hand, boys are more likely to be stunted than girls.³⁸

Although there are no global gender differences in rates of undernutrition and there is little evidence that girls and boys have differential access to nutrition services, the inadequacy of these services in general in many countries does have a disproportionate negative impact on women and girls. In addition, gender issues such as low levels of female literacy, low social status and low autonomy have been shown to affect the nutritional status of children.

Pregnant and lactating women have greater nutritional needs for biological reasons, and these are often not addressed. Further, food insecurity has additional negative consequences for women's health and for the survival and development of their infants, and food aid, food security and social protection programmes often do not include any targeted measures to address this. At the same time, the evidence from cash transfer programmes in a number of countries has shown that if the benefit is given to women, the health and nutrition status of the household is positively affected, as women are much more likely to spend the cash on food and health care.³⁹ A number of cash transfer

³⁷Dancer, Diane, Anu Rammohan and Murray D. Smith, 'Infant Mortality and Child Nutrition in Bangladesh', *Health Economics*, vol. 17, no. 9, September 2008, pp. 1015–1035.

³⁸Wamani, Henry, et al., 'Boys are More Stunted than Girls in Sub-Saharan Africa: A meta-analysis of 16 demographic and health surveys', *BMC Pediatrics*, vol. 7, no. 17, 10 April 2007.

³⁹Duflo, Esther, *Grandmothers and Granddaughters: Old age pensions and intra-household allocation in South Africa*, National Bureau of Economic Research, Cambridge, Massachusetts, December 2000.

programmes, often with women as primary recipients, have shown positive outcomes in terms of child nutrition status – with 7 out of 10 programmes reporting on stunting outcomes showing a positive impact.⁴⁰

Significant disparity in child nutritional status exists in terms of mothers' education and literacy. A number of studies and analyses have found a significant association between low maternal literacy and poor nutrition status of young children. An analysis of survey data from 17 developing countries, for example, confirms a positive association between maternal education and nutritional status in children 3–23 months old, although a large part of this association is the result of education's strong link to household economics.⁴¹ A study in Pakistan revealed that the majority of infants with signs of undernutrition had mothers with virtually no schooling. The study also observed that the introduction of complementary foods for infants at an appropriate age (6 months old) improved when mothers were educated.⁴²

In many developing countries, **the low status of women** is considered to be one of the primary determinants of undernutrition across the life cycle. Women's low status can result in their own health outcomes being compromised, which in turn can lead to lower infant birthweight and may affect the quality of infant care and nutrition. A study in India showed that women with greater autonomy (indicated by access to money) were significantly less likely to have a stunted child when compared with their peers who had less autonomy.⁴³

An in-depth search of the literature on gender dimensions of nutrition (and child health) is currently under way at the Liverpool School of Tropical Medicine, and this should provide valuable evidence, as well as recommended

tools to conduct formative research and gender analysis for the YCFSD area.

Maternal nutrition and IYCF

A child's future nutrition status is influenced by a number of factors before conception and is greatly dependent on the mother's nutrition status prior to and during pregnancy. A chronically undernourished woman will give birth to a baby who is likely to be undernourished as a child, and for girls, chronic undernutrition in early life can later lead to their babies being born with low birthweight, which can lead again to undernutrition as these babies grow older. Thus a vicious cycle of undernutrition repeats itself, generation after generation.

Maternal undernutrition, particularly low body mass index, which can cause fetal growth retardation, and non-optimal IYCF, are the main causes of faltering growth and undernutrition in children under 2 years old.⁴⁴ During this period, nutritional deficiencies have a significant adverse impact on child survival and growth. Chronic undernutrition in early childhood also results in diminished cognitive and physical development, which puts children at a disadvantage for the rest of their lives. They may perform poorly in school, and as adults they may be less productive, earn less and face a higher risk of disease than adults who were not undernourished as children. Once children are stunted, it is difficult for them to catch up in height later on, especially if they are living in conditions that prevail in many developing countries.

Anaemia, two thirds of which is caused by iron deficiency, is highly prevalent among women in developing-country settings, and increases the risk of maternal death.⁴⁵ Anaemia affects about

⁴⁰ Sridhar Devi, and Arabella Duffield, 'A Review of the Impact of Cash Transfer Programmes on Child Nutritional Status and some Implications for Save the Children UK Programmes' Save the Children UK, London, November 2006. Examples include Mexico's PROGESA/Oportunidades programme, Nicaragua's Red de Proteccion Social and the conditional cash transfer programme in Colombia, as well as a pilot programme in Malawi and the South African Child Support Grant.

⁴¹ Cleland, John G., and Jeroen K. van Ginneken, 'Maternal Education and Child Survival in Developing Countries: The search for pathways of influence', *Social Science and Medicine*, vol. 27, no. 12, 1988, pp. 1357–1368.

⁴² Liaqat, Perveen, et al., 'Association between Complementary Feeding Practice and Mothers Education Status in Islamabad', *Journal of Human Nutrition and Dietetics*, vol. 20, no. 4, 17 July 2007, pp. 340–344.

⁴³ Shroff, M., et al., 'Maternal Autonomy is Inversely Related to Child Stunting in Andhra Pradesh, India', *Maternal and Child Nutrition*, vol. 5, no. 1, 1 January 2009, pp. 64–74.

⁴⁴ Shrimpton, Roger, et al., Worldwide Timing of Growth Faltering: Implications for nutritional interventions, *Pediatrics*, vol. 107, no. 5, May 2001, pp. 5–6.

⁴⁵ Black, Robert E., et al., 'Maternal and Child Undernutrition: Global and regional exposures and health consequences', *The Lancet*, vol. 371, no. 9608, 19 January 2008, pp. 243–260.



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25 per cent of the world's population, or almost 2 billion people. Women and young children are most vulnerable: 42 per cent of pregnant women and 47 per cent of preschool-age children in developing countries are anaemic, compared with only 12 per cent of men.⁴⁶ While insufficient iron consumption is one cause, blood loss during menstruation and parasitic infections such as intestinal worms and malaria, as well as other infectious diseases such as HIV and tuberculosis, can aggravate the condition. Anaemic women may give birth to premature babies or low birthweight infants who will then suffer from infections, weakened immunities, learning disabilities and/or impaired physical development, and who, in severe cases, will die. The breastfed infants of anaemic mothers are likely to also be anaemic. Iron deficiency causes weakness and fatigue, and reduces physical ability to work. Adults suffering from anaemia are less productive than adults who are not anaemic.⁴⁷

Globally, there are no gender differences in stunting and underweight rates, and no differences in breastfeeding rates.⁴⁸ In some areas, however, girls are more stunted than boys,⁴⁹ while in others boys are more stunted than girls.⁵⁰ Pregnant and lactating women have greater nutritional needs for biological reasons, and these are often not addressed. Maternal undernutrition (measured by low body mass index) ranges from 10 per cent to 19 per cent in most developing countries.⁵¹ The evidence for greater nutritional requirements during pregnancy is clear, but the evidence base for the positive impact on pregnancy outcomes of food supplementation during pregnancy is small⁵² and the implementation of effective programmes is very limited. Coverage of iron supplementation during pregnancy is woefully inadequate in most countries. For example, in India, where 59 per cent of pregnant women are anaemic, only 23 per cent used iron-folic acid supplements. Similarly, in Nigeria, while 67 per cent of

⁴⁶World Health Organization, *Worldwide Prevalence of Anaemia 1993–2005: WHO global database on anaemia*, WHO, Geneva, 2008.

⁴⁷Hunt, Joseph M., 'Reversing Productivity Losses from Iron Deficiency: The economic case', *Journal of Nutrition*, vol. 132, no. 4, 1 April 2002, pp. 794S–801S.

⁴⁸United Nations Children's Fund, *Progress for Children: A world fit for children statistical review*, UNICEF, New York, December 2007.

⁴⁹Dancer, Diane, Anu Rammohan and Murray D. Smith, 'Infant Mortality and Child Nutrition in Bangladesh', *Health Economics*, vol. 17, no. 9, September 2008, pp. 1015–1035.

⁵⁰Wamani, Henry, et al., 'Boys are More Stunted than Girls in Sub-Saharan Africa: A meta-analysis of 16 demographic and health surveys', *BMC Pediatrics*, vol. 7, no. 17, 10 April 2007.

⁵¹Black, Robert E., et al., 'Maternal and Child Undernutrition: Global and regional exposures and health consequences', *The Lancet*, vol. 371, no. 9608, 17 January 2008, pp. 243–260.

⁵²Bhutta, Z., et al., 'What Works? Interventions for maternal and child undernutrition and survival', *The Lancet*, vol. 371, no. 9608, 17 January 2008, pp. 417–440.

pregnant women are anaemic, only 21 per cent used iron-folic acid supplements.⁵³

Micronutrients for young children

Vitamin and mineral deficiencies are highly prevalent throughout the developing world. Those highlighted in this document include iron, iodine and vitamin A, but other deficiencies such as zinc and folate are also common.⁵⁴

Iodine and iron deficiency can undermine children's school performance and cause a variety of health and developmental problems.⁵⁵ Iodine and iron deficiency in pregnancy is particularly risky for both the mother and the fetus. The intelligence quotients of children suffering iron deficiency in early infancy were lower than those of their peers who were not deficient.⁵⁶ Iron deficiency makes children tired, slow and listless, so they do not perform well in school.

Iodine deficiency is the primary cause of preventable learning disabilities and brain damage, having the most devastating impact on the brain of the developing fetus and young children in the first few years of life. Iodine deficiency also increases the chance of miscarriage and stillbirth. Studies show that children from communities that are iodine deficient can lose 13.5 IQ points on average, compared with children from communities that are non-deficient. These seemingly normal children will later have difficulty learning and staying in school. Some children born to iodine-deficient mothers can suffer from extreme physical and mental disabilities, manifesting

in goitre (an enlarged thyroid gland), speech defects, deafness and cretinism.

Globally, iodine deficiency rates tend to be higher in girls compared with boys, while vitamin A deficiency rates tend to be higher in boys.⁵⁷ Global data for anaemia in preschool-age children are not disaggregated by gender, but once girls reach adolescence and adulthood, they are subject to anaemia rates more than double that of men (30 per cent for non-pregnant women and 12 per cent for men).⁵⁸ Coverage data for vitamin A supplementation does not show any gender differences.⁵⁹ Vitamin A supplementation strategies, such as Child Health Days, are a 'gender equalizing' measure. Salt iodization is promoted to the entire population and only in very specific circumstances are iodized oil capsules recommended for pregnant and lactating women.⁶⁰

Management of acute malnutrition

Globally, there are no significant differences in rates of acute malnutrition between boys and girls, although the wasting prevalence among boys appears to be slightly higher than that of girls.⁶¹ Data on the proportions of boys vs. girls treated for severe and moderate acute malnutrition are not systematically available. Various barriers to optimal young child nutrition, health seeking and care may have gender dimensions that need to be analysed and addressed in order to reduce the rates of acute malnutrition and improve access and uptake of treatment for severe acute malnutrition.

⁵³ United Nations Children's Fund, *Tracking Progress on Child and Maternal Nutrition: A survival and development priority*, UNICEF, New York, 2009.

⁵⁴ A search of the literature would be needed to determine if there are any gender differences in zinc and folate status, and this may be carried out at a later stage.

⁵⁵ Bleichrodt, N., and M. Born, 'A Meta-Analysis of Research into Iodine and its Relationship to Cognitive Development', in *The Damaged Brain of Iodine Deficiency*, edited by John B. Stanbury, Cognizant Communication Corporation, New York, 1994, pp. 195–200.

⁵⁶ Lozoff, Betsy, Elias Jimenez and Julia B. Smith, 'Double Burden of Iron Deficiency and Low Socio-Economic Status: A longitudinal analysis of cognitive test scores to 19 years', *Archives of Pediatric & Adolescent Medicine*, vol. 160, no. 11, November 2006, pp. 1108–1113.

⁵⁷ Sommer, Alfred, and Keith P. West, 'Vitamin A Deficiency: Health, survival and vision', Oxford University Press, New York, 1996.

⁵⁸ World Health Organization, *Worldwide Prevalence of Anaemia 1993–2005: WHO global database on anaemia*, WHO, Geneva, 2008.

⁵⁹ United Nations Children's Fund, *Vitamin A Supplementation: A decade of progress*, UNICEF, New York, 2007, p. 13.

⁶⁰ World Health Organization and United Nations Children's Fund, *Reaching Optimal Iodine Nutrition in Pregnant and Lactating Women and Young Children*, WHO and UNICEF, Geneva and New York, 2007.

⁶¹ UNICEF database 2010, based on 76 countries that have wasting information by gender. Estimates calculated according to World Health Organization Child Growth Standards. The difference between boys and girls could simply be noise from randomness.

ASSESSMENT

Assessment of gender aspects of nutrition status, practices and programme coverage

Data sources for gender-disaggregated data include multiple indicator cluster surveys and Demographic and Health Surveys, national nutrition surveys and micronutrient studies, as well as programme data on coverage. The data must be analysed by region, geographic area (e.g., rural vs. urban) and population/ethnic group. Additional analysis of the survey data may be required to assess if there are any gender differences or to obtain data by maternal education status. The characteristics of populations with poor nutrition status, or those who do not receive nutrition services or are not being fed optimally, should also be analysed to determine if a gender dimension exists: How does the nutrition data correlate with other socio-economic data such as residence, income levels, ethnicity, access to services, etc.?

Gender equity related to nutrition outcomes (nutrition status and practices)

- Do anthropometric data show any differences between females and males in **nutrition status among children under 5** years old (stunting, wasting and underweight)?
- Do data on nutrition status for male and female **adolescents and adults** (body mass index, if available) show any differences between the sexes?
- Are there any differences between males and females in rates of early initiation of **breastfeeding**, exclusive breastfeeding and breastfeeding at 20–23 months?
- Are there any differences in the proportion of male and female children 6–23 months old who are fed a **minimum acceptable diet** (if data are available)?
- Do **micronutrient** deficiency data for children show any differences between the sexes (vitamin A deficiency, anaemia, iodine deficiency)?
- What do the data on **anaemia among adolescent and adult males and females** show?
- Does any of the available disaggregated data indicate that girls and boys and men and women are disproportionately affected? If so, why?
- Are there any differences in nutrition status by **maternal education**?

Sociocultural determinants of nutrition, behaviours and barriers or enabling factors

Information availability and gaps need to be identified and the need for formative and qualitative research must be determined in order to assess the implications of gender on maternal and child nutrition. Specific tools for qualitative and formative research on gender dimensions of nutrition and child health are currently under analysis and development at the Liverpool School of Tropical Medicine (UNICEF contract, output due by October 2011). Various generic tools for qualitative research are available, including participatory methods.

Dimensions to assess and correlate the nutrition status, practices and utilization of nutrition services include:

- Women's social status, autonomy and agency;
- Feeding, care and health-seeking practices for boys and girls;
- Roles and responsibilities of women and men in the household with regard to care and feeding of children and accessing nutrition services;
- Access to food in the household by women and men;
- Control over and decision-making regarding food and other resources in the household;
- Access to services by girls and boys, and women and men; and
- Coping strategies and responses to emergency by women, men, boys and girls.

NUTRITION AND GENDER ASSESSMENT, ANALYSIS AND PROGRAMMING TIPS

... CONTINUED

Gender equity in nutrition programmes

- Do **micronutrient supplementation programmes** for children under 5 years old show any differences between boys and girls? (e.g., vitamin A supplementation, deworming or multi-micronutrient supplementation)
- Does the data from **community-based management of acute malnutrition and moderate acute malnutrition programmes** show any differences between the number of boys and girls enrolled for treatment?
- What type of **programmes addressing child and maternal nutrition** are there in communities and health facilities in the country, and what is their coverage? Is there a communication strategy for nutrition, and how and at what scale is it implemented?
- Does the **health system** disaggregate information on service statistics by sex?
- What proportion of the health providers are **female vs. male**?
- Have the health professionals received any **training and sensitization on gender issues**?
- Are there any differences by sex and other social markers in participation, decision-making and planning of interventions at community, service delivery, organizational and policy levels?

ANALYSIS

Data to answer some of these analytical questions may need to be collected using a variety of qualitative tools, and the analysis must be derived from a participatory process with all key stakeholders.

Gender dimensions of nutrition outcomes (nutrition status and practices) and their relationship with social determinants

- Are there **sociocultural practices, social norms, cultural beliefs or caring practices** that affect the nutrition status of women, girls, boys and men in different ways? Are there any differences in feeding and care practices for young girls or boys? How do men and women view feeding and care of young children and maternal nutrition? Who is responsible, what is needed and what should or should not be done or given? Furthermore, who decides, who controls and who influences?
- How does the **status of women** among different socio-economic groups within a country and between countries influence the nutritional status of children?
- Are there **differences for women, girls, boys and men in terms of access to food**? How is food distributed within the household? Are men traditionally given priority in food allocation because of their ostensibly heavier workloads, or just because they are men?
- **Who in the household controls the resources** and does this have a different impact on the access to food or the feeding habits of women, girls, boys and men? If women are heading households and/or family groups, are they accessing sufficient food, especially when they are pregnant or lactating?
- What are the **differences between women's and men's roles** and responsibilities with regard to nutrition, especially regarding young children and women themselves? How does the **gender division of labour and decision-making patterns in the household** affect the nutrition of girls, boys, women and men within the household and in terms of accessing services?
- In **crisis situations** and in situations of widespread and severe poverty where food security is poor, do women and girls reduce their food intake as a coping strategy in favour of other household members?

Nutrition programmes

Health system programmes and services for nutrition

Service provision:

- What is the level of **representation of women** in decision-making positions on nutrition, and does this influence the level of priority given to nutrition programmes?
- Do the health services give adequate priority to appropriate **maternal nutrition** services, including counselling, micronutrients, nutrition screening and provision/referral for supplements, if required? Does the health system collect data on maternal weight, mid-upper arm circumference or body mass index?
- Does the **sex of the staff** providing nutrition services affect the uptake of the services – for example, are there traditional barriers for women to be examined and counselled on breastfeeding by male health providers?
- Do the promotional nutrition services in the health system (e.g., counselling and communication) only target mothers, or do they attempt to **reach out to men** as well?
- Does the health system produce **reliable information** on the specific issue of maternal nutrition during pregnancy and lactation?
- Does the health system **disaggregate** information on service statistics by sex?
- Do **pregnant and lactating women receive adequate macronutrients and micronutrients** to meet their needs? If not, why? How does this relate to poverty, gender roles whereby men eat first and eat more, lack of awareness, lack of utilization of services due to gender barriers, etc.?
- What, if any, gender dimensions constrain or facilitate health system **efforts to reach unserved populations**?
- How do the **gender division of labour and patterns of decision-making** affect the programme/project, and how could the programme/project affect the gender division of labour and decision-making in the community?
- What is the **counterpart/partner capacity** for gender-sensitive planning, implementation and monitoring?

Demand and attendance:

- What **barriers and constraints exist for women and men participating** and benefiting equally from the programme/project?
- Is regular uptake of nutrition services affected by **women's difficulties to pay** user fees in clinics and to pay for transport?
- How do gender relations and roles affect **decision-making for women to attend** nutrition services, including being allowed to travel to the clinic or finding the time to attend the clinic?
- Do pregnant and lactating women receive or comply with maternal nutrition services or recommendations? If not, why don't they seek antenatal care? Why don't they collect or take iron or multi-micronutrient supplements?

Community-based nutrition programmes

- Are **women involved in the assessment, design and implementation** of community nutrition programmes? If so, what is the level of their engagement?
- Does the **sex of the community health workers** providing breastfeeding promotion services affect the uptake – for example, are there traditional barriers for women to be counselled regarding breastfeeding by male community health workers?
- How does the **selection of community health workers** consider gender issues related to implementation of nutrition programmes? Does the society constrain women's participation in such programmes?
- Do the community nutrition programmes **address maternal nutrition**?
- **Who has access to and control** over resources, assets and benefits in the programme/project at the community level?
- Do the services for nutrition in the community only target mothers, or do they attempt to **reach out to men** as well?

NUTRITION AND GENDER ASSESSMENT, ANALYSIS AND PROGRAMMING TIPS

... CONTINUED

Communication for Development (C4D) on nutrition

- Does the communication strategy for nutrition only target mothers, or does it attempt to **reach out to men** as well?
- Are **women involved** in the design, planning and implementation of the communication strategy?
- Does the communication strategy address the **identified gender-related barriers** to optimal nutrition practices and utilization of services?

Emergency and other sectoral programmes

- In **emergencies**, are girls and boys, and women and men, being affected differentially in terms of access to nutrition and food through emergency nutrition services/food aid?
- In emergencies, are relevant and appropriate services to support IYCF and maternal nutrition being provided for these vulnerable groups, and are women accessing them?⁶²
- How do gender issues affect provision, access and uptake of **social protection schemes** that are intended to improve young child nutrition?

ACTION

Develop specific strategies to address barriers and constraints at different levels, with **participation** from men and women beneficiaries. Integrate the strategies and adequately resource them in programme/project design and implementation at different levels:

- At the **household level** through behaviour and social change communication and support involving both men and women, with evidence-based messages and approaches to address the specific gender barriers related to nutrition; work on addressing the social norms that affect nutrition.
 - At the **community level** through appropriate selection of male and female community health workers and other community cadres; training of community health workers on the gender dimensions of nutrition; counselling; community support groups, workplace support for lactating women; social mobilization; and advocacy with leaders and strategies to modify social norms, targeting both men and women;
 - At the **service delivery level** through appropriate data disaggregation; provision of relevant gender-sensitive services for nutrition, including outreach to bring the services closer to communities; counselling on nutrition; professional support; appropriate selection of male and female health providers; training of health and nutrition providers on gender-sensitive service delivery; referral for supplementation and social protection schemes; and links with livelihood, income generation, microfinance, education, employment, etc., programmes to benefit and empower women.
 - At the **policy level**, ensure that gender considerations are stipulated as appropriate in the data on nutrition that the health system and nutrition programmes collect and analyse, that design of interventions to address nutrition is gender sensitive and incorporates the results of gender analysis of immediate and underlying causes, and that gender considerations are addressed in the selection and training of nutrition programme staff and health providers delivering services to address nutrition.
- Assess the potential of the programme/project to **empower women and men**, and also address strategic gender needs and **transform gender relations**.
 - Apply the above information and analysis throughout the programme/project cycle.

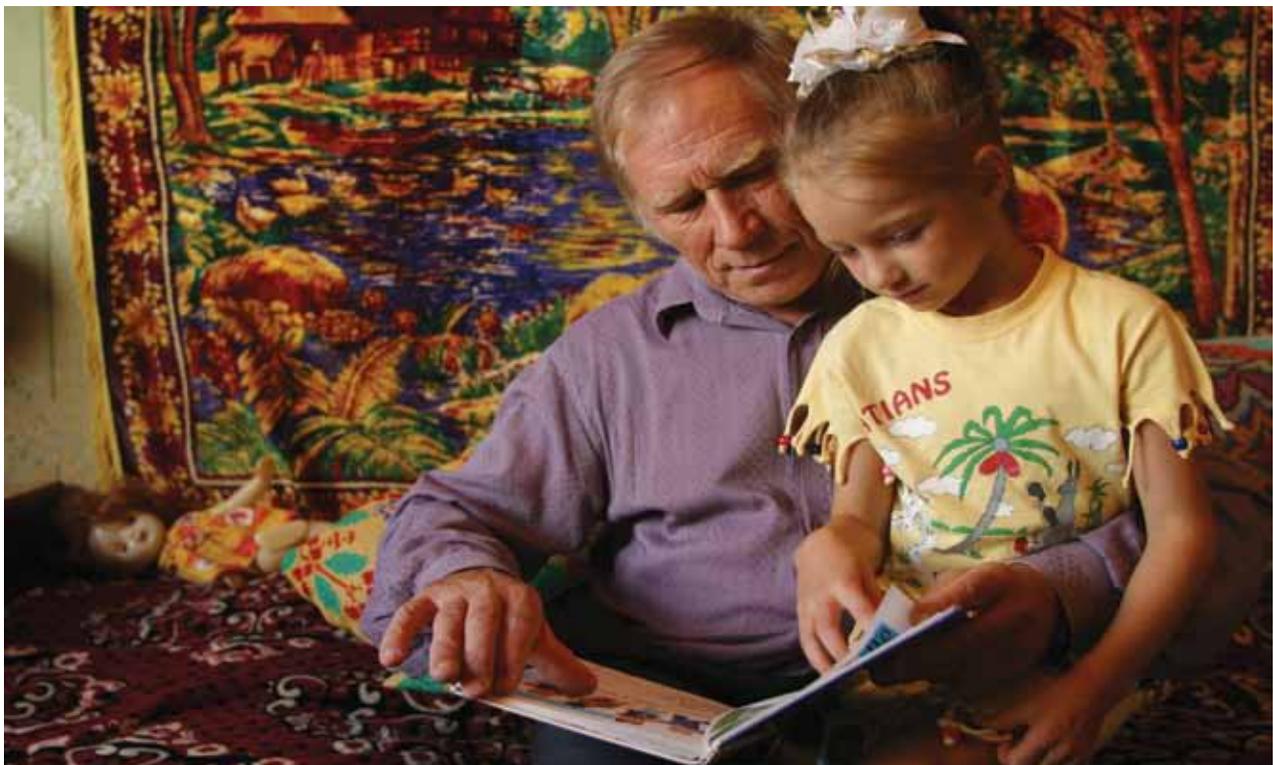
⁶²See the IASC Gender Handbook for more questions and considerations on gender and nutrition in emergencies.

NUTRITION AND GENDER ASSESSMENT, ANALYSIS AND PROGRAMMING TIPS

... CONTINUED

MONITORING AND EVALUATION:

- Include gender-equality experts on evaluation and assessment teams.
- Design a participatory process that includes women and men, and girls and boys, involved in the evaluation itself and in the review of findings.
- Track outcomes against gender equality indicators, both quantitative and qualitative, established during planning stages such as:
- **Sex-disaggregated data from household surveys and programme information systems:**
 - Anthropometric data for children under 5 years old (stunting, wasting (global acute malnutrition, severe acute malnutrition and moderate acute malnutrition and underweight)
 - Early initiation of breastfeeding, exclusive breastfeeding and breastfeeding at 20–23 months
 - Children 6–23 months old fed a minimum acceptable diet (if data are available)
 - Body mass index (adolescents and adults)
 - Micronutrient deficiency data for children under 5 years old (vitamin A deficiency, anaemia)
 - Numbers and per cent of boys and girls supplemented (vitamin A supplementation, multi-micronutrients) and dewormed
 - Numbers and per cent of boys and girls screened, treated, defaulting, cured and died from acute malnutrition (moderate and severe acute malnutrition)
 - Numbers and per cent of women of childbearing age and children supplemented with iron-folic acid
- **Intermediate process and outcome indicators to monitor changes at household, community and service delivery levels.**



UNICEF/NYHQ2004-0685/Giacomo Pirozzi

WASH

WASH, also known as WES and WESH within UNICEF country offices, stands for water, (environment), sanitation and hygiene, which are closely linked interventions that underlie good health and nutrition, and which are required to achieve sustainable livelihoods, environmental sustainability and human rights. UNICEF focuses its work in WASH on achieving the water and sanitation targets of MDG 7 (to ensure environmental sustainability), but also recognizes that WASH underpins all MDGs and especially MDG 4 (child mortality), MDG 5 (maternal health) and MDG 2 (primary education).

Gender is not new to WASH programming. In the early 1980s, because experience had shown that the provision of water and sanitation facilities alone did not ensure that everyone had equal access to services, WASH practitioners, including those within UNICEF, began to mainstream gender equality and promote women's participation when developing new demand-responsive approaches. Understanding gender, culture and social relations has proved to be essential in assessing, designing and implementing effective and sustainable WASH programmes. A guiding principle of the 1992 Dublin International Conference on Water and the Environment⁶³ was that women must play a

central role in the provision, management and safeguarding of water. Today, the consensus among WASH practitioners is that "...putting women at the centre of WASH improvements leads to better women's health and well-being because: pregnancies are healthier; maternal morbidity and mortality are reduced; women suffer less physical damage from constant lifting and carrying heavy loads; [and] women are exposed to diminished risk of physical and sexual assault."⁶⁴

Promoting gender equality is integral to the 2006–2015 UNICEF WASH strategy. In addition, within Key Result Area 3 (Target 7C), UNICEF is required to study the impact of water and sanitation, including climate-induced water stress (from both a quality and quantity perspective), on gender equality.

A balanced WASH programme is built upon three pillars of action that enable UNICEF to advocate, facilitate and coordinate appropriate approaches to enhance child survival and development. These pillars include: **increasing access to water and sanitation services; promoting behavioural change; and supporting an enabling environment.** Key gender issues related to these pillars of action are described below.

Access to services

Community leaders, typically men, have a strong role in the management and control of water and sanitation facilities and services, and often make the major decisions related to the location and type of WASH facilities available. An evaluation undertaken by women in Sewukan community, Magelan District in Java, Indonesia, showed that the women who reviewed designs that they had not previously been consulted on came up with very concrete design errors, such as a too-low ratio of cement to sand in concrete mixing and a too-low entry point for the water pipes in the reservoirs.⁶⁵

Globally, women and girls are responsible for water collection in 72 per cent of households. Women and girls shoulder a still higher burden when water is not available at their premises (piped, improved supply).⁶⁶ In many countries in Africa, more than one quarter of the population spends more than 30 minutes on each round trip to collect water. Collection and exposure to unsafe water exerts a physical and health burden on girls and women, especially pregnant women, and reduces the time available for women and children to attend to other development opportunities, such as education.

⁶³ See the International Conference on Water and the Environment website for more information.

⁶⁴ United Nations Children's Fund, Gender and Water Alliance, and Norwegian Ministry of Foreign Affairs, *For Her it's the Big Issue: Putting women at the centre of water supply, sanitation and hygiene*, Water Supply and Sanitation Collaborative Council, Geneva, 2006.

⁶⁵ United Nations Development Programme, *Resource Guide for Mainstreaming Gender in Water Management: A practical journey to sustainability – A resource guide*, UNDP, New York, 2003.

⁶⁶ World Health Organization and United Nations Children's Fund, *Joint Monitoring Programme: Progress on sanitation and drinking water: 2010 update*, WHO and UNICEF, Geneva and New York, 2010.

Women are potentially more affected by unsustainable supply, including when caused by the effects of climate change. As water resources become increasingly scarce, women are required to travel greater distances to find a safe and adequate supply to meet their families' needs. Women are up to 14 times more likely than men to die in natural disasters, and could suffer more as hazards increase in frequency and intensity due to climate change.⁶⁷ For example, in the 1991 cyclone in Bangladesh, women over the age of 40 accounted for 31 per cent of the mortality rate. However, women can also be key agents of change, helping to adapt to climate change and to mitigate the damage. The United Nations Population Fund and the Women's Environment & Development Organization have developed a comprehensive resource kit on gender, population and climate change to reduce vulnerabilities and help position women to adapt to change.⁶⁸

Women and girls suffer disproportionately from poor sanitation. A lack of access to suitable sanitation facilities results in women and girls, especially at school going for long periods without relieving themselves, especially at school, as they are reluctant in most cultures to expose themselves in public. This can affect their health and exposes them to the risk of assault as they search for privacy. Analysing current data on sanitation access is vital to determine the various gender perceptions to sanitation.⁶⁹ Women often place a higher priority on sanitation than men do for reasons of privacy and dignity, yet they often have no voice in the articulation of these needs.

For women and girls, menstruation adds to the need for private and separate sanitary facilities with available water supplies, including facilities for disposal of waste. Girls who have reached puberty and female school staff need privacy; it should be noted that because many girls start school late and repeat grades, the onset of puberty may occur when they are still in lower primary school. If no privacy is provided, students may not use the facilities at schools, resulting in absenteeism rates that can reach 10–20 per cent of school time.⁷⁰ Creating school environments that encourage girls to complete their education

Privacy matters for women and for men

As part of the emergency public health response to the October 2005 earthquake in Pakistan, screened bathing and toilet units were constructed in some camps. This was felt to be particularly important because many of the women who were living in the camps had previously been living in purdah (seclusion). Both men's and women's toilet and bathing units were screened and both proved successful. While it was probably more necessary for the women's units to be screened for added privacy, it was felt to be good practice for the men's units to be screened also. This was because the men were also facing a lack of privacy in the camps. In addition, if the men were bathing in open areas, this would lead to added discomfort for the women who had to pass by or avoid them.

Source: Harvey Peter, 'Excreta Disposal in Emergencies: A field manual', Water, Engineering and Development Centre, Leicestershire, United Kingdom, 2007.

has far-reaching implications for women's health and a nation's economy. Women who have been to school are less likely to die during childbirth; each additional year of education is estimated to prevent two maternal deaths for every 1,000 women. Research also shows that for every 10 per cent increase in female literacy, a country's economy can grow by 0.3 per cent. Promoting WASH in schools ensures that girls feel comfortable and engaged during their full schooling years and provides a strong platform for advocacy to improve access to services in the community.

A global survey conducted by UNICEF shows that only 37 per cent of primary schools have adequate sanitation facilities and many have no available water to provide for washing.⁷¹ UNICEF

⁶⁷ United Nations Population Fund, *Resource Guide on Gender and Climate Change*, UNDP, New York, 2009,

⁶⁸ Ibid.

⁶⁹ United Nations Development Programme, *Humanitarian Development Report 2006*, UNDP, New York, 2006.

⁷⁰ IRC International Water and Sanitation Centre, 'Adolescent Girls and School Hygiene, Sanitation and Water', *School Sanitation and Hygiene Education Notes & News*, IRC, Delft, the Netherlands, May 2005, pp. 1–8.

Mozambique undertook a study in 2000 and found that 80 per cent of all primary schools had neither toilets for boys and girls nor hand-washing facilities, and that few schools promoted hygiene.⁷² In Alwar District, India, the school sanitation programme increased girls' enrolment by one third, leading to a 25 per cent improvement in academic performance for both boys and girls.⁷³ In Bangladesh and India, innovative projects have demonstrated that menstrual hygiene can be incorporated into broader WASH in Schools interventions. Training and information for peer groups of children and female teachers have shown how women and girls can be empowered through improved menstrual hygiene management.

It is considered that a lack of access to water and safe sanitary facilities is a significant factor in sexual assault. Harassment and rape of adolescent girls at schools is a widespread problem, and a survey conducted in South Africa revealed that more than 30 per cent of female students had been raped at school.⁷⁴ Many of the rapes occurred in school toilets, particularly those that were isolated from the protective environment of the school. Women and girls risk assault, sexual harassment and rape in rural areas, slums or refugee camps when they seek privacy for ablutions in the darkness away from their homes. In Albanian

refugee centres, women were forced to go to the toilet in pairs because the toilets had no locks on the doors. Due to a lack of water within camp confines and appropriate latrines in camps for internally displaced people in northern Uganda, women and girls have been sexually assaulted and even killed when going into bushes to defecate at night. Children, both boys and girls, have also been abducted by rebels in similar situations.⁷⁵ Having access to water without needing to travel far from the security of the home or school is essential to improve safety for girls and women.

For families where men are permanently absent or absent for extended periods, such as during an emergency, women are increasingly becoming heads of households. Where entire families move, they have different vulnerabilities as they are forced to live without traditional support structures. These added burdens and reduced resources can negatively impact women's coping mechanisms, putting them at even greater risk in devastating times. In response to the 2005 earthquake in Pakistan, water and sanitation facilities constructed to protect women, including the establishment of a lighted corridor, resulted in women being unwilling to use the WASH facilities because their movements became the object of observation by men within the camp.

Behavioural change

As in other parts of society, gender discrimination is prevalent within schools. In many cases, this discrimination is related to cultural beliefs and traditions; sometimes, it is caused by unrecognized problems and needs. Lack of WASH in schools causes girls to miss school days; makes students more vulnerable to harassment; and hinders children from gaining the knowledge, attitudes and skills they

need for good personal hygiene and health. A WASH in Schools evaluation in Kenya indicated that girls were absent less in schools where there was more hand washing and very high latrine use.⁷⁶

Another example of the gender dimensions regarding behaviour change concerns maternal hand washing with soap. Hand washing by birth

⁷¹ WASH in Schools Partnership 2010, 'Joint Call to Action 2010: Raising clean hands – Advancing learning, health and participation through WASH in Schools'. NB: Of the 60 countries involved in the survey only 25 reported data for sanitation.

⁷² United Nations Children's Fund, *Introduction to Hygiene Promotion: Tools and approaches*, UNICEF, New York, 2009.

⁷³ UN-Water, 'Sanitation Contributes to Dignity and Social Development', *International Year of Sanitation Factsheet no. 3*, UNICEF, New York, 2008, p. 1.

⁷⁴ IRC International Water and Sanitation Centre, 'Adolescent Girls and School Hygiene, Sanitation and Water', *School Sanitation and Hygiene Education Notes & News*, IRC, Delft, the Netherlands, May 2005, pp. 1–8.

⁷⁵ Harvey, Peter, 'Excreta Disposal in Emergencies: A field manual', Water, Engineering and Development Centre, Leicestershire, United Kingdom, 2007.

⁷⁶ Njunguna, Vincent, et al., *The Sustainability and Impact of School Sanitation: Water and hygiene education in Kenya*, United Nations Children's Fund and IRC International Water and Sanitation Centre, New York and Delft, the Netherlands, 2008, p. 3.

attendants before delivery has been shown to reduce mortality rates by 19 per cent, while a 44 per cent reduction in risk of death was found if mothers washed their hands prior to handling their newborns.⁷⁷ Another dimension is that men are often excluded from advocacy campaigns, promoting hygiene behavior change with the assumption that hygiene matters to women and not men. A study undertaken by the London School of Hygiene & Tropical Medicine found that only 32 per cent of men washed their hands after using the latrine, compared with 64 per cent of women.⁷⁸ The easy access to water with taps that don't lead to cross contamination is essential to embed hand washing as part of the toileting routine.

From the UNICEF Mozambique study cited earlier, UNICEF learned that schoolchildren, particularly girls, are able to advocate and educate their peers, families and communities on the importance of safe water, good hygiene and accessible sanitation facilities.

It is important to use a gender task analysis to better understand the roles

and responsibilities of men, women, boys and girls in all aspects of WASH, but most specifically with respect to hygiene. A tool such as *task target analysis* could be used to help families and communities better understand the current roles and responsibilities, the burdens of duty and the interrelationships between the various tasks and hygiene behaviours/status in the home. Analysing possible behavioural triggers for the various subgroups (and they will vary) will assist in determining appropriate messaging and the stratification of target groups which will often vary by age and gender. The results of Project Champion, supported by UNICEF, suggest that older girls are a core target group for the introduction of new hand-washing behaviours for several reasons: teenage girls not only already care for siblings but are on the cusp of becoming mothers themselves and therefore caring for the next generation; acute hygiene sensitivity is believed to surface during the teenage years and for women around childbirth; and finally, around the birth of a first child, women are developing the parenting habits that will not only last a lifetime but potentially be handed down to their own daughters.

Enabling environment

The role of men and women in the design and implementation of water supply, sanitation and hygiene facilities is vital to their use and management. Externally imposed designs and standards may not be easy to use nor meet the needs of the family as a whole, and engagement of the community in the discussion processes must ensure the participation of everyone. Assessing and analysing the role and engagement of community facilitators is vital to this process to ensure that they, too, promote equality and are sensitive to the needs of everyone. Local by-laws and traditional laws should also be analysed and discussed to ensure they facilitate the type of programming required.

Attention is needed to understand community dynamics and gender and equity issues to ensure that marginalized members of the community are heard. Community to community visits and knowledge-sharing can provide a useful opportunity to learn, as well as successful and problematic approaches to WASH.

Water allocation decision-making mechanisms have different implications for men and women. Power relations influence water allocation and the choice of technology. If there is competition for water resources, women and children often lose their entitlements and access. The participation of women in water-management decisions

⁷⁷ Rhee, Victor, et al, 'Maternal and Birth Attendant Hand Washing and Neonatal Mortality in Southern Nepal', Arch Pediatric Adolescent Medicine, vol. 162, no. 7, 2008, pp. 603–608.

⁷⁸ More information on the study is available at <www.hygienecentral.org.uk/pdf/washing_with_soap.pdf>.

improves sustainability, targeting and efficiency.⁷⁹ Women have access to only 5 per cent of the concessions given worldwide to manage and use natural resources.⁸⁰

Technical solutions for providing access to safe water should be accompanied by support for programmes that promote effective governance, including inclusion of women in local user groups and in policy-level decision-making processes. In some cases, a situation will naturally result in women taking a greater role in water management. In Liberia, there are increasingly more women in high-profile government and community leadership posts, including those in water departments.⁸¹ For instance, communities in Zambia reported that women usually make more competent treasurers in water point committees because the availability or non-availability of water affects them most.⁸²

The recognition that instituting behavioural change and creating an enabling environment are needed to ensure real and sustainable improvements – together with investing in community mobilization instead of hardware – is at the heart of UNICEF’s holistic approach to WASH, such as demonstrated in the Community Approaches to Total Sanitation (CATS) initiative. The objective of these approaches is that men and women demand, effect and sustain a hygienic and healthy environment for themselves. The role of schools, health centres, traditional leadership structures, women and girls is emphasized. For example, since March 2008, UNICEF Pakistan has promoted CATS among the village women by encouraging families to assess their own sanitation with water supply, and then finance and build their own facilities.



UNICEF/NYHQ2010-2088/Susan Markisz

⁷⁹ United Nations Children’s Fund, *Water, Sanitation and Hygiene Annual Report 2008*, UNICEF, New York 2008.

⁸⁰ United Nations Development Programme, *Resource Guide on Gender and Climate Change*, UNDP, New York, 2009.

⁸¹ ACF-International Network, *How to Successfully Make WASH Projects Sustainable and Successfully Disengage in Vulnerable Contexts: A practical manual of recommendations and good practices based on a case study of five ACF-in water, sanitation and hygiene projects*, AFC-International Network, 2007.

⁸² Harvey, Peter, and Bob Reed, ‘Rural Water Supply in Africa: Building blocks for handpump sustainability’, Water, Engineering and Development Centre, Leicestershire, United Kingdom, 2004.

WASH PROGRAMMING TIPS

ASSESSMENT

In WASH programmes, it is important to identify the gender information gaps as well as to disaggregate data that exists. This is a fundamental part of the situation analysis and of any special study that may occur during the programme cycle.

Critical information includes the following:

- Household numbers disaggregated by sex, age and whether headed by a male, female or child;
- Customary and cultural practices (including water gathering, hygiene and sanitation), preferences and needs (such as water sources and access to sanitation), disaggregated for men and women; and
- Gender roles in infrastructure design, operation, maintenance and distribution.

Participatory methods of data collection within the community can be very effective, particularly when attempting to get data that is quantitative. Methods may include: community mapping; pocket chart voting; transect walks; focus group discussions; surveys; and many more. Participatory methods can be designed to collect information from both men and women in ways that allow both groups to speak freely and participate fully. Existing literary resources, both internal and external to UNICEF should be considered prior to undertaking a participatory exercise, as it will give guidance on cultural and gender-appropriate methods that will achieve maximum results.

Additional to the general gender-related data requirements listed above, additional data are required to address each pillar:

Services/Access

Assessment of WASH services in homes, communities and schools should seek not just to determine coverage levels for men and women, and boys and girls, but also cultural norms and practices which dictate whether services are accessed equitably. For example, in many cultures a daughter-in-law will not share a water cup/tap or a toilet with a father-in-law or other man, and women will not share the same facilities as men. Issues for consideration include:

- The design and type of facilities used should also be assessed (accessibility of water for supply, robustness of water withdrawal system and taps, squat, sit, available water for hygiene use, etc.) to determine if they are appropriate for all family members, especially women and girls because their needs differ from those of men.
- Cultural norms, including the exclusion of menstruating women and girls, should be noted during the assessment phase.
- Women should be actively involved in the assessment (and indeed all phases).
- Privacy is a key issue in the home, school and community, especially as it relates to sanitation; and its perceived importance should be assessed.
- Community norms on existing defecation practices should be assessed.

Behavioural change

Behaviours and practices are key in all elements of WASH. For hygiene-specific behaviours such as water conservation to reduce trips to gather water, using water for cleaning and hand washing with soap and water, women play a key role in safeguarding the hygienic status in the home. Assessing current practices and access to enabling services (i.e., soap, water, tippy tap) is important, as is understanding people's knowledge of the importance of improved hygiene. While women play a key role in this area, the role of men and boys is also vital, as they too need to have good hygiene behaviour. Assessment of current WASH practices should focus on how water is used, hand washing with soap and water, disposal of children's faeces and menstrual hygiene management.

WASH PROGRAMMING TIPS

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Enabling environment

It is important to understand the existing international and national obligations and commitments to gender equity. It is necessary to examine the existing national policies on water and sanitation; determine who currently sets priorities and what the criteria are; and how gender sensitive these policies are. For example, when the South African Government drafted a new water law in 1995, it produced a white paper that recommended the provision of information to women, as well as their representation on water committees and in technical and managerial positions. Reviewing community-based protocols, such as access to water, sanitation programming and hygiene promotion, is also vital to ensure that they promote equality and consider all gender dimensions. For example, hygiene promotion programmes that only focus on women will not necessarily have the desired impact if men are the key decision makers regarding resources in the household (i.e., water access and soap purchase).

ANALYSIS

A number of analytical methods may be used when addressing each of the three pillars of action, including rapid appraisal (such as surveying to understand the division of labour in collection of water activities); pre-feasibility studies (such as participatory dialogue to gauge strongest needs and priorities for those accessing water facilities, and availability of sustainable water sources); and gender and social assessments (such as an in-depth analysis of social disparities in resource allocation). Analysis should also consider ensuring gender diversity of assessors, translators and programming staff, and provision of gender-focused training and support.

Appropriate analysis will enable programme designers to understand how gender inequality and inequity is an issue, including the influence of discriminatory social norms; gender roles; the relative status of women and men, and girls and boys; inequalities and discrimination in legislation and policies; and inequalities in access to and control of resources.⁸³ Further detail on an approach to undertaking a gender analysis in water supply and sanitation projects, as well as key action points in a project cycle is provided in the Asian Development Bank's gender checklist.⁸⁴ Additionally, the IASC gender handbook (for emergencies) also provides a useful checklist for undertaking a gender analysis.

ACTION

The design and implementation phases of a programme depend on a robust gender-informed assessment and analysis, with key stakeholders and the accumulation of evidence to deliver locally specific interventions.

A key element of the design stage is to identify major objectives to be achieved during the planning cycle, with particular focus on reducing gender gaps and empowering all community members. Consider the importance of fostering learning and identifying key stakeholders to enhance outcomes. Particular attention should be given to how to elicit views from and engage all community members in decision-making process at the community level, particularly women if they are at risk of being excluded.

The 'Gender Guidelines: Water supply and sanitation' produced by AusAID provide a useful tool to supplement understanding of important issues when designing programming through a gender lens.⁸⁵ Some key issues for the design and planning stages applied with a gender focus relative to the specific pillar of action are discussed below.

⁸³ United Nations Population Fund, *Water: A critical resource*, UNFPA, New York, 2002.

⁸⁴ Asian Development Bank, 'Gender Checklist: Water supply and sanitation', <www.adb.org/Documents/Manuals/Gender_Checklists/Water/default.asp?p=genchck>.

⁸⁵ AusAID, 'Gender Guidelines: Water supply and sanitation', AusAID, Canberra, Australia, April 2005.

WASH PROGRAMMING TIPS

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Services/Access

Women, men, girls and boys should all be involved in the design, implementation and maintenance of water and sanitation infrastructure and services. Design of water services should consider issues such as: sustainability of supply and resource; location of water distribution sites; storage needs; distribution mechanisms, including the difficulty of drawing and delivering sufficient water; maintenance responsibility; and procedures that are accessible to everyone. Sanitation facilities should be culturally appropriate. If communal facilities are to be considered, they must be carefully designed to ensure that they are secure and appropriate for all members of society. For example, in El Salvador, even though sanitation facilities were provided, women refused to use latrines (that had been designed without their input), because their feet showed below the door and offended their notions of privacy.⁸⁶

Also, design should consider who is responsible for maintaining the facilities, to ensure the burden is shared among the entire community and does not fall exclusively to women. Likewise, if the role of women is simply the upkeep of water points, this is of little consequential value in determining gender equity.⁸⁷

Water supplies that are not designed to consider gender, the poor and other traditional victims of social exclusion may appear to perform well technically, but may leave an important segment of the population unserved and result in continuing reliance on less safe water sources.⁸⁸ This leads to inequity.

Both women and men make competent pump repairers, but women repairers are not always accepted by community members who have decision-making powers, and there often appears to be a higher acceptance of women in non-technical roles such as environmental health assistants and pump caretakers (responsible primarily for keeping the pump surrounds clean). The designs of pumps and delivery systems by women can be markedly different from those of men. For example, women often use approaches to reduce heavy lifting by maximizing the use of natural forces such as gravity and leverage.

Child-friendly, gender-segregated latrines that have water available are an essential component of this, as well as of activities related to menstrual hygiene.

Behavioural change

To achieve sustainable social change, community dialogue and action must be based on trust, commitment, ownership and empowerment. The process must be cyclical, relational and provide an outcome of mutual change (therefore, the gender perspective must benefit men, women, girls and boys). Behaviour-change programming should aim to share responsibility equitably, as well as target priority risks and behaviours and reduce overburdening.

For example, fetching water for household and school use puts an additional burden on adolescent girls and enforces the belief that it is typically a woman's task. WASH in schools should be designed to challenge traditional gender norms: boys, as well as girls, should be given WASH-related tasks in school – such as fetching water or cleaning. WASH in schools should be designed to foster individual self-respect, empowering all students – and especially girls and female teachers. Both girls and boys can be encouraged to learn about important hygiene issues. Schools have an important role in enabling open discussions where children feel free to talk about issues such as menstruation.

⁸⁶ Gender and Water Alliance, 'The Gender and Water Development Report 2003: Gender perspectives on policies in the water sector, 2003.

⁸⁷ Joshi & Fawcett, *Water Projects and Women's Empowerment: People and Systems for Water, Sanitation and Health*, Proceedings of the 27th WEDC Conference, WEDC, Loughborough University 2001.

⁸⁸ IRC International Water and Sanitation Centre, 'Participatory Learning and Action Initiative', IRC, Delft, The Netherlands, 2002.

WASH PROGRAMMING TIPS

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Enabling environment

National legislation and policy frameworks need to consider the direct and indirect implication on gender. Additionally, policies/strategies, guidelines and by-laws should be updated to incorporate the promotion of gender equity, together with training and promotion programmes, operational guidelines, etc.

Creating school environments that enable girls to complete their education has far-reaching implications for women's health and a nation's economy.

Both men and women should be trained in the use and maintenance of WASH facilities and delivery of WASH services (such as hygiene promotion). Through training and capacity building, women can be involved more fully in the identification of safe and accessible water supply sites and sanitation facilities. Additionally, through training, the value of obtaining information from diverse sources can be recognized and control over resources (including water storage and containers and access) can be more equitably managed. Discriminatory practices hindering women's participation in decision-making processes, such as water-management groups, can be managed through programmes that support empowerment, such as creating opportunities for women and men to speak freely without judgement.

MONITORING AND EVALUATION

Monitoring and evaluation must be considered throughout the programme planning cycle, to improve impact and sustainability. Process indicators measure the gender sensitivity of the implementation process and outcome indicators measure access, coverage and impact of interventions with age- and sex-disaggregated data. The monitoring and evaluation process will form part of the situation analysis, midterm review and periodic reporting (i.e., annual report). This process may also be useful to identify opportunities for learning, both within WASH and cross sectorally at all stages during the programming cycle.

Indicators by which success can be measured should be chosen based on the availability of time to measure local and programming relevance. Indicators may be the same for development or emergency-focused work; however, they may be limited where sufficient information is available, particularly at the early stages of an emergency. Monitoring should allow for flexibility that ensures all available evidence through a programme cycle can be gathered and measured. The meaningful participation of national and sub-national institutions and affected communities in choosing indicators will ensure they are locally relevant, appropriate and feasible. Indicators should be clearly defined and technically sound, as well as measure trends over time and aim to measure outcomes and impact over outputs.

'Second-effect' indicators can provide a gender-sensitive view of the implications of inadequate water and sanitation. For example, the quality of drinking water and extent of hygiene activity in a community can indicate/flag labour burdens that fall on women; i.e., if people fall ill from unsafe water, it is often women who are responsible for looking after them.

Key global- and country-level sources of WASH monitoring data include the World Health Organization/UNICEF Joint Monitoring Programme, UN-Water/World Health Organization Global Annual Assessment of Sanitation and Drinking-Water, United Nations Development Programme, World Bank, IASC and United Nations Development Fund for Women. Further information on general gender-sensitive indicators can be found in the Canadian International Development Agency's 'Guide to Gender-Sensitive Indicators'.⁸⁹ Specific indicators that may be useful during monitoring and evaluation relative to the specific pillar of action are shown below.

⁸⁹Canadian International Development Agency, 'Guide to Gender-Sensitive Indicators', CIDA, Quebec, 1997.

WASH PROGRAMMING TIPS

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Services/Access

Indicators may include:

- **Equitable access to water supplies:** the adequacy and availability of water at the household level for daily needs, distinguishing between reproductive and productive activities of men and women.
- **Safe water provision:** water testing at source; inspection of water containers in households and at water points.
- **Women's right to economic work:** the time spent, by sex, to collect water, further distinguishing between that work done by adults and children (and collected by urban/rural).
- **Equitable access to sanitation:** what kind of sanitation facilities (if any) are actually used by men and by women, and who is not using facilities, and why. These data should be further disaggregated by income and by urban/ rural setting. Also, do refugee camps provide women-only toilets in safe locations?
- **Women's and girl's privacy and dignity:** WASH facilities in schools, including specific information on whether facilities are provided separately for males and females, the extent to which existing facilities are actually used by male and female schoolchildren, and the extent to which those facilities meet the specific needs of girls in terms of safety, privacy, proximity, hygiene, cleanliness, water and provision for menstruation.

Behavioural change

Indicators may include:

- **Relationships between transportation and gender in collecting water,** with particular care taken to distinguish between carrying vs. assisted transport (whether animal or mechanized).
- **Safe WASH practices:** storage containers of appropriate design and access to WASH services do not create environmental problems.
- **Hygiene practices:** hand washing is actively undertaken at sanitation facilities, soap or similar material for hand washing available in all households and children's faeces properly (environmentally sound) disposed of.
- **Women and girl's privacy and dignity:** appropriate menstrual hygiene management products are available to all women and girls.

Enabling environment

Indicators should evaluate community participation: all users are involved in the maintenance of water and sanitation facilities; representatives from all sections of the community are consulted in all stages of the programme development; and the majority of the community is satisfied with provision of facilities and services.

EARLY CHILDHOOD DEVELOPMENT

This section describes key observed gender disparities and critical gender issues in early childhood development. It also includes programming tips for the assessment, analysis, action, and monitoring and evaluation phases of the programme cycle.

Most brain development happens before a child reaches 3 years old. Long before many caregivers recognize, the brain cells of a new infant proliferate, synapses crackle and the patterns of a lifetime are established. During their first 36 months, children develop the abilities to think and speak, and learn and reason, which lays the foundation for their values and social behaviours as adults.⁹⁰ This is also the time that children start socializing into gender roles.

Gender roles are learned through complex interactions between a child and his/her immediate environment. Preferences for a boy or girl child can affect the parental/caregiver's interactions with babies right from birth, and determine the quality of care for child's survival and development. Throughout their life cycle, children become aware of their gender, and play styles and behaviours begin to crystallize around that core identity of girl or boy. They receive powerful messages within the social contexts of family, school, peer groups and the media regarding how boys and girls should look, act and feel, and internalize gender perceptions, values and norms from the culture around them.

Adults may impose (conscientiously or not) gender beliefs and practices through their interactions with young boys and girls. Young children are exposed to images that portray males as strong, brave, powerful and dominant, while females appear submissive, emotional and focused on romantic relationships. This early socialization process sets a gendered trajectory for their development that shapes virtually all aspects of life. Girls and boys who experience gender discrimination in early childhood come to understand this treatment as the norm, which can prevent them from perceiving it.

Paternal leave promotes men's involvement in parenting

Although paternity-leave programmes in wealthy countries, such as the Scandinavian countries, have received particular attention, numerous countries in the Global South are introducing paternity leave. Although the number of days is fewer than maternity leave and special conditions sometimes apply, examples include Argentina (2 days), Bahamas (1 week), Cambodia (10 days), Cameroon (10 days), Djibouti (10 days), Guatemala (2 days), Paraguay (2 days), the Philippines (7 days), Romania (5 days), Rwanda (2 days), South Africa (3 days) and Turkey (3 days).

Source: Barker, Gary, et al., 'What Men Have to Do With It: Public Policies to Promote Gender Equality', Men and Gender Equality Policy Project, 2010, pp. 57-58

UNICEF supports gender-sensitive child care and rearing in early childhood to ensure that all young girls and boys develop to their fullest potential. The disadvantages that girls face across a wide range of domains – from accessing education and bearing a disproportionate burden for domestic tasks to suffering the ill effects of harmful traditional practices and being exposed to sexual exploitation and abuse – have begun to receive international attention. Although there has been progress in addressing the needs of girls and adolescents starting from their primary school years through to the birth of their first child, early gender socialization still needs to be effectively addressed. Doing so is as important for the healthy development of boys as it is for the healthy development of girls.

⁹⁰United Nations Children's Fund, The State of the World's Children 2001, UNICEF, New York, 2001, p. 9.

EARLY CHILDHOOD DEVELOPMENT PROGRAMMING TIPS

ASSESSMENT

- Collect sex/age-disaggregated data regarding early childhood development and child care and rearing practices in developing countries (use multiple indicator cluster survey questions for early childhood development, child disciplining and women).
- Conduct comprehensive and qualitative studies on early gender socialization in developing countries and develop a strategy to promote positive gender socialization and child-rearing practices starting with pregnant mothers and expectant fathers. Include information on how baby girls and boys are perceived during pregnancy. (Do baby girls and boys evolve in the same protective and developmental environment? Is there data on prenatal sex selection and infanticide if these practices exist in the community/country?)
- Gather information on how newborn and young boys and girls are cared for and loved. (Do they have equitable opportunities to access optimum nutrition, health and opportunities for learning? Are they afforded the same environment for psychosocial learning and attachment? Is their cognitive development stimulated in the same or different ways? Are there gender differences in the ways in which girls and boys are encouraged to express their emotions and in the types of responses offered by caregivers? Are boys and girls given the same level and type of holding and physical attention?)
- Collect/review basic demographic data on infant and under-five mortality rates disaggregated by sex, which afford information about the differential treatment of girls and boys.
- Review data on gender gaps in other aspects of YCSD (nutrition, health, WASH, child-rearing practices, early stimulation and learning) for children under age five and link it to other data on child care and education practices of children older than 5 years old, in order to analyse the continuum of care and education along the life cycle.
- Cross-analyse gender-related data with other data, including data on women's empowerment, community interventions, governance, and availability of social and public policies for quality childcare facilities for poor working parents.
- Gather information about the capacity of local partners to understand and address gender inequality in early childhood development.

ANALYSIS

- What are the common child-care and rearing practices that instil limiting or harmful gender roles for girls and boys?
- What practices need to be changed? How can they be changed without creating cultural conflict and resilience?
- How can they be linked to overall social transformation and normative changes in a given social and cultural context?
- What is the causal reason (often economic) for why prenatal sex selection and infanticide is practiced (if it is)?
- How do the cultural norms regarding appropriate emotional expression for girls and boys affect responsive and appropriate caregiving?
- How can families and communities encourage boys and girls to develop proper life skills without discriminatory practices?
- How can gender-sensitive care practices for child's survival, growth and development be well-packaged together with health/nutrition and WASH interventions for young children and families and delivered as one integrated intervention?
- What kinds of social protection policies, local governance and community-based mechanisms should be in place to promote positive gender-socialization processes throughout the life cycle?
- What is the best capacity development strategy for service providers and service users?
- What are advocacy tools? How can communication channels in a given community for knowledge, attitude and behaviour change towards positive gender-socialization processes?
- What is to be measured? With what tools?

EARLY CHILDHOOD DEVELOPMENT PROGRAMMING TIPS

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ACTION

The following strategies hold promise:

- **Reaching directly into the household** to promote family interaction for the development of positive gender roles among young female and male children. Help parents realize that boys and girls need the same things to develop physically, emotionally and intellectually; both need tender care and boisterous play, mental and physical stimulation, protection from harm. This can be mainstreamed into maternal, neonatal and child health home-visiting programmes. It could also be part of the women support groups of IYCF programmes, as well as other home-based interventions where young children and their caregivers are directly involved.
- **Building the self-confidence of caregivers as well as children** by promoting positive male involvement in the development of young girls and boys and by reassuring parents of their inherent ability to promote the healthy development of their children. Parenting programmes need to be reviewed and revitalized. They can be delivered through informal and non-formal (adult) education programmes and community-based interventions, including faith-based networks, women's groups, parent associations, etc. Promote other means to encourage father involvement, such as encouraging fathers to come into schools for special presentations and providing paternity leave programmes to complement or even match maternity leave.
- **Supporting communications strategies** to promote gender-sensitive childrearing, starting with pregnancy and gender-sensitive early childhood learning, and to advocate models of gender-sensitive caregiving for adults that encourage egalitarian views and developmentally appropriate family care practices. This includes both traditional media and digital technology (radio, TV, traditional theatres, mobile telephone texting, etc.).
- **Improve social protection and local governance systems for sustainable implementation** and scaling up of gender-sensitive family and community care practices for child survival, growth and development.

MONITORING AND EVALUATION:

- Establish composite early childhood development indicators (multiple indicator cluster survey, early childhood development module) and collect data by age and sex, and establish baseline data on child's overall developmental status by age and sex.
- Develop benchmarks and monitoring tools for gender-sensitive child-rearing practices for young boys and girls (use multiple indicator cluster survey indicators, add culturally relative, positive gender-socialization practices identified during the situation analysis, and establish baseline data by age and sex).
- Develop benchmark and monitoring tools for gender-sensitive social protection and governance systems for improved family and community care for child survival and development.
- Prepare a monitoring and evaluation framework to monitor results as per benchmark and indicators, and evaluate impact on young boys and girls. Examples of benchmarks and sex- and age-disaggregated indicators that assist in assessing the impact of early childhood development programmes on overall gender equality objectives include the extent to which growth and development differs between boys and girls in their first year of life, as well as the extent to which these differences are being reduced with programme interventions.
- Include indicators and benchmarks to track gender differences or equality in the detection and treatment of developmental problems and learning disabilities in early childhood.
- At the country level, monitoring systems can provide the potential for comparative analysis between districts and provinces concerning gender-equity early childhood development goals.

CONCLUSION

Gender – the social roles of men and women, and boys and girls – as well as the relationships among them – in a given society at a specific time and place, is of critical importance to YCSD. Effective YCSD programmes must respond to how gender influences **the character of social norms, processes of decision-making, division of labour and differences in access to resources among girls, women, boys and men**. In these ways, gender determines **exposure to risks, programme responses and outcomes** at household, community, service delivery system and policy levels.

Gender matters because biological differences create different vulnerabilities, e.g., the increased nutritional needs and increased susceptibility to malaria of pregnant women. Gender matters because social norms can create inequitable burdens on different groups, for instance when girls are taken out of school to help care for sick relatives or to queue for their families' water supply. Moreover, gender matters even when no apparent difference in outcomes between girls and boys exists, for instance when the boys and girls of highly educated mothers are more likely to get immunized than the boys and girls of mothers with little education.

Addressing gender issues is a core job of all UNICEF staff; doing so is central to the obligation of all staff to promote the full realization of every person's human rights. It is also central to development effectiveness and to achieving the MDGs with equity.

RECOMMENDED RESOURCES

Cross-cutting YCSD:

The Americas and the Caribbean Regional Office (UNICEF), *Gender Strengthening Initiative Training Module: Gender and young child survival – Growth and development*, TACRO, 2009.

Cross-cutting (Health, nutrition, WASH), related to emergency settings:

Inter-Agency Standing Committee, 'Women, Girls, Boys and Men: Different needs – Equal opportunities', IASC, New York, December 2006, <www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_gender-default&bodyid=1&publish=0>.

Health:

World Health Organization Department of Gender, Women and Health, Instituto Promundo. 2007. 'Engaging Men and Boys in Changing Gender-Based Inequity in Health: Evidence from programme interventions', WHO, Geneva, January 2007, <www.who.int/gender/documents/men_and_boys/9789241595490/en/index.html>.

World Health Organization web page for documents on gender and health including fact sheets, <www.who.int/gender/documents/en/>.

Sen, Gita, Asha George and Piroska Östlin, 'Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it exists and how we can change it', September 2007 (final report to the World Health Organization Commission on Social Determinants of Health by Women and Gender Equity Knowledge Network), <www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf>.

Gender analysis in health tools developed by Liverpool School of Tropical Medicine, <www.lstmliverpool.ac.uk/groups/gender_health/index.html>.

World Bank Institute: Gender, health and poverty e-learning course, <<http://web.worldbank.org/WBSITE/EXTERNAL/WBI/WBIPROGRAMS/HNPLP/0,,contentMDK:21248191~menuPK:461082~pagePK:64156158~piPK:64152884~theSitePK:461054,00.html>>.

Nutrition:

Food and Agriculture Organization web page, 'Why Gender', <www.fao.org/gender/gender-home/gender-why/why-gender/en/>.

Meinzen-Dick, Ruth, et al., 'Gender: A key dimension linking agricultural programs to improved nutrition and health', International Food Policy Research Institute, Washington, D.C., February 2011, <www.ifpri.org/sites/default/files/publications/2020anhconfbr09.pdf>.

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Smith, Lisa C., et al., 'The Importance of Women's Status for Child Nutrition in Developing Countries', Chapter 6 in *Household Decisions, Gender, and Development: A synthesis of recent research*, edited by Agnes R. Quisumbing, International Food Policy Research Institute, Washington, D.C., 2003, pp. 41–50, <www.ifpri.org/sites/default/files/publications/ab131.pdf>.

Oniang'o, Ruth, and Edith Mukudi, 'Nutrition and Gender', International Food Policy Research Institute/United Nations Systems Standing Committee on Nutrition. 2002, <www.ifpri.org/sites/default/files/publications/intnut_07.pdf>.

WASH:

Asian Development Bank, 'Gender Checklist: Water supply and sanitation', <www.adb.org/Documents/Manuals/Gender_Checklists/Water/default.asp?p=genchck>.

AusAID, 'Gender Guidelines: Water supply and sanitation', AusAID, Canberra, Australia, April 2005, <www.ausaid.gov.au/publications/pdf/gender_guidelines_water.pdf>.

Gender and Water Alliance, 'The Gender and Water Development Report 2003: Gender perspectives on policies in the water sector', Gender and Water Alliance, the Netherlands, 2003, <www.unwater.org/downloads/Gender_Perspectives_Policies.pdf>.

United Nations Development Programme, *Resource Guide for Mainstreaming Gender in Water Management: A practical journey to sustainability*, UNDP, New York, 2003.

United Nations Population Fund, *Resource Guide on Gender and Climate Change*, UNFPA, New York, 2009, <www.un.org/womenwatch/downloads/Resource_Guide_English_FINAL.pdf>.

United Nations Children's Fund, *Introduction to Hygiene Promotion: Tools and approaches*, UNICEF, New York, 2009, <www.humanitarianreform.org/Default.aspx?tabid=343>.

United Nations Population Fund and Women's Environment & Development Organization, *Climate Change Connections: A resource kit on climate, population and gender*, UNFPA/WEDO, New York, 2009, <www.unfpa.org/public/site/global/lang/en/pid/4028>.

Early childhood development:

Zayas, Luis H., and Fabiana Solari, 'Early Childhood Socialization in Hispanic Families', *Professional Psychology: Research and Practice*, vol. 25, no. 3, August 1994, pp. 200–206.

United Nations Children's Fund, 'Early Gender Socialization' and UNICEF, New York, 2009, <www.unicef.org/earlychildhood/index_40749.html>.

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June 2011

Cover Photo: UNICEF/NYHQ2007-1447/Anita Khemka