A Gender Assessment of USAID/Senegal’s Health Program

*Strengthening Gender Integration for Improved Gender Equitable Health Outcomes*

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This Gender Assessment Report provides a context analysis of key gender and health issues in Senegal, a gender performance review of USAID/Senegal’s health program in responding to key issues and based on the results, provides recommendations for improving gender integration and impact in future programming.
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<th><strong>DESCRIPTION</strong></th>
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<tbody>
<tr>
<td>ASBEF</td>
<td>Association of Senegal for the Wellness of the Family</td>
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<tr>
<td>AOR</td>
<td>Agreement Officer Representative</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retroviral treatments</td>
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<tr>
<td>BG</td>
<td>Badienou Gokh</td>
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<tr>
<td>CAC</td>
<td>Community Action Cycle</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CEP</td>
<td>Community Empowerment Program</td>
</tr>
<tr>
<td>CFVW</td>
<td>Committee fighting Violence against Women</td>
</tr>
<tr>
<td>CHP</td>
<td>Community Health Program</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker (ASC)</td>
</tr>
<tr>
<td>CNLS</td>
<td>National Committee Fighting against HIV and AIDS</td>
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<tr>
<td>DGEE</td>
<td>Direction of Gender Equity and Equality</td>
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<tr>
<td>DHS</td>
<td>Demographic Health Survey</td>
</tr>
<tr>
<td>FAWA</td>
<td>Federation of Women’s Associations of Senegal</td>
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<tr>
<td>FGC</td>
<td>Female genital cutting</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
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<td>GA</td>
<td>Gender assessment</td>
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<tr>
<td>GDI</td>
<td>Gender-related Development Index</td>
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<tr>
<td>GFP</td>
<td>Gender Focal Point</td>
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<tr>
<td>GHI</td>
<td>Global Health Initiative</td>
</tr>
<tr>
<td>GII</td>
<td>Gender-Index Indicator</td>
</tr>
<tr>
<td>GoS</td>
<td>Government of Senegal</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HEIO</td>
<td>Health Education and Information Officer</td>
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<tr>
<td>HIS</td>
<td>Health Services Improvement (Program)</td>
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<tr>
<td>HSS</td>
<td>Health Systems Strengthening (Program)</td>
</tr>
<tr>
<td>HTP</td>
<td>Harmful traditional practices</td>
</tr>
<tr>
<td>IBNs</td>
<td>Impregnated mosquito bednets</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education Communication</td>
</tr>
<tr>
<td>IGWG</td>
<td>Inter-agency Gender Working Group</td>
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<tr>
<td>IMPAC</td>
<td>Integrated Management of Pregnancy and Child Birth</td>
</tr>
<tr>
<td>IP</td>
<td>Implementing partner</td>
</tr>
<tr>
<td>IPV</td>
<td>Intimate partner violence</td>
</tr>
<tr>
<td>ISP</td>
<td>Indoor Spraying Program</td>
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<tr>
<td>IPT+</td>
<td>Intermittent prevention of malaria in pregnancy</td>
</tr>
<tr>
<td>MARPs</td>
<td>Most at risk populations</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MoE</td>
<td>Ministry of Education</td>
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<tr>
<td>MoFWC</td>
<td>Ministry of Family, Women and Children</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health and Social Action</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NSPFA</td>
<td>National Strategic Plan to Fight Against AIDS</td>
</tr>
<tr>
<td>NSHEI</td>
<td>National Health Education and Information Service</td>
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</tbody>
</table>
PAQ  Partnership for Improving Quality  
PISQ  Integrated package of high quality health services  
PMI  President’s Malaria Initiative  
PNDS  National Health Development Plan  
RMNCH  Reproductive, maternal, neonatal child health  
SBC  Social behavior change  
SBCC  Social behavior change communication  
SJN  Sigil Jigueen Network  
SP  Sulfadoxine-pyrimethamine (IPTp-SP)  
SNEIPS  National Service for Health Education and Information  
STIs  Sexual transmitted infections  
SWAA  Society of Women against AIDS  
TB  Tuberculosis  
VCT  Volunteer Counseling and Testing
ACKNOWLEDGEMENTS

This gender assessment was driven by the commitment of the USAID/Senegal health team to find better ways to address gender inequalities impacting the health of Senegalese women and men. The consultant team appreciates the help and support of the USAID/Senegal health team throughout the process from giving their precious time for interviews to providing constructive feedback on drafts. A special thank you goes out to Mary De Boer, the health team Gender Focal Point and AOR for the HIV/AIDS and TB Program, whose leadership, guidance and effective planning helped keep things on track from start to finish. The team benefitted from many individuals, representing donors, non-governmental organizations and women’s associations, who shared their concerns and recommendations. The consultant team is also grateful to the support of implementing partners, IntraHealth, ADEMAS, Abt. Associates, ChildFund and other participating consortium members, Plan International, World Vision and Africare. Staff gave their time for interviews, and were extremely helpful in sharing information and organizing and facilitating interviews at regional levels.

The team extends a special word of gratitude to ChildFund and IntraHealth staff who arranged all interviews at district health center, health post and community health hut levels. Their strong relationships with health care providers facilitated our interactions with them during interviews. Health personnel interviewed were extremely open and available despite other demands on their time. Last but not least, the depth of this assessment was made possible by the careful reflections, opinions and experiences shared by government, donor and NGO representatives, health care workers and volunteers, community leaders and male and female community members on the ground.
EXECUTIVE SUMMARY

Evidence shows that addressing gender inequalities is both a necessary condition and positive strategy to achieving equitable health outcomes. Recognizing this, USAID/Senegal is committed to addressing gender equality and female empowerment in its work. This gender assessment was conducted by a four-member consultant team of international and national gender and public health experts. It served to identify ways to build upon the current gender work of the health program and provide actionable strategies for strengthening gender integration and impact in future programming.

Objectives of the assessment

The objectives of this gender assessment (GA) were: 1) to provide a gender context analysis of gender-based constraints and opportunities impacting women's and men's health; 2) to identify key gender-related policies and programs that are responding to these issues in Senegal; 3) to review the major gender accomplishments, achievements and gaps of the current health program in responding to this context; and 4) based on this analysis, to put forward recommendations on how the USAID/Senegal health team and implementing partners (IPs) can enhance internal and program gender sensitivity and effectiveness for greater gender impact in health.

Methodology

This gender assessment is based on a desk review of program and research documents and primary data collection. Participatory qualitative methodologies of semi-structured interviews and focus group discussions (FGDs) were carried out with the USAID/Senegal health team, IPs, other donors, national and local non-governmental organizations, key Ministry of Health (MoH) and Ministry of Family, Women and Children (MoFWC) representatives, health care providers and female and male program beneficiaries. Five regional sites were chosen based on ensuring representation of key health delivery points; grand regions targeted by the Mission's health program; and regional and urban/rural health and gender disparities.

Major Findings

Uneven gender norms and relations overburden women with domestic and care duties and limit their social, educational and economic opportunities. They put them in a lower social status relative to men and limit their ability to access and use health services they need. Partly due to a history of reproductive health interventions focused on women-exclusively, gender ideals and men's preoccupations with making ends meet, men tend to neglect their health. They are not well-informed or engaged in positive health seeking behaviors, such as visiting health facilities for themselves or for their partners' and children's health. Women's and girls' low decision making power and their expectations and dependency on men paying for health care and men's lack of information on health contribute to delays in women seeking prompt, available health services. This unequal gender relations can contribute to worsening ill-health, bring complications in pregnancy and childbirth and restrict women's reproductive and sexual health choices in contraceptive-use and sexual relationships.

Gender based constraints are worse in the Southern region of Senegal, where ethnic-based socio-cultural practices, porous borders, deep poverty and inequality have led to higher rates of early and forced marriage, unintended pregnancies, gender based violence (GBV) and HIV/AIDS. Other social inequalities based on social identity, age, ability/disability and rural/urban location further define vulnerability to illness and added barriers to seeking health care. In HIV/AIDS, the most at risk populations (MARPs) are commercial sex workers (CSWs) and men who have sex with men (MSM). Other vulnerable groups are mainly women and young women due to the feminization of poverty.
and women’s added physical vulnerability. HIV rates are highest in Southern and South-Eastern regions.¹

Gender inequalities also interplay with ongoing challenges in the supply and demand of health care. Issues such as wait time, negative attitudes of health personnel and lack of affordable transportation (e.g. an ambulance) create disincentives for women and men to seek prompt health services and bring delays and risks to pregnancy and childbirth. A major issue on the demand side is most pregnant women delay going to a health facility until they are in their second trimester due to cultural beliefs, dependency on men and heavy workloads in domestic and productive activities.

The Government of Senegal (GoS) has important gender policies and programs that have responded to some of these gender inequalities impacting health. There have been improvements in primary education, age of first marriage and slight reductions in female genital cutting (FGC). One major challenge to making more significant changes are male-dominated decision making structures in the institutions responsible for many of these programs. With this, there is a lack of political will and inadequate resources for implementation. For example, gender-based violence (GBV) may be prohibited by law, but as of yet, there is no multi-sector response to address high rates of GBV.

Recommendations

This assessment recommends prioritizing three overarching, high impact strategies based on the context analysis and on the gender performance review of the USAID/Senegal health program.

USAID is the main donor partner of the MoH and should become a leader and driver in supporting the Ministry of Health’s institutionalization of gender: Consider mobilizing other donors and partners to develop a common approach and program for strengthening the MoH’s capacity to respond to gender inequalities in health, with priority given to reproductive, maternal, neonatal, child health (RMNCH). The main entry points are: building the capacity of the MoH Gender Unit and gender focal points (GFPs) to lead the process; and supporting capacity building and system-strengthening activities that support adoption of gender equitable internal practices and systems. From this, improve gender and social equity in service delivery by fully integrating gender considerations into the integrated package of quality services using a more gender sensitive Tutorat Plus. One consideration is to find ways to use performance-based financing as a mechanism to ensure equitable service provision. Gender and other social equitable targets and indicators of success can the used to measure performance.

The gender performance review of the current health program identified many good practices to promoting availability of equitable health services and positive community health such as training health professionals on how to respond to GBV within a multi-sector response. The second overarching recommendation is to scale up existing good practices across programming and use

¹ A detailed table of gender-related health statistics for Senegal is found in Annex 1.
evidence-based gender sensitive to gender transformative approaches, strategies and actions to strengthen their transformative potential to promote equity in health.

The USAID gender integration approach commits to both female empowerment and gender equality promotion. Following this good practice, the last overarching recommendation is to develop a dual female empowerment/increasing engagement of men and boys strategy focused on one to three gender-specific sub-projects. Key areas are GBV prevention and response and increased male engagement and shared couple decision making in health promotion in RMNCH.

1. INTRODUCTION

In October 2014, the USAID/Senegal Health Office commissioned a four-person consultant team to conduct a gender assessment of their health portfolio. The team was comprised of an international Dakar-based medical anthropologist and gender specialist (Team Lead), two local gender and public health experts and one local sociologist and gender specialist.

The purpose of the gender assessment was to deepen USAID/Senegal’s knowledge of key gender issues, constraints and opportunities to health in Senegal. It was meant to complement results from the mid-term evaluation (2014) of the current health program (2011-2016) and inform the development of the next Health Strategy (2016-2021) and accompanying Project Appraisal Document (PAD). Ultimately, it serves to provide both strategic and programmatic recommendations for strengthening gender integration and impact of USAID/Senegal’s health program. It is required for program approval based on USAID institutional mandates (e.g. ADS 200-203 and in ADS 205, the Global Health Initiative (GHI) and President’s Malaria Initiative (PMI).2

This report presents the assessment methodologies, main findings and recommendations based on the results. It serves to strengthen gender integration in future programming and is meant primarily for the USAID/Senegal Health team and IPs.

1.1 CORE OBJECTIVES

This gender assessment consists of a gender analysis of health issues in Senegal and a gender review of USAID/Senegal’s health program performance in responding to key gender and health issues. It aimed to meet the following objectives:

1) Enhance the mission’s understanding of gender norms and gender-based constraints and opportunities affecting men's and women's equitable participation in and access to health programs and services;

2) Assess key gender-related policies and programs of the Government of Senegal, the donor coordination forum, the Reproductive, Maternal, Neonatal, and Child Health (RMNCH) platform, and other development partners to identify opportunities for collaboration and mutual strengthening of approaches to respond to gender inequalities that impact health;

3) Produce an “Inventory” listing major gender achievements and gaps that may still need to be addressed based on what extent the current program is addressing key gender issues that limit/enhance health outcomes, gender equality and the overall Mission’s development objective 2, specific to health; and

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2 For an explanation on this, see http://www.igwg.org/igwg_media/IGWG-GenderAssessmentGuide-2013.pdf.
4) Identify a “Road Map” of actionable recommendations the USAID/Senegal health team and IPs can use to enhance gender sensitivity and effectiveness of future programs.

1.2 ASSESSMENT QUESTIONS

To meet the objectives, the gender assessment (GA) was guided by the following basic questions:

1) What are the different constraints and opportunities faced by women/girls and men/boys in health and wellbeing and variations across regional and ethnic differences in Senegal?
2) How do gender relations and broader institutional arrangements at community, regional and institutional levels influence health outcomes and the achievement of sustainable results?
3) How have policies, programs and activities currently supported by the Mission, Government of Senegal (GoS) and others affected the relative status of women/girls and men/boys?
4) How can the Mission best respond to gender inequalities in the health sector?

1.3 BACKGROUND

Increasing evidence shows that addressing gender and other social inequalities is necessary to achieve positive health outcomes and sustainable human development. Due to gender disparities and constraints, women and girls are often denied rights to health and wellbeing. This negatively affects their families, communities and the broader society. Recognizing this, USAID recently renewed prioritizing gender equality and female empowerment in all its work.

Global and national evidence clearly shows direct correlations between gender equality and women's empowerment and the achievement of the Millennium Development Goals (MDGs). Recent reviews of health programs worldwide have demonstrated that when gender-based inequalities and female empowerment are effectively addressed, more equitable health is realized.

Supporting gender equality is necessary to USAID/Senegal and the GoS' health priorities in RMNCH. Using a gender integration approach, all country Missions are required to develop strategies to address gender inequalities that limit women and girls from reaching their full potential and to advance gender equality in the whole program cycle. This gender assessment will help USAID/Senegal meet this requirement and to formulate a more strategic gender agenda.

1.3.1 OVERVIEW OF USAID/SENEGAL HEALTH PROGRAM

Within the 2012-2016 USAID/Senegal Country Development and Coordination Strategy (CDCS), the USAID/Senegal Health Office is responsible for Development Objective Two (DO2): to improve the

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5 IGWG (2011).
health status of the Senegalese population, with the following intermediate results (IR): IR1- Increased availability of an integrated package of quality health services; IR2- Improved health seeking and healthy behaviors; and IR3 - Improved performance of the health system. The program is aligned with the GoS National Health and Development Plan (2009-2018) to meet MDGs 1, 4, 5 & 6 and the overall Mission’s goal. It centers on five, bilateral, integrated program components.7

1.3.1.1 GENDER IN THE PROGRAM
USAID/Senegal has made efforts to consider gender issues internally and in all programming.8 It has a Gender Mission Advisor and GFPs in each sector to ensure gender integration internally and in programs, has conducted a Mission gender assessment (2010) and gender analyses of its PMI and Feed the Future programming. The Mission’s CDCS document has strengths and gaps in gender integration, however there is no clear gender sensitive objectives, strategy or action plan to ensure gender is systematically considered in all areas of work. This assessment will discuss existing and new gender-equitable strategies to increased gender responsive programs.

2 ASSESSMENT METHODOLOGIES & PROCESS
The assessment used a participatory, mainly qualitative methodology to assess the program. The two main methods were a comprehensive literature review and primary data collection. A desk review of quantitative and qualitative information was collected from the USAID Mission, partners and internet searches and consisted of:

- Pertinent USAID/external context-specific data and country and regional studies, reports, policies and programs dealing with gender and health issues in Senegal;
- Other USAID/Senegal strategies and/or sector gender reports and results frameworks;
- Cooperative agreements, contracts, and grants and associated quarterly and annual reports;
- Studies and assessments concerning gender conducted by donors, NGOs, the GOS, regional organizations, and the academic community;
- National statistics on women and men from the national statistics institute (e.g. Demographic Health Surveys), UNDP Human Development Index and other global gender indexes and reports;9 and
- Recent literature on gender in specific sectors and areas of strategic interest for the Health Mission.10

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8 http://www.k-state.edu/smil/research/gender/Senegal_Gender_Assessment_Jun-2010.pdf
9 Annex 1 has a detailed breakdown of all gender-related health data on Senegal that informed the analysis of this report.
10 See References section for a full list of documents reviewed.
Primary data collection was carried out over a four-week period from October 20th to November 14th, 2014. It was conducted using mainly qualitative, semi-structured interviews and focus group discussions (FGDs). An interview guide structured interviews and allowed for collecting both qualitative and quantitative data. Purposive sampling was used to identify a wide range of stakeholders for the primary research. The range of people and regions consulted and multi-dimensions covered in each interview allowed for cross-checking and triangulation to effectively validate themes and trends and ensure reliability in the analysis.

In total, the field work involved 33 health service site visits representing the three levels of Senegal’s health care system of district health centers, health posts and community health huts in five regions. 65 key informant interviews were conducted with representation of USAID/Senegal health team staff, IPs at national and regional levels, donors and relevant non-governmental organizations (NGOs) and women's associations; 85 health care workers including volunteer community health workers (CHWs), matrons and outreach workers were interviewed. In addition, a total of 89 male and female key informant interviews with health service clients and approximately 250 male and female program beneficiaries at the health hut level were interviewed. Among these community members were badienou Gokh (BG), outreach workers, village and religious leaders and women and men of a range of ages and social status including grandmothers, pregnant and young mothers, married women and young men and fathers.11 Table 1 summarizes total numbers of health workers and program beneficiaries interviewed.

<table>
<thead>
<tr>
<th>Table 1: Summary of Interviews and FGDs at Health Site Levels</th>
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<tbody>
<tr>
<td>Total Numbers (#s)</td>
</tr>
<tr>
<td># of Sessions</td>
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<tr>
<td>----------------</td>
</tr>
<tr>
<td>Total number of female FGDs with program beneficiaries</td>
</tr>
<tr>
<td>Total number of male FGDs with program beneficiaries</td>
</tr>
<tr>
<td>Total number of regions</td>
</tr>
<tr>
<td>Total number of health centers</td>
</tr>
<tr>
<td>Total number of health posts</td>
</tr>
<tr>
<td>Total numbers of health huts and sites</td>
</tr>
<tr>
<td>Total number of clients</td>
</tr>
<tr>
<td>Total number of health care workers</td>
</tr>
</tbody>
</table>

A total of 5 regions were selected based on ensuring representation of the grand regions targeted by USAID/Senegal’s health program, and to capture regional and urban/rural health and gender disparities.12 Sites were: Dakar (Guediawaye and Diaminiadio) & Pikine Department in Western Grand Region; Fatick urban and Diofior rural districts in Fatick; Kaolack urban and Ndofane rural districts in Kaolack in Central Grand Region; Ziguinchor urban and Bignona rural districts in Southern Grand Region; and Saint Louis urban and Pale rural districts in Northern Grand region.

2.1 Frameworks and Tools of Analysis

This GA draws from the Agency’s Gender Integration approach, key gender concepts,13 frameworks of analysis, gender assessment tools and evidence-based good practice standards in gender and

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11 A full list of organizations and individuals interviewed are found in Annex 2.
13 See USAID Gender Equality and Female Empowerment Policy (2012, p.3) definitions of gender, gender equality, female empowerment and gender integration.
An overarching approach was applying a gender analysis to identify the socio-cultural, economic, and political factors that shape Senegalese women/girls and men/boys’ lives at individual, community, facility and institutional levels. Quantitative data analysis was applied to calculate basic statistical formulas such as averages and frequencies by sex. Where possible, the team collected sex-disaggregated data from health facilities. The IGWG Gender Integration Continuum was used to assess whether and to what degree programs are gender blind, gender sensitive or gender transformative for supporting gender equitable health outcomes.

The following section presents the key gender and health issues in Senegal based on the literature review and primary data collection.

3 **KEY GENDER AND HEALTH ISSUES IN SENEGAL**

Senegal has made significant strides in reducing gender disparities in education and health. Despite progress, both primary and secondary data show that both poverty and gender inequality remain key determinants of health outcomes and of health service provision.

3.1 **CONTEXT OF GENDER RELATIONS IN SENEGAL**

Senegal is a politically stable, democratic and peaceful low-middle income country of 14 million in population. It is ranked 154 out of 187 countries in the 2013 Human Development Index (HDI) and 115 out of 148 countries in the 2012 Gender Inequality Index (GII). There are major gender disparities between women and men in education, employment and political representation that impact on women’s and children’s health and wellbeing. Gender related inequalities persist particularly along wealth, education, ethnic, regional and urban/rural lines. Moreover, there are regional and urban/rural inequalities in health care service delivery and access.

3.1.1 **GENDER NORMS AND PRACTICES**

Both primary and secondary data showed that dominant gender norms and practices define women, men and boys and girls’ self and collective identities and support uneven gender relations. These gender dynamics influence positively and negatively differences in women’s and men’s health seeking behaviors, health status and overall wellbeing.

**Gendered Roles and Responsibilities**

Senegalese society is characterized by a strong social hierarchy based on differences in gender, age and social position. Men/husbands have more power over women/wives and older generations...
have ultimate authority over younger generations. Those with less power must show full respect and obedience. Certain socio-religious rites of passage and social restrictions define and help uphold this social order. In this way, boys and girls are socialized to understand that women have a lower social status than men and that married women must show deference to their in-laws. Certain male authority figures such as village chiefs and Imams have powerful influence and decision-making power in local communities as socio-religious authorities and more often than not, as elders. These social distinctions are practiced across all major ethnic groups, Wolof, Fulani, Serer, Diola and Mandinka.

These unequal social distinctions are more pronounced in rural Senegal than in urban contexts. With urbanization and greater access to information, education and overall improved quality of life, generally, urban women and girls have a higher social and economic status than women and girls from rural underserved regions. Urban women's additional opportunities enable them to have greater autonomy in decisions related to their health and of their children.

For most Senegalese women, their social identity is strongly linked to marriage and childbirth. In effect, very few Senegalese women remain single. Dominant gender role expectations are that women and girls should marry and be good wives. They should take on a more supportive role to their husbands and show obedience and respect to him and in-laws. They should give him children and be good mothers. These same male-biased values guide sexual relations. Women should sexually satisfy the man’s desires, and this becomes even more important in the polygamous context of Senegal. A wife will want to keep her husband's attention and love to ensure his support and to distract him from looking for another wife. A married women's public reputation is strongly influenced by how others view her relationship with her husband and whether he is economically successful and a good provider.

Mother-in-laws and grandmothers are seen and act as traditional advisors and leaders. They have decision making power over their son- and daughter-in-law including decisions related to maternal and child health. Their influence may encourage both positive and negative health seeking choices. In several interviews in Diofior district, health workers explained that among the dominant ethnic group, the Serer, a grandmother can force a daughter-in-law to delay visiting a health clinic for her prenatal visits. For a newly married woman, having a child can be an important

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22 MoFWC (2005: 25-26).
23 Evidence of this can be found in DHS 2010-2011 and 2012-2013.
24 64% of women between 15 and 49 years in Senegal are married or in a couple relationship (DHS 2012-2013).
26 MoFWC (2005: 26).
way to be accepted by her mother-in-law and husband's family.\textsuperscript{30} For this reason, family planning (FP) is sometimes seen as a threat to building these important family relationships; a daughter-in-law who goes on FP may be seen by their in-laws as purposely trying to create barriers between themselves, the husband and his family.\textsuperscript{31} If a mother-in-law does not agree with FP, she may discourage her daughter-in-law from taking contraceptives.

Social expectations and socialization processes that women and girls hold a lower position than men and boys may influence women and girls’ self-esteem and confidence. They may be less willing or able to speak out about their opinions and needs in their couple relationships, with in-laws and with more educated and powerful health care providers. Moreover, their lower educational and social status often means girls and young women are less informed and have less power to voice their opinions than older women. Global evidence indicates that most young women are uncomfortable in formal health care settings and unable to communicate their real needs to doctors, especially male ones.\textsuperscript{32}

Other social factors such as age, urban/rural location, wealth status, ethnicity and ability/disability influence women and girls and men and boys’ differing statuses, identities, barriers, opportunities and experiences. In the case of Senegalese women and girls living with disabilities, they often face multiple forms of discrimination due to social stigmatization and other structural barriers. They may have specific reproductive and sexual health needs that current health services are not meeting. One study found that some women and girls living with disabilities will engage in unprotected sexual relationships out of pressure to become pregnant. They face personal and social pressures to fulfill expectations of motherhood but faced with physical and or psychological impairments, pregnancy may be more difficult. These situations put them at higher risk of gender based violence and HIV and AIDS and STIs.\textsuperscript{33}

Men and boys are socialized and understand themselves to be the household head, the main breadwinner of the household and primary and ultimate decision-maker in control of household resources. In this gender dynamic, violence of a man towards his partner may be considered an acceptable way of ensuring his wife shows respect and remains submissive to him.\textsuperscript{34} The responsibility of provider can also put a lot of pressure on men. As most of the urban and rural sites the assessment team visited were disadvantaged and resource-poor communities, many men were unemployed. They explained in FGDs that they struggle daily to earn enough money to fulfill their role as income-provider. They used the wolof term “gorgorlou,” which means to get by on a daily basis. Women and men interviewed described men as rarely home and as often absent from daily household life. Poverty and lack of resources were common reasons given for why women and men might not use or may delay going to a health facility. In the case of men, it was said that they will prioritize feeding their family first over seeking health care. Buying food was considered more important to survival.

In these unequal gender norms and relations, women/girls are often overburdened with all domestic and care giving responsibilities including looking after children, the sick and elderly. They

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\textsuperscript{30} Sen Ingenierie Consult (2014:11).
\textsuperscript{31} Ibid (2014:11).
\textsuperscript{32} \url{http://www.prb.org/jgwg_media/summary-report-gender-perspectives.pdf}.
\textsuperscript{34} GoS (2005), National Strategy for Gender Equality and Equity (SNEEG): pages 18-19.
\end{flushright}
are less educated and have limited access and control over productive assets. In rural and resource-poor areas, they may be time and labor-constrained with domestic duties and managing small scale businesses. These multiple burdens leave them little time or energy to take advantage of socio-economic opportunities and can negatively impact their health and hinder their capacities to look after sick loved ones.

Health care workers interviewed for this gender assessment explained that most pregnant women delay going to a health facility until they are four to six months pregnant. Reasons given were due to gender roles and other cultural factors. Most women wait until they are absolutely sure and to avoid the “evil eye” of others who could make her abort. Another key factor is their heavy work load and not having time to bring their child or themselves to a health facility promptly. For example in Dominique Health Post in Pikine Department, 2457 women came for antenatal care consultations. Out of these, only 37% went for the minimum four WHO-recommended prenatal visits because many delayed coming until the second trimester. In addition, only 67% of pregnant women received their second IPT shot—the remaining 33% did not attend their next prenatal visit (Health worker interview, Dominique Health Center, Pikine Department, October 28, 2014).

Across this assessment’s interviews and FGDs, health care was seen as a “women's domain.” When asked who comes most often to a health facility, almost all health care workers stated that more women than men come and that in most cases, it is a woman who brings a sick child to the clinic. The main reason given was that it is their responsibility as the mother and wife and men are away working. They were also seen as the parent closest to the child and thus most likely to notice if a child was sick.

**Gender Dynamics in Decision Making**

Women are expected to care for their families as mothers and wives and have been the central target of health policy and programming in Senegal. Women’s low status, low literacy, lack of access and control over resources, weak decision making power and authority of men and in-laws over women and girls/daughters are major barriers to women and girls promptly seeking health care. These unequal gender norms and relationships constrain women’s ability to negotiate their needs and interests for seeking health care for themselves and for their children; and in sexual relationships and contraceptive use. How and to what degree this plays out varies by the particular individuals involved and their differing age, wealth, ability/disability and urban/rural location.

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35 Ba (2010: 15-17).
80% of clients interviewed responded that men are the main household decision makers and dominate in decisions on health care. When asked specifically if they made the decision to visit the health care facility on the day of the interview, only 61 percent of female clients stated it was their decision compared to 89 percent of male clients.

Based on this GA data, women’s lack of decision making power and economic dependence on men has a negative impact on her health and that of her children. She will wait to get his permission and to obtain money from him to pay for the services. She likely does not have the money or she may prefer waiting and asking for her husband’s approval first in order to abide by her husband/in-laws’ decisions. She might even make him look bad and feel ashamed and angry if she pays beforehand. It may look like he failed to fulfill his role as the breadwinner. As public reputation is important, it is better for her to consult first. In polygamous marriages, in order to stay in good relations with the husband, she will wait for his permission to make sure he uses his money on her and not on another wife. She also expects him to pay because it is his duty.37

There was evidence that many women have small businesses. Some of them may use this money to pay for health care including topping off from what their husband is able or willing to give. Others may favor keeping their money for themselves and even push their husbands to pay as the main provider. There are also married women who may have an absent husband and so pay for health care based on their small business or stable income. In urban and suburban areas where more women are in formal employment and have easier access to private and public health services, they likely have more autonomy in deciding on their health care and in paying for it.38 There are variations in women’s and girls’ health status and decision making power based on intersecting factors of wealth, education, gender identity, ability/disability, ethnicity and urban/rural location.

Overall, women’s low decision making power, economic dependency and unequal gender relations contribute to delays in women seeking needed health care for themselves and their children. These situations can aggravate existing ailments or lead to pregnancy and child birth complications.

**Men’s Health and Agency**

A history of reproductive and health care focus on women and children has led to the unintended result of neglecting to target and ensure men’s support of and engagement in community and clinical health care promotion and services. There has been an over-focus on women’s reproductive roles as mothers and caregivers and a lack of attention to the wider context of gender and social relationships influencing her agency. This perspective has contributed to the current situation of the vast majority of volunteer health workers being under and unpaid women. In our interviews and FGDs, it was explained that men are less interested in volunteering in the health sector because they see no economic benefits. They see health issues as more a “women’s domain.”

In addition, social constructions of masculinity are that men should be independent, strong, virile and actively engaged in the public sphere and earning an income. These ideals contribute to their general negligence or lack of prioritizing their own health and undervaluing the need for health care for their wives in pregnancy and child birth. It supports unsafe and risky sexual behaviors such

37 Foley (2010: 118-121).
38 In urban areas, 48% of women are in some form of formal employment (DHS 2012-2013).
as multiple sexual partners and a general acceptance that men's promiscuity should be accepted because it is "natural." Men's health seeking behaviors vary according to individual men and their exposure to health information and other factors.

One of the major themes coming out of the primary data is that men and boys lack knowledge of positive health practices. This lack of proper medical knowledge showed in their different health seeking itineraries. Women were reported to be well informed and more likely to choose formal health facilities as a first health care option. This did not rule out first trying self-medication and traditional healers. In contrast, men's first choice for health care was defined as self-medication and then consulting a traditional healer or marabout and only turning to formal care as a last resort. These different preferences may also create disagreements or tensions in the couple, household and community relationships.

The emphasis on targeting women in reproductive health has led to men's negligence of their own health and disengagement in health matters at the individual, household and community levels. In the end, women become overburdened with care responsibilities at the detriment of their own health and lack the decision making power to make the right choices. As men may not prioritize health or fully understand the health issue, his influence over the final decision or delay in making a decision may actually put his own health, his wife's or child's health at risk.

3.1.2 Harmful Traditional Practices

In certain communities and regions across Senegal, early marriage and child bearing, female genital cutting (FGC), gender based violence (GBV) and wife inheritance have negative impacts on women and girls' health. They create intergenerational cycles of inequality. These harmful traditional practices (HTPs) are often socially sanctioned by gender norms and values such as valuing women and girls for their fertility. While not all elements of HTPs are harmful, many elements are such as promoting early sexual intercourse. A women’s age of first sexual experience is much younger than men. These age differences impact unfairly on women and girls’ abilities to negotiate sex and make healthy choices. They lead to early pregnancy and childbirth and put young Senegalese women at high risk of dying from pregnancy and childbirth complications and or to suffer from fistula.

Youth Sexual Health

Health workers interviewed in this assessment commonly made the observation that female and male youth are uncomfortable visiting health care services and may avoid or delay going. Young men and women who need contraceptives may dislike or even choose not to visit a health facility out of fears of being judged by a health care worker or by older community members who see them going to the clinic. These situations may lead to untreated STIs and undesired early pregnancy. Parents and health care providers were described as often being uneasy with broaching discussions on sexuality with younger generations. A main issue raised is that older generations believe adolescent girls and young women should not engage in sexual relations before marriage. Only in

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39 These HTPs vary across regions and within regions and by ethnic and broader social cultural and political factors.
40 41% of women 20-49 years of age have had sex by age 18 and half by 19.6 years. For men aged 35-59 years of age, their first sexual experience is much later at 22.7 years of age (DHS 2010-2011).
41 http://www.who.int/mediacentre/factsheets/fs348/en/
some ethnic groups in the South and South-East is early sexual experience and teenage pregnancy socially sanctioned.42

**Early Marriage**

The age gap between a young wife and older husband creates unequal power relations in sexual relations and household decision making. These situations often mean early and forced sexual relations, greater vulnerability to early pregnancy and child birth, more vulnerability to HIV/AIDS and other STIs, more births over the life-span and a loss of economic and social opportunities.43

Another problem is women’s unequal legal and customary rights in marriage and inheritance compared to men. The Family Code bans forced and early marriage but defines the legal age of marriage to be 16 years for women and 18 years for men. It mandates full and free consent in marriage for both spouses. There are, however, limitations. According to the Family Code, if a wife consents to the marriage as polygamous, the husband can marry up to four wives. Men have sole parental authority and decide the place of residence and receipt of family allowances. For civil marriage, either spouse can obtain a judicial divorce, but in most rural areas, traditional marriage systems prevail. Men are able to “unilaterally divorce their wives under a Muslim tradition of 'talaq' and have stronger rights to children after a divorce.”44 In the case of inheritance, Islamic and customary laws may take precedence over civil laws and this is even more the case in rural areas. Civil law inheritance grants women the same rights as sons but Sharia Law gives daughters only half of what a son may inherit and women one eighth of their husband’s property.45

In some ethnic groups, such as those predominantly in the Southern Region, levirate marriage is practiced. The widow is supposed to marry the brother of her deceased husband or she may try to get support from her son.46 These legal and customary laws and practices restrict women’s choices making it more difficult for women living in abusive marriages to leave. They are economically and socially dependent on the man and have little recourse to fall back on. They also fear losing their children. These legal and customary rights violations have an impact on women of all ages’ ability to lead healthy, productive lives.

**Female Genital Cutting**

With concerted government and civil society actions, FGC rates have gone down from 31% of women aged 45-49 years of age to 25.7% of girls aged 15-19 years of age (C-DHS 2012-2013). Dominant cultural values, however, still work to justify FGC. In 1999, the GoS instated a national law making it illegal. Despite this, 18% of girls under 15 still undergo FGC and 91% of them between 0 and 4 years of age. In this assessment’s study findings for Zigiunchor, midwives consulted at health center and health post levels stated that most women coming in for obstetric care had been circumcised. It was generally reported that many families do it in secrecy and or cross the borders to Mali or Guinea to have it done.

In this study data, male and female clients were asked about their views on GBV and FGC. For the most part, both women and men did not agree that a man had the right to be violent with his wife. 83% of women and 74% of men disagreed with the statement, “FGC is a necessary rite of passage for girls to become women.” While it may be that clients interviewed were not completely honest

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42 NCFA (2010: 16-17).
43 IGWG (2011: 5-6).
44 USAID/Senegal Gender Assessment (2010: 13).
45 USAID/Senegal Gender Assessment (2010).
and the sample is too small to make generalizations, this data suggests that some women and men’s views are changing in positive ways. One study by UNFPA-UNICEF on FGC in Senegal further supports this. It found that communities that had been targeted by community awareness and behavior change programs, mainly Tostan’s Community Empowerment Program (CEP), had resulted in increased understandings among community members of the negative effects of HTPs.47 Another positive result was increasing numbers of communities publicly declaring their abandonment of FGC.48

**Gender Based violence**

A recent UNFPA study (2012) conducted on GBV in Senegal indicates that there are increasing rates of GBV. The highest numbers of registered cases of violence were found in Dakar, Thies and Kaolack. Poverty, promiscuity, rapid urbanization and unequal gender power relationships between women and men were the main causes identified. Among cases treated at health facilities, 50% were due to rape, 17% due to cuts and bruises, and another 8% due to abduction.49

Social-cultural beliefs justify violence against women and girls. In Senegal, 60% of women think it is justified for men to beat their wives (DHS 2010-2011). On the positive side, with increasing education and wealth status, this acceptance of violence goes down (DHS 2010-2011). Data from Senegal’s southern region and conflict affected areas of Ziguinchor, Sedhiou, Kolda and Kedougou suggest much higher rates of GBV than other regions.50 These higher rates may be attributed to its open borders, certain socio-cultural traditions practiced by its main ethnic groups, the Dioula and Mandinka and years of civil conflict.51

In Kolda, a multi-decade study conducted by the Senegalese Health and Development Institute revealed that violence against school girls is particularly common and blatant—46 percent of reported rapes had been committed against schools girls; 66 percent of the girls knew their aggressors, and 53 percent had been attacked in broad daylight. This violence affects key populations at risk for HIV, as well: 43 percent of men who have sex with men (MSM) reported having been raped at least once; 37 percent had been raped in the last 12 months.52 Based on a HIV and AIDS knowledge, attitudes and practices (KAP) study among people with disabilities, it was found that “9.3% of women with disabilities versus 3.4% among men with disabilities reported coerced sex during their first sexual encounter.”53

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50 UNFPA (2009).

51 USAID (2014), USAID Concept Paper for the Incentive Fund to Address GBV.

52 UNFPA (2009).

In the gender assessment data for Ziguinchor region, health care workers interviewed identified school girls as particularly vulnerable to early sexual relations, unwanted early pregnancy and dropping out of school. Different situations were described where either a girl drops out of school and may be alone to look after the child, rejected by both the father of her baby and her own family. Other situations were given where health care staff, the school and parents will support the girl to have the child and to return to school after.

Key contributing factors are socio-cultural values that devalue girls’ education and status. Another issue is the practice of “Mbaraane” whereby girls and women enter into relationships with men who have money, such as border guards, teachers and police officers, for economic-sexual exchanges. Deep levels of poverty characterizing the Southern region also exacerbate girls’ disempowerment and particular health related vulnerabilities. Early pregnancy was also reported as a concern in other regions. In the Dakar region of Guediawaye, informants reported high rates of illegal abortions among young women.

In the south and southeast of the country, intimate partner violence (IPV) is deemed acceptable at rates well above the national average of 60 percent (DHS 2010-2011). For example, in Kedougou, 85 percent of women agree that intimate partner violence (IPV) is justifiable for reasons such as burning dinner or declining sex, as do 80 percent of women in Sedhiou and in Kolda (DHS 2011).

In society at large, there is a lack of impunity and general silencing of GBV. Contributing factors include the social acceptance of men’s abuse of power over women in the home, social pressure for the victim/survivor to stay with her husband and have the issue resolved privately within the family and similar acceptance and hostility faced by women and girls in medical, police and court services. The UNFPA (2012) study showed that young female victims/survivors are almost completely absent from the records of police and gendarmerie stations. The highest

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54 (2010: 16).
55 USAID (2014: 1).
56 NCFA (2014: 26); UN Women (2012).
registered cases were from health facilities and then courts and finally police and gendarmerie. 57 This data shows that health providers have an important role to play in prevention and response to victims/survivors of violence.58

In the gender assessment data collection, most health care providers were asked whether their health facility has a referral system for suspected GBV cases. Most stated there was no formal system in place but that certain positive steps were taken but this depended on the attitude and sensitivity of the health worker(s) involved. Many male and female health workers stated that if a woman comes claiming to have suffered from a domestic conflict or other form of violence, the typical response is to ensure she is consulted by a female staff member such as the midwife. She might be referred to the nearest hospital in order for her to get a medical certificate proving rape or sexual or physical violence. Many hospitals also have psychological services.

A few female RH Coordinators and midwives shared positive individual strategies for helping victims/survivors of violence such as referring them to appropriate services. In Guediawaye, male and female health providers reported sending women to a local women’s shelter for abused women and children, la Maison Rose. In the Zinguinchor health center, a volunteer outreach worker was trained in how to counsel and support women and girls that have gone through GBV. Another option shared by some health workers was to support the family's decision to keep the issue in the family and not get involved.

Based on the interviews conducted for this study as well as other national studies, there is a culture of silence around gender based violence. Women victims/survivors may inquire about reporting or bringing their husband to court using the local justice system but most drop their complaints out of fear of what others will say and mostly out of fear of losing their children.

Generally due to societal pressures, victim/survivors end up resolving the issue within their family relationships and not reporting cases. Other data on Senegal show that a common practice among families and communities faced with a sexual violence situation committed against a child or adolescent is to silence and hide the situation. This practice is based on “soutoura,” a wolof term for being discrete and of “neup-neupal” or camouflaging and hiding the situation due to the dishonor it can bring to the family.59 Police rarely intervene and few cases end up in court.60 “Women are victims of our society that expects women to withstand suffering for the good of the children” stated one person interviewed. In short, the data suggests that patriarchal gender biases and sociocultural norms make certain forms of violence against women of all ages acceptable and without social or legal redress.

59 NCFA (2014: 26).
60 http://www.wikigender.org/index.php/Gender_Equality_in_Senegal
3.1.3 SEXUAL AND REPRODUCTIVE HEALTH

A common remark among health workers interviewed in this study was that women and men are often uncomfortable and ashamed to treat health ailments linked to sexually transmitted diseases. As the physical symptoms of a sexual transmitted infection (STI) are much more evident in women, and they are more likely to be routinely checked during prenatal consultations, they are often the first in the couple to know of a STI. Several health workers reported a common strategy of trying to convince female clients to invite her husband for couples counseling. They may even ask an outreach worker to call on the couple at home to convince the husband of the need to come. Another common statement was that most men refuse to come. In our interviews with health care workers, we asked whether couples come together for consultations, most said not at all or very rarely. Some RH Coordinators and midwives interviewed explained that they tried to work around this barrier by giving two prescriptions to the wife, one for her and the other for her husband.

In Ziguinchor, in a FGD with members of a local woman’s association and a local partner of the USAID/Senegal HIV/AIDS and TB Program, it was stated that STIs, HIV/AIDS, and TB can be very sensitive issues for couples. They explained that women and men have great fear that their partner may abandon them if they find out they have these illnesses associated with social transgressions and sexual promiscuity.61 For this reason, men will try to avoid going to a health facility when they think they have these illnesses. This data indicates that social stigmatization of sexually transmitted diseases is particularly difficult in couple relationships.

3.1.3.1 FERTILITY AND ACCESS AND KNOWLEDGE TO FAMILY PLANNING

Senegal’s high fertility rates can be attributed to many factors: women and girls’ low status and decision making power; early sexual debut; early marriage; low contraceptive use; and limited birth spacing. Other factors are that reproductive health interventions have over-focused on women-exclusively and neglected to engage men in sharing responsibility.62 In Senegal, additional issues are the high value given to procreation based on social and religious norms.

According to a situational analysis done for the National Communication Campaign on Family Planning in 2011, there are both gender-related opportunities and constraints to addressing high fertility and low contraceptive prevalence. In this study sample, it was shown that women can take the initiative in the couple to discuss family planning. Moreover, the study found that there is a general socio-cultural valuing for child-spacing or not experiencing what is called “nef” in wolof. This is when a pregnancy follows prematurely from another one when the first child is still breastfeeding.

61 FGD with members of the Women’s Association – Djiyito Dimalaguene, Ziguinchor Town, Ziguinchor, November 11, 2014.
62 IGWG (2011: 5-6, 16-17).
According to this study results, a main challenge is the lack of communication in couple relationships and the fact that 74% of women in a couple relationship stated that they needed their husbands’ permission to go on FP. Many women of reproductive age assume that the number of children they have is God’s will. 65% stated they were not planning to use any kind of contraceptive. Some men justified opposition to the use of contraceptives on the grounds that it was anti-Islamic because it stops procreation.

In the same study, 80 percent of women interviewed stated that they would not continue with the family planning method after experiencing secondary effects. Rumors were said to be creating resistance and fear to family planning. Some men fear that if their wives go on FP, their wives will pursue multiple sexual partners. Some imams interviewed did not agree with family planning. Due to their power and influence, they likely discouraged men and women followers to stop. Some women have suffered from secondary reactions and have lost interest. In the gender assessment data, similar forms of resistance were described in health workers’ responses to whether some women and men are resistant to or shy about certain services or treatments. A common answer was that some women and men will resist family planning because they think it can bring infertility or enable wives to be sexual promiscuous.

In addition, a husband’s support of family planning was considered essential to the decision to go on family planning. Only 24% of women said they discuss family planning with their husbands. Moreover, as the 2010-2011 DHS showed, the proportion of women who use family planning increases with the number of couple decisions she participates in. It goes from about 10% for those women who participate in no decisions to 14% for those who participate in several decisions. This situational analysis provides important data on gender norms and unequal power relations influencing women and men's reproductive health. In this gender assessment data, some respondents said that there are some women who will go on family planning in secret without asking their husbands’ permission.

### 3.1.4 Ethnic and Regional Specific Constraints

Both secondary and primary data clearly show that the Southern Region and specific ethnic groups, e.g. Dioula, Fulani and Mandinka, continue to value and practice FGC, early marriage and other cultural traditions and practices. These HTPs seriously harm women and girls’ health and limit men and boys’ participation and engagement in reproductive and maternal and child health. For the Dioula, according to gender assessment interviews with stakeholders at all levels, men never visit maternity services due to the cultural belief that if a man sees or touches menstrual or blood associated with pregnancy or birth, he can become very sick and even die. There are also ongoing social taboos about women in pregnancy such as not eating certain nutritional foods like eggs or expectations that a pregnant woman should work hard and do physical labor until she gives birth.

Based on interviews with health workers in Diomniadio and Guinarails, there are socio-cultural barriers for certain ethnic groups (e.g., Pular or Fulani) and migrant populations from Guinea that affect their demand for health services. Some households refuse family planning and childhood vaccinations due to misconceptions that contraceptives bring infertility and vaccinations are dangerous. These misconceptions make it difficult for health workers using the extended outreach strategy to immunize and provide contraceptives to these populations. One RH Coordinator from

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Diaminiadio Health Center explained that women from these groups are refusing such treatments because their husbands prohibited it.

In the Ziguinchor region, interviewees shared information about annual, summer cultural events featuring high levels of sexual activity and promiscuity. The Southern Region also has the highest rates of HIV/AIDS in Senegal.

### 3.1.5 Maternal and Child Health

Most maternal deaths happen during labor, child birth and the immediate postpartum period due to obstetric hemorrhage. They are easily preventable and are often due to deep inequities in the health system. In Senegal, many health services are improving, however, problems with service delivery are ongoing and will influence whether women seek prompt maternal health care. According to a recent Service Provision Assessment, only 38% of health workers offering maternal service are trained in Integrated Management of Pregnancy and Childbirth (IMPAC). Other gaps are poor infrastructure, lack of equipment, medication or treatments, low capacity, absenteeism and negative attitudes of health personnel. In our sample, the costs and distances to health facilities were disincentives for women and for their husbands to support their wives to seek proper health care.

A major issue reported by female and male respondents in the gender assessment data collection was the distance to the nearest health center and the high costs for accessing an ambulance or other mode of transport in cases of obstetric emergencies. In Senegal, only 51% of health facilities have an emergency ambulance. This lack of affordable transportation and limited ambulance service put many women and children's lives at risk.

From a gender perspective, it was mentioned by several health workers that women and men prefer being treated by someone of the same sex and if an older person, by someone of similar age. Several interviewees stated that women disliked being treated by male head nurses at health posts. The multiple factors that might act as disincentives are illustrated in this male health workers' narrative; “Before we had no proper maternity and there were no midwives. Women were not coming but now we have a proper maternity wing. For family planning, women may not come because they know the personnel. We try to create privacy but we have no real counseling rooms” (Diofior Health Center, November 11, 2014).

Similarly, in this assessment’s field work, many health care facilities at the district health center level visited did not have any separate and confidential spaces to respond to youth sexual health care needs. The few youth centers that were mentioned such as Fimela Youth Center, in Diofior or youth centers in Ziguinchor town or in Guediawaye, were said to be low functioning and neglected. One problem is that many youth centers were supported by one program, but once the program ended; many centers were unable to self-sustain themselves such as to hire and pay for a trained professional.
health care professional. There is a lack of youth-friendly services to respond to young people’s sexual health needs for information and support.

3.1.6 HIV/AIDS

Based on the gender related health data Table (Annex 1), in HIV/AIDS, the most at risk populations (MARPs) are commercial sex workers (CSWs) and men who have sex with men (MSM). Other vulnerable groups are mainly women and young women due to the feminization of poverty and women’s added physical vulnerability. Highest HIV/AIDS rates are in Southern and South-Eastern regions.  

While most health facilities offer HIV Voluntary Counseling and Testing (VCT), very few facilities have ARV prophylaxis and or visual or auditory privacy or screened off space for VCT. In this study, these health service challenges were raised as huge obstacles for health care workers in the facilities this study team visited. Such private spaces are basic and necessary services to confidential couples counseling for PMTCT, treating STIs and responding appropriately to situations of GBV.

3.1.7 The Link Between Women’s Education and Maternal and Child Health

In Senegal, girls and women’s increasing years of education and wealth status positively impact on reducing fertility and maternal, child and infant mortality rates. As women’s education and wealth increases, she has fewer children (C-DHS 2012-2013). For women who have reached at least a secondary education, they have on average 2.9 children as compared to 5.8 children for women with no formal education (DHS 2010-2011). Furthermore, while three-quarters of children between 12-23 months have received all the recommended vaccines (DHS 2012-2013), rates rise to 81% of children born to mothers with secondary or higher education and fall to only 69% of children born to mothers with no formal education. Likewise, malaria prevalence varies with the educational status of the mother and household wealth: parasitemia was 4% among children whose mother has no formal education compared to only 1% of children whose mother has a secondary or higher education (DHS 2012-2013). These promising sets of data indicate the need to address women/girls’ access and completion of school, employment access and health all together.

These findings clearly show the urgent need to address gender-based barriers impacting health. The next section describes the wider national and international development policy and program response to addressing gender inequality and health issues for women/girls and men/boys. Positive advancements for gender equality are discussed as well as challenges and opportunities and entry points for USAID/Senegal to strengthen its engagement and collaboration with those able to make the most difference.

3.2 National Response to Gender Inequality

3.2.1 Gender Policy Environment

Strengths

The Government of Senegal (GoS) has ratified international UN human rights agreements and developed national gender legislation and programs for non-discrimination and equality for all. Examples include a Gender Based Violence (GBV) Law (1999); Reproductive Health Law (2005); and HIV/AIDS Law (2010). It has a National Strategy for Gender Equality and Equity (SNEEG) (2005-2015) and action plan (2009-2015) and GFPs in all ministries. Overall, it has a "relatively gender equitable legal infrastructure and history of both political support for women by its national leaders and an active community of women's and human rights in civil society."

These kinds of government efforts have helped reduce rates of early marriage and FGC, bring gender parity at primary education levels and facilitate donor support for gender equality. The Direction of Gender Equity and Equality (DGEE), Ministry of Family, Women and Children (MoFWC) is responsible for implementation of the SNEEG. The Gender Coordinator of the DGEE stated in this gender assessment interview that her role is to institutionalize a favorable social, political and cultural environment for equality and equity in development. With her staff, they provide technical advice on gender mainstreaming for gender units across at least 14 ministries. The DGEE's current action plan (2009-2015) prioritizes ensuring integration of gender equity and equality (GEE) in all national policies based on Senegal's main national development plan, the Plan Senegal Emergent (2014-2017). The SNEEG is a comprehensive framework for action with a results framework and indicators for tracking success. For example, it tracks changes in the percentage of institutions supported that are effectively applying a gender approach to their mandate.

In 2012, the government endorsed its Gender Parity Law which requires political parties to ensure that at least half their candidates in local and national elections are women. The new law has increased the number of women elected to the national assembly. Challenges remain due to lack of political will and other factors discussed below.

3.2.2 GENDER IN THE HEALTH SECTOR
The Government of Senegal is a committed partner in the health arena. With USAID/Senegal, among others, it is working to reduce maternal, neo-natal and under-five mortality using an integrated package of health services and community-based high impact interventions at community and clinical levels. Priority has been uptake of family planning. Strengthening community-based health services has produced many positive results.

**Gender Mainstreaming in the Ministry of Health and Social Action**
In 2013, the Ministry established a Gender Cellule or unit and coordinator whose sole mandate is to promote and integrate gender into the MoH’s activities. This national coordinator is supported by

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73 E.g. 2001 Constitution defines equality for all citizens regardless of sex, age, religion etc & the 1989 Family Code protects women’s equal rights.
74 USAID (2010).
75 SNEEG (2005) and DGEE (2009), Strategic Intervention of the Direction of Equity and Gender Equality and National Action Plan to Implement the SNEEG. DEEG (2009-2015), (March 2009). Major focus areas of the SNEEG are ensuring gender is fully institutionalized into organizational and operational functions of all development institutions; changing behaviors, attitudes and practices of male and female citizens to foster gender equality and equity and putting in place legislation and regulatory mechanisms to support women and men’s equal access to decision making in all spheres.
GFPs in each of the twenty-four different divisions and directions within the MoH. The Gender Unit's directive is to build gender capacity of ministry staff; facilitate integration of gender into all planning, programming, and budgeting; to monitor implementation and results; secure funds for promoting gender into the ministry and set up a system of exchange and discussion on gender in relation to the SNEEG.77

In 2013, the coordinator had approved a road map for gender integration within the ministry focused on expanding gender training and awareness among regional and district medical teams. Based on a key informant interview with the national coordinator in October, 2014, the Minister of Health had just officially endorsed conducting a ministry-wide organizational and programming gender audit that month. Over 2015, the coordinator planned to conduct the gender audit and develop a gender strategy and gender integration plan (GIP) based on the audit recommendations.

In October and November 2014, the coordinator was expanding the GFP structure to have one GFP per district health teams. In late October, 2014, 13 districts out of 76 had identified GFPs of which 5 are men and 8 are women. The aim is to have 25% men and 75% women. Establishing GFPs at decentralized levels is a good way of ensuring that there are staff and structures in place for assuring gender mainstreaming. Another good practice is training these newly identified regional and district GFPs in gender in order for them to help conduct the gender audit among their medical teams. The audit process can be a learning opportunity to identify gaps and strengths in MoH internal operations and in service delivery.

**Weaknesses and Gaps**

**Male biased Working Environment**
While the GOS has put in place progressive gender policies, deep gender biases at all levels of government undermine implementation of gender-related policy commitments and lead to weak political leadership and inadequate allocation of human and financial resources for effective implementation. Leadership, decision making and ways of working are more favorable to male interests such as most senior leadership in the MoH is male.

**General Resistance to the concept of “Gender”**
Another issue is the general resistance and dislike among many interviewed in this study to the term gender as a Western imported concept about “women's rights” and women-only issues that threatens traditional African values of the family. These perspectives can be espoused by women or men.

**Low Gender Knowledge and Capacity of Health Managers and Workers**
In our interviews with district health teams, the Chief Medical Officers often mentioned that they had to or had recently selected a GFP for their district. Many were uncertain as to what these GFPs would do to address gender in clinical settings. Some newly selected GFPs were interviewed. They mentioned the need to have the right skills and knowledge to know how to integrate gender into their clinical work.

**Lack of Financial and Human Resources Needed for Effective Gender Capacity Building**

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77 Gender Unit, MoH (2013). Action Plan for the Gender Unit.
78 The MoH decision to set up its own gender unit was based on results from a final evaluation of the National Action Plan for Women (PANAF) which showed weak integration of gender issues in national development policies and programs. GFPs in each ministry did not have clearly defined responsibility to integrate gender into their ministry (MoH (2013), TDR Cellule).
Another major gap is the lack of financial and human resources to ensure full appropriation of gender in the MoH. A good example is the fact that the national coordinator of the MoH’s Gender Unit is the only full time staff person to champion gender across the whole MoH. It will likely be difficult for her to build the capacity of and provide support to all GFPs in terms of ongoing gender training, coaching, and backstopping.

The MoFWC is understaffed and underfunded. In the Southern region, this gender assessment team consulted the regional director of the MoFWC who explained that there is only 6 staff to cover the whole region. MoFWC should be coordinating all activities but does not because of these obstacles. These gaps make it difficult for it to carry out its ambitious plan to ensure all government ministries have integrated gender into their plans and programs. According to one donor informant, the SNEEG initiative was done more to satisfy donor demands than out of a real commitment to gender justice.

**Lack of Female Leadership and Gender Champions**

According to several key informants from the MoH itself, male biases make it much harder for women to succeed and to lead. In interviews with female MoH staff and donor partners, the MoH working environment was described as male-dominated and sometimes hostile to women in more senior positions. Generally, women play more supportive roles than taking on senior management positions. Women have to work harder in order to prove their equal competency and skill. One MoH respondent explained that a common remark among senior male MoH staff is when an issue goes wrong, it is blamed on the fact that women were in charge.

Issues were raised on the gender dynamics between male and female health staff. Based on this assessment’s selected health centers and posts, out of the 11 chief medical officers interviewed, only one was female. In her interview, she explained that although she is the manager of a whole district health system, she is still under social pressure to take full responsibility for managing all domestic and family duties in her home.

While there have been improvements, there is still a lack of visible female leadership in the Ministry. Out of the 14 regions for instance, only one Regional Chief Doctor is a woman and only one female technical advisor is assigned to gender. There is a need to support the MoH to better manage its human resources from a gender perspective. In the interviews with IntraHealth staff at national level and in Fatick, they mentioned the challenge of trying to get female staff to go to rural areas and a problem with high turnover of midwives. Several respondents raised the issue of women not wanting to work in more isolated regions because of their husband or concerns that there are no good schools for their children.

Similarly in interviews with Chief Medical Officers in all five regions, they stated that with only a few midwives to work with, if one goes on maternity leave or is transferred, they face the challenge of not having this desperately needed specialist and may have to resort to using a nurse temporarily. These issues impact the MoH’s capacity to offer a gender equitable health system.

In the health centers, posts and health huts visited by this assessment team, most male staff were the chief medical officer, head nurse, and or nurse supervisors working in the curative section. All midwives and RH coordinators were female. Most CHWs or *agent de santé communautaire* were male and volunteer matrons, outreach workers and BG were for the most part female. Most respondents described the health sector as a “women’s domain.”

**Opportunities**
There is an important opportunity to support the MoH’s gender unit’s current activities from the gender audit to the development of the Ministry’s gender strategy to strategic support in strategy implementation. Ideally, the MoH’s gender strategy will require staff engagement at all levels and a shared practice of taking into account the needs and interests of males and females. It will require collecting and analyzing sex-disaggregated data; developing guidance across departments; ensuring structures are in place to implement that guidance and strong leadership championing the agenda. Such responsibilities will be difficult with competing demands posed on staff and challenges of gender capacity and buy-in from across all levels. USAID/Senegal can initiate discussions with the MoH and its Gender Unit to formulate a common vision and gender integration approach that is inclusive and just. It should challenge assumptions that gender is only about women but is an issue that concerns all society and is for the benefit of all. Such a gender transformative approach will be necessary in all training and in all strategy planning and programming to build a commitment to gender among all staff.

A Strategic Focus in Reproductive, Maternal and Child Health

With little time to reach the MDGs 4 and 5, there has been a global effort to develop a more coordinated approach to address reproductive, maternal, and neonatal and child health (RMNCH). Donors like the World Bank, World Health Organization (WHO), Global Fund, UNICEF, UNFPA and USAID are among the key players. The Senegalese MoH’s commitment to the global strategy is articulated in the recent establishment of a national Directorate for Maternal Neonatal Child Health; a national committee to implement an ambitious multi-sectoral roadmap for reducing maternal and child mortality and a national campaign to accelerate the reduction of maternal mortality. Donors such as USAID, UNFPA and others, worked with the Direction of Reproductive and Child Health (DSRSE) on some of these activities. As RMNCH is a shared strategic priority for USAID and Senegal, a good choice is to support the MoH to address gender issues in these health areas.

The table below provides a summary of donor and NGO partnerships and initiatives with the MoH for USAID/Senegal to consider for strengthening synergies and mutual collaboration. These activities are supporting the institutionalization of gender into the MoH and in RMNCH.

Table 2: Summary of Opportunities for Partnerships in Gender Mainstreaming

<table>
<thead>
<tr>
<th>Partner(s)</th>
<th>Activities and Opportunities for Partnerships</th>
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<tr>
<td>MoFWC</td>
<td>MoH recently signed a Memorandum of Understanding (MoU) (Draft, 2014) with the MoFWC that defines points of cooperation along mutual interests and priorities. Focus areas described in the MoU are to mutually support increasing contraceptive use from the 12% rate in 2009 to 27% by 2015. To achieve this, they want to join efforts in supporting collective and individual social behavior change for positive reproductive and family health. They aim to work at community levels engaging women, men, male/female youth, religious leaders and local authorities for increased FP. There is an opportunity to strengthen this inter-ministry collaboration and sharing of information in reproductive health, especially to increase community-based health education and services that address gender and health issues.</td>
</tr>
<tr>
<td>Donor Coordination</td>
<td>Comprised of donors and international NGOs, coordinated by UN Women. The group develops plans and strategies to support and push the government to mainstream gender into policies</td>
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<tr>
<th>Group on Gender</th>
<th>USAID is a member, represented by the USAID Mission Gender Advisor. In this assessment’s interviews, some donor members remarked that USAID has not been as active in this group as in the past.</th>
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<tbody>
<tr>
<td>Luxdev</td>
<td>Supports the MoH to institutionalize gender including conducting the gender audit, developing an action plan based on the gender audit results and developing concrete strategies and steps to be integrated into all levels of the pyramid of health services.</td>
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<tr>
<td>Belgian Technical Cooperation (BTC)</td>
<td>Since 2013, donors like Luxdev and BTC have been pushing the MoH to report on its gender results, but the MoH has struggled to provide the right sex-disaggregated data. In response, BTC brought in a gender M&amp;E expert to work with the Gender Unit Coordinator to build her capacity in how to collect and track gender results. Based on the need to build greater capacity, BTC assigned a full-time gender technical advisor to support the MoH Gender Unit to implement its 2013-2015 Roadmap for developing a Gender Integration Plan. BTC works alongside USAID/Senegal’s government to government direct financing program. It has required that gender be a conditional factor in performance reporting including reporting on sex-disaggregated data. Several donors and NGOs are working together to harmonize their support, including BTC, LuxDev, UN Women, and NGOs like IntraHealth &amp; FHI 360. There is an opportunity for USAID/Senegal to take leadership in coordinating and harmonizing donor support to push and strengthen the MoH’s efforts to effectively integrate gender into the sector and to build on other donor supported activities.</td>
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</tbody>
</table>
| World Health Organization (WHO) | WHO is helping the Ministry develop gender tools for gender mainstreaming and to train MoH staff on how to integrate gender into their annual work planning. These efforts are in support of the global initiative Commission on Information and Accountability for Women and Children’s Health recommendations. 


| UN Women | In addition to supporting the government to mainstream gender across all ministries and joint programming in GBV, UN Women supports the MNCH platform through several West and Central African programs: Muskoka, H4+, UBRAF/HIV/AIDS with the Trust Fund and G4GE focused specifically on female empowerment. The Muskoka initiative is a G8 funding initiative to accelerate progress toward the achievement of Millennium Development Goals 4 and 5. |
| Alliance Française for Development (AFD) | AFD has a maternal and child health program that supports health education activities to raise women’s negotiating power in their couple relationships. In the past, the AFD has also supported the construction of youth centers in Louga, Sedhiou and Kolda to respond to gaps in reproductive and sexual health needs of youth. |
| UNFPA | UNFPA has a reproductive health program focused on women and adolescent and young women in collaboration with the MoFWC. It works on reducing maternal mortality through increasing use of family planning, and supporting women’s empowerment for their increased decision making power in regions not covered by USAID such as Matam. It worked with the USAID/Senegal CHP Program to support implementation of the National Campaign on Family }
Planning (2013-2014). This campaign engaged men and couples in culturally sensitive messages about shared responsibility in child spacing for better health for all that brought up contraceptive rates. UNFPA works with multiple stakeholders including imams and marabouts; supported the first youth centers and supported the DSRSE in developing the Badienou Gokh Program. It is also working on a research program with UNICEF that engages men in Tamba with a local partner, ASBEF.

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<tr>
<th><strong>JICA</strong></th>
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<tr>
<td>JICA developed a Project entitled Health Service Improvement in Maternal and Neonatal Care (PRESSMN Phase 1 and 2). The first phase was piloted in the regions of Tamabacounda and Kedougou from 2009-2011. Results showed significant improvements in maternal and neonatal service delivery. The program trained health care workers to support women-directed childbirth using a humanized child birth approach and established new child delivery norms and protocols based on WHO international best standards.</td>
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<tr>
<td>Positive elements that address some gender based constraints to pregnancy and child birth are: ensuring husbands, in-laws or others accompanying the woman in labor feel welcomed; respect for the right to privacy for the women in labor; rights to have food to ensure her energy for child labor; an empathetic support from the midwife or nurse during child birth such as using reassuring words and giving freedom to the woman to decide what positions and how she wants to give birth. In this gender assessment field research in Fatick, health care workers had been trained in this program and proudly wore their vests and spoke of how it had changed their support to women in labor in very positive ways and had increased the numbers of women giving birth in their facility.</td>
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These kinds of donor efforts are important entry points for USAID/Senegal to consider, engage in and further strengthen. USAID/Senegal can use the strengths of its TutoratPlus capacity building program of health care workers to support the MoH to effectively mainstream gender into its internal systems (E.g. human resource management) and ensure gender equity in health services, particularly in RMNCH. One possible approach is to build the necessary gender-responsive client-oriented skills of health managers and workers to be responsive to the different needs and interests of female and male patients.

Another strategy might be to support the MoH to develop gender equality benchmarks for what different health personnel and levels of the health system must be expected to achieve in gender. One example might be targets for increasing the numbers of male and couple client visits and measurements of their reported satisfaction with services. Another example might be certain targets at the regional district level of increasing or retaining equal number of female/male health care providers in rural areas. These gender equality benchmarks can become part of performance-based financing and are aimed at improving reproductive, maternal and child health.

Overall, there is an opportunity for USAID/Senegal to take leadership in working with the MoH, MoFWC and Donor Coordination Group on Gender. Building on existing partnerships, USAID/Senegal can work with these partners to harmonize all activities in support of gender integration in the MoH and focus on initiatives that reduce gender-related constraints to RMNCH at clinical and community level.
3.2.3 POLICIES AND PROGRAMS

The next section looks at specific policies and programs that are addressing key gender related issues impacting health such as gender based violence prevention initiatives. Various donors and international, national and local NGOs and community based organizations and associations work on gender related issues in the health sector.

3.2.3.1 GBV AND HUMAN RIGHTS VIOLATIONS

The Penal Code, Law #65-60, penalizes pedophilia, excision, rape, and sexual harassment with the accused risking up to ten years of prison. While this is an important piece of legislation, the challenge is that it has not been supported by a multi-sector response to GBV to ensure it is implemented. So far, the government has established GBV focal points in the Ministries of Women, Health, Justice, and Education in efforts to develop a multi-sector response to GBV.

There are some important government/donor programs to address different forms of gender based violence and support a multi-sector response. The key players in these programs are UN agencies, UN Women, UNFPA and UNICEF. The main government ministries are the MoFWC, MoH, and Ministries of Education, Justice and Police and Security. National organizations and women’s associations play important roles in prevention and response. Several women’s rights organizations such as the Siggil Jigeen Network (SJN), Federation of Women’s Associations (FAWA) and Committee Fighting Violence against Women (CFVW) are pushing the government to protect women’s rights and offer direct economic, social, psychosocial services. They also do advocacy work to push for policy changes. In an interview with the CFVW representative in Ziguinchor, she recommended the need for funding legal assistance, awareness-raising on GBV and support to child victim/survivors. Tostan is also working on reducing GBV using its CEP.

The main donor supported programs are summarized in Table 3 below. Please note that this list is not exhaustive but highlights the GoS’ main donor partners in addressing GBV and brings to light possible opportunities for programming.

Table 3: Donor Programs in GBV Prevention and Response

<table>
<thead>
<tr>
<th>Partnerships</th>
<th>Program/Activities</th>
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<tbody>
<tr>
<td>UNICEF, UNFPA &amp; MoFWC</td>
<td>Joint Program to Eliminate GBV and Promote Human Rights is a regional West and Central African Program to support national governments to set up national multi-sector responses to GBV including ending early and forced marriage and FGC. This program is the overarching program to others named below. Through this joint program, the MoFWC is implementing a GBV program in 6 regions in Senegal (Kolda, Sedhiou, Zinguinchor, Dakar, Tambacounda and Matam), funded through a joint United Nations program consisting of UN Women, UNESCO, UNICEF and UNFPA. In these various programs, efforts are being made to collect data for improving data collection and information systems on national GBV prevalence.</td>
</tr>
<tr>
<td>MoFWC and UNFPA and UNICEF</td>
<td>UNFPA and UNICEF are supporting the MoFWC to implement its National Action Plan to Accelerate the Abandonment of FGC (2010-2015). The vision is total abandonment by protecting girls and women’s rights to good health, physical integrity and full rights fulfillment.</td>
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**UNICEF**

- The main strategies are to engage whole communities in social transformation for FGC abandonment, engaging women and men, young and old, with a special focus on the leadership of religious and traditional leaders; and using a strong coordinated results-based approach. This program is being implemented in Dakar, Fatick, Kaolack, Kaffrine, Kedougou, Kolda, Matam, Saint-Louis, Sedhiou, Tambacounda, Thiès and Ziguinchor. A wider stakeholder response is supported including whole communities that have already abandoned FGC, religious leaders, the media, traditional leaders, jurists, the police, gendarmeries and penitentiary system. UNFPA has also supported the Association of Female Jurists of Senegal’s legal aid clinics for women and girls. In 2015, a final program evaluation should be conducted.

<table>
<thead>
<tr>
<th>UNICEF</th>
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<tbody>
<tr>
<td>Protection of Vulnerable Children focuses on GBV, FGC and child marriage working at national, regional and local levels. Locally, it works in the most underserved regions of Kedougou, Kolda, Ziguinchor, St-Louis and Matam. It works mainly on building community awareness raising and facilitation of community dialogues for gender equitable social transformation. Some good practices are setting up “community protection committees” by neighborhood and in each department, to respond to risky situations of FGC, GBV and child marriage. The main implementing partners are Tostan, Handicap International and Enda-Action. At the national level, UNICEF’s Child Protection program supports advocacy so that national authorities take steps to protect and work to create a system to respond to situations of child abuse and GBV on minors. Key stakeholders are the MoH, Ministry of the Interior, MoFWC and international and local NGOs.</td>
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**Weaknesses and Gaps**

**Lack of a well-functioning multi-sector systems approach**

Despite donor, government and local NGO efforts, the national response to all forms of GBV lacks coordination and a multi-sectoral approach to deal holistically with the multiple needs of victims/survivors. There is a need for up-to-date data on the prevalence and causes of GBV. In this assessment visits to health facilities, no facility was formally recording cases of rape, incest, or domestic violence. No health personal identified a formal referral system for responding to cases of possible GBV. The issue of silencing the issue and lack of redress for victims/survivors at national, community and household levels is discussed in the context analysis.

**Opportunities**

In summary, across all these interventions there are common approaches and coordinated efforts. The two main strategies are using a “whole community approach” to challenge and change socio-cultural norms supporting HTPs and GBV. At the national level, the main strategy is to have a strong multi-sectoral response involving all key ministries and actors including the MoH to offer psychosocial and health care support, and legal, police protection and social support services. USAID/Senegal’s IPs, IntraHealth and FHI are currently supporting the MoH to develop a protocol to respond to cases of GBV within health services. Other important strategies are supporting women’s organizations that provide critical holistic services for victims/survivors. Efforts to improve national data collection systems on numbers of GBV cases to inform a better response are important. There is an opportunity for USAID/Senegal to support the MoH’s role and capacity in this multi-sector response to GBV.

Other initiatives to build upon are from USAID/Senegal’s own past and prospective programming.
Table 4: Learning from USAID/Senegal’s Past and Prospective Programming

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Program/Activities</th>
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<tr>
<td>USAID/Senegal joint program (Health and Education Teams) and MoH/MoE.</td>
<td>Main Implementers: IntraHealth &amp; MoH Bureau of Prevention and Trauma This program supported the development of a life skills curriculum of eight sessions with boys and girls from end of primary to early secondary levels. Combined with this, the program worked with FAWE, an African women’s rights organization with evidence based good practices for ensuring girls stay and learn in school. Teachers and male school administrators were trained in participatory life skills to support their students to delay early marriage, to reject GBV and to support girls with teenage pregnancies. The program had regular multi-sector working groups of parents and partners. <strong>Opportunity</strong>: These innovative interventions have much potential to increase girls’ empowerment and deal with biased gender-based norms that hinder positive and more gender equitable and respectful relationships between boys and girls and women and men. The multi-sector approach helps create integrated structures needed to respond early and more effectively to GBV.</td>
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<tr>
<td>Middle school-based reproductive health and gender-based violence program in the GBV high prevalence regions of Kolda, Sedhiou, and Kedougou (2011)</td>
<td>This three-year project implemented by World Vision aimed to increase girls’ empowerment and support broader community social transformation to reduce high prevalence of early pregnancies and marriage, FGC and GBV in Velingara zone in the Southern Region. Two main strategies were using a critically reflective community dialogue approach, and the leadership of grandmothers who act as traditional advisors to younger women. Using these two main methods, the project engaged different male/female segments of targeted communities and organized them into discussion groups using innovative behavior change methods to increase dialogue and communication between generations and among respected elders, schools, parents and girls. After three years, a final evaluation showed significant reductions in FGC, early pregnancies and attitudes supporting GBV and increased age of first marriage.</td>
</tr>
<tr>
<td>USAID/Senegal funded Community Health Program/Grandmother Project/World Vision “Holistic Development of Girls” (2008-2011)</td>
<td>Proposed program was to support strengthening the Senegalese national response to intimate partner violence (IPV) by enhancing its multiple systems approach to community prevention and response to IPV. The program fits with the United States’ Strategy to</td>
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83 The curriculum covered sexual health, life visioning and life skills, and negotiation and communication skills such as how to protect oneself against GBV and were adapted to the Senegalese context.

84 FAWE organized and facilitated parenting discussion groups to teach parents in five to six lessons good parenting based on human rights standards and to ensure parents of students support their daughters to stay in school and not marry them off too early.

85 Assia Saou Musoko et al. (2011: 47).

86 As described in the April 2014 concept note, USAID/Senegal Concept Paper for the Incentive Fund to Address Gender Based Violence, a multi-pronged approach is proposed to build up a USAID’s GBV support program integrated into current sub-programs. This program would create synergies and strengthen collaboration to address a neglected gender issue in the USAID health program, gender based violence. It supports Senegal’s national-level priorities, and with the Ministry of Health’s priority of developing a national policy on GBV to guide its interventions in the health sector. Proposed partners for the program are already engaged in the HIV/AIDs and TB Program, CFVW and the Center for Child and Family Guidance (CCFG), who are establishing a network of care providers (medical staff, and psychosocial and legal services) who can treat those affected by GBV and then refer them.
There is an important opportunity for USAID/Senegal to reconsider past and present good practice interventions for addressing gender related barriers from GBV to uneven gender norms contributing to health inequalities. Good options include building on gender capacity building efforts of IPs like IntraHealth to the MoH. Another alternative is learning from the successes of social behavior change programs like the grandmother project or adolescent school based life skills program curriculum. These program approaches and innovative methodologies deal directly with the underlying root causes of gender inequalities undermining health. These kinds of approaches could be reworked into USAID/Senegal’s current Community Health Program.

3.2.3.2 HIV/AIDS

Senegal has strong gender sensitive policies and programs for addressing gender and HIV/AIDS issues. It has a National Strategic Plan to Fight against AIDS 2014-2017 (NSPFA). This plan is based on a contextual analysis of the causes and consequences and key issues for the most vulnerable populations, MARPs and women. It has specific targets to reduce new infections and to ensure those living with HIV/AIDS receive appropriate services for an improved quality of life.

Weaknesses and Gaps

Lack of scale up of what works
The main weakness in current gender and HIV/AIDS programming are to ensure good practices are brought to scale and properly evaluated and reviewed for their impact. Initiatives such as youth and couple counseling or CSW and MSM peer mediators in clinics are important to equitable access and HIV/AIDS prevention and testing. To date, these activities remain small scale and have not been scaled up to be available in all health centers and posts.

**Opportunities**

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Program/Activities</th>
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<tbody>
<tr>
<td><strong>CNLS National Policy on Gender and HIV/AIDS (2014)</strong></td>
<td>In the last three years, through the support and collaboration of its main USAID/Senegal partner, FHI, the MoH’s National Committee to Fight HIV and AIDS (CNLS) now has a policy to prioritize women, girls and gender equality as part of national priorities and in accordance with the UNAIDS gender agenda. This plan aims to focus on developing holistic HIV/AIDS interventions that target high risk groups and heterosexual couples (which constitute 70% of new infections) using mainly social behavior change approaches. Key players are women’s organizations, lesbian, gay, bisexual and transgender (LGBT) rights organizations and associations of people living with HIV/AIDS. Women’s associations and regional focal points of organizations like SWAA are extremely motivated and have programmatic approaches that deal with the holistic issues of women’s disempowerment. The USAID/Senegal HIV/AIDS and TB Program under FHI work with these organizations. In Ziguinchor, SWAA and the Association of Djiyito Dimaleguene support youth and couple awareness-raising on HIV/AIDS and reproductive health. Another key funding partner for these organizations is the UN Global Fund.</td>
</tr>
<tr>
<td><strong>Small initiatives to pay attention to LGBT organizations</strong></td>
<td>There are 11 organizations in Senegal working on LGBT rights who have important roles to play in defending and speaking out for LGBT rights. USAID/Senegal’s current HIV/AIDS and TB Program is working with these organizations who are staffing district health centers with LGBT mediators whose primary responsibility is to ensure some form of LGBT-friendly services are available in these facilities.</td>
</tr>
<tr>
<td><strong>Enda Santé GBV Prevention Program for CSWs, under USAID/Senegal’s HIV/AIDS and TB Program</strong></td>
<td>Enda supports income-generating activities for commercial sex workers (CSWs) to increase their economic independence and provides training and capacity building in gender and HIV/AIDS to build up CWS’ individual and collective knowledge and power to negotiate their interests in sexual relationships. Finally, another innovative approach is to increase men’s awareness of their responsibilities toward their families and the need to respect women; this program targets CSW’s regular partners and boyfriends.</td>
</tr>
<tr>
<td><strong>Progressive Religious organizations working on sexual education such as</strong></td>
<td>Other important players to pay attention to are religious leaders and organizations that are advocates of family planning. One such organization is Union Sans Frontier that is providing sex education for young women and men based on Koranic teachings using culturally sensitive approaches to broach sex education. It has supported women’s groups to develop health micro-financing to cover child birth costs. Religious leaders have a very</td>
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87 LGBT make up 3-5% of the population and are seriously stigmatized (USAID/Senegal Gender Advisor interview, Dakar, October 22, 2014).
the Union Sans Frontier (Association of Imams) have a strong influence on Senegalese women and men. These religious leaders that are champions of gender equality must be furthered supported and included in society and community wide efforts.

There is an opportunity to look closely at the Enda Santé program in terms of a gender transformative program in HIV/AIDS prevention. It is worth assessing whether its combined approach of female economic and social empowerment and engaging men in behavior change is worth adapting to the general population for gender equality.

4 USAID/SENEGAL’S HEALTH PROGRAM GENDER PERFORMANCE REVIEW

This section reviews the performance of USAID/Senegal’s health program in responding to key gender and health issues raised in the situational analysis of this report. It first examines USAID’s and IPs internal capacity and systems to integrate gender and looks broadly at gender achievements, gaps and opportunities from a cross-programming perspective. It then reviews the level of gender integration and achievements, gaps and opportunities in addressing key gender inequalities relative to each of the five main program components. The gender continuum and GHI supplement on gender inform the review below. Recommendations are in the final section of this report.

4.1 INSTITUTIONAL CAPACITY AND SYSTEMS IN GENDER

USAID’s Gender Policy (2012) requests all missions to integrate gender systematically into internal operations and programs by developing a gender strategy called a “Mission Order on Gender.” It provides good practice standards on gender mainstreaming stating that each country mission should: 1) integrate explicit gender equality and female empowerment objectives in program design; implementation and M&E; 2) have a gender sensitive budget in operating plans and budgets; 4) have gender sensitive indicators in reporting and Performance Plans and Reports and 5) the right gender staff and expertise to implement the gender commitments. These guidelines help measure the current mission’s quality and level of gender integration in the health program.

4.1.1 GENDER ACHIEVEMENTS, GAPS AND OPPORTUNITIES

Table 6: Achievements/Gaps in Internal Gender Capacity and Systems

<table>
<thead>
<tr>
<th>Steps</th>
<th>Achievements and Good Practices</th>
<th>Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Planning</td>
<td>The Mission’s Country Development Cooperation Strategy (CDCS) (2012-2016) document recognizes gender-based constraints that the program must address. In IR 1, the CDCS document states that programming must engage men and boys due to dominant gender ideals and roles that assign Senegalese men as ultimate household</td>
<td>The CDCS lacks an explicit gender strategy that defines how gender will be fully dealt with in its five program components. Gender is more an add-on to the mainstream program, isolated to one or two sentences in the whole strategy document.</td>
</tr>
</tbody>
</table>

88 USAID (2012: 15).
and community decision makers. There is recognition of the need for a multi-sector approach to maximize development results.

<table>
<thead>
<tr>
<th>Gender knowledge and dedicated staff</th>
<th>Health team members’ knowledge of gender, gender equality and gender integration are strong. They understand gender as socially constructed and based on unequal relationships between women and men.</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID/Senegal staff interviewed expressed uncertainty about the roles and responsibilities of the Mission gender advisor or focal point for the health team. The fact that gender is an additional task of the GFPs and is not part of their job descriptions or performance reviews makes it hard for them to dedicate the needed time to play a gender advisor role. Staff are overworked; and preoccupied with achieving program results to which gender is not a priority.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Design and Program Approval</th>
<th>Gender integration in program design, implementation and M&amp;E was a mandatory requirement in the 2011-2012 call for proposals and contracting agreements. All IP proposals have at least one paragraph explaining how gender will be addressed in the program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>In four out of the five IPs program component proposals, gender is added on in a few paragraphs and not effectively integrated with gender considered across the objectives and intended results, components, activities, M&amp;E and defined staff expertise.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implementation</th>
<th>See programming sub-sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID/Senegal health team and partners identified lack of knowledge, skills and practical easy-to-use tools on how to consider gender in program work as a gap.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Planning, Monitoring and Evaluation (M&amp;E)</th>
<th>In the last year, USAID/Senegal health team members have become more concerned with level of gender integration in the five programs. In meetings with IPs, they started challenging IPs to think beyond the assumption that gender is just about counting numbers of women and men per activity. To this end, the June 2014 Quarterly Reporting Format added guidelines on “gender integration” requiring reporting on how program activities are ensuring equitable access of health services for women and men and references USAID ADS gender guidelines. These demands precipitated greater reflection and questioning among IPs on their gender knowledge and practice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>In reviewing the health program proposals and quarterly and annual reporting, gender has been more of an add-on rather than a strategic and deliberate approach integrated into the whole program cycle. There is no set of clearly defined strategies to fully and effectively address gender based constraints and opportunities linked to the objectives and outcomes of the program.</td>
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</table>

Until recently, most IPs explained in interviews that USAID/Senegal was only asking for sex-disaggregated data in quarterly and annual reporting. Several partners assumed that by disaggregating data by sex, gender was being addressed. There is very little reporting on gender specific activities that address gender inequalities impacting health; the one
A good practice is disaggregating all data by sex.

The health team has a total of 50 indicators for monitoring progress. Most reflect a women-in-development (WID) approach to measure women’s reproductive needs and women and men’s health needs. Good indicators include: maternal and child mortality ratios, total fertility rates and indicators for tracking women’s and men’s rights to basic services and knowledge to prevent key illnesses (e.g. couples-years of protection and percent of target population who know how to prevent key illnesses). Disaggregated by sex, they can help track whether there are improvements in equity in knowledge and access.

**Learning and documenting good practices**

<table>
<thead>
<tr>
<th>Learning and documenting good practices</th>
<th>There are no systems in place for USAID/Senegal and its implementing partners to document and share good practices in gender.</th>
</tr>
</thead>
</table>

**Opportunities**

There is a stronger push within the health team to address gender issues more strategically in the next five year program. In interviews, staff affirmed that female empowerment and gender equality should be key interventions to USAID/Senegal’s health programming. The fact that USAID globally has made gender a priority and is increasing attention to key issues can help define and support USAID/Senegal’s own efforts to strengthen gender in its work.

USAID Washington requires reporting on gender results in the Performance Plan and Report (PPR). This provides a platform for USAID/Senegal Mission and health team to reflect on its level of gender integration, female empowerment and gender equality results in all sectors and as a whole. It is a means to solicit support and guidance from a wider network of gender experts in USAID.

FHI360 and IntraHealth have strong gender capacity and commitment partly because it is institutionally mandated. They both have a gender expert among their staff who is championing gender in their program. These staff has played key roles in building the capacities of all the other IPs and in strengthening the gender capacity of the MoH. Depending on these partners’ interests, their strong gender capacity building skills could be further exploited in a more deliberate fashion for skills-building of program staff and partners including the MoH.

IPs increased their attention to gender because USAID/Senegal health team members began questioning them about whether their activities are really gender equitable. This change

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89 A Women-in-Development” (WID) approach aims to improve women’s health status based on their traditional roles and needs rather than their strategic interests that would contribute to shifts in power. A WID approach is often compared to a more transformative “Gender and Development” approach which explicitly aims to redress and change power inequalities for more gender and socially equitable dynamics. Based USAID’s gender policy, USAID programs should aspire to be transformative.
demonstrates how important it is for USAID/Senegal health team members to regularly engage with partners on gender. Individual and group meetings between IPs and USAID/Senegal health team staff are key entry points to clarify USAID gender priorities and requirements and to build capacity for partners to better address gender in the programs.

The Abt-led cross-program technical working group is a potential learning and knowledge sharing space for establishing a more regular system of communication and exchange on gender issues, bottlenecks and successes.

4.1.2 OVERALL PROGRAM RESULTS IN GENDER

Achievements

USAID/Senegal’s health program is aligned with the MoH priority to reduce the burden of high maternal and child morbidity and mortality. Findings from this assessment indicate many accomplishments.

Overall, the USAID health program is having a significant impact on improving access and quality of health care by increasing access to family planning; quality obstetric care; assisted births; pre and neonatal care and malaria control (E.g. long-lasting impregnated bed nets (IBNs)). In Fatick district, the percentage of pregnant women completing all four antenatal visits went from 35.55% in 2010 to 40.44% in 2014. The percentage of assisted births steadily increased from 75.6% in 2010 to 94% in 2014 of all deliveries.90

In interviews with health care workers, they were asked to what extent USAID/Senegal support to their health facility improved access for and demand from women, men and marginalized groups. Health care workers were quick to identify significant changes for women but less so for men and marginalized groups.

USAID and MoH program efforts to build up women’s knowledge of pregnancy, the risks involved and value of following a pregnancy plan to have a healthy pregnancy and safe delivery have been very effective. In all evidence, new approaches in service provision such as increased use of the Integrated Management of Pregnancy and Childbirth (IMPAC) have increased women's interests in seeking regular and proper care and in adopting positive maternal practices.

Weaknesses and Gaps

Neglect in targeting men and youth

The USAID/Senegal health program has not effectively improved access and demand for health care services for men and male and female youth. Most informants in this assessment emphasized that program activities over-focus on women’s needs and roles as mothers and caregivers, neglecting men and boys’ needs and strategic interests. No facilities visited in this assessment had youth friendly spaces and thus were not responding to youth needs for specific safe spaces to access health information and medical care especially in sexual and reproductive health. There is a need to pay attention to the sexual health of pre-adolescents between 10 and 14 years of age to prevent unprotected sexual relations and risk of early and unwanted pregnancies and STIs.

Inconsistent and inadequate physical conditions of health huts

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90 This data is based on a power point document of the Fatick District Health Center health data from 2010-2013, entitled “Région Médicale de Fatick: Synthèse des Données du District de Fatick de 2010-2013” (2014). This information was shared by a Medical Officer at the health center during an interview, November 7, 2013.
Another problem is the variation in quality and physical conditions of health huts. Some health huts visited in this assessment had no electricity, water or doors nor a maternity room. There was no privacy or space for the matron or CHW to consult pregnant women. The poor physical conditions of these health huts discourage women and men from seeking community based care and force them to travel farther to access a health post or center. For some women who have little power in the home and no resources, this further brings delays or the choice not to visit a clinic.

Lack of a volunteer incentive system for community health workers
There is volunteer staff turnover due to weak or no systematic remuneration system whether in cash or in kind. Volunteers interviewed raised the fact that they often are given no incentives for their volunteer work and yet may face pressures from home to stop the work to fulfill their duties at home, whether as income provider or as a housewife.

Women in early to mid-pregnancy delay seeking health services
On the demand side, there is a challenge with most pregnant women still waiting till they are in their second and sometimes even third trimester before visiting a health facility. Due to this, many health facilities have low numbers of pregnant clients coming for all four prenatal consultations. Another factor that dissuades laboring women from going directly to the nearest clinic is the lack of privacy and basic equipment like water or gloves in the maternities.

Opportunities
There are many gender accommodating interventions that are helping to address gender issues impacting health. One key opportunity is to build on the positive changes of Tutorat Plus by fully integrating gender considerations into all training and on the job support. There is an opportunity with the organization of the community health volunteers into community based organizations (CBOs) to support them to generate some income or material benefit to compensate them for their hard work.

4.2 REVIEW OF FINDINGS BY PROGRAM
This section details how each program component is addressing gender constraints and opportunities; and highlights achievements, gaps and opportunities for enhancing gender integration in the future. The IGWG Gender Continuum was used to assess each program’s level of gender integration.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>LEVEL OF GENDER INTEGRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID/Senegal Health Program</td>
<td>Gender aware and accommodating with some elements of gender exploitation due to over-focus and reliance on women as caregivers and clients based on traditional stereotypical roles as mothers and caregivers. Weak institutionalization of gender in whole program.</td>
</tr>
<tr>
<td>Health Services Improvement (HSI) Program</td>
<td>Gender aware and accommodating</td>
</tr>
<tr>
<td>Community Health Program</td>
<td>Gender aware and accommodating</td>
</tr>
</tbody>
</table>
HIV/AIDS/TB Program | Gender transformative  
Health Communication and Promotion Program | Gender blind to aware  
Health Systems Strengthening Program | Gender blind to aware  

Details on why each program was given a certain rating are discussed in detail below.

4.2.1 HEALTH SERVICES IMPROVEMENT (HSI) PROGRAM

**Brief Description**

Implemented by IntraHealth and its partners, Helen Keller International, Medic Mobile and Siggil Jigeen Network (SJN), the HSI program aims to increase use of an integrated package of high quality health services (IPHQS) in 11 regions and a package of high impact malaria services in 14 regions of Senegal. A key objective of this program is to contribute to reducing high maternal and child morbidity and mortality rates in support of the MoH’s focus on achieving the MDGs 4 and 5. The program focuses on building health staff capacity at the facility and district levels and expanding and strengthening service delivery at health posts, health centers and private sector facilities.

To achieve its objectives, HSI uses *Tutorat Plus*, a site-based performance-improvement method that mobilizes all essential actors in a collective process to identify weaknesses and gaps in public and private sector service delivery, clinic functioning and individual/clinic performance. It has specific situational analysis and performance measurement tools for enabling trained health supervisors and staff to identify shortfalls and actions to address them. As part of the HSI program, it has a MNCH strategy to address the underlying causes of morbidity and mortality. One activity is working with CHP volunteers to encourage them to reach out to pregnant women and direct them to seek early obstetric care, to give birth in a health facility and go for facility-based postpartum care.

4.2.1.1 GENDER ACHIEVEMENTS, GAPS, AND OPPORTUNITIES

**Achievements**
The HSI is a gender aware and accommodating program. It recognizes gender inequalities and different needs, interests and roles of women and men in health. It has accomplished both small and more significant successes to addressing gender inequalities impacting health, particularly reducing women’s specific vulnerabilities in reproductive and maternal health.

<table>
<thead>
<tr>
<th>Achievements &amp; Good Practice</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender sensitive tools for conducting a clinic situational analysis and health committee analysis</td>
<td>Tools enable districts, providers, and health committees to identify, examine and address gender and other barriers that affect quality, access and use. These tools are what the MoH has now adopted as possible gender mainstreaming tools for supporting and monitoring equitable access to health services at facility levels.</td>
</tr>
<tr>
<td>Protocol to address GBV in service delivery and GBV prevention tools</td>
<td>To ensure health workers know how to treat and examine victim/survivors in consultations, the MoH’s Bureau of Prevention and Trauma, IntraHealth and other partners developed a set of guidelines and training tools. In 2015, the protocol will be pilot tested in 10 regions to build capacity of health care providers in using the protocol. This protocol has a set of guidelines to respond to GBV for all key responders including</td>
</tr>
</tbody>
</table>

Final Report 12/2014
| **TutoratPlus** | This capacity building approach has accomplished positive change. Findings indicate greater sensitivity of some midwives towards female clients in how they welcome and inquire into the women’s gynecological history and try to invite husbands in for couples counseling. Efforts to strengthen the continuum of care by building close collaboration between matrons, midwives and RH nurses in health centers, posts and at health hut level has helped. Empowering them all to work together to extend outreach services to the community level improves overall availability of maternal and child health care. These approaches are gender accommodating. Improvements are made to women’s access to RH services but deeper gender barriers supporting men’s disengagement from their personal and family health is not addressed. |
| **HSI – CHP Interlinkages using Community Health Workers (Volunteers)** | Outreach workers, community health workers (ASCs) and matrons’ roles to provide women with information on various health issues have contributed to improvements in availability and demand for facility based services. The fact that health information on different packages of services is integrated into all information sharing enhances opportunities for building women’s knowledge of proper maternal and child health practices. The outreach strategy for district and health post personnel to go into communities near health huts for mass vaccinations or HIV/AIDS VCT events is another important strategy. In maternity services at district health center and post levels, midwives have strong support from volunteer matrons. They will work together to provide information sessions and facilitate discussions on key maternal and other health related issues addressed in the package of quality services from malaria, child and maternal nutrition, prenatal consultations to planning the birth. These sessions often take place while women are waiting to be seen by a midwife or matron. It increases women’s knowledge and sharing of information and helps keep them busy and engaged rather than frustrated with having to wait till their turn. It likely increases their interest in coming back for another appointment. |
| **Table de Lumière (The chart of light)** | This monitoring tool helps midwives, nurses and matrons track and follow up with pregnant women, women on family planning or women and their newborns to ensure they come back on time for their next prenatal, family planning and post-natal care. At the end of each month, health staff review patient cards found in the pocket for that month. They will contact these women to remind them of their appointment; and often work with a matron, BG or relays who will go directly to women in the community to convince them to go for their appointment. |
These combined interventions have helped improve access and demand for women and improved access to qualified health care workers and volunteers for women, men and children, including in more isolated communities.

**Weaknesses and Gaps**

**Lack of prioritizing male engagement**

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91 This community-clinic partnership was adapted from a Intrahealth Rwanda model called *Partenariat pour l’Amélioration de la Qualité,* or PAQ. These committees serve to increase clinic responsiveness to community needs and community involvement in solving clinic problems. They serve to increase representation of different social groups such as women’s groups, youth groups and teachers in monitoring and improving quality of service including using funds at their disposal to address specific quality concerns.
The original program proposal committed the program to reaching out to men in their actual work contexts where they spend more time and to engage men in health promotion and awareness raising. As discussed above, the program to increase male workers’ awareness of PIQS and their role in family health is a good initiative. A major weakness, however, are delays in implementation. With only one year left in the program, it is still not fully running in all targeted companies. This is a loss both in terms of supporting men’s health and engagement but also for learning what SBCC techniques are most effective. Another activity has been to train health care providers in counseling and participatory BCC techniques as part of Tutorat Plus. In primary data collection, however, no information on such activities was mentioned.

Need to support MoH to be more sensitive to female health staff’s specific work-life balance issues
In our interviews, district medical officers shared the challenges of staff turnover and gaps in staffing. When female staff go on maternity leave, this can cause challenges for the facility if they do not have someone else to replace them. Female staff, especially the RH coordinators and midwives, explained that their jobs are extremely demanding. For those now acting as Tutorat Plus coaches, they are also expected to go to the health posts once a month to do training and supervision. Female staff said it was difficult to balance their home life responsibilities and the demands of their jobs.

Weak integration of gender in Tutorat Plus training
The Tutorat Plus tools and training modules include gender and teen reproductive health but as very small themes of the whole package. All health care workers interviewed stated that they had never been given any gender training with the HSI program.

Gap in Tutorat PAQ’s role to provide an equitable community feedback mechanism
In this assessment field research, it was found that in some places, the Tutorat PAQ committees are not functioning effectively. They should provide a platform for female and male community members, including different social groups, to voice their concerns and interests in how health services can be improved.

Lack of youth friendly services
The original program proposal makes reference to creating youth-friendly clinics and supporting youth referral networks outside the clinics in schools, health huts and Centers for Youth Counseling to encourage youth to come to health clinics. Secondary and primary data from this assessment indicate that male and female youth are seriously neglected at facility and community levels. This gender assessment team heard that activities to support youth were just beginning to be implemented at the end of this third year of the program implementation. In 2015, IntraHealth’s Ziguinchor Regional staff will be setting up youth friendly services in schools in Ziguinchor and Bignona and will train teachers in adolescent sexual and reproductive health.

Need to assess implications of gender-disaggregated data on program

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92 These strategies are based on national youth friendly service standards as detailed in the National Adolescent Health Policy (2005).
In IntraHealth quarterly and annual reports, the numbers of health providers who received on site training is disaggregated by sex. What is missing is a gender analysis of the relevance of this data to the program. Issues to examine might be whether women and men equally participate in the trainings or whether there is a gender imbalance in the numbers of males versus females participating and why. Such a gender analysis would provide more insights on whether the Tutorat Plus equally benefits male/female health workers.

**Opportunities**

- The proposal mentions supporting human resource assessments and performance targets. This is an opportunity to help the MoH integrate gender sensitive human resource practices such as ensuring gender equitable hiring, retention and promotion and developing formal and informal systems to acknowledge staff who is championing gender. Possible criteria are: all health staff must have a gender objective in their work plans and job performance reviews.

- The SBCC program in private companies to increase men’s engagement in health should be assessed in terms of its potential as a model for scale up to be adapted to multiple settings including health facilities and community levels.

- The HSI engagement to support health facilities to use gender sensitive clinic and community situational analysis tools is very innovative and provides practical ways for district health teams to concretely address gender barriers.

- Opportunities exist in the Tutorat Plus planning cycle to integrate into this system, gender sensitive questions, interventions and benchmarks. This gender integration would assure responsiveness to the different needs and interests of women and men of varying ages and social identities. For example, have indicators that measure provider client responsiveness and client satisfaction with services based on gender, age, social status, disabilities etc.

4.2.2 **COMMUNITY HEALTH PROGRAM (CHP)**

**Brief Description**

The CHP supports the achievement of IR1 with the intended result of increased access to quality community health services. Its main goal is to provide a basic package of preventive and curative services that can respond to pressing primary health care needs of rural communities using a community-based health structure, the health hut. It is focused on ensuring the sustainability and appropriation of these services within the larger health care system and by the communities themselves. The program is implemented by a consortium of seven NGOs, led by ChildFund. The program ensures that health huts have a proper supply of essential health products including contraceptives.

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93 Health huts typically consist of a room for patient consultations and a room for deliveries but conditions of these facilities varies greatly. Some communities have managed to get private funding to improve the physical conditions of the facility while others are in very poor condition and do not even have a functional maternity.

94 Members are ChildFund, Africare, Catholic Relief Services, Plan, World Vision, Enda Santé and Enda Graf Sahel.
These structures are serviced by a team of community volunteers. A Community Health Worker (CHW), or Agent de Santé Communautaire (ASC), is in charge of treating patients in the facility and referring those requiring treatment by a trained health provider to the nearest health post. They offer essential services from rapid testing and treatment of mild cases of malaria to treatment of cuts and bruises, to family planning to treatment of diarrhea and mild malnutrition. There is one or more trained birth attendants, or matrons who provide advice on pregnancy and pre and post natal care, attend emergency deliveries, and offer family planning to interested women. Finally there is a network of outreach workers or relais communautaires, who do most of the community outreach. They play key roles in national health prevention efforts. One example is in malaria control campaigns to encourage all households in the communities they serve to use IBNs (MILDA). Working with health centers and posts, they distribute IBNs to all households and raise awareness on the benefits of using them. These efforts have significantly reduced malaria prevalence.

All volunteer health workers use various community-based participatory approaches such as social mobilisation, facilitated discussions and home visits to discuss health issues, promote healthy behaviors, and encourage use of preventive and curative services available to them at the health hut, health post and health center. They use what Child Fund calls “innovative strategies” to organize community members into interest groups to promote positive health practices. The groups include the grandmothers’ groups, young fathers’ groups, solidarity circles of young mothers and community action cycle (CAC) groups for women, men and youth. These groups focus on peer-to-peer learning and problem-solving all in the name of better health for all. Consortium member field staff also work with these groups to facilitate discussions about changing socio-cultural norms and practices that contribute to poor health practices.

4.2.2.1 GENDER ACHIEVEMENTS, GAPS AND OPPORTUNITIES

Achievements and Good Practices

One key gender related achievement in this program is providing essential and affordable health services to rural women and men close to where they live. This service provision increases women and men’s access to family planning, basic curative care, child nutrition monitoring and malaria testing and treatment. This increased availability to services helps reduce barriers for resource-poor women who may have limited resources to pay for transportation to a health post or center. Another important accomplishment has been to address the deeper socio-cultural norms that contribute to men and boys’ disengagement in health; women and girls’ weak decision making power in health and sexual relations and HTPs such as FGC and GBV.

95 Most CHWs and matrons offer some forms of contraceptives, mainly barrier methods and oral contraceptives. Since 2009, the MoH decided to train CHWs and matrons to offer clients an additional long term contraceptive, injectables, namely Depo-Provera. Not all health huts have been supplied with these methods.

96 NPFA (2014).
Achievements and Good Practices | Evidence
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**Some gender sensitivity in program design – recognizes gender inequalities affecting health** | In the small section on gender in the program proposal, it is recognized that women’s abilities to adopt family planning are constrained by men’s power over them and that men are less interested and involved in village level health activities. To address these gender-based constraints, the program proposal commits to developing and implementing target-specific IEC and participatory education strategies that target not only women-of-reproductive age but male decision makers.\(^97\)

**Increased availability of essential medication and services for resource-poor rural women** | Rural women may be limited in their mobility and access to resources to visit and pay for health care. The CHP’s support to ensuring affordable close-to-home basic services and availability of basic medication and oral contraceptives increases these women’s access to health care. Home visits and community-based information and social mobilization efforts of the volunteer health workers, outreach workers and BG has given rural women greater access to information on maternal and child health and nutrition and other health issues to make healthier choices.

**Engaging with men through home visits and one-on-one counseling** | Community volunteers do home visits and sometimes specifically for the purposes of reaching out to husbands and men on weekends or in the evening to adapt to men’s different schedules. Findings from the gender assessment suggest these strategies are working to increase men’s support of women and children’s health. Outreach workers will do both group-based awareness-raising and home visits to counsel couples. Using a one-to-one approach during a home visit, these volunteers provide more detailed information about family planning to the husband who may be prohibiting his wife from going on FP. The volunteers will try to convince him to be more caring and supportive to his wife and to see the value in child spacing.

**Working with traditional religious and cultural leaders** | Efforts of BGs, outreach workers and of CBOs to reach out to male leaders including imams, priests and local and traditional male and female authorities were considered very important interventions in this assessment’s interviews.

**“Comité de Veille” to create a community based prevention teams against pregnancy and child birth complications** | These committees of women and men are responsible for identifying ways to protect any pregnant women in their communities who may be at risk of child birth complications during labor. They try to put in place a response system to ensure a woman gives birth in a proper health facility on time. Both men and women are mobilized as members, thus engaging men to be agents of change for maternal and child health.

**Solidarity circles of pregnant women** | These groups provide safe spaces for mutual support and sharing birthing experiences and promote good practices for safe delivery. At Tambacounda health hut, Ziguinchor region, the Africare community agent of the CHP actively supported the formation of innovative strategies. In this community--there were four solidarity circles of young women supported

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\(^97\) Care groups are about supporting existing women’s groups to integrate health promotion discussions and activities into their other work.
by the outreach workers, BGs and matrons. These women’s groups use the tradition of tontines\textsuperscript{98} to support pregnant women members before, during and after birth to have basic supplies such as soap, towels, diapers etc. Older generations of women are also members and share their experiences. In turn, they are likely supporting their daughters, daughters-in-law and sons to adopt positive maternal health practices.

### Community Health Care Volunteerism

Based on results from the interviews at community levels, the mobilization and hiring of community health volunteers, of which a large proportion are women, of outreach workers, matrons and CHWs has created opportunities for women to increase their self-esteem, knowledge of positive maternal health practices, their social status, and practice leadership skills. In turn, in accessing various mutually supporting group structures, these women collectively have improved social solidarity including community based savings using the tontines. There is evidence that for women who participate in various groups, they are then better able to express themselves in other groups like the community health committees.

The BG has a whole series of responsibilities which are very similar to the CHP community outreach workers, matrons and CHWs except they do not provide health care services.

Results from the BG initiative have shown that their activities have helped promote female leadership in reproductive health; increased visits to health services and use of contraceptives; increased the numbers of HIV/AIDS tests for pregnant women; increased numbers of pregnant women doing all four PNVs and increased numbers of assisted births.\textsuperscript{99}

This assessment’s field work found similar results from the volunteer health workers’ health promotion activities in terms of increasing community members’ positive health seeking behaviors. It was observed that there is an even greater impact when the BG and outreach workers collaborate in their health promotion activities.

### Community Action Cycle (CAC) approach to address the socio-cultural barriers to adopting positive health practices.

CAC is a best practice community based social behavior change approach that involves individual and group problem identification and solving on pressing health issues. It is well-documented that participatory community-based facilitated dialogues can address delicate gender issues in culturally sensitive ways and allow all stakeholders an opportunity to speak out.\textsuperscript{100} The challenge is how often and over how long these CAC cycles have actually been organized to allow community stakeholders the time and reflection to begin shifting their attitudes and practices towards healthier behaviors.

### Links to GoS’ Bedienou Gokh Initiative

The 2014 Quarterly report states that 7,289 BG were identified by the CHP but only about 50% were actively working. It reports that the CHP supported the remobilization and revitalization (refresher training) of the BGs. These efforts helped revitalize BG activities such as giving orientation sessions to women and men of reproductive age on reproductive health; and conducting home visits to educate women and men on important positive health practices.

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\textsuperscript{98} Informal savings mechanisms.

\textsuperscript{99} Alihouou, Cecile. (2012). Badiene Gokh Initiative, An Community-based approach typically Senegalese to reduce matneral and infant mortality.” Power point presentation, 5\textsuperscript{th} World Congress of SID11EF, Geneva 2012.

\textsuperscript{100} In this method, women and men are organized into age and sex based groups such as the grandmother group, the young women’s group, the men’s group, the pregnant women’s group and the adolescent group. The groups work separately to identify key problems and develop action plans for addressing the issues. Every three months the groups come together to share their problem solving and actions and decide how all the groups can work together.

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practices such as hygiene, use of IBNs to prevent malaria, nutrition and family planning.

<table>
<thead>
<tr>
<th>Supporting men’s groups for maternal health</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the ChildFund national office FGD, staff described support to men’s groups under the CHP. In these groups, it was said that men discuss their role in ensuring safe pregnancy and childbirth for their wives such as not delaying giving money. In Diamniadio, one ChildFund staff member explained that his father’s groups were engaged in debates about how to be attentive to their wives’ health, particularly if she is pregnant and might need to be reminded to take her prescriptions regularly.</td>
</tr>
</tbody>
</table>

**Weaknesses and gaps**

Addressing gender inequalities requires long-term human and financial investments in community behavior change interventions. The innovative strategies have been neglected. The innovative strategies require top-heavy facilitation and support from an experienced facilitator. Consortium member community development agents interviewed in this study described themselves as overworked and unable to supervise all sites and activities under their responsibility. The task of building capacity and supervising communities to take ownership of the health huts was already a large enough responsibility. In the end, support to groups like the solidarity circle of pregnant women or grandmothers groups were no longer functioning in some health hut sites visited due in part to lack of supervision.

**Lack of male and youth community health outreach workers**

Sometimes older female BG/outreach workers or matrons may not be comfortable engaging with youth and men on sexual health. This gender assessment team met very few young and male community volunteers to take on such a task.

**Lack of gender sensitive indicators to track socio-cultural norm changes relevant to gender equality**

A main gap in this program’s design and subsequent reporting is the lack of any gender sensitive or gender specific indicators to track socio-cultural norm changes that might be supported by the various community based interventions. In annual reports for the first two years (2011-2012 and 2012-2013), no reference is made to gender or to gender related activities. Reports present for example, numbers of community health huts revitalized or numbers of trainings conducted in new FP methods but no reporting on numbers of community discussions held and whether there are any signs of socio-cultural norm change.

**Danger of increasing women’s existing work burdens**

There is a need to consider how to remunerate the mainly female community volunteers in a more systemic and realistic way. An unintended consequence of using mainly female community volunteers is increasing women’s work burdens and their low economic status. Moreover, a challenge shared by female volunteers interviewed is the pressure from their husbands, in-laws and children to fulfill their roles as housewives or income-earners and not be community development agents. Some volunteers end up abandoning their jobs as matrons or community mobilizers or BGs because they have to find money for their families or cannot resist the pressure.

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101 Formation of these groups actually came from women themselves who said men must also be organized into groups to increase their awareness.

102 Such indicators include changes in women and men’s perceptions of the acceptability of GBV; or changes in women and men’s control over fertility decisions (E.g. number of children).

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from their families. This staff turnover has had a negative effect on female and male community members’ interest in using the health huts. The program may be gender-harmful, by reinforcing women’s existing heavy burdens and stereotypes that health is a women’s domain. Second in doing this, men disengage from playing a shared and active role in health care decision making. If volunteers are called, men will send their wives.

The CH program has been organizing the community volunteers into community-based organizations (CBOs) to form savings groups to increase their economic standing. One gap is that there is no funding currently available in the program to support these CBOs of BGs, matrons, outreach workers and CHWs to have access to funds for saving and income generating activities.

**Opportunities**

In 2015-2016, there is a plan by USAID/Senegal to support one of the consortium members to run a revolving fund for the community health volunteer CBOs to generate funds both for individual members and for improving the running of the community health huts and outreach work. This program is an opportunity to consider more strategically how to support women’s economic empowerment.

There is an opportunity to strengthen and scale up the various community groups and to invest in developing a cadre of skillful female and male community facilitators. A good model to learn from is Tostan’s CEP and engagement of community facilitators. The aim would be to better organize these various groups to address gender constraints and opportunities for promoting positive maternal and health practices as in the 2006-2011 CHP. The groups like the men’s groups or grandmother groups are important strategies for promoting positive social change. In the previous CHP (2006-2011), CAC cycles to address resistance to FP and to reduce GBV and community protection committees to stop GBV, early marriage and other HTPs were organized. They were, however, supported on a small scale. There is an important option to increase support to such approaches and to effectively monitor and evaluate them for their gender impact on improved health of women and men.

Another opportunity is to strengthen existing collaboration between USAID/Senegal’s own sector programs. The Feed the Future Yaajeende program is supporting Senegalese women farmers to organize into cooperatives to move up the value chain. In the regions of Matam, Kolda and Kedougou, the USAID/Senegal CHP and Yaajeende are implementing in the same communities. Program IPs plan and work together on maternal health and nutrition by targeting the same women’s groups and trying to reinforce each others’ common objectives. Yaajeende is supporting the formation and organization of *mother to mother groups* led by grandmothers that save together, have collective gardens and raise awareness on maternal and child health and nutrition. The CHP also supports these groups under the innovative strategy of care groups. Their combined support will have an even greater impact both on women and children’s health but also on female empowerment.

**4.2.3 HIV/AIDS AND TB PROGRAM (2011-2016)**

**Brief Description**

This program aims to contribute to two USAID/Senegal health program objectives, IR1 and IR 2. Its main objective is to provide targeted, relevant technical assistance and institutional support to the GoS and its partners to maintain a low national prevalence of HIV/AIDS. It aims to reduce transmission in high prevalence areas and among most vulnerable populations (MARPs), and to
improve the quality and availability of treatment, care and support for people living with HIV/AIDS (PLWHIV). Strengthening national capacity to plan and oversee these programs and advocate for appropriate policies is key to the success of this program component.

4.2.2.1 GENDER ACHIEVEMENTS, GAPS AND OPPORTUNITIES

**Achievements**

Out of all the five program components of USAID/Senegal’s health program, this program has more gender transformative approaches and strategies for reducing gender related health disparities. Right from design, gender considerations were integral to the program objectives and activities. The program proposal has a cross-cutting gender strategy. Another major strength is its main implementing partner, FHI360 and its strong institutional commitment and capacity in gender. 103 A full time Social and Behavior Change (SBC) and Gender Technical Advisor plays a central role in the program. Achievements are discussed in the table below.

<table>
<thead>
<tr>
<th>Achievements &amp; Good Practices</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Design is based on solid gender analysis</td>
<td>The program proposal identifies clearly how gender plays a significant determining role in an individual’s vulnerability to disease, ability to access and receive health services and capacity to adopt healthy behaviors. It clearly describes how women’s low decision-making power influences her ability to reduce risks of infection or to live positively with the disease. This strong gender approach is built on a gender study conducted in 2009 on the feminization of the HIV epidemic in Senegal.</td>
</tr>
<tr>
<td>USAID/Senegal’s solicitation for this program required gender as a condition of the contracting agreement including a gender expert</td>
<td>With the hiring of a strong gender expert from the beginning of this program component, she has played a key influential role in raising gender issues in the program and in building gender capacity of the MoH staff such as the National Coordinator of the Gender Unit. She has supported strong gender integration in national responses to HIV and AIDS as exemplified in her role in drafting and finalizing the CNLS Gender and HIV/AIDS policy (2014). Acting as a coach and mentor, she has built awareness and capacity among other USAID/Senegal IPs in gender. In the gender assessment FGD with ChildFund, staff mentioned the important advisory role she has played in helping them better understand gender issues in the CHP.</td>
</tr>
<tr>
<td>Successful gender capacity builder of MoH’s National Committee Fighting Against AIDS</td>
<td>FHI plays an important support role to the National Committee on Fighting HIV/AIDS (CNLS). It has built CNLS’ gender commitment and capacity as evidenced by the establishment of a <strong>CNLS national Gender Committee</strong> to help design appropriate tools for integrating gender into the national HIV programming framework.</td>
</tr>
<tr>
<td>National Gender and HIV/AIDS Policy</td>
<td>FHI360 supported the NCFA to finalize and have approved a national gender and HIV/AIDS policy closely tied to the national HIV/AIDS policy. The policy proposes to develop specific activities to reduce gender inequalities in services that lead to vulnerabilities to HIV such</td>
</tr>
</tbody>
</table>

103 See FHI360 (2012), *Gender Integration Framework: How to integrate gender in every aspect of our work.* FHI360: Washington D.C. US.
Weaknesses and Gaps

- There are some additional innovative gender strategies in the original proposal that have not yet been implemented. One key example is the suggestion of supporting the establishment of a national gender observatory. This observatory would initiate an ongoing structured dialogue with selected communities of women and men of all ages on the what, how and why of gender and HIV to produce culturally adapted communication messages and strategies.

- Of some concern, in several districts where the assessment team went, district health center staff explained that FHI360 had not been as active in the last year in supporting their health services.

- There are ongoing socio-cultural barriers that discourage most men from visiting a health center and thus make it difficult to get men to come in for couples counseling as part of PMTCT.

Opportunities

There are many gender transformative strategies worth noting that could be further reviewed for adaptation and application in the wider USAID/Senegal health program. Good strategies include:

- Focus on MARPs and adapt services to their needs and interest such as using a mobile clinic in Dakar to reach MARPs and mobile phone messaging to build health awareness.

- Working through local NGOs such as the Society of Women against AIDS in Africa (SWAA) and women’s associations who have focal points at regional and district levels who are expert gender, HIV/AIDS and community change facilitators. These local IP staff are placed in health centers and posts to act as CSW and MSM mediators to ensure these vulnerable and often marginalized groups are better welcomed and serviced at facility levels. They offer couples counseling in the facilities. These experts have also trained outreach workers to take on this role.

- FHI works on promoting shared decision making on couple’s fertility desires about family planning. It promotes a dual method use.

- It encourages members of professional and social associations to integrate gender and HIV considerations into the workplace.

- Another good practice is recent efforts of FHI360, ADEMAS and IntraHealth to support couples counseling for prevention of mother to child transmission (PMTCT). FHI360 is training health care workers in gender sensitive HIV/AIDS VCT to encourage couples counseling as part of PMTCT. Based on this assessment’s interviews with health care workers in health posts and centers, midwives, nurses and doctors are trying to encourage pregnant women during antenatal visits to invite their husbands for HIV VCT. With greater attention to engaging men and boys, couple counseling could become an effective approach in clinical settings to promoting more gender equitable decision making in household health care.

- Local IPs work with FHI 360 on HIV/AIDS/TB/STIs awareness-raising and SBC and transformation. The CBOs run monthly “dialogue spaces,” which are facilitated discussions based on selected topics and themes from a pre-analysis of the target groups’ needs. These
facilitators will work with women’s groups, men’s groups, young men’s groups and young women’s groups dividing them up and also bringing them back together to then share differing perspectives. Using these expert facilitation skills and culturally sensitive participatory methodologies, they facilitate the discussions in ways that encourage women and men to reflect on more positive gender equitable values and behaviors. The assessment team did not observe these discussions but only heard from the actual facilitators about their positive impacts.

- Using legal boutiques (Boutique de droit) to provide more accessible legal and psychological support to victims/survivors of GBV. These community based services increase women and girls’ rights to information, psychosocial support and justice following human rights abuses.
- As shown, incorporating a gender position into the solicitation impacts very positively on strong gender integration in a program. There is an opportunity to make mandatory gender expertise in all solicitations including IPs key program staff and in all monitoring and evaluation teams.

There is an opportunity for USAID/Senegal to learn and exchange with its IPs on what works for addressing gender issues in its health programming based on the focus of the specific sub-programs. FHI360 has a role to play in sharing its good practices. Another option to explore is FHI360 building the capacity of other IPs’ gender capacity in the various sub-programs.

FHI360 is supporting associations of PLWHA to offer socioeconomic support services in the form of microcredit, health insurance and micro-gardening. These initiatives might be worthwhile for supporting the CBOs of community health volunteers, women solidarity circles and men’s groups to enable them to better save and create mutual health insurance mechanisms.

4.2.4 HEALTH COMMUNICATION AND PROMOTION (HCP) PROGRAM

**Brief Description**
Implemented by a Senegalese NGO, ADEMAS, the HCP program contributes to achieving IR2, improvements in health seeking and healthy behaviors. Using a variety of advocacy, behavior change communication and social marketing interventions, the program objective is to support the Senegalese MoH and other private and civil society groups to foster positive and sustainable health practices among Senegalese individuals, households and communities. Its main government partner is the National Health Education and Information Service (SNEIPS) and its Bureaus for Health Education and Information (BREIPS) working at regional and district levels. SNEIPS is the main government body coordinating communication and messaging around the promotion of healthier behaviors for all health concerns in the country. ADEMAS works in close collaboration with the other USAID/Senegal health program components, HSS, CHP and HIV/AIDS and TB Program components.

4.2.4.1 GENDER ACHIEVEMENTS, GAPS AND OPPORTUNITIES

**Achievements**
This program’s greatest achievement is basing its social marketing and communication messaging for behavior change on in-depth contextual analyses that pay attention to gender and socio-cultural

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104 For maternal health and family planning, its main target groups are married women of reproductive age with an unmet need for FP and pregnant women. In Malaria, the target groups are pregnant women and caregivers of children under five. In child survival, it is caregivers of under five year olds and in HIV/AIDS, it is mobile populations, mainly men 25-49 years of age that have multiple sexual partners and live and work in high risk areas. It also targets young women (15-24) with multiple partners in high risk areas. In TB, it targets mainly people living with HIV/AIDS (PLWHA) who live in poor crowded living conditions.
factors. In this way, its interventions have responded to important gender issues influencing uptake of family planning by women and men. Below is a list of worthy achievements and good practices that the gender assessment identified:

<table>
<thead>
<tr>
<th>Achievements and Good Practice</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender sensitive analysis informing design of social marketing and communication interventions in HIV/AIDS and reproductive health/FP</strong></td>
<td>The context analysis in the proposal discusses how unequal gender relations and cultural norms impact risk to HIV/AIDS. Based on this analysis, the program proposal commits to promoting greater gender equality for women and girls and to developing program interventions that take gender issues into account and strive to portray more equitable roles for both women and men in social marketing and communication messaging. It commits to targeting the most infected and vulnerable to HIV/AIDS. In addressing reproductive health issues, it emphasizes the need to target women of reproductive age including younger women who are most at risk of unplanned pregnancies.</td>
</tr>
<tr>
<td><strong>Supported SNEIPS’ National Communication Campaign for Family Planning (2013-2014)</strong></td>
<td>Conducted an in-depth situational analysis that involved consulting with women and men of varying ages, ethnic backgrounds, social identities and geographic locations to fully understand how gender/age based relationships impact on decisions and uptake on FP. Results showed the need to first target men because of their power over women’s decision making. The FP interventions shifted from women-only to encouraging joint responsibility. A culturally valued norm to avoid having children too close together, “moytou nef” was chosen as the main campaign message. Other messages such as “My choice, for my family and my wellbeing,” “I discuss with my wife and I support her. I speak with my husband” focused on shared decision-making. The campaign used a variety of mixed media and educational and SBCC techniques including the media, radio, TV, advertisements and facilitated discussions. Radio programs catered to men’s sexual health and reproductive health responsibilities, as well as in facilitated community discussions. In the 2014 Mid-term Evaluation, one significant result is that 23% of men that had been against family planning reported that they were for it after listening to messages from the campaign. This campaign is ADEMAS’ best accomplishment in addressing gender issues.</td>
</tr>
<tr>
<td><strong>Campaigns on condoms</strong></td>
<td>Messages target men and encourage them to take double protection for his wife, other women and himself.</td>
</tr>
<tr>
<td><strong>Track sex-disaggregated data</strong></td>
<td>In tracking behavior change (BCC), sex-disaggregated data are collected to track how many men and how many women who are exposed to training or to a series of messages, change their behaviors.</td>
</tr>
</tbody>
</table>

**Weaknesses and Gaps**

105 The other main partners for this campaign were the MoH’s National Health Education and Information Service and the Direction of Reproductive Health and Child Survival (DSRSE) in partnership with IntraHealth/Senegal Initiative for Urban Health (ISSU) and UNFPA.
A recent Midterm evaluation (2014) of the National Campaign for Family Planning shows that many women and men know about the messages but have not fully changed their behavior from it. One reason is the campaign neglected to fully address prevailing socio-cultural and religious norms that were identified in the situational analysis but require more community-based behavior change interventions and possibly over a longer period of time well-beyond the time frame of the campaign.

This program has no gender strategy, gender sensitive indicators, or staff capacity to fulfill the commitments to gender mainstreaming it defined in its original program proposal. As a result, some of the commitments were never achieved.

**Opportunities**

There are several important opportunities to build on. While ADEMAS' communications and information programming is more gender accommodating in the sense that the objective was to respond to male/female differing interests to using different family planning methods, the MoH/ADEMAS situational analysis of family planning reveal the complex socio-cultural and religious values that impede full acceptance of FP. The next campaign must look more closely at how to address the complex underlying causes from a gender perspective.

One opening is targeting religious leaders. Across the HCP program, different partners have worked with power holders and change leaders in communities to promote health. Religious leaders and Islamic brotherhoods have enormous power and influence on women and men's support or rejection of an issue. There is an opportunity to make a real difference in targeting these groups in campaigning.

When this study team visited ADEMAS, staff interviewed requested much greater support from USAID/Senegal in helping the organization understand gender and how to consider gender in its situational analysis of an issue and resulting campaigns and communication strategies.

4.2.5 Health Systems Strengthening (HSS) Program

**Brief Description**

Implemented by Abt Associates, the HSS program aims to improve performance of the decentralized public health system of Senegal at regional and district levels. This initiative supports the MoH’s own strategic priority of health system strengthening. It aims to build effective and efficient program policies, planning and budgeting at the central level and provides technical and direct implementation support to regional and district medical teams. It is pilot testing Performance Based Financing and looking at ways to strengthen the capacity and sustainability of community-based health insurance schemes. Another sub-component of the program is playing a coordinating and planning role for all the different program components of the USAID/Senegal health program.

4.2.5.1 Gender Achievements, Gaps and Opportunities

**Achievements and Good Practices**

The HSS program pays attention to inequities in access to health in its attention to finding ways to support government policies that can enable more vulnerable populations to access health. The table below details positive achievements and good practices from the HSS program:
<table>
<thead>
<tr>
<th>Achievements and Good Practice</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender and social inequity issues considered in program design.</td>
<td>The program proposal states that the social impact of policy reform at all stages of the policy reform process from central to district levels will be monitored; “Abt’s approach will involve analysis of possible positive and negative downstream effects of policies on quality of care and on specific population segments, including the poor, the disabled, and people living with HIV/AIDS (PLHWA), youth, and women.” It proposes to do this by supporting the MoH to develop socially equitable financing strategies to ensure underserved populations have accessible health facilities.</td>
</tr>
<tr>
<td>Gender considerations in implementation and monitoring</td>
<td>In implementation, social inequity in access to health is being dealt with by improving planning and financing systems. This includes supporting the MoH’s universal free coverage plan and establishment of health micro-insurance schemes.</td>
</tr>
<tr>
<td>Informally pushing for women's increased representation in health microfinance groups (Mutuels de santé)</td>
<td>Based on interviews with USAID/Senegal staff and Abt Associates, Inc, the program tries to ensure women’s representation in new and/or existing private and public health insurance groups. One strategy shared was to initiate discussions with these groups on the advantages of having female leadership and membership such as that many women are better at saving than men.</td>
</tr>
<tr>
<td>Using performance-based financing to create incentives to health facilities to improve reproductive and maternal health services and outcomes</td>
<td>Another good practice is strengthening incentives to provide quality services and meet standards through performance based financing (PBF) to improve maternal and child health outcomes. Other objectives are to use PBF to increase health workers’ productivity and improve health systems performance in terms of clinical quality, information systems and decentralized management. The approach is to have indicators of success that reflect health priorities. Such indicators can measure connections between improvements in the health system, women/men’s increased access to health services and improvements in health outcomes by sex.</td>
</tr>
</tbody>
</table>

**Gaps**

This program is mainly gender blind. The proposal makes commitments to track how policy reforms impact vulnerable groups’ health but there is a lack of a clearly defined approach or set of measurable targets for tracking whether policy changes increase or decrease inequities. The program aims to improve policies guiding health service delivery and support health reforms but nowhere is there attention to how gender inequities should be addressed. In leadership and governance, the program provides capacity building of district and regional health teams but nowhere is there attention to ensuring gender equality in these teams or that women are equally represented in senior leadership. In this assessment’s interviews, district chief medical officers were asked whether they consider gender in their work planning. Most replied that they do not. They do disaggregate health data by sex, but it does not appear that they know or are required to monitor equity issues.

**Opportunities**

This program is about creating equity-driven policies. It could do a lot more if it integrated gender into its approaches and tools for building capacity of the regional and district medical teams who need gender training on how, as decision makers, they can use sex-disaggregated data to track whether improvements to their quality of service and system-delivery is equally improving women and men’s access to services and health status.

There are potential entry points to address gender issues in Abt’s monitoring and capacity building of central, regional and district medical staff. Entry points include integrating gender considerations and tools into its capacity building tools such as in the organizational assessment.
tool called – Reinforcing Capacities through Participatory Self-Evaluation (ORCAP). Another entry point is using the Performance Based Financing Technical Working Group Quality checklist which measures providers’ capacity to practice quality standards. This is a clear entry point for promoting and measuring gender equality.

In addition, FHI360 is also a partner in this program and is responsible for tracking quality of service. This presents two opportunities. First of all, FHI360 has strong gender capacity and could work on measuring quality of service delivery using gender equality standards and targets. As part of trying to maintain downward accountability to the community, the original proposal refers to engaging women's groups at community level in consultations to assess quality of care in RMNCH. This is a good initiative and should be fully realized. It could be done through the Tutorat PAQ community-health provider committees.

Another important entry point is the program’s support to expanding alternative health financing mechanisms by helping increase mutual health insurance initiatives in the context of decentralization. The HSS is supporting the government to promote professional management at the collectivity level of such micro-insurance groups. There are opportunities to set quotas on female/male representation in these collectivities and to train women managers in leadership and communication skills building.

There are opportunities to support the MoH human resources hiring system to be more gender equitable and balanced for addressing gender based gaps in service delivery by a review of the status of women and men in health care workforce to look at:

- Needs and distribution of health care service providers per health centers, posts and health huts;
- Ways to increase retention and needed numbers such as number of midwives needed per health post and center; or
- Need for both male and female employees to ensure offer of culturally sensitive client oriented services;
- Why and how to support retention of women staff in hard to reach places.

The MoH needs support to monitor and redress gender impacts of reductions and relocations of human resources within the health system:

- Are there gendered patterns of segmentation in the health workforce? What is the cause, policies, gender norms at work or gender based constraints such as mobility, domestic responsibilities or security;
- Assess different implications of new assignments for women/men staff due to different gender roles;
- What is the gender breakdown of male/to female staff across the pyramid of the health care system; why are there fewer women in higher level health facility management positions than men?; check whether there is equal pay for equal work and gender equitable promotion.

Opportunities for mutual strengthening and collaboration
The HSS program is responsible for facilitating collaboration and synergies between and among USAID/Senegal’s health program components. In this role, there is an opportunity to work with other program component gender champions on identifying opportunities to strengthen collaboration and impact on gender across all program components.
There are opportunities for mutual strengthening and collaboration with other donors working on performance based financing in maternal and child health and gender capacity building. In future programming, an organization like IntraHealth could play a technical capacity building role. In all the various assessments for quality control, there should be gender criteria for measuring performance in offering gender sensitive services responsive to the different needs and interests of women and men, male and female youth and vulnerable groups. Potential points for collaboration and mutual strengthening are with WHO and LuxDev. These two donors are committed to building capacity in gender mainstreaming, to improving equity in the health system and to using performance based financing as a mechanism for achieving these goals.

4.3 CONCLUDING REMARKS

In summary, there are significant improvements in access and demand of women for all health care services due to the USAID/Senegal health program. There are many good practices to promoting equitable health services and to engaging women and men in challenging socio-cultural norms and practices that hinder women and men from adopting positive health practices and taking advantage of health care services. The absence, however, of a program wide gender strategy and action plan has meant that some of the good work ends up being piecemeal and unsustainable.

A more comprehensive set of gender sensitive objectives and activities across the program would seriously improve the program’s effectiveness and impact on both making the national health care system more gender and socially equitable and responsive and lead to greater reductions in gender inequalities affecting health including other social factors based on ability/disability and age. Interventions must focus on building the capacity of the government health system to be gender responsive and building community knowledge, relationships and structures at individual and household levels for women’s greater economic autonomy for health and wellbeing and for greater joint decision making in health issues. Future programs must pay particular attention to men’s limited involvement in health care promotion and neglect of their health and that of their wife and family. It must also look at how women’s weak decision making limits their capacity to seek prompt care for herself and her children. It must also look at the heterogeneity of women, girls, men and boys’ health needs and statuses. Intersecting factors such as age, ability, educational status and wealth create further disadvantages and specific needs for different marginalized and vulnerable groups.

5 GENDER ASSESSMENT RECOMMENDATIONS

This section draws from the findings of the gender analysis and review of the current health program’s performance in responding to key gender and health issues to define key recommendations. Three overarching recommendations are given and then detailed recommendations are presented, categorized as short, medium and long-term priorities.

5.1 OVERARCHING RECOMMENDATIONS

1. USAID is the main donor partner of the MoH and can use this influence to support the MoH’s recent increased interest to pay closer attention to gender issues affecting health. **Consider mobilizing other donors and partners to develop a harmonized approach and program**
for strengthening institutionalization of gender in the MoH to improve gender responsiveness to inequalities in health, with priority given to RMNCH. Key strategies are:

- Building the capacity of the MoH Gender Unit and GFPs to lead the process;
- Supporting capacity building and system-strengthening activities that support adoption of gender equitable internal practices and systems;
- Fully integrate gender considerations into Tutorat Plus and the integrated package of quality services to promote gender/social equitable service provision; and
- Establish gender and social equitable targets and indicators of success to measure GoS performance.

2. The gender performance review of the current health program identified many good practices to promoting equitable health services and positive community health such as training health professionals on how to respond to GBV. The second overarching recommendation is to **build up and scale up existing good practices** across all five programs using evidence-based gender sensitive to gender transformative approaches and interventions.

3. As the USAID gender integration approach is defined as two-track (female empowerment and gender equality promotion), the last overarching recommendation is to **develop a dual female empowerment/increasing engagement of men and boys strategy that would focus on piloting one to three gender-specific sub-projects.** These projects could consist of GBV prevention and response; increased male engagement in health promotion in RMNCH and women’s economic empowerment for health. For this last project, consider establishing a revolving fund for community health volunteer CBOs and women’s groups for the dual purposes of economic empowerment and mutual health insurance.

As raised by all the interviews, priority must go to engaging men and boys and to create a sense of joint couple and collective responsibility for health. To engage more men, there is a need to encourage more male volunteers as community health workers who represent male youth, fathers and influential leaders.

Women’s and gender sensitive organizations that work directly in communities should be given greater attention by USAID/Senegal. They know the specific socio-cultural and ethnic-based issues underlying certain gender-related barriers affecting health such as cultural beliefs and practices that impede acceptance for family planning or weak intergenerational and couple communication.

Organizations representing marginalized groups should also be more closely consulted and partnered with to ensure USAID/Senegal’s health program addresses the multiple gender and social inequalities affecting health. One example is working with organizations that support the rights of women/girls and men/boys living with disabilities.

### 5.2 ORGANIZATIONAL RECOMMENDATIONS

In order to be able to implement strong gender sensitive to gender transformative programming, certain steps will have to be taken to build the internal capacity and systems of USAID/Senegal health team and its partners.

**Immediately**
The USAID/Senegal team must share the overall findings and recommendations of this Gender Assessment with other USAID/Senegal sector teams. It should hold a stakeholders meeting with the health team and partners to decide on next steps for moving forward a stronger gender agenda for the development of the next health sector or mission strategy. Senior health team leadership should engage with other senior management staff at USAID/Senegal to discuss implications of this gender assessment for strengthening gender integration in the next CDCS.

**Short-term Recommendations (0-1 year)**

- The MoH should be supported to take leadership in reviewing and bringing forward gender assessment recommendations that are directly relevant to its work. It should call a meeting of all relevant partners to discuss the implications of this Gender Assessment’s recommendations to its own agenda and of all partners.
- Select a task team with senior leadership to review the gender assessment recommendations; review with all IPs to identify immediate, short term and longer term actions for strategy development.
- AORs from each program component should meet with key implementing partner staff to review the context analysis and gender performance review of their respective programs.
- Develop a gender strategy for the USAID/health program that supports achievement of the USAID Gender Policy goal and strategic outcomes. Consider full integration of gender into all aspects of the health program. Ensure appropriate sex-disaggregated, gender-sensitive and gender specific performance indicators.
- Review the current list of indicators and integrate a mix of both gender sensitive and gender-equality specific qualitative and quantitative indicators. Qualitative indicators might include: changes to individual or couple decision making in seeking health care or family planning; women’s and men’s attitudes towards gender roles and norms; health-related knowledge for boys/girls/men/women; and changes in attitudes and practices towards HTPs.¹⁰⁶
- Develop a common understanding of key gender concepts, approaches and a vision of change in designing the strategy involving the whole health team and IPs.
- Establish a system for partners and USAID to regularly share good practices, challenges and concerns about gender work in program components and the program as a whole.
- Consult/exchange/collaborate with the Donor Coordination Group on gender & its members to harmonize efforts on supporting gender mainstreaming efforts of MoH and its partnership with MoFWC. Establish a shared system for reporting on and learning from results.
- Involve the MoH and MoFWC to identify common priorities, results and indicators of success.
- Reconsider the role of GFPs in the Mission to ensure gender staffing for moving forward gender agenda; consider making gender a part of all staff job descriptions and performance reviews.
- At partner level, consider making FHI360 and IntraHealth the official technical capacity builders for USAID/Senegal health team, other IPs and the MoH.
- Gender strategy strategies, activities and expected results must be integrated into all relevant program planning and individual and team work plans.
- Create and strengthen partnerships with local women’s organizations, progressive religious associations and dynamic NGOs such as ENDA Santé, LGBT organizations and organizations representing particular marginalized groups such as people living with disabilities.
- Play a more visible and active role in raising gender issues in health regularly and strategically in regular donor and government meetings, in the donor group on gender, with partners and actively seek out and strive to engage in public sessions and meetings where gender and health

¹⁰⁶ FHI 360 (2012: 16). An excellent source is the Compendium of Gender Scales (2011) by C-Change, supported by FHI360 and USAID. It provides relevant gender-equality measures for developing and evaluating interventions in terms of addressing gender norms that undermine health.
issues are themes being discussed and addressed. This more active role will support health
team staff to be more informed on gender and health issues, to play a more influential role and
to be better informed and stimulated on more cutting edge gender and health programs and
research.

**Medium term Recommendations (1-2 years):**
- Gender must become a condition of approval of all program/project documentation. Develop
gender criteria for approval of all solicitations and request for applications; ensure designated
staff and systems are in place.\(^\text{107}\)
- Facilitate training on integrating gender into programming on health. Work with the Regional
Bureau Gender Advisor to collect the most pertinent tools;
- Establish a working relationship with USAID Gender Advisors who can support the health team
in gender integration when needed.
- Conduct an inventory of current gender related tools relevant for integrating gender into
organizational and programmatic plans.
- Identify and establish clear gender guidelines and benchmarks for gender integration in the
program management cycle from design/approval to monitoring and evaluation. USAID already
has such tools and benchmarks, but these must be adopted and socialized among all staff and
partners.
- Establish clear guidelines and a system for ensuring data collection, reporting and M & E
processes consider gender and age and other social inequities. Disaggregated data by sex and
age and if possible by ability/disability and urban/rural location and so on, should be analyzed
and steps taken to address any concerns.
- Be more present and clear on USAID/Senegal commitment to gender equality and female
empowerment in the donor coordination group on gender and in all engagements with MoH.

**Long-term Recommendations:**
- Consider hiring additional technical expertise in gender and public health.
- Establish clear human resource guidelines to support gender equality for partners.
- Strengthen exchange and dialogue with USAID missions and bureaus in Africa region that are
implementing innovative programs; learn and exchange.
- Create ways to consult with female and male program beneficiaries and other marginalized
groups. Consider using Tutorat PAQ groups.

5.3 **PROGRAMMING RECOMMENDATIONS**

**RESULTS AREA: Increasing use of an Integrated Package of Quality Services**

To address inequalities in access and availability of services to women, men, and young women and
men, gender and other social inequity issues must be considered in the comprehensive integrated
package of health services in a systematic and strategic way. At community level, the overarching
recommendation is to look for ways to address underlying gender norms, roles, relations, attitudes
and practices that drive unhealthy behaviors and weak utilization of services. The main issues are
women and girls’ low decision making power and economic dependency on men and men and boys’
disengagement in health issues at all levels.

**Short term recommendations:**

\(^{107}\) See “Sample Evaluation Summary” to assess degree of gender considerations in a proposal (Greene (2013: 22).
● Strengthen and ensure active community feedback mechanisms through which women, girls, men and boys and marginalized groups can voice their concerns and opinions about health care service.

● Strengthen existing partnerships between community health volunteers and facility level health care workers to work together to identify and follow up with husbands or couples to encourage and counsel them in reproductive health and HIV VCT. Use multiple strategies from home visits and individual counseling to opportunities presented when husbands and couples visit a health hut or clinic;

● Consider forming couple groups, like the solidarity circle of pregnant women, to support couples’ communication and joint decision making on health and well-being.

● Scale up health worker capacity building and response to recognize and address GBV.

● Monitor adherence to GBV standards for health care workers.

● Integrate into quality service control mechanisms, specific criteria and strategies for increasing male and youth friendly services and outreach strategies at facility and community levels. These strategies must increase men’s knowledge and awareness of and participation in health care, for themselves but also to be supportive to their wives and children’s health in households and communities.108

● Improve physical conditions of health huts to meet basic standards to increase access of quality service so that more women have access and choose to go in order to increase demand.

● Start revolving funds to support community health volunteers’ CBOs to carry out income generating activities for collective savings for mutual health insurance, helping individual members increase their economic security and for fundraising for the CHH and the groups' collective health promotion, information and basic health care service delivery.

● Increase capacity building of MoH staff at all levels of the health care system and support the Gender Cellule’s efforts to set up gender structures (the GFPs) and a gender integration plan for the whole ministry starting with the gender audit. Consider using IntraHealth’s gender sensitive quality service tools as tools that can be piloted tested and standardized as MoH gender capacity building and monitoring tools for facility staff to identify gender barriers and ways to improve services to respond to these barriers.

● Reinforce and integrate response and referral and screening of GBV into health service delivery including provision of post-exposure prophylaxis (PEP) and emergency contraception (EC) as well as psychosocial support; and

● Increase attention to and address gender and other barriers to women promptly accessing RMNCH services specifically in terms of cost and transportation. Ensure health care workers at health post level are doing outreach and increase and strengthen community organizing such as the Solidarity circles of pregnant women and community protection committees to monitor pregnant women.

Medium term recommendations:
● Review evidence based good practices in making health services more male/youth friendly. Merge with existing strategies.

● Integrate gender into all Tutorat Plus modules; support GFPs to be trained

● Increase, mobilize and engage male and youth relays who can act as role models to and educators for men/youth. Consider using positive deviance techniques.

Long term recommendations:
• Develop a multi-sector GBV IP prevention program focused on most vulnerable women in the Southern region such as CSWs and young married women.

RESULTS AREA: Improved Health Seeking and Healthy Behaviors

Short-term Recommendations:
• Ensure strong gender sensitive situational analysis and considerations in multi-media and multiple channel campaign design.
• Invest in female and male community facilitators who could organize and support the innovative groups to address gender constraints and opportunities for promoting positive maternal and health practices. These group spaces and participatory approaches are important strategies in this program for promoting positive social change.
• Strengthen synergies and collaboration between USAID/Senegal’s own sector programs. Begin with Yaajeende and the health program’s support to women's groups in maternal and child health and nutrition in the regions of Matam, Kolda and Kedougou.

Medium term recommendations
• Review what the best evidence based social and behavior change and communication approaches for community social and gender transformation. Approaches should engage women and men, and boys and girls and have representation of diverse social groups including people living with a disability and female traditional influencers like mother-in-laws and traditional leaders and local authorities. Review best strategies for positive deviance activities and group-based education for engaging men and youth to be supportive partners and role models in health promotion. Learn from Tostan, the MoFWC and UN donors. Some possible interventions that could be integrated into existing innovative strategies are:
  ▪ Consider the Stepping Stones curriculum that engages women and men separately and then together in facilitated conversations about positive and negative aspects of gender norms and relations that may be harmful to communities and specific community members and community based solutions to change them to benefit all.
  ▪ Other important initiatives is the Instituto Promundo (www.promundo.org.br) and Program H that work with men and boys on gender norms and practices that support GBV and poor health and development outcomes.
  ▪ Tostan’s Community Empowerment Program (CEP) is grounded in universal human rights; uses a holistic non-formal educational development process; works in local languages and methods of communication and learning; is based on long-term engagement in the communities in which the program works; and pays attention to the specific socio-cultural context of West Africa. Several studies and evaluations of Tostan’s CEP program have shown its positive impacts on social behavior change, community empowerment and overall health and wellbeing.
  ▪ Consider adopting and learning from the USAID-funded Health Commodity Capacity Collaborative (HC3) approaches and research for addressing gender inequalities that impede

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109 Positive deviance is a social, organizational, and individual behavior change approach based on identifying role models in a community who may demonstrate uncommon exemplary behaviors to health and everyday problems that enable them to better deal with health issues. In this approach, these individuals or groups are identified and encouraged to influence their peers and to lead by example. Go to http://www.comminit.com/global/spaces-frontpage.
Infuse the best evidence based gender equitable participatory methods into all innovative strategies; track impacts. Innovative strategies include the men’s groups, CAC community organizing and action planning, GBV protection committees and surveillance for pregnant women; dialogue spaces with couples; youth spaces in clinics and support to relevant youth centers that have recently been neglected.

RESULT AREA: Gender Sensitive Health Systems Strengthening

Short term recommendations:

- Support gender training and capacity building of leadership, mainly district and regional medical teams; and the development of criteria and tools for ensuring gender considerations in annual technical plans, in data collection and reporting.

Medium term recommendations

- Strengthen existing efforts of donors to support the MoH to effectively mainstream gender into its internal systems (e.g. human resource management) and its services and products.
- Support the MoH to develop gender equality benchmarks for what different health staff and levels of the health system must be expected to achieve in gender. The strategic focus can be in RMNCH. In setting gender equitable targets, both medical and wider social indicators of changes to gender relations as linked to health outcomes should be used. Important changes and differences to capture in indicators and targets are: evidence of gender sensitive hiring, retention and promotion of staff, or reported male and female client satisfaction with services or increases in men and couple consultations.
- USAID/Senegal should consider supporting a system for sharing and using the gender equality results information to feedback into improving health services and equity for improved performance.
- Consider officially recognizing IntraHealth and FHI to be the technical capacity builders of the MoH and other partners in gender integration.
- USAID recently published an etraining course in gender and health systems strengthening – USAID staff should do the 2.5 hour course.
- Support the MoH to integrate gender sensitive human resource practices such as ensuring gender equitable hiring, retention and promotion and developing formal and informal systems to acknowledge staff championing gender. Possible criteria are: all health staff must have a gender objective in their work plans and job performance reviews.
- Set quotas on female/male representation in some collectivities and train women managers in leadership and communication skills building. There are entry points to work with the agricultural sector program and its work with and support to rural farmers groups and possible women’s groups to learn to save and use a percentage for funding health care insurance.

113 Payne, S. (2009) How can Gender Equity be addressed through health systems?
● There are opportunities to support the MoH human resources hiring system to be more gender equitable and balanced for addressing gender based gaps in service delivery by a review of the status of women and men in health care workforce.

**Long term recommendations**
● In performance based financing, gender integration benchmarks could be set up for reviewing different levels of the health system and facility level of effective gender mainstreaming. Equality indicators could include evidence of gender sensitive hiring, retention and promotion of staff, or reported male and female client satisfaction with services or increases in men and couple consultations. Other tools that can help are: gender budgeting, gender impact assessments, targets for health outcomes and gender tools. In setting gender equitable targets, both medical and wider social indicators of changes to gender relations as linked to health outcomes should be used.\(^{114}\)

In Annex 7, a roadmap of actionable recommendations and approaches based on these recommendations is provided.

\(^{114}\) Payne, S. (2009), *How can gender equity be addressed through health systems?* Policy Brief 12. WHO Regional Office for Europe: Copenhagen.
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115 Please note that the Ministry of Family, Women and Children’s name varies. In this report, the Ministry is referenced by the French Acronym (MoFWC). Its name varies from the Ministry of Family, National Solidarity, Women’s Entrepreneurship and Microfinance and Children to Ministry of Women, Children and Women’s Entrepreneurship to Ministry of Family, Women and Children.

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### Annex 1: Gender-related Data for Senegal

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population of Senegal&lt;sup&gt;116&lt;/sup&gt;</td>
<td>14.13 million</td>
<td></td>
</tr>
<tr>
<td>Human development index&lt;sup&gt;117&lt;/sup&gt;</td>
<td>154&lt;sup&gt;th&lt;/sup&gt; out of 187 countries</td>
<td></td>
</tr>
<tr>
<td>Gender Inequality Index (GII)</td>
<td>115th out of 148 countries</td>
<td></td>
</tr>
<tr>
<td>Gender-related Development Index&lt;sup&gt;118&lt;/sup&gt;</td>
<td>163&lt;sup&gt;th&lt;/sup&gt; out of 187 countries</td>
<td></td>
</tr>
<tr>
<td>Social Institutions and Gender Index (SIGI)&lt;sup&gt;119&lt;/sup&gt;</td>
<td>Ranked medium</td>
<td></td>
</tr>
<tr>
<td>No formal education (F/M, 15-49 years)&lt;sup&gt;120&lt;/sup&gt;</td>
<td>39.4%/ 57.9%</td>
<td></td>
</tr>
<tr>
<td>Primary education gender parity index&lt;sup&gt;121&lt;/sup&gt;</td>
<td>1.07</td>
<td></td>
</tr>
<tr>
<td>Secondary education gender parity index&lt;sup&gt;122&lt;/sup&gt;</td>
<td>0.93</td>
<td></td>
</tr>
<tr>
<td>Employment (F/M)</td>
<td>66.1%/88.4%</td>
<td></td>
</tr>
<tr>
<td>Women in parliament (in %)&lt;sup&gt;123&lt;/sup&gt;</td>
<td>41.6%</td>
<td></td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>5.3</td>
<td></td>
</tr>
<tr>
<td>% of women married before the age of 18</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Girls aged 15-19 years of age who are married, divorced or widowed&lt;sup&gt;124&lt;/sup&gt;</td>
<td>29.7%</td>
<td></td>
</tr>
<tr>
<td>Maternal mortality rate&lt;sup&gt;125&lt;/sup&gt;</td>
<td>392</td>
<td>Per 100, 000/births</td>
</tr>
<tr>
<td>Adolescent fertility rate</td>
<td>89.7</td>
<td>Per 1000 births</td>
</tr>
<tr>
<td>% of girls who have given birth or were pregnant by the time they reached 20 years of age in 2010&lt;sup&gt;126&lt;/sup&gt;</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Infant mortality rate&lt;sup&gt;127&lt;/sup&gt;</td>
<td>65</td>
<td>Per 1000 live births</td>
</tr>
<tr>
<td>Births attended by a skilled provider&lt;sup&gt;128&lt;/sup&gt;</td>
<td>51%</td>
<td></td>
</tr>
<tr>
<td>Births attended by a skilled provider for the lowest wealth quintile</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Births attended by a skilled provider for women from rural areas</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>% of women who received antenatal care from a skilled health provider</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS prevalence rates by F/M</td>
<td>0.8%/0.5%</td>
<td></td>
</tr>
<tr>
<td>Highest rates for women and men by region</td>
<td>Kedougou &amp; Kolda</td>
<td></td>
</tr>
<tr>
<td>Men who have sex with men (MSM) – MARPs&lt;sup&gt;129&lt;/sup&gt;</td>
<td>18.5%</td>
<td></td>
</tr>
<tr>
<td>Commercial sex workers (CSWs) - MARPs&lt;sup&gt;129&lt;/sup&gt;</td>
<td>18.5%</td>
<td></td>
</tr>
<tr>
<td>Other vulnerable populations to HIV/AIDS</td>
<td>Women and young women and men; mobile populations that move internally or across borders</td>
<td></td>
</tr>
</tbody>
</table>

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<sup>118</sup> GDI is often defined as providing the gender dimensions of the HDI. It looks at wealth and wellbeing differences by groups and gender gaps in life expectancy, education and income.

<sup>119</sup> [http://genderindex.org/ranking](http://genderindex.org/ranking).

<sup>120</sup> DHS (201-2011).

<sup>121</sup> The Gender Parity Index (GPI) is a key measure of gender equality and women’s empowerment in education. GPI describes sex-related differences in school participation ratios based on the ratio of female to male enrolment, attendance or completion. A GPI of 1 means there is equality between school participation ratios for males and females and a lower GPI than 1 indicates that there are more males than females in school.

<sup>122</sup> DHS (2010-2011).

<sup>123</sup> Both employment and political representation data come from Senegal’s Human Development Report (2013).

<sup>124</sup> DHS (2010-2011).

<sup>125</sup> DHS (2010-2011).

<sup>126</sup> DHS (2010-2011).

<sup>127</sup> DHS (2012-2013).

<sup>128</sup> All data on attended births are from the C-DHS (2012-2013).

including security forces, truck drivers, fishermen and women, traders and miners.  

<table>
<thead>
<tr>
<th>Highest HIV/AIDS states among young women and men by region</th>
<th>Kolda (1.4%), Sedhiou (1.1%), and Ziguinchor (0.9%).</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of people living with HIV/AIDS that have access to ARVs</td>
<td>56%</td>
</tr>
<tr>
<td>% of health centers and posts that offer PMTCT services</td>
<td>97%</td>
</tr>
<tr>
<td>Girls aged 20 and below who have already given birth or are pregnant</td>
<td>19%</td>
</tr>
<tr>
<td>Modern Contraceptive prevalence</td>
<td>5% in 1992 to 16% today</td>
</tr>
<tr>
<td>Urban/rural disparities in modern contraceptive use</td>
<td>27%/9%</td>
</tr>
<tr>
<td>Lowest/highest wealth quintiles use of modern contraceptive rates</td>
<td>6%/30%</td>
</tr>
<tr>
<td>% of women/men who can name at least one form of contraception</td>
<td>90%</td>
</tr>
<tr>
<td>Unmet need for FP</td>
<td>29%</td>
</tr>
<tr>
<td>% of girls under 15 who undergo FGC</td>
<td>18%</td>
</tr>
<tr>
<td>% of women 15-49 years who have undergone FGC</td>
<td>26%</td>
</tr>
<tr>
<td>% of girls who have undergone FGC between 0-9 who underwent the most extreme form of genital infibulations</td>
<td>7%</td>
</tr>
<tr>
<td>Highest rates of FGC by region</td>
<td>Southern (47%) and Northern (33%) regions</td>
</tr>
<tr>
<td>% of women per ethnic group who have undergone FGC</td>
<td>78.2% of soninke, 73.7% of mandingue, 62.1% of pulaar, 59.7% of diola, 1.8% of serer and 1.6% of wolof ave undergone FGC.</td>
</tr>
<tr>
<td>Girls aged 15-19 years married, divorced or widowed</td>
<td>29.7%</td>
</tr>
<tr>
<td>% of service delivery points that offer at least one modern method of FP</td>
<td>85%</td>
</tr>
<tr>
<td>Three most popular FP methods</td>
<td>1) Long term injectables; 2) Oral contraceptive pills; and 3) Implants</td>
</tr>
<tr>
<td>% of health facilities that offer injectables</td>
<td>63% (progestin-only) 38% (combined)</td>
</tr>
</tbody>
</table>

130 Additional vulnerabilities are worth noting. Among minors, women are more vulnerable than men (2.5%/0.8%). Among truck drivers, those who are least educated, in polygamous marriages, and dependent on alcohol are more at risk. Those living with disabilities are also more vulnerable such as 1.2% in Dakar and 2.7% in Ziguinchor. Note that in most regions young women are more vulnerable than men except in Kolda and Tambacounda where rates are higher among younger men than younger women. This data was taken from http://www.cnls-senegal.org/index.php/2013-05-28-20-19-22/situation-epidemiologique, 12/12/2014.
133 DHS (2012-2013). This service includes which include HIV voluntary testing and counseling (VTC) for pregnant women and infants born of HIV positive mothers; infant and child nutrition counseling, family planning for HIV-positive mothers and ARV prophylaxis for HIV positive pregnant women.
134 DHS (2010-2011).
135 C-DHS (2012-2013).
136 C-DHS (2012-2013).
137 DHS (2010-2011).
138 C-DHS (2012-2013).
139 C-DHS (2012-2013).
141 DHS (2010-2011).
ANNEX 2: LIST OF ORGANIZATIONS AND INDIVIDUALS CONSULTED

<table>
<thead>
<tr>
<th>Organization</th>
<th>Individuals</th>
<th>Position</th>
<th>Contact Details</th>
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<tbody>
<tr>
<td>USAID</td>
<td>Ramatoulaye Dioum</td>
<td>Deputy Director, Advisor on Reproductive Health/Maternal Health</td>
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<td>AOR ABT Associates</td>
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</tr>
<tr>
<td></td>
<td>Oumar Sagna</td>
<td>AOR G2G</td>
<td>775677330; <a href="mailto:osagne@usaid.gov">osagne@usaid.gov</a></td>
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<tr>
<td></td>
<td>Moussa Diakete</td>
<td></td>
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<tr>
<td></td>
<td>Khadidiatou Aw</td>
<td>AOR Ademas</td>
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<td></td>
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<td></td>
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<tr>
<td></td>
<td>Mary de Boer</td>
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<td>+221-33-879-4566; <a href="mailto:mdeboer@usaid.gov">mdeboer@usaid.gov</a></td>
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<tr>
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<td>Debbie Gueye</td>
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<tr>
<td></td>
<td>Abdouraman Diallo</td>
<td>Mission Gender Specialist</td>
<td><a href="mailto:abdiallo@usaid.gov">abdiallo@usaid.gov</a></td>
</tr>
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<td>John Bernon</td>
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</tr>
<tr>
<td></td>
<td>Pape Dieye</td>
<td>Economic Strengthening, Yajende Program</td>
<td><a href="mailto:pdieye@usaid.gov">pdieye@usaid.gov</a></td>
</tr>
</tbody>
</table>

Implementing Partners

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|               | Francois Diop | Cheif of Party, USAID funded Health Strengthening Program |

Child Fund – National Office & Regions

| Dr Aida Tall | Technical Advisor, Chief of Operations; Community Health Program | 221 766370041; amfaye@senegal.childfund.org |
| Mme Adji Faye | Focal Point for the Community Health Program, Dakar Region; Gender Focal Point for Child Fund |
| Sebastien Diatte | National Advisor for Reproductive Health/Family Planning USAID |
| Mr Mboye | National Coordinator for Child Health, Assistant in M&E |
| Mme. Sisi | Program Assistant for Reproductive Health/Family Planning |
| Pape Aboulaye Dieng | Regional Supervisor, Diamniadio, Dakar | 77 509 0231 |
| Philip Gomes | Community Development Officer, Guinarails |
Moussa NDOUR  Regional Supervisor, Kaolack

Gorgui Sarr  Community Development Officer, Diofior

Abdou Salam Diatta  Zonal Representative, Ziguinchor  77 5364 13; asdiatta@africare.org

Oumou NIANG  Community Development Officer, Kaolack  77 445 49 99

Omou Kalsoum Niang  Community Development Officer, St-Louis

Pape Moussa Kamara  Espace Ado (Youth Space), TB Supervisor for Plan, Trainer VGB  77 5408417

Alison Malmqvist  Executive Director, ADEMAS

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Mr. Amadou Loum Diop  Regional Supervisor, ADEMAS  76 639 2124; damadouloum@ademas.sn

Kémo Diatta  Supervisor, ADEMAS, Ziguinchor

Gayessiry Niang  Regional Supervisor, ADEMAS, St-Louis  77 655 50 06

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Dr. Moussa Dia  Gender focal point, HSI

Dr. Gueye  Director, IntraHealth

Ibrahima Faye  Regional Coordinator, Fatick  77 1056269

Malick Sarr  Regional Coordinator, Ziguinchor  77 105 94 28

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JICAS

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Dr. Miriam Sylla  766841960; mmsdiene@unicef.org

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AMREF

DR NGOM  Director  77333 6442

FHI360

Abdoulaye Hanne Ndoye:  Technical Director

Maimouna Ndoye  Gender Advisor

Mmsdiene@unicef.org

Maimouna Ndoye  Gender Advisor

acanssfhi@fhi.org
<table>
<thead>
<tr>
<th><strong>Women’s Associations (FAFS)</strong></th>
<th><strong>Dieng</strong></th>
<th><strong>Fatou Ndiaye Turpin</strong></th>
<th>Program Coordinator</th>
<th>77 6564131 ; siggiljigeen@gmail;com</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alliance Francaise for Development (AFD)</strong></td>
<td><strong>Dr. Malick Ndiaye</strong></td>
<td>Program Coordinator, Health Program for Women and Children</td>
<td>77 6306727</td>
<td></td>
</tr>
<tr>
<td><strong>Women’s Association – Djyito Dimalaguene,</strong></td>
<td><strong>Mme Silandinga Sane</strong></td>
<td>Director with 8 other members including only male member (SWAA), Ziguinchor (SWAA partner)</td>
<td>77 655 6263</td>
<td></td>
</tr>
<tr>
<td><strong>UNWOMEN</strong></td>
<td><strong>Mbarou Gassama</strong></td>
<td>Representative</td>
<td>774560561, <a href="mailto:mbarou.gassama@unwomen.org">mbarou.gassama@unwomen.org</a></td>
<td></td>
</tr>
<tr>
<td><strong>Society of Women Living with AIDS in Africa (SWAA)</strong></td>
<td><strong>Mme. Mariam Diallo</strong></td>
<td>Focal Point, SWAA, Ziguinchor</td>
<td>77 592 7958</td>
<td></td>
</tr>
<tr>
<td><strong>Committee Fighting against Violence against Women (CLVF)</strong></td>
<td><strong>MRS Mame Diarra DIOP</strong></td>
<td>Coordinator, Committee against Violence to Women</td>
<td>77 2457869</td>
<td></td>
</tr>
<tr>
<td><strong>Belgian Technical Cooperation (BTC)</strong></td>
<td><strong>Mr. Issa Diagana</strong></td>
<td>Gender Advisor</td>
<td>77 559 9805, <a href="mailto:Issa.diagana@btccctb.org">Issa.diagana@btccctb.org</a></td>
<td></td>
</tr>
<tr>
<td><strong>Lux-Dev</strong></td>
<td><strong>Mr. Mor Gueye</strong></td>
<td>Representative</td>
<td>776404992, <a href="mailto:mor.gueye@luxdev.lu">mor.gueye@luxdev.lu</a></td>
<td></td>
</tr>
<tr>
<td><strong>WHO</strong></td>
<td><strong>Dr. Fatim Tall Thiam</strong></td>
<td>Representative</td>
<td>775547854, <a href="mailto:tallf@who.int">tallf@who.int</a></td>
<td></td>
</tr>
<tr>
<td><strong>Dr. Selly Kane</strong></td>
<td><strong>UNFPA</strong></td>
<td></td>
<td>77 8424505, <a href="mailto:kanewane@unfpa.org">kanewane@unfpa.org</a></td>
<td></td>
</tr>
<tr>
<td><strong>Radio Kassoumaye</strong></td>
<td><strong>Georges Selou</strong></td>
<td></td>
<td>774247888</td>
<td></td>
</tr>
<tr>
<td><strong>Radio Alfayda</strong></td>
<td><strong>Imbrahima Gaye</strong></td>
<td>Person Responsible</td>
<td>77 6403566</td>
<td></td>
</tr>
<tr>
<td><strong>CBO Red Cross Communale</strong></td>
<td><strong>Mbagnick Ndiaye</strong></td>
<td>Person Responsible</td>
<td>77 647 4568</td>
<td></td>
</tr>
<tr>
<td><strong>Radio Communautaire Laghem FM, Ndoefane Kaolack</strong></td>
<td><strong>Mr Moussa Sadio</strong></td>
<td>Coordinateur Croix Rouge projet avec ADEMAS; Coordinateur projet Intermonde avec FHi</td>
<td></td>
<td></td>
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<tr>
<td><strong>Midterm Evaluation of USAID/Senegal Health Program Team</strong></td>
<td><strong>Ruth Kornfield</strong></td>
<td>Team Lead</td>
<td><a href="mailto:rkornfield@yahoo.com">rkornfield@yahoo.com</a></td>
<td></td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>Mr. Daff</td>
<td>DSRE (Direction for Reproductive Health), MoH</td>
<td>77 644 9222; 77 555 4417</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>---------</td>
<td>-----------------------------------------------</td>
<td>--------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MR DIAGANA</td>
<td>Gender Technical Advisor, MoH</td>
<td>77 6361724; <a href="mailto:Ndeyeminguendiate@hotmail.fr">Ndeyeminguendiate@hotmail.fr</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MRS GAKOU</td>
<td>National Coordinator, Gender Unit</td>
<td>77 6361724; <a href="mailto:Ndeyeminguendiate@hotmail.fr">Ndeyeminguendiate@hotmail.fr</a></td>
<td></td>
</tr>
</tbody>
</table>
|                     | DR NABOU DIAKHATE | National Gender Advisor | 776394418
|                     | Aissatou sanou COLY | National Coordinator of Family Planning | 776318258
|                     | Seni KONTE | Gender focal point of Direction of Sexual Reproductive Health (DSRSE) | 77 525 54 53 |
|                     | Mme. Toure Asta DIOP | Gender focal point, Regional Medical Office, Fatick, Focal Point Reseau Siggui Jigueen (RSJ)/IntraHealth; Representative of SWAA; and Coordinator of FAFS, Fatick | diopndeyeasta@yahoo.fr |
| Ministry of Women, Family and Children (Femmes, Famille et de l’Enfance) | Pape Diallo | Regional Director, Southern Region | 221-77 645 77 91 |
|                     | MRS Absa Wade | Director, Direction of Gender, Ministry of Women, Family and Children) | 779606512/777406958
|                     | Mr Abdoulaye Djiby Sambou | Regional Director, Saint Louis | wadabsa@yahoo.fr |
| AEMO (Action éducative en milieu ouvert (AEMO) | Mme Dabo | Lawyer, legal aid, Fatick, (Child Protection & GBV) | 779606512/777406958
|                     | Mme Dabo | Lawyer, legal aid, Fatick, (Child Protection & GBV) | wadabsa@yahoo.fr |
ANNEX 3: TOOLS OF ANALYSIS

The gender analysis looked at gender issues affecting health status at the individual, community and institutional levels and variations within and between regions. It looked at gender-based power dynamics and norms and practices that influence women, girls and men and boys’ health. These more hidden factors have changed over time and vary across and between regions and ethnic groups. As they are changeable, they must be considered and addressed in any health program.

The gender analysis used USAID’s gender integration (GI) approach. Based on the 2012 Gender Policy, all country Missions should develop strategies that address gender inequalities that both limit women and girls from reaching their full potential and advance equality between males and females in the whole program cycle. This requires addressing gender inequality in program/project design, implementation, monitoring and evaluation. These institutional directions provided clear guidelines on how the USAID/Senegal country mission should integrate gender internally and across all policies and programs.  

A gender analysis typically involves examining:

- Differences in the status of women and men and their differential access to assets, resources, opportunities and services;
- The influence of gender roles and norms on the division of time between paid employment, unpaid work (including subsistence production and care for family members), and volunteer activities;
- The influence of gender roles and norms on leadership roles and decision-making; constraints, opportunities, and entry points for narrowing gender gaps and empowering females; and
- Potential differential impacts of development policies and programs on males and females, including unintended or negative consequences.

It will identify how gender norms and inequalities may undermine health and should be addressed in programming. It will collect data on gender relations, roles, and identities relevant to the achievement of program outcomes and analyze gender data for constraints and opportunities that may affect, impede, or facilitate program objectives. National descriptive statistics on the status of males and females, ideally disaggregated by age, income, ethnicity, location, lesbian, gay, bisexual and transgender (LGBT) or other socially relevant category as appropriate, in: education, health, political participation, economic activity and earnings, time use, violence and other domains etc will be integrated in the analysis. This data helps understand the relative roles and opportunities of men and women to the social, economic, and political situation of Senegal.

Domains of analysis will include:
- Laws, Policies, Regulations, and Institutional Practices that influence the context in which men and women act and make decisions. Laws include formal statutory laws and informal and

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142 See USAID Gender Equality and Female Empowerment Policy (2012, p.3) definitions of gender, gender equality, female empowerment and gender integration. The main guidelines are found in “Tips for Conducting a Gender Analysis at the Activity or Project Level” (USAID 2011); Guide to Gender Integration and Analysis: Additional Help for ADS Chapters 201 and 2013” (USAID 2010); “ADS Chapter 205: Integrating Gender Equality and Female Empowerment in USAID’s Program Cycle” (2013); GHI Supplemental Guidance on Women, Girls, and Gender Equality Principle” (2011).
customary legal systems. Policies and regulations include formal and informal rules and procedures.

- **Cultural Norms and Beliefs**: Every society has cultural norms and beliefs (often expressed as gender stereotypes) about what are appropriate qualities, life goals, and aspirations for males and females. Gender norms and beliefs often limit or enable women/girls and men/boys’ life choices and status in society.

- **Gender Roles, Responsibilities, and Time Used**: The most fundamental division of labor within all societies is between productive (market) economic activity and reproductive (non-market) activity. This is the central social structure that characterizes male and female activity. Gender analysis should examine what males and females do in these spheres, including roles, responsibilities, and time used during paid work, unpaid work (including in the home), and community service to get an accurate portrait of how people lead their lives and to anticipate potential constraints to participation in development projects.

- **Access to and Control over Assets and Resources**: A key component of gender analysis is an examination of whether females and males own and/or have access and the capacity to use productive resources – assets (land, housing), income, social benefits (social insurance, pensions), public services (health, water), technology – and information necessary to be a fully active and productive participant in society. While gender gaps in access to resources can be identified at the country level, they are especially important at the project/program level.

- **Patterns of Power and Decision-making**: This domain of gender analysis examines the ability of women and men to decide, influence, and exercise control over material, human, intellectual, and financial resources, in the family, community and country. It also includes the capacity to vote and run for office at all levels of government. Analyses should examine to what extent males and females are represented in senior level decision-making positions and exercise voice in decisions made by public, private, and civil society organizations.

It will identify the strengths and weaknesses of government, donor, multilaterals (United Nations, World Bank, and others), the private sector, the media, and NGO representatives with regard to gender and health, and the opportunities for working with these groups to address gender inequalities and improve health. Guiding questions for the analysis are:

- What do you see as the major gender issues in health and other sectors that affect health?
- In each relevant sector (e.g., health, education, agriculture, youth, women’s affairs/gender, labor force), what are some of the major policies, laws, and regulations that might affect health? Do any policies or programs work to reduce legal and policy disparities affecting health?
- What are the roles and opportunities for men and women in this country? How do these roles and opportunities differ among various ethnic and religious and geographical groups? How do they vary according to other differences, such as socioeconomic class, sexual orientation, and disability?
- How have they changed over time and how do they differ by age across the life cycle?
- What do the major social, economic, and political indicators tell us about gender inequality in Senegal? What are the most acute gaps, disparities, and constraints faced by women/girls and men/boys?

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143 See USAID ADS Gender Guidelines.
What are the links between the prevailing gender norms (both attitudes and practices), gender inequality, and health outcomes of interest?

The IGWG Gender Integration Continuum was used to measure the USAID/Senegal health program performance in gender integration and impact. It provides three standard levels to assess whether and to what degree programs were gender sensitive and had transformative potential for gender equitable health outcomes.

- **Gender blind** programs and policies ignore gender differences and treat all beneficiaries the same. Some gender-blind programs or policies may benefit women and transform inequalities without having accounted for gender differences. For example, a policy for improving quality of health care services might significantly improve access for women and men. When gender is not considered at all, interventions may be gender-harmful or exploitative. These strategies or programs may unintentionally widen or exacerbate inequalities between men and women or boys and girls and even reinforce social stereotypes or rely on existing inequalities and social norms to obtain a development end. Such strategies should be avoided.

- **Gender sensitive** or aware programs recognize the specific needs and realities of women and men, boys and girls based on the social construction of gender roles and respond to them accordingly. This level of awareness may be informed by a sound gender analysis that has looked at the specific assets of men and women and assessed how to accommodate their different roles and needs. These approaches, however, may not transform social or cultural barriers that perpetuate uneven gender power relations.

- **Gender transformative** programs seek to transform gender roles and promote more gender-equitable relationships between men and women. This level of awareness is informed not only by an analysis of the practical needs of males and females based on their respective roles, but also the underlying structural and systemic issues that have created and sustained the different needs of men and women. This type of program is designed to not only meet the practical needs of men and women but also respond to the strategic interests for greater, more sustainable equity between sexes.

The term **gender accommodating** was used to describe interventions that recognize gender differences and inequalities and “[...] seek to develop actions that adjust to and often compensate for them” but without addressing the deeper gender norms or structures that reinforce gender inequalities. In this way, interventions may follow a “Women in Development” (WID) approach whereby activities aim to improve women’s health status based on their traditional roles and needs rather than their more strategic interests. This is opposed to a more transformative “Gender and Development” approach which explicitly aims to redress and change power inequalities for more gender and socially equitable dynamics. Based USAID’s gender policy, USAID programs should aspire to be transformative. **Benchmarks of success of USAID/Senegal programming in maternal and child health, reproductive health, community health, HIV/AIDS and TB** also informed the analysis. A synthesis of key USAID gender mandates and guidelines is found in Annex 5.

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145 These concepts of gender-blind to gender sensitive were coined by Naila Kabeer (2003).
146 Greene (2013: 3).
## ANNEX 4: SUMMARY OF HEALTH SITES AND HEALTH WORKER INTERVIEWS

<table>
<thead>
<tr>
<th>REGION 1</th>
<th>HEALTH CENTERS</th>
<th>Positions of staff interviewed</th>
<th>Number of women</th>
<th>Number of men</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Pikine Department and City of Dakar</td>
<td>Guedeweye District</td>
<td>District Medical Officer, RH Coordinator</td>
<td>1</td>
<td>1</td>
<td>2</td>
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<tr>
<td></td>
<td>Dominique</td>
<td>RH Coordinator; District Medical Officer, Majeur de Service, Head Midwife</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Diamniadio</td>
<td>District Medical Officer, Education in Health Officer, RH Coordinator, Midwife and Majeur de service</td>
<td>3</td>
<td>2</td>
<td>5</td>
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<tr>
<td></td>
<td>Guinarails South</td>
<td>Chief Nurse, Midwife and Head Midwife</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Toubab Dialo</td>
<td>2 matrons</td>
<td>2</td>
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<td></td>
<td>Ndoyenne &amp; Dene Youssou site</td>
<td>CHW (ASC), Matron, Outreach Workers and Bejenu Gox</td>
<td>4</td>
<td>1</td>
<td>5</td>
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<tr>
<td>REGION 2</td>
<td>HEALTH CENTERS</td>
<td>Positions of staff interviewed</td>
<td>Number of women</td>
<td>Number of men</td>
<td>Total</td>
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<tr>
<td>Grand Central Region - Fatick and Diofior</td>
<td>Fatick</td>
<td>District Medical Officer, Head Midwife, &amp; RH Coordinator</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Diofior</td>
<td>District Medical Officer, Nurse/Supervisor, RH Coordinator</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Tattaguine</td>
<td>Chief nurse, Head midwife, and 2 nutritionists</td>
<td>3</td>
<td>1</td>
<td>4</td>
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<tr>
<td></td>
<td>Keur Samba Dia</td>
<td>Chief nurse, Midwife and Matron</td>
<td>2</td>
<td>1</td>
<td>3</td>
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<tr>
<td></td>
<td>Ndiosmone</td>
<td>1 CHW, 1 Matron and 2 Outreach Workers</td>
<td>3</td>
<td>1</td>
<td>4</td>
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<tr>
<td></td>
<td>Baboucar</td>
<td>CHW (ASC), &amp; 1 Matron</td>
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<td>1</td>
<td>2</td>
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<tr>
<td>REGION 3</td>
<td>HEALTH CENTER</td>
<td>Positions of staff interviewed</td>
<td>Number of women</td>
<td>Number of men</td>
<td>Total</td>
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<tr>
<td>Kaolack - Kaolack Urban and Ndofane Rural Districts</td>
<td>Kaolack District</td>
<td>Chief Medical Officer, nurse/majeur, RH Coordinator, Head Midwife &amp; Supervisor/Nurse</td>
<td>4</td>
<td>1</td>
<td>5</td>
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<tr>
<td></td>
<td>Ndofane District</td>
<td>District Medical Officer, nurse/majeur, RH Coordinator, Head Midwife, Supervisor/nurse, Social</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

| HEALTH POST | Assistant | | | | |
| --- | --- | --- | --- | --- |
| Sibasor | Chief Nurse | 1 | 0 | 1 |
| Keur Baka | 1 Head Nurse | 1 | 1 | 2 |
| Diommkhel | N/A | 1 | 0 | 1 |
| Sikatroum | CHW (ASC) | 1 | 1 | 2 |
| CHH | Grand Southern Region - Ziguinchor and Bignona Districts | Position of Staff Interviewed | Total number of women | Total number of men | Total |
| Ziguinchor District | District Medical Officer, Nurse/GFP, Head Midwife and SR Coordinator | 2 | 2 | 4 |
| Bignona District | District Medical Officer, RH Coordinator, Social Assistant and Head Midwife | 2 | 2 | 4 |
| Adeane | CHW (ASC), Dispenser/Matron and Matron | 2 | 1 | 3 |
| Badjonkotur | Head Nurse, Doctor, Midwife and 2 Matrons | 3 | 2 | 5 |
| Tambacounba | 1 CHW (ASC) and 1 Outreach Worker | 1 | 1 | 2 |
| Falméré | CHW (ASC) and 1 Matron | 1 | 1 | 2 |
| CHH | Northern Grand Region - Saint-Louis and Pale Districts | Position of Staff Interviewed | Total number of women | Total number of men | Total |
| Saint-Louis District | District Medical Officer, nurse/majeur, RH Coordinator, Head Midwife, Supervisor/Nurse, Supervisor SS, Education for health officer | 4 | 1 | 5 |
| Pale District | Head midwife & Supervisor/Majeur | 1 | 1 | 2 |
| Sor Daga | 1 Head nurse, 1 Midwife | 1 | 1 | 2 |
| Rao | Matron | 1 | 0 | 1 |
| Khar Yallha | Matron | 1 | 0 | 1 |
| Merina Sall | Matron and CHW (ASC) | 2 | 1 | 3 |
### ANNEX 5: USAID GENDER INDICATORS

#### 7 PPR indicators for GHI

- Number of laws, policies, or procedures drafted, proposed or adopted to promote gender equality at the regional, national or local level
- Proportion of female participants in USG-assisted programs designed to increase access to productive economic resources (assets, credit, income or employment)
- Proportion of females who report increased self-efficacy at the conclusion of USG supported training/programming
- Proportion of target population reporting increased agreement with the concept that males and females should have equal access to social, economic, and political opportunities.
- Number of laws, policies or procedures drafted, proposed, or adopted with USG assistance designed to improve prevention of or response to sexual and gender based violence at the regional, national or local level.
- Number of people reached by a USG funded intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other)
- Percentage of target population that views Gender-Based Violence (GBV) as less acceptable after participating in or being exposed to USG programming

#### PEPFAR gender indicators

- Male Norms and Behaviors: Number of people reached by an individual, small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS.
- Gender Based Violence and Coercion: Number of people reached by an individual, small group or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS.
- Women’s Legal Rights and Protection: Number of people reached by an individual, small-group, or community-level intervention or service that explicitly addresses the legal rights and protection of women and girls impacted by HIV/AIDS.
- Number of people reached by an individual, small group, or community-level intervention or service that explicitly aims to increase access to income and productive resources of women and girls impacted by HIV/AIDS.

#### Feed the Future gender indicators

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicators relating to:</th>
</tr>
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<tbody>
<tr>
<td>Production</td>
<td>• Input in productive decisions            • Autonomy in production</td>
</tr>
<tr>
<td>Resources</td>
<td>• Ownership of assets                      • Purchase, sale, or transfer of assets</td>
</tr>
<tr>
<td>Income</td>
<td>• Control over use of income                • Access to and decisions on credit</td>
</tr>
<tr>
<td>Leadership</td>
<td>• Group member                             • Speaking in public</td>
</tr>
<tr>
<td>Time</td>
<td>• Workload                                 • Leisure</td>
</tr>
</tbody>
</table>

#### MEASURE Evaluation indicators on gender

- Percent of women who have completed at least four years of schooling
- Percent of women who have completed at least ten years of education
- Percent of women who earn cash
- Percent of women who mainly decide how their own income will be used
- Percent of women who own property or productive resources in their name
- Participation of women in household decision-making index
- Percent of women who have weekly exposure to mass media
- Age at first marriage
- Law requires free and full consent of parties to a marriage
### ANNEX 6: SOURCES OF GUIDANCE ON INTEGRATING GENDER INTO USG PROGRAMS RELATED TO HEALTH AND NUTRITION

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Guidance on Gender</th>
</tr>
</thead>
</table>
| **Global Health Initiative**      | One of the seven guiding principles is a focus on women, girls, and gender equality. The ten elements for promoting the women, girls and gender equality principle are:  
  ● Ensure equitable access to essential health services at facility and community levels.  
  ● Increase meaningful participation of women and girls in planning, design, implementation, monitoring, and evaluation of health programs.  
  ● Monitor, prevent, and respond to gender-based violence.  
  ● Empower adolescent and pre-adolescent girls by fostering and strengthening their social networks, educational opportunities, and economic assets.  
  ● Engage men and boys as clients, supportive partners, and role models for gender equality.  
  ● Promote policies and laws that will improve gender equality, and health status, and/or increase access to health and social services.  
  ● Address social, economic, legal, and cultural determinants of health through a multi-sectoral approach.  
  ● Utilize multiple community-based programmatic approaches, such as behavior change communication, community mobilization, advocacy, and engagement of community leaders/role models to improve health for women and girls.  
  ● Build the capacity of individuals, with a deliberate emphasis on women, as health care providers, caregivers, and decision-makers throughout the health systems, from the community to national level.  
  ● Strengthen the capacity of institutions – which set policies, guidelines, norms, and standards that impact access to, and quality of, health-related outreach and services – to improve health outcomes for women and girls and promote gender equality. |
| **President’s Emergency Plan for AIDS Relief** | PEPFAR identifies five areas of programmatic focus on gender inequality and gender norms as they affect HIV:  
  ● Increasing gender equity in HIV/AIDS programs and services  
  ● Reducing violence and coercion  
  ● Engaging men and boys to address norms and behaviors  
  ● Increasing women and girls’ legal protection  
  ● Increasing women and girls’ access to income and productive resources, including education |
| **USAID Gender Policy**            | Overarching outcomes:  
  ● Reduce gender disparities in access to, control over and benefit from resources, wealth, opportunities and services – economic, social, political, and cultural;  
  ● Reduce gender-based violence and mitigate its harmful effects on individuals and communities; and  
  ● Increase capability of women and girls to realize their rights, determine their life outcomes, and influence decision-making in households, communities, and societies.  
  Guiding principles underpin this policy:  
  1. Integrate gender equality and female empowerment into USAID’s work;  
  2. Pursue an inclusive approach to foster equality; |

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148 This table is from USAID/Ethiopia HAPN Gender Assessment (2012: 14-16).
3. Build partnerships across a wide range of stake-holders;
4. Harness science, technology, and innovation to reduce gender gaps and empower women and girls;
5. Address the unique challenges in crisis and conflict-affected environments;
6. Serve as a thought-leader and a learning community;
7. Hold ourselves accountable.
8. Implementation of the policy will be evaluated in 2015.

**Automated Directives System**

The Automated Directives System requires gender to be incorporated into planning and programming in an integrated way. Any analysis conducted for the ADS should be structured by two key questions to be addressed at every stage of the planning/program cycle:

- How will the different roles and status of women and men within the community, political sphere, workplace, and household (for example, roles in decision-making and different access to and control over resources and services) affect the work to be undertaken?
- How will the anticipated results of the work affect women and men differently?

Findings from gender analyses should help to determine the integral positioning of gender in the procurement process, the project activities, and the performance management systems and evaluations. In sum, the design of all projects and activities must take gender analyses into account.

**Feed the Future**

The gender analysis conducted for the Feed the Future program defines the following key principles for gender equitable agricultural growth and nutrition programming:

- Overcome gender-based constraints to agricultural productivity
- Address the distinctive needs of women
- Improve the resiliency of vulnerable rural populations
- Design equitable access to the rewards from agricultural enterprises
- Engage men and women in improving nutrition of all household members
- Foster equitable participation in decision-making processes at all levels (e.g., community organizations, producer associations, local government)
- Promote the use of gender analysis by policymakers and policy analysts as a tool to improve the enabling environment
- Improve knowledge of the performance of USG investments in supporting women and reducing gender inequalities in agricultural and nutrition programs.
- Strengthen capacity and confidence of USAID personnel in all offices to lead gender-equitable agriculture and nutrition programs.

From Feed the Future which is key to informing CDCS
### ANNEX 7: ROAD MAP OF IMPLEMENTING GENDER ASSESSMENT RECOMMENDATIONS

**Goal:** Improved equitable health outcomes for Senegalese women and men, boys and girls and most vulnerable groups

<table>
<thead>
<tr>
<th>GOAL &amp; STRATEGIC OBJECTIVES</th>
<th>SHORT TERM (0-1 YEAR)</th>
<th>MEDIUM TERM (1-2 YEARS)</th>
<th>LONG-TERM (2-5 YEARS)</th>
<th>RESPONSIBLE</th>
<th>SAMPLE INDICATORS</th>
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<tbody>
<tr>
<td><strong>Goal:</strong> USAID/Senegal and Partners have the capacity, organizational culture and systems to implement gender equitable health programming</td>
<td>Share/Review/Communicate Gender Assessment findings and recommendations with Mission, partners and key stakeholders.</td>
<td>Properly build awareness and train staff and partners on strategy and action plan so that all are clear on their roles and responsibilities.</td>
<td>Hold Biannual learning events and annual gender reviews of progress in meeting gender strategy.</td>
<td>Gender assessment results reviewed and communicated; gender strategy and action plan produced by USAID/Senegal and approved; biannual and annual GS reviews held.</td>
<td>100% of health team and IP staff informed of current status and report clarity of USAID/Senegal health team gender vision and understand how it relates to their role.</td>
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<tr>
<td><strong>Gender strategy (GS) and action plan operationalized, regularly reviewed and updated.</strong></td>
<td>Assign task team consisting of Mission staff and IPs to review and prioritize gender assessment findings and recommendations</td>
<td>Hold a stakeholder meeting to define a USAID/Senegal health team gender strategy and action plan informed by the Gender Assessment results and recommendations; develop a shared vision and common set of key concepts and approaches; involve MoH staff representations from all levels/regions; key NGOs and women’s groups</td>
<td>USAID/Senegal, and IP leadership, staff and systems foster gender equality</td>
<td>Integrate gender strategy into next CDCS strategy development</td>
<td>Increase strategic engagement with key donors/ donor coordination group on gender; establish joint strategies and gender capacity building program</td>
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<tr>
<td>Build staff and partner knowledge, skills, capacity and systems to support gender sensitive programming</td>
<td>Clearly define gender advisor and gender focal points roles and responsibilities in meeting gender strategy objectives/results</td>
<td>Develop series of practical tailor-made gender capacity building training for all USAID/Senegal staff and IPs with on the job support and peer to peer learning. Key themes: gender integration in the whole program cycle; gender and health systems strengthening; gender and good practice mixed multi-media approaches and SBCC methodologies for equitable health; engaging men and boys; gender responsive health service provision and training on USAID good practice gender tools and methods in RH and GBV.</td>
<td>Consider hiring additional technical expertise in gender and public health</td>
<td>Gender Advisor and GFPs for USAID/Senegal staff and IPs capacity building with support from the Regional Bureau Gender Advisor. IntraHealth and FHI360 gender advisors can support capacity building of other IPs.</td>
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<td>All staff and teams integrate relevant gender strategy and plan responsibilities into their work plans and performance management plans</td>
<td>Conduct an inventory of current gender related tools relevant for organizational and programming gender integration</td>
<td>Establish clear human resource guidelines to support gender integration and gender equality for partners.</td>
<td>USAID/Senegal Gender Advisor, GFPs and IntraHealth and FHI360 gender advisors</td>
<td># of partners with gender policies and action plans; 100% of partners have gender staff expertise and capacity; % of staff work plans and PMPs with measurable gender objective and activities.</td>
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<tr>
<td>Develop/run series of trainings and learning sessions catered to staff role and responsibilities and by topic to build staff gender knowledge, skills and capacity in gender integration</td>
<td>Establish clear gender guidelines, minimum standards and benchmarks for gender integration into the program management cycle for USAID/Senegal</td>
<td>Establish a terms of reference and work plan with specific staff to be responsible to</td>
<td>USAID/Senegal Gender Advisor, GFPs and IntraHealth and FHI360 gender advisors</td>
<td># of gender sensitive reports; Mission health team/partners report stronger commitment and knowledge and skills in how to integrate gender into whole program management cycle; # of activity approval documents, scope...</td>
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<tr>
<td>Build capacity to track and build evidence of gender equality results</td>
<td>Establish approval process to verify gender integration in all solicitations and request for proposals.</td>
<td>Establish approval process to verify gender integration in all solicitations and request for proposals. of works, RFPs, RFAs and contracting agreements approved to meet agreed upon gender standards.</td>
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<td>Revise health team indicators to have a mix of gender sensitive and gender equality specific indicators that measure quantitative and qualitative changes for gender equitable health outcomes; Regularly share good practices, challenges and concerns among partners and between program components. Consider using Abt led cross program technical working group meetings.</td>
<td>Synchronize indicators for tracking joint efforts/results among donors and government in making GoS health system more gender responsive with improved gender equitable outcomes.</td>
<td>Collaborate with MoH and MoFWC and key donors to strengthen and set up improved monitoring system for tracking gender sensitive indicators and data. Monitor on ongoing basis through regular meetings.</td>
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<td>Strengthen exchange and dialogue with USAID missions and bureaus in Africa region that are implementing innovative programs; learn and exchange.</td>
<td>Create ways to consult with female and male program beneficiaries and marginalized groups about activities. Strengthen Tutorat PAQ community feedback mechanisms through which women, girls and men and boys and marginalized groups can voice their concerns and opinions about health care service.</td>
<td>Improvements in MoH national health information system reporting on sex-disaggregated data and analysis; 100% of USAID/Senegal quarterly and annual reports contain sex and age disaggregated data and actionable recommendations to improve project/program implementation and evidence of successful gender integration approaches.</td>
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<td>Create new strategic partnerships with key donors supporting gender mainstreaming and RMNCH of MoH and with MoFWC at regional levels.</td>
<td>Be more present and clear on USAID/Senegal commitment to gender equality and female empowerment in the donor coordination group on gender and in MoH.</td>
<td>Play a more visible and active role in multiple forums and spaces.</td>
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<td># of reports and monitoring visits that include reporting on consultations with women and men and marginalized groups.</td>
<td># of gender and health events and donor coordination on gender and MoH meetings where gender issues are discussed and addressed; increased mechanisms for women and men in communities to give feedback on</td>
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<tr>
<td>PROGRAMMING LEVEL</td>
<td>USAID supported programming</td>
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<td><strong>SO2: MoH leadership and staff have the knowledge, skills, leadership and capacity to provide gender equitable health services</strong></td>
<td><strong>Consult and develop a shared cross-donor agenda on supporting gender mainstreaming in the MoH, with focus on RH and GBV prevention and micro health financing</strong></td>
<td><strong>Establish a harmonized approach/program to support the MoH’s gender mainstreaming activities to build capacity and systems</strong></td>
<td><strong>Joint donor initiative to support gender mainstreaming of MoH for greater impact in RH and reducing GBV established</strong></td>
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<tr>
<td><strong>MOH leadership, and staff have strengthened capacity to mainstream gender into the MoH focused on the priority area of RMNCH (RH and GBV)</strong></td>
<td><strong>Consult and develop a shared cross-donor agenda on supporting gender mainstreaming in the MoH, with focus on RH and GBV prevention and micro health financing</strong></td>
<td><strong>Establish a harmonized approach/program to support the MoH’s gender mainstreaming activities to build capacity and systems</strong></td>
<td><strong>Joint donor initiative to support gender mainstreaming of MoH for greater impact in RH and reducing GBV established</strong></td>
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<td><strong>Conduct an inventory of current gender related tools relevant for organizational and programming gender integration for MoH</strong></td>
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<td><strong>Joint donor initiative to support gender mainstreaming of MoH for greater impact in RH and reducing GBV established</strong></td>
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<td><strong>Integrate gender considerations into all Tutorat Plus full package of services and all relevant health worker training and capacity building; establish youth/male friendly services; increasing RH services, establish GBV provider service &amp; referral system</strong></td>
<td><strong>Consult and develop a shared cross-donor agenda on supporting gender mainstreaming in the MoH, with focus on RH and GBV prevention and micro health financing</strong></td>
<td><strong>Establish a harmonized approach/program to support the MoH’s gender mainstreaming activities to build capacity and systems</strong></td>
<td><strong>Joint donor initiative to support gender mainstreaming of MoH for greater impact in RH and reducing GBV established</strong></td>
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<td><strong>Pilot test and standardize MoH gender capacity building and monitoring tools (IntraHealth tools) for facility staff to identify gender barriers and ways to improve services</strong></td>
<td><strong>Consult and develop a shared cross-donor agenda on supporting gender mainstreaming in the MoH, with focus on RH and GBV prevention and micro health financing</strong></td>
<td><strong>Establish a harmonized approach/program to support the MoH’s gender mainstreaming activities to build capacity and systems</strong></td>
<td><strong>Joint donor initiative to support gender mainstreaming of MoH for greater impact in RH and reducing GBV established</strong></td>
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<td><strong>Integrate into quality service control mechanisms, specific criteria and strategies for</strong></td>
<td><strong>Consult and develop a shared cross-donor agenda on supporting gender mainstreaming in the MoH, with focus on RH and GBV prevention and micro health financing</strong></td>
<td><strong>Establish a harmonized approach/program to support the MoH’s gender mainstreaming activities to build capacity and systems</strong></td>
<td><strong>Joint donor initiative to support gender mainstreaming of MoH for greater impact in RH and reducing GBV established</strong></td>
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**Improved gender equitable service provision at all levels and regions, responsive to the needs and interests of women and men, boys and girls, youth and most vulnerable groups**

- Male/female volume of patients visiting facility/CHH; providers’ counseling content, style and ability; assessment of changes in clients attitudes/appreciation for services; # of gender sensitive service assessments and action plans developed, implemented and reported on for meeting gender equality targets; increases in couple counseling; youth visits; increase in FP; gender and age mix for each service provided at facility

- Men’s increased consultations at community/facility level health services

- Increased numbers of male

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<table>
<thead>
<tr>
<th>Improved joint decision making and equitable engagement of women and men in positive health seeking and healthy behaviors supportive of gender equality in health</th>
<th>SO3: Increased adoption of gender equitable health seeking and healthier behaviors among women and men of all ages with reduced GBV and increased men and boys’ engagement</th>
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<tbody>
<tr>
<td><strong>Increasing male and youth friendly services and outreach strategies at facility and community levels</strong></td>
<td><strong>Build and track health worker capacity to recognize and address GBV as a negative factor contributing to negative health status</strong></td>
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<tr>
<td><strong>Strengthen referral and linkage system between MoH and other services, especially for GBV; and reinforce and integrate response and screening of GBV into health service delivery including provision of post-exposure prophylaxis (PEP) and emergency contraception (EC) as well as psychosocial support</strong></td>
<td><strong>Provider awareness of signs of violence and referral system; community attitudes; #s of cases of GBV reported to other services</strong></td>
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<tr>
<td><strong>Build and track health worker capacity to recognize and address GBV as a negative factor contributing to negative health status</strong></td>
<td><strong>Review evidence-based, gender equitable, participatory methods and combine with innovative strategies; infuse best practice interventions that work in Senegal consulting with Tostan, the MoFWC and UN donors; and scale up good practices so that there are multiple reinforcing strategies for increasing men and boys’ engagement in health, to encourage increasing couple dialogue and communication and to increase women’s groups for supporting safe spaces for sharing positive maternal practices and building social solidarity and individual/group savings.</strong></td>
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<tr>
<td><strong>Track impacts; invest in female and male community facilitators to pilot test and more strategically organize these various groups</strong></td>
<td><strong>Increase of male engagement in community health volunteering; increasing numbers of men using clinics; increased age of first marriage; increased #s of men participating in group discussions on FGC/early marriage; increased reporting of women and men participating in joint decision making on family planning; increase in girls’ age at marriage &amp; first birth; Men’s knowledge of family planning; RH rights; knowledge, attitudes and practices among men about rights, violence and gender relations; number of community dialogues held; satisfaction of male</strong></td>
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<tr>
<td><strong>Further increases numbers of men/youth and couples visiting/engaged in RMNCH services; decline in restrictions on services and information; gender and age mix for each service provided at facility</strong></td>
<td><strong>Final Report 12/2014</strong></td>
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<tr>
<td><strong>Development</strong></td>
<td><strong>Implementation</strong></td>
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<tr>
<td>Develop a multi-sector GBV program on intimate partner violence focused on MoH leadership.</td>
<td>Establish standards for effective prevention and response to GBV in all health facilities using national protocol and strengthen on the job service training and monitoring of effective GBV response among health care workers; strengthen referral system between health facilities and other first line responders (E.g. women’s associations offering psychosocial and legal support); and build up community based responses to GBV using Child Fund innovative strategies (E.g. GBV protection communities) and adopt/infuse in evidence based good practices (E.g. Tostan Community Empowerment Program)</td>
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<tr>
<td>Increase/scale up use of men’s groups and CAC community mobilizing around reducing GBV; adopting positive health seeking practices and engaging men specific and couple groups in changing and challenging dominant socio-cultural norms and practices that support gender inequalities in health and wellbeing</td>
<td>Design and implement program to increase, mobilize and engage male relays who can act as role models for male engagement in health; incorporate group education activities with men and boys in community, the workplace; using male spaces such as sports</td>
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</table>

**Strengthen existing partnerships between community volunteers and facility level health care workers in encouraging male youth and husbands using home visits and other strategies; and encouraging couple counseling; consider integrating into these couple counseling sessions discussions on joint decision making.**

Support innovative multi-media and multiple channel campaigns based on strong gender sensitive situational analysis and considerations in campaign design; use affirming messages that underscore positive roles men and boys can play to improve their own health and in support of health and rights of women, girls and communities at large

Number of events that specifically addressed gender inequality issues related to health; number of BCC activities and materials developed, pretested and disseminated; men’s knowledge and behavior related to women’s RH; increased couple decision making and uptake of family planning

**Increased knowledge, support and positive health seeking behaviors of men and boys**

**Design and implement program to increase, mobilize and engage male relays who can act as role models for male engagement in health; incorporate group education activities with men and boys in community, the workplace; using male spaces such as sports**

% increase in numbers of men who visit and seek care at clinics; increase in couple counseling and health facility visitations; increased numbers of male outreach workers; increased numbers of community social mobilization, facilitated discussions and home visits for men; increased numbers of male role models supporting men/boys engagement in health including in reducing GBV
<table>
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<tr>
<th><strong>Increase women’s economic decision making and leadership for positive health</strong></th>
<th><strong>Strengthen and build synergy between Yaajeende and health program on supporting women’s groups – collaborate with micro schemes to support women’s group savings and support community-based transportation efforts</strong></th>
<th><strong>Set gender balance and leadership quotas in program supported committees such as in community health committees; expand their responsibility to supporting community feedback mechanisms through which women, girls and men and boys and marginalized groups can voice their concerns and opinions about health care service</strong></th>
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<td><strong>Support women’s leadership and micro savings for mutual health and women’s economic empowerment; consider young adolescent/women groups and grandmother groups</strong></td>
<td><strong>% of microcredit funds used for health services; cost and time needed for transportation</strong></td>
</tr>
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</table>