IAMANEH Schweiz | Suisse
Gesundheit für Frauen und Kinder
Santé pour femmes et enfants

MÉDECINS DU MONDE

Women's Hope International
Starke Frauen, sichere Geburten,
Heilung von Fisteln

GENDER EQUALITY & HEALTH ALLIANCE

Access to health and gender justice for a life in dignity

2021-2024 Programme

Table of contents Page

Abbreviations

ABR	Adolescent Birth Rate
ANC	Antenatal Care
CBO	Community-Based Organisation
CSO	Civil Society Organisation
DRC	Democratic Republic of the Congo
EMB	Engaging Men and Boys
FDFA	Federal Department of Foreign Affairs
GC	General Coordinator
GII	Gender Inequality Index
HDI	Human Development Index
HRBA	Human Rights Based Approach
IAMANEH	International Association for Maternal and Neonatal Health
LNOB	Leaving No One Behind
MdM	Médecins du Monde
MMR	Maternal Mortality Rate
MoU	Memorandum of Understanding
NGO	Non-Governmental Organisation
OPT	Occupied Palestinian Territory
OF	Obstetric Fistula
PCD	Participatory Community Diagnosis
PPC	Paediatric Palliative Care
PCM	Project Cycle Management
PNC	Postnatal Care
POP	Pelvic Organ Prolapse
PPP	Public Private Partnership
PSEAH	Prevention of Sexual Exploitation Abuse and Harassment
RPN	Risk Priority Number
SC	Steering Committee
SDC	Swiss Agency for Development and Cooperation
SDG	Sustainable Development Goal
SEED	Supply-Enabling Environment-Demand
SGBV	Sexual and Gender-based Violence
SRHR	Sexual and Reproductive Health and Rights
ToC	Theory of Change
WHI	Women's Hope International
WHO	World Health Organisation

Executive summary

The Gender Equality & Health Alliance is composed of the three Swiss non-governmental Organisations IAMANEH Schweiz, Médecins du Monde Suisse, and Women's Hope International. All three members, anchored in Swiss civil society, have considerable strategic and operational experience and extensive knowledge in the areas of gender equality and women's rights, as well as in related challenges in the healthcare sector, especially pertaining to Sexual and Reproductive Health and Rights (SRHR) and the fight against harmful practices and Sexual and Gender-based Violence (SGBV) damaging the physical and psychosocial well-being of women and children. Within the Alliance, the members will develop common approaches and join forces to boost their technical capacities, create synergies aiming to multiply the impact of their programme, in order to become a unique centre of excellence in the Swiss development cooperation sector.

The Alliance's international programme covers 19 partner countries in Eastern Europe, Southern Asia, Sub-Saharan Africa, the Middle East, Latin America and the Caribbean. While these show varying levels of human development, they all have in common persisting high levels of gender inequality in all areas of social and economic life, combined with – for most – alarming rates on the fragility index, with increased vulnerability especially for women and children.

Fragility and gender inequality – measured in respective indexes – are the two core context factors of the Alliance's country portfolio and its programme: among our 19 partner countries, 13 are ranked in the lowest classification of the Gender Inequality Index (GII), while eight are ranked at alert level of the Fragile States Index (FSI), and most of the others at a warning level. As per experience Gender Inequality risks to be reinforced in a context of fragility and vice versa, which means that these context factors have to be considered throughout programme planning and implementation.

In its previous phase, covering the 2017-2020 period, the three Alliance members implemented programmes in the domains of gender equality and health, reaching effective results and significant impact, by applying different approaches, such as engaging men and boys in order to promote gender transformative processes, improving access to services for particularly vulnerable women, providing protection and care in the area of SGBV or SRHR. Some of these specific results are presented below under Chapter 4.

Based on the objectives and experiences of its members, the Alliance has designed a programme which sets as its overall goal that "more women and children have improved access to SRHR and realize their rights free from violence and other forms of discrimination, making self-determined and informed decisions about their lives". The programme contributes to the Agenda of the Sustainable Development Goals (SDG) and its core vision Leaving No One Behind (LNOB). It specifically addresses SDG 3 "Ensure healthy lives and promote well-being for all at all ages" and SDG 5 "Achieve gender

equality and empower all women and girls". By working in fragile contexts and explicitly targeting vulnerable groups, the Alliance is in line with the LNOB perspective. Following SDG 17, the Alliance bases its programme on extensive partnerships with different stakeholders, including civil society organisations, local authorities and private organisations, in order to strengthen sustainability. Finally, the Alliance sees its work with women and children – who are the most affected by extreme poverty, on the reduction of gender inequality and on health determinants, as a contribution to poverty reduction and thus to SDG 1.

With this strategic orientation, the Alliance's programme will directly contribute to the Swiss development agenda, with its aim to promote health and gender equality. Its members will participate actively in policy dialogue and forums organised by the Swiss development cooperation to foster exchanges between partners. Similarly, within countries of intervention, the Alliance supports its partners not only on an operational level, but also on the level of policies and thus contributes to the strengthening of civil society voices for constructive dialogue.

The programme of the Alliance is based on an impact model, presented in a Theory of Change (ToC below in Chapter 6 and in annex) and a log frame, constructed around five outcomes referring to "National and International Laws and Policies", "Systems and Services", "Communities" and, on the level of individuals, "Women and Children" and "Men and Boys".

The underlying key assumptions are: (1) gender equality is essential to the realisation of human rights for all and hence constitutes a goal in itself; (2) sustainable change in gender equality and health within communities has to be supported by an enabling environment that ensures inclusive quality services and systems and (3) the five outcome-pathways are based on the social ecological model and need to be synergistically addressed.

The Alliance's programme is based on the specific programmes of each partner, as well as by joint actions and approaches. This allows the Alliance to amplify its resources (where the added value is more than the addition of three programmes), to strengthen capacity building and common learning with partners and, lastly, to create synergies between approaches.

The interventions of the Alliance in the respective partner countries are planned and implemented in partnership with local actors in order to strengthen ownership, to make use of local frameworks and in alignment with local or national policies. The main action lines include lobbying and advocacy, capacity building of institutions and partners, mobilising communities as well as empowering women and children to claim their rights and engaging men and boys aiming at the transformation of gender roles. The general interventions of the Alliance as well as specific contributions of each member are presented under Chapter 7.

The Alliance has established a Steering Committee (SC) comprised of the directors of each member organisation and, when needed, representatives of other stakeholders. The Steering Committee bears the overall responsibility for the planning, supervision and evaluation of the programme including strategic, operational and financial requirements. The Alliance has also elaborated a sound risk management system, as well as the necessary instruments and tools aligned with Project Cycle Management (PCM) standards. It guarantees that quality assurance mechanisms are in place and effective throughout programme implementation.

PART A

THE NGO ALLIANCE AND ITS MEMBERS

1 Rationale and vision

Worldwide discrimination against women is one of the most widespread human rights violations, with dire effects on their physical and psychological well-being and on their chances to become self-determined actors of their lives. Equally women and children are the main victims of poor health systems and of unequal access to healthcare and the most at risk of violence.

The Alliance shares the vision of a gender-equal world, free of gender-based discrimination and violence. A world in which all, including the most vulnerable, enjoy their sexual and reproductive rights and access quality sexual and reproductive healthcare services. Through partnerships with local actors (SDG 17), the goal of the Alliance is to promote gender equality (SDG 5) and improve sexual and reproductive health and rights (SDG 3), thus contributing to poverty reduction (SDG 1).

2 Comparative advantage of the Alliance

Advantages compared to working as stand-alone organisations: Through the Alliance, the member organisations multiply the impact of their activities towards improving sexual and reproductive health, gender equality and towards reducing gender-based violence. They establish institutional and operational synergies throughout their activities, from programming and policy dialogue to knowledge sharing, resource mobilisation, management and impartial conflict resolution. In addition to cooperating on operations, they engage in conducting joint needs assessments, programme monitoring and evaluations. The impact of the Alliance members' advocacy is amplified, with stronger representation internationally for engagement with various international networks, with an historic anchorage in three different geographical regions in Switzerland, and a wider international geographical coverage.

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The members share their knowledge on international fundraising mechanisms and join forces in identifying new financial sources. The Alliance programme serves as a basis for joint geographic and thematic funding applications.

Comparative advantage compared to other organisations: The Gender Equality & Health Alliance intervenes in two fields key to sustainable human development: gender and health.

Afghanistan
Albania
Bangladesh
Benin
Bosnia & Herzegovina
Burkina Faso
Cameroon
Chad
DRC
Ethiopia
Haïti
Mali
Mexico
Nicaragua
Palestine
Togo
Senegal
South Africa
Switzerland
Zimbabwe

While gender equality is increasingly included as a cross-cutting issue in the strategies of Swiss-based NGOs engaged in international cooperation, only a few engage in gender-specific work. And while many organisations work in the health sector, most with a focus on specific themes or target groups, the Gender Equality & Health Alliance distinguishes itself by its combination of extensive technical medical know-how and specialisation on one determinant of health: gender.

The Alliance will not merely work on health and gender as two separate fields of intervention: it will instead work on them simultaneously, in an interlinked manner, with each topic used as an angle to achieve better results in the other field.

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Alliance members are equipped with broad and sound knowledge and experiences and have developed specific approaches in gender and health. They show a high strategic and operational complementarity and the potential for exploring further synergies and new fields of joint cooperation. As an Alliance, they create a unique centre of excellence on gender and health in Switzerland.

3 The members of the Gender Equality & Health Alliance

IAMANEH Schweiz is a non-political, not-for-profit, un-denominational organisation with a strong commitment to human rights. Its interventions aim at closing gaps in access to sexual and reproductive health and at preventing all forms of gender-based violence so that women and girls can live a healthy, self-determined life free from violence.

This goal is pursued through i) interventions that aim at ensuring access to comprehensive sexuality education as well as information and services, including family planning to prevent unwanted and early pregnancies; ii) measures that aim at improving maternal health through the strengthening of respectful, inclusive, quality reproductive health services in view of improving birth outcomes and reducing birth injuries; iii) measures that aim at preventing gender-based violence (e.g. domestic/structural violence, female genital cutting/mutilation, early/forced pregnancy), iv) the provision of shelter, counselling and support to women and children survivors of violence with the goal of re-establishing their psychosocial health and well-being v) as well as perpetrator counselling.

IAMANEH is today known for its expertise and experience in promoting gender transformative processes and the engagement of men and boys in sexual and reproductive health and rights and Sexual and Gender-based Violence. IAMANEH strives to encourage women, men, girls, boys, political decision-makers and authorities, representatives of institutions and communities to critically reflect on gender norms and values. They are encouraged, through their own behavioural changes, to lay the foundation for change in systems and structures that reduce gender inequalities in social power relations that affect the sexual and reproductive health of women and girls and their exposure to violence.

Médecins du Monde Suisse (MdM) is an independent humanitarian health organisation founded in Neuchâtel in 1993. It is a member of the international Médecins du Monde network, composed of 16 chapters. MdM aims to sustainably improve access to health for vulnerable populations – particularly women and children – both in Switzerland and around the world.

Healthcare systems healthcare systems too often fail women and children who suffer from unequal access to services. MdM is by their side, providing medical and social support to victims of violence while defending their rights, ensuring pain-free medical treatment to children, and helping women and girls make informed choices regarding their own bodies and sexuality, plan their pregnancy and give birth safely. To achieve these goals, the organisation develops programmes in three thematic areas: SRHR, violence prevention and response, and paediatric palliative care.

MdM treats patients and bears witness, in order for everyone's right to healthcare to become effective, with no financial, social or geographical barriers. From local to global, the organisation adopts integrated approaches to bring lasting and complete solutions to unequal access to healthcare. It monitors and accompanies regional, national and international powers to improve access to healthcare and promote human rights. MdM bears witness in front of decision-making bodies, in order to push for national and global sustainable changes.

Women's Hope International (WHI) is an organisation engaged in international cooperation, focusing on improving SRHR. Since WHI's foundation in 2003, its programmes have evolved from treating obstetric fistulae to applying a comprehensive approach to SRHR.

Globally, women and girls are exposed to SGBV. Due to unequal access to healthcare, they are also at higher risk before and after pregnancy and during childbirth. WHI aims to guarantee SRHR for all women and girls as well as the provision of safe pregnancies and births attended by skilled health personnel. To achieve its mission, WHI is working in three lines of intervention: access to specialised obstetric treatment and prevention of injuries, strengthening the healthcare system, and the elimination of SGBV with a particular focus on child marriage and female genital mutilation.

By applying the Supply-Enabling Environment-Demand (SEED) model approach, WHI is strengthening the supply and the demand side as well as fostering the enabling environment in healthcare provision. Projects are implemented together with partner organisations as well as through WHI's local offices. Strengthening the capacity of local partners is a central component in all projects. WHI is strongly committed to a Human Rights-based Approach and views itself as a learning organisation.

4 Governance processes of the Alliance

The Alliance members have signed a Memorandum of Understanding (MoU) which defines their rights, obligations and responsibilities and provides for a Steering Committee (SC). The MoU describes the communication channels between the members and externally, as well as conflict resolution mechanisms and escalation processes, in the event of a misunderstanding or disagreement between them.

The SC constituted by the directors of each member, oversees programme management, monitoring and evaluation. It meets semi-annually or more frequently if needed. The SC revises the risk analysis and identifies means of mitigation, monitors and supports members' adherence to best practices and is a space for exchange on good governance approaches. This includes inter alia sharing policies and strategies on PSEAH, anti-corruption, child protection. It also analyses the Alliance members' financial and audit reports and monitors their compliance with audit recommendations. Its members are strengthened through the exchange of experience and best practices.

The respective Executive Board of each member assumes the overall responsibility for its organisation. Each defines the strategies of the individual organisations which serve as the basis for the joint programme.

The Alliance members rely on their own financial monitoring system to report to the SDC as well as to other donors and their respective boards. The accounts are audited annually by recognised Swiss audit firms and follow the Swiss GAAP FER 21 recommendations, Swiss legislation, ZEWO standards and SDC requirements.

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SDC funds are received by a dedicated bank account and shared among members as per their budget allocation. The financial information per outcome is calculated on a statistical basis, supported by the members' financial reports. Members share audit reports, management letters and adopted measures to comply with the audit recommendations. The Alliance's Steering Committee monitors their implementation.

PART B

THE INTERNATIONAL PROGRAMME

1 Context

1.1. General context

The Alliance's international programme spans 19 countries in Eastern Europe, Southern Asia, Sub-Saharan Africa, the Middle East, Latin America and the Caribbean. These countries show varying levels of human development. However, nearly all face persistently high levels of gender inequality and enduring state fragility. In other words, fragility and gender inequality are important context factors that characterize the Alliance's country portfolio and consequently drive the Alliance's actions.

In the last two decades, international aid actors have made continuing efforts towards modernising, deepening and broadening development cooperation which resulted in the blueprint for maximising the impact of aid: the Busan Partnership Agreement in 2011, endorsed to date by over 100 countries.[1] Concomitantly, humanitarian aid actors strive to transfer more ownership and responsibilities to local authorities and civil society organisations as agreed in the World Humanitarian Summit's Grand Bargain in May 2016. Notably, the nexus between development and humanitarian became a cross-cutting commitment of the Grand Bargain Agreement.[2]

Despite the global reduction of poverty, which should continue in the next decade, economic, health and social inequality is growing. The financial gap is reducing more slowly in fragile countries and rural areas, and extreme poverty is concentrated in South- and East-Asia, the Pacific, and Sub-Saharan Africa. The predictions for 2030 estimate that this will continue to be the case, and specific regions and populations might not benefit from their country's economic growth. Despite the general benefits of globalisation, intersecting inequalities may get higher, if targeted development efforts are not deployed in regions where it is the most needed.

On the other hand, man-made and natural emergencies are getting more complex and are increasingly protracted. As internal crises and urban violence are more frequent, reaching vulnerable communities is getting more difficult and hazardous due to both risk factors and governmental restrictions. Furthermore, poverty and violence combined create a context of increasing insecurity.[3]

Important health indicators globally have improved: the number of children dying younger than five years old is decreasing and both maternal and infantile mortality rates have been reduced. However, the situation remains critical for vulnerable populations as children born in the poorest communities are three times more likely to die before their 5th birthday than those living in the richest families, and maternal and neonatal mortality rates remain unacceptably high in low-resource settings and are often preventable: according to UNICEF, every day in 2017, approximately 800 women died from causes related to pregnancy and childbirth.

[1] — The notable High-Level Fora on Aid Effectiveness in Rome, Paris, Accra and Busan in 2003, 2005, 2008 and 2011 that led to the Busan Partnership Agreement.

[2] — HPG working Paper, ODI, May 2018, Marc Dubois: "The new humanitarian basics": https://www.odi.org/sites/odi.org.uk/files/resource-documents/12201.pdf

[3] — The Future of aid, p. 66

Moreover, gender inequalities persist in all areas of social and economic life and across countries. Violence against women is one of the most common human rights violations in the world today and constitutes a public health concern across all countries: 1 woman in 3 is a victim of physical or sexual violence at some point in her life. This number excludes victims of other types of violence such as psychological and economic violence, and it does not account for the physical and mental damage also caused to the victim's familial and social environment. Every year, almost 70 million girls worldwide are married before their 18th birthday. It is estimated that 650 million women alive today were married when they were children, and 3 million girls are at risk of undergoing female genital mutilation. In short, child marriage denies agency to a girl and autonomy in her home, in sexual and reproductive decisions, reduces her chance of being educated, undermines her future and stops her from realising her full potential in life.[4] The harmful practices that result from unequal gender norms can further impede access to SRH services and limit a woman's rights and choices in all areas of her life.

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Gender inequality and discrimination against women are at the root of SGBV and of poor access to SRHR. Unequal power relations and patriarchal structures are driving forces that deprive women of their basic rights including their right to take self-determined decisions about their body and their lives. In many of the Alliance's intervention countries, men still decide on women's access to maternal and health services while at the same time, prevailing masculinity perceptions prevents them from taking responsibility for SRH, care work and fatherhood.

In many of the intervention countries, civil society organisations are increasingly raising their voices for gender equality, and social and economic rights. Simultaneously during the last 20 years in many countries, authoritarian regimes increasingly restricted the space for civil society action. To support these organisations in their defence of human rights and of women's rights is an indispensable role for actors in international cooperation.

[4] — UNFPA State of the World Population Report 2019. p. 76

1.2. Context per area

The Gender Inequality Index (GII) sheds light on the loss in potential human development in 160 countries due to gender disparities in three major dimensions: reproductive health, empowerment and economic status. For each country, the GII yields a value between 0 and 1; higher GII values pointing out greater variation between women and men and greater the loss to human development. One limitation to the GII is that it does not consider data on SGBV.

Having the best GII value and rank in 2017 (see graph below), Switzerland can be used as a comparative standpoint for other countries. The state of reproductive health is calculated based on the Maternal Mortality Rate (MMR) and Adolescent Birth Rate (ABR), which respectively are 5 deaths per 100'000 live births and 3 births per 1'000 women aged between 15 and 19 in Switzerland. Women's empowerment is based on the gender repartition percentile of parliament seats between sexes and secondary education rates of women and men (SE_F and SE_M). In 2019, only 29.3%[5] of Swiss parliament seats were occupied by women. This discrepancy does not exist when it comes to secondary education (SE_F=96.4 and SE_M=97.2). Finally, the labour force participation rates of women and men ($LFPR_F$ and $LFPR_M$) are used to indicate the economic disparities between men and women. In Switzerland, $LFPR_F$ is 62.9% and $LFPR_M$ is 74.1%.

[5] — Since October 2019 the proportion of women has risen to 42%

Country	Gender Inequality Index rank (2017)	Gender Inequality Index value (2017)	Human Development Index rank (2018)	Fragile States Index (2019)
Switzerland	1	0.039	2	Very Sustainable
Bosnia and Herzegovina	37	0.166	77	Elevated Warning
Albania	52	0.238	68	More stable
Mexico	76	0.343	74	Warning
South Africa	90	0.389	113	Elevated Warning
Nicaragua	106	0.456	124	Elevated Warning
Ethiopia	121	0.502	173	Alert
Senegal	124	0.515	164	Elevated Warning
Zimbabwe	128	0.534	156	Alert
Bangladesh	134	0.542	136	High Warning
Togo	140	0.567	165	High Warning
Cameroon	141	0.569	151	Alert
Haiti	144	0.601	168	Alert
Burkina Faso	145	0.61	183	High Warning
Benin	146	0.611	163	Elevated Warning
DRC	152	0.652	176	Very High Alert
Afghanistan	153	0.653	168	High Alert
Mali	157	0.678	182	Alert
Chad	158	0.708	186	High Alert
Palestine	NA	NA	119	Elevated Warning

top third
middle third
low third

Applying the GII lens, the Alliance's partner countries can be analysed as follows: 13 of 19 countries have GII values higher than 0.5 (low third category). Except for Albania, all the countries show fluctuating degrees of warnings (ranging from a simple warning to high alert) in terms of state fragility.[6] State fragility and gender inequality therefore remain among the main obstacles of effective, sustainable development and social well-being in the Alliance's partner countries.

Bosnia and Herzegovina, Albania and Mexico are the three best performing Alliance countries in regard with their GII value. However, they still face challenges regarding the achievement of gender equality. For example, Mexico still has an adolescent birth rate of 60.3 whereas Albania has the second highest maternal mortality rate in Europe (29 of 100'000 live births). Bosnia and Herzegovina perform much lower on the Human Development Index (HDI) than on the GII. This is explained mainly by the country's good performance on reproductive health indicators. Regarding female labour market participation and political representation, Bosnia and Herzegovina ranks the lowest in comparison with the two other countries.

Cameroon and Bangladesh stand out in the chart as both having a medium HDI rank which is higher than most of the other countries, but they also show important gender inequalities. The difference comes from the statistics on which the two indexes are based and recalls that Human Development Indicators does not take states' health, gender or economical inequalities into account. Bangladesh's health indicators are such that the situation must be addressed: MMR is 176, and ABR is 83.5. In Cameroon, the values are even more alarming: MMR is 596, and ABR is 105.8. The country also shows great inequalities as only 33% of women engage in professional activities, against 79.8% of men, despite an equal secondary education rate of 44% for both men and women.

The Occupied Palestinian Territory, for its part, does not have a GII value or rank because a necessary value in the calculation of the index is missing. Without information on the parliament repartition between genders, women's empowerment state cannot be properly evaluated. However, by comparing literacy statistics, we can see where the Occupied Palestinian Territory stands regarding our main fields of action: health indicators show 45 deaths per 100'000 live births, and 56.2 births per 1'000 women between 15 and 19. The most important inequality of the country is in the labour force participation rate, with 19.5% of women versus 81.2% of men either working or looking for work.

[6] — Fund for Peace: 2019 Annual Report – Fragile States Index 2019: by J.J. Messner, Nate Haken, Patricia Taft, Ignatius Onyekwere, Hannah Blyth, Marcel Maglo, Daniet Moges, Charles Fiertz, Christina Murphy, Wendy Wilson, Kevin Obike: Available at: https://fragilestatesindex.org/wp-content/uploads/2019/03/9511904-fragilestatesindex.pdf

2 Key results of Alliance members with international programmes in previous phases

Using a participatory approach, Alliance members contribute to reducing gender inequalities and increasing health and well-being of women and children by ensuring access to SRHR and addressing multiple forms of violence and discrimination. They support the development and implementation of policies at national and international level, as well as national efforts to reinforce health systems, while advocating for improved access to quality SRH and a stronger respect for human rights.

IAMANEH Schweiz

Key institutional developments, results and achievements:

- IAMANEH has been an early adopter of promoting the innovative approach of gender-transformative processes and the promotion of male engagement in sexual and reproductive health and gender-based violence.
- With support from Swiss experts, IAMANEH introduced work with perpetrators in Albania from 2008, and accompanied its further development in Albania and Bosnia and Herzegovina[7]; from 2015, IAMANEH introduced the evidence-based approach of Engaging Men and Boys in its project portfolio in West Africa; altogether, representatives of over 21 local partner organisations were trained in techniques and tools for gender-transformative work.
- IAMANEH contributed to reduced exclusion and discrimination of particularly vulnerable women and communities. In Bosnia and Herzegovina, the interventions targeted Roma women with information and education on SRHR, while in Mali they ensured access to medical treatment and psychosocial counselling for women survivors of obstetric fistula. In rural settings women benefited through improvement of health infrastructure and financial and geographical accessibility of services.
- IAMANEH promoted knowledge transfer and exchange between Swiss and Bosnian / Albanian shelters for women survivors of SGBV.

Key programmatic results and achievements:

Improved access to sexual and reproductive health and rights, quality information and services for women and youth:

- IAMANEH's interventions contributed to attitude and behaviour change in men as to their role in SRHR and the prevention of gender-based violence: since 2016, 1'300 "model" men were organized in all-male groups to learn about, and reflect on topics relating to SRHR and more balanced distribution of care work including responsible fatherhood; model men are actively engaging with their peers for their increased engagement in SRHR and change to discriminatory gender norms.

[7] – See Loncarevic, M. / Reisewitz, R., 2016: "Introducing perpetrator counseling in Western Balkan countries: The challenge of gender-transformative action in a patriarchal society", Graduate Journal of Social Science November 2016, Vol. 12, Issue 3, pp. 206–221.

- A tangible increase in all relevant intervention zones was observed between 2016 and 2018 in the number of women that accessed modern contraception, that accessed one, resp. four or more antenatal care services, and of facility-based births. For example, in a hard-to-reach area in Togo, an increase from 22% to 32%, resp. 8% to 10% in antenatal care coverage (one, resp. four or more consultations) was achieved. The aggregated increase in relevant intervention zones to 1'382, resp. 1'367. During the same period, 1'579 more women aged 15 to 49 years used family-planning thus increasing coverage in individual intervention zones up to 30% (from 18% in 2016).

Prevention of gender-based violence:

- In view of contributing to sustainable reduction of domestic violence in Albania and Bosnia and Herzegovina, IAMANEH supported the training of 45 counsellors plus 2 master trainers for working with perpetrators. As of 2018, 629 perpetrators of gender-based violence were counselled and learned strategies to deal with conflict in a non-violent manner. Since its initiation, the uptake of counselling services has steadily increased to reach 234 men counselled in 2018. Counselling is provided in altogether 3 counselling centres of which two were newly set up since 2013 (plus 5 pilot groups in various parts of the two countries).
- Achieved commitment of multiple communities in Mali to end female genital mutilating/cutting and child marriage.
- Promoted integrated management of cases of SGBV through the strengthening of interinstitutional cooperation. Almost 8'000 reported cases were managed in a coordinated manner and thus improved survivor's access to rights and services.

Protection, care and treatment for woman and girl survivors of gender-based violence and obstetric fistula:

- Since 2013, over 17'500 woman and girl survivors of gender-based violence contacted the protection and counselling services provided by IAMANEH partners and were provided with psychosocial and legal counselling and/or medical and socio-economic support.
- Over 2'000 women and girls were able to leave the cycle of violence and take up living perspectives free from violence following targeted interventions.
- The physical health of 500 women diagnosed with obstetric fistula was restored following free surgical intervention and active support for reintegration into their families and communities.
- Through advocacy and SDC-supported policy dialogue, IAMANEH partners were able to secure the commitment of local governments for the integration of selected protection services in Bosnia and Herzegovina as well as in Albania into the state budget, thus representing an important step in improving the sustainability of these services.

Médecins du Monde

Key institutional developments, results and achievements:

Since its creation in 1993, MdM has built, in partnership with Swiss and international experts from the private and public sector, technical know-how in three thematic areas related to maternal and child health: sexual and reproductive health, gender-based violence, and paediatric palliative care. In 2016, in order to work more comprehensively on patient well-being, MdM added an expertise in mental health to its portfolio.

In line with its commitment to sustainable change, MdM perfected a non-substitution approach, developing strategies and tools for building and maintaining stronger collaborations with authorities, the private sector and civil society organisations. Following patient and partner feedback, MdM also started in the early 2010s to elaborate and implement advocacy strategies and to empower civil society organisations to conduct advocacy on their own.

Through strategic partnerships with Swiss academic institutions, MdM finetuned an Anthropology of Health approach, which allows for a better understanding of inequalities in health and for programming targeting individual determinants of health. Participatory methodology standards and tools were developed in 2014, in order to guarantee the systematic inclusion of communities and the most marginalised groups in needs assessments and evaluations.

Key programmatic results and achievements from 2013 to 2019:

Target populations have acquired individual and collective skills to remain in good health:

- Through engagement with the wider community and specific stakeholder groups such as parents, systems became more inclusive, with a direct impact on people's well-being. In Benin for instance, recorded health issues among children beneficiaries fell from 58% in 2015 to 15% in 2016.
- 550'488 people are now able to take better care of their health, thanks to MdM health promotion programmes.

Barriers to care have been reduced in target intervention areas:

- The well-being of child victims of detention and their families in the Occupied Palestinian Territory improved through an innovative pilot project bringing social work to the streets, in order to better reach adolescents.
- Access to quality care was ensured for migrant populations: from 2015 to 2017, MdM carried out more than 135'000 medical consultations and 8'726 psychosocial support sessions. By operating laboratories inside the refugee camps, MdM contributed to the early detection of chronic diseases and a better management of paediatric cases.

Quality of care has been improved in target facilities:

- Maternal and neonatal mortality decreased through safer deliveries: over the course of 5 years, 20'616 women delivered in facilities and with personnel supported by MdM. In Cameroon, the neonatal mortality rate fell from 139 to 8.7 per 1'000 live births.
- MdM's family planning programmes in support of national strategies contributed to an increase in contraceptive prevalence from 4.1 in 2016 to 6.2 in 2017 in Benin and from 10 in 2017 to 16.5 in 2018 in Haiti.
- MdM technical capacity building sustainably improved local, provincial and national health surveillance and statistical systems. In Cameroon, MdM contributed to a shift in statistical compliance of health facilities from 67% in 2014 to 100% in 2015.
- The basic service package offered by partner facilities was broadened. In Haiti, the Integrated Management of Childhood Illnesses was introduced in 14 health centres and 2 hospitals, leading 866 malnourished children to receive adequate care over the course of three years, with a 95% cure rate.
- MdM remains a pioneer in the development of paediatric palliative care in developing countries: it improved the skills of 1'754 health personnel in 4 countries through its training programme; ensured the availability of morphine in key health institutions; and contributed to the development of an international network for paediatric palliative care.

Advocacy has made it possible to ensure the sustainability of the health services developed:

MdM advocacy and programmes had a direct impact on improving patient well-being:

- Paediatric palliative care: not only was palliative care introduced into the national health strategies in Benin, the Democratic Republic of Congo, Nicaragua and Togo, but both Benin and DRC created specific national programmes dedicated to it.
- Maternal and child health: the first national public university diploma specialised on neonatology was launched in Nicaragua.
- Gender-based violence: in Benin, standard medical certificates (covering assault and rape) were adopted by the Ministry of Health for use by health personnel and the Ministry committed to supporting financially four Centres offering integrated care to victims of violence. In Cameroon, the Ministry of Health drafted its first protocols for the psychosocial and medical management of GBV.

Women's Hope International

Key institutional developments, results and achievement:

- In the last 6 years, WHI has shown a long-term commitment in all partner countries, by successfully navigating its projects through various transitions between humanitarian and development contexts.
- WHI deliberately targeted neglected rural areas for its interventions and aimed to collaborate with particularly vulnerable groups, such as widows, mothers of disabled children, poor women, etc.
- Increasingly, WHI shifted to greater involvement of communities on the grassroots level in SRH projects inspired by the WHO approach of participatory community assessment.
- WHI has duly heeded its commitment to furthering professional development of national capacities in its partner countries, hence contributing to improving the quality of SRH services.

Key programmatic results and achievements:

Improving access to specialized treatment and prevention of obstetric injuries (OF and POP):

- WHI's origin and expertise lay in the specialized treatment of obstetric fistula. WHI broadened its obstetric fistula (OF) interventions to increasingly integrate pelvic organ prolapse (POP) based on evidence from the partner countries, considering the lack of available skilled surgeons and closely related surgical procedures. Additionally, social consequences of both obstetric injuries severely affect a woman's quality of life by limiting her physical, social, psychological and sexual functions.
- WHI has substantially supported the reestablishment of physical health of 2'003 women suffering from OF since 2013. Additionally, since 2016, 129 women with POP were successfully healed.
- In Afghanistan, over 25 Afghan female doctors were trained in fistula care, of which 93% still practice locally. 4'642 health workers in remote areas were trained on identifying fistulae, leading to an increase of referrals from primary to tertiary level.

Strengthening health systems in sexual and reproductive services:

- Aiming at reducing maternal and infant mortality, WHI substantially improved access to urgently needed 24/7 medical support emergency obstetric services for 5'853 women with high-risk pregnancies who delivered their babies safely in maternal waiting homes in Ethiopia. Approximately 35% of these deliveries were caesarean sections.
- WHI has contributed to the achievement of the following outcomes in essential SRH indicators: institutional deliveries, antenatal care (ANC) and postnatal care (PNC) visits, SRH/FP counselling visits.

- WHI supported 84'654 deliveries in supervised health facilities (all levels). In a multi-year project in Ethiopia, safe deliveries increased by 33% as opposed to baseline data of the same area (4 woredas).
- 103'090 pregnant women ages 14 to 49 realized at least one ANC and 78'154 women went to at least one PNC visit. In a multi-year project in Ethiopia, an improvement of ANC1 coverage by 24% in the intervention zone in comparison to the overall province was achieved.
- In view of enhancing women's capacities for informed decisions, 309'944 women were sensitized on SRH issues, including various forms of modern family planning methods.
- Quality service provision being a crucial factor in the success of any intervention in maternal health, WHI has since early on vowed to itself to improve local medical capacity at all levels to reduce maternal morbidity and mortality: since 2013, 785 midwives and traditional birth attendants were trained and redeployed in the majority of cases in rural areas. Besides gaining qualified education, nurses, TBA and other health staff were trained on diagnostic, referral and treatment of obstetric fistulae, whenever possible.
- Additionally, 72 health centres were substantially renovated and equipped.

Promoting the elimination of Gender-based Violence:

- By the end of 2018, 600 women's group with 1'200 participants were active in Bangladesh. Daughters of single parents, orphans and girls from very poor families being particularly at risk of getting married early and dropping out of school, members of these women's group receive seed capital, know-how and support to generate additional income. In this way, it is preventable that the girls are married early because of poverty.
- Committed and convinced of the importance of engaging men and boys in the elimination of child marriage, WHI has adapted its approach in 2018 and has sensitized 5'919 men (3'230 men, 2'689 boys) on child marriage.

3 Coherence of the international programme with strategic priorities of SDC and SDG Agenda 2030

The Gender Equality & Health Alliance concentrates its programme on the overall goal that "more women and children have improved access to SRHR and realize their rights free from violence and other forms of discrimination and make self-determines and informed decisions about their lives". The Alliance, composed of three Swiss NGOs, bases its work on the specific competencies of the members and on their long-year experiences in these domains. It works in cooperation with relevant actors in the respective countries including official institutions, civil society and community-based organisation as well as in multi-stakeholder settings, which can – depending on the specific context and challenges – include international organisations, universities and the private sector.

The SDG 2030 Agenda: Recognising gender inequality as a main root of Sexual and Gender-based Violence, and inadequate access to Sexual and Reproductive Healthcare and Rights, the Alliance programme particularly refers to the SDG 3 "Ensure healthy lives and promote well-being for all at all ages" and SDG 5 "Achieve gender equality and empower all women and girls". So, besides the above-mentioned engagement on the level of institutions and communities, the Alliance also promotes gender equality by working with men and boys and by promoting access to psychosocial, medical and juridical support for victims of violence or insufficient healthcare. The Alliance has a long tradition in systematically cooperating with institutional actors, with academics and partners from civil society. Guided by SDG 17, the Alliance will additionally explore partnerships with the private sector mainly in the health sector in order to create a broader base for multi-stakeholder partnerships. Finally, the Alliance contributes to SDG 1 as women and children are the most affected by extreme poverty, and poverty rates are usually higher in fragile contexts. By addressing women and children in fragile contexts and improving their living conditions, the Alliance programme contributes to the reduction of poverty.

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Coherence to Switzerland's international cooperation: The strategic approach of Switzerland's international cooperation 2021-2024 defines four objectives which include health and gender equality. Its goal No. 3 "Human development" targets amongst others the strengthening of equal access to good quality basic services. Under the title "Peace and governance", goal 4 explicitly mentions the strengthening of human rights and gender equality. Other official strategies such as the "Swiss Health Foreign Policy" (2019-2024) or the "FDFA Strategy on Gender equality and Women's rights" (adopted in 2017) underscore the interdependence of gender equality and health.

For the actual phase 2017-2020, the Alliance and SDC have been engaged in a strategic dialogue on gender equality which for example has contributed to strengthening innovative approaches such as the engagement with men and boys in a gender transformative perspective. The Alliance will contribute to furthering SDC's engagement in the field of gender equality.[8]

Thus, Alliance visions and perspectives are comprehensibly aligned to the goals and strategies of Switzerland and of the international community. Its interventions are a complementary contribution to Switzerland's development cooperation objectives by supporting CBO/CSO and strengthening these organisations to participate in policy dialogue, to raise the voice of civil society, and to claim their rights at the level of national and international politics. The Alliance facilitates national organisations to participate to policy dialogue forums and engages with international organisations and within its networks to strengthen policy dialogue on an international level.

4 Strategic orientation

The Gender Equality & Health programme addresses the most vulnerable women and children in its partner countries. A special focus is on rural or remote areas. The Alliance works in 19 partner countries. Eight of them - Chad, Mali, DRC, Haiti, Cameroon, Afghanistan, Ethiopia and Zimbabwe - have alarming scores on the global fragility index.

Gender equality as a key condition for the reduction of vulnerability and poverty: As highlighted in Chapter 3 and stated in SDG 1, there is a strong link between high poverty rates and state fragility. Women and children are disproportionally affected by poverty. SDG 5 underlines gender equality as a fundamental human right and essential for sustainable social and economic development.

By working in fragile contexts and remote areas with vulnerable women and children in order to promote gender equality and improve access to rights and to SRHR, the Alliance contributes to the reduction of vulnerability and to the creation of better living conditions for its target groups. This is a real approach for poverty reduction.

Leaving no one behind: With the above presented orientation, the pledge of the Agenda 2030 of "leaving no one behind", is at the heart of the Alliance. Women and girls worldwide are still exposed to a wide range of discrimination. In addition to gender-based disadvantages, other factors such as ethnic or religious background, migration, societal or economic status impact the lives of women and children. This intersectional discrimination increases their level of vulnerability. The Alliance takes this into account by analysing and identifying the most vulnerable groups in its intervention regions, by collecting disaggregated data and by planning inclusive and/or specific programs to reach out to the most disadvantaged - for

[8] — In 2017, 5% of SDC funds went into gender-principal interventions. See SDC, 2017: Status Report on Gender Equality 2017 – Closing the Gender Gap, p. 12.

example, to Roma women in South Eastern Europe, or to migrant women, either internally displaced or on transition routes.

Stakeholders: The Alliance programme is always based on extensive partnerships with different stakeholders including civil society organisations, local authorities and private organisations and thus involves a plurality of partners in each intervention. For each intervention, the context of stakeholders and partners is carefully assessed. By working with official authorities on national, regional and local levels, the Alliance ensures that programs are aligned to respective national policies and strategies. The reinforcement of civil society and its organizations is seen as a crucial element to build an adequate response to the needs and expectations of the projects' beneficiaries and to strengthen opportunities for advocacy. The Alliance gives priority to the integration of the local partner in all stages to promote ownership and capacity building for empowerment.


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Vision for the future: The Alliance's emphasis on creating sustainable enabling environments and empowering its partners to achieve gender equality and guarantee equal access to SRHR, calls for a more long-term engagement. Consequently, beyond the current 2021-2024 cycle, the Alliance members are committed to continue working together, to respond to the needs of the most marginalised. In this sense, the Alliance acts as a catalyst for processes which are demanded by civil society groups and which in the medium term will lead to empowered local actors taking over responsibility.

5 The impact model: Theory of change

The five outcome pathways and their respective sets of intermediate change all contribute to the overall goal of the Alliance: *"Women and children have improved access to SRHR, realize their rights, live free from violence and other forms of discrimination, and make self-determined and informed decisions about their lives."*

The Alliance's TOC explicitly recognises and responds to the complexity of improving the state of gender equality and health outcomes. This reflects growing evidence and recognition of the need for a holistic approach for interventions on SRHR, SGBV (including work with perpetrators) and other forms of discrimination.

The key underpinning assumptions to the realisation of the overall goal are as follows:

- Gender equality is essential to the realization of human rights for all and hence constitutes a goal in itself. Women and girls are discriminated against at all levels, especially in health, education, political life, the labour market and so forth. The multiple forms of discrimination and violence such as intimate partner violence, FGM or child marriage negatively impact their development of capabilities and freedom of choice, as well as their use and access to services. Similarly, sociocultural norms surrounding a narrow definition of masculinity may hinder men and boys from seeking preventive and curative SRH services and/or from displaying caregiving and emotional intimacy because it is perceived as "feminine" and weak. These gender inequalities impose costs on the health and well-being of men, women and children and hence undermine a society's prospects for development. This illustrates the importance of redressing gender equality, whenever possible with gender-synchronized approaches.
- Sustainable positive change in gender equality and health within communities has to be supported by an enabling social, institutional and political environment that ensures inclusive quality services and systems.
- All outcome-pathways are based on the ecological model, are interdependent and mutually supportive and need to be synergistically addressed.

To reach our overall goal, a holistic approach is required with interventions at various levels: international, regional, national, district, facility, community and individual levels. The outcomes-pathways reflect those levels of intervention, rather than the programmatic topics covered through the Alliance. They range from national and international policy level (Outcome 1), to the relevant systems (Outcome 2), to the community (Outcome 3), and to the individual level (Outcome 4 and 5).

Within each outcome-pathway, specific actors and differentiated lines of actions are vital for intermediate changes. The graphic presents the lines of action per area of intervention that the Alliance, jointly with their local partners, will be implementing in order to achieve an enabling social, institutional and political environment. Regarding the actors of change, aside from multiple relevant stakeholders in positions of power (e.g. policy makers, medical staff, law enforcement officers, etc.), those left behind are clearly included (e.g. survivors of obstetric injuries or SGBV, women from discriminated communities, migrant women, etc.), both as beneficiaries and as agents of change for their own lives and within their communities.

All intermediate changes lead to at least one outcome whereas all outcomes lead to the overall goal. The interactions within one outcome-pathway as well as between the different outcomes are illustrated through different types of arrows. Wherever possible

gender synchronization between interventions targeting women and girls and men and boys is the objective.

Overarching Alliance strategies are defined that will contribute to scaling up the interventions and maximising the impact of the Alliance. These strategies include knowledge sharing, mutual learning, synergies and joint interventions between Alliance members as well as empowerment of the civil society and capacity building for the local partner organisations of the Alliance.

6 Intervention strategy

6.1. General intervention strategy

The Alliance's intervention is built on the impact model presented above. The Alliance will be jointly working towards the five commonly defined outcomes which its members understand as interlinked and connected to each other. Its programme is guided by a clear and ambitious gender strategy, orienting the Alliance's actions and institutional goals towards the realization of gender equality. And it is the synthesis of the missions and strategies of the members participating. The Alliance and its members understand themselves as a learning organisation that will continuously improve the effect of its work through quality management. The following aspects are mandatory interventions of the Alliance.

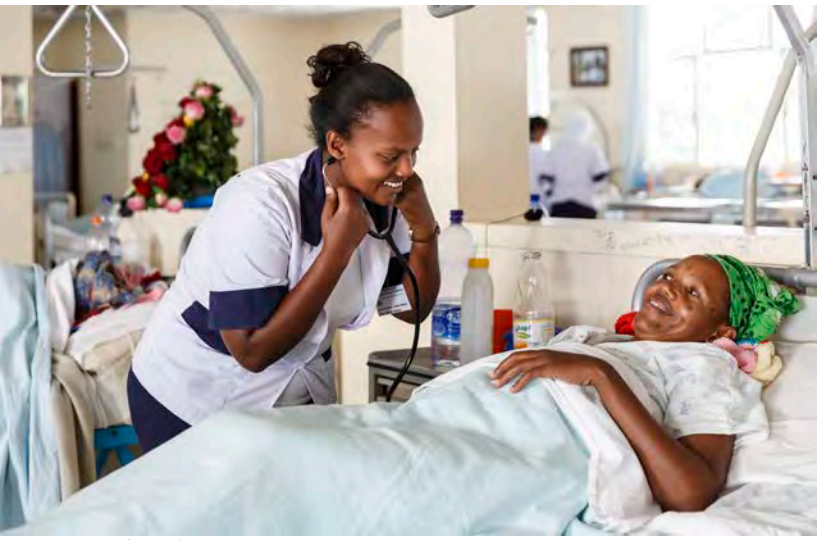
Good practices: Good practices can be characterised by various criteria such as a proven positive impact on efficiency and effectiveness, contextualisation, and innovative response to a specific challenge, among others. Good practices deriving from former experiences of the Alliance members inspire the actual Alliance programme:

- The complementarity of the work on operational and on policy levels is essential to promote sustainable change: individual women and children are empowered to become actors of their own health and to claim their rights. Partners are strengthened to engage in a policy dialogue to ensure the development and implementation of just legal frameworks that protect the rights of all, and to establish health services and equal access to it.
- Capacity building for the civil society partners is a means to increase their operational and managerial efficiency and to strengthen their voice in policy dialogue.
- Working with national and local actors ensures an appropriate contextualization of the interventions and local ownership.

Innovation and sustainability: The intervention includes innovative practices and approaches such as:

- Technology-based tools such as mobile applications for medical diagnosis or specific care design.

- Hotlines for facilitating complaint mechanisms or providing distant psychological support.
- Strengthening of local partners in working with men and boys in view of fostering the transformation of gender roles, attitudes and traditions discriminating against women and children.



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Interventions are aligned with national priorities and are implemented through extensive partnerships with civil society organisations, local authorities and private organisations – from the definition of the programme and throughout its implementation, thus involving a plurality of partners in each intervention. This creates a strong sense of national ownership and increases the likelihood for sustainability and the programme's continuity and success. Furthermore, Alliance members are engaged in tailored capacity building of partner organisations and other stakeholders as one of the effective drivers for sustainable development. Lastly, through the Alliance's gender-transformative approach, the programme invests in the sustainable human development of women and children and men and boys, which is leading towards a positive and long-lasting change in society as a whole.

Human Rights-based Approach: Working on Gender Equality & Health means working on human rights. A HRBA emphasises that the ultimate goal of all health policies, strategies and programmes is to further advance the realisation of the right to health and other health-related human rights as laid down in national and international human rights legislation. The same applies to the domains of women's rights and gender equality.

The Human Rights-based Approach is reflected throughout the Alliance programme in addressing:

- The rights-holders – women and children – by empowering them to know their rights and to make use of this knowledge and claim their rights;
- The duty bearers by strengthening and supporting them to introduce and to enforce respective norms and legislation and to provide and to improve the necessary systems and institutions and to ensure equitable access to information and services.

This HRBA even more challenging in fragile contexts with often weak state systems and poor public services such as healthcare or protection.

Humanitarian – Development Nexus: The fragile countries the Alliance is working in are all recipients of international humanitarian aid which contributes to cover the basic needs or the populations. In applying a Human Rights-based Approach and by addressing

the needs and rights of women and children in fragile settings and migration contexts, the Alliance is contributing to strengthening the nexus between humanitarian aid and development cooperation in these regions. It is considering Disaster Risk Reduction in its programmes, providing immediate support to victims of discrimination and violence while at the same time tackling structural causes, and as such, promoting sustained change.

Conflict-sensitive programme management: The Alliance members permanently re-estimate the risks in the environment where their programme is implemented. They do so with the expertise and information of local stakeholders, analysing with them the conflicts in which they are involved and reflecting on their role. They implement their programmes with the objective to reduce tensions, ensuring a transparent information on their activities and working as much as possible across the parties in conflict. As a minimal measure they apply a Do No Harm (DNH) approach to all of their projects.

Partnerships on local, national and international levels: The Alliance programme includes member-specific contributions within the common framework as well as joint approaches (see below, 6.2. and 6.3.). It understands the promotion of exchanges and collaboration between the public, private, community and scientific spheres within the same programme as an aim to increase the quality and overall impact of its actions. By working with official authorities on national, regional and local levels, the Alliance ensures that programmes are aligned to respective policies and strategies and - wherever possible - developed together with these official representatives. The reinforcement of civil society and its organizations is seen as a crucial element to building an adequate response to the needs and expectations of the projects' beneficiaries and to strengthening opportunities for advocacy. The Alliance gives priority to the integration of local partners at all stages to promote ownership and capacity building for empowerment. Accordingly, the Alliance members have developed mechanisms and tools to systematically include local partners from the conception to the execution and evaluation of their projects in order to ensure that interventions are relevant, locally owned and sustainable, while applying a development and humanitarian nexus lens.

In addition to local implementation partners, the Alliance promotes synergies with the international community and develops partnerships with international actors susceptible to providing thematic or cross-sectoral added value. These partnerships enable a greater impact of the programmes carried out as well as the optimization of resources in a country.

Country systems: The use of country systems strengthens local ownership and avoids the creation of parallel structures. Wherever possible the Alliance uses the respective systems for example in the areas of administrative systems, community processes, purchase and/or production of goods and services according to national procedures.

Main action lines: The Alliance's main action lines include lobbying and advocating for the development and regulation of laws; on capacity building on the level of institutions and partners; on awareness raising and mobilising communities; on empowerment of women, children and youth; and lastly on engaging boys in aiming at transforming gender roles.

PCM: The Alliance applies all principles of the PCM and continuously improves the quality of its interventions. The identification phase involves the analysis of the context, needs, determinants of gender inequality and health, existing actors and responses, opportunities and risks. The Alliance promotes participatory community diagnosis (PCD), bringing together the community's various stakeholders in a dynamic of dialogue, allowing problems to be identified and solutions to be formulated by all members of the community.

Organisational structure of the intervention: The members of the Alliance bear the responsibility for the programmes under their management, ensuring participatory project planning, implementation and monitoring, according to the Alliance's overarching strategy and log frame. To do so, they maintain regular contact with teams and partners in the field, who ensure daily project implementation, security and safety management and coordination between stakeholders.

6.2. The intervention strategies of the members

6.2.1 IAMANEH

IAMANEH Switzerland has been committed to women's health and empowerment since 1978. Through interventions in the fields of SRHR and gender-based violence it is working towards its vision that women and girls, especially the most marginalized, live a life free of any type of violence, and are empowered to make informed, independent and self-determined decisions regarding their health and all other areas of their lives in a gender equal and just world.

IAMANEH pursues this goal through the improvement of access to information and services on SRHR, including family planning/ contraception, comprehensive sexuality education for youth and access to means for healthy menstruation hygiene, systems and community-based interventions for healthy, respectful and safe pregnancy, the strengthening of measures for preventing gender-based violence and the protection, counselling and support to women and children survivors of gender-based violence.

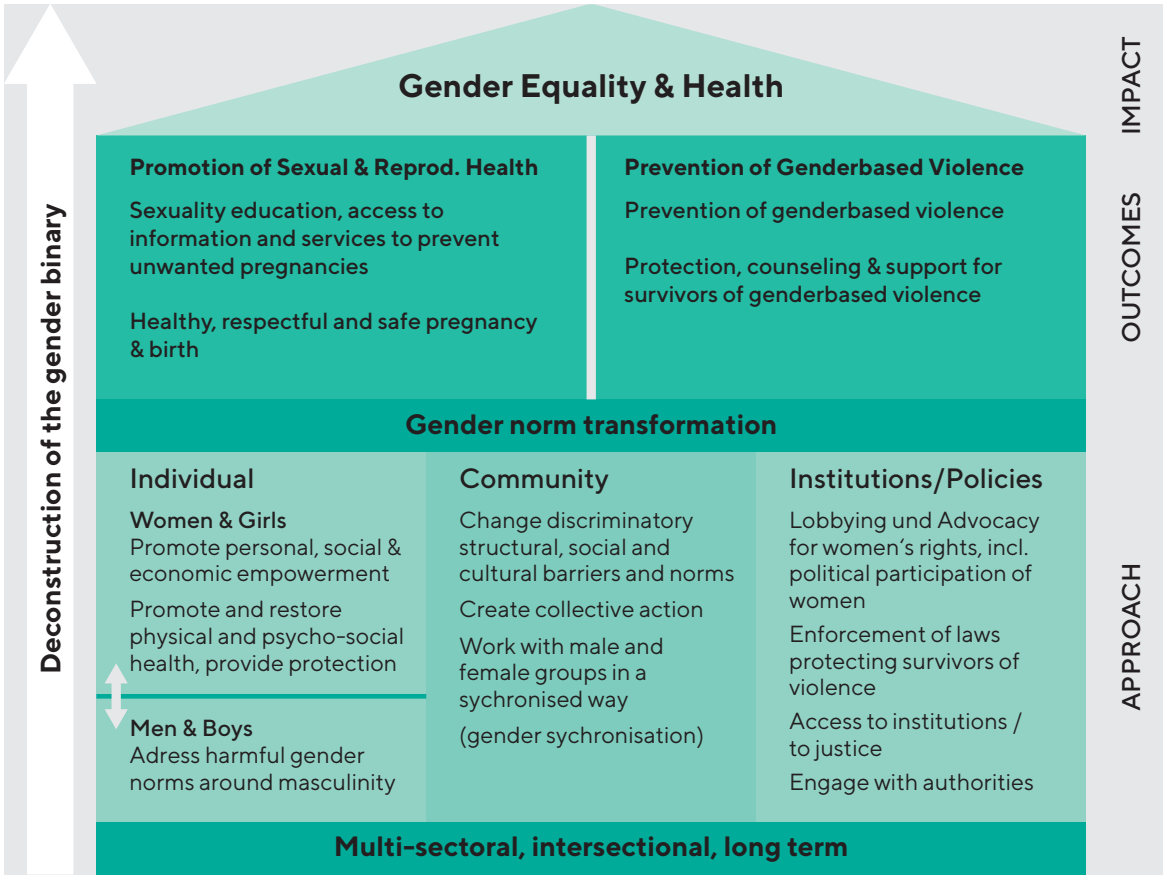
IAMANEH's interventions are implemented in Western Africa and the Western Balkans with projects in Mali, Senegal, Burkina Faso, Togo, Bosnia and Herzegovina and Albania.

For over 10 years, IAMANEH has been committed to gender-transformative work by addressing the root causes of gender inequality and by engaging men and boys for social norms change; in the Western Balkans through the lens of women's' health and

violence prevention, in various contexts and with a variety of target groups, including youth and perpetrators of violence; in West Africa since 2015, through the engagement of men and boys in promoting SRHR and the challenging of rigid gender roles.

During the period 2021-2024, gendertransformative work will continue to play an important role within the IAMANEH programme. Successful programmes implemented in Albania as well as in Bosnia and Herzegovina will be replicated and younger interventions in West Africa focussing on increased responsibility of men for SRHR, more balanced sharing of family care work including responsible fatherhood will be deepened. A particular focus will be put on synchronization of gender-transformative work with women and men.

IAMANEH's strategic and programmatic working approach: IAMANEH implements projects uniquely through local partner organisations. They are strengthened so that they can be an effective organ of civil society and to hold governments accountable. IAMANEH adopts a systemic and multi-level approach to addressing the barriers to women and girls accessing SRHR and to preventing SGBV. Within its programme, IAMANEH pays attention to the multiple and intersecting forms of vulnerability by considering women from ethnic minorities, women in rural areas, migrant women and women excluded from society as a result of obstetric injuries.



Within its 2014-2024 programme IAMANEH plans to further develop in particular the following:

- Reinforce gender-transformative work with institutions (justice, police, health) so that they provide services that are respectful to the rights of women and girls and apply existing standards and laws in a non-discriminatory manner; with policy-makers and authorities so that they more engage in policy development that is protective of the rights of women;
- Engage in gendertransformative work with media journalists in view of strengthening unbiased reporting on SGBV and reducing the reproduction of harmful gender stereotypes;
- Strengthen gender-synchronized work with women and men, improve dialogue and openness for change;
- Lobby for increased government financing of protection as well as counselling services for survivors of SGBV and systems integration of perpetrator counselling for sustainable availability of services;
- Extend IAMANEH's expertise in SGBV and SRHR to displaced women, girls and youth;
- Extend and deepen gendertransformative work with youth.

IAMANEH's specific contribution to the Gender Equality & Health Alliance: Within the Alliance, IAMANEH contributes to all five outcomes. The focus of IAMANEH's interventions is on Women and Girls (Outcome 4), notably through measures including psychosocial and legal counselling and access to medical treatment for survivors of violence as well as women affected by obstetric fistula, access to microcredit and professional training, life skills and leadership trainings, social mobilisation as well as information and communication work on SRHR, violence and gender equality.

Parallelly, interventions aiming at changing Men & Boys' attitudes towards more balanced gender norms and relations remain key to IAMANEH's programme (Outcome 5). Measures include the organization of platforms for men and boys to critically reflect on gender norms and to develop positive masculinity norms, the support of progressive men and boys who engage as promotors of SRHR and women's rights and actively address their peers, as well as the counselling of perpetrators. Measures targeting women, girls, men and boys are embedded in interventions aiming at community-based awareness norms change (Outcome 3).

At the systems level (Outcome 2), IAMANEH continues, together with their local partners in the Western Balkans, to advocate for increased commitment of local government to fulfil its legal obligations as to the financing of shelters for survivors of SGBV, and the systems integration of perpetrator counselling. In Western Africa, advocacy for improved and sustainable services, among others, targets the financing of health services. At the institutional level, IAMANEH actions will include capacity strengthening of, and

gendertransformative work with judiciary, police, health personnel as well as media journalists.

At the policy level (Outcome 1), IAMENEH's actions, on the one hand, target policy makers and authorities with gendertransformative work and on the other hand, local partner organisations in view of supporting their active participation in policy dialogue and the strengthening of legal frameworks and their effective application.

6.2.2 Médecins du Monde

MdM has been working since 1999 on fostering Sexual and Reproductive health and Children's health and currently develops three main areas of action: Sexual and Reproductive Health and Rights, Prevention and Management of Violence, and Paediatric Palliative Care. MdM's mission is to improve access to health for excluded populations in a sustainable way. Priority is given to women and children, who are the main victims of access barriers and failures of healthcare systems. MdM works with them, with a view to holistic care, according to their needs and the difficulties they encounter, to improve their physical, mental and social well-being.

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MdM develops people's capacities to be active in their health, prioritising the promotion of their autonomy and community involvement. To ensure effective action and lasting effects, MdM considers the specific characteristics and needs of vulnerable populations when determining its interventions. To this end, MdM favours social sciences methodologies, more specifically those of anthropological research and community participatory assessment.

MdM's international programme contributes to SDG 3, 5 and 16. Its intervention focuses on Sub-Saharan and Southern Africa, Latin America and the Caribbean, the Middle East and South Asia, with projects in Bangladesh, Benin, Cameroon, Democratic Republic of the Congo, Mexico, Haiti, Nicaragua, Palestine, South Africa, Togo and Zimbabwe.

In order to reduce health inequalities and ensure better health and well-being of its beneficiaries, MdM develops in each context an analysis of the determinants of health, and always works on a multidimensional approach to health. In this context, MdM pays particular attention to the following determinants of health: gender, environment and climate change, migrations and education.

MdM cares and bears witness, so that the right to health is effective for all, without financial, social, cultural or geographical obstacles. From the local to the global, MdM favours an integrated approach to provide sustainable and comprehensive solutions to inequalities in access to health. MdM calls on and supports regional, national and international authorities to improve access to healthcare and promote human rights.

MdM's strategic and programmatic working approach: MdM's action consists in carrying out, in partnership with communities, civil society organisations or the authorities, health programmes aimed at strengthening local skills, in order to bring about long-term changes. MdM equally promotes partnerships with international cooperation actors in Switzerland and members of NGO networks, with the aim to strengthen its role and impact in advocacy campaigns and policy dialogue.

MdM implements its programme through direct management, thus retaining responsibility for mobilising and effectively using the necessary resources to achieve the expected results. Operating with a largely decentralised system, most of the human resources are in the field. MdM's headquarters is responsible for supervising the various country programmes.

MdM's portfolio is mainly development oriented. MdM restricts its emergency and humanitarian interventions to countries where it already has a presence. It strives to ensure a continuity between emergency intervention and its development programme by applying common approaches for the identification of needs and objectives.

MdM benefits from a framework's or a project's agreements for all of its interventions. Projects are systematically aligned to national or local strategies and programmes, with the view to support their sustainable implementation. MdM extensively uses country systems for the delivery of its development assistance. It avoids creating project structures by locating whenever possible its project staff within the local partners' premises.

All projects include a governance component, in order to sustainably increase the capacity and accountability of managers and service providers, as well as to improve the active and inclusive participation of users in the management and qualitative development of services' provision.

MdM's specific contribution to the Gender Equality & Health Alliance: MdM contributes to all of the outcomes of the Gender Equality & Health Alliance. MdM develops specific advocacy to develop and implement health standards and policies (Outcome 1), supports health system's stakeholders on developing more inclusive and sustainable health services (Outcome 2), includes communities through participatory assessment and process (Outcome 3), empowers women and girls and men and boys to claim their rights and to create an environment conducive to gender equity.

Having long-standing experience and expertise in advocacy, MdM will create synergies with the other members of the Alliance by sharing its technical approach and methodology to support international and national entities in developing end ensuring new policies and quality standards on gender and health (Outcome 1).

In regard to the strengthening of health services (Outcome 2), MdM specifically brings to the Alliance its expertise on pain management ensuring pain-free treatments for the Alliance's beneficiaries. MdM

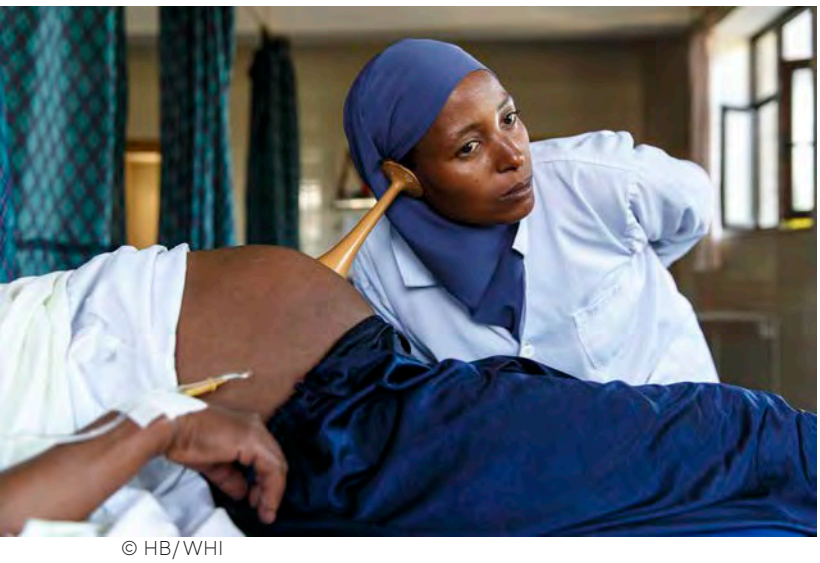
also contributes to the programme of the Alliance by sharing its expertise on a mental health programme's implementation as well as its specific expertise in developing and supporting the implementation of SGBV care protocols and medical certificates.

In terms of community inclusion and behaviour changes (Outcome 3), MdM contributes to the Alliance by sharing its methodology on community participatory assessment as well as its approach on anthropological research to develop better fitted response.

Having developed an extensive expertise in its multi-dimensional approach of health, MdM contributes to the global goal of the Alliance by sharing its expertise on including various health determinants in a project's design, allowing better equity in access to health for vulnerable populations. To develop a better comprehension of specific health systems by the Alliance, MdM contributes by sharing its anthropological approach.

6.2.3 Women's Hope International

WHI has been working since 2004 on fostering SRHR for women and girls. Its programmes are implemented in predominantly rural areas in Ethiopia, Afghanistan, Bangladesh and Chad. Through its multi-stakeholder approach, WHI is ensuring that all relevant actors are participating in all phases of the PCM. Together with its partners, WHI conducts participatory community assessments to identify problems, needs, and strengths in a community which in turn helps setting the right priorities and formulate objectives which lead to a sustainable impact.



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WHI is implementing its projects in partnership with specialized local civil society organisation. In particularly fragile areas, WHI established local offices to better accompany the planning, monitoring and implementation of the projects. All of WHI's interventions are closely aligned with national strategies and in coordination with regional and local health bureaus and other governmental entities. Furthermore, WHI's programme is closely linked with and is directly contributing to achieving SDG 3 and SDG 5.

WHI's strategic and programmatic working approach: WHI is applying a comprehensive intervention strategy and programmatic approach on the basis of the SEED-model . The SEED-model stands for Supply-Enabling Environment-Demand. It attends to the availability and quality of services and other supply-related issues, strengthens health systems, and fosters an enabling environment for SRHR-seeking behaviour as well as increasing the demand for it. Investments in one component will have an impact in another area. Activities that are well-coordinated and mutually reinforcing will yield optimal impact.

[9] — https://www.engenderhealth.org/files/pubs/family-planning/seed-model/SEED-8pg-English.pdf

WHI's intervention strategy 2020-2024 for all country programmes is based on three components with conflict sensitivity and resilience being addressed as cross-cutting themes:

1. Access to specialised obstetric treatment, care and prevention
2. Elimination of SGBV
3. Strengthening of the health governance system

Specific contribution to the Gender Equality & Health Alliance: WHI is significantly contributing to the Alliance Outcomes 2-4. With WHI's long-standing experience and expertise in providing specialist trainings for traditional birth attendants, midwives and gynaecologists - particularly in the field of obstetric birth trauma - WHI creates synergies with the other Alliance partners.

At the centre of WHI interventions lies the empowerment of women and girls to become agents of change. Together with partner organisations, WHI strengthens survivors of SGBV and obstetric fistula trauma by providing psychological support and physical rehabilitation, raises awareness about SRHR with a focus on child marriage and Female Genital Mutilation, and addresses key leaders to promote gender equality in their communities. WHI is applying a gender transformative approach in some of the most fragile countries globally, such as Afghanistan and Chad. WHI's experiences will enhance the learning opportunity for the Alliance and create approaches which can be adapted and replicated in other countries and contexts.

WHI is breaking new grounds in supporting innovative, ecological, sustainable and suitable health centre infrastructure by testing the earth-bag-structures (Super Adobe Domes[10]) in one of its projects in Chad. After assessing the pilot, WHI can share experiences with the Alliance members for further replication in other Alliance countries in Sub-Saharan Africa.

One of WHI's strong points lies in its proximity to the communities in which it works. WHI is applying the participatory community assessments to gather relevant baseline data, mobilise the different stakeholder in the communities and build trust[11]. By working with particularly marginalised and remote communities, WHI is ensuring that the most vulnerable of the communities are reached and are therefore supporting the commitment of the Swiss Agency for Development and Cooperation (SDC) to LNOB.

[10] — https://www.calearth.org/intro-superadobe

[11] — https://apps.who.int/iris/handle/10665/254989

6.3. Synergies, complementarities and cooperation

Building on each member's strengths, identified complementarities and shared vision, the Gender Equality & Health Alliance will, in its first joint cycle, benefit from programmatic and organisational synergies, and seize new opportunities for cooperation as they arise.

The areas Management, Finance and Knowledge & Approaches are focusing on the institutional cooperation and its benefits. The areas Programme and Policy Dialogue & Sensitisation are looking into complementarities in terms of the joint programme in the South and East as well as engagement in Switzerland.

Management: Within the Steering Group, the members are strengthened through the exchange of experiences, good practices and lessons learned. For example, they can carry out joint risk assessments and identify means of mitigating risks. This concerns contextual risks such as security and programmatic risk as well as institutional ones (e.g. SEAH, corruption, etc.). Another field of cooperation would be the exchange on approaches in good governance. This encompasses, but is not limited to, the sharing of policies in the fields of PSEAH, anti-corruption, child protection, etc.

Joint workshops for staff and/or partner organisations of Alliance members have been identified as one of the tools for making efficient use of limited resources. Topics could include HRBA, complaint mechanisms, Code of Conduct, PSEAH, gender mainstreaming, etc. Alliance members' staff members who are specialised in specific topics could also provide tailored capacity development at headquarter offices or in the field.

Finance: Areas such as cost transparency, efficiency and good financial and resource management are important concerns for all members of the Alliance. In order to submit a consolidated financial report on the joint Gender Equality & Health programme to the SDC, cooperation between the different finance departments is established. IAMANEH, MdM and WHI guarantee compliance with ZEWO and GAAP FER21 regulations and Swiss auditing standards. Audit reports and ZEWO re-accreditation confirmations will be exchanged between the members.

Another common area of interest is fundraising. The Alliance members are engaged in 19 countries, 10 of which are in Sub-Saharan Africa. This opens a potential field of cooperation for joint fundraising for specific projects or regional programmes.

Knowledge & approaches: With the Alliance members' high expertise in health and gender equality, an excellent opportunity exists to pool funds and human resources for developing new approaches. This includes investing in research, e.g. on fragility, in-depth context- and risk analyses, and on matters related to innovative approaches on for example maternal and new-born health, SGBV, etc.

Together, the Alliance will be able to capitalise on and further develop good practices and produce publications with a wider outreach through translating the documentations into German, English and French.

IAMANEH, MdM and WHI maintain a wide range of partnerships utilizing Swiss expertise. The organisations collaborate with academia for research (Universities of Lausanne, Fribourg and Bern, and the Swiss Tropical and Public Health Institute in Basel), mandating Swiss specialists for backstopping and capacity development as well as for quality management purposes. The cooperation as an Alliance allows tapping into these sources and benefitting from information and knowledge sharing.

During 2020 and in the programme phase 2021-2024, the Alliance will be assessing opportunities to increase the scope for engaging in public-private-partnerships (PPP) with Swiss and international actors. A good current example for such a PPP is an intervention where MdM facilitates the transfer of technical expertise from a private hospital to a public sector health facility.

Programme: The geographical overlap is currently in two countries: Togo (IAMANEH/MdM) and Bangladesh (MdM/WHI). On a regional level, all Alliance members are implementing programmes in Sub-Saharan Africa. Hence, there is an opportunity to develop joint projects benefitting from the different experience and expertise of the Alliance members. Potential fields for common projects are for example SGBV, fistula, and engaging men. The Alliance would also like to foster South-South Cooperation between the Alliance members' partner organisations.

While each Alliance member will be responsible for its own programme monitoring, knowledge and experience sharing will help in improving baseline studies, measuring indicators, and achieving results. There is also an opportunity for the Alliance members to participate in programme evaluations of other members (peer-review).

Policy dialogue & sensitisation: IAMANEH, MdM and WHI are engaged on different levels in policy dialogue nationally and internationally, as well as sensitisation of the public in Switzerland.

A close cooperation of Alliance members is foreseen in conducting joint events such as conferences, exhibitions, panel discussions, etc. The Alliance anticipates a better outreach to all of the geographical regions in Switzerland as well as to a wider audience. Lastly, Alliance members participate in different networks including participation in UN forums. Through this engagement, the Alliance will benefit from having a stronger presence and access to decision-making bodies.

7 Resources

The Alliance members manage their own staff in Switzerland and in the countries of intervention, amounting to 22 at headquarters and 52 in the field. The Alliance itself will not recruit any personnel but will rely on existing competences within the members' teams. Consultants will be mandated for tasks where the technical nature or the volume exceed the actual capacity of the members' team. Members' personnel consists of managerial, technical and medical staff, with specific expertise and extensive experience in the management and implementation of international development programmes. The teams are composed of both national and expatriate staff, with an egalitarian representation in terms of gender, ethnicity, social origin and impairment, in all functions or level of the organisations. All members and operational partners' staff adhere to a Code of Conduct and are sensitised to the prevention and detection of abusive comportments. The members have developed an alert system providing confidentiality to whistle-blowers and other stakeholders. The members share their in-house specific expertise through joint workshops and cross visits. They develop their staff competences through training activities, internal rotation and promotion.

The Alliance members ensure their financial independence and stability through a large diversification of their financial sources, in full respect of their Code of Ethics. Their competence at headquarters and in the field allows them to develop their resources in a coordinated manner between private, philanthropic, corporate and institutional donors. They can mobilise enough matching resources to ensure the full implementation of the proposed programme and have enough reserves to cover their operational costs for a minimum period of 6 months.

The overall budget of the programme amounts to 41'089'318 CHF for the period 2021 to 2024, including direct programme costs, programme support costs and transaction costs. It is based on the Alliance members' 2020 forecasts and includes moderate growth. The members plan to identify areas amongst existing projects where a collaboration with another Alliance's partner could add to the globality of the approach. The budget comprises the costs of these thematic extensions. SDC pledged to cover 36% of this budget through an Institutional Partnership programme contribution, amounting to 13'924'000 CHF.

	2021	2022	2023	2024	Total
International programme cost	9'325'699	9'594'768	9'976'584	10'218'369	39'115'420
SDC contribution 36%	3'481'000	3'481'000	3'481'000	3'481'000	13'924'000

8 Gender Equality & Health Alliance's risk management

Risk management is the activity of dealing with risks. This includes all measures for the identification, analysis, evaluation, monitoring and control of risks. According to ISO, risk management is a management task in which the risks of an organization are identified, analysed and evaluated. Risk management is an ongoing process and must be applied throughout the organization.

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The safe and effective implementation of development cooperation programmes depends on the careful management of risks that may arise at different levels. The member organisations of the Alliance therefore each have their own risk management system, which defines various risk areas and identifies the corresponding guidelines for action.

Members of the Alliance, and the Alliance as a whole, systematically integrate a Conflict-Sensitive Programme Management (CSPM) approach throughout their Programme Cycle Management. They observe the principles of Do No Harm to seek prevention and transformation of conflicts. This includes careful and regular analysis of contextual, programmatic and institutional risks for all interventions, specifically taking into consideration potential effects of a project's design, planning and implementation phases on local latent and open conflicts. When opportune the Alliance members work on conflicts by reducing their structural causes and developing local capacities for their peaceful transformation.

In dealing with crises, the members of the Alliance see a strategic advantage in being part of an Alliance because they can support each other. However, the goal is not joint crisis management. Within the framework of the Alliance, action plans and criteria for emergency management and communication strategies for crisis situations can be optimised and adapted to ensure the safety of employees and beneficiaries and the protection of the organisations against loss of image or economic weakening.

Various organisation-specific documents record the different risk areas and describe the corresponding measures, action guidelines and guidelines for risk minimisation. Examples of such relevant risk areas in international cooperation are:

- Programme development and implementation in fragile contexts
- Programme and project financing
- Acting through local partner organisations
- Corruption / corruption prevention
- Sexual exploitation, abuse and harassment
- Labour and child exploitation

In order to ensure professional risk management, Alliance members carry out a risk analysis using the FMEA tool (Failure Mode and Effects Analysis). This tool enables a meaningful analysis using three factors:

1) "Significance/Consequence for the organization"
2) "Likelihood of occurrence"
3) "Possibility of discovery or influence today"

The above-mentioned topics as well as other relevant areas such as project work, labour law, prohibition of discrimination, criminal law risks, organisational processes, release regulations, tax law/donation law, data loss, infrastructure, communication with the outside world, etc. of the individual member organisation, are evaluated.

Based on these 3 assessments, a separate risk priority number (RPN) is calculated for each risk. From a high RPN (>200), measures are defined in order either to minimize the risk or to increase its detection potential. In the case of a very high RPN (>600), immediate measures are taken.

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The new measures and findings are then supplemented in the "Risk Management" document and updated as necessary. The risk analysis is reviewed at regular intervals (at least every 2 years) to ensure that it is up to date. New risks arising from complaints and/or reports, statutory provisions, etc. are also included in the risk analysis and assessed.

With the risk management instrument described, the member organizations always have an up-to-date overview of the risks and the measures to be taken and can, if necessary, adapt their regulations and rules to reflect the latest developments.

9 Monitoring and steering

The implementation of the Alliance programme is conducted by a steering committee (SC), composed of the directors of the three member organisations and representatives of various stakeholders such as donors, beneficiaries and local implementing partners. The SC has the overall responsibility for the planning, monitoring and evaluation of the programme. It ensures alignment between the members and facilitates the effective coordination of all actors.

The SC meets on a semi-annual basis, or more often if needed, usually in Switzerland, but abroad when relevant. The SC revises the Alliance's risk analysis on a yearly basis, following the evolution of the general and specific contexts, or on an ad hoc basis in the event of a crisis. It monitors and supports members' adherence to good practices and to SDC requirements in terms of PSEAH. The SC supervises the development of the programme monitoring system, foreseen to be established during the programme's first year. The SC assesses programme performance and progress towards reaching the identified outcomes and proposes adjustments in the programme implementation itself or in the monitoring system. It also analyses the financial and audit reports of the Alliance's members and monitors their adherence to audit recommendations.

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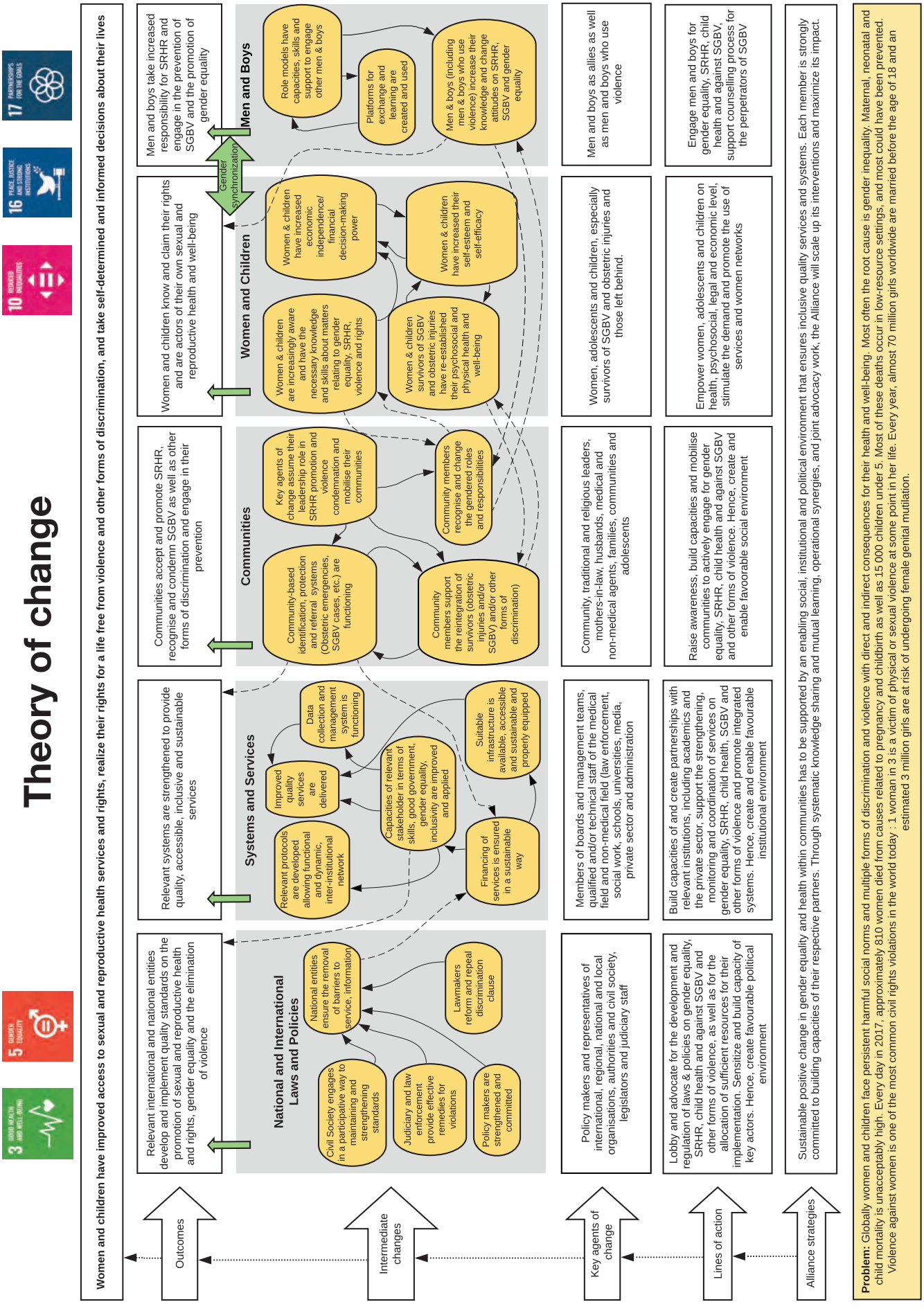
Each member of the Alliance is responsible for the monitoring of its results at project level, in coherence with the logical framework and following the common monitoring methodology and system developed. The Alliance members are also responsible for the management of their part of the funds provided by SDC for the implementation of the international programme and for its financial monitoring. The SC supervises the yearly aggregation of the collected data on programmatic and financial results. The SC is responsible for the production of the Alliance annual report.

The Alliance programme will be reviewed at mid-term, and an external evaluation is planned for 2023. The external evaluation will provide information and recommendations to the SC for it to assess the opportunity and, if pertinent, the format of a subsequent joint programme.

Annex: Theory of change



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