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HEART
HEALTH & EDUCATION ADVICE & RESOURCE TEAM

Social Development and Human Development

Topic Guide

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About HEART

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Overview

This Topic Guide aims to answer the question 'What is the interaction between social development issues and human development outcomes?' An individual's right to lead a long and healthy life, to be educated and to enjoy a decent standard of living cannot be realised without addressing social development issues. This is because these issues determine individuals' access to resources – who gets what, where, and how. This in turn affects whether human development is inclusive and equitable or perpetuates inequalities and exclusion.

Two main rationales for considering social development emerge from the literature. Without understanding and addressing social drivers of development, human rights will not be realised and development gains will be undermined. Secondly, by taking social development issues on board, development actors will achieve better results and better value for money.

This guide provides an overview of available evidence on how social development influences human development outcomes. It focuses on five social development issues (human rights, accountability, gender inequality, age and social exclusion) and their influence on four human development sectors: 1) health; 2) sexual and reproductive health (SRH); 3) education; and 4) water, sanitation and hygiene (WASH).

Human rights-based approaches form the basis of much of the literature. Rights underpin the purpose of human development interventions, and provide the guiding structure for measuring outcomes. As such, human rights encompass all aspects of social development. There are, however, four distinct social development issues under the human rights umbrella that deserve particular attention:

- **Accountability** of governments, services, and interventions helps ensure transparency and fulfilment of obligation in realising human development. Rights-based development is based on development actors' accountability in protecting and delivering those rights.
- **Gender inequality** remains a significant driver of poverty and gender inequity. Unequal power relations between men and women affect people's ability to fully access resources, services, institutions and power that lead to human development. This applies at both individual and structural levels.
- **Children, adolescents and older people** warrant special consideration in the realisation of human development. Poor human development at an early age can have a strong impact on the rest of life. Adolescents and older people have specific vulnerabilities and human development needs, which may not be adequately catered for in broadly targeted programmes.
- **Socially excluded groups** experience discrimination and inability to access services and institutions. Ethnic minorities, people living with disabilities (PWD), and those in isolated, rural locations experience individual and structural disadvantages, which restrict their ability to realise their rights and human development.

Almost all of the literature in this guide adopts an **equity or inequality approach**. Many papers recommend an equity approach to service provision. An equity approach is firmly embedded in human rights and, by recognising different individual and group needs, ensures greater access to services for a greater number and range of people than a blanket approach which offers the same services to everyone. On the whole, the literature recommends a **multidimensional, relational, and inter-sectoral approach** to research and interventions.

1 Concepts and debates

1.1 Key concepts

'Social development' refers to many of the non-economic processes and outcomes of development, including but not limited to: reduced vulnerability; inclusion; wellbeing; accountability; people-centred approaches; and freedom from violence.[1] It is fundamentally concerned with human rights, formal and informal power relations, inequality and possibilities for building greater equality among individuals and groups within societies.

'Human development' is a process of enlarging people's choices by building human capabilities to lead lives that they value.[2] This involves the capability to lead long and healthy lives, to be educated, to access resources and social protection, and fair employment. As such, human development is also fundamentally concerned with human rights, including those to life, health and wellbeing.

This Topic Guide explores how social development issues influence human development outcomes. It shows that addressing social development issues is crucial to optimising success in all efforts to promote human development.

1.2 How does social development influence human development outcomes?

Addressing social development issues can improve and sustain human development and reduce individual and community vulnerability. Poverty, gender inequality, social exclusion and geographic location can all affect a person's ability to realise their right to a decent standard of living. Moreover, individuals and groups may face multiple barriers to realising their rights. These barriers can negatively reinforce each other. For example, girls and women living with disabilities, or poor women living in rural areas, are likely to face greater barriers than most women living in better-off, urban settings. Challenges to human development can change throughout a person's life and especially at particular periods. For example, the early years of life, the transition from school to work and from work to retirement are periods when human development challenges are high.

Realising rights to human development involves understanding and addressing the social drivers of development. Without doing so, gains made will be undermined. By taking social development issues on board, development actors will achieve better results and better value for money.

This guide breaks down social development issues and human development sectors for conceptual clarity, but in reality the issues are intersecting and interdependent. Specifically, although human rights are addressed in one section of this guide, they apply to all the social development sections.

[1] World Bank, Social development overview: http://www.worldbank.org/en/topic/socialdevelopment/overview#1
[2] UNDP, Human development reports: http://hdr.undp.org/en/humandev

1.3 Key debates and challenges

Development actors have sought to incorporate a social development lens through **approaches** such as a human rights-based approach, Political Economy Analysis, inclusive institutions, and good governance. The literature recommends an inter-sectoral approach including engaging with other sectors of government and society to address influences outside of human development sectors.

The **international discourse** has been strongly influenced by the Millennium Development Goals' (MDGs) focus on human development outcomes. The new Sustainable Development Goals (SDGs) involve moving from a technical approach for increasing human development towards an equity/inclusion approach that focuses on 'leave no-one behind' (Starfield, 2007). Discussions draw on analysis of underlying power relations to understand intersecting inequalities and how these affect equitable outcomes. There is an increased emphasis on social norms and understanding social institutions, and on politics – including informal politics such as clientelistic relationships – and political analysis. Citizen engagement for increasing accountability is a strategy that donors generally support (Gaventa & Barrett, 2010).

The value-added of a social development approach is recognised in academic literature and policy. However, working to increase equity and shift power relations can be **difficult to put into practice**. Cultural norms are difficult to change, and donors can be reluctant to engage with an overtly political approach. Some of the **barriers** to including a social development lens include a lack of expertise in specific areas, such as gender, age or disability, difficulty working across sectors, and technocratic approaches to human development. Barriers also exist because people working in development and in basic services hold the same social and cultural norms as do their clients, and are subject to the same, or similar, social prejudices.

Starfield, B. (2007). Pathways of influence on equity in health. ***Social Science & Medicine, 64(*****7), 1355-1362.** http://dx.doi.org/10.1016/j.socscimed.2006.11.027
What are the pathways that generate inequities and through which they may be addressed? The literature shows that:

- Inequities are greater for severity of illness than for occurrence of illness, and the extent of inequities is greater at younger ages.
- Geographic aggregation of data influences conclusions on the nature and extent of inequities.
- Health services can contribute to reductions in inequity particularly through primary care services. However, this contribution depends on the type of health services, attention to the type and orientation of the health services system and not just simply the presence of health services. Failure to recognise the existence of health problems associated with inequity may be more important than failing to intervene when the problem is recognised.
- Efforts to improve average health are generally associated with increasing inequities, because new and effective interventions often reach the more advantaged first.

Gaventa, J. & Barrett, G. (2010). ***So what difference does it make? Mapping the outcomes of citizen engagement*** **(Working Paper 347). Brighton: IDS.** www.ids.ac.uk/files/dmfile/Wp347.pdf
This paper presents results from a meta-analysis of 100 research studies of citizen engagement in 20 countries. By mapping over 800 observable effects of citizen participation, the authors created a typology of four democratic and developmental outcomes – construction of citizenship; strengthening of practices of participation; strengthening of responsive and accountable states; and development of inclusive and cohesive societies. Citizen participation produced positive effects across these outcome types in 75 per cent of the outcomes studied, although in each category there were also examples of negative outcomes. These outcomes also vary according to the type of citizen engagement and political context.

See also the GSDRC Topic Guides on:

- Gender: gsdrc.org/topic-guides/gender/
- Human rights: gsdrc.org/topic-guides/human-rights/
- Inclusive institutions: gsdrc.org/topic-guides/inclusive-institutions/
- Service delivery: gsdrc.org/topic-guides/service-delivery/
- Social exclusion: gsdrc.org/topic-guides/social-exclusion/
- Voice, empowerment and accountability: gsdrc.org/topic-guides/voice-empowerment-and-accountability/

2 Human development and human rights

Human rights encompass civil, political, economic, social and cultural rights. They include everyone having a right to health, sexual and reproductive health and rights (SRHR), education and safe drinking water and sanitation. These rights have been formally and universally recognised by all countries from the 1948 Universal Declaration on Human Rights and reaffirmed through multiple treaties and declarations since. International human rights law sets out the obligation of states to respect and fulfil human rights for all. The international human rights framework can provide guidance on incorporating human rights into policy and practice. Human rights for human development rely on mutual accountability, whereby all actors, including citizens, communities, organisations and the government, are responsible for respecting and fulfilling mutually agreed human rights obligations.

Recent policy discussions have focused strongly on an **equity and inclusion approach** that targets the least served first (Pullan et al., 2014). In the health sector, this is health equity and health for all, meaning that everybody has healthcare appropriate to their needs and situation, rather than equal healthcare, where everybody receives the same care options (MacLachlan et al., 2012). In education, the Education for All initiative aims to ensure equitable access to education, including for individuals from vulnerable groups. In the water sector, there is a realisation that global progress on MDG7 has masked a failure to reach people and areas in most need of access to drinking water and sanitation (Pullan et al., 2014). An equity approach requires recognising the different needs of individuals and providing services that are accessible and affordable (Narayanan et al., 2012). *All* individuals have a right to access *quality* healthcare, education and safe drinking water and sanitation without discrimination or exclusion.

2.1 Health

Health policy draws on the right to *the enjoyment of the highest attainable standard of physical and mental health*. Health and human rights are inextricably linked: human rights violations may have health consequences, and the design or implementation of health policies and programmes may either protect or violate human rights (MacLachlan et al., 2012). For example, the lack of access to effective care for most people living with most diseases in poor countries can be viewed as a violation of human rights (Gruskin et al., 2007). Marginalised groups are especially vulnerable (MacLachlan et al., 2012). Poor health of a minority can undermine the health of an entire population. Human rights are imperative in the delivery of care and implementation of public health programmes. For example, a human rights-based approach has a strong potential for improvements in mental health policy and implementation (Jenkins et al., 2011).

MacLachlan, M., Amin, M., Mannan, H., El Tayeb, S., Bedri, N., Swartz, L., ... McVeigh, J. (2012). Inclusion and human rights in health policies: Comparative and benchmarking analysis of 51 policies from Malawi, Sudan, South Africa and Namibia. *PLoS One*, *7*(5), e35864. http://dx.doi.org/10.1371/journal.pone.0035864
How does health policy reflect human rights? If social inclusion and human rights do not underpin policy formation, it is unlikely they will be realised in service delivery. This examination of policies from Malawi, Namibia, South Africa, and Sudan shows that advances in the rights discourse around vulnerable groups is not reflected in country-level policy. It establishes that the four countries had generally high levels of core concepts of human rights included in their policies, but lower to poor inclusion of specific policies for vulnerable groups.

Gruskin, S., Mills, E. J. & Tarantola, D. (2007). History, principles, and practice of health and human rights. *The Lancet 370*(9585): 449-455. http://dx.doi.org/10.1016/S0140-6736(07)61200-8
This review provides a brief history of health and human rights and uses HIV/AIDS as an example of the effectiveness of the human rights approach in improving health-related policy and practice. Integration of

human rights in health systems is essential for improvement of public health at the individual and population level. The authors identify three topics that urgently need further work: 1) developing adequate monitoring instruments that measure both health and human rights concerns; 2) building evidence of the effects of applying the health and human rights frameworks to health practice; and 3) creating a research agenda on associations between health and human rights.

Jenkins, R., Baingana, F., Ahmad, R., McDaid, D. & Atun, R. (2011). Social, economic, human rights and political challenges to global mental health. *Mental Health in Family Medicine*, *8*(2), 87-96.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3178190/
This paper discusses the social, economic, human rights and political challenges to mental health, highlighting implementation issues at country level and in relation to the global development agenda. It draws on the small amount of published literature. It highlights the gaps in the global architecture for mental health and the need to strengthen the links between mental health and social development to ensure that factors that influence mental wellbeing, including access to adequate care, are effectively addressed. Human rights are an important lever for mental health policy and implementation. However, they have been used less effectively in low- and middle-income countries than in high-income countries, partly because of a relative lack of resources and, in some countries, less democratic systems. More international financing is needed to address growing mental illness.

2.2 Sexual and reproductive health

Sexual and reproductive health rights have been developed from the International Conference on Population and Development and the Beijing Platform for Action. They include rights to decide freely and responsibly on all aspects of sexuality, and the number and spacing of children; to be free from discrimination; and to attain the highest standards of sexual and reproductive health.[3]

Development discourse has been slow to recognise these rights, and policymakers are often reluctant to legislate on what is seen as a highly politicised and delicate area. The MDGs included SRHR in terms of reducing maternal mortality and ensuring universal access to reproductive health services (MDG5; Yamin & Boulanger, 2013). Whilst the MDGs increased attention to these issues, they reduced the wider discussion around SRHR and women's control of their bodies to a simplistic maternal health approach (Yamin & Boulanger, 2013). This excludes and simplifies the feminist and inequality agenda, shifting the discussion away from rights towards a technocratic and instrumentalist approach (Yamin & Boulanger, 2013). A rights-based approach allows a view of women and men as **active subjects** with control over their bodies, not passive objects of development programmes (Yamin, 2013).

Yamin, A. E. & Boulanger, V. M. (2013). Embedding sexual and reproductive health and rights in a transformational development framework: lessons learned from the MDG targets and indicators. *Reproductive Health Matters, 21*(42), 74-85.
http://dx.doi.org/10.1016/S0968-8080(13)42727-1
This article argues that the MDGs have embedded normative values into the development discourse, which has been particularly detrimental for sexual and reproductive health rights. Whilst setting simple MDGs raised awareness and defined quantified targets, policy attention was diverted from structural human rights concerns. The MDG agenda has depoliticised women's rights, and has undercut some of the gains made by the feminist movement. Women's health is viewed as a basic need rather than a right, which removes women's agency and choice. The article argues that there must be a strong narrative on social transformation to advance social, political, and gender justice.

[3] http://www.srhrguide.org/what-is-srhr/definitions

Yamin, A. E. (2013). From ideals to tools: applying human rights to maternal health. *PLoS Medicine*, *10*(11): e1001546 http://dx.doi.org/10.1371/journal.pmed.1001546
This article outlines achievements in applying human rights frameworks to maternal mortality and SRHR. It argues that human rights-based approaches can help shape policy decisions. It charts some of the historical development of this approach through the 1990s onwards, including pressures from the women's movement, the MDGs, and significant Human Rights Council decisions.

2.3 Education

Everyone has a right to *enjoy access to quality education, without discrimination or exclusion*. The right to education is affirmed in numerous human rights treaties and recognised by governments in international goals including the Education for All (EFA) goals. Education must be available; accessible (including to the most marginalised); of acceptable quality, relevant, non-discriminatory and culturally appropriate; and adaptable to suit local context. Education is not only a right: it is key to human development through improving health, reducing poverty and fostering peace, democracy and economic growth.

However, formal education is still denied to millions around the world due to lack of resources, capacity and political will. Providing non-formal education can provide people with the life skills they need, and can be a route back into the formal education system (Selim et al., 2013). Whilst international focus has been on providing access to education, *quality* and retention in education has not received the same attention. Consequently, even if children are attending school, the quality of education can be extremely poor and insufficient to equip children with the skills and knowledge they need to lift themselves out of poverty (UNICEF & UNESCO, 2007). A quality education cannot be achieved without recognising and committing to the human rights of children while they are in school. This includes respecting their identity, agency and integrity and addressing their rights to freedom from discrimination, to an adequate standard of living and to meaningful participation. Children cannot achieve their optimum development when they are subjected to humiliating punishment or physical abuse (UNICEF & UNESCO, 2007).

Selim, M., Abdel-Tawab, N., Elsayed, K., El Badawy, A. & El Kalaawy, H. (2013). *The Ishraq program for out-of-school girls: From pilot to scale-up - Final report.* Cairo: Population Council.
http://www.popcouncil.org/uploads/pdfs/2013PGY_IshraqFinalReport.pdf
The Ishraq (Sunrise) multi-dimensional programme for 12 to 15 year-old out-of-school girls started in 2001. It prepares girls in rural Upper Egypt for re-entry into formal schooling using group-based programming. This report describes the reach and effects of the programme on participants and communities. One outcome was that 81 per cent of participants who took the national literacy exam passed, and more than half of those girls joined formal schooling.

UNICEF & UNESCO. (2007). *A human rights-based approach to education*. UNICEF and UNESCO.
http://unesdoc.unesco.org/images/0015/001548/154861e.pdf
This document describes what is meant by a human rights-based approach to education, and its key issues and challenges. It provides a framework to guide policy and programme development and implementation to attain Education for All.

2.4 WASH

Access to *safe drinking water (a water source that is protected from contamination)* and *sanitation facilities* are fundamental human rights and are essential for good health. The right to safe drinking water and sanitation was fully recognised by the United Nations General Assembly and the United Nations Human Rights Council in 2010. Governments, considered as the primary duty bearers of rights, are obliged to include the rights to water and sanitation in their national legal systems and to ensure these rights are enforced. The meaning and legal obligations of these rights have been explained in a recent handbook (UN Special Rapporteur, 2014).

Where countries have recognised the right to sanitation, accelerated progress in coverage has been noted (DFID, 2011). So a human rights approach is likely to be more equitable and inclusive than the approach in those countries that have no specific rights focus (Narayanan et al., 2012). Although there is progress in reaching MDG7, high geographical inequality in drinking-water supply and sanitation (WSS) across sub-Saharan Africa highlights the need to reduce inequalities to reach the lowest coverage areas and population groups (Pullan et al., 2014).

Pullan, R. L., Freeman, M. C., Gething, P. W. & Brooker, S. J. (2014). Geographical inequalities in use of improved drinking water supply and sanitation across sub-Saharan Africa: Mapping and spatial analysis of cross-sectional survey data. *PLoS Medicine, 11*(4). http://dx.doi.org/10.1371/journal.pmed.1001626
This paper uses data on household reported use of open defecation and improved WSS from 138 national surveys undertaken from 1991–2012 in 41 countries. The data are used to develop maps of WSS coverage in sub-Saharan Africa and show geographical inequalities beyond simplistic rural-urban analysis, which provides the entry point for an equity and inclusion approach. Identifying and targeting inequalities in access and use are essential to achieving the goal of universal water and sanitation.

UN Special Rapporteur. (2014). *Realizing the human rights to water and sanitation: A Handbook.* OHCHR. http://www.ohchr.org/EN/Issues/WaterAndSanitation/SRWater/Pages/Handbook.aspx
This handbook is the product of six years of work by the first UN Special Rapporteur on human rights to water and sanitation. It is presented in nine booklets for governments, donors and national regulatory bodies. It explains the legal obligations that arise from these rights, provides guidance on implementation, and shares examples of good practice.

DFID. (2011). *Assessing the impact of a right to sanitation on improving levels of access and quality of services: Executive summary*. London: DFID in association with Coffey International Development.
http://r4d.dfid.gov.uk/PDF/Outputs/Water/60835_RTS-synthesis-for-SACOSAN-April.pdf
Does formal recognition of a right to sanitation (RTS) increase levels of availability and access to quality, affordable and adaptable sanitation services? This study finds that progress towards these goals seems to be faster in countries that have recognised an RTS. It is highly probable that sanitation services in countries seeking to fulfil an RTS will be more equitable and inclusive than elsewhere. However, attributing successes to a rights approach will require better monitoring and evaluation that includes rights-sensitive indicators. A further finding is that what makes formal recognition meaningful is a participatory approach to working to fulfil rights: citizen-state engagement is crucial.

Narayanan, R., van Norden, H., Gosling, L. & Patkar, A. (2012). Equity and Inclusion in Sanitation and Hygiene in South Asia: A Regional Synthesis. *IDS Bulletin, 43(*2), 101-111.
http://dx.doi.org/10.1111/j.1759-5436.2012.00314.x
This paper strongly advocates an equity approach to WASH which specifically targets the excluded. In part, this is to prevent elite capture and an increase in the inequality gap. In South Asia, the gains in sanitation have mainly been among the richest quintiles. An equity approach requires addressing the attitudinal, environmental and institutional barriers to adequate WASH.

See also:

- Combaz, E. (2013). *Poor people's rights and successful legal actions* (GSDRC Helpdesk Research Report). gsdrc.org/publications/poor-peoples-rights-and-successful-legal-actions/
- Crichton, J., Haider, H., Chowns, E. & Browne, E. (2015). *Human rights: Topic guide.* (Revised ed.) GSDRC gsdrc.org/topic-guides/human-rights/rights-and-health-water-and-sanitation/
- The Right to Education Project: www.right-to-education.org
- The Rights To Water And Sanitation: www.righttowater.info

3 Human development and accountability

Accountability is about ensuring that governments and service providers are **answerable** to their citizens and deliver on their commitments (political, financial or service delivery). To allow this, citizens must have a voice, and governments and service providers must have the ability and motivation to respond. This requires effective **redress** mechanisms when duties and commitments are not met.[4] Accountability relationships can occur at and between various levels – local, national and international, and be both vertical and horizontal. Transparency and accountability of services, organisations and institutions help improve their quality, responsiveness and answerability (O'Meally, 2013).

Accountability between citizens and public service providers can be understood as involving **two pathways: short and long.** Short route accountability links citizens directly with service providers, while long route accountability delegates citizens' authority to political representatives, who govern bureaucracies and service providers (Fox, 2014). **'Tactical accountability'** approaches aim to improve society's voice and access to information, while **'strategic accountability'** approaches use multi-pronged practices which also encourage enabling environments and government responsiveness reforms (Fox, 2014). Strategic approaches show more evidence of impact, while tactical approaches have only very limited evidence of effectiveness (Fox, 2014).

Context plays an important role in shaping accountability. Relevant contextual factors include inequalities in society, the ability of elites and states to respond to demands, and the nature of the political settlement and informal politics (O'Meally, 2013). It is important for accountability actors to consider formal and informal politics and power relationships, and to focus on increasing responsiveness and effectiveness, not just on increasing demand (O'Meally, 2013). Strategic accountability packages need to be built on strong contextual analysis and, where possible, be locally led and owned (Fox 2014).

Fox, J. (2014). Social accountability: What does the evidence really say? (Draft paper for GPSA). Washington, DC: World Bank. http://gpsaknowledge.org/wp-content/uploads/2014/09/Social-Accountability-What-Does-Evidence-Really-Say-GPSA-Working-Paper-11.pdf
This paper re-evaluates the body of evidence on impacts of social accountability initiatives. It suggests that there is more positive evidence for multi-pronged, strategic initiatives that encourage enabling environments and state capacity to respond. These have more impact than tactical interventions, which only promote citizen voice and access to information.

O'Meally, S. C. (2013). ***Mapping context for social accountability: A resource paper*****. Washington, DC: World Bank.** https://openknowledge.worldbank.org/handle/10986/16490
This paper finds that context shapes the form and effectiveness of social accountability in unpredictable and complex ways. The main messages are:

- Think 'politically' in designing and implementing social accountability, as formal and informal politics and power dynamics have strong effects.
- Build synergies between social and political forms of accountability, and work across the supply and demand divide.
- Build on what is already there, embed social accountability in 'organic' pressures for pro-accountability change, and 'work with the grain'.
- Take a multipronged approach to accountability reform, and address issues of poverty, inequality, and exclusion more systematically in social accountability programming. Address the global dimensions of accountability failures.
- Adopt longer time horizons and an adaptable learning-by-doing approach.

[4] http://www.transparency-initiative.org/about/definitions

3.1 Health

A systematic review suggests that there is no rigorous evidence on what works to improve accountability in healthcare (Berlan & Shiffman, 2012). Healthcare providers in low- and middle-income countries demonstrate limited accountability to consumers. This may have adverse effects on the quality of the healthcare they provide and on health outcomes (Berlan & Shiffman, 2012).

Berlan, D. & Shiffman, J. (2012). Holding health providers in developing countries accountable to consumers: a synthesis of relevant scholarship. *Health Policy and Planning, 27(*4), 271-280.
http://dx.doi.org/10.1093/heapol/czr036
What works in developing health care provider accountability? This is a systematic review of research on health provision in low-, middle- and high-income countries. The evidence base on what works is extremely weak. However, the research suggests four mechanisms that may improve provider responsiveness: 1) creating official community participation mechanisms in the context of health service decentralisation; 2) enhancing the quality of health information that consumers receive; 3) establishing community groups that empower consumers to take action; and 4) including NGOs in efforts to expand access to care.

3.2 Sexual and reproductive health

The literature suggests that accountability for SRHR is considered to be important in holding policymakers to internationally agreed goals, transforming services and meeting family planning needs (Boydell & Keesbury, 2014). There is almost no evidence on programme impact or effectiveness of accountability interventions for SRHR (Boydell & Keesbury, 2014).

Accountability addressing SRHR problems and solutions at the global level is very different to the complex reality that people experience in frontline health services. Approaches to accountability need to begin with the dynamics of power in the health services on the ground (Freedman & Schaaf, 2013).

Freedman, L. P. & Schaaf, M. (2013). Act global, but think local: accountability at the frontlines. *Reproductive health matters*, *21*(42), 103-112.
http://dx.doi.org/10.1016/S0968-8080(13)42744-1
How do women and men experience SRHR accountability with local level health service providers? This paper makes the case for a changed approach to accountability that begins with the dynamics of power at the frontlines, where people encounter health providers and institutions. Conventional approaches to accountability do not usually engage with power dynamics and the institutional incentives of policymakers and service providers. The authors suggest that approaches drawn from implementation science and systems science are better suited to understanding the political dynamics of health systems. An understanding of power and politics improves accountability towards health service users.

Boydell, V. & Keesbury, J. (2014). *Social Accountability: What are the Lessons for Improving Family Planning and Reproductive Health Programs? A Review of the Literature* (Evidence Project Working Paper). Washington, DC: Population Council.
http://evidenceproject.popcouncil.org/resource/working-paper-social-accountability-what-are-the-lessons-for-improving-family-planning-and-reproductive-health-programs/
This systematic review first presents the state of the evidence on accountability in the broader health sector. It then focuses on the family planning and reproductive health fields. In these fields, activities are often broader than social accountability (which tends to focus on the community or service delivery level), focusing instead on tracking the fulfilment of global and national policy and financial commitments. Some programmes are also applying the principles of social accountability to the delivery of rights-based, voluntary, high-quality FP/RH services.

3.3 Education

There is little information on accountability in education, but lessons from the health and WASH sectors might be applicable to education. Although the evidence is weak, it is known that participation helps make services responsive to users and ensures that they are used effectively. Schools function best when they respond to local needs and priorities, and local governance and accountability structures directly contribute to quality of schooling (Pradhan et al., 2011). Accountability to communities has an impact on keeping more children in school, and in improving their learning and ultimately their job prospects (Pradhan et al., 2011).

Pradhan, M., Suryadarma, D., Beatty, A., Wong, M., Alishjabana, A. & Gaduh, A. (2011). *Improving educational quality through enhancing community participation: results from a randomized field experiment in Indonesia.* Washington, DC: World Bank. http://dx.doi.org/10.1596/1813-9450-5795
To address deficiencies in service provision, is it effective to make schools accountable for performance? This study evaluates the effect of four randomised interventions aimed at strengthening school committees, and subsequently improving learning outcomes, in public primary schools in Indonesia. It concludes that measures that foster outside ties between the school committee and other parties, particularly the village council, are more effective than reinforcing existing school committee structures or providing grants and training interventions. This suggests that local governance contributes to improved learning.

3.4 WASH

Improved water accountability improves sanitation and hygiene, leading to improved health. There is a considerable body of literature on water services and governance, although less on water accountability specifically. The literature emphasises the role of community, both individuals and organisations, in managing water services accountably. Sanitation in particular requires locally appropriate technologies and solutions. Progress on sanitation is restricted by a lack of commitment from governments, which may change over time as sanitation became a human right in 2010.

Nicol, A., Mehta, L. & Allouche, J. (2012). Introduction: 'Some for all rather than more for some'? Contested pathways and politics since the 1990 New Delhi Statement. *IDS Bulletin, 43*(2), 1-9.
http://dx.doi.org/10.1111/j.1759-5436.2012.00300.x
This introduction provides a historical look at the development of the water and sanitation international discourse since 1990. It challenges the wider global water and sanitation community to rethink approaches and emphases, shifting from targets and technocratic terms to politics, sustainability and local knowledge. Water management has a complex political, social, economic and ecological landscape, which affects access, sustainability and control. There is an ongoing debate about whether water is an economic good or a right. The paper also challenges the perception of communities' ability and willingness to lead management of WASH delivery.

See also:

- Broadbent, E. (2010). *Public financial management and frontline service delivery* (GSDRC Helpdesk Research Report 653). http://www.gsdrc.org/docs/open/HD653.pdf
- Carter, B. (2014). *Transparency and accountability* (GSDRC Helpdesk Research Report 1067). http://www.gsdrc.org/docs/open/HDQ1067.pdf
- GSDRC Topic Guide on Service delivery: http://www.gsdrc.org/topic-guides/service-delivery/
- GSDRC Topic Guide on Voice, empowerment and accountability: http://www.gsdrc.org/topic-guides/voice-empowerment-and-accountability/

- HEART. (2010). *Education and community empowerment* (HEART Helpdesk report). http://www.heart-resources.org/2010/11/education-and-community-empowerment/
- HEART. (2012). *Voice and accountability in the education sector* (HEART Helpdesk report). http://www.heart-resources.org/2012/09/voice-and-accountability-in-the-education-sector/
- HEART. (2013). *Accountability in education* (HEART Helpdesk report). http://www.heart-resources.org/2013/01/accountability-in-education/
- HEART. (2013). *Community engagement in health service delivery* (HEART Helpdesk report). http://www.heart-resources.org/2011/11/community-engagement-in-health-service-delivery/
- HEART. (2013). *Voice and accountability in the health sector* (HEART Helpdesk report). http://www.heart-resources.org/2013/06/voice-and-accountability-in-the-health-sector/
- Rao, S. (2013). *Addressing high rates of public service absenteeism* (GSDRC Helpdesk Research Report 988). http://www.gsdrc.org/docs/open/HDQ988.pdf

4 Human development and gender inequality

Persistent and entrenched gender inequalities mean that women often experience lower human development outcomes than men. There are strong pressures on both men and women to behave in certain ways, and clear structural inequalities based on sex. A gender perspective on human development helps address the underlying social factors perpetuating gender inequality. These factors result in women's disproportionate ill health, lower educational levels and poor access to services. A gender perspective is rooted in a rights-based approach, and this chapter of the report is closely linked to the human rights chapter. As there is so much focus on women's sexual and reproductive roles, here the health and SRH sections are merged.

Women's vulnerability to poor human development is affected by the intersection of their class, gender, and other aspects of their social status (Iyer et al., 2008). Interventions are therefore most effective if they address the **multiple dimensions of inequality** that women face. This can be achieved with, for example, improved access to post-primary education, economic and political opportunity and the guarantee of women's safety.

Health, education and WASH services sometimes provide better services to men than to women. Women face individual-level barriers to access, such as girls being required to stay at home to care for relatives, and structural barriers, such as being less able than men to finance under-the-counter payments or bribes (Govender & Penn-Kekana, 2008). Women's rights to participate in public life and to make decisions for themselves are not always supported by laws or informal institutions. Violence against women and girls remains a systemic problem globally, with multiple human development effects such as mental and physical health problems and school dropout. Women's care roles and domestic duties also remain important mediating factors affecting their human development, limiting their access to paid work and schooling, and taking up a disproportionate amount of women's 'free' time.

4.1 Health / Sexual and reproductive health

The health of both men and women can be placed at risk due to prevailing notions of **manhood and masculinity**. These notions stem from patriarchal structures and social norms (Barker et al., 2007). Programme evaluations suggest that men and boys who adhere to more rigid views of masculinity are more likely to have used violence against a partner, to have had a sexually transmitted infection, to have been arrested and to have used substances (Barker et al., 2007). In general, men are poorer users of healthcare systems than women, and may find it harder to express vulnerability (Govender & Penn-Kekana, 2008). **Men and women sometimes receive differential care** for similar illnesses, owing to differences in health-seeking and provider behaviour (Govender & Penn-Kekana, 2008; Berlan & Shiffman, 2012). Women also carry the **main burden of caring** for sick relatives and household members (Esplen, 2009). This may undermine their rights and limit their opportunities, for example when girls drop out of school to care for family members (Esplen, 2009).

Many countries do not support women's rights in their **legal and policy frameworks**. This affects SRHR in particular. Restrictive laws and policies on access to contraception and abortion have significant human development costs, particularly when women seek unsafe abortion. Globally, forty per cent of women live in countries with restrictive abortion laws (Rasch, 2011). Unsafe abortion results in a large number of health consequences, including death. Poorer women are more likely to seek an unsafe method than richer women (Rasch, 2011).

Female Genital Mutilation/Cutting (FGM/C) is a serious violation of women's human rights. It is a form of violence against women and girls held in place by powerful social norms.[5] Up to nine out of ten women in parts of North and West Africa have undergone FGM/C (Berg & Denison, 2013). FGM/C causes a wide range of health complaints such as chronic pain, infections, fistula and difficulty in passing urine and faeces, severe psychological and emotional trauma, and can cause death (Berg & Denison, 2013). A recent systematic review confirms that, as there is no medical or religious requirement for FGM/C, its continuation and prevention are upheld by cultural practices and beliefs. Successful interventions have included legislation, awareness raising campaigns, and working through religious leaders and community health practitioners (Berg & Denison, 2013). More generally, **violence against women** is rooted in entrenched gender inequalities and must be tackled through community-based interventions that raise public awareness and challenge social norms, rather than by focusing on individuals (Garcia-Moreno et al., 2006).

Women's empowerment is well-evidenced to increase use of maternal health services. A systematic review (Prost et al., 2013) suggests that women's groups that focus on participatory learning and action are effective in reducing maternal mortality, neonatal mortality and stillbirths.

Iyer, A., Sen, G. & Östlin, P. (2008). The intersections of gender and class in health status and health care. *Global Public Health, 3(*S1), 13-24.http://dx.doi.org/10.1080/17441690801892174
Different axes of social power relations, such as gender and class, intersect. This paper provides a comprehensive literature review, suggesting that the impacts of single dimensions of inequality change significantly when they intersect with other inequalities. Studies confirm that measures of socio-economic status cannot fully account for gender inequalities in health. This strongly suggests that economic class should not be analysed by itself, and that apparent class differences can be misinterpreted without gender analysis.

Govender, V. & Penn-Kekana, L. (2008). Gender biases and discrimination: a review of health care interpersonal interactions. *Global public health*, *3*(S1), 90-103.
http://dx.doi.org/10.1080/17441690801892208
This comprehensive literature review shows that gender inequality, either alone or in combination with other inequalities, influences interactions between health care providers and patients. This negatively affects both women and men. Much of the gender bias reflects societal norms, and so needs to be tackled at the societal level. The health system is a site where gender norms can be challenged.

Barker, G., Ricardo, C. & Nascimento, M. (2007). *Engaging Men and Boys in Changing Gender based Inequity in Health: Evidence from Programme Interventions.* Geneva: WHO / Promudo.
http://www.who.int/gender/documents/Engaging_men_boys.pdf
How do social constructions of masculinity affect health equity? What kinds of interventions can produce behavioural change in men and boys? This review of 58 evaluations assesses the effectiveness of programmes seeking to engage men and boys in achieving gender equality and equity in health. The most effective programmes are those that include gender-transformative elements, which seek to change the social construction of masculinity and promote more gender-equitable relationships, and those that are integrated with wider community outreach or mobilisation initiatives.

Esplen, E., (2009). *Gender and care: overview report.* Brighton: Institute of Development Studies.
http://www.bridge.ids.ac.uk/reports/cep_care_or.pdf
How can we move towards a world in which individuals and society recognise and value the importance of different forms of care, but without reinforcing care work as something that only women can or should do? Three approaches are explored: challenging gender norms to encourage more equal sharing of unpaid care responsibilities between women and men and a less gender- segmented labour market in the

[5] The customary or informal rules that govern behaviour in groups and societies.

care professions; greater recognition of the huge amount of unpaid care work performed and the value of this work; and the social policy measures needed to ensure that care-givers are not disadvantaged because of their unpaid care responsibilities. The report also considers measures to better protect the rights of paid carers – to decent working conditions, minimum wages, basic benefits and protections, and the freedom to form associations and trade unions.

Rasch, V. (2011). Unsafe abortion and postabortion care–an overview. *Acta Obstetricia et Gynecologica Scandinavica, 90*(7), 692-700. http://dx.doi.org/10.1111/j.1600-0412.2011.01165.x
This article describes how restrictive laws are associated with the occurrence of unsafe abortion. It is based on a near-systematic review of articles from 2005 to 2010, and includes 67 publications. It describes providers and methods used to obtain unsafe abortion and the associated health consequences. Finally, it discusses post-abortion care as a means to address unsafe abortion. The most effective means of reducing unsafe abortion is legal change in restrictive laws, although this does not tackle anti-abortion attitudes in healthcare providers, or social norms.

Berg, R. C. & Denison, E. (2013). A tradition in transition: factors perpetuating and hindering the continuance of female genital mutilation/cutting (FGM/C) summarized in a systematic review. *Health Care for Women International, 34*(10), 837-859. http://dx.doi.org/10.1080/07399332.2012.721417
This systematic review examines 21 studies. Six key factors underpin the continuance of FGM/C: cultural tradition, beliefs on sexual morals, marriageability, religion, health benefits, and perceptions of male sexual enjoyment. Four key factors are perceived to hinder FGM/C: health consequences, it not being a religious requirement, it being illegal, and the rejection of FGM/C in host society discourse. The results show that FGM/C is used as a tool of social control and control of women's sexuality.

Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L. & Watts, C. H. (2006). Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet, 368*(9543), 1260-1269. http://www.dx.doi.org/10.1016/S0140-6736(06)69523-8
This study estimates the prevalence of IPV by conducting standardised population-based household surveys in ten countries between 2000 and 2003 on women aged 15 to 49. The findings confirm that physical and sexual partner violence against women is widespread. The reported lifetime prevalence of physical and sexual IPV, or both, varied from 15 to 71 per cent and from 4 to 54 per cent in the past year. In all but one setting, women were at far greater risk of physical or sexual violence by a partner than of violence from other people.

Prost, A., Colbourn, T., Seward, N., Azad, K., Coomarasamy, A., Copas, A., ... & Costello, A. (2013). Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. *The Lancet, 381*(9879), 1736-1746.
http://dx.doi.org/10.1016/S0140-6736(13)60685-6
What are the effects of women's groups practising participatory learning and action, compared with usual care, on birth outcomes? This paper conducts a systematic review and meta-analysis of randomised controlled trials undertaken in Bangladesh, India, Malawi, and Nepal to assess the effects in low-resource settings. The results show that exposure to women's groups was associated with a 23 per cent non-significant reduction in maternal mortality, a 20 per cent reduction in neonatal mortality, and a 7 per cent non-significant reduction in stillbirths. The authors conclude that women's groups practising participatory learning and action are a cost-effective strategy to improve survival, when at least a third of pregnant women are participating.

4.2 Education

Gender gaps persist in education in a number of ways: sex disparities in enrolment or completion; girls experiencing violence at school; informal institutions reinforcing gender stereotypes; self-esteem; and aspirations. Schools are spaces that replicate wider societal power dynamics and gender roles; along with formal learning, they also transmit social expectations and attitudes (Reilly, 2014).

In general, girls' access to school is responsive to **external variables** – the higher the distance or cost, the fewer the girls that go to school (Glick, 2008). Removing school fees has had a significant impact, increasing the numbers of girls in school. Boys tend to be sent to school even when there are high costs. Other factors also have more impact on whether girls, as opposed to boys, can access schooling. These factors include safety when walking to school, separate school toilets for boys and girls, and demand for domestic work (Glick, 2008). The policy implications are that schools closer to home, and reduced costs, will have disproportionately greater positive effects on girls' education.

Violence keeps girls (and boys) out of school (Reilly, 2014). **Gender-based violence** at school or on the way to school can include corporal punishment, sexual harassment, transactional sex, and child-to-child violence. Sexual violence is, in the main, perpetrated by male teachers on female students, often in exchange for good grades (Reilly, 2014). Poorer girls are more vulnerable than others to sexual abuse if they cannot pay for school-related expenses, or are at risk of failing exams. When girls do not want to take up this kind of relationship, they often drop out of school to avoid it.

The Young Lives study shows that **gender biases work against both boys and girls**, and are often context-specific, varying with location and age of the child (Dercon & Singh, 2013). It is important for policymakers to target the specific biases in each community (Dercon & Singh, 2013).

Glick, P. (2008). What policies will reduce gender schooling gaps in developing countries: Evidence and interpretation. *World Development, 36*(9), 1623-1646.
http://dx.doi.org/10.1016/j.worlddev.2007.09.014
This paper uses an economic model of why parents might invest in children's human capital, and how policy can change this. The evidence is mostly drawn from econometric analyses and some randomised experiments. Girls appear to benefit more than boys from gender-neutral policies such as increasing the general quality of schooling. A common finding is that girls' education is constrained more than boys' by the distance to school, and is more sensitive to the direct and indirect costs of schooling. Gender-targeted interventions have also been very effective for girls, and may be more expedient where there are large gender gaps. In particular, household subsidies and financial incentives to teachers for enrolling girls are successful. Gender-targeted interventions are broadly more effective for girls than gender-neutral ones.

Reilly, A. (2014). Adolescent girls' experiences of violence in school in Sierra Leone and the challenges to sustainable change. *Gender & Development, 22*(1), 13-29.
http://dx.doi.org/10.1080/13552074.2014.902239
How is gender-based violence in schools reduced? Plan UK have addressed violence in Sierra Leone through an integrated programme for adolescent girls focusing on four areas: the attainment of a quality basic education, freedom from violence, economic empowerment, and the enjoyment of sexual and reproductive health and rights. Physical and sexual violence is common for girls in schools, and parents and school boards often turn a blind eye. Plan has found that a holistic approach has helped reduce violence, through girls' and boys' rights clubs, teacher training, community discussion of the issue, engaging men and boys, and new school regulations.

Dercon, S. & Singh, A. (2013). From nutrition to aspirations and self-efficacy: gender bias over time among children in four countries. *World Development, 45,* 31-50.
http://dx.doi.org/10.1016/j.worlddev.2012.12.001

The Young Lives longitudinal study collects data from 12,000 children across Ethiopia, India (Andhra Pradesh), Peru, and Vietnam. This paper uses the data to assess gender gaps in nutrition, education, aspirations, subjective wellbeing, and psychosocial competencies. The paper finds that while gender gaps in child wellbeing persist, there is no overall trend in favour of boys, and trends vary considerably with location and age. It is suggested that gender inequalities in one dimension can perpetuate inequalities across different dimensions.

4.3 WASH

Poor and rural women and girls bear the brunt of the consequences of unsafe water and inadequate sanitation (Kevany & Huisingh, 2013). Poor WASH services have **disproportionately negative** effects on women and girls because they use these services the most (UNICEF, 2012). Girls and women are often responsible for fetching water for the household, and often have to walk long distances every day (UNICEF, 2012). Any risks associated with travelling, or travelling after dark, therefore apply disproportionately to women. Women often have to wait until after dark to defecate if there are no suitable facilities, which leaves them open to health problems and increased risk of sexual assault (Fisher, 2006). Shortages of water or inability to collect enough sometimes results in repercussions, such as domestic violence against women (Kevany & Huisingh, 2013).

There is a culture of embarrassment and taboos surrounding **menstruation** (Mahon & Fernandes, 2010). In parts of South Asia, it is common for women to be considered 'polluted' while menstruating, and for them to restrict their public and private interactions (Mahon & Fernandes, 2010). Around the world, girls often miss several days of school while they are menstruating. This is usually due to the lack of privacy and water in latrines for washing themselves and menstrual cloths, and because of anxiety and social stigma (Mahon & Fernandes, 2010). Access to facilities is not enough to improve menstrual hygiene; cultural norms must also be taken into account (Mahon & Fernandes, 2010).

It is well-established that a gender perspective significantly improves WASH programmes' effectiveness and sustainability, improves women's lives, and improves health in the wider community (Fisher, 2006).

Kevany, K. & Huisingh, D. (2013). A review of progress in empowerment of women in rural water management decision-making processes. *Journal of Cleaner Production, 60,* 53-64.
http://dx.doi.org/10.1016/j.jclepro.2013.03.041
What are the links between water infrastructure, water policies, processes and protections, and women's leadership and decision-making? This comprehensive literature review takes the approach that privatisation, climate change, and cost negatively affect women's access to water. It identifies seven key issues that affect women: 1) water insecurity contributes to poor mental wellbeing; 2) spiritual and physical wellbeing are undermined by eco-disequilibrium and disrespect; 3) gender violence is associated with unsafe and inaccessible water; 4) climate change, inconsistencies in rainfall, harvests, community income, and global pressures in commodity trading affect rural wellbeing and gender equality; 5) legislation that prohibits women's entitlement to resources and land creates problems; 6) gender inequality is maintained by political philosophies, policies and practices; and 7) strategies to privatise and commercialise water are rapidly expanding. The paper outlines the international policy principles responding to these issues.

UNICEF. (2012). *Water, Sanitation and Hygiene. 2012 Annual Report.* UNICEF.
http://www.unicef.org/wash/files/2012_WASH_Annual_Report_14August2013_eversion_(1).pdf
This annual report outlines UNICEF's work and progress on WASH globally. It contains chapters on emergency coordination, the environment and climate change, gender and monitoring.

Fisher, J. (2006). *For her it's the big issue: putting women at the centre of water supply, sanitation and hygiene* (Water, Sanitation and Hygiene: Evidence Report). Geneva: Water Supply and Sanitation

Collaborative Council. https://dspace.lboro.ac.uk/dspace-jspui/bitstream/2134/9970/20/wsscc_for_her_its_the_big_issue_evidence_report_2006_en.pdf
How does women's involvement in WASH create benefits? This paper uses case studies to show that women's involvement in WASH has: improved interventions' efficiency and effectiveness; promoted changes in hygiene practices; changed traditional gender roles; increased opportunities for women's employment; increased girls' school attendance; reduced child mortality; and increased women's safety.

Mahon, T. & Fernandes, M. (2010). ***Menstrual hygiene in South Asia: a neglected issue for WASH (water, sanitation and hygiene) programmes.*** **WaterAid.**
http://www.wateraid.org/~/media/Publications/menstrual-hygiene-south-asia.pdf
Why is menstrual hygiene management not generally included in WASH initiatives? What are the social and health impacts of this neglect on women and girls? Women are often excluded from decision-making and management of WASH programmes, which compounds the reluctance to speak openly about menstruation. This paper provides examples of successful approaches to tackling menstrual hygiene in WASH in South Asia. It is supported with a case study of WaterAid in India.

See also:

- Kangas, A. (2011). *Female Genital Mutilation/Cutting and gender indicators* (GSDRC Helpdesk Report). http://www.gsdrc.org/docs/open/HDQ734.pdf
- Kangas, A., Haider, H., Fraser, E. & Browne, E. (2014). *Gender: Topic Guide*. (Revised ed.) GSDRC. http://www.gsdrc.org/go/topic-guides/gender/sexual-and-reproductive-health-and-rights
- HEART. (2011). *Safe transport for girls* (HEART Helpdesk report). http://www.heart-resources.org/2011/07/safe-transport-for-girls/
- HEART. (2013). *Community-led total sanitation in Africa* (HEART Helpdesk report). http://www.heart-resources.org/2013/05/community-led-total-sanitation-in-africa/
- HEART. (2013). *Women's literacy and the links between maternal health, reproductive health and daughter education* (HEART Helpdesk report). http://www.heart-resources.org/2010/07/womens-literacy-and-the-links-between-maternal-health-reproductive-health-and-daughter-education/
- HEART. (2014). *Family planning topic guide.* http://www.heart-resources.org/topic/family-planning/
- MacAslan Fraser, E. (2012). *Risks, effects and prevalence of VAWG* (GSDRC Helpdesk report). http://www.gsdrc.org/docs/open/HDQ775.pdf
- Mcloughlin, C. (2011). *Impact evaluations of programmes to prevent and respond to violence against women and girls* (GSDRC Helpdesk report). http://www.gsdrc.org/docs/open/HD789.pdf
- Miller, J. (2013). *Female Genital Mutilation* (HEART multimedia resources). http://www.heart-resources.org/mmedia/heart-talks-jane-miller-on-female-genital-mutilation/
- Tomlinson, M. (2014). *Maternal mental health in the context of community based home visiting: 'Acting urgently, building slowly'* (HEART multimedia resources). http://www.heart-resources.org/mmedia/maternal-mental-health-context-community-based-home-visitingacting-urgently-building-slowly/
- UNFPA & UNICEF (2013). *UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating change 2008-2012. Final report* (Volume I). New York: UNFPA & UNICEF http://www.unicef.org/evaluation/files/FGM-report_11_14_2013_Vol-I.pdf

5 Human development and age

How does age affect human development outcomes? It is widely known that the first five years of a child's life are crucial to later development, with impacts echoing throughout life. A large amount of literature across international development topics looks at this period of life. Adolescence also involves specific needs and impacts, as young people transition from school to work, and from childhood to adulthood. In addition, as countries experience longer life expectancy and ageing populations, research and policy interest has turned towards the specific needs of older people.

Age often **equates with power**: children and young people may not be able to exercise influence or make decisions for themselves, and older people may be more respected but dependent on others for care. Human development for these groups may therefore be mediated through their working-age, able-bodied family members.

There is a considerable **demographic transition** underway globally, with youth[6] and older people the key sectors. In general, there is a global shift towards older populations, particularly in higher-income countries, while low-income countries, particularly in sub-Saharan Africa, have a youth bulge. Globally, the population aged over 60 is growing, and the world's population is ageing rapidly (HelpAge International, 2014). Currently one in nine people is over 60, and this is expected to increase to one in five by 2050 (HelpAge International, 2014). Sub-Saharan Africa has a growing adolescent population, but globally, the number of adolescents is declining (UNICEF, 2011). Sub-Saharan Africa is expected to have more adolescents than any other region in 2050. This youth bulge may result in a demographic dividend, if young people can be fully employed and contributing to the national economy. These demographic changes mean that social policy must also change to secure human development for all people.

There is most **evidence** on the specific needs of children and adolescents. Human development factors for children are well-evidenced and discussed in much development literature. The literature on adolescents almost exclusively refers to their sexualities (Kabiru et al., 2013). In the health sector this mainly addresses SRH needs, and in WASH it mainly addresses the sanitation needs of adolescent girls (covered in the Gender section of this guide, so there is no WASH section below). There is therefore a gap in the literature around the other human development issues for adolescents. There is a reasonable literature on older people's additional health needs, but almost nothing on their specific SRH, education or WASH needs. The demographic shift signals an urgent need to consider the specific vulnerabilities and circumstances of older people in developing countries.

The references cited below overlap across the human development categories of health, sexual and reproductive health and education.

HelpAge International. (2014). ***Why health systems must change: Addressing the needs of ageing populations in low- and middle-income countries*** **(HelpAge briefing). HelpAge International.**
http://www.helpage.org/global-agewatch/reports/helpage-briefing-why-health-systems-must-change/
This is an analytical report on a two-year HelpAge programme piloting a range of interventions to address the health needs of older people in Cambodia, Mozambique, Peru and Tanzania. It confirms the perception that older people face unique health and living challenges that demand innovative solutions. It suggests: good care; health literacy; availability of essential treatments; health curriculum reform; and simultaneous bottom-up and top-down strategies.

UNICEF. (2011). ***The state of the world's children 2011: Adolescence an age of opportunity*****. UNICEF.**
http://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report_EN_02092011.pdf

[6] 'Youth' refers to people between 15-24 years old; and 'adolescents' are people between 10-19.

This report outlines the challenges adolescents face in health, education, protection and participation, and the risks, vulnerabilities and opportunities of this pivotal stage of life.

5.1 Health

Household **decisions about healthcare for children** are usually made by parents or guardians, and can be strongly mediated by cultural and social factors. These include beliefs and illness perceptions, perceived severity of the illness and of the efficacy of treatment options, rural location, gender, household income and cost of treatment options (Colvin et al, 2013).

Maternal education, empowerment and status are important social determinants of child health and survival, as mothers often have primary responsibility for children's care. Adolescent mothers are the most likely to be poor, and to pass on poverty to their children (UNICEF, 2011). Women can have restricted access to and control over resources (Richards et al., 2013) and decision making in seeking care (Colvin et al, 2013). Exposure of children to **domestic violence** can affect their health, growth and nutrition (Yount et al., 2011). It is important to ensure efforts to improve children's health empower women rather than reinforcing gender inequities.

Adolescents are generally healthier than in previous generations, and accidents are the greatest cause of death for this group (UNICEF, 2011). Young people are often treated in adult health centres, but may not be responsive to their needs – which include limited knowledge, distrust, fear of mistreatment, shyness, lack of money, barriers related to marital status and stigma for seeking SRH care (Kabiru et al., 2013; UNICEF, 2011). UNICEF recommends adolescent-friendly health facilities.

For **older people**, the burden of ill health becomes greater as they age, needing more care at home and more medical attention. The demographic shift towards an ageing population means there are fewer infectious diseases and more chronic and degenerative diseases (HelpAge International, 2014). Older people may find it difficult to travel to health centres, and may have lower incomes due to not working. They require health and social care simultaneously. HelpAge recommends a holistic continuum of care for older people, focusing on community and home-based care. Coordinating associations may help them to navigate the healthcare system. It is also essential for older people to have health literacy.

Colvin, C. J., Smith, H. J., Swartz, A., Ahs, J. W., de Heer, J., Opiyo, N., ... & George, A. (2013). Understanding careseeking for child illness in sub-Saharan Africa: A systematic review and conceptual framework based on qualitative research of household recognition and response to child diarrhoea, pneumonia and malaria. *Social Science & Medicine, 86,* 66-78.
http://dx.doi.org/10.1016/j.socscimed.2013.02.031
This systematic review synthesises qualitative evidence on factors that underpin household recognition and response to child diarrhoea, pneumonia and malaria in sub-Saharan Africa. Factors that influence household care-seeking include: cultural beliefs and illness perceptions; perceived illness severity and efficacy of treatment; rural location; gender; household income; and cost of treatment. Previous experience with health services and habit also play a role.

Richards, E., Theobald, S., George, A., Kim, J. C., Rudert, C., Jehan, K. & Tolhurst, R. (2013). Going beyond the surface: Gendered intra-household bargaining as a social determinant of child health and nutrition in low and middle income countries. *Social Science & Medicine*, 95, 24-33.
http://dx.doi.org/10.1016/j.socscimed.2012.06.015
Can a woman's intra-household bargaining power influence child health and nutrition? This comprehensive literature review examines the evidence of the impact of gender relations in the household on child health and nutrition. Women's access to resources can improve health and nutritional outcomes for their children, but women do not always have control over the distribution of those resources, and can have lower levels of income than men. This decision-making process often relies on

negotiation among household members, in many cases between the mothers and fathers, but also between older and younger members (such as mothers-in-law and mothers).

Yount, K. M., DiGirolamo, A. M. & Ramakrishnan, U. (2011). Impacts of domestic violence on child growth and nutrition: a conceptual review of the pathways of influence. *Social Science & Medicine, 72*(9), 1534-1554. http://dx.doi.org/10.1016/j.socscimed.2011.02.042
Children's exposure to domestic violence (CEDV) predicts poorer health and development. Evidence is emerging that CEDV affects child growth and nutrition, but this is an under-studied area. Younger children are disproportionately exposed to domestic violence because they spend more time with their mothers than do older children. Prevention of domestic violence could improve child growth and nutrition.

5.2 Sexual and reproductive health

The literature on **SRH and age** mainly focuses on adolescents. Immature bodies mean adolescents are more vulnerable to STIs, HIV, and negative pregnancy outcomes). Girls are susceptible to coercive relationships with older men, and boys are societally expected to have many sexual experiences. Condom use is still not high, remaining at around a third to half of adolescents at most recent sex, although it is increasing (Bearinger et al., 2007). Adolescents often avoid seeking healthcare for SRHR, because of long waits, distance, lack of money to cover costs, and the lack of a welcoming atmosphere (UNICEF, 2011). There is almost no literature on the SRHR needs of older people.

The health consequences of **Child**, **Early and Forced Marriage (CEFM)** include isolation and depression, risk of STIs and cervical cancer, risks during pregnancy, labour and delivery and high rates of maternal and infant morbidity and mortality (Raj & Boehmer, 2013). Adolescent pregnancy, whether inside or outside marriage, involves high health risks (UNICEF, 2011). Current research suggests HIV is not more prevalent among nations that are more affected by child marriage, although this is under debate (Raj & Boehmer, 2013). Although child marriage includes boys, girls are most affected. Policymakers need to address the social and cultural aspects of child marriage in order to mitigate the health consequences.

Other approaches for adolescent SRHR include: friendly clinical services; sex education programmes that provide developmentally appropriate, evidence-based curricula; and youth development strategies to enhance life skills, connections to supportive adults, and educational and economic opportunities (Bearinger et al., 2007). UNICEF (2011) suggest that adolescent-friendly health centres are the most effective way to encourage uptake of services.

Bearinger, L. H., Sieving, R. E., Ferguson, J. & Sharma, V. (2007). Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential. *The Lancet*, *369*(9568), 1220-1231. http://dx.doi.org/10.1016/S0140-6736(07)60367-5
What are the trends in adolescent SRHR? This paper synthesises the global findings from reviews. There are huge variations across regions and countries, but some patterns in behaviours, access to services and interventions. Young people need access to quality clinical services that offer effective treatments and vaccines, coupled with sex education that gives medically accurate information and teaches skills for negotiating sexual choices.

Raj, A. & Boehmer, U. (2013). Girl child marriage and its association with national rates of HIV, maternal health, and infant mortality across 97 countries. *Violence Against Women*, *19*(4), 536-551. http://dx.doi.org/10.1177/1077801213487747
Are nations with higher rates of girl child marriage at increased risk for poorer maternal and child health indicators and HIV? The authors used regression analysis on national indicator data from 2009 United Nations reports from 97 nations for which girl child marriage data were available. Countries with higher rates of girl child marriage are significantly more likely to contend with higher rates of maternal and infant mortality and non-use of maternal health services, but not HIV.

5.3 Education

The key educational issues for younger children are mainstreamed throughout this guide. There is increasing attention paid to adolescent and post-primary education. Adolescence is a period when school dropout is most likely: one in five adolescents are out of school globally (UNICEF, 2011). Secondary schools are often more costly and further from home. There are increasing incentives to drop out in order to work. Early entry into the labour market has associations with reduced earning potential, exploitation, and susceptibility to gang recruitment, among others (Kabiru et al., 2013). Young married girls are also very likely to drop out of formal schooling (Lee-Rife et al., 2012). A recent systematic review suggests that an effective way of reducing CEFM is providing financial incentives for girls to stay in school (Lee-Rife et al., 2012). Education delays marriage, pregnancy and childbearing, and school-based sex education can be effective in changing the attitudes and practices that lead to risky sexual behaviour in marriage (Lee-Rife et al., 2012).

Kabiru, C. W., Izugbara, C. O. & Beguy, D. (2013). The health and wellbeing of young people in sub-Saharan Africa: an under-researched area? *BMC International Health and Human Rights*, 13(1), 11.
http://www.biomedcentral.com/1472-698X/13/11
There are few SSA-based long-term studies on youth development that can clarify linkages between health and the social, political, and economic contexts that define the lives of African youth. Youth health and wellbeing literature mainly focuses on sexual and reproductive health. This paper briefly reviews how the literature treats the following issues in relation to young people: education, urbanisation, globalisation, HIV/AIDS and conflict.

Lee-Rife, S., Malhotra, A., Warner, A. & Glinski, A. M. (2012). What works to prevent child marriage: A review of the evidence. *Studies in Family Planning*, *43*(4), 287-303.
http://dx.doi.org/10.1111/j.1728-4465.2012.00327.x
This article systematically reviews 23 child marriage prevention programmes carried out in low-income countries. Most programmes included child marriage as a secondary aim. The primary focus was gender inequality, poverty or other issues. The evidence suggests that programmes offering incentives and girls' empowerment can be effective in preventing child marriage and can foster change relatively quickly. It remains unclear whether impacts are sustained after the programme ends. Also unclear are the details of how change happens.

See also:

- Haider, H. (2011). *Early marriage and sexual and reproductive health* (GSDRC Helpdesk report). http://www.gsdrc.org/docs/open/HD784.pdf
- M'Cormack, F. (2012). *Political commitments to improve adolescent sexual and reproductive health* (GSDRC Helpdesk report). http://www.gsdrc.org/docs/open/HDQ779.pdf
- HEART. (2011). *The Impact of girls' education on early marriage* (HEART Helpdesk report). http://www.heart-resources.org/2011/09/the-impact-of-girls-education-on-early-marriage/
- HEART. (2013). *Child health and parents' education* (HEART Helpdesk report). http://www.heart-resources.org/2011/11/child-health-and-parents-education/
- Mcloughlin, C. (2010). *Child marriage* (GSDRC Helpdesk report). http://www.gsdrc.org/docs/open/HD663.pdf
- Rohwerder, B. (2014). *Integrated programmes supporting adolescent girls* (GSDRC Helpdesk Research Report 1125). http://www.gsdrc.org/docs/open/HDQ1125.pdf

6 Human development and social exclusion

Exclusionary processes create inequitable distribution of resources and unequal access to capabilities and rights necessary for human development (Popay et al., 2008). Social exclusion mediates access to services, which has a strong impact on human development outcomes. Sometimes marginalised groups are directly discriminated against and stigmatised, but they are also structurally excluded by factors including geographical distance from services, language barriers, physical difficulties, or unsupportive laws and policies. Human rights-based approaches are particularly important for tackling social exclusion.

Lack of clarity on what 'social exclusion' means makes measuring its relationship with human development difficult (Popay et al., 2008). There is no agreement on social exclusion as a broad concept rather than a state affecting certain groups, and it is **not clear whether exclusion is a risk factor or an outcome or both** for human development processes (Popay et al., 2008). Most studies focus on a single dimension of exclusion, so there is a large body of evidence on those specific dimensions.

There is most **evidence** on discrimination and exclusion in the health and WASH sectors. There is a strong focus on people living with disabilities, although still insufficient evidence on this group. There is almost no information on social exclusion and sexual and reproductive health except for PWD, so in this chapter the SRH and health sections have been merged. Children with differing and increased learning requirements still face inequalities in education. Most focus is on girls, and children living with disabilities. The literature on WASH and social exclusion mainly focuses on access to water and accountable water services, and there is a growing literature on slum dwellers. Ethnic minorities, indigenous peoples and low-caste people remain less visible in these sectors. Women and girls are more excluded than men and boys.

The disability literature highlights an important lesson for social exclusion: access to the necessary information and services are mediated by **attitudes and ignorance** about disability issues, rather than by the disability itself (Groce, et al., 2009).

Popay, J., Escorel, S., Hernández, M., Johnston, H., Mathieson, J. & Rispel, L. (2008). ***Understanding and Tackling Social Exclusion. Final Report of the Social Exclusion Knowledge Network of the Commission on Social Determinants of Health*****. Geneva: WHO.**
http://www.who.int/social_determinants/knowledge_networks/final_reports/sekn_final%20report_042008.pdf
In the SEKN conceptual model exclusion is viewed as a dynamic, multi-dimensional process driven by unequal power relationships. It has four main dimensions – economic, political, social and cultural – and operates at different levels, including individual, household, group, community, country, regional and global. The report provides case studies on social exclusion, an overview of its meaning and measurement, and a review of policies and actions undertaken by states, civil society and the private sector.

6.1 Health / Sexual and Reproductive Health

Exclusionary processes restrict social, cultural, economic and political participation, which has negative impacts on health and wellbeing (Popay et al., 2008). The poorest and most marginalised people are usually the least able to claim their health rights (Lang et al., 2013). Marginalised groups often experience **discrimination at the point of service** (Govender & Penn-Kekana, 2008; Berlan & Shiffman, 2012). This is often shaped by the gap between patient and provider in gender, class, caste, or ethnicity (Govender & Penn-Kekana, 2008). Minority ethnic or marginalised groups are less likely to seek health treatment (Thornicroft, 2008), as are urban slum-dwellers (de Snyder et al., 2011).

People living with disabilities are more likely to seek healthcare, but are less likely to receive adequate care (Lang et al., 2013). They are less likely to have regular employment, and are therefore less able to pay for healthcare (Lang et al., 2013). PWD are more likely to experience physical, emotional, and sexual abuse and other forms of gender-based violence, more likely to become infected with HIV and other STIs, and sometimes experience forced decisions about their SRH (Groce et al., 2009). WHO recommends that SRHR programmes and activism include disability needs, rather than creating separate programmes (Groce et al., 2009). People living with disabilities have historically experienced medical professionals exerting undue influence on their decision-making, such as their choice to attend school, and right to marry (Lang et al., 2013).

The type of health issue may itself cause worse human development outcomes. **Mental health disorders** carry a greater degree of stigma and discrimination than physical health conditions, and people with mental health conditions are very likely to be socially excluded (Thornicroft, 2008). Aside from financial barriers and lack of knowledge, the social factors creating this situation are: 1) reluctance to seek help because of the anticipation of stigma; and 2) reluctance of diagnosed people to advocate for better mental health care for fear of shame and rejection on disclosure (Thornicroft, 2008). HIV is highly stigmatised and isolating (Popay et al., 2008). Populations at high-risk of **HIV,** such as people who inject drugs, men who have sex with men, and sex workers, are often highly stigmatised and experience structural barriers to accessing care and prevention services (Gruskin et al., 2013). **Harmful laws and policies** create barriers that inhibit an effective HIV response, which is especially damaging for populations already marginalised (Gruskin et al., 2013).

Lang, R., Groce, N., Cole, E. (2013). *Conceptualising the linkages between the social determinants of health and disability* (Leonard Cheshire Disability and Inclusive Development Centre, Working Paper Series, no. 19). London: LCDIDC. http://www.ucl.ac.uk/lc-ccr/centrepublications/workingpapers/WP19_Linkages_between_the_SDH_and_Disability.pdf
This paper outlines the links between two policy directives: the Social Determinants of Health framework and disability issues. The analysis highlights strong similarities and synergies, particularly in promoting a human rights agenda and addressing the inequalities and inequities in access to healthcare and rehabilitation services. Such inequalities must be placed in the context of much broader social, political and economic contexts within and between countries.

Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. *Epidemiologia e Psichiatria Sociale*, *17*(01), 14-19. http://dx.doi.org/10.1017/S1121189X00002621
Why do people avoid seeking care for mental health disorders? Evidence from descriptive studies and epidemiological surveys suggest that factors increasing the likelihood of treatment avoidance, or long delays include: 1) lack of knowledge about the features and treatability of mental illnesses; 2) ignorance about how to access assessment and treatment; 3) prejudice against people who have mental illness; and 4) expectations of discrimination. These results appear to be consistent across a wide range of settings and conditions.

de Snyder, V. N. S., Friel, S., Fotso, J. C., Khadr, Z., Meresman, S., Monge, P. & Patil-Deshmukh, A. (2011). Social conditions and urban health inequities: realities, challenges and opportunities to transform the urban landscape through research and action. *Journal of Urban Health, 88(*6), 1183-1193. http://dx.doi.org/10.1007/s11524-011-9609-y
This secondary review of literature describes how social exclusion contributes to urban health inequities. Poorer health outcomes are widely observed among socially excluded urban residents, particularly slum-dwellers. Factors influencing health outcomes include: education, employment, health care services, social capital and social networks. Lower levels of any of these factors affect health outcomes, and socially excluded groups are much more likely to have lower levels.

Groce, N.E., Izutsu, T., Reier, S., Rinehart, W. & Temple, B. (2009). *Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA guidance note.* WHO: Geneva.
http://www.who.int/reproductivehealth/publications/general/9789241598682/en/
SRH for people living with disabilities deserves attention because these needs have been widely and deeply neglected. PWD have equal rights to be sexually active as those without disabilities, but often do not receive general or specific information and support about their SRHR. This guidance note lays out a five point framework for inclusion: 1) establish partnerships with organisations of PWD; 2) raise awareness and increase accessibility within own organisations; 3) ensure that all sexual and reproductive health programmes reach and serve PWD; 4) address disability in national SRHR policy, laws, and budgets; and 5) promote research on SRHR of PWD at local, national, and international levels.

Gruskin, S., Ferguson, L., Alfven, T., Rugg, D. & Peersman, G. (2013). Identifying structural barriers to an effective HIV response: using the National Composite Policy Index data to evaluate the human rights, legal and policy environment. *Journal of the International AIDS Society*, *16*(1).
http://dx.doi.org/10.7448/IAS.16.1.18000
This paper examines law and policy data from 171 countries to assess attention to human rights in national legal and policy environments. It looks specifically at the health and rights of key HIV populations such as people who inject drugs, men who have sex with men and sex workers. Most countries (78 out of 106) report the existence of laws and policies that make it harder for key populations to access HIV services. Yet there are also laws and policies that positively affect access to HIV-related services. A supportive legal environment can play a strong role in building a responsive framework for HIV services.

6.2 Education

Social factors shape access to school, and broadening access to education means **targeting specific groups of children** who are excluded. Intersecting inequalities mean that age, gender, location, class, ethnicity and income all affect how well children are able to learn (Save the Children International, 2013). Inequalities persist in access to schooling; although many more girls are now in school, children living with disabilities, children from ethnic or religious minorities or those in remote locations still do not have sufficient access to school (Hossain, 2010). Only 10 per cent of children living with disabilities are in school (Miles & Singal, 2010). Exclusion from school has multiple impacts on **perpetuating poverty** (Hossain, 2010).

Children in school face problems of **inequitable quality of learning** when schools do not meet children's differing and specific needs (Save the Children International, 2013). The already disadvantaged groups suffer most from inadequate teaching, facilities and materials (Save the Children International, 2013).

There is a debate in policy between the Education for All (EFA) and the inclusive education agendas (Miles & Singal, 2010). EFA is a rights-based commitment to ensure every child and adult receives basic education of good quality. It aims to be an inclusive agenda that reaches all learners, but has historically overlooked disability. There is a growing agreement among international agencies that children living with disabilities should be integrated into mainstream programmes and schools. The inclusive education agenda presses for developing inclusive schools that respond to the needs of all learners, no matter their ability level. Inclusivity has no consensus in the literature, and does not provide conceptual clarity, but inclusive education is commonly understood as being mainly about children living with disabilities. In practice, this often means separate special schools.

Save the Children International. (2013). *Ending the hidden exclusion: Learning and equity in education post-2015.* Save the Children International. http://www.worldwewant2015.org/node/343570
This paper discusses the 'learning crisis' for in-school children. Although many more children are now attending school, a large number of them are not learning the basics and are struggling to achieve

learning goals. Children with pre-existing disadvantages suffer most. This paper puts forward a framework for the post-2015 goals that focuses on inequity and quality in schools.

Hossain, N. (2010). School exclusion as social exclusion: the practices and effects of a conditional cash transfer programme for the poor in Bangladesh. *The Journal of Development Studies, 46*(7), 1264-1282.
http://dx.doi.org/10.1080/00220388.2010.487096
This article argues that being excluded from school leads to further social exclusion. Exclusion from education increasingly entails exclusion from economic opportunities, and from knowledge of the tools, language and actions required for citizen engagement with the state. The case study of a cash transfer programme in Bangladesh shows that this programme tends to reinforce social inequalities by failing to target the ultra-poor.

Miles, S. & Singal, N. (2010). The Education for All and inclusive education debate: conflict, contradiction or opportunity?. *International Journal of Inclusive Education*, *14*(1), 1-15.
http://dx.doi.org/10.1080/13603110802265125
This paper explores the history of the international Education for All (EFA) programme and its tendency to overlook some marginalised groups of children, in particular those seen as having 'special educational needs' or impairments and disabilities. Inclusive education is in part a response to this agenda, and is seen as focusing mainly on children living with disabilities, which fills the gap left by EFA. The paper argues for greater collaboration and synergy between these initiatives, and suggests ways in which practitioners and policy makers can develop more sustainable, and context-appropriate, policies and practices.

6.3 WASH

The most commonly noted inequalities in the WASH sector are between rural and urban populations, and particular socio-economic groups (Pullan et al., 2014). Narayan et al. (2011) note that WASH services often do not reach those most in need and highlight three barriers to social inclusion in WASH: institutional, environmental and attitudinal. Programmes in South Asia that have tackled all three barriers together have been shown to be successful.

Community-Led Total Sanitation (CLTS) aims to support improved sanitation through community awareness-raising and ownership. Although it aims at inclusion, PWD and other socially excluded people tend to have their needs overlooked, or to be represented by others at community meetings (Wilbur & Jones, 2014).

The **design of facilities** is crucial to make them accessible to PWD. Technical barriers include steps, height, and distance of facilities, lack of transportation and unsuitable equipment; while social barriers include stigma, low self-esteem if requiring help to use facilities, lack of understanding from service providers, and lack of knowledge about where to access services (Groce et al., 2011; Lang et al., 2013). Despite these known challenges, there is no body of knowledge on the WASH or health needs of people living with disabilities (Groce et al., 2011). The CLTS programme provides some concrete recommendations for improving inclusion (Wilbur & Jones, 2014).

Groce, N., Bailey, N., Lang, R., Trani, J. F. & Kett, M. (2011). Water and sanitation issues for persons with disabilities in low-and middle-income countries: a literature review and discussion of implications for global health and international development. *Journal of Water and Health, 9*(4), 617-627.
http://dx.doi.org/10.2166/wh.2011.198
How do people living with disabilities access WASH? This comprehensive literature review presents what is currently known about access to water and sanitation for PWD in low- and middle-income countries from the perspective of both international development and global health. It identifies gaps in research, practice and policy that are of pressing concern if the water and sanitation needs of this large population

are to be addressed. It emphasises that there are low-cost, low-tech interventions that work, such as universal design, but that there are few documented examples of good practice, and most are small-scale.

Wilbur, J. & Jones, H. (2014). *Disability: Making CLTS fully inclusive* (Frontiers of CLTS: Innovations and Insights Issue 3). Brighton: IDS.
http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/media/Frontiers_of_CLTS_Issue3_Disabilities.pdf
This paper focuses on people living with disabilities and their particular needs for access to WASH. The paper acknowledges the many forms of disability. PWD tend not to be present at CLTS community triggering events. They often lack voice in the community, have their needs overlooked, and may even be hidden by their families. They face physical, organisational and institutional barriers. The paper outlines how CLTS facilitators can include PWD. It highlights that many of the lessons from PWD can be applied to other excluded groups.

See also:

- HEART. (2011). *Language of instruction* (HEART Helpdesk report). http://www.heart-resources.org/2011/06/language-of-instruction/
- HEART. (2013). *Inclusive and effective schools* (HEART Helpdesk report). http://www.heart-resources.org/2013/07/inclusive-and-effective-schools/
- HEART. (2013). *Mother tongue education – Girls and poor/vulnerable children* (HEART Helpdesk report). http://www.heart-resources.org/2011/11/mother-tongue-education-girls-and-poorvulnerable-children/
- HEART. (2013). *Universal design of schools and classrooms* (HEART Helpdesk report). http://www.heart-resources.org/2013/07/universal-design-of-schools-and-classrooms/
- HEART. (2014). *Inclusive learning topic guide.* http://www.heart-resources.org/topic/inclusive-learning/
- Heise, L. (2013). *STRIVE and the drivers of HIV* (HEART multimedia resources). http://www.heart-resources.org/mmedia/heart-talks-lori-heise-on-strive-and-the-drivers-of-hiv/
- Paxton, W., (2013). *Will Paxton on opportunities to address inequality in education* (HEART multimedia resources). http://www.heart-resources.org/mmedia/will-paxton-on-opportunities-to-address-inequality-in-education/
- UNICEF. (2013). *State of the world's children 2013: Children with disabilities.* United Nations Children's Fund. http://www.unicef.org/sowc2013/files/SWCR2013_ENG_Lo_res_24_Apr_2013.pdf
- Walton, O. (2011). *Self-esteem, shame and poverty* (GSDRC Helpdesk report). http://www.gsdrc.org/docs/open/HD788.pdf
- Walton, O. (2012). *Economic benefits of disability-inclusive development* (GSDRC Helpdesk report). http://www.gsdrc.org/docs/open/HDQ831.pdf
- WHO & World Bank (2011). *World report on disability*. World Health Organization. http://www.who.int/disabilities/world_report/2011/en/

7 Analytical tools and monitoring and evaluation

This section lists key programme design and evaluation tools on integrating social development principles into human development programmes.

7.1 Human rights

de Albuqerque, C. (n.d.). *On the right travel: Good practices in realising the rights to water and sanitation*. Geneva: UN. http://www.ohchr.org/Documents/Issues/Water/BookonGoodPractices_en.pdf

Freedman, L. P. (2001). Using human rights in maternal mortality programs: from analysis to strategy. *International Journal of Gynecology & Obstetrics, 75(*1), 51-60. http://dx.doi.org/10.1016/S0020-7292(01)00473-8

UNICEF (2014). *Child rights education toolkit: Rooting child rights in early childhood education, primary and secondary schools* (First Edition). UNICEF. http://www.unicef.org/crc/files/UNICEF_CRE_Toolkit_FINAL_web_version170414.pdf

WHO. (2014). *Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations.* Geneva: WHO. http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748_eng.pdf?ua=1

7.2 Accountability

CARE. Mutual Accountability Tool. http://bbnc.care.org.au/mutual-accountability-tool

de Asís, M. G. (2009). *Improving transparency, integrity, and accountability in water supply and sanitation*. Washington, DC: World Bank. https://openknowledge.worldbank.org/handle/10986/2628

EdQual. (2010). *A framework for education quality* (Policy Brief No. 10). Bristol: EdQual http://www.heart-resources.org/doc_lib/framework-education-quality/

Fritsche, G. B., Soeters, R. & Meessen, B. (2014). *Performance-based financing toolkit*. Washington, DC: World Bank. https://openknowledge.worldbank.org/handle/10986/17194

Global Water Partnership Toolbox. http://www.gwp.org/en/ToolBox/

Kar, K. & Chambers, R. (2008). *Handbook on community-led total sanitation*. London: Plan UK. http://www.communityledtotalsanitation.org/resource/handbook-community-led-total-sanitation

Muller, M., Simpson, R. & Van Ginneken, M. (2008). *Ways to improve water services by making utilities more accountable to their users: a review* (Water working note 15). Washington, DC: World Bank. http://documents.worldbank.org/curated/en/2008/05/9567119/ways-improve-water-services-making-utilities-more-accountable-users-review

World Bank Group Health Results Innovation Trust Fund. (2014). *RBF: A smarter approach to delivering more and better reproductive, maternal, newborn and child health services.* Washington, DC: World Bank. http://www.rbfhealth.org/sites/rbf/files/HRITF%202014%20Annual%20Report_0.pdf

7.3 Gender

House, S., Ferron, S., Sommer, M. & Cavill, S. (on behalf of WaterAid). (2014). *Violence, gender and WASH: A practitioner's toolkit.* http://violence-wash.lboro.ac.uk/

House, S., Mahon, T. & Cavill, S. (2012). *Menstrual hygiene matters: a resource for improving menstrual hygiene around the world.* WaterAid.
http://www.wateraid.org/~/media/Files/Global/MHM%20files/Compiled_LR.pdf

Interagency Gender Working Group (IGWG) Gender and Health Toolkit.
https://www.k4health.org/toolkits/igwg-gender

UNICEF (n.d.). *Promoting gender equality through UNICEF-supported programming in basic education: Operational Guidance.* UNICEF. http://www.unicef.org/gender/files/BasicEducation_Layout_Web.pdf

United Nations Girls' Education Initiative (UNGEI) resources.
http://www.ungei.org/resources/index_3216.html

USAID (2007). *Training guide: Continuum of approaches for achieving gender integration in programming: A decision-making tool for education officers.* Prepared by the EQUATE team for USAID.
http://www.ungei.org/resources/files/USAID_EQUATEGenderContinuum.pdf

WHO. (2011). *Human rights and gender equality in health sector strategies: How to assess policy coherence.* Geneva: WHO. http://whqlibdoc.who.int/publications/2011/9789241564083_eng.pdf?ua=1

WHO. (2013). *Responding to intimate partner violence and sexual violence against women* (WHO clinical and policy guidelines).
http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/

WHO guidelines on maternal, reproductive and women's health.
http://www.who.int/publications/guidelines/reproductive_health/en/

Wilson, E., Reeve, J. & Pitt, A. (2014). Education. Period. Developing an acceptable and replicable menstrual hygiene intervention. *Development in Practice*, *24*(1), 63-80.
http://dx.doi.org/10.1080/09614524.2014.867305

7.4 Age

HelpAge International guidelines on working with older people:
http://www.helpage.org/resources/practical-guidelines/

Uhlenberg, P. (2009). *International handbook of population aging*. (Vol. 1). Dordrecht: Springer.
http://link.springer.com/book/10.1007/978-1-4020-8356-3/page/2

UNICEF. Child Friendly Schools. http://www.unicef.org/cfs/

UNICEF. *Water, Sanitation and Hygiene (WASH) in schools* (A companion to the Child Friendly Schools Manual). http://www.unicef.org/publications/files/CFS_WASH_E_web.pdf

WHO guidelines on child health: http://www.who.int/publications/guidelines/child_health/en/

7.5 Social exclusion

Booth, T. & Ainscow, M. (2011). *Index for inclusion: Developing learning and participation in schools* (Third Edition). Bristol: Centre for Studies on Inclusive Education. http://www.csie.org.uk/resources/inclusion-index-explained.shtml

DFID. (2009). *Gender and social exclusion analysis: How to note* (A DFID Practice Paper). London, UK: Department for International Development. http://www.gsdrc.org/docs/open/SE9.pdf

Hinds, R. (2013). *Tools for participatory analysis of poverty, social exclusion and vulnerability* (GSDRC Helpdesk Research Report 959). Birmingham, UK: GSDRC, University of Birmingham. http://www.gsdrc.org/docs/open/HDQ959.pdf

Lang, R., Kett, M., Groce, N. & Trani, J. F. (2011). Implementing the United Nations Convention on the rights of persons with disabilities: principles, implications, practice and limitations. *ALTER-European Journal of Disability Research, 5*(3), 206-220. http://dx.doi.org/10.1016/j.alter.2011.02.004

Rheingans, R., Anderson, J. D., Luyendijk, R. & Cumming, O. (2014). Measuring disparities in sanitation access: does the measure matter? *Tropical Medicine & International Health, 19*(1), 2-13. http://dx.doi.org/10.1111/tmi.12220

UNESCO (2008). *Equity and inclusion in education: Tools to support education sector planning and evaluation.* Paris: UNESCO http://www.unesco.org/bpi/pdf/iatt_equity_inclusion_tools_042008_en.pdf

UNESCO Bangkok (2004-13). *Embracing diversity: Toolkit for creating inclusive learning-friendly environments.* Bangkok: UNESCO. http://www.unescobkk.org/education/inclusive-education/resources/ilfe-toolkit/

Annex I: Evidence table

What do we know about the effects of social development on human development outcomes? The table below organises the research and evidence included in this guide into four human development sectors – health; sexual and reproductive health (SRH); education; and water, sanitation and hygiene (WASH) – and five social development issues (human rights, accountability, gender inequality, age and social exclusion).

Limitations of the evidence base

Overall, the size and quality of the evidence on social development and human development is rigorous and reliable in the health and SRH sectors, but less so in education and WASH. There are several systematic reviews in health and education, which provide robust conclusions.

The human rights evidence base for these issues has a disproportionate focus on SRH, reflecting the politicisation of this issue. SRH is very closely linked to gender inequality. The evidence on social development issues is generally heavily weighted towards gender inequality.

Evidence on age-related issues, including children, adolescents and older people, focuses almost exclusively on health and SRH; there is little to no rigorous evidence on how age affects education or WASH. Disability, included here under social exclusion, is poorly evidenced and hardly visible in some sectors, such as sexual and reproductive health. Much of the literature on disability is policy-oriented, advocacy-based, or secondary, and does not provide any evidence.

The evidence base is weighted towards easily measureable impacts and the prevalence of particular issues. There is much less evidence on power relations, how to shift inequalities, or addressing cultural norms.

Almost all of the literature included here focuses on sub-Saharan Africa and South Asia.

Strength of the evidence base: how well studied are the links between social development issues and human development outcomes?					
		Human development outcome			
		Health	**Sexual and reproductive health**	**Education**	**Water, sanitation and hygiene**
Social development factor	**Human rights**	(6) (8) (16) (20)	(16) (27) (29) (34) (35)	(8) (29)	(21)
	Accountability	(4) (12) (33)	(34) (35)	(10) (12) (24)	(10) (12)
	Gender inequality	(1) (3) (5) (7) (8) (9) (11) (14) (19) (25) (30)	(1) (2) (3) (25) (27) (28) (34)	(7) (8) (9) (13) (29) (31)	(8) (9) (21)
	Age	(2) (5) (17) (20) (27) (30) (32)	(2) (22) (27) (32)	(29) (32)	
	Social exclusion	(5) (7) (16) (20) (23)		(18) (31)	(15) (26) (33)

Each number in the table refers to a study listed on the following pages. More numbers in each cell indicate more available evidence in the papers listed in this guide; fewer numbers, or blank spaces, indicate a lack of evidence in these papers.

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Key: type of research

[P&E] Primary and Empirical
[EXP] Experimental
[OBS] Observational

[S] Secondary
[SR] Systematic Review
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