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The gender responsiveness of social entrepreneurship in health – A review of initiatives by Ashoka fellows

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ABSTRACT

There are vocal calls to act on the gender-related barriers and inequities in global health. Still, there are gaps in implementing programmes that address and counter the relevant dynamics. As an approach that focuses on social problems and public service delivery gaps, social entrepreneurship has the potential to be a closer health sector partner to tackle and transform the influence of gender in health to achieve health systems goals better. Nevertheless, social entrepreneurs' engagement and impact on gender and health remain understudied. Using the Ashoka Fellows database as a sampling frame in November 2020 (n = 3352, health n = 129), we identified and reviewed the work of 21 organizations that implemented gender-responsive health-related programmes between 2000 and 2020. We applied the UNU-IIGH 6-I Analytic Framework to review the gender issues, interventions, included populations, investments, implementation, and impact in each organization. We found that a low proportion of fellows engage in gender-responsive health programming (<1%). Many organizations operate in low-and middle-income countries (16/21). The gender-responsive programmes include established health sector practices, to address gendered-cultural dynamics and deliver people-centred resources and services. Interestingly, most organizations self-identify as NGOs and rely on traditional grant funding. Fewer organizations (6/21) adopt market-based and income-generating solutions - a missed opportunity to actualise the potential of social entrepreneurship as an innovative health financing approach. There were few publicly available impact evaluations-a gap in practice established in social entrepreneurship. All organizations implemented programmes at community levels, with some cross-sectoral, structural, and policy-level initiatives. Most focused on sexual and reproductive health and gender-based violence for predominantly populations of women and girls. Closer partnerships between social entrepreneurs and gender experts in the health sector can provide reciprocally beneficial solutions for cross-sectorally and community designed innovations, health financing, evidence generation and impact tracking that improve the gender-responsiveness of health programmes, policies, and systems.

1. Introduction

Gender is a known determinant of health, where evidence of gender's influence on health is established in women and girls, the transgender community, men and boys (Kennedy et al., 2020; Reisner et al., 2016; Ruane-McAteer et al., 2019; World Health Organization, 2019). Health risks and behaviours, service access and uptake, treatment outcomes and ultimately health status are influenced by gender-inequitable norms and power imbalances such as divisions of labour, people's agency in health decision-making, access to resources, gender-based or intimate partner violence, preserved notions of masculinity and patriarchy, and the experience and performance of stigma and discrimination (World Health Organization, 2014, 2018).

There is global and high-level recognition of the value of addressing gender dynamics at interpersonal, household, community, structural and policy levels (Gupta et al., 2020; Heymann et al., 2019a; Taukobong et al., 2016). The 2019 Political Declaration on Universal Health Coverage identifies the importance of a gender perspective and gender-responsive interventions when designing health systems, policies and programmes (United Nations, 2019). Similarly, the Addis Ababa Action Agenda (AAAA) for development recognizes multi-stakeholder partnerships, transformative financing and the

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allocation of sufficient budgetary resources as paramount to achieving gender equality (United Nations Department of Economics and Social Affairs, 2015). Nevertheless, there is still inadequate levels of gender-responsive programming and financing in healthcare, particularly at structural or systemic levels (Levy et al., 2020), and within low-and-middle-income countries (Morgan et al., 2018).

High impact gender-responsive programmes, particularly those that are transformative of women's or gender-diverse people's position and agency within society, require multi-actor, multilevel and multisectoral partnerships (Heymann et al., 2019b). Gender dynamics crosscut multiple sectors, such as labour, education, and social services (Östlin et al., 2006). Gender inequalities outside the health system can also affect health, such as in formal, informal and non-standard employment that determines levels of employment-based health entitlements (Vijayasingham et al., 2020a). However, gaps in national or local resources, capacities, the organizational and political will to prioritize and implement gender-responsive programmes at scale are known barriers within the global health ecosystem. Engagement with broader stakeholders such as social innovators, social movements, and community activists to pursue change and accountability is required (Hay et al., 2019). Together, new ways to deliver and finance gender-responsive healthcare to achieve people-centred and systemic universal health coverage goals can be co-designed and implemented.

Social entrepreneurship can contribute to this call for action. As a concept and practice, social entrepreneurship broadly refers to individuals, organizations, or networks, including non-profit, for-profit, and charity-based institutions, that use innovative, frugal, and community or user co-designed approaches, to address social or structural challenges that populations, economic markets, national public sector and governments face (Baporikar, 2017; Berzin, 2012; Light, 2006; Mair and Marti, 2009).

Social entrepreneurship is not new to the health sector. It is often considered a private sector activity outside formal public health systems as both a competitor and complementary partner in delivering health resources (Calò et al., 2018; Mason et al., 2015). Indeed, there have been many positive examples of how social entrepreneurship is used to deliver health and social care services, to complement mainstream public provision and enhance community involvement in service design, particularly in resource-scarce and rural contexts (Farmer et al., 2012; Hazenberg and Hall, 2016; Munoz et al., 2015). In low-and-middle-income countries, social entrepreneurship programmes hold the potential to increase availability and accessibility to quality care using targeted strategies to shape their services, sustainability, social and organizational impact (Lokman and Chahine, 2021).

Amidst dwindling development aid and increasing pressures for national governments to mobilize local health financing sources, social entrepreneurship can present as a complementary health financing strategy to mobilize additional financial resources for national health systems - especially for gender-responsive programming that is often not prioritised in global health organizations and budgets. Where market-based income-generating approaches are used, the financial surplus can be reinvested to sustain, upscale, or broaden the scope of health programming. In grant or donation funded work, social entrepreneurship is often an intersectoral initiative that opens up the potential for the intersectoral co-financing of interventions that confer health gains by 'non-health' funders (McGuire et al., 2019). Windows of opportunities are unfolding to pursue this approach, with networks of social entrepreneurs seeking to break the silos between and within sectors and different stakeholders (Ashoka Deutschland gGmbH, 2021).

However, there is comparatively little research within the health sector on social entrepreneurship's process, impact, and contributions to health system goals (Caló et al., 2019). Even less research investigates the influence of gender in health-focused initiatives and how gender features in the broader scope of work in social entrepreneurship (Clark Muntean and Ozkazanc-Pan, 2016; Lewis and Henry, 2019; McKague et al., 2021; McKague and Harrison, 2019). Nevertheless, available research on social entrepreneurship in health has broadly shown positive health impacts such as in mental health, protective health behaviours, and initiatives to reduce stigmatization and build social capital, all of which contribute to overall health and well-being (Roy et al., 2014). These existing studies mostly come from high-income countries. However, there are many notable cases from low-and-middle-income countries that offer 'proof of concept' that social entrepreneurship can match public delivery mechanisms when good operational and business models are applied and adequately funded, especially in community or rural settings (Calò et al., 2018; Caló et al., 2019; Lokman and Chahine, 2021; Mason et al., 2015). The high-income country focus is consistent with the broader field of social entrepreneurship research, which tends to prioritize North American or European centric data, theory, and perspectives, missing the opportunity to obtain nuanced and novel insights from other contexts (Chandra and Kerlin, 2021; Lim and Chia, 2016).

This paper is a review of the integration of a gender lens and the implementation of gender-responsive health interventions by a sub-set of social entrepreneurs in the health sector. Drawing from publicly available documents on 21 organizations led by Ashoka Fellows (a global social entrepreneurship support and funding organization), we focus on how gender features in the organizations' goals, focus populations, activities, investments, and impact tracking. This review offers insights into how the health sector can benefit from stronger collaborations and knowledge exchange with social entrepreneurs and vice versa. The latter can leverage strengths and address practice gaps to contribute more actively as designers, funders, and implementing partners of gender-responsive health programmes.

2. Methods

We conducted a desk-based review of gender-responsive health programming implemented by Ashoka fellows (organizations). This was done by extracting information from fellow's online profiles and retrieving publicly available digital reports, studies, and other communications (i.e., interviews and blogs). A similar sampling frame and approach was used by Chandra and colleagues to identify the types of interventions used by Ashoka fellows in the HIV/AIDs response (Chandra and Shang, 2021) and more broadly in healthcare delivery worldwide by Ashoka, Schwab Foundation and Echoing Green fellows (Chandra et al., 2021).

2.1. *Analytic framework & conceptual background*

2.1.1. *Gender-responsive health interventions*

Gender-responsive interventions refer to 'programmes that consider gender norms, roles and inequality with measures taken to actively reduce their harmful effects' (World Health Organization, 2019). These factors can be accommodated or transformed through the framing of health issues, design of solutions - particularly its acceptability and accessibility by women and girls, the transgender community, men and boys (Pederson et al., 2015; World Health Organization, 2019).

Gender-responsive interventions are not limited to a focus on women. Interventions for transgender and intersex people, men, and boys are also crucial. Nevertheless, attention on women and girls must not be weakened. Additionally, considerations of intersectionality (Gkiouleka et al., 2018; Kapilashrami and Hankivsky, 2018) is also necessary to address and disrupt the multiple accumulative forms of privilege and disadvantage that institutional, cultural and systemic bias perpetuates. This includes the influence of socioeconomic status, indigeneity, ethnicity and race, age, sexuality, educational attainment, disability, and migration status in interactions with gender and health across different settings.

For women and girls, interventions include activities that address and counter the risk of violence, income disparities, unequal access to resources, disproportionate domestic and care work, limited social independence, and restrained agency over their bodies. This includes

removing access barriers within health systems, such as eliminating user fees in health facilities (Witter et al., 2017) and shifting care sites to communities. Based on evidence from the HIV sector, social interventions that work to transform gender norms, address violence against women and promote positive health results include training, peer and partner discussions, and community-based participatory learning (Hardee et al., 2014). Additionally, cross-sectoral, structural and community-based programmes such as abolishing school fees, extending compulsory education, cash transfers, microfinance and income-generating activities contribute to positive health outcomes such as HIV risk prevention and protective condom use - when there is context-adapted implementation (Hardee et al., 2014).

For transgender and intersex individuals, responsive interventions include gender-affirming surgery or hormonal treatment by NGOs or within health insurance coverage (Reisner et al., 2016). Training programmes for healthcare workers to actively prevent biases in promotions and discrimination experienced by women, transgender and intersex individuals as patients are also beneficial.

For men and boys, interventions that address their higher inclination towards risky behaviours, risk of violence, the influence of harmful gender norms on masculinities and resultant health-seeking behaviours, and their roles in perpetuating inequalities such as in women's agency, health-seeking, and care work, can help shift inequalities. While mainly focused on sexual and reproductive health, evidence on addressing masculinities and male engagement strategies suggest that multi-component and multi-level activities such as education and mobilization of wider communities by trained facilitators over sufficient durations are useful (Ruane-McAteer et al., 2019).

The WHO Gender Responsive Assessment Scale (WHO, 2011a), which illustrates a continuum of how health interventions or programmes consider and address gender dynamics, was used to assess the gender-responsiveness of programmes led by Ashoka social entrepreneurs. An organization's implementation of health programming was considered gender-responsive if the implemented interventions were gender-sensitive (considers and adapts to gender norms, roles and relations in the design of interventions), gender-specific (intentionally targets and benefits a specific group of women or men to achieve particular policy or programme goals or meet specific needs) or transformative (addresses the causes of gender-based health inequities, and includes ways to transform harmful gender norms, roles and relations) (World Health Organization, 2011).

2.1.2. *Social entrepreneurship*

In this review, we focused on key dimensions of social entrepreneurship-sociality, innovation, and market orientation (Maas and Grieco, 2017; Nicholls and Cho, 2008). Sociality refers to the extent to which an organization intentionally and effectively pursues the advancement of social objectives rather than just organizational and shareholder wealth (Zadek and Thake, 1997). Many contemporary for-profit businesses adopt a socially conscious approach through 'Corporate Social Responsibility (CSR). However, the priority of the social mission distinguishes social enterprises and entreprenuership from these corporations, where profit maximization and shareholder value creation remain the ultimate goal, even in CSR engagement (Carroll and Shabana, 2010). Aligned to sociality is the achievement of impact. Recognizing that social impact conceptualisation and measurement in social entrepreneurship is evolving (Maas and Grieco, 2017; Rawhouser et al., 2019), we view impact as the gender-related health outcomes in the intended focus population and systemic shifts that result from gender-responsive health interventions. We also note the established existing gaps in achieving and measuring impact in social entrepreneurship across sectors (Han and Shah, 2020).

Innovation refers to new, context-adaptive and creative organizational models, activities, products and services that address societal challenges or meet an unmet need, especially within underserved or marginalised communities (Dako-Gyeke et al., 2020; Huybrechts and Nicholls, 2012). In healthcare, there are many case studies of lean, socially rooted, community or citizen co-created, cross-sectorally implemented, low-cost innovations that bridge gaps in service delivery and meet affordability needs in resource-scarce settings (Bhatti et al., 2017; Farmer et al., 2018; Reeder et al., 2019; Rhule and Allotey, 2020; van Niekerk et al., 2020). Innovation often requires collaboration at individual or organizational levels, bringing together different perspectives from communities, innovators, researchers, and policymakers (Ayob et al., 2016), drawing on differing lived experiences, tacit knowledge, and disciplinary training.

Market orientation refers to the business models used to ensure financial sustainability and response to competitive market pressures (Nicholls and Cho, 2008). This feature differentiates many social enterprises from traditional not-for-profit organization models that rely primarily on philanthropic or external funding sources. We expand this point also to consider the various financing sources used by the not-for-profit organizations.

Drawing on the above key dimensions of social entrepreneurship, we developed and applied the UNU-IIGH 6-I's Analytic Framework (Fig. 1), adapted from a prior gender scan of health programmes (Vijayasingham et al., 2020b). This framework guided the data extraction, analysis and reporting process. Domains in this framework cover the gender-related issues identified by the social entrepreneurs, gender considerations in intervention planning and included populations, financial investments and financing strategies used, implementation methods, and programme impact assessments.

2.2. *Sampling frame- Ashoka Fellows*

Ashoka, a social entrepreneurship support organization and social venture capital fund (Ashoka, 2020a), was used as a sampling frame in this research due to its history, global presence, number, and selection process of fellows. Ashoka fellows are at various stages of experience in their endeavours. They operate individually or within organizations structured as for-profits, non-profits and hybrid-business entities. Fellows are selected based on the novelty and creativity of their proposed goals and solutions, assessments of their entrepreneurial quality, the likelihood of achieving social impact, and ethical conduct (Leviner et al., 2006). As of November 2020, Ashoka had 3352 fellows across eight fields of work, with 116 fellows who work primarily in health.

2.3. *Search strategy*

The Ashoka Fellow database (Ashoka, 2020b,c,d,e,f) and work category tags were used to identify organizations that worked on health issues, with a visible gender dimension in their programming. Table 1 shows the inclusion and exclusion criteria. A manual search and review of these listings were also done to identify organizations that fit the inclusion criteria.

2.3.1. *Data sources and analysis*

Profiles of Ashoka fellows that met the inclusion criteria were extracted from the Ashoka website. Case narratives were built from their profiles and supplemented by an internet search of peer-reviewed journals (SCOPUS, PubMed, and Google Scholar) and grey literature (organization websites and reports, news articles, blogs, and social media platforms). Internet search terms were the organization names and 'gender', 'health', 'impact', 'outcome', 'evaluation' and 'assessment'. Table 2 lists the sources of information retrieved.

3. Results

3.1. *Search results*

As of November 2020, Ashoka listed the profiles of 3352 fellows on the website. Using Ashoka's categorization of organizations that work

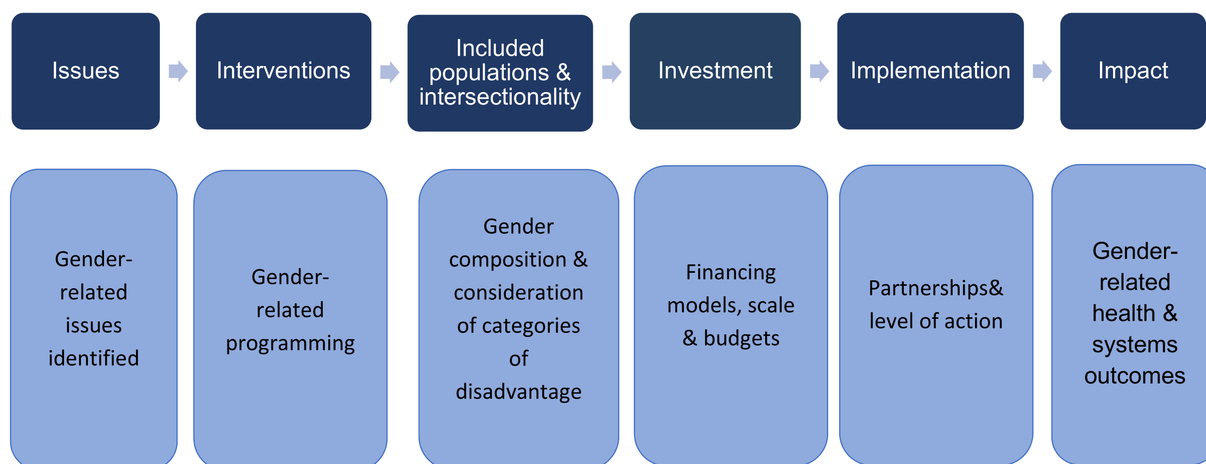

Fig. 1. The UNU-IIGH 6-I's Analytic Framework.

Table 1
Sample inclusion and exclusion criteria.

Inclusion criteria
• Profiles classified under Ashoka health (healthcare, reproductive health, family planning, maternal health, HIV/AIDS/STDs, disability) and gender (gender equity, girls' development, boys' development, women's issues, men's issues, Lesbian Gay Bisexual Transexual Queer [LGBTQ+] rights, domestic violence) work category tags.
• Organizational profiles not classified under the 'gender' work category tag but had elements of a gender-responsive focus as assessed using the WHO Gender Responsive Assessment Scale.
• Organizations that are active, with an online presence and publicly available documents.
Exclusion criteria
• Organizations with no internet presence or where fellows may no longer be active.

Table 2
Source of information.

Source of Information	Number	Social enterprise
Official website	19	A - G, I - Q, S, T, U
SE annual report	10	C, D, I, J, L, M, N, O, P, S
Peer-reviewed article	9	B, C, F, L, N, P, R, S, T
Dissertation	1	F
Book chapter	1	K
Self-published internet report	9	A, D, E, G, I, M, N, O, P
Media article/interview	16	A - G, K, L, M, N, P, R, S, T, U
Newsletter	3	B, K, O
Blog	5	H, R, G, S, U
Social media	11	A - G, I, J, T, U

Key: A The Bear Clan Patrol (Canada), B Minnesota Prison Doula Project/Ostara (United States), C Callisto (United States), D Roots of Health (Philippines), E Samsara (Indonesia), F FOXY (Canada), G Women Safe Institute (France), H Grupo Matizes (Brazil), I Rodrigo Mendes Institute (Brazil), J Association SOS Santé et Développement (Burkina Faso), K Mental Health Action Trust (India), L Healthy Entrepreneurs (Netherlands/ Multiple countries), M Zana Africa (Kenya), N Grandmother Project (Senegal), O Santé Sud (France/ Multiple countries), P Dance4Life (Netherlands/ Multiple countries), Q CEDOICOM (Brazil), R Lua Nova (Brazil), S Basic Healthcare Services (India), T Union of Mothers of Angels (Brazil), U Safe Motherhood Alliance (Zambia).

on health and well-being, we identified 129 organizations with a health-related focus (3.8% of fellows). Of these, we identified ten organizations that engage in gender-responsive work using the gender and health category filters, 12 organizations through a hand search of organizations not included under the gender filter, and three new organizations that had yet to be tagged. We excluded four fellows from this subset of 25 because they did not have an internet presence or evidence of ongoing operations. A final cohort of 21 organizations (about 0.7% of fellows) working in health and gender met the inclusion criteria, and all 21 were included in our analysis (see Fig. 2). Table 3 provides descriptions of the organizations.

3.2. Issues identified

Most gender-related issues that the social entrepreneurs sought to address centred around sexual and reproductive health and rights (SRHR; see Table 4). This is consistent with the broader body of scholarship on gender and health, where there is a concentration of research around SRHR (Lopes et al., 2019; Malhotra, 2021). Most of the organizations (n = 18) positioned gender as a primary focus, where gender dynamics such as gender-related differences in health outcomes (prevalence, incidence, mortality), gender inequities (viewed as drivers of disease risk, service uptake, treatment adherence and health outcomes), and gender issues at a systems level (context, norms, health systems, legal barriers, etc.) were central to the organization objectives.

3.3. Interventions

Overall, the interventions identified include a broad scope of gender-responsive activities that considered or sought to counter the gender-related risk of violence, cultural norms and perceptions, power distribution, agency, and access to resources within and beyond the health sector. These activities align to health sector practices, where evidence on 'what works in gender and health' is emerging in areas beyond SRHR, gender-based violence and HIV. Table 5 outlines the types of interventions implemented by each of the organizations.

3.3.1. Addressing gendered-cultural dynamics at multiple sites

Shifting cultural understanding and practice surrounding gender is an established approach in health programming. Still, how this is designed and implemented by the different organizations can be considered innovative and context adapted. For instance, The Grandmother Project (GP) in Senegal uses an innovative 'Change through Culture' approach that recognizes the wisdom and experience of grandmothers and empowers them to promote positive aspects of existing cultural roles, values and traditions to change harmful ones (Grandmother Project, 2020). The organization engages communities through culturally appropriate activities, inter-village gatherings, intergenerational forums, peer group discussions, open dialogue on issues related to girls' development, children well-being, education and problem-solving, and 'under the tree' non-formal education sessions – with grandmothers, mothers and adolescent girls and boys.

School and university-based programmes are also implemented. For

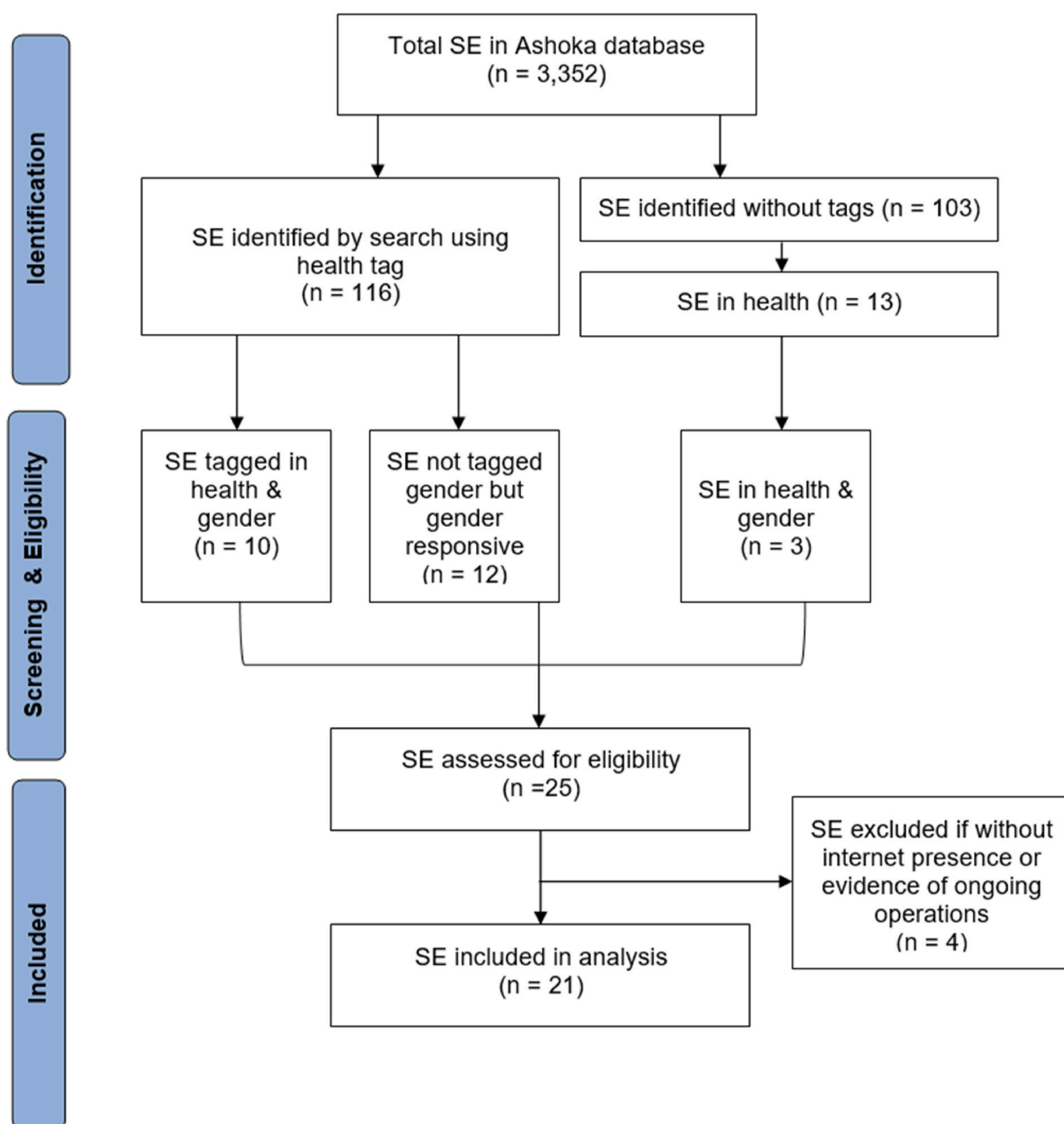

Fig. 2. Identification of social enterprises for analysis.

example, Roots of Health provides SRHR education to students in the Philippines through classes and seminars on healthy relationships, dealing with peer pressure, making informed sexual choices, and the basics of contraception, pregnancy, sexually transmitted infections and related topics (Roots of Health, 2019). Also, teacher training is conducted to present a Comprehensive Sexuality Education (CSE) Guide, a curriculum-based method of educating about cognitive, emotional, physical, and social facets of sexuality that is scientific, age and developmentally appropriate, culturally gender-responsive, and with a rights-based approach. Grupo Matizes in Brazil partners with universities and academics to produce educational material to inform society and demystify erroneous perspectives on sexual diversity and rights (Ashoka, 2020c). The universities host a week of academic and cultural activities that unite LGBTQ + entities and other social movements to engage in dialogue with society, to change social perceptions of the LGBTQ + population in the academic, cultural, and familial spheres.

3.3.2. Cross-sectoral and community-centred services

Gender crosscuts other domains of life beyond health, and cross-sectoral programming can address these influences. For example, the Association SOS Santé et Développement (ASD) in Burkina Faso promotes food production in rural communities with high HIV incidence through innovative and affordable techniques to enable people living with HIV to have increased access to better nutrition, income, and health. Community solidarity is built through training and social events.

Women-centred approaches focus on women's rights to control their health. Social entrepreneurs have designed programmes that acknowledge women's preferences in obtaining health care, and their life roles as caregivers, partners, and mothers. For example, Lua Nova provides community-based rehabilitation to chemically dependent mothers while incorporating parenting techniques, professional skills, and basic human rights education. The organization recognizes clients' roles as mothers and caregivers and provides psychological and medical treatment to women alongside their children, facilitating the bonding between

Table 3
Description of sample.

Description		Number	Social Enterprise
Ashoka work category tag	Health and Fitness	13	C, E – N, Q, R
	Healthcare	6	A, B, D, G, M, O
	Maternal Health	1	B
	Reproductive Health	7	D, E, F, L, M, N, R
	HIV/AIDS/STD	5	H, J, L, P, Q
	Human Rights and Equality	9	B - I, N
	Gender Equity	5	C, E, F, G, H
	Domestic Violence	1	A
	Violence and Abuse	1	G
	Women's Issues	3	B, C, D
	Girl's Development	2	D, I
	Boy's Development	1	I
	Disability	1	I
Organization type	Community-based organization	1	A
	Non-profit/Non-governmental organization	15	C - K, N, O, Q, R
	International NGO and social franchise	1	P
	Hybrid non-profit organization	1	B
	Social enterprise	2	L, M, U
	Family Business	1	T
Year founded	2011–2017	8	A, C, F, G, L, S, T, U
	2000–2010	8	B, D, E, H, K, M, N, P
	1980–1999	5	I, J, O, Q, R
Fellowship start	2017–2020	11	A - F, J, K, L
	2011–2016	6	G, H, M, N, O
	2000–2010	4	I, P, Q, R,
Country of operation	High-income country (HIC)	5	A, B, C, F, G
	Low and middle-income country	13	D, E, H - K, M, N, Q, R
	Based in a HIC, operate in multiple LMIC	2	L, O
	Based in a HIC, operate in multiple LMIC/HIC	1	P
Programme site	Single country	18	A – K, M, N, Q - T, U
	Multi-country	3	L, O, P
Health and gender theme	Sexual and reproductive health and rights	8	D, E, F, J, M, N, O, P
	Maternal health and parenting support	2	B, U
	Gender-based violence	3	A, C, G
	Primary healthcare	2	L, S
	Disability inclusion	2	I, T
	Mental Health	2	K, Q
	Drug prevention and rehabilitation	1	R
	LGBTQ + rights	1	H
Gender focus	Primary Focus	18	B - H, K, L - U
	Secondary Focus	3	A, I, J,
Investment/ financing	Business Model	6	B, L, M, P, U, V
	Predominantly grant funding	15	A, C - K, N, O, Q - T
Strategy level	Individual and community	21	A - U
	Structural	21	A - U
	Policy	8	B, D, F, H, M, Q, R, T

Key: A The Bear Clan Patrol (Canada), B Minnesota Prison Doula Project/Ostara (United States), C Callisto (United States), D Roots of Health (Philippines), E Samsara (Indonesia), F FOXY (Canada), G Women Safe Institute (France), H Grupo Matizes (Brazil), I Rodrigo Mendes Institute (Brazil), J Association SOS Santé et Développement (Burkina Faso), K Mental Health Action Trust (India), L Healthy Entrepreneurs (Netherlands/Multiple countries), M Zana Africa (Kenya), N Grandmother Project (Senegal), O Santé Sud (France/Multiple countries), P Dance4Life (Netherlands/Multiple countries), Q CEDOICOM (Brazil), R Lua Nova (Brazil), S Basic Healthcare Services (India), T Union of Mothers of Angels (Brazil), U Safe Motherhood Alliance (Zambia).

Table 4
Gender-related issues identified.

Health area	Number of cases	Social enterprise	Countries of implementation
Sexual and reproductive health and rights	8	D, E, F, J, M, N, O, P	Philippines, Indonesia, Canada, Burkina Faso, Kenya, Senegal, France/multiple countries, Netherlands/ multiple countries
Gender-based violence	3	A, C, G	Canada, United States, France
Maternal health and parenting support	2	B, U	United States, Zambia
Primary healthcare	2	L, S	Netherlands/multiple countries, India
Disability inclusion	2	I, T	Brazil
Mental Health	2	K, Q	India, Brazil
Drug prevention and rehabilitation	1	R	Brazil
LGBTQ + rights	2	H, Q	Brazil

mother and child. Courses on community development, training and income alternatives are also provided to contribute to women's positive re-entering into society and seeking housing and employment.

3.3.3. *Use of technology*

Many organizations use technology as platforms or resources to deliver the intervention, especially in resource-limited settings. Healthy Entrepreneurs operates a fully integrated end-to-end supply chain to deliver health products and services to families via a network of trained Community Health Entrepreneurs (CHEs). The latter are also community health workers (Healthy Entrepreneurs, 2020). CHEs digitally manage educational outreach using digital aids built from World Health Organization (WHO) and UNICEF content, product stock, products and payments using solar-powered tablets. Using informational videos, tools for screening and consultation, CHEs also educate and detect the need for further care in family planning, gender-based violence, HIV, and other sexually transmitted diseases (STDs), exclusive breastfeeding, and children's immunizations and nutrition. In 2018, HE piloted an innovative 'doctor at a distance' program, where 150 CHEs offer additional services, including screening for hypertension and diabetes, sharing the data with doctors that are geographically distanced using an app. Using this data and a phone call with the patient, the doctors are able to provide consultations and diagnoses to patients (Healthy Entrepreneurs, 2018).

In India, technology is utilized to shift care dynamics, creating an efficient process by which patients from rural areas can get support. The MHAT provides community-based and volunteer-led mental healthcare services in India's remote locations using a task sharing system and outpatient telepsychiatry visits that allow psychiatrists and medical professionals to diagnose patients remotely. Basic Healthcare Services (BHS) clinic offers community-based primary healthcare services to tribal communities through resident female nurses and doctors who visit the clinic once weekly but are available for teleconsultation round-the-clock.

Technology is also particularly prominent where discretion and privacy are considered essential design features for intervention success. For example, in Indonesia, single women, teenagers, and married women who do not wish to seek their husbands' permission are prevented by law from accessing abortion or anonymous reproductive health services. Samsara provides comprehensive SRHR information to women with unplanned pregnancies who may have no other knowledge and support source via anonymous hotline counselling services, a widespread web presence, and an interactive chat platform (Gerdts and Hudaya, 2016). In the USA, Callisto uses a technology platform to enable assault survivors to record and disclose assault incidents on college

Table 5
Gender-related interventions and included populations.

	Social Enterprise	Intervention	Gender-responsive assessment	Included populations	Approach
A	Bear Clan Patrol (Canada)	• Run community-based patrols providing safety and conflict resolution, led by women in alignment with indigenous traditional matriarchal leadership. • Help in the search of missing women and children.	Gender-sensitive	Indigenous communities	NPO
B	Minnesota Prison Doula Project (United States)	• Helped pass legislation that legally entitles incarcerated women access to labour support. • Washington State House Bill (WA HB 2016), modelled after MPDP outcomes, permits certified midwives and doulas to provide pregnancy and parenting support for pregnant inmates in "no touch" facilities.	Gender-transformative	Incarcerated women	Hybrid NPO
C	Calisto (United States)	• Designed an app for reporting and tracking sexual assault in educational institutions. • Integrates the needs and agency of women, men and gender non-conforming survivors, and directs them to specific information about reporting options and resources, including legal avenues and counselling support.	Gender-sensitive	College going victims of sexual assault or professional sexual coercion	NPO
D	Roots of Health (Philippines)	• Partners and works with the Provincial and City Departments of Health and Education to implement reproductive health programmes that support underserved and resource-scarce communities and share data to help these institutions make relevant and effective policy decisions. • Created Municipal Implementation Teams of government and health leaders, principals and teachers to provide more enabling environments for young people to access clinical services. • Sits on the Local Health Board and the Local Aids Council, the Provincial Family Health Council of Palawan, and the Provincial Maternal Death Surveillance and Response Council, enabling influence on health policies and budget allocations.	Gender-transformative	Women and youth	NPO
E	Samsara (Indonesia)	• Provide comprehensive anonymous counselling on unplanned pregnancy via telephone hotline, website and mobile apps. • Developed a Sexual Reproductive Health School and curriculum covering eight SRHR topics, including gender issues. Educate communities in rural areas through workshops and engage village communities, local civil society organizations, schools, religious organizations, and universities to conduct seminars on SRH for youth.	Gender-specific	Pregnant women	NPO
F	FOXY (Canada)	• Integrated into policy circles and discussions that are changing policies at the territorial level. • Partner with the regional Department of Education to secure official accreditation for girls who complete leadership training and implement a social change project. • Responded to community demand for a boys-focused intervention by creating SMASH (Strength, Masculinities, and Sexual Health) programme to tackle sexual health and expectations of men in a patriarchal society, healing from trauma, and developing Indigenous identity.	Gender-transformative	Indigenous communities	NPO
G	Women Safe Institute (France)	• Provide women victims of violence with personalized legal and social support and medical consultations through a comprehensive team of professionals. • Developed innovative tools to enable women to speak with nurses comfortably, and groups where women can express themselves in a secured, empathic and caring environment. • Negotiate prices with psychologists and local community partners to provide affordable and discreet care, housing and phone loans to women. • Organize agreements with administrative institutions to temporarily regularize undocumented immigrant women to ensure their presence on the territory during the support process. Provide women victims of violence with personalized legal and social support and medical consultations through a comprehensive team of professionals. • Developed innovative tools to enable women to speak with nurses comfortably, and groups where women can express themselves in a secured, empathic and caring environment. • Negotiate prices with psychologists and local community partners to provide affordable and discreet care, housing and phone loans to women. • Organize agreements with administrative institutions to temporarily regularize undocumented immigrant women to ensure their presence on the territory during the support process.	Gender-specific	Women victims of violence	NPO
H	Grupo Matizes (Brazil)			The LGBTQ + community	NPO

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Table 5 (*continued*)

	Social Enterprise	Intervention	Gender-responsive assessment	Included populations	Approach
		• Works with public agents to change policy based on the LGBTQ + population needs. Engages public agents and provide them with resources and legal sentences that demonstrate the benefits of recognizing a certain right, increasing social awareness and chances of implementation. • Developed partnerships with press, universities, and social and legal movements, through which public discussions and educational activities accompany judicial claims. • Lead discussions at the national level, civil society organizations and agencies to exchange best practices and models to be replicated throughout Brazil. • Uses extensive research and legal groundwork to influence national laws: • In 2006, GM contested the Brazilian Health Surveillance Agency's prohibition of gays and bisexuals donating blood, providing the LGBTQ + community with rights formerly denied to them. • In 2009, GM challenged Brazil's Receita Federal regulation preventing LGBTQ + taxpayers from declaring their partners as dependents for income tax purposes, changing this convention at a national level.	Gender-transformative		
I	Rodrigo Mendes Institute (Brazil)	• Brings together various stakeholders to identify and develop strategies for disability inclusion and disseminate them to institutions such as museums, galleries, and schools. • Offers training and support for disabled and non-disabled students to become marketable professionals. • Create projects that demand close teamwork, the school forces students to overcome prejudices toward each other and recognize mutual abilities. • Implement a training programme with public and private schools, cultural and educational institutions and citizen organizations interested in inclusion.	Gender-sensitive	People with disabilities, the public school system	NPO
J	Association SOS Santé et Développement (Burkina Faso)	• Increases agricultural productivity through simple techniques in order to improve the nutrition and health of PLWHIV. • Build community solidarity through trainings that bring everyone together, dialogue and social events, including dance and theater. • Organize awareness sessions on HIV prevention and unwanted pregnancies in high schools. • Implemented a project for the socioeconomic empowerment of women, youth and internally displaced persons through the creation of agricultural jobs.	Gender-sensitive	People living with HIV	NPO
K	Mental Health Action Trust (India)	• Established a Women's Mental Health clinic providing mental health services to women, including maternal mental health during and after childbirth. • Established community run care centres, often run by housewives, chaiwallahs and farmers, to provide safe spaces for patients to develop skills and behaviors and engage in family group therapy and self-empowerment groups. • Economically empower patients by linking them to local sources of employment.	Gender-specific	Low-income communities	NPO
L	Healthy Entrepreneurs (Netherlands)	• Train women microentrepreneurs to sell medicines and health related products, providing them with a single sustainable source of income. • Offers self-guided diagnostic questionnaires that lead to specific educational material and higher quality treatment. Topics are on general and reproductive health, starring locals in familiar situations using local language(s) on relevant topics to ensure the message is spread in an educational approach. • Provide SRH information to youth through a non-discriminatory and inclusive educational approach.	Gender-sensitive	Low-income communities in remote areas	Social enterprise
M	Zana Africa (Kenya)	• Leverage data and experiences lista hygiene management; work with key stakeholders and the media locally and internationally to support, organize and celebrate this day.	Gender-transformative	Girls and women	Social enterprise
N	Grandmother Project (Senegal)	• Engages communities through culturally appropriate activities - coaching, non-formal education, and community recognition of grandmothers, to contribute to restoring their traditional role as advisors, allies and educators for children. • Works with communities to identify 'grandmother leaders' and strengthen their leadership capacity. • Organize inter-village gatherings to publicly recognize grandmothers' contributions to family and community well-being and empower them as leaders.	Gender-specific	Women and children	NPO

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Table 5 (*continued*)

	Social Enterprise	Intervention	Gender-responsive assessment	Included populations	Approach
		• Organizes intergenerational forums to improve communication between generations, and to facilitate the collective decision-making process. • Bring together traditional community leaders, religious leaders, grandmothers, grandfathers, men, women, adolescents, health workers and teachers for open dialogue on issues related to girls' development, children well-being, problem-solving to address girls' development and education. • Provide community education through "under the tree" non-formal education sessions – with grandmothers, mothers and adolescent girls, adolescent boys meet separately with grandmothers and mothers. • Work to improve school-community relationships through grandmother-teacher workshops, development of booklets on cultural values for use in schools, training with teachers to integrate cultural education into curricula and bringing grandmothers into classrooms to teach traditional values.			
O	Santé Sud (France/ multiple countries)	• Works alongside the health authorities and civil society organizations to improve the sexual and reproductive health of poor populations. • Support women and men to play a key role in improving their SRH, protecting themselves against sexually transmitted diseases and directing them to family planning and pregnancy monitoring services. • Analyzed the needs of women and children in Mayotte to design a SRH project following a law and gender approach that meets the urgent needs of these vulnerable populations.	Gender-sensitive	Isolated rural communities	NPO
P	Dance4Life (Netherlands/ multiple countries)	• Created programmes distributed by local franchisees, and partner organizations through schools: Schools4Life: in-school awareness campaign about HIV/AIDS and SRHR, Skills4Life: Offers workshops on negotiation, peer-to-peer inspiration, how to talk about sex, how to overcome counter arguments, and so on, and Act4Life: Participants are invited to undertake concrete action for social change. • Engages youth in fundraising and other youth-led activities in the fight against HIV/AIDS.	Gender-specific	Youth	International NGO/ Social Franchise
Q	CEDOICOM (Brazil)	• Acts as a parliamentary adviser on the drafting of laws, trying to ensure the approval by the Rio de Janeiro City Council of a law granting incarcerated women the right to conjugal visits. • Work in schools and churches with programmes to help prevent young black women from turning to crime and provide health education. • Created a reference center to support academic research, fostering the documentation and analysis of the conditions of women and women prisoners.	Gender-transformative	Incarcerated women	NPO
R	Lua Nova (Brazil)	• Negotiated agreements for support from São Paulo State's Secretary for Social Assistance and is engaging the Federal Department for the Welfare of Minors employees to influence public policies on rehabilitation and reintegration of adolescent mothers with a history of drug use. • Developed partnerships with government institutions and businesses to strengthen and expand the programme e.g., teaching the Sorocaba Municipal Government staff to apply the Lua Nova's methodology to its social assistance projects.	Gender-transformative	Young, low-income, chemically dependent mothers	NPO
S	Basic Healthcare Services (India)	• Recruit and upskill young tribal women nurses, recognizing that they are most likely to live and work in rural areas. • Nurses deliver antenatal and postnatal care, follow up on chronic patients and supervise Community Health Workers who influence positive health behaviours, run health education and counselling services and build trust for uptake of clinic services. • Partnered with a livelihood and financial inclusion organization that works with tribal communities that depend on migration and labour to co-create a health loan product for TB patients with flexible payment models.	Gender-specific	Tribal communities	Start-up NPO
T	Union of Mothers of Angels (Brazil)	• Lead strong community-based advocacy to guarantee better living conditions for mothers of children with ZVCS. • Changed the laws of a federal public housing programmes, guaranteeing that mothers and families of children with ZVCS became its priority. • Behind the approval of a law that provides anticonvulsive medications free for people with disabilities and prioritizes children with ZVCS in the Social Security programmes. • Participated in public hearings on inclusive education with the Court of Justice, the Brazilian Bar Association and municipal	Gender-transformative	Children with the Zika Virus Congenital Syndrome and their families	Family business

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Table 5 (*continued*)

	Social Enterprise	Intervention	Gender-responsive assessment	Included populations	Approach
		councils and obtained an official document that obliged schools to receive children with the appropriate infrastructure. • Alerted the State Department of Education on the importance of an inclusive educational system, mobilizing it to speak on the subject.			
U	Safe Motherhood Alliance (Zambia)	• Identifies and trains traditional birth attendants in partnership with the Ministry of Health and equips them with pre-packaged birth kits to sell in the community and local clinics. • Partnered with local clinics where traditional birth attendants dispel myths about pregnancy and encourage facility births, and marker the baby delivery kit to women during health talks. The conversation about the kit and creating familial ownership over the birth process is also had with the male partners.	Gender-specific	Traditional birth attendants	Social enterprise

* NPO=non-profit organisation.

campuses and link them to other victims of the same perpetrator to identify repeat offenders. The platform focuses on survivors' needs, offering tailored information about reporting options and resources, including legal avenues and counselling support.

3.3.4. *Responsive and adaptive service delivery amidst COVID-19 pandemic*

This analysis was conducted during the COVID-19 pandemic in 2020. We found that at least eight of the organizations implemented gender-responsive health programmes with adapted delivery models to reach the targeted populations during the pandemic. This included mobile clinical reproductive health services, health and well-being information dissemination, and community health collaborations. The pandemic exacerbated the health challenges women and girls face. Restrictions to leave their homes and overburdened health facilities often translate into constrained access to sexual and reproductive healthcare and an increased risk of gender-based violence. Amid lockdown restrictions, Roots of Health used social media (Facebook Messenger and Live) and remote programming to consult clients and offer online counselling and instructional SRHR videos. Licensed health providers hosted live SRHR 'Q & A′ sessions in Tagalog for women and girls. Through a safe, non-judgmental online space, women and girls choose their preferred birth control to prevent unplanned pregnancies during the pandemic (Roots of Health, 2020a). The organization also offers discrete mobile clinical reproductive health services to women and girls who are unable to leave their homes or communities or are restricted from using contraceptives by their partners or family (Roots of Health, 2020b).

In collaboration with Hotıì ts'eeda, a research unit governed by Canadian Northwest Territories (NWT) indigenous governments, FOXY launched a social media campaign using culturally relevant comics to inform indigenous communities about social distancing (Hotıì ts'eeda, 2020). Similarly, Zana Africa created educational SRHR content in a series of comics designed to improve girls' health and resilience during the pandemic. Many out-of-school girls are at heightened risk for sexual and gender-based violence, pregnancy, anxiety, and depression. Kenyan schools closed due to the pandemic. The comics debunks myths on COVID-19 infection, supports girls' mental health and well-being by engaging in self-care exercises and provides a hotline for access to SRHR education services (ZanaAfrica Foundation, 2020a). In collaboration with NGO Plan International, the organization distributed sanitary pads in the Kibera slum in Kenya to further support vulnerable girls and young women in crisis (Plan International, 2020). Dance4Life created a COVID-19 Youth Guide to help young people navigate their lives, health, and well-being during the pandemic. The guide includes information on social and physical distancing, domestic violence, sexual and gender-based violence experienced by women and girls in lockdown, sexual health, mental health, stigma and discrimination, myths and facts about the virus and the vulnerable groups (Dance4life, 2020). Institut Women Safe (IWS) in France wrote and shared articles on gender-based violence in the face of lockdowns and increased domestic and intra-family violence worldwide, with information on how to react to violence, such as through the organization's hotline (Institut Women Safe, 2020).

3.3.5. *Capacity-building within health systems*

Gender was also integrated into interventions targeting the health workforce's capacity building. Basic Healthcare Services (BHS) provides female tribal nurses in rural areas with accommodation, intensive induction, and monthly training to develop professional skills, including on standardized protocols, the ability to diagnose, analyze and make decisions on cases, patient communication and counselling (Amin et al., 2020). HE trains health workers as community health entrepreneurs (CHEs) to provide targeted health information, medicines, health products and services corresponding to the needs and demands of families living in remote, isolated communities. The organization identifies potential entrepreneurs, preferably women, with basic healthcare knowledge and a secondary school certificate. In 2018, HE trained over 4000 CHEs (78% women) in five countries (Healthy Entrepreneurs, 2018). Safe Motherhood Alliance (SMA) trains experienced traditional birth attendants (TBAs) on modern birthing practices, entrepreneurship skills and building and maintaining trust relationships with mothers (Borgen Magazine, 2020). The TBAs are equipped with delivery kits and provide them as part of their birth delivery services. SMA partners with local clinics where TBAs work to dispel pregnancy myths, promote facility delivery during ante-natal health talks and market the delivery kit to women and their spouses.

3.4. *Included populations and intersectionality*

Overall, there is a higher focus on populations of girls and women (see Table 5). Nevertheless, several organizations integrate a working focus on diverse gender and sexual identities, men and boys, and the influence of other intersectional statuses and identities. FOXY, an organization that provides public health education to indigenous girls, launched a Strength, Masculinities, and Sexual Health (SMASH) programme for young men and masculine-identifying youth in 2016. This was in response to the indigenous community's demand for a programme that focuses on men's expectations in a patriarchal society, healing from trauma and developing an indigenous identity (Ashoka, 2021). Through school-based and peer leader workshops, the programme teaches sexual health, consent, healthy relationships, and positive masculinity. Young men are educated and encouraged to define their masculinity, including practical, realistic discussions about sexual health and relationships, straightforward strategies for communication, consent, and discussion of boundaries.

In SRHR focused organizations, populations included girls, women and youth, women with unplanned pregnancies, indigenous women, people living with HIV, and rural communities. Gender-based violence

issues were mainly addressed in high-income countries, citing high rates of violence against women (France), a high number of missing persons reports (indigenous Canadian communities), and increased incidences of sexual assault or coercion among college-going women (USA). In maternal health programmes, the focus populations included incarcerated women and traditional birth attendants (TBAs) in the delivery side.

3.5. Investments

Descriptions of scale, budget or spending on gender-responsive activities were not identified. Information extraction hence focused more on the financing models used to implement overall activities by the organizations. Much of the programming occurs in low and middle-income countries (n = 16) with broad and notable health system financing, capacity and infrastructure gaps, and dependence on private or bi/multilateral overseas development aid. The 21 organizations included traditional non-profit organizations (n = 16/21) that predominantly rely on grant funding and those that use market-oriented financing strategies or hybrid organization business models (n = 6/21; see Table 5). The 16 organizations in the first category acquire resources from diverse donors, including multilateral agencies, bilateral agencies, NGOs, federal/state grants, and individual donations. These include resource mobilization through global funders and multilateral organizations such as the United Nations Children's Fund (UNICEF), UNFPA, and embassies, private commercial organizations such as banks, telecommunication companies, and philanthropic foundations funded by sports teams, and at a community level, through community co-operatives and local businesses that contribute monetary and in-kind donations.

The six organizations identified in the latter category primarily used market-based strategies to raise revenues, increase investments and generate income that is reinvested in their health programming. Healthy Entrepreneurs (HE) (Healthy Entrepreneurs, 2020) is an example of a hybrid organization that receives support from multiple organizations and uses a micro-entrepreneurship model to empower community health workers as CHEs. Through an initial investment of USD 40–50, CHEs are provided with a starter kit with essential medical products worth USD 70–100 on credit. The entrepreneurs sell to the community and repay within a year. During their training, the local entrepreneurs also receive a solar-powered tablet to educate clients, promote new products, and order new medical stock. HE manages its end-to-end distribution chains, buying reliable products as cheaply as possible and delivering them directly to the entrepreneurs on-site via local depot. Similarly, in collaboration with the Ministry of Health in Zambia, SMA sells pre-packaged birth kits containing essential sterile materials to TBAs at USD 10/kit, which they sell to the community and in the local clinics at a commission (Borgen Magazine, 2020). The programme also trains TBAs on modern birthing practices, entrepreneurship, and relationship-building skills.

Some organizations use hybrid-financing models incorporating donor-funded and income-generating programmes. For instance, over 20% of Ostara's (WHO, 2007) funding comes from income and contracts with prison facilities. Zana Africa is the social impact business arm of the commercial Zana Africa Group (ZanaAfrica Foundation, 2020) which manufactures and distributes quality, low-cost feminine hygiene products through the marketplace using aspirational brands designed for women by women, creating safe spaces to learn about health and reclaim dignity (Birech, 2019). Dance4Life's act4life programme includes an income-generating training component through collaborations with famous DJs, artists, world leaders, and social ambassadors (Hermanns et al., 2009).

3.6. Implementation

3.6.1. Collaboration with public and other private sector actors

All 21 organizations implemented health intervention programmes by building partnerships with private and public sector actors to achieve their objectives. These include ministries of health, local and municipal governments, media and press outlets, universities, and other social movements. Union of Mothers of Angels in Brazil develops partnerships with private and public actors and local institutions, such as the media and police, to unite the mothers of children with ZVCS and create solutions that address their challenges in accessing healthcare, medicines, and government aid. Through a partnership with RREAL-a US-based solar company, SMA supports five rural clinics with solar batteries, so mothers do not deliver their babies in the dark.

Many primary care systems are poorly utilized within the health sector due to weak linkages with higher levels of care. In India's rural tribal communities, where poverty and geographic isolation push the menfolk to migrate to cities for work, women face significant challenges in seeking timely healthcare for themselves and their families in the absence of the primary male member. BHS forges social contracts with private hospitals to provide near-free referral care. The public system enables targeting health entitlements to families, such as free diagnostics and conditional cash transfers (Basic Healthcare Services, 2020). To further optimize resources, BHS clinics partnered with a livelihood and financial inclusion organization, led by an Ashoka Fellow, that works with tribal communities that depend on migration and labour to create a health loan with flexible payment models for tuberculosis patients (Ashoka, 2020). Partnerships link the health workforce (such as CHWs/TBAs) with the Ministry of Health programmes and guidelines and improve health facility capacities. For example, Safe Motherhood Alliance, through an agreement with the Ministry of Health, uses local and international partnerships to augment the capacity of the clinics in rural Zambia.

3.6.2. Community-level action

All 21 organizations implemented programmes at the community level, often collaborating with various underutilized non-medical health workforces such as community health workers and volunteers. The Mental Health Action Trust (MHAT) set up community health centres in India to offer comprehensive community-based and volunteer-led mental healthcare services to low-income, and resource-scarce communities. To reduce gender disparities in mental health treatment, MHAT's clinic for women provides gender-sensitive services to address women's distinct psychological needs. In partnership with community palliative care centres, primary health care centres, and Civil Society Organizations, MHAT taps into existing cadres of health workers. In this community-based system of care, psychiatrists and medical professionals assume the role of trainers and advocates and local community health workers and volunteers are responsible for home visit support, psychosocial rehabilitation, family group therapy, economic empowerment, and the creation of self-help groups. Community centres also run day-care centres to provide safe spaces for patients to develop skills and behaviours lost to years of mental illness and strengthen support systems across local communities.

The BCP offers community-based safety patrol services by mobilizing community volunteers to provide an early response to crises and restore the community's responsibility and capacity to protect vulnerable members. Experienced members train new volunteers on CPR, first aid, non-violent crisis intervention, post-traumatic stress management, applied suicide intervention, dementia awareness and Naloxone administration. The patrollers are a strong and consistent presence on the streets, fostering non-violent and non-threatening interactions. BCP helps the police force search for missing individuals (mostly women and children), using a BCP missing person's social media post with a broader reach beyond the police search capacity. They also organize a food security programme for the community, serving vulnerable groups such as indigenous women and children. BCP opens new communication lines by inviting police officers to patrol and experience the ground realities from the community perspective. This helps counter the mistrust, biases, and misconceptions between police, service providers, and indigenous

communities.

3.6.3. Policy and systems-level action

Eight organizations were active in policy or system-level action-addressing the causes of gender-based health inequalities and transforming harmful gender roles, norms and relations at the community, institutional and policy levels. These organizations advocated for and contributed to policy and public budget changes by working with various local and national departments, including health and education. Grupo Matizes works with public agents to implement public policies that contribute to the inclusion and citizenship of the LGBTQ + population in Brazil (Ashoka, 2020c). In 2006, GM challenged the Brazilian Health Surveillance Agency's prohibition of gays and bisexuals to donate blood, providing the LGBTQ + community across Brazil with rights formerly denied.

Minnesota Prison Doula Project (MPDP), rebranded as Ostara, has been an instrumental stakeholder in establishing legislation that prohibits the shackling of incarcerated women during pregnancy and in the post-partum period, and facilitating their legal entitlements to doula care (Ashoka, 2020; Minnesota Prison Doula Project, 2020). The Washington State House bill (WA HB 2016), passed in March 2018, was modelled after MPDP outcomes and permits certified midwives and doulas to provide prenatal care, childbirth services and counselling for pregnant inmates in no-touch facilities (Washington State Legislature, 2018). MPDP also helped pass legislation in Oklahoma that legally entitles incarcerated women to access to doula care. Similarly, CEDOICOM (Center for Documentation of Women's Issues), as a parliamentary adviser of the Rio de Janeiro City Council on drafting laws, is trying to ensure incarcerated women in Brazil are given the right to conjugal visits (Ashoka, 2020).

Zana Africa (ZA) participates in the Kenyan government Technical Working Groups to integrate menstrual health management into SRHR policies and engage international agencies, NGOs and key stakeholders to prioritize menstrual health management and ingrain menstrual and reproductive health and rights into global aid priorities and development agendas (ZanaAfrica Foundation, 2020). From 2010 to 2018, ZA successfully supported the Kenyan government and health ministry to include sanitary pads as essential school items in the national budget and develop a policy strategy on hygiene products and manufacturing safety. On an international level, in 2016, ZA backed menstrual equity advocates and activists in New York and London to abolish the tampon tax.

3.7. Impact assessments

While social impact is a central pursuit in social entrepreneurship, only under half the organizations (n = 10/21) made formal impact assessments and related peer-reviewed studies available in the digital domain. These include reports from the organization's websites and annual reports available in the public domain. Impact evaluations of some organizations and their initiatives were undertaken by external agencies and commissioned either by the fellows or other donor partners who funded specific programmes. Overall, gender was included in the assessments primarily through descriptions of gender ratios in the

Table 6
Gender-related outcomes.

Social Enterprise	Evaluation	Assessment	Output	Outcome	Impact
Healthy Entrepreneurs (L)	*The association between CHEs in the HE programmes and the SRHR status of rural households in West Uganda.*	*Evidence supporting the role of CHE in providing rural communities with SRHR care.*	• *4000 CHEs trained (78% women)* • *6,000,000 people reached in rural areas*	*Households reported more often to use at least one modern contraceptive method, more knowledge of modern contraceptive methods, STIs and symptoms.*	*CHE has a positive effect on rural communities SRHR status.*
Zana Africa (M)	The provision of sanitary pads and RH education on girls' education and RH outcomes in Kenya.	Addressing menstrual health challenges as part of CSE programmes tackling stigma and shame, access to products, inequitable gender norms and SRHR knowledge gaps instead of a girl's education intervention.	• 50,000 girls supplied with sanitary pads, RH education • 4000 girls provided with a transformative rights-based RH magazine	Girls felt more positively about menstruation, knew more about SRHR, had more equitable gender norms and were more self-confident.	On their own or together, neither sanitary pad distribution nor RH education improved school attendance or class participation.
Grandmother Project (N)	The Girls' Holistic Development programme implementation in 40 villages in southern Senegal.	Robust empirical support for the Girls' Holistic Development Theory of Change	• 9675 students participated in education programmes • 1636 grandmothers trained	Improved social cohesion, girls' health, well-being, and education	A grandmother-inclusive strategy builds community-wide consensus for the adoption of girl-friendly norms and practices.
Dance4Life (P)	Programmes in Uganda and Russia	The programme had a positive impact on participants' lives.	Uganda: • 146,768 youth reached • 78, 674 agents for change Russia: • 224,086 youth reached • 53,477 agents for change	Increased participation, decision-making, ownership, responsibility, agency and the ability to create change among peers.	Youth involvement at the individual level is meaningful; sustainability requires multilevel (collective or institutional) participation.
	Programmes in Argentina	Peer education is highlighted as a positive factor for all stakeholders.	• 2000 youth facilitators trained • Programme implemented in 20 public high schools	- 93% identified HIV transmission modes - Knowledge on contraceptive use was high (68% for injectable; 99% for condom). - Positive attitude changes: 72% had a newfound respect for people living with HIV, 60% in their capacity to talk about sexuality openly, 80% knew how to avoid unwanted sex.	Peer-led HIV prevention education programmes impact both the young people receiving and leading the intervention.

Source: Healthy Entrepreneurs [63], Zana Africa [64], Grandmother Project [66], Dance4Life [67].

population groups, but gender analysis or gender-focused research questions within the impact assessments were rarely prioritised and answered. Table 6 outlines the output, outcome, and impact of some organizations and the gender-responsive interventions.

Outcomes assessment of gender-specific initiatives such as in the promotion of menstrual health in the Healthy Entrepreneur and Zana Africa programmes, offer examples of gender-related impact assessments in the cohort (Borst et al., 2019). A study protocol for the evaluation of the Nia menstrual health management intervention (Zana Africa) outlines a longitudinal (18 month), cluster-randomized controlled study with multiple components including a baseline and endline survey, a school quality survey, qualitative data collection, and school attendance tracking, to assess the impact of reproductive health education and sanitary pad distribution on girls school attendance and engagement, reproductive health knowledge and attitudes, gender norms, and self-efficacy (Muthengi and Austrian, 2018). Assessment results suggest that while reproductive health education did improve reproductive health outcomes, these programmes did little to improve primary school attendance (Austrian et al., 2020). Other causes of school absenteeism, such as poverty, the low cultural prioritization of girls education and instability in households, will likely need to be considered to achieve an impact on school attendance (Austrian et al., 2020).

Other examples of impact research in the cohort include assessments of Dance4Life's programmes in Uganda and Russia, which found that the programme positively impacted participants' lives, yet noted a lack of sustained involvement of schools and students (Van der Kwaak et al., 2012). The programme also had positive results in Argentina, including increased awareness of sexuality and confidence in decisions about sex. Yet, project sustainability to assure lasting effects on school culture and health system integration to improve health outcomes remains challenging (Brizuela et al., 2017). A more recent evaluation of the Journey4Life programme implemented by a social franchising model in Ghana, Nepal, Russia and Tanzania reported that local franchisees perceived Dance4Life support as effective (Baruch et al., 2018). The evaluation mainly focused on franchisee's perception of support and their ability to implement the initiative. While Dance4Life provided financial support to frachisees, engaging and convincing potential funders about the model and its value for money were perceived as barriers. Areas for improvement identified in this recent evaluation included a more extensive translation of the programme and the piloting of its curriculum (Baruch et al., 2018).

4. Discussion & conclusion

Based on our analysis, we propose that social entrepreneurship holds the potential to contribute more strongly as actors that address gender-related health barriers by building on its cross-sectoral strengths, leveraging its resource mobilizing mechanisms and addressing its known challenges, especially in impact tracking. Closer engagement with gender experts, and embedment within the health sector can also provide relevant and targeted resources to achieve these points. The organizations in the study broadly demonstrate a good affinity to identify and tackle important gender-related health sector issues. The available documentation suggests that the reviewed organizations have implemented gender-responsive programming at community, policy and systemic levels by harnessing public-private partnerships and mobilizing private-sector financing for health programmes amidst declining funding from international donors and governments. Many partnerships with multi-sectoral non-health sector partners such as education and criminal justice systems were identified, which created linkages with existing health sector infrastructure and aligned their methods with health sector goals and principles for action-such as culturally-sensitive innovations and community-led approaches. Nevertheless, there were only a few examples of income-generating financing models in this study. There is scope to consider and adopt innovative financing models from broader social entrepreneurship initiatives and scholarship to increase domestic resources for gender and health. Fig. 3 provides a summary of our finding.

More conceptual awareness of the influence of gender in health and capacity-building towards gender-responsive programming can enhance the number of social entrepreneurs that engage in gender-responsive work in the future. We found that only a small percentage of Ashoka fellows work on health issues. A smaller proportion had visible dimensions that respond to gender-related issues, inequalities, and barriers in health through programme design, populations of focus, and implementation strategies. Addressing cultural or context-specific influences that determine men's, women's, and gender-diverse people's health-seeking or terms of health access can contribute to better programmatic outcomes and broader improvements in health outcomes and health system performance. Health programme implementation that ignores the often subtle, private and informal gender-related nuances (Davies et al., 2019) is likely to not adequately address gender-based and broader global health challenges. For example, two new fellow organizations excluded from the sample focused on improving access to medication for tuberculosis and other chronic illnesses in various LMICs. Tuberculosis is predominantly male-disproportionate in many settings. Tailored and context-adapted interventions to engage men, such as through peer support workshops, with male-sensitive approaches and communication at mobile locations such as the workplace, bars, and churches, can help address negative constructions of masculinity to encourage early health-seeking and treatment adherence (Beia et al., 2021; Chikovore et al., 2020). We note that the general area of gender and health programming requires more evidence generation on interventions and implementation strategies that work (Lopes et al., 2019; Malhotra, 2021). Nevertheless, many existing tools and frameworks can offer social entrepreneurs' practical guidance to engage more efficiently and effectively in gender-responsive health programming. These include the WHO Gender and health planning and programming checklist (WHO, 2011b) and the recent Gender Equality and Social Inclusion (GESI) Toolkit for Health Partnerships (THET Partnerships for Global Health, 2020). Through closer partnerships and knowledge exchange initiatives, gender experts can share relevant documented evidence and examples of successful gender-responsive interventions such as within HIV, and SRHR programmes, to guide planning and implementation of gender-responsive health programmes (Hartmann et al., 2016; Malhotra, 2021; Theobald et al., 2017; USAID, 2011). We also note the broad overall gaps in impact measurement, achievement and reporting documented in social entrepreneurship practice and scholarship. As it stands, there is broadly inconclusive evidence of whether and how social entrepreneurs produce positive social impacts, including reducing health inequities (Calò et al., 2018; Roy et al., 2018). In a recent study of over 3000 social enterprises worldwide, only 33% of the organizations were found to measure and report impact (Maas and Grieco, 2017). We were also unable to identify requirements for Ashoka fellows to assess and publicly report their impact. Ashoka impact reports mainly state fellows' success without describing how all fellows achieve social impact. Indeed, social impact assessments are still in their infancy-conceptually and in practice (Maas and Grieco, 2017; Noya, 2015). Development of impact assessments through formal documentation of both positive and negative lessons learned in the design, experimentation, and implementation will help future social entrepreneurs and programme design achieve sustainability, scale, and scope of programming. As an essential requirement, impact assessments should also monitor programmes' outcomes, especially to ensure no unintended negative consequences or harms emerge from the implementation. Formal and rigorous assessments of impact are also likely to strategically support further investments and resource mobilization, such as from private impact investors and venture capitalists to sustain and upscale initiatives (Maas and Grieco, 2017; Noya, 2015).

This review reported the gender-related impact as described by the retrieved studies and assessments. We were able to extract and report some mainly gender-specific impact outcomes-addressing the specific

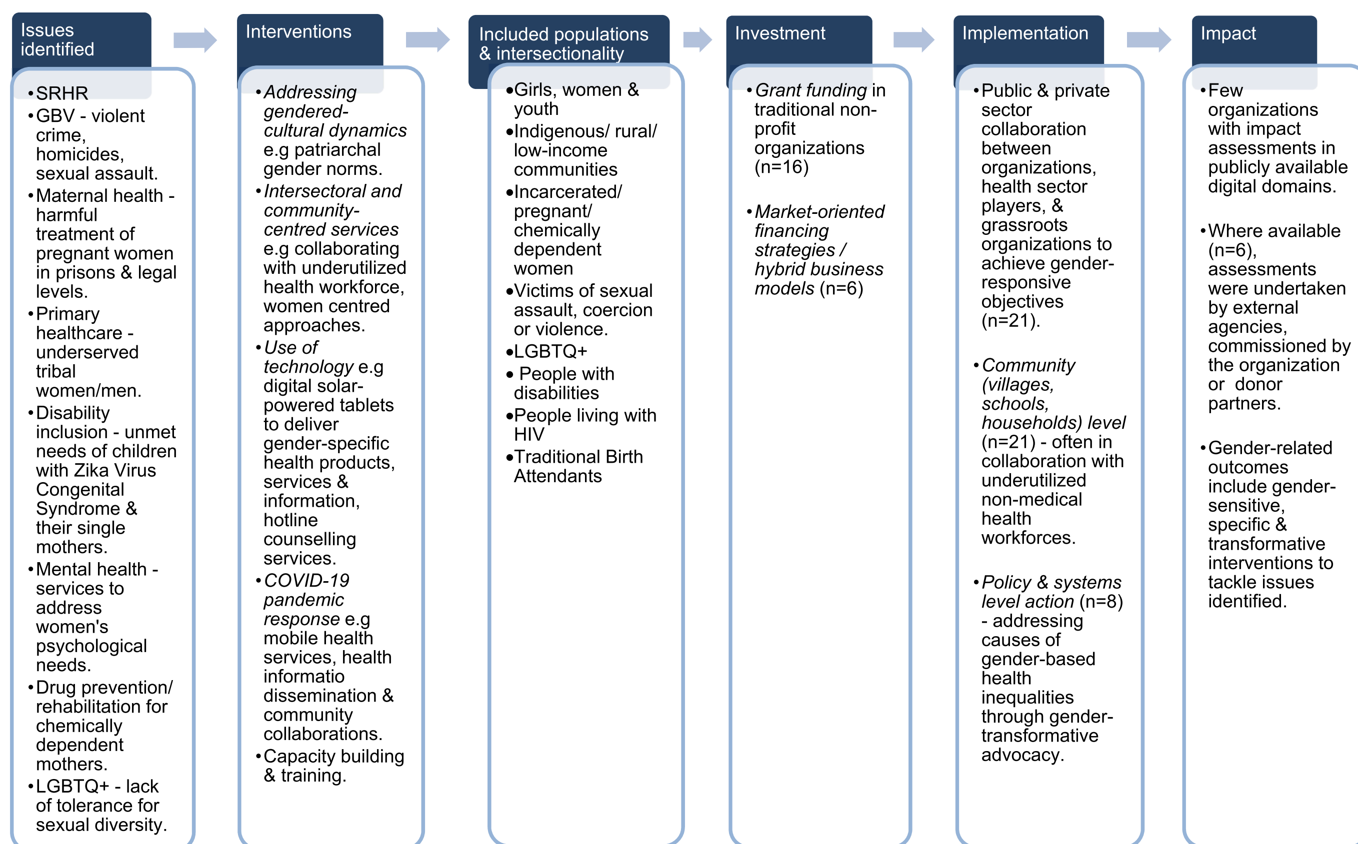

Fig. 3. Summary of findings.

gender-related needs of women in these cases. Nevertheless, as in broader global health work, there needs to be a more concerted effort to collect gender data, conduct gender analyses of the issues and implementation of the programmes, monitor, evaluate and then report the impact of the endeavours. In short, social entrepreneurs and their organizations should begin with a gender-responsive impact strategy, set achievable goals, and identify relevant indicators, including through the use, collection and reporting of gender and age disaggregated health data, to demonstrate the impact they set out to achieve.

Social entrepreneurs are already calling health systems and governments for closer support and collaboration (Bishop, 2020; World Economic Forum, 2020). To respond to these calls, gender and health experts can offer technical assistance in gender-responsive programming and help resolve some challenges social entrepreneurs and enterprises face, including achieving scale, maintaining quality, assessing impact, and influencing government policies to produce systemic change (Baporikar, 2017). For instance, gender in health researchers can support research data collection and introduce rigour into the process, not as ‘authoritative’ or ‘prescriptive’ experts but collaboratively, with the motivation to exchange knowledge (Rhule and Allotey, 2020). The health sector and the local community can combine their understanding of local problems (norms, culture, regulations, individual, community, structural) and jointly build on strategic resources and strengths to navigate these problems. The health sector can also support social entrepreneurs in aligning with and pursuing health system goals, such as universal healthcare coverage, and integrating other health system frameworks such as social determinants of health and people-centred and community-based programmes.

These relationships can be reciprocally rewarding. Gender-responsive health programming, policies and systems change needs champions, change-makers, and other change agents. Indeed, even global health organizations struggle to prioritize gender-responsive programming and often need to manoeuvre averse political climates, patriarchal organizational cultures, and issues of cohesion and agreement on the approach and framing within the gender and health network (Shawar and Shiffman, 2020). Global social entrepreneurs, their organizations and networks that promote innovation and impact, such as Ashoka, can play a role in pushing this agenda forward. Ashoka can leverage its robust peer support platforms and networks for knowledge sharing to increase the intentionality and implementation of gender-responsive programmes. Additionally, Ashoka can draw on its multi-sectoral internal network of fellows to share transferable ideas, lessons, and strategies from other sectors, to facilitate the financing potential of social entrepreneurship to self-generate and mobilize more financing for gender-responsive health programming.

Some social entrepreneurship scholars have noted that Ashoka fellows tend to focus on engaging with private firms, educational institutions and foundations, rather than public service, governments and policy-makers (Teasdale et al., 2020). Nevertheless, as exemplified by the eight organizations that engaged at a structural level alongside partners in this study, new ways of organizing through fluid open teams to create new networks and collaborations in the health sector can provide a pathway to transformational change in gender-related norms, structures, policies, and laws.

In turn, at a structural level, health systems can support emerging or start-up organizations through enabling financial and non-financial incentives such as subsidies, tax-rebates, contracts, endorsing statements, supportive media campaigns, sustainable public procurement and fees and in-kind resources (Bozhikin et al., 2019). Improved understandings of how organizations address health outcomes will also support the health sector in determining how to allocate resources, particularly in contexts where governments seek to achieve policy goals by leveraging the local knowledge, resources, and community and market actors (Suchowerska et al., 2020).

The scope and approach of this literature-based review provide some initial insights into the extent of gender-responsive health programming by a subset of social entrepreneurs. Descriptions of the programmes also provide new and existing social entrepreneurs with some ideas on how to include gender-responsive elements in their programme design and expansions. Admittedly, there are some constraints to our approach. While the Ashoka network is an appropriate sampling frame, we acknowledge that there are other positive examples of social entrepreneurship in health outside the Ashoka system (Lokman and Chahine, 2021; McKague et al., 2021). Further research is needed to assess the gender responsiveness of these organizations as well. We also predominantly relied on Ashoka's work category tags on its website to identify gender-responsive organizations. There is a possibility that we may have missed organizations that engage in gender-responsive programming that is not clearly articulated through public documentation or descriptions. Internal documents or tacit understanding of programmes could be identified through direct engagement with Ashoka fellows through in-depth interviews or site visits. Additionally, organizational features and leadership were not integrated into our analytic framework. These factors can also be enablers in creating positive social impact. Further understanding of how organizational structures, cultures and processes, including gender representation in leadership and key decision-making roles, influence health impacts are essential areas for future research (Suchowerska et al., 2020).

Overall, we suggest that social entrepreneurs are strategic health system partners that can promote innovations and offer access to multisectoral ideas, knowledge, networks, and resources. Closer partnerships between gender experts, health systems actors, and social entrepreneurs can enhance intentionality to integrate gender-responsive programmes and support more rigorous data collection and evaluations to provide accountability and more evidence on interventions that address gender-related barriers inequities in health. While the financing potential to self-generate income and financial resources may not be as well achieved in this cohort, there are opportunities to draw on the expertise and ideas from other sectors to actualise this potential. Further research and relationship-building are required to extend understanding, actualise the potential, and build stronger partnerships between gender in health stakeholders and social entrepreneurs.

Author statement

Shazmin Khalid: Data extraction, Analysis, Writing – original draft; Writing- Reviewing and Editing Shrijna Dixon: Data extraction and analysis Lavanya Vijayasingham: Conceptualisation, Methodology, Analysis, Writing – original draft; Writing- Reviewing and Editing, Supervision.

Declaration of competing interest

None

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