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Applying an Intersectional Lens to Understanding the Social Determinants of Maternal Health in The Gambia: Insights from the SIMAH Project

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Executive summary

Maternal mortality is among the most significant disparities between developed and developing countries and an essential marker of gender inequality. Although maternal mortality has declined significantly in The Gambia, it remains high, estimated at 289 per 100 000 live births.

Research into the factors affecting maternal health in The Gambia has primarily focused on examining health services and sociocultural factors through a social determinant of health (SDH) approach. However, within the broader field investigating health inequalities, intersectionality has emerged as a complementary critical theory and an approach that can be used to examine the factors affecting maternal health in The Gambia. The aim of this case study report is to document learning from applying an intersectional lens to understanding the social determinants of maternal health in The Gambia, using the case of the Shifting Gender Norms for Improved Maternal and Adolescent Health (SIMAH) project in The Gambia and Ghana. The SIMAH project aimed to address the demand-side and supply-side factors that impact maternal health and access to maternal health services of pregnant adolescents in The Gambia**.** The project employed an intersectional, mixed-methods approach that included collecting quantitative data through a baseline survey that comprised 401 husbands and 465 young pregnant and nursing women, as well as qualitative data through focus groups with 16 husbands and key informant interviews with eight community-based decision makers.

The SIMAH project sought to explore and highlight the intersections, particularly of age, ethnicity and education, in prenatal care attendance among young pregnant women as well as their husbands' accompanying them during prenatal care visits. Using multiple logistic regression, the project baseline survey findings revealed that women aged 20 to 39 years had higher odds of never having been accompanied by their husbands to prenatal check-ups compared to women aged 40 years and above. It was also found that women with no education and those with elementary school had higher odds of not been accompanied by their partner to prenatal check-ups during the last pregnancy. Husbands with high school, technical school or university education levels had higher odds of not accompanying their partner to prenatal check-ups during the most recent pregnancy. Women of Fula and Mandinka ethnicity were also less likely to have been accompanied by their partners to prenatal check-ups during their most recent pregnancy compared to women from the Wolof or Serer and Fula ethnicity.

The findings from the qualitative interviews also revealed the effects of gender and other social stratifiers, such as class, on maternal health access and use for vulnerable and marginalised women. The qualitative interviews revealed that, compared with more economically stable pregnant adolescents, pregnant adolescents from poorer households tended to report limited prenatal care visits and access to maternal health services because they had limited resources, including finance and means of transport. Some husbands also said they could not afford to accompany their wives for prenatal care check-ups during their last

pregnancy because they lacked the finances. These findings provide insights into the possible interactions of age, ethnicity and education as significant social determinants of maternal health. However, the baseline survey findings are limited in that the analysis does not explicitly distinguish between each intersecting category. It also does not provide any measures of coefficient estimates. We acknowledge these limitations and will explore them further in our ongoing research.

A crucial lesson from this project is that understanding the social determinants of maternal health in The Gambia demands a multifaceted approach. Relying on a single data source is insufficient. Instead, a comprehensive understanding of these determinants necessitates the use of mixed methods, encompassing surveys, focus group discussions and key informant interviews. The combination of these data collection methods can also allow more in-depth exploration of social norms, attitudes, behaviours and systems that represent the root causes – rather than the symptoms – of gender inequality affecting maternal health. This not only ensured that women's and men's voices and lived experiences were central to the research process but could contribute to challenging patriarchal norms.

The project also involves delivering training on a gender transformative approach (GTA) to birth preparedness and complication readiness (BP/CR) for pregnant adolescents and their husbands. Studies have shown that support from husbands for their wives during pregnancy and childbirth is associated with improved birth outcomes. Despite this importance, husbands' involvement in BP/CR in The Gambia remains limited. The design and organisation of the GTA training for husbands was informed by the analysis and findings of the baseline data, which showed how women's access to maternal healthcare services and husbands' involvement in birth preparedness and complication readiness (BP/CR) could be shaped by intersecting variables such as age, ethnicity and education level.

The implementation of the GTA training showed that the participation of husbands fostered a sense of empowerment among husbands and equipped them with knowledge necessary to effect positive change in gender norms with respect to maternal health. Some husbands who participated in the GTA training workshops have already started conducting awareness-raising sessions with their peers and with other community members, including women, on the importance of husband participation in BP/CR. However, the SIMAH project encountered challenges in ensuring the active participation of marginalised groups, including women and men with disabilities.

Another challenge has been social backlash from men as a result of ethnic and cultural differences. These challenges reflect the opportunities for and challenges of incorporating an intersectional lens into maternal health programs aiming to improve maternal health through active male partner participation. Despite these challenges, the GTA training adopted by the SIMAH project has proven to be an effective approach in addressing the complex interplay of social and cultural factors that influence husbands' participation in birth preparedness and complication readiness (BP/CR) in The Gambia.

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Acronyms

BP/CR	Birth preparedness and complication readiness
CBC	Community-based committee
FGD	Focus group discussion
GTA	Gender-transformative approach
IDRC	International Development Research Centre
LSC	Local steering committee
SDH	Social determinants of health
SIMAH	Shifting Gender Norms for Improved Maternal and Adolescent Health project
SEM	Socio-ecological model
SSWH	Society for the Study of Women's Health

Introduction

Maternal mortality is among the most significant disparities between developed and developing countries and an essential marker of gender inequality. Although the rate of maternal mortality has declined significantly in The Gambia, it remains high, estimated at 289 per 100 000 live births (Gambia Bureau of Statistics and ICF, 2021). The factors affecting maternal mortality in The Gambia are wide-ranging but include health services factors, such as poor quality of care and limited access to maternal health services, as well as socio-cultural practices which may also limit the opportunities and resources available to pregnant women, resulting in adverse health consequences.

Research into these factors affecting maternal health in The Gambia has primarily focused on examining health services and sociocultural factors through a social determinant of health (SDH) approach. The SDH approach is a framework used in public health to understand and address various non-medical factors, such as the conditions in which people are born, grow, work, live and age, as well as broader systems and social forces, that influence maternal health and well-being (Braveman & Gottlieb, 2014). It recognises that health outcomes are not solely determined by access to healthcare services or individual behaviours but are heavily influenced by social, economic, environmental and structural factors. However, within the broader field of health inequalities, intersectionality has emerged as a complementary critical theory and approach that can be used to examine the factors affecting maternal health in The Gambia. Intersectionality argues that social categories and identity factors such as gender, race, sexuality and others overlap and intersect in dynamic ways to shape health outcomes, well-being and access to services (Kelly et al., 2021). There is a rising interest in integrating an intersectional perspective with the SDH approach, as demonstrated in a 2019 study by Batist that analyzed maternal mortality in Africa.

This paper documents what we learned from applying an intersectional lens in a project that aims to better understand the social determinants of maternal health in The Gambia, titled Shifting Gender Norms for Improved Maternal and Adolescent Health (SIMAH). The SIMAH project is part of a cohort of gender-transformative research projects to improve sexual, reproductive and maternal health in Africa, which includes a focus on intersectionality, funded by the International Development Research Centre (IDRC) from Canada.

The paper discusses how the SIMAH project applies an intersectional lens in framing the research objective, questions, and methodological approach. It also examines the achievements, opportunities, and diverse identities and experiences essential for engaging husbands effectively in maternal health during pregnancy and childbirth. The analysis acknowledges the challenges of applying an intersectional perspective and suggests ways to enhance the researcher's and practitioner's capacity for using this approach in maternal health interventions for young pregnant women in sociodemographic contexts similar to The Gambia.

Overview of Research Project

In The Gambia, young pregnant women face many barriers to accessing and using existing healthcare services. The barriers to access and use healthcare services for adolescent boys and girls and young pregnant women include restrictive laws and policies, the limited capacity of the healthcare system, attitudes of healthcare providers, lack of information, harmful cultural practices, and social norms (Lowe M, Sagnia PIG, Awolaran O, Mongbo YAM, 2021). These factors are restricting young pregnant adolescents' sexual and reproductive health (SRH) and rights, and their ability to access and utilise existing maternal healthcare services and information. These barriers stem from entrenched power hierarchies, patriarchal masculinities, and harmful gender norms and beliefs.

To address the demand and supply-side constraints hindering adolescent boys and girls, as well as young pregnant adolescents, from accruing healthcare services in Ghana and The Gambia, the Youth Harvest Foundation-Ghana (YHFG) and Society for the Study of Women's Health (SSWH) in The Gambia, implemented the SIMAH Project. The project activities in Ghana seek to promote access to youth-friendly services (YFS) among adolescent boys and girls by working with health providers. In contrast, in The Gambia, the project – led by the Society for the Study of Women's Health (SSWH) – focuses on improving knowledge and understanding of the importance of birth preparedness and complication readiness (BP/CR) among young pregnant adolescents. It also promotes husbands' (and by extension unmarried adolescent boys') involvement in the activities preparing for birth and for complications that may arise during this period. This case study is limited to the insights from the project activities in The Gambia. The case study will focus on how the project incorporated an intersectional lens to better understand the social determinants of maternal health, especially around birth preparedness and complication readiness (BP/CR) among young pregnant women, with the ultimate aim of improving maternal health and husbands' involvement in maternal health issues regarding pregnancy and childbirth.

The SIMAH project conducts baseline qualitative and quantitative data collection and analysis using an exploratory mixed-methods, participatory action research approach. It employs an intersectional perspective, involving husbands and young pregnant women. Additionally, the project includes gender transformative approach (GTA) training on birth preparedness and complication readiness (BP/CR), fatherhood and child care, following the GTA model from Rutgers International (Rutgers, 2020a). A gender transformative approach seeks to promote gender equity and empower individuals to challenge and transform societal attitudes and behaviours related to gender norms, roles, and inequalities. Evidence suggests that attitudes rooted in long-established ideas about gender roles and age-appropriate behaviour can be transformed through GTA training that encourages self-reflection (Rutgers, 2020a). When Rutgers' GTA tool was applied to health workers in Kenya, the authors reported improvements in the quality and inclusiveness of sexual and reproductive health services to young people, especially women and girls and young people with diverse sexual orientations and

gender identities (Rutgers, 2020b). Again, when the GTA tool was applied to comprehensive sexuality education teachers in Zambia the authors demonstrated that teachers' gender biases can be shifted over the course of a GTA intervention (Rutgers, 2020a). Similarly, a GTA intervention among couples to promote male engagement in reproductive and maternal health and violence prevention in Rwanda reported positive effects, including increasing male accompaniment at antenatal care (Doyle et al., 2018).

The GTA model encompasses six interconnected key principles that can be seamlessly incorporated into activities, programs, strategies, and policies. These include:

i) Place human rights at the centre and focus on agency and rights of young people;
ii) Address harmful norms and values underlying gender inequality and violence;
iii) Understand and address unequal power relations;
iv) Empower girls and young women to make informed decisions;
v) Engage adolescent boys and young men as an essential part of the solution;
vi) Provide sexual and reproductive services to young people from all sexual and gender diversities.

The SIMAH project builds on these experiences to identify and explore the various ways that a GTA training can contribute to enhancing birth preparedness and complication readiness in The Gambia, with a focus on the role of male involvement. The GTA training is expected to increase knowledge and understanding of the importance of BP/CR among pregnant young women and promote husbands' and unmarried adolescent boys' participation in BP/CR by shifting their gender attitudes and norms regarding gender and the sexuality of young women. The GTA training also aims to address patriarchal notions about pregnancy and childbirth – rooted in social norms, attitudes, and beliefs – and increase awareness and critical thinking on gender and power imbalances by addressing their root causes and stimulating a process of transformation that starts at the individual level, influencing attitudes and behaviour to become more gender-transformative and equitable. Our assumption in using the GTA is that if husbands participate in the GTA training, their participation in BP/CR will increase, ultimately resulting in improved maternal health outcomes for young pregnant women.

Social Determinants and Intersectionality

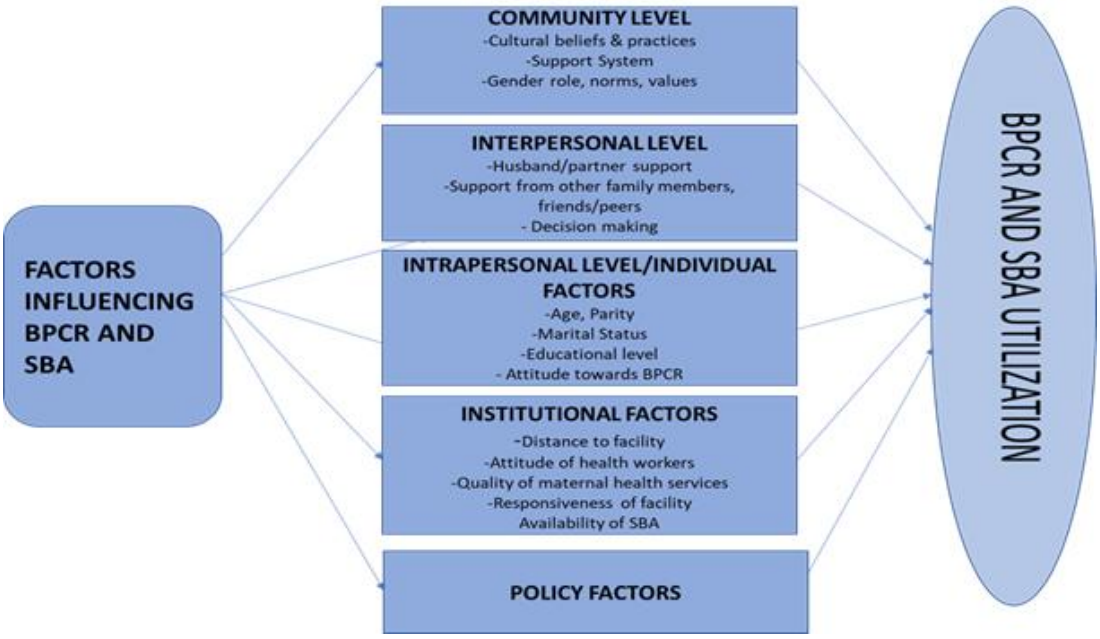
Social determinants of health (SDH) argues that the health outcomes of people are largely determined by the conditions in which they are born, grow, work and live, as well as the macro systems shaping people's socio-economic circumstances (Braveman & Gottlieb, 2014). An intersectional approach, on the other hand, holds that people's health outcomes, well-being and access to service are shaped by the interaction of factors such as gender, race and sexuality, which intersect in dynamic ways rather than operating in isolation from one another (for example, gender as separate from race) or in an additive way (for example, gender plus race equals greater disadvantage) (Hankivsky, 2014). These interactions occur within a context of connected

systems and structures of power, through which interdependent forms of privilege and oppression, shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy, are created (Hankivsky, 2014).

Drawing on the complementarity of an intersectional approach or lens and that of SDH, the SIMAH project applies what it calls a "gendered intersectional approach" to understand the social determinants of maternal health in The Gambia. This means considering how factors such as age, education and ethnicity interact with gender to shape the social determinants of health, and, by doing so, contribute to interventions that seek to change maternal health outcomes in The Gambia. The gendered intersectional approach taken by the project– is based on a gender transformative approach (GTA) as well as an intersectional theoretical framework and the socio-ecological model (SEM).

The SIMAH project used the SEM and GTA models because they too complement each other. The SEM emphasises that behavioural change needs to take place at different levels at the same time to have an impact, which is similar to the GTA model, which postulates that for gender transformation change to happen, change in societal attitudes and behaviours related to gender norms, roles and inequalities needs to occur beyond the individual level. The complementarity and synergy between these models made them suitable for use in the SIMAH project. We used the SEM and GTA models because they consider factors beyond gender, such as age, education and ethnicity, while also appreciating their importance at different ecological levels – individual, household and community (See Figure 1). We have also used the SEM and GTA because we think they can be used to look at these factors as interacting in dynamic ways, and as non-additive.

Figure 1. Adapted version of the socioecological model



Using the SEM and GTA models allowed us to reflect on how gender intersects with other variables to affect pregnant adolescent women's access to, and use of, maternal healthcare services. It also allowed us to

respond to health inequalities faced by young pregnant women not as static, inevitable disadvantages suffered by them, but differentiated by age, ethnicity, education and other factors, within the interlocking social systems and patriarchal structures of power they are embedded in (Larson et al., 2016). These approaches informed our research design and methodological approach, which aimed to understand the gendered intersectional determinants of adolescent girls' access to, and use of, existing maternal health services and husbands' participation in BP/CR.

Intersectionality and Research Design

Our review of the extant literature revealed gender, education, age and ethnicity as major social determinants of maternal health in The Gambia. To address these determinants of maternal health, an intersectional approach is essential to effectively contextualise how women's social positions shape their maternal health and access to health services (Batist, 2019). From this premise, and demonstrating the usefulness of intersectionality as a lens, the SIMAH project sought to explore the intersections of gender, age, ethnicity and education with maternal health outcomes in the baseline data on young pregnant women in The Gambia.

Gender is a critical social determinant of maternal mortality in The Gambia. In their study on gender dynamics' impact on maternal health in rural Gambia, Lowe et al. (2016) revealed that pregnant women in rural Gambia typically lacked household privileges due to their heavy workloads, limited sick leave options and nearly non-existent resources for prenatal care. Additionally, pregnant women's decision whether to receive care from trained personnel was often beyond the women's control, resulting in birth-related complications.

Systemic gender inequalities are embedded within the fabric of many African countries such as The Gambia, where male-dominated social ideals and systemic mores continue to silence and marginalise women (Batist, 2019). The Gambia, by all indications, is a male-dominated society. The dominance of men over women has been a matter of increasing controversy. The struggles of, for instance, Gambian peasant women against patriarchal control over land, labour and agricultural income have become a classic example of male dominance in The Gambia (Bellagamba, 2013).

Recently, focus on gender equality has increased, which has stimulated discussions on an extended range of gender-related issues, including women's access to education and land for income generation. These discussions have significant implications for improving women's maternal health outcomes in The Gambia.

Age and ethnicity also serve as important determinants of health outcomes for adolescent women in The Gambia. A study examining ethnic differences in age at sexual debut among adolescent girls in The Gambia showed that the lowest median age at sexual debut is among Mandinka and Wolof girls (14 years) and noted that girls in the Mandinka and Wolof ethnic groups are approximately 20% less likely to initiate sex at an early

age than girls in the Fula ethnic group (Lowe & Mendez Rojas, 2021). These differences have implications for sexual and reproductive health of young pregnant women.

Gender, age, and ethnicity intersect with *education levesl* and other social stratifiers, such as economic status, to further marginalise women, deny them access to vital maternal health services in The Gambia, and contribute to adverse maternal health. Evidence suggests that illiterate pregnant women are less likely to access the necessary health services (Batist, 2019). Since their illiteracy hinders their ability to be adequately informed about maternal healthcare options, they feel ill-equipped to make autonomous decisions about their health (Batist, 2019). Similarly, illiteracy affects access to and use of contraception: less educated women are less likely to participate in protected sexual encounters (Batist, 2019).

Based on the critical role of gender, age, education and ethnicity in determining maternal health, the SIMAH project sought to study how these variables interact and intersect to affect adolescent girls access to, and use of, existing maternal health services. Cognisant of the low level of involvement of male partners in maternal health issues in The Gambia, we further asked if training in a GTA could promote positive gender norms that would address the limited participation of husbands in maternal health issues in The Gambia, with a focus on birth preparedness and complication readiness. It is well documented that husbands' involvement in maternal health in The Gambia is low, primarily due to socio-cultural norms and beliefs that traditionally assign pregnancy and childbirth to be the sole role of women. Additionally, many husbands do not believe that pregnancy chores warrant their efforts compared to competing social commitments (Lowe, 2017).

Using Mixed Methods to Understand Intersectional Determinants

The SIMAH project adopted a participatory, mixed-methods approach that included both quantitative and qualitative data collection, including a cross-sectional household survey, focus group discussions and key informant in-depth interviews. A mixed-methods approach was essential to prioritise gender issues and intersectionality, and amplify the voices and experiences of young pregnant women and their husbands, challenging patriarchal norms. These data collection methods facilitated a deeper exploration of the intersecting social norms, attitudes, behaviors, and systems that represent the root causes – rather than the symptoms – of systems driving gender inequality in maternal health and the involvement of husbands in birth preparedness and complication readiness (BP/CR). The quantitative and qualitative data collection methods used are further described below.

Quantitative data collection

Quantitative data was collected through a cross-sectional household survey targeting 465 pregnant adolescents and nursing mothers and 401 husbands. Two survey questionnaires were employed: one for men and another for women. The questionnaire aimed at men asked about respondents' ages, religion, education

levels and number of children, as well as their experiences of having a child, involvement in BP/CR and views on gender roles and relations between husband and wife related to child care, pregnancy and childbirth. The questionnaire aimed at women also collected information about respondents' ages, religion, education levels and number of children, their experiences of preparing to have a child or having a child, decision-making about maternal health service use and reproductive choice, and views on gender roles and relations between husband and wife related to child care, pregnancy and childbirth.

Quantitative data collection prioritised achieving minimum sample sizes for each group in the analysis, to enable meaningful statistical analysis. We strategically oversampled rural women and urban men to allow sufficient statistical power for cross-group comparisons and intersectional analyses. Additionally, we used snowball sampling to recruit marginalised or hidden rural ethnic minority women and adolescent girls who would be difficult to access using traditional sampling methods.

Qualitative data collection

Qualitative data was collected through focus group discussions and key informant interviews with community-based decision makers. Each focus group was limited to ten participants for ease of management. The focus group discussions were conducted separately for women and men and based on age category in two districts. In each district, the research team conducted three focus group discussions, including pregnant women and husbands, and reflected on ethnic diversity. The focus groups focused on the difficulties women faced in keeping themselves healthy, as well as health-related problems they had experienced during pregnancy and delivery. Based on the issues they raised, the research team prompted them to describe their situations, how relevant decisions were made within their households, and how they managed to cope with difficulties. This discussion was supplemented by interactive questions about such topics as obtaining prenatal care, travel arrangements at the time of delivery, and division of labour when they were pregnant.

A focus group discussion guide, developed mutually and agreed upon by the project team, was used to facilitate the discussion. The guide was developed based on a literature review of previous studies conducted in the Gambia on social and cultural factors affecting maternal health and husbands' involvement in maternal health issues (Lowe, 2017; Lowe et al., 2016). The focus group discussion guide was pilot tested with participants who had inclusion criteria similar to those who were to participate in the focus group discussions, and was ethically approved long before primary data was being collected. No change was made following ethical approval.

The guide was designed to be open ended and contained specific questions, such as: "What are the obstacles pregnant women in your community face in seeking and receiving care during pregnancy and childbirth?"; "Do any of you travel to a nearby place in anticipation of delivery?"; "Was this visit a burden to your family or yourself?"; "How were transportation arrangements made for you?"; "Who made the decision for you to seek

care?"; "Why was this person very important in your decision to seek care?"; What do your partners do to help you with your pregnancies?; "What would you like your partners to do to help you with your pregnancies?"; "In your community, what is seen as normal for a man to do to help his female partner while she is pregnant?"; "Do you think that men are always supportive of their partners, or do they become more supportive and involved when their partners are pregnant?"; and " Do you think that male partner support is helpful for antenatal care attendance?".

In the men's focus group, husbands were asked to discuss the difficulties they faced in taking care of their wives during pregnancy and delivery. They were also encouraged to express their views on husbands' involvement in maternal health concerning pregnancy and childbirth. The focus group discussions for men also asked specific questions such as: "Do you feel that pregnancy is purely a women's issue, or is pregnancy something that both men and women should be involved in?"; "What do you feel is a man's role during pregnancy and childbirth?" and "If you have ever experienced your partner's pregnancy outcome which was life-threatening, can you please describe what was your attitude toward fitting in during the care encounter with medical professionals?". In addition, three key informant interviews with community-based decision makers, including women leaders, social and religious leaders and village and community health workers, were also conducted in the three communities selected in each district. The key informant interviews explored the perceptions of the stakeholders towards husbands' involvement in BP/CR.

For both the quantitative and qualitative data collection, we ensured that the sample was heterogeneous enough to capture the various intersecting factors that impact on maternal health in The Gambia. We also paid extra attention to confidentiality and anonymity. We ensured that anonymised data, including demographic information, birth data, ethnicity and sex, did not offer sufficient information for others to recognise participants. Given that reproductive health decision-making is male dominated and largely done by men, we considered the gendered power dynamics and relations in the data collection by conducting separate focus group discussions for men and women. Women and men were separated to ensure freedom of expression without fear of reprisal from the other sex. Gender considerations also influenced the composition of the research team, which included both male and female data collectors responsible for conducting surveys, interviews and focus group discussions with men and women in a respectful manner.

Analysing Data for Intersectional Insights on Maternal Health

The key insights derived from our data collection and analysis emphasised that understanding the social determinants of maternal health in The Gambia requires a multifaceted approach. Instead of relying solely on a single data source and analysis, we have learned that a more comprehensive and effective approach involves using exploratory, dialogical and participatory mixed methods, including surveys, focus group discussions and key informant interviews. The combined use of these data collection methods allowed us to delve deeper into

the intersecting variables and systems that serve as the underlying root causes—rather than merely addressing the symptoms—of gender inequality affecting maternal health and the role of husbands in birth. The combined use of these data collection methods also ensured that young pregnant women's voices and experiences are central to the research process.

Findings from the baseline data highlighted how *age, education and ethnicity* overlap and intersect to shape the maternal health of pregnant women and affect husbands' involvement in BP/CR in The Gambia. Using multiple logistic regression, the project baseline survey findings revealed that women aged 20 to 39 years had higher odds of never having been accompanied by their husbands to prenatal check-ups than women aged 40 years and above. It was also found that women with no education and those with elementary school have higher odds of not having been accompanied by their partner to prenatal check-ups during the most recent pregnancy. Husbands with high school, technical school or university education levels had higher odds of not accompanying their partners to prenatal check-ups during the most recent pregnancy. Women of Fula and Mandinka ethnicity were also less likely to have been accompanied by their partners to prenatal check-ups during their most recent pregnancy than women from the Wolof or Serer and Fula ethnicity.

The findings from the qualitative interviews also revealed the effects of gender and other social stratifiers, such as class, on maternal health access and use for vulnerable and marginalised women. The qualitative interviews revealed that, compared to more economically stable young pregnant adolescents, young pregnant adolescents from poorer households tended to report limited prenatal care visits and access to maternal health services because they had limited resources, including finance and means of transport. Some husbands also said they could not afford to accompany their wives for prenatal care check-ups during their most recent pregnancy because they lacked the finances. These findings provide insights into the possible interactions of age, ethnicity, and education as significant social determinants of maternal health. However, the baseline survey findings are limited in that the analysis does not explicitly distinguish between each intersecting category. It also does not provide any measures of co-efficient estimates. We acknowledge these limitations and will explore them further in our ongoing research.

We plan to run further analysis of separate multinomial logit regressions to include economic variables of young pregnant women and their husbands, which will be categorised into non-poor young pregnant women, poor husband, poor pregnant women, poorest husbands and poorest pregnant women, and use chi-square tests to investigate differences according to age, ethnicity, education and gender gaps. These statistical analysis methods have the potential to correct for any heteroscedasticity and have proven to be more robust in the study of the intersections between gender and other class inequalities.

Lessons from Gender Transformative Training and LSC Meetings

The SIMAH project includes providing gender transformative training on BP/CR to young pregnant adolescent women and their husbands. The design and organisation of the GTA training for husbands was informed by the analysis and findings of the baseline data, which showed how women's access to maternal healthcare services and husbands' involvement in BP/CR is shaped by intersecting variables such as age, ethnicity and education level. The GTA training covered topics such as men's engagement in fatherhood, caregiving, maternal and child health, and distribution of information, education and communication materials on spousal communication and decision-making on reproductive health matters.

In the SIMAH project, the implementation of the GTA training yielded valuable insights and lessons. Interactions with SIMAH project officers and members of the local steering committee, both during and after the GTA training sessions, indicate a significant increase in knowledge regarding the role of gender as a social determinant of maternal health in The Gambia. The project officers and members of the local steering committee explained that their participation in the GTA training has made them more aware of the effect of age, ethnicity and gender inequalities that are at the root of poor maternal health in The Gambia. This newfound understanding has equipped them to effectively organise community engagement forums and discussions, emphasising the importance of husbands' active participation in preparing for delivery and addressing potential complications.

The GTA training tailored for husbands has further deepened their comprehension of critical issues related to pregnancy and childbirth, as well as the significance of challenging prevailing gender norms for the well-being of mothers and their children. Through engaging discussions and activities in the training sessions, husbands have experienced a sense of empowerment, arming them with the tools needed to instigate positive changes within their respective communities.

This success underscores the efficacy of GTA training in addressing the sociocultural determinants influencing maternal health and promoting husbands' involvement in birth preparedness and complication readiness in The Gambia. The positive role of GTA training in transforming long-established attitudes related to gender roles and age-appropriate behaviour has been shown in other studies and country contexts. When Rutgers' (2020b) GTA tool was applied to health workers in Kenya, the authors reported improvements in the quality and inclusiveness of sexual and reproductive health services to young people, especially women and girls and young people with diverse sexual orientations and gender identities (Rutgers, 2020b). Again, when the GTA tool was applied to comprehensive sexuality-education teachers in Zambia, the authors demonstrated that teachers' gender biases can be shifted over the course of a GTA intervention (Rutgers, 2020a). Similarly, a GTA intervention with couples to promote male engagement in reproductive and maternal health and violence prevention in Rwanda reported positive effects, including increasing male accompaniment to antenatal care (Doyle et al., 2018).

The interactive and participatory nature of the GTA training workshops organised for husbands by the SIMAH project has fostered active engagement, collaboration and the exchange of personal experiences. Within this dynamic learning environment, participants not only learned from the facilitators but also from one another, enhancing the overall learning experience. The transformative nature of these workshops has enabled participants to acquire knowledge and, importantly, challenge existing gender norms that hinder their engagement in BP/CR initiatives.

The project also incorporated a multi-sectoral and intersectional lens into its approach to the dissemination of results, which targeted specific population groups. During the preparatory phase, five committees were set up by the project. The committees included a local steering committee (LSC), composed of representatives of key policy and program stakeholders involved in women's empowerment and social welfare at national, regional and community level, and four community-based committees (CBC) from the project intervention communities, consisting of people with disabilities, including men and women and community-based decision makers from each of the four main ethnic groups with equal representation of both sexes. The community-based committees (CBC) were divided into women-only groups and men-only groups during planning and dissemination meetings to ensure freedom of expression without fear of reprisal from the opposite sex. These meetings were also designed to facilitate meaningful contributions from women who may otherwise remain silent in the presence of men due to the patriarchal nature of rural Gambian communities. A participatory approach was used, involving members of both the LSC and CBC, to co-create a package of project interventions. This ongoing interaction uses findings from the project's baseline survey, as well as ongoing monitoring and learning, to guide and support the implementation of the interventions. This participatory approach also ensures that marginalised groups, especially disabled women, are well-informed of the findings and actively participate in co-creation of the SIMAH project package of interventions. Disabled women were part of the co-creation of these interventions because disability is another important intersecting variable relating to maternal health. This inclusion was highlighted by members of the LSC as a key factor in addressing the social determinants of maternal health.

The project team periodically updates the Local Steering Committee (LSC) and community-based committees on the progress of the SIMAH project. A variety of communication channels, including radio and newspapers, and approaches including face to face community engagement forums and discussion sessions, are used to share the research findings and information about the project with direct beneficiaries and diverse stakeholders, including health workers and traditional and religious leaders. The radio programs and GTA training for husbands included topics and discussions around the difficulties disabled women face in accessing maternal healthcare services and how these challenges can be alleviated by their husbands and other members of their household.

Several key moments, and the resulting tensions we experienced during the LSC meetings, reflect broader debates on the opportunities for and challenges of incorporating intersectionality into practice in

development research (and policy). One of these challenges revolved around the imperative of ensuring that marginalised groups have a voice in intersectional research.

During the LSC meetings, members provided valuable inputs to enhance the SIMAH project. These inputs included emphasising the importance of amplifying women's voices within the project. The LSC, comprising six men and four women, including a disabled women leader, recognised the issue of low self-esteem among many women. Therefore, they stressed the need to create a space where these voices could be heard. They highlighted the importance of ensuring that group discussions did not allow individuals with louder voices to dominate the narratives. Additionally, the LSC recommended that project activities, especially community sensitisation efforts regarding husbands' involvement in maternal health, should be based on evidence to build trust within the community.

One LSC member advised that the Society for the Study of Women's Health (SSWH) should consider cultural and ethnic variations when discussing gender norms affecting male partners' involvement in maternal health, as these norms can differ among different ethnic groups, as indicated by the baseline survey findings. However, they firmly believed that gender norms impacting women's health and well-being should be challenged. To enhance communication, the LSC suggested using social media platforms such as WhatsApp for regular project updates. They proposed organising quarterly reflection sessions with all stakeholders and emphasised the importance of involving LSC members in some of the GTA training sessions within the communities to ensure ongoing project monitoring, even after its completion. Finally, they underscored the need to pay special attention to people with disabilities, as they are among the most vulnerable and could be easily excluded if not adequately addressed.

Conclusion

This case study report has sought to document lessons from applying an intersectional lens to understand the social determinants of maternal health in The Gambia, drawing on the SIMAH Project.

The findings from the baseline survey highlighted how *age, education, economic status and ethnicity* overlapped and intersected with gender to shape the maternal health of pregnant women and affect husbands' involvement in birth preparedness and complication readiness (BP/CR) in The Gambia. The findings suggest that the factors affecting the health of pregnant women in The Gambia go beyond gender and include age, education and ethnicity. These factors can affect women's decision-making autonomy within the household and their access to and use of maternal healthcare services, which may result in adverse maternal health outcomes. Therefore, to effectively address the effects on maternal health of age parity between a woman and her husband, the low education level of women and ethnicity, it is essential to apply an intersectional lens to effectively contextualise how these factors interact to put women at a disadvantage in an unfavourable position. This understanding is also necessary for developing gender-transformative

interventions for promoting husbands' involvement in birth preparedness and complication readiness in The Gambia.

We conclude with four insights and lessons that researchers and practitioners can draw from our project's attempt to adopt an intersectional lens for understanding the social determinants of maternal health.

First is the recognition that addressing the multifaceted challenges faced by young women in accessing maternal healthcare services in The Gambia cannot be effectively achieved through relying solely on an SDH approach or a narrow focus on health service related factors. Health service factors have been the primary focus of research and programmatic intervention in The Gambia, overlooking the intersecting nature of gender, education and socio-economic determinants. These factors create tangible barriers to maternal health on the demand and supply side. An intersectional lens is critical to overcoming these persistent challenges.

Second is the importance of a mixed methods approach, encompassing surveys, focus group discussions and key informant interviews, to gain a comprehensive understanding of these determinants. The combination of these data collection methods can also allow more in-depth exploration of social norms, attitudes, behaviours and systems that represent the root causes – rather than the symptoms – of gender inequality affecting maternal health.

Third is the importance of policymakers and program managers framing the intersecting factors affecting maternal health not only at the individual or community level, but also at the institutional level (or health system level) from an intersectional perspective.

Fourth, and finally, we conclude that to effectively address the complex intersectional drivers and social identity aspects that affect maternal health, it is crucial for policy and programmatic interventions to move beyond simply acknowledging these issues. Instead, they must actively work towards the transformation of existing gender norms (and their intersections with age, ethnicity, education, and other factors, such as socio-economic class) that have a detrimental impact on maternal health outcomes.

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