Gender Perspectives Improve Reproductive Health Outcomes: NEW EVIDENCE

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The examples provided in this publication include experiences of organizations beyond USAID. This publication does not provide official USAID guidance but rather presents examples of innovative approaches for integrating gender into reproductive health and HIV programs that may be helpful in responding to the Agency requirements for incorporating gender considerations in program planning. For official USAID guidance on gender considerations, readers should refer to USAID's Automated Directive System (ADS).

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Gender Perspectives Improve Reproductive Health Outcomes: NEW EVIDENCE

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Executive Summary

In 2004, the Interagency Gender Working Group (IGWG) published *The "So What?" Report: A Look at Whether Integrating a Gender Focus into Programs Makes a Difference to Outcomes.* The 2004 report presented evidence of the value of integrating gender into programs for promoting positive reproductive health (RH) and gender outcomes. The purpose of this new 2009 review is to assemble the latest data and update the evidence as to what difference it makes when a gender perspective is incorporated into RH programs.

The review focuses on five components of reproductive health programs, including interventions related to:

- Unintended pregnancy;
- Maternal health;
- HIV/AIDS and other STIs;
- Harmful practices, including early marriage, female genital mutilation/cutting, and gender-based violence; and
- Youth.

The authors examined gender-related barriers to each component of reproductive health and the strategies undertaken by programs to address the barriers. Out of nearly 200 interventions reviewed, 40 are included here as examples of programs that integrate gender to improve reproductive health outcomes.

The interventions selected for inclusion were limited to those that have been evaluated—meaning they established criteria for assessment that were related to the goals of the intervention and followed an evaluation design—and that used accommodating or transformative approaches. The results of these programs suggest that the field is evolving toward a deeper understanding of what gender equality entails and a stronger commitment to pursue this equality in reproductive health programs.

Reducing Unintended Pregnancies

Several of the projects to reduce unintended pregnancy countered the traditional practice of aiming family planning (FP) services at women only; they encouraged husbands and other males to take more responsibility in this area. The strategies included enlistment of men who hold power, such as community or religious leaders, to support FP; influencing husbands to encourage their wives to use FP services; and providing a male-controlled contraceptive method. Other projects encouraged joint decisionmaking, shared responsibility in FP, and the institutionalization of gender into RH services. Addressing the balance of power between health-care service providers and female clients, quality of care initiatives aimed to sensitize providers about the role of gender in their practice.

Many of these programs took place in settings where women have little autonomy in their daily lives and little assertiveness in their relationships. By using a gender perspective, unintended pregnancy can be addressed not only through programs targeting women, but also by targeting men, leaders, and decisionmakers.

Improving Maternal Health

A common feature of all the projects to improve maternal health was their recognition that decisions about ante- and post-natal care typically are not made by young pregnant women and new mothers, but more often by husbands or mothers-in-law. Particularly successful gender transformative approaches sought to create a supportive environment to improve women's use of services by reaching out to husbands and mothers-in-law, in addition to women. Several projects reached out to couples through counseling and information.

Through educational materials and couples' counseling, health facilities broadened their reach to include husbands as well as pregnant women, addressing the particular roles that both partners can play in improving maternal health. Other projects aimed to improve the quality of antenatal care services and to change attitudes and practices among service providers with an emphasis on women's rights to a basic standard of care and to be treated respectfully as clients.

Reducing HIV/AIDS and Other STIs

Evaluations of a number of interventions to reduce HIV/AIDS and STIs provide strong evidence that addressing gender norms, promoting policies and programs to extend equality in legal rights, and expanding services for women and men can result in improved HIV/AIDS and gender outcomes. Some of the interventions are designed for groups that are particularly vulnerable to HIV/STIs; some attempt to reach clients through reproductive health services, members of particular demographic groups, or those who are in need of care and treatment for HIV.

A common feature of successful programs was to stimulate dialogue on the relationship between gender norms and sexual behavior. These messages were communicated through a variety of channels, such as peer groups, workshops, or mass media. Some programs used peer educators to deliver the messages, while others used health professionals, HIV/AIDS specialists, or spokespersons and celebrities. Another approach to addressing HIV/AIDS was to include a gender perspective in promoting the use of health services. Sensitizing service providers to the gender components of risky behaviors and health-care seeking patterns helped to improve quality of care.

These interventions demonstrated that strategies that incorporate gender in order to reduce HIV/AIDS and other STIs are becoming increasingly sophisticated in their approach to addressing gender dynamics. Many programs also focused on helping men identify and begin to question their gender roles, both the advantages conferred to them and the risks to which these roles expose them.

Harmful Practices: Barriers to Reproductive Health

Harmful practices, including early marriage, early childbearing, female genital mutilation/cutting, and gender-based violence, play a substantial role in undermining reproductive health, especially among young women. The harmful practices interventions reviewed were broad in focus, but shared common features. All employed gender transformative elements and sought to influence attitudes and behaviors of a range of community stakeholders, including women, men, parents, leaders, and entire communities.

Linking social vulnerability and limited life options with vulnerability, life-skills education projects with unmarried adolescent girls aimed to increase their self-esteem and literacy. Interventions were often partnered with educational modules on topics such as rights, problem-solving, hygiene, and women's health. Behavior change communication messages were disseminated through multiple channels, including community meetings, performances, and mass media activities.

Meeting the Needs of Youth

The interventions addressing youth focused on gender norms, providing information, and building skills related to sexual and reproductive health (SRH). The themes of gender attitudes, partnerships, life skills, and participation of youth were common throughout many interventions.

Several sought to improve adolescent reproductive health by promoting gender equitable norms. The interventions themselves often comprised life skills education and training, such as skills to provide opportunities for out-of-school youth. Other programs aimed to reach youth with RH information and services, empowering them to address their own needs. Some programs sought support of communities for the activities, through village committees made up of a broad group of stakeholders. These committees helped define and support the recruitment and program activities. Some used interventions at multiple community levels for policy, youth-friendly services, behavior change communication, and livelihood skills training.

Conclusions

In the past five years there has been a clear increase in the evidence that integrating gender does improve reproductive health outcomes. Today, women and men are reaping the benefits of gender-integrated programming that uses a gender-transformative approach and stronger evaluations are measuring the effects. This new review makes an important contribution to the growing body of literature on gender-based approaches to policy and programming. The evidence presented here suggests that incorporating gender strategies contributes to reducing unintended pregnancy, improving maternal health, reducing HIV/AIDS and other STIs, eliminating harmful practices, and meeting the needs of youth – all broadly included under the term "reproductive health."

In addition, this report generated several new findings:

- Gender-integrated strategies are stronger and better evaluated than they were five years ago;
- Incorporating a gender strategy leads to a better understanding of RH issues;
- Formative research is critical;
- Programs that integrate gender can benefit from working at multiple levels; and
- Projects that integrate gender need to focus on costs, scale-up, and identifying policy and systemic changes required to "mainstream" gender.

The way forward, focusing on well-evaluated projects that address policy, systems, and cost issues, scaling up gender integration, and addressing sustainability of equitable gender relations over time, will make important contributions to the health and lives of women, men, and families around the world.

1 Introduction

International initiatives to achieve reproductive health (RH) outcomes—such as reducing unintended pregnancy, stopping the spread of HIV/AIDS, and improving maternal health—are increasingly recognizing that these outcomes are affected by gender, or the roles that are commonly assumed to apply to women and men (see the gender definition in the box below). This includes the roles that affect intimate and sexual relationships.

> Gender refers to the different roles men and women play in society, and to the relative power they wield. While gender is expressed differently in different societies, in no society do men and women perform equal roles or hold equal positions of power.
>
> Riley, 1997: 1

Governments worldwide are working to achieve the Millennium Development Goals, including Goal 3: *to promote gender equality and empower women*. Most international donor agencies have embraced the idea that RH policies and programs should support women's empowerment and gender equity, and have included this in their goals and strategies. For example, the United States Agency for International Development (USAID) has long required that gender issues—both the potential effect of gender on proposed objectives and the impact of results on gender relations—be addressed within its projects, including health programs. USAID provides guidance on gender through its Automatic Directive System (ADS).[1] Since 1997, the Interagency Gender Working Group (IGWG), funded by USAID, has supported development of evidence-based materials and training for the implementation of programs that integrate gender into RH programs. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR), which is a key component of the Global Health Initiative, has provided technical assistance and guidance for the integration of gender into HIV prevention, treatment, and care programs, including the implementation of five PEPFAR gender strategies.[2]

The United Nations (UN) and the World Health Organization (WHO) have encouraged "gender mainstreaming" for the last decade.[3] The Global Fund to Fight AIDS, Tuberculosis, and Malaria is developing a gender strategy that promotes increased attention to gender in country grants and within the organization itself.[4] The World Bank adopted a gender and development mainstreaming strategy in 2001 and issued a revised Operational Policy and Bank Procedures statement in 2003.[5] More recently, through the Gender Action Plan, it created a guiding framework to advance women's economic empowerment in order to promote shared growth and MDG3.[6] Many other bilateral and multilateral organizations also support policies and programs that promote gender equality.

UNFPA's State of the World Population 2008 Report states that "Gender equality is a human right. In all cultures there are pressures towards and against women's empowerment and gender equality." The 2008 report goes on

1 The ADS 200 and 300 series specify requirements for mandatory integration of gender considerations into planning, programs implementation, and evaluation. The latest version can be found at www.usaid.gov/policy/ads.

2 The five gender strategies include: 1) increasing gender equity; 2) addressing male norms and behavior; 3) reducing violence and sexual coercion; 4) increasing income generation for women and girls; and 5) increasing women's legal protection and property rights.

3 UN, 2002, 2008; WHO, 2002, 2007.

4 OSI and PAI are currently undertaking an analysis of evidence from gender programming to support implementation of the Global Fund's Gender Strategy.

5 World Bank, 2003.

6 World Bank, 2006.

to advocate culturally sensitive approaches in pursuing international development goals.[7] Consistent with this perspective, the authors have based this IGWG report on the premise that RH policies and programs should support social and culturally competent approaches in favor of women's empowerment and gender equality, as a contextual factor influencing multiple RH outcomes, and in pursuit of advancing human rights.

Many international organizations and governments have increasingly focused on results and impact of programs and have sought to make investments that rest on *evidence* that gendered approaches actually improve outcomes. Until 2004, when the IGWG published The *"So What?" Report: A Look at Whether Integrating a Gender Focus Into Programs Makes a Difference to Outcomes,* such evidence had not been brought together in a systematic fashion. **The purpose of this 2009 review is to assemble the latest data and update the evidence as to what difference it makes when a gender perspective is incorporated into RH programs.**

Background

The 2004 *"So What?"* report used the term "reproductive health" in its broadest sense, as defined at the 1994 International Conference on Population and Development (ICPD), to cover interventions to reduce unintended pregnancy and abortion; reduce maternal morbidity and mortality; and to combat the spread of STI/HIV/AIDS. Interventions to improve quality of care were also assessed. Out of 400 interventions that were reviewed, 25 were found to have either accommodated gender differences or to have transformed gender norms to promote equality. The report presented evidence of the value of integrating gender into programs, for promoting both positive RH and gender outcomes. The report recommended: 1) stronger integration of gender in designing program interventions; and 2) more rigorous evaluations of interventions that integrate gender.[8]

Objective

The current review, also supported by the IGWG,[9] looks at new projects and research findings with the objective of determining whether progress has been made in the intervening years both in gender and RH programming and in its evaluation.

Are interventions more strongly focused on transforming inequitable gender relations? Are interventions that incorporate gender evaluated using more rigorous approaches?

None of the interventions reviewed in the 2004 report are included here. In addition to assessing whether RH outcomes are enhanced with the integration of gender, the authors of this review explore the following two questions in this newer set of gendered programs:

- Are the interventions more strongly focused on transforming inequitable gender relations rather than accommodating them?
- Are interventions that incorporate gender evaluated using more rigorous approaches?

Intended Audience

This document is intended primarily for gender and health experts who design, implement, manage, and evaluate programs in developing countries. The findings on the effect of integrating gender are intended also for donors, policymakers, civil society, and advocacy groups to make the case for gender integration in health programs.

Methods

The authors identified documents for this review through online literature searches and by contacting key informants in the international reproductive health field. This report uses both published and unpublished documents found in English, primarily evaluation reports, project summaries, and published jour-

7 UNFPA 2008.

8 Boender et al., 2004: 3.

9 Population Action International funded co-author Karen Hardee's time for this review.

nal articles. Databases of reproductive health, development, and academic literature were searched extensively.[10] The authors also searched peer-review journals (e.g., *Studies in Family Planning*, *Reproductive Health Matters*, *International Family Planning Perspectives*, *Population and Development Review*, *Violence Against Women*, and *The Lancet*) and organization websites, such as Population Council, International Center for Research on Women (ICRW), the Interagency Youth Working Group, and the American Public Health Association (APHA).

To extend the reach of the review beyond what is available online, experts and practitioners from organizations worldwide were contacted to locate additional program evaluation documents and identify other organizations and people involved in gender and reproductive health programs. Nearly 100 individuals spanning 40 organizations were contacted to request information about relevant interventions or suggest additional key informants.

After completing the literature search, the authors reviewed approximately 200 project documents that have been published since the year 2000. This year was selected as the start of the search range in order to capture the most recent publications and minimize overlap with the previous "So What?" review; search results were filtered to exclude any publications reviewed at that time. The documents cover a range of reproductive health interventions, cross-sectoral development and life skills programs with reproductive health components, and pilot and operations research projects.

Criteria for Inclusion in the Review

Interventions selected for this update had to meet the following criteria:[11]

1. Does the intervention integrate gender?
2. Has the intervention been evaluated?
3. Does the intervention have measured reproductive health outcomes?

Forty studies from developing countries were found to meet all three criteria.[12] Only programs that used accommodating or transformative approaches were included in this review. (See Appendix A.1 on page 71 for a table of the 40 projects, including their objectives, strategies, and reproductive health and gender outcomes.)

Types of Gender Integration Strategies

The IGWG has developed a continuum of the ways that gender is approached in projects (see Figure 1 below, the *Gender Integration Continuum*). This continuum[13] categorizes approaches by how they treat gender norms and inequities in the design, implementation, and evaluation of programs or policy.

The term **"gender blind"** refers to the absence of any proactive consideration of the larger gender environment and specific gender roles affecting program/policy beneficiaries. Gender blind programs/policies give no prior consideration for how gender norms and unequal power relations affect the achievement of objectives, or how objectives impact on gender. In contrast, **"gender aware"** programs/policies deliberately examine and address the anticipated gender-related outcomes during both design and implementation. An important

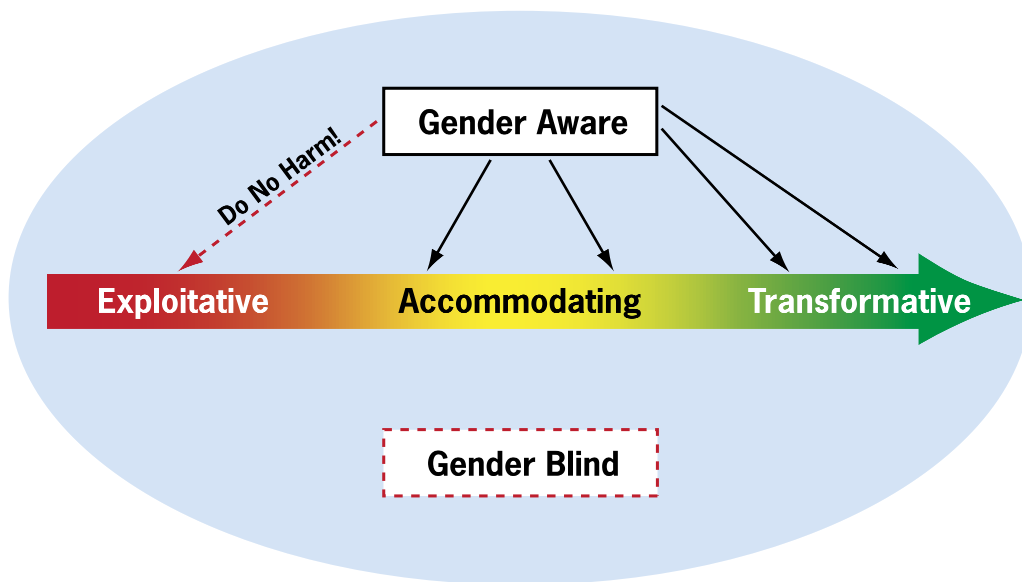
10 The complete list of databases searched includes: POPLINE, the Development Experience Clearinghouse, Expanded Academic, Interagency Youth Working Group, HRH Global Resource Center, PubMed, and the WHO Reproductive Health Library. All databases were searched with equal rigor and the same set of search terms.

11 These are the same criteria that were used in the 2004 report.

12 A significant number of the final 40 projects were funded in whole or in part by USAID, who has also funded this review and publication. USAID projects frequently require evidence of program impact through structured evaluations. As a result, many USAID programs met the evaluation requirements for inclusion in this review as they were able to demonstrate the impact of their gender programs.

13 This framework draws from a range of efforts that have used a continuum of approaches to understanding gender, especially as they relate to HIV/AIDS. See Geeta Rao Gupta, "Gender, Sexuality and HIV/AIDS: The What, The Why and The How" (Plenary Address at the XIII International AIDS Conference), Durban, South Africa: 2000; Geeta Rao Gupta, Daniel Whelan, and Keera Allendorf, "Integrating Gender into HIV/AIDS Programs: Review Paper for Expert Consultation, 3–5 June 2002," Geneva: World Health Organization, 2002; and WHO/ICRW, "Guidelines for Integrating Gender into HIV/AIDS Programmes," forthcoming.

FIGURE 1.1. The Gender Integration Continuum[14]



prerequisite for all gender-integrated interventions is to be gender aware.

In the graphic above, the circle depicts a specific program environment. Since programs are expected to take gender into consideration, the term "gender aware" is enclosed in an unbroken line, while the "gender blind" box is defined by a dotted, weak line. Awareness of the gender context is often a result of a pre-program/policy gender analysis. "Gender aware" contexts allow program staff to consciously address gender constraints and opportunities, and plan their gender objectives. Programs/policies may have multiple components that fall at various points along the continuum, which is why multiple arrows exist.

The IGWG emphasizes the following two gender integration principles:

- First, **under no circumstances should programs/policies adopt an exploitative approach** since one of the fundamental principles of development is to "do no harm."
- Second, the **overall objective of gender integration is to move toward gender transformative programs/policies**, thus gradually challenging existing gender inequities and promoting positive changes in gender roles, norms, and power dynamics.

14 While this gender continuum framework has been adopted by the IGWG and applied to USAID's work, other organizations may use different gender frameworks; see, for example, the World Health Organization gender strategy at http://www.who.int/gender/mainstreaming/strategy/en/index.html

Gender exploitative approaches, on the left of the continuum, take advantage of rigid gender norms and existing imbalances in power to achieve the health program objectives. While using a gender exploitative approach may seem expeditious in the short run, it is unlikely to be sustainable and can, in the long run, result in harmful consequences and undermine the program's intended objective.

Gender accommodating approaches, in the middle of the continuum, acknowledge the role of gender norms and inequities and seek to develop actions that adjust to and often compensate for them. While such projects do not actively seek to change the norms and inequities, they strive to limit any harmful impact on gender relations. A gender accommodating approach may be considered a missed opportunity because it does not deliberately contribute to increased gender equity, nor does it address the underlying structures and norms that perpetuate gender inequities. In situations where gender inequities are deeply entrenched and pervasive in a society, however, gender accommodating approaches often provide a sensible first step to gender integration. As unequal power dynamics and rigid gender norms are

recognized and addressed through programs, a gradual shift toward challenging such inequities may take place.

Gender transformative approaches, at the right end of the continuum, actively strive to examine, question, and change rigid gender norms and imbalance of power as a means of reaching health as well as gender-equity objectives. Gender transformative approaches encourage critical awareness among men and women of gender roles and norms; promote the position of women; challenge the distribution of resources and allocation of duties between men and women; and/or address the power relationships between women and others in the community, such as service providers or traditional leaders.

[T]he field is evolving toward a deeper understanding of what gender equality entails and a stronger commitment to pursue this equality in health programs.

A particular project may not fall neatly under one type of approach, and may include, for example, both accommodating and transformative elements. Also, while the continuum focuses on gender integration goals in the design/planning phase, it can also be used to monitor and evaluate gender and health *outcomes*, with the understanding that sometimes programs result in unintended consequences. For instance, an accommodating approach may contribute to a transformative outcome, even if that was not the explicit objective. Conversely, a transformative approach may produce a reaction that, at least temporarily, exacerbates gender inequities. Monitoring and evaluating gender outcomes against the continuum allows for revision of interventions where needed.

Accommodating or Transformative?

In some cases a particular intervention strategy may be accommodating in one context and transformative in another, depending on the nature of the intervention and how it is implemented. For example, a project may work with male power holders such as local religious leaders to try to enlist them in encouraging (or to stop opposing) contraceptive use among women. This could be seen as an accommodation to the gender status quo in which males holding power act as gatekeepers. It could also be seen as transformative if the leaders are explicitly engaged to question or change their traditional role in regard to family planning communication.

Transformative strategies may experience greater challenges to implementation in that they explicitly address the structural underpinnings of gender inequality in social systems, and therefore are likely to encounter resistance. For the same reason, however, they have the potential to bring about long-term and more sustainable benefits for women and men.

Programs and policies may transform gender relations through:

- Encouraging critical awareness of gender roles and norms;
- Empowering women and/or engaging men, thus achieving gender equality and health equity objectives; or
- Examining, questioning, and changing the imbalance of power, distribution of resources, and allocation of duties between women and men.

A majority of the interventions in this review employ transformative approaches. This suggests that the field is evolving toward a deeper understanding of what gender equality entails and a stronger commitment to pursuing equality in health programs.

Intervention Evaluations

The interventions selected for inclusion in this report were limited to those that have been evaluated – those that established criteria for assessment that were related to the goals of the intervention and followed an evaluation design. The evaluations are of varying quality and thoroughness, employing methods ranging from randomized-control trials (RCT) to post-test-only designs, a few of which used qualitative methods exclusively (see Table 1.1).[15]

Table 1.1

Methodologies Used in Evaluation of Gender Integrated Interventions

METHODOLOGY	NUMBER OF STUDIES
Quantitative (primarily)	**37**
Experimental design	5
Quasi-experimental design	17
Non-experimental design	15
Qualitative (exclusively)	**3**

Countries Represented

Twenty-five countries were represented in the interventions to improve reproductive health outcomes by integrating gender. Most interventions were located in Africa (10), followed by Asia and Latin America and the Caribbean (6 each), the Near East (2) and Other (1). Some countries had multiple interventions. Two countries, India and South Africa, were home to the most interventions (eight and seven interventions, respectively).

Table 1.2

Countries Included in the Analysis of Outcomes Related to Gender-integrated Interventions

Africa (10)	Asia (6)	LAC (6)	Near East (2)	Other (1)
Ethiopia (3)	Afghanistan	Bolivia	Egypt (2)	Georgia
Ghana	Bangladesh	Brazil	Jordan	
Guinea	Cambodia	Ecuador		
Kenya (2)	India (8)	El Salvador		
Liberia	Nepal	Nicaragua		
South Africa (7)	Philippines	Peru		
Tanzania (2)				
Senegal				
Sudan				
Uganda				

Note: some programs and evaluations were conducted in multiple countries. Some programs were implemented in multiple countries without all countries being included in the evaluations. Only countries that had evaluations are included in this table.

Reproductive Health Outcomes

The outcomes highlighted in this report cover a range of indices in reproductive health and family planning, as well as broader indicators such as age at marriage and knowledge about sexual and reproductive health, as well as indicators of gender outcomes (see Tables 1.3 and 1.4). The authors have limited this review to programs with measured reproductive health outcomes, although broader indicators and gender outcomes are included when available.

Organization of the Report

This report is divided into seven chapters: an introduction; four chapters corresponding to reproductive health issues (unintended pregnancies; maternal health; HIV/AIDS and other sexually transmitted infections (STIs); and harmful practices); a chapter on meeting the needs of youth (due to the large number of programs targeted to this vulnerable and demographically important group, as well as the special strategies needed to reach youth); and, finally, a conclusion. Each chapter contains at least two detailed case studies, highlighting particularly noteworthy projects with strong evaluations and transformative approaches. Noteworthy projects that had less information available were included in the summary within each chapter.

Of the 40 programs that met the criteria for inclusion, 18 are cross-cutting interventions, addressing two or more RH issues. In these cases, the programs are categorized in the chapter on the RH issue they most directly address. In addition, many of the interventions included in this report related to working with

15 See the Glossary, page 93, for definitions of evaluation and research methodology terms.

Table 1.3

Number of Interventions Reporting Selected* Reproductive Health Outcomes**

REPRODUCTIVE HEALTH ISSUE OUTCOMES	NUMBER OF INTERVENTIONS
Reducing Unintended Pregnancy	
Greater contraceptive knowledge	11
Greater contraceptive use	11
Greater awareness of fertility	2
Increase in communication and joint decision-making with partner about contraception	2
Improved provider clinical skills and knowledge of FP methods and STI detection/treatment	1
Improving Maternal Health	
Increase in use of skilled pregnancy care	3
Reduced case fatality rate	1
Increase in screening of pregnant women for Syphilis	1
Increase in women's emergency obstetric care needs being met	1
Greater knowledge of warnings signs in pregnancy	1
Increase in awareness of prenatal care	1
Reducing HIV/AIDS and Other STIs	
Greater knowledge of HIV/AIDS transmission and prevention	7
Greater condom use:	
At last sex	3
With primary partner	4
Increase in visits to centers that provide HIV/AIDS and STI services	5
Lower reported STI symptoms	2
Greater knowledge of STI symptoms	1
Increased exclusive breastfeeding	1
Greater receipt & ingestion of nevirapine	1
Greater CD4 testing	1
Eliminating Harmful Practices	
Decrease in belief that IPV/SV is justified under some circumstances	3
Greater knowledge of IPV/SV resources	2
Decrease in incidence of violence	3
Increased community action and protest against harmful practices	2
Attitudes toward IPV/SV	4
Decrease in risk of IPV/SV	1
Decrease in controlling behavior by intimate partner	1
Increased uptake of RH services	1
Greater knowledge of harmful consequences of FGM/C and advantages of not cutting girls	3
Decrease in belief that FGM/C is necessary	2
Increase in number of men who marry uncircumcised girls	1
Decrease in FGM/C incidence	2
Increase in age at marriage	1
Increase in interval between marriage and first birth	1
Greater knowledge of risks of early childbearing	1
Fewer adolescent pregnancies	1
Fewer adolescent marriages	1
Meeting the Needs of Youth	
Greater sexual and reproductive health knowledge	4
Increase in decision-making ability related to:	
Condom use	2
Sex	1
Increase in age at sexual debut	1

*Additional RH outcomes were measured beyond those listed here. Please see the program reports for additional information.

**Interventions addressing more than one reproductive health outcome are listed more than once.

men. These interventions are included under each of the main chapters because the constructive engagement of men and boys is an integral part of integrating gender into programs.

Each chapter begins with a summary of the issues surrounding the reproductive health outcome discussed in the section. Next, summaries of interventions and studies are presented, highlighting each project's gender approach as well as evaluation design. At the end of each chapter, readers will find expanded case studies that highlight selected interventions, including their gender integration strategies and evaluations. Information on costs has been included where available. Some of the program areas had more intervention examples than others and the amount of detail on each of the methodologies and approaches of the interventions is limited by the quality of description found in reports and communications.

The 2004 *"So What?"* report, reflecting the state of the field at the time, did not have separate chapters on harmful practices or youth. Interventions in these areas certainly existed, but most had not been evaluated, or had not been evaluated extensively enough to be included in the review. Also, the 2004 report had a separate chapter on gender in quality of care initiatives. Quality of care has increasingly been incorporated as a standard component of RH programming; therefore, quality of care initiatives are not highlighted separately here.

Table 1.4

Number of Interventions Reporting Selected* Gender Outcomes**

GENDER OUTCOMES	NUMBER OF INTERVENTIONS
Increased partner communication about reproductive health or family planning	11
Increased equitable gender attitudes and beliefs	9
Women's increased self-confidence, self-esteem or self-determination	5
Women's increased participation in the community and development of social networks	3
Higher scores on an empowerment scale for women	3
Increased support (emotional, instrumental, family planning, or general support) from partners or community	2
Increased life and social skills	2
Women's increased decision-making power	1
Higher formal educational participation for women or girls	1
Women's increased mobility	1
Improved gender relations within the community	1
Women more articulate in discussing IPV/SV and RH	1
Decreased tolerance for kidnapping of girls	1

*Additional gender outcomes were measured beyond those listed here. Please see the program reports for additional information.

**Interventions addressing more than one gender outcome are listed more than once.

2 Reducing Unintended Pregnancies

Unintended pregnancy is a critical issue throughout the world. Data from 53 countries indicate that one in seven married and one in 13 never-married women have an unmet need for contraception[16] and are thus at risk of unintended pregnancy. Unmet need is highest in sub-Saharan Africa, where one in four married women have an unmet need for contraception. In the regions of Latin America and the Caribbean, North Africa, West and Central Asia, and South and Southeast Asia, unmet need is lower, but still significant.[17]

PROGRAM	COUNTRY
Male Motivation Campaign	Guinea
Together for a Happy Family	Jordan
Cultivating Men's Interest in Family Planning	El Salvador
Reproductive Health Awareness	Philippines
PRACHAR	India
REWARD	Nepal
CASE STUDY: Women's Empowerment Model to Train Midwives and Doctors	Afghanistan
CASE STUDY: PROCOSI Gender-Sensitive Reproductive Health Program	Bolivia

Numerous gender-related barriers that contribute to unintended pregnancy have been identified, some at the institutional and policy level, and others at the levels of the family and community. Fertility control has often been seen as women's domain, and women are often construed as targets of family planning (FP) programs rather than beneficiaries of reproductive health care. As a result, programs have been slow to engage men and address gender-based inequities. Men's power over women in the household also has implications for contraceptive use and reducing unintended pregnancies. Women are often in a weak position in negotiating the timing and circumstances of sexual intercourse.[18] The perception that women are responsible for FP may mean that women without their own sources of income are unable to use family planning services unless they are free of charge.[19] Women are often blamed for unplanned pregnancies[20] even though men often play important roles in regulating women's access to RH services through control of finances, women's mobility, means of transportation, and health care decisions.[21] Women in some settings would rather undergo abortions than risk repeated conflicts with their husbands over contraceptive use.[22]

Women are disadvantaged by unequal power relations outside the home as well as within it. Gender power imbalances in client-provider relationships often are exacerbated by disparities in social status and education, which are likely to be greater when the client is female and the provider is male.[23] This may encourage providers to behave in an authoritarian fashion that often results in compliance and passivity from their clients.[24] Regardless of the sex of the provider, female clients often fail to ask questions or voice concerns that may affect the success of their family planning use.[25] Additionally, gender norms may discourage

16 Women who prefer to space or limit births but are not using any form of contraception are considered to have unmet need for family planning.

17 Sedgh et al., 2007. Based on data from Demographic and Health Surveys (DHS).

18 Schuler et al., 1994.

19 Schuler et al., 2002b.

20 Hoang et al., 2002.

21 Robey et al., 1998; Goldberg and Toros, 1994.

22 Biddlecom and Fapohunda, 1998; Schuler et al., 1994.

23 Upadhyay, 2001.

24 DiMatteo, 1994; Schuler et al., 1994.

25 Schuler et al., 1985; Schuler and Hossain, 1998.

women, especially young women, from appearing to know or acquiring knowledge about sexual matters or suggesting contraceptive use.[26] At the same time, the social construction of masculinity may contribute to male risk–taking in the form of unprotected sex and expectations to prove sexual potency.[27]

Interventions

Several of the projects reviewed both for this chapter and for the chapter on maternal mortality and morbidity countered the traditional practice of aiming FP services at women only; they encouraged husbands and other males to take more responsibility in this area. The strategies included enlistment of people who hold power—for example, religious leaders and, in one case, the royal family—to support FP; influencing husbands to encourage their wives to use FP services; and providing a male-controlled contraceptive method. Other projects encouraged joint decisionmaking and shared responsibility in FP and the institutionalization of gender into RH services.

The two projects selected as case studies reduce unintended pregnancy through a gender-transformative approach. They are the **Women's Empowerment Model to Train Midwives and Doctors** and the **PROCOSI Gender-Sensitive Reproductive Health Program** (see pp. x and x). The Women's Empowerment Model was used to train midwives and doctors on clinical skills in family planning, particularly IUD insertion, and to increase family planning knowledge in Afghanistan. The PROCOSI gender-sensitive program adopted a long-term perspective and worked with a large number of institutions in Bolivia to integrate gender into reproductive health services.

Of the other six interventions that met the criteria for this review, the first four described here aimed to meet the RH goal of reducing unintended pregnancy through constructive engagement of men. Their approaches range from accommodating to transformative, and sometimes encompass elements of both.

26 Bezmalinovic et al., 1997; Population Council, 2000.

27 UNFPA, 2008.

28 Blake and Babalola, 2002.

Table 2.1 lists the key gender strategies used to reduce unintended pregnancy in the projects reviewed.

Table 2.1

Strategies Used in Programs to Reduce Unintended Pregnancy

Strategies
Improving male partners' accurate knowledge about RH and FP; and Encouraging male partners to take more responsibility for FP
Encouraging joint decision-making and shared responsibility for FP
Institutionalization of gender into NGO RH services, including accreditation
Advocacy with religious leaders and policymakers
Integration with non-health development activities (water and sanitation)
Use of established male networks to diffuse information, refer to services, and expand method choice
Empowering female providers
Increasing gender awareness and sensitivity of health providers
Empowering women and girls

Male Motivation Campaign[28]

Country: Guinea

Implementing organizations: Johns Hopkins University Center for Communication Programs (JHU/CCP) and the Guinean Ministry of Health

Through constructive engagement of men, this intervention sought to increase knowledge and use of quality health care services and the adoption of positive health practices in Guinea. The first phase of this campaign consisted of advocacy with religious leaders—a strategy that falls somewhere between gender accommodating and transformative. In the context of a patrilineal and male-dominated society in Guinea, the program accommodated existing power structures by reaching out to male religious leaders, knowing that empowering religious leaders would help to ensure social support for family planning. In the second phase, the project utilized multimedia interventions to educate married men about FP and persuade them to talk with their wives and encourage them to use FP services. Engaging community men and those in positions of leadership has the potential to transform gender relations to a greater equity by expanding lim-

ited traditional male roles to include knowledge of, and engagement in, FP/RH. In addition to the two primary audiences, the campaign also addressed women of reproductive age and service providers. The project covered a relatively large population; for example, about 30,000 people attended community mobilization events surrounding 30 rural health centers.

The evaluation of the Male Motivation Campaign in Guinea had two components: a panel study with religious leaders and a population-based study with men and women of reproductive age. In the first component, 98 religious leaders were interviewed at two points in time. In the second component, a sample of 1,045 men and women who were interviewed in the 1999 Guinea Demographic and Health Survey were re-interviewed. Following the intervention, involvement in advocating for modern family planning methods became more widespread among religious leaders and fewer believed that FP methods were prohibited by Islam. Multiple regression analysis controlling for confounding effects of prior ideation showed that campaign exposure was associated with considerable and significant change in an "ideation index" measuring awareness of and approval of FP; discussion of FP with spouse, friends, or relatives; and spousal approval of FP. Actual use of contraception, however, did not increase significantly among women and stagnated among men.

Together for a Happy Family[29]

Country: Jordan

Implementing organizations: Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU/CCP) in collaboration with the Jordanian National Population Committee

This project engaged men by encouraging couple communication and joint decision-making. The project worked with religious leaders and the royal family in Jordan, where many people were unaware that Islam permits use of modern FP methods. In Jordan, husbands' opposition to family planning, preferences for large families, perceived religious prohibitions, and health concerns all limit the use of modern FP methods. For a two-year period beginning in March 1998, national-level, multi-media behavior change communication messages were used to enlist men in making informed decisions with their wives to use family planning. The premise of the project was that highly-respected people would be able to influence men effectively.

Project researchers, with staff from the Jordanian Department of Statistics, compared the project's 1996 knowledge, attitudes, and practices (KAP) survey results with findings from the 2001 Men's Involvement in Reproductive Health Survey (MIRHS) following the campaign. The analysis showed improved knowledge and substantially more positive attitudes among both men and women regarding specific modern FP methods. The majority of both men and women reported in 2001 that they decided together on the number of children they planned to have, compared with about one-third who said they decided together in 1996. Similarly, in 2001 nearly 80 percent of MIRHS respondents said that husbands and wives share responsibility for avoiding unwanted pregnancies. Survey respondents were given a list of topics from which they were to rank issues discussed and actions taken as a result of exposure to the campaign. Respondents ranked discussing issues with spouses and sharing decision-making as the top actions taken. They also included treating sons and daughters equitably and adopting a FP method. Comparison of the 1996 and 2001 surveys showed a decrease in ideal family size from 4.3 to 3.8. While it is not possible to attribute these changes entirely to the "Together for a Happy Family" campaign, the magnitude of the changes is notable.

Cultivating Men's Interest in Family Planning[30]

Country: El Salvador (rural)

Implementing organizations: The Institute for Reproductive Health (IRH) of Georgetown University, the El Salvadoran Ministry of Health, and Project Concern International, with its local El Salvador affiliate PROCOSAL (Programas Comunitarias para El Salvador)

This was a pilot project carried out in 13 small villages in rural El Salvador. The objective was to integrate family planning—specifically increasing male involvement in family planning

29 JHUCCP, 2003.

30 Lundgren et al., 2005.

and use—into a water and sanitation program. It sought to facilitate couple communication and joint decision-making regarding family planning. The initiative also aimed to integrate women into water committees which had previously been monopolized by men. Results of interviews with men and women defined as having unmet need indicated that some men were unwilling to use modern contraceptive methods, or to have their wives use them, both because of concern about side effects and because they worried that their wives might be unfaithful. The researchers found that the practice of periodic abstinence was common, but that most people could not correctly identify their fertile days.[31] The project sought to use networks established around issues men cared about and in which they were already involved. These networks were used to diffuse information, facilitate referrals, and expand method choice (with an emphasis on the Standard Days Method™ or SDM). The project creatively used a metaphor to promote family planning: fertile cycles of the land were equated with the fertile cycles of women. Moreover, the incorporation of men into FP decisionmaking was construed as a natural parallel to including women in decisionmaking in development efforts. Thus, gender-equity strategies from a project in the environmental sector were imported into a FP initiative, furthering the objective of reducing unintended pregnancy as well as promoting gender equality.

The evaluation of this project employed community-based surveys of individuals of reproductive age prior to the start (January 2001) and at the end of the project (September 2002). Logistic regression analyses showed substantial differences in knowledge, attitudes, and behavior after the FP intervention. Communication between partners also increased. The differences between participants and non-participants were small, suggesting a community-level effect. The researchers attribute the program's success to the way the intervention was integrated into an already successful water and sanitation project equipped with its own outreach infrastructure for involving many men and women in the community.[32]

31 Lundgren et al., 2005.

32 Lundgren et al., 2005.

33 Palabrica-Costello, 2001.

Reproductive Health Awareness (RHA)[33]

Country: Philippines

Implementing organizations: KAANIB in the Philippines; evaluation conducted in collaboration with FRONTIERS/Population Council, the Institute for Reproductive Health (IRH, Georgetown University), and the Research Institute for Mindanao Culture (RIMCU at Xavier University).

In this male engagement intervention, KAANIB worked with small farmers and agrarian reform beneficiaries and implemented the RHA intervention through its trained volunteer couple members. The RHA project sought to promote constructive engagement of men in reproductive health by improving awareness, knowledge, health-seeking behavior, and couples communication on RH. The project used a couples approach, but emphasized husbands' needs and involvement in RH. The volunteer couples were trained on four topics: fertility and body awareness; family planning; RTI/STI and HIV/AIDS; and couples communication on RH. These topics had been identified as gaps in knowledge during a 1997 baseline survey of male involvement conducted by the FRONTIERS Project and IRH/Georgetown.

The evaluation included a pre- and post-test nonequivalent control group design. At pre-test (prior to the RHA intervention), 210 couples who were members of KAANIB and 249 couples from the comparison areas were interviewed. At post-test, 183 of the original 210 couples in KAANIB areas were found and interviewed, as well as 217 couples in the comparison areas. In the intervention area, significant positive changes were found in supportive attitudes by husbands toward RH, and in husband-wife communication, as reported by husbands and their partners. Knowledge and awareness about anatomy and physiology, fertility, family planning methods, and STI increased significantly among women but not among men. No changes were found in family planning use. Statistically significant improvements were found among men in the program area regarding communication with spouses on the fertile period and use of family planning. The intervention demonstrated the feasibility of using couples as RH educators in the community.

PRACHAR[34]

Country: India

Implementing organizations: Pathfinder International with 30 local NGOs in Bihar, India.

The PRACHAR project aimed to raise awareness about FP and the healthy timing and spacing of pregnancy among young people and community leaders. The project worked with married and unmarried young people, both male and female, as well as with mothers-in-law and other family members of young couples and respected community elders and community leaders. The three-year project that began in 2001[35] worked in 452 villages and provided information on RH/FP issues to over 90,000 adolescents and young adults and over 100,000 parents and other adults in the communities. Educational messages regarding the risks and disadvantages of early marriage and childbearing, and the benefits of delaying and spacing births, were tailored for these different audiences. The project also provided contraceptives and worked with community-based practitioners to increase their skills in providing basic maternal and child health and RH/FP services. The transformative approach focused on empowering girls and women, increasing men's knowledge and sensitization to FP, and on open communication between partners on issues related to childbearing, family size, and use of contraception. The PRACHAR project's evaluation relied on project monitoring data and pre-/post surveys in intervention and control areas to assess impact. Key RH results included:

- The percentage of the population (all respondents) who said they believed that contraception is both necessary and safe increased from 38 percent to 81 percent. Among unmarried adolescents, this figure increased from 45 percent to 91 percent.
- The percentage of recently married couples using contraceptives to delay their first child more than tripled, from five percent to 20 percent, and the interval between marriage and first birth increased from 21 months to 24 months.
- The percentage of recently married contraceptive adopters who began using contraception within the first three months of the consummation of marriage increased dramatically, from less than one percent to 21 percent.
- The percentage of first-time parents who used contraception to space their second child increased from 14 percent to 33 percent.

34 Information from Wilder et al.. 2005. See also, E.E. Daniel et al., 2008.

35 This section relates to data from Phases I and II of the PRACHAR project. As this publication goes to press, the project is currently in Phase III.

REWARD[36]

Country: Nepal

Implementing organizations: The Centre for Development and Population Activities (CEDPA), The Nepal Red Cross Society (NRCS), and the Centre for Research on Environmental Health and Population Activities (CREHPA).

The NRCS, in collaboration with CREHPA, implemented the **REWARD** (Reaching and Enabling Women to Act on Reproductive Health Decisions) Project to strengthen women's capabilities for informed decisionmaking to prevent unintended pregnancy and improve reproductive health in three districts of Nepal. The project worked with Village Development Committees and supported a network of more than 700 community-based staff and volunteers engaged in delivering reproductive health information and methods (pills, condoms, and Depo-Provera) at the community level. It aimed both to provide services and referrals and to create an enabling environment to strengthen women's informed RH decisionmaking. Two components of this strategy were educational sessions to increase gender awareness among program managers and service providers, and encouragement of women's participation at all levels of the NRCS. The project also created women-only community action groups (CAGs) that met monthly to discuss reproductive health issues. At the program's peak, there were 495 active CAGs with nearly 10,000 members.

After the **REWARD** project in Nepal was phased out in 2002, CEDPA conducted an evaluation that included two components: 1) an assessment of project performance based on secondary data; and 2) a population-based sample survey in one district (security concerns prevented a more extensive survey). Comparison of baseline and endline data suggested increases in contraceptive prevalence and "couple years of protection" (CYP); increased popularity of reversible contraceptives such as DMPA, condoms, and pills; and increased use of maternal and child care services during the course of the project.

36 CEDPA, 2004; and CREHPA, 2002.

REDUCING UNINTENDED PREGANCIES CASE STUDY

INTERVENTION:

Women's Empowerment Model to Train Midwives and Doctors

COUNTRY: **Afghanistan**

TYPE OF INTERVENTION: **Health provider training**

IMPLEMENTING ORGANIZATIONS: **Family Health Alliance (FHA)**

Gender-Related Barriers to RH

Women in Afghanistan are among the least empowered groups in the world. Afghan women often lack agency to make the most basic decisions, including those regarding reproductive health and family planning. Additionally, the country has one of the highest maternal mortality rates in the world.[37] This is a direct result of the patriarchal structures prevalent across Afghanistan, and the ensuing constraints placed on women's lives. The restrictions limit women's educational and economic opportunities, as well as their access to reproductive health care. In addition, years of conflict and instability have devastated Afghanistan's health care facilities and health professional capacities, further impacting women's health.

Objective

This intervention (implemented 2005 – 2007) sought to address maternal mortality in Afghanistan by preventing unwanted pregnancies and promoting birth spacing through the expansion of family planning services.

Strategy

FHA sought to improve RH outcomes by training female midwives and doctors using the Women's Empowerment Model. This training program focused on clinical skills in family planning, particularly IUD insertion, and increasing family planning knowledge. The project sought to reduce infections, enhance detection and treatment of STIs, and improve their approach in educating clients in HIV/AIDS/STI prevention. FHA trained 47 female family planning service providers from more than 10 provinces. The rationale for using a women's empowerment approach was that this model would lead to increased communication and changes in gender norms and decision-making power. Additionally, empowered women health providers could become more valued members of the healthcare system and be better able to meet their clients' healthcare needs.

The program used five empowerment strategies:

1. Role modeling. The project recruited professional Muslim women trainers from Iran.

2. Developing critical thinking skills. Trainers focused on the status of Afghan women and compared them with other women in the region.

3. Individual consultations. The project encouraged one-on-one meetings between trainers and trainees to discuss barriers to trainees completing the program (e.g. obtaining husbands' permission).

4. Fostering teamwork and personal responsibility. Trainees were involved in problem-solving tasks during the program.

5. Overcoming fatalism. The project promoted women as agents of change and a culture of "it can be done."

Evaluation Design: Single sample pretest-posttest

The program was evaluated using pre- and post-tests of trainees' knowledge and clinical skills.

Reproductive Health Outcomes

Findings showed a significant increase, from 53 percent to 89 percent, in trainee knowledge of family planning methods, counseling strategies, and STIs and HIV/AIDS. Clinical skills tests showed an average score of 86 percent in the areas of infection prevention procedures, correct use of medical instruments, counseling strategies, IUD insertion and removal, and detection and treatment of STIs.

Gender Outcomes

Results showed that trainees demonstrated increased understanding of the importance of applying women's empowerment strate-

37 UNICEF and CDC, 2002.

gies when interacting with their family planning clients.

Limitations

While this intervention demonstrated the improvements in healthcare providers' skills that can happen when careful attention is paid to the cultural barriers that they face, this was also a missed opportunity for understanding how gender integration affects gender outcomes in addition to health outcomes. An evaluation design that included, for example, a woman's empowerment scale to measure gender attitudes, would have been a complement to the knowledge and clinical assessments, providing richer data and a clearer understanding of the empowerment process.

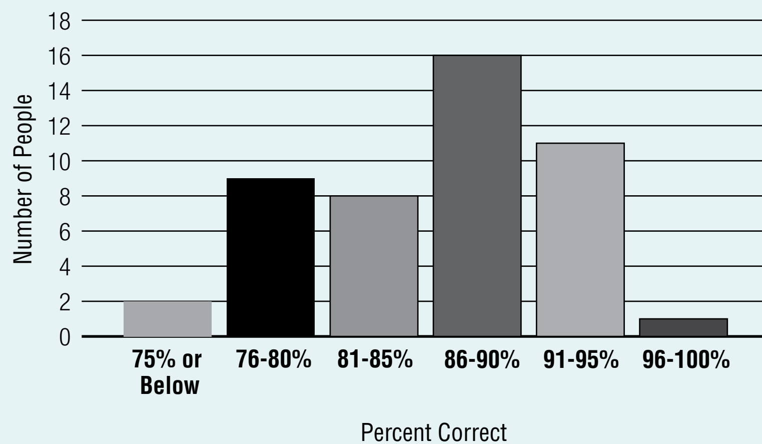
Conclusions

The results indicate that a women's empowerment training model can effectively help female health providers to develop high levels of competency in clinical skills and greater knowledge of family planning methods, counseling strategies, and STIs and HIV/AIDS. Trainees also developed a greater appreciation of women's empowerment strategies that could be used with family planning clients.

Figure 2.1

Results of Clinical Assessment: Kabul and Mazar Combined

n=47



Note: Results indicate percent of questions answered correctly after health provider trainings.

Source: T. R. Salke, 2007.

References

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Taraneh R. Salke, *Lessons from the Field: Using a Women's Empowerment Model to Train Midwives and Doctors in Afghanistan*. Presentation at 2007 APHA Conference. Washington, DC: FHA, 2007.

REDUCING UNINTENDED PREGNANCIES CASE STUDY

INTERVENTION:

PROCOSI Gender-Sensitive Reproductive Health Program

COUNTRY: **Bolivia**

TYPE OF INTERVENTION: **Reproductive health service delivery**

IMPLEMENTING ORGANIZATIONS: **PROCOSI (Programa de Coordinación en Salud Integral)**

COST**: Average cost of intervention only: $23,148**

Gender-Related Barriers to RH

Bolivia has a long history of discrimination against women, evident in many national health and well-being indicators where women suffer from higher rates of poverty, illiteracy, unemployment, domestic violence, and lower rates of political participation. Healthcare clinics often overlook the inequities between women's and men's lives, including power, decision-making capacity, and access to resources, as well as varying communication patterns. These inequities limit women's ability to access and use reproductive health services.

Objective

The objective of this project was to assess the effects and cost of incorporating a gender perspective into existing RH service programs.

Strategy

PROCOSI is a network of 24 Bolivian NGOs that coordinates and implements health programs throughout the country. The "Incorporating Gender Program" was implemented from 2001 – 2003 by 17 of the PROCOSI partner NGOs. First, all PROCOSI organizations were invited to participate in the program. Next, PROCOSI adapted a framework developed by International Planned Parenthood Federation (IPPF)[38] to operationalize a gender perspective. The framework evaluated seven organizational areas through 71 indicators. The organizational areas included: institutional policies and practices; practices of providers; client satisfaction; client comfort; use of gendered language; information, communication and training; and monitoring and evaluation.

PROCOSI trained evaluation teams from each of the 17 organizations. The teams completed baseline evaluations and analyzed the results. Each team then participated in two workshops to decide which areas the organization should improve upon. An action plan was developed for each selected indicator and then implemented over a 15-month period. All participating organizations received a package of print materials and videos related to gender, reproductive health, and family planning for distribution to clients and providers.

Table 2.2

Married, Non-Pregnant Women With Unmet Family Planning Needs

SURVEY UNMET NEED FOR:	PRE (N=707) %	POST (N=830) %
Limiting with desire to use*	10.6	7.1
Spacing with desire to use*	6.1	3.8
Limiting and spacing*	25.5	20.8
Limiting and spacing with desire to use*	16.7	10.9

* Significant statistical difference between periods with a confidence level of 95 percent

Source: E. Palenque, et al., *Effects and Costs of Implementing a Gender-Sensitive Reproductive Health Program*, 2004.

Evaluation Design: Mixed-methods, pretest-posttest

Household surveys of health service users and their partners were administered pre- and post-intervention. Nine organizations from the participating 17 were initially selected, from which 10 clinics were chosen for evaluation. IPPF provided technical assistance to conduct the baseline and endline studies. The evaluation included: 1) exit interviews with clients after their visits to the clinics, before and after the gender interventions; 2) follow-up interviews with the same women in their households three months after the exit interviews; 3) a survey with a sample of the women's partners; 4) analysis of service statistics; 5) a cost analysis to estimate the costs of incorporating a gender perspective into service delivery; and 6) monthly visits to each clinic to qualitatively assess changes in the organization. Student's T and Chi square tests were used to test significance.

Reproductive Health Outcomes

Results showed significant decreases in unmet need for family planning when all sites were aggregated. Unmet need for tetanus vaccination among pregnant women and for contraceptive services among non-pregnant women were used as proxy indicators to assess the impact of the interventions on users' health. There were no significant changes in meeting unmet needs related to tetanus vaccines for pregnant women.

There were significant changes in outcomes related to quality of care, including more comfortable interactions with the health provider and changes in provider practices, such as mentioning SRH issues. There was a significant increase in the proportion of women who reported that providers asked them questions or gave them specific information to actively explore their health needs, on topics such as cervical or breast cancer, STIs/HIV/AIDS, sexuality, and domestic and sexual violence. There were also significant increases in screening for FP needs. The proportion of women screened on the above topics, however, remained below half at endline.

Gender Outcomes

The evaluation measured changes in partner communication, couple decisionmaking, and attitudes toward gender roles and gender-based violence. Findings showed modest changes. There were no significant changes

38 IPPF, *Manual to Evaluate Quality of Care from a Gender Perspective*, 2000.

Table 2.3

Women's Perceptions of Characteristics of Their Interaction with Health Providers (significant outcomes)

VARIABLE	PRE-SURVEY (%) N= 1,060	POST-SURVEY (%) N= 1,062
Felt uncomfortable during the interaction	8.3	5.8
Called by her name	72.7	86.8
Provider used visual aids in his/her interactions	16.8	32.6
Provider informed her she had right to ask questions	20.3	47.8
Had time to ask questions	77.8	83.3
Asked questions	73.6	80.1

Source: *Palenque et al., 2004.*

Table 2.4

Affirmative Answers on Variables Related to Gender Roles

VARIABLE	PRE-SURVEY (%)	POST-SURVEY (%)
Women		
It is not correct for a woman to initiate sexual relations	56.3%	52.0%
Women's work should be mainly in the home	46.0%	27.5%
In certain circumstances men have the right to beat their partner	4.4%	1.8%
Men		
Women's work should be mainly in the home	42.5%	28.3%

with regard to women's perceptions of their partners' attempts to control them; however, there was a significant decrease in the proportion of men who said they always decided what their partner had to do, forbade her from wearing certain kinds of clothes, and did not allow her to speak in social gatherings.

In both surveys, but particularly at endline, the majority of women said they could speak easily to their husbands regarding FP methods, when to have children, sexual relations, STIs, and family health.

With regard to perceptions of gender roles, significant changes in women's responses toward more gender-equitable views were found in two indicators: it is not correct for a woman to initiate sexual relations, and women's work should be mainly at home. One indicator—women's work should be mainly in the home—was significant for men.

The proportion of women who believed that there are circumstances in which men have the right to beat their partners decreased significantly from 4.4 to 1.8 percent. No significant changes were found among men.

Replication

As a follow-up to the above intervention, in 2005 FRONTIERS collaborated with PROCOSI to test the feasibility and costs of a certification system for verifying that its member organizations provided gender-sensitive reproductive health services. Service-delivery facilities were required to comply with 80 percent of 65 pre-established standards on quality of care and gender. The categories included institutional policies and practices, provider practices, personnel knowledge of reproductive health, client comfort, use of gendered language, information, education, communication and training, client satisfaction, and monitoring and evaluation.

The certification process was implemented in three steps: an initial diagnostic assessment; development and implementation of workplans; and finally an external evaluation to issue the two-year certification.

The initial diagnostic assessment showed that the NGO facilities complied with an average of 14 percent of the gender- and quality-related standards. At the endline assessment, the facilities met 94 percent of the standards.

Average costs for improvements across the seven facilities were lower than the case study intervention, averaging $4,004, compared to $23,148. Excluding staff time, the average cost was $2,039, with the majority of expenses due to meetings, workshops, and infrastructure improvements in the three facilities that required infrastructure changes.

Limitations

The high cost of the intervention poses a considerable challenge to replicating or scaling up this intervention. As the follow-on project by FRONTIERS and PROCOSI demonstrated, a more cost-effective approach to operationalizing a gender perspective may be to develop a certification system with teams from the NGOs implementing all training activities, infrastructure changes, procedures, and revisions of statutes with their own resources. Under this approach, 14 out of 15 organizations were able to meet 80 percent of the standards, costing, on average, $19,144 less than the incorporating gender program.

Conclusions

PROCOSI'S gender program produced a number of positive RH outcomes, including a decrease in unmet need for contraception, improved client satisfaction and quality of care, increased staff awareness of SRH, and positive changes in behavior among male and female staff.

The intervention produced moderate but important gender outcomes, including women's increased confidence in their capacity to discuss SRH and awareness of their rights to use contraceptive methods. Among partners, a decrease in tolerance of gender-based violence was found.

References

E. Palenque, L. Monano, R. Vernon, F. Gonzales, P. Riveros, and J. Bratt. *Effects and Costs of Implementing a Gender-Sensitive Reproductive Health Program. Frontiers Final Report*. (Washington, DC: Population Council, 2004).

E. Palenque, P. Riveros Hamel, and R. Vernon. *Consolidating a Gender Perspective in the PROCOSI Network. Frontiers Final Report*. (Washington, DC: Population Council, 2007).

3 Improving Maternal Health

According to the 2006 *Lancet* Maternal Survival Series, "The risk of a woman dying as a result of pregnancy or childbirth during her lifetime is about one in six in the poorest parts of the world, compared with about one in 30,000 in Northern Europe."[39] This disparity highlights the enormous difficulty of meeting the fifth Millennium Development Goal—reducing maternal mortality by 75 percent between 1990 and 2015. Most maternal deaths occur during labor, delivery, and the immediate postpartum period, with the main medical cause of maternal deaths being obstetric hemorrhage.

PROGRAM	COUNTRY
FEMME Project	Peru
Men in Maternity Project	India
CASE STUDY: Involving Men in Maternity Care	South Africa
CASE STUDY: Social Mobilization or Government Services	India

The social, economic, and political causes are many and include gender inequality.[40] Gender-related barriers amplify the physiological dangers associated with motherhood. For example, women's lack of decision-making power may deny them access to health care and negatively affect maternal health outcomes.[41] Women's limited access to education can impede their understanding of basic health care concepts such as danger signs in pregnancy. In many settings, women's limited mobility outside the home may make them uncomfortable in institutional settings, such as clinics and hospitals, and interfere with their communication with health care providers.

Men are often the primary wage earners; as a result, their health may be valued more than women's,[42] and families may be reluctant to use resources for pregnancy-related care. Pregnant women may be reluctant to consume extra calories or seek care when danger signs arise,[43] or may be scolded by husbands or mothers-in-law for doing so.[44] Men are often primary decisionmakers about their wives' health care, yet they are often ignorant about their wives' health before, after, and even during labor and delivery.[45]

In some societies, gender norms require that women demonstrate their strength by suffering through labor and childbirth with little or no assistance.[46] Physicians and other obstetric service providers may discourage or forbid family members from being present or providing support during labor[47] despite the many studies that have demonstrated the beneficial impact of labor companions on clinical outcomes.[48] These types of gender-related barriers to maternal health come from the personal, family, and community levels, and together create significant barriers to women's ability to access services.

39 Ronsmans and Graham, 2006; accessed online Dec. 1, 2009 at www.womendeliver.org/pdf/Maternal_Lancet_series.pdf

40 Sen, Ostlin, and George, 2007.

41 See Atkinson and Farias, 1995; Nachbar, 1997; Vissandjee et al., 1997; World Health Organization, 1995; Roth and Mbizvo, 2001.

42 Schuler et al., 2002.

43 Hoang et al., 2002.

44 Raju and Leonard, 2000.

45 Raju and Leonard, 2000.

46 Bradby, 1999; Sargent, 1998.

47 Jessop et al., 2000: 54; Boender et al., 2004:32.

48 Zhang et al., 1996; Hodnett, 2001; Sosa et al., 1980.

Interventions

Four projects met the review's criteria and incorporated gender approaches in interventions to reduce maternal mortality and morbidity (see table. 3.1 for gender strategies). Of these four, two were chosen as case studies because of their successful gender transformative approaches (see pages 25 and 27). The **Social Mobilization or Government Services Project** in India sought to create a supportive environment to improve women's use of services by reaching out to husbands and mothers-in-law, in addition to women. In South Africa, the **Involving Men in Maternity Care Project** followed two broad strategies: improving antenatal care services and reaching out to couples through counseling and information.

A common feature of all four projects was their recognition that decisions about ante- and postnatal care typically are not made by young pregnant women and new mothers, but more often by husbands or mothers-in-law. These projects, therefore, focus on men or older women as well as young women. The strategy of involving men in maternity care may be seen as either gender-accommodating, in building on men's roles as gatekeepers, or gender-transformative insofar as it encourages men to expand their traditional gender roles.

These projects also sought to change attitudes and practices among service providers, drawing on some of the longstanding work developed under earlier quality of care initiatives. This emphasis on women's rights to a basic standard of care, and to be treated respectfully as clients, makes some of the projects transformative, since inequitable gender norms typically deprive women of rights.

Table 3.1

Strategies Used in Programs to Improve Maternal Health

Strategies Used in Programs to Improve Maternal Health
Improving use of MH services by improving accurate RH knowledge and changing attitudes of mothers-in-law, husbands
Testing models to encourage husbands' participation in wives' antenatal and postpartum care
Providing couples counseling and information and encouraging men to attend services
Training health providers to understand women's right to basic standard of care

FEMME Project (Foundations for Enhancing Management of Maternal Emergencies)[49]

Country: Peru

Implementing organizations: CARE/Peru; the Peruvian Ministry of Health; Columbia University

This project was implemented in a region of Peru's Southern Highlands. The technical component of the FEMME Project aimed at improving clinical quality of care in obstetric emergencies through standardized handling of clinical cases using a new set of emergency obstetric care guidelines. The project combined this intervention with a rights component stressing women's rights to decent and humane care, and including information for patients, privacy during care, and an emphasis on respect for local customs and beliefs.

Of the four projects reviewed in this section, the FEMME project had the most extensive evaluation. It used a quasi-experimental study design with a non-equivalent control group, incorporated both quantitative and qualitative methods of data collection, and mea-

49 CARE, 2007.

sured health outcomes rather than process variables only. The evaluation covered five intervention and five control health facilities. The study found that the FEMME approach was well accepted among health personnel (doctors, obstetricians, and nurses). The evaluation results show markedly higher scores in the intervention facilities in the correct use of clinical obstetric protocols, dramatic increases in the treatment of obstetric complications, and a reduction of over 80 percent in case fatalities. The maternal mortality rate declined by 49 percent in the intervention facilities, compared with a 25 percent decline in the comparison group. The total cost of the FEMME Project was approximately US$750,000, including the years of intervention as well as administrative closure and documentation activities (2000-2006).

Men in Maternity Project (MiM)[50]

Country: India

Implementing organizations: The Employees' State Insurance Corporation (ESIC) and the Population Council.

This project tested a model that encouraged husbands' participation in their wives' antenatal and postpartum care. Addressing the fact that many women depend on men for access to healthcare, further complicated by socio-cultural norms on appropriate sexual behavior for men and women, the interventions included: 1) individual or group counseling sessions for men and women separately, in the antenatal clinic; 2) couples' counseling sessions during antenatal and postnatal clinics; 3) screening of all pregnant women for syphilis; and 4) syndromic management of men reporting urethral discharge and men and women reporting genital ulcers.

The MiM project used a non-equivalent control group study design to examine the effects of the intervention. Three of 34 ESIC dispensaries in Delhi with the highest antenatal clinic attendance that also had laboratory facilities were selected as intervention sites and three as control sites. Concerning FP/RH outcomes, the study found improved knowledge of FP among both men and women and improved knowledge of pregnancy danger signs among women but not men, and no improvements in STI knowledge or condom use. There was a significant increase in screening of pregnant women for syphilis with the establishment of a universal syphilis screening program.

As for gender outcomes, husbands' involvement was significantly higher in the intervention group during antenatal consultation, family planning consultation, postpartum visit, and presence during labor and delivery. Communication between spouses increased in the postpartum period on baby's health, breastfeeding, and family planning issues, but communication on STIs was low and did not significantly increase. More women from the intervention group compared to the control group reported making joint decisions on family health and family planning issues. Improvements were also documented in client-provider interaction and satisfaction.

50 Varkey et al., 2004.

IMPROVING MATERNAL HEALTH CASE STUDY

INTERVENTION:

Involving Men in Maternity Care

COUNTRY: **South Africa**

TYPE OF INTERVENTION: **ANC and postpartum care program**

IMPLEMENTING ORGANIZATIONS: **Reproductive Health Research Unity (RHRU), University of the Witwatersrand, FRONTIERS, KwaZulu Natal Department of Health**

COST: **Total cost of intervention only = $97,552; Cost per clinic = $16,258**

Gender-Related Barriers to RH

In the traditional Zulu community where this intervention took place, family planning has been predominately the woman's responsibility. Men, however, are often the primary household authority, controlling income and expenditures and granting permission for their partner to seek health care. It is usually the male partner who decides which contraceptive method, if any, will be used. These gender roles impact a woman's reproductive health decisionmaking abilities and communication with her partner. These roles also limit men's understanding of RH and MH, and their participation as supportive and engaged partners. The contradiction between women's expected responsibilities and limited agency, coupled with norms indicating that men are the sole decision-makers in a household, can negatively affect reproductive health outcomes.

Objective

The main goal of the intervention was to design and test an expanded antenatal and postpartum care program to improve women's and men's reproductive health by increasing the use of postpartum family planning and protective behaviors for STIs and HIV/AIDS. The intervention (implemented from 2000 – 2003) sought to encourage men's participation in their partners' maternity care by adjusting services to welcome men and encourage couples' counseling.

Strategy

Two clinic-based strategies were used. The first strategy, improving existing antenatal care services, included information, education, and communication through dissemination of an information leaflet and an antenatal booklet for couples. The second strategy, couples' counseling, trained health providers on constructive engagement of men and invited partners of women to attend counseling during and post pregnancy.

Formative research was carried out to inform the intervention, including: a facility-based analysis; a case study on syphilis screening and management in antenatal clients; client flow analysis and a time motion study of how providers spent their time; focus group discussions; and record reviews.

To ensure program support, several meetings were held with key stakeholders, including Department of Health officials at local, provincial, and national levels; clinic managers; and health care providers. Several technical working groups developed information, education, and communication materials and in-service training modules, and made recommendations for creating a couple-friendly environment.

Two trainings were held, one for all clinic and support staff and a second for 65 professional nurses working in the intervention clinics. Topics in this second training included pregnancy, preparation for delivery, postnatal care, involving men in maternity, sexual health, basic counseling, quality improvement, and infection control.

Each clinic developed its own plan regarding how to schedule couple counseling. Invitation letters were sent encouraging men's participation in the counseling sessions (two letters during antenatal care and one post-delivery) and attendance certificates were given to men who attended counseling sessions during work hours to present to their employers. Nurses facilitated the interactive group couple-counseling sessions, which covered antenatal care procedures, physiological and emotional changes, pregnancy danger signs and care seeking, delivery plan, post-delivery care for mother and baby, STI and HIV/AIDS prevention and management, family planning, and infant feeding.

Evaluation Design: Cluster randomized-controlled trial

The study design was a cluster randomized-controlled trial with six clinics implementing the intervention and six control clinics continuing to provide services as normal. Individual interviews were collected to evaluate the program. Baseline interviews (995 respondents in the intervention group and 1081 in the control group) were collected prior to the women's first antenatal appointment. Follow-up interviews were conducted six months post-delivery (follow-up rate: 68 percent for women and 80 percent for men). Focus group discussions were conducted with health providers at intervention clinics to evaluate their satisfaction with the intervention activities. Cost data were collected on the costs of planning, implementing, and monitoring the intervention.

Reproductive Health Outcomes

In emergency situations, a significantly higher proportion of men in the intervention group assisted their partners compared to men in the control group. Significantly more couples in the intervention

continued on next page

group discussed topics related to STIs, sexual relations, immunization, and breastfeeding.

Among women exposed to counseling and the booklet, the intervention significantly improved the knowledge of condoms for dual protection; no similar improvement was seen in their male partners.

Compared to those in the control group, women in the intervention group were significantly more likely to be assisted by their partners when experiencing problems during pregnancy. There were no significant differences in knowledge of obstetric danger signs or in the following indicators: use of contraception or methods at six months postpartum, STI and HIV/AIDS knowledge and risk behavior, syphilis testing and management, and breastfeeding practices.

Table 3.2

Issues Discussed by Matched Couples

TOPICS DISCUSSED	CONTROL COUPLES % (N=528)	INTERVENTION COUPLES % (N=588)
STI	64	75*
Sexual relation	75	81*
Family planning	70	77
Whether to have more children	49	54
Immunization	75	81*
Breastfeeding	83	87*
Baby's health	71	78

* $p<0.05$

Source: Frontiers.

Gender Outcomes

As mentioned above, communication among the couples improved and couples were more likely to discuss such topics as STIs and sexual relations.

Limitations

The intervention failed to achieve significant outcomes on some of the indicators. One explanation for this may be that the evaluation results under-represent the project's impact due to possible contamination effects in service delivery. The same supervisors and managers were responsible for both the intervention and control clinics, and may have unknowingly changed services at the control clinics because of their experience at the intervention clinics.

Clinic statistics were used to match clinics and randomly assign them to the treatment groups. Clinic records were not always accurate, however, and some could not achieve the expected numbers of participants. This meant that some clinics had too few participants to be included in statistical comparisons.

A number of project and research design components could have been improved to address the overall low levels of significance. Programming could have been enhanced by extending the intervention period or including mass communication strategies, and the research design could have been strengthened by reducing chances for contamination.

Conclusions

The intervention successfully demonstrated that male participation in this context is feasible. That one-third of couples attended the counseling is notable, given that this was a new concept in a community where there was negligible male participation in maternity care and most couples were not cohabitating. Other men expressed willingness to participate, but were unable due to work schedules, lack of permission from employers, or not being told about the counseling by their female partners.

The evaluation provided evidence that the intervention was effective in significantly changing couple communication and partner assistance during emergency situations and improving knowledge of condoms as a dual protection method.

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IMPROVING MATERNAL HEALTH CASE STUDY
INTERVENTION:

Social Mobilization or Government Services

COUNTRY: **India**
TYPE OF INTERVENTION: **Community-based mobilization and government RH services**
IMPLEMENTING ORGANIZATIONS: **Foundation for Research in Health Systems (FRHS), ICRW**
COST: **Total cost of implementation and evaluation: $93,248. (Social mobilization – 42%; Government services – 18%; Research and administration – 40%.)**

Gender-Related Barriers to RH

Rates of adolescent marriage and early childbearing in India are among the highest in South Asia. Sexual and reproductive health education is a taboo subject for unmarried girls and so young women who enter into marriage are likely to be uninformed about issues such as contraception, pregnancy, STIs, and disease prevention. After marriage, gender restrictions and social norms (including limited mobility and decisionmaking), in addition to an unsupportive environment for young women's reproductive health, may prevent young women from accessing RH care and family planning services. Mothers-in-law often play a significant role in their daughters-in-law's lives and control their health-seeking behavior.

Objective

This study, implemented from 2001 – 2006, examined the relative effectiveness of addressing supply versus demand constraints to improve RH for young married women.

Strategy

The intervention targeted newly married couples in two comparable neighborhoods of Ahmednagar district in Maharashtra. Social mobilization and government health service improvement strategies were used to address the demand and supply constraints, respectively. The strategies were developed in response to formative research carried out from 1996–1999 as part of a larger program that identified constraints to women's reproductive health.

The social mobilization strategy was implemented through existing community-based organizations and in collaboration with youth and women's groups. These groups served as interactive health education sessions for married adolescent girls. Young girls' husbands participated in male group forums. FRHS anticipated that engaging male youth groups and women's groups would encourage husbands and mothers-in-law to participate in and support young women's reproductive health-seeking, thereby creating a more supportive environment. Two FRHS social workers and two members from the government's district training center organized the social mobilization activities.

The government health service improvement strategy was implemented in partnership with the government health system and focused on training local health officials. Government health providers were also sensitized to adolescents' health needs and trained on how to provide couple counseling to married adolescent girls and their husbands.

Evaluation Design: 4-Cell experimental design

Four interventions were each implemented in one primary health center (PHC) area: One PHC had only social mobilization strategies; a second focused only on improving government health services; a third had both strategies concurrently (SM+GS); and a fourth, the control area, received neither. The interventions and control PHC were assigned randomly. Across the four PHCs, 22 sub-center villages were encompassed.

FRHS conducted a baseline survey of 1,866 married girls and women ages 16-22 years across the study villages, collecting data on adolescent girls' health needs and constraints; health-seeking patterns; and experiences and perceptions of quality of care for a number of reproductive health outcomes. Similar surveys were completed at the midpoint (N=2,100) and endline (N=2,359).

Mid-intervention, 972 husbands of young women were surveyed to collect data on their knowledge of, and involvement in, their wives' health-seeking. Similarly, 75 mothers-in-law were interviewed at midpoint to assess their attitudes toward their daughters-in-law.

Reproductive Health Outcomes

Of the four study arms, the two arms that included social mobilization strategies saw the greatest improvement in reproductive health outcomes. The social mobilization area was most effective in improving women's knowledge of maternal health, contraceptive side effects, and abortion, and increasing behaviors related to postnatal check-ups, contraceptive use, treatment of gynecological disorders, and partner treatment of reproductive tract infections and STIs.

The SM+GS site saw the greatest increase in basic awareness of reproductive health and infertility. One explanation for this outcome may be that a new female doctor who took a special interest in these issues began working in this site in the middle of the intervention. The government services-only site did not see significant improvements in most outcomes.

Gender Outcomes

Qualitative interviews with mothers-in-law indicated that the social mobilization intervention contributed to an increase in supportive attitudes toward daughters-in-law's health-care seeking.

Surveys of husbands at mid-point showed that most had gained an awareness

of basic maternal care issues and were willing to seek treatment for problems during pregnancy and childbirth.

Limitations

Due to the popularity of the health education sessions, representatives in the control arm began implementing their own health education sessions. Therefore, some contamination of the research design may have occurred.

Although husbands' data showed increased awareness and willingness to seek maternal care for their wives, only a minority of husbands actually accompanied wives to the health care centers. This may be partly because social norms and health centers, which offer minimal privacy, discourage male participation.

Conclusions

This study illustrates the effectiveness of social mobilization in increasing young married women's knowledge of RH, increasing use of RH services, and changing social norms and attitudes of mothers-in-law toward their daughters-in-law's RH.

The research team expected the combination arm to generate the best outcomes, by addressing both the demand and supply constraints of women's health-seeking. The SM-only arm, however, performed better for many outcomes; having a more focused and concentrated intervention may be one explanation for this.

The project's work with mothers-in-law and husbands showed some success as well. The evaluators found the inroads with husbands to be especially notable because maternal care in this society typically is regarded as a "woman's issue." Efforts should continue to be made to encourage male participation in their wives' maternal care.

Table 3.3

Percent Change from Baseline to Endline, By Strategy

	SM	GS	SM + GS	CTRL
Need for full ANC	66.1	18.5	-3.4	50.2
Need for PNC	129.5	43.5	24.6	81.7
Spacing FP methods	14.4	14.1	12.4	9.7
Had PNC check-ups	40.5	-17.8	2.9	2.9
High-risk delivery care	4.7	4.2	29.8	24.4
Treatment-RTI symptoms	49.5	44.8	98.2	26.7

Source: ICRW, 2006.

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4 Reducing HIV/AIDS and Other STIs

Much has been written about the effect of gender on the HIV/AIDS pandemic.[51] Gender contributes to the epidemic by increasing vulnerability to the virus and exacerbating the impact of living with HIV and AIDS.

Gender norms affect both women's and men's sexual behavior and ability to protect against HIV/AIDS. When gender norms, customs, and laws relegate women to a lower status than men it makes women particularly vulnerable to HIV. In a review of Ghana's response to HIV/AIDS, the authors write that "[g]ender issues are at the core of the Ghanaian – and sub-Saharan – epidemic" and add that the epidemic is "basically fueled by sexual behavior and women often have little or no decision-making power in sexual relations."[52] Worldwide, almost half of the people living with HIV or AIDS are women; in sub-Saharan Africa, 61 percent of those living with HIV or AIDS are women.[53]

PROGRAM	COUNTRY
Somos Diferentes, Somos Iguales	Nicaragua
Men as Partners	South Africa
Yaari Dosti	India
Play Safe	Cambodia
Mothers2Mothers Program	South Africa
Integration of RH Services for Men in Health & Family Welfare Centers	Bangladesh
Involving Men in Sexual and Reproductive Health Services	Ecuador
CASE STUDY: Tuelimishane	Tanzania
CASE STUDY: Stepping Stones	South Africa
CASE STUDY: Program H	Brazil

Gender norms pertaining to men—norms that prescribe roles such as early, risky sex with multiple partners—also puts them at increased risk.[54] Moreover, men may be reluctant to seek medical information and services for HIV and AIDS, because of gender norms that portray health-seeking behavior as weak and non-masculine. Failure to access such services negatively impacts both men and their partners.

A UNAIDS report notes that in many countries women are "receiving more than expected coverage for antiretroviral therapy," and that additional research is needed to explore the reasons for the imbalance. In one study of antiretroviral treatment (ART) centers in 13 countries that included over 33,000 individuals, 60 percent of the patients on treatment were women. Noting masculine roles that present barriers for men accessing treatment, the study concluded that, "More attention needs to be paid to ensuring that HIV-infected men are seeking care and starting HAART [Highly Active Anti-Retroviral Therapy]."[55] It is important to assess whether or not treatment coverage mirrors patterns of infection to determine if any groups are facing unequal access to services.

Economic realities can also compound gender inequality and power relations as a risk factor for HIV/AIDS and a barrier to treatment. While women are generally resilient and play key roles in the fight against HIV/AIDS, women are also less likely to have access to resources and more likely to depend on men for financial survival for themselves and their children. Women, particularly young women, have a range of motivations for seeking out multiple

51 See UNIFEM, Gender and AIDS Web Portal, 2009.

52 Antwi and Oppong, 2003, p.6.

53 UNAIDS, 2007.

54 UNAIDS, 2007.

55 Britstein et al., 2008, p. 48.

partners, and operate on a continuum of volition[56] that often makes it difficult to negotiate safer sex, regardless of their motivation. For many women, having more than one partner and engaging in cross-generational and transactional sex are economic survival strategies to support themselves and their dependents.[57]

Moreover, the economic disadvantage of women in many societies leads to a lack of sexual negotiation power. Women's need for economic support from husbands or partners—particularly if they have children—can lead women to remain silent on matters of sex and fidelity in relationships that confer some level of economic security. The fear of economic abandonment by husbands or partners may be greater when extramarital relationships are explicit, resulting in an increased powerlessness to negotiate safe sex just when the risks of STI transmission are the highest.[58]

In some countries, HIV-positive women (and men) face employment discrimination because of their HIV status. For example, some employers require HIV testing as a condition of employment, while others have abused the employment rights of workers who test positive.[59] Legal frameworks that insure nondiscrimination on the basis of sex can empower women. Conversely, inequality under the law, for example with regard to property and inheritance rights, can increase women's vulnerability to HIV/AIDS. For many women, loss of a husband to HIV/AIDS is followed by loss of property and land, exacerbating the impact of the disease and limiting their ability to protect themselves and their families.[60]

Interventions

Evaluations of a number of interventions in this chapter provide strong evidence that addressing gender norms, promoting policies and programs to extend equality in legal rights, and expanding services for women and men can result in improved HIV/AIDS and gender outcomes. It should be noted that the outcomes identified in these projects are intermediary outcomes such as knowledge, risk perceptions and behavior change such as increased condom use. These outcomes are routinely measured in behavioral surveys that constitute second-generation surveillance, and are considered forbearers to reductions in HIV incidence. Measuring reductions in HIV incidence would require longer-term interventions and evaluations than would be possible with the projects included in this review.

The evaluations show that changing gender norms requires long-term interventions. As aptly noted by Mozambique's former Prime Minister, Pascoal Mocumbi, "To change fundamentally how girls and boys learn to relate to each other and how men treat girls and women is slow, painstaking work. But surely our children's lives are worth the effort."[61]

Of the 10 interventions reviewed in this chapter, six undertook gender transformative approaches and four focused primarily on accommodating gender differences. Among the gender transformative interventions, six addressed gender norms related to HIV and AIDS. Three projects were selected as case studies: **Tuelimishane**, **Stepping Stones**, and **Program H**. Tuelimishane in Tanzania is a community-based HIV and anti-violence program for young men in Dar es Salaam that combined community-based drama and peer education.[62] The interventions for young men were designed around three themes that emerged from formative research, namely, infidelity, sexual communication, and conflict. Stepping Stones, originally designed to address the HIV epidemic in Uganda in the mid-1990s, is now among the most widely used prevention interventions around the world, having been used in over 40 countries.[63] Program H in Brazil was developed on the premise that gender norms, which are passed on by families, peers, and institutions, and are interpreted and internalized by individuals, can be changed.

The 10 interventions indicate that strategies to reduce HIV/AIDS and other STIs that incorporate gender are becoming increasingly sophisticated in their approach to addressing gender dynamics. Gender integration in HIV and other STI prevention projects is primarily

56 Weissman et al., 2006.

57 Hope, 2007.

58 Boender et al., 2004.

59 Human Rights Watch, 2004.

60 Human Rights Watch, 2002.

61 Edwards, 2001: 1.

62 Mbwambo and Maman, 2007; Maganja et al., 2007.

63 Jewkes et al., 2007.

transformative in nature in that the focus is on changing the dynamics of interaction between women and men. The projects reviewed in this chapter focused on increasing women's empowerment and on challenging gender norms that affect men's health. While behavior takes longer to change than knowledge and attitudes, these projects show promising results toward achieving this behavior change.

Table 4.1 lists the key gender strategies used to reduce HIV/AIDS and other STIs in the programs reviewed.

Table 4.1

Strategies Used to Reduce HIV/AIDS and Other STIs
Participatory learning workshops
Follow-on community activities to put training into action
Community-wide condom social marketing campaign using gender-equitable messages
Community-based drama and peer education about HIV and violence
Weekly TV drama and radio call in show, linked with SRH services and organizations
BCC and condoms distributed through both van outreach and peer educators
Female peer educators and social support
Increasing male awareness and participation in RH services, including RTI/STI

Somos Diferentes, Somos Iguales
(We're Different, We're Equal)[64]

Country: Nicaragua

Implementing organizations: Puntos de Encuentro; Evaluation by PATH, Horizons/Population Council, the National Autonomous University of Nicaragua's *Centro de Investigacion de Demografia y Salud* (CIDS), local consultants, and *Puntos de Encuentro*.

This Nicaraguan project used a communications for social change strategy aimed at promoting the empowerment of young men and women and preventing HIV infection.The project considered *machismo* (a construction of masculinity that emphasizes power, aggressiveness, and sexual prowess, among other characteristics) as a risk factor for HIV/AIDS. *Somos Diferentes, Somos Iguales* used the weekly drama TV series *Sexto Sentido* (Sixth Sense), which was also broadcast in Costa Rica, Guatemala, Honduras, Mexico, and the U.S., and the call-in radio program *Sexto Sentido*, to promote the gender transformative and HIV-prevention messages. It worked with nearly 300 partners and local organizations to reduce access barriers and provide SRH services for young people.

The impact evaluation of *Somos Diferentes, Somos Iguales* included a cohort of 4,800 young peoples ages 13 to 24 who were randomly selected in three cities in Nicaragua in 2003 and who were interviewed three times (at the beginning, middle, and end of the intervention). Two hundred young people were included in focus group discussions and in-depth interviews with participants and non-participants. Baseline data found that young people had good knowledge about HIV/AIDS; however, AIDS-related stigma was prevalent and safer sex was not regularly practiced. The final survey found widespread exposure to the project, particularly the TV series *Sexto Sentido*, and that high exposure to project activities led to a significant reduction in stigmatizing and gender-inequitable attitudes, an increase in knowledge and use of HIV-related services, and a significant increase in interpersonal communication about HIV prevention and sexual behavior. The evaluation found that participants with greater exposure to the intervention had a 44 percent greater probability of having used a condom during last sex with a casual partner compared to their counterparts with less exposure to the intervention. It also found that men with greater exposure to the intervention had a 56 percent greater probability of condom use with casual partners during the past six months.

The evaluation highlighted that the SRH realities of Nicaraguan youth are complex and difficult to capture with simple outcome measures such as condom use, and that individual behavior is embedded in social contexts and processes. An interesting gender-related finding of the evaluation was that while, over time, the sample of young people moved toward greater equity in gender norms, that movement did not appear to result in changes in sexual norms that are also affected by gender relations.

64 Solórzano et al., 2008.

Men as Partners (MAP) Program[65]

Country: South Africa

Implementing organizations: EngenderHealth

The Men as Partners (MAP) Program, developed in 1996, has two interrelated goals.The first is to increase access to information and services that could improve men's sexual and reproductive health and to promote the constructive role that men could play in both the prevention of HIV/STIs and gender-based violence as well as in maternal care and family planning. The second goal is to actively promote gender equality by engaging men to challenge the attitudes and behaviors that compromise their own – and women's and children's – health and safety. The MAP program is based on applying three related elements of constructive men's engagement in both service delivery and community settings:

- That gender roles often give men the ability to influence and/or determine the reproductive health choices made by women;
- That gender roles also compromise men's health by encouraging men to equate a range of risky behaviors with being a "real man," while encouraging them to view health-seeking behaviors as a sign of weakness; and
- That men have a personal investment in challenging the current gender order and can serve as allies to improve their own health as well as the health of women and children who are often placed at risk of violence and ill-health by these gender roles.

An external evaluation of one MAP workshop in Western Cape, South Africa found that participants came away from the workshops with more equitable beliefs than were held by a comparison group of men. For example, workshop participants were three times as likely to believe that women should have the same rights as men and that it was not normal for men to beat their wives, and to be aware that children from abusive homes could become abusive parents and that sex workers could be raped.[66]

Yaari Dosti (Friendship/Bonding Among Men)[67]

Country: India

Implementing organizations: CORO and Horizons/Population Council with support from Instituto Promundo

This project is an adaptation of Program H for young men in Mumbai, India that was undertaken first as a six-month pilot program on gender, sexuality, masculinity, and educational activities with 126 young men.The evaluation of the pilot project included pre- and post-intervention surveys that used the GEM scale (see explanation in the case study of Program H on page 42) and other outcome measures and qualitative interviews with 31 participants. The survey findings were similar to those in Brazil: at the start of the program, a substantial portion of the young men supported many inequitable gender norms which shifted to much less support for inequitable gender norms after the program (most changes were significant at the $p<.05$ level). *Yaari Dosti* was then expanded to include a rural area of Uttar Pradesh and, in some sites, to include a community-based social marketing campaign to promote gender equality and HIV prevention.[68] The sample of young men included married and unmarried young men ages 16-29 in the urban areas and ages 15-24 in the rural settings. In the pre-intervention survey, 886 young men were included in Mumbai and 1,040 in Uttar Pradesh. The post-intervention surveys included 537 young men from Mumbai and 601 from Uttar Pradesh.

The findings were similar to those of the pilot. Gender-equitable beliefs and attitudes improved, partner communication got better, and there was a significant increase in condom use at last sex with all types of partners in the intervention sites. Logistic regression showed that men in the Mumbai and rural Uttar Pradesh interventions sites were more likely (1.9 times and 2.8 times, respectively) to have used condoms with all types of partners than in the comparison sites. Furthermore, self-reported violence against partners declined in the intervention sites.

65 Levack, 2001.

66 Kruger, 2000, cited in Levack, 2001.

67 Verma et al., 2006; see also Verma et al., 2008

68 Verma et al., 2008.

Play Safe[69]

Country: Cambodia

Implementing organizations: Reproductive Health Initiative for Youth in Asia; evaluation by CARE International.

This adolescent reproductive health project was conducted under EU/UNFPA's Reproductive Health Initiative for Youth in Asia (RHIYA). It incorporated concepts of gender equality and human rights into activities in response to growing evidence of criminal behavior toward women within Cambodia by middle class young men. The project used male peers as a way to engage young men with information about HIV/STIs and to change their behavior. Play Safe also seeks to empower young males to create positive social networks and to use them to encourage safe and responsible sexual practice. Information and behavior change communication (BCC) materials and messages and condoms were distributed through both van outreach and peer educators. An evaluation, carried out by CARE International in Cambodia, used primarily qualitative techniques, including a peer interview tool to collect data from 77 young people and the "most significant change (MSC)" technique, a story approach in which participants answer questions about change. The MSC was used to collect data from 20 peer educators and 40 youth. These techniques do not generate data representative of the group exposed to the project, but do provide in-depth explanations of behavioral outcomes and their potential associations with the project. Data were collected at two points during the project between 2004 and 2006.

The evaluation of Play Safe found that young men had a variety of sexual partner-

Improving Sexual Health for Men Who Have Sex with Men (MSM)

Among sexual minorities, gender relations and power dynamics within individual relationships and the community, and between those communities and larger societies, affect the vulnerability to and the impact of HIV/AIDS. For example, gender-related issues facing men who have sex with men (MSM) and transgendered (TG) people are complex and relate to stigma against same-sex relationships and against individuals whose behavior deviates from "accepted" masculine behavior in many societies. These populations lack power in society, are often socially marginalized, and have limited legal rights and protection. In addition, these populations are subject to gender-based violence – both within relationships and against MSM and TG by other groups. Much more work is needed to understand and address the gender dynamics among sexual minorities and societies, and the factors that increase vulnerability and magnify impact. Special care must be taken in reaching MSM and TG individuals with programs and services.

The three projects described in this box provide examples of gender-transformative approaches used to meet the needs of MSM, including promoting legal and social rights and social acceptance. All three took place in Asia.

Bandhu Social Welfare Society (BSWS) Project[70]

Country: Bangladesh

Implementing organizations: BSWS with FHI, USAID, and PEPFAR

The Bandhu Society began as a male reproductive health organization in 1997, offering counseling and services through outreach, drop-in centers, and health services. In 2000, FHI began supporting BSWS on a range of activities, including strengthening advocacy, research, and communication systems. BSWS adapted the Naz Foundation International sexual health promotion model or service framework, which consists of: center services, including drop-in services, counseling, education and training; field services, including outreach, community mobilization, condom and lubricant distribution, and referrals; and health services, including STI and general health treatment, HIV testing, and pre- and post-test counseling. BSWS also conducted sensitization meetings with media representatives and journalists, local leaders and elites, law enforcement agencies, activists, and students. They also held coordination meetings with representatives from government and non-governmental organizations and participated in World AIDS Day activities.

An evaluation was conducted of BSWS's activities, with outcomes assessed through Behavioral Surveillance Surveys (BSS) at two points in time. No outcomes were measured related to the advocacy and

69 Hayden, 2007.

70 FHI, 2007.

ships, ranging from "sweethearts" to casual partners to sex workers. Men's perceptions and treatment of these partners differed, with sweethearts being treated the best and sex workers often subjected to the degrading practice of *bauk*, or forced group sex—perceived by young men as a fun way to bond with buddies and have sex inexpensively. The second round of the evaluation found that the project was successful in reducing the practice of *bauk*, but only in that young men were more concerned about their own health rather than any awareness of the effects of *bauk* on women, who were in effect being gang raped. One conclusion reached by the evaluation was that, "While it appears that these young men are increasingly able to make 'safe' and 'responsible' decisions for themselves; to use condoms with 'risky' partners, access services, and seek information; they appear unable or unwilling to extend the concepts of safety and responsibility into their interactions with their female partners. Amongst the group of young men targeted by this research and Play Safe, this is clearly not an issue of knowledge, but of attitudes." In the evaluation, the messages related to gender concepts, social change, and human rights were the least well-recalled and least well-followed. The evaluation called for more research on gender identity in Cambodian youth culture and for stronger programs to help men develop alternative ways to express and affirm their masculinity that are respectful of women and promote gender equality and respect for rights. In this context, stronger gender-transformative approaches are needed in future interventions in order to impact gender norms related to masculinity and women's status that underlie the practices exhibited in *bauk*.

communication activities. The evaluation found a sharp increase in distribution of condoms from 6,672 in 2000 to 321,112 in 2004 and of lubricant from zero to 5,870 tubes during the same period. Risk perception rose from 3 to 30 percent and condom use with all partner types increased. Uptake of STI services also increased.

Aksi Stop AIDS (ASA)[71]

Country: Indonesia

Implementing organizations: FHI, USAID, and PEPFAR

This project sought to decrease HIV prevalence among MSM, male sex workers (MSW), and *waria* (transgender) populations in selected Indonesian provinces by increasing and sustaining safer sex and health seeking behaviors (including use of condoms and lubricants). In addition, ASA worked to create a favorable environment to support program implementation and behavior change through advocacy with government agencies and networking with other organizations. Outcomes were assessed through Behavioral Surveillance Surveys (BSS) and/or Integrated Biological and Behavioral Surveys (IBBS) in 2002 and 2004. The evaluation for *waria* found that all key sexual and health seeking behaviors showed increases during the two-year time period between BSS, including a number of statistically significant increases. However, testing remained low at 43 percent among *waria* in Jakarta and 20 percent in Surabaya. One benefit noted for the program for *waria* was that staff providing services were also *waria*, which facilitated contact with beneficiaries. BSS results for MSM and MSW showed positive trends in the two cities; however, given low coverage of the project, it is difficult to confirm the effect of the intervention on the results. No gender outcomes were measured.

In an analysis of the three interventions for MSM, the evaluation recommended that a stronger advocacy strategy be developed that "includes a local or field-level focus, with staff at different levels working more with local police officers, religious leaders, shopkeepers, guards and other gatekeepers, to enable staff to conduct field activities more effectively and to influence community norms."[72]

Blue Diamond Society[73]

Country: Nepal

Implementing organizations: Blue Diamond Society and FHI

In Nepal, MSM are stigmatized, harassed, and often subject to brutal violence. As a result, SRH services for this population have often been neglected by both the government and NGOs, while MSM are often

continued on next page

71 FHI, 2007.

72 FHI, 2007: 48.

73 FHI, 2007.

mothers2mothers (m2m) Program[74]

Country: South Africa

Implementing organizations: mothers2mothers (an NGO headquartered in South Africa); Evaluation by Horizons/Population Council with Health Systems Trust.

This program focused on prevention of mother-to-child transmission of HIV (PMTCT), empowering pregnant and postpartum women to improve their health and the health of their babies, fighting stigma, and encouraging and supporting disclosure.The program offered educational and psychosocial support to HIV-positive pregnant women and new mothers, assisted women to access PMTCT services, and followed up to ensure care of mothers and infants after delivery. The evaluation of the m2m program was undertaken in KwaZulu Natal, South Africa, by HORIZONS/Population Council in collaboration with Health Systems Trust, using a pre- and post-quasi-experimental design. At baseline, 183 HIV-positive pregnant women and 178 HIV-positive postpartum women were interviewed; at follow-up, one year after m2m was introduced, 345 HIV-positive pregnant women and 350 HIV-positive postpartum women were interviewed. In addition to a number of knowledge and practice outcomes that were measured, the evaluation assessed psychosocial well-being among the women. The evaluation found that the m2m program provided a strong continuum of care to the women and infants. Compared to non-participants, m2m participants had greater psychosocial well-being and greater use of PMTCT services and outcomes. Postpartum program participants were significantly more likely than non-participants to have disclosed their status to someone, and to have done so prior to delivery.

Integration of RH Services for Men in Health and Family Welfare Centers[75]

Country: Bangladesh

Implementing organizations: National Institute for Population Research and Training (NIPORT), Directorate of Family Planning, and FRONTIERS/ Population Council.

This intervention research study focused on training service providers about men's sexual health needs, raising awareness in the community about reproductive tract infections (RTIs) and sexually transmitted infections (STIs) in men, and improving RTI and STI services. The evaluation used a quasi-experimental non-equivalent control group design, with eight Health and Family Welfare Centers as intervention sites and four as control sites. Data were collected through service provider interviews, focus group discussions, inventory surveys, client exit inter-

Improving Sexual Health for Men Who Have Sex with Men (MSM) *continued from previous page*

hesitant to seek such services, leaving them more vulnerable to contracting HIV and other STIs. Since 2001, the Blue Diamond Society has worked to improve SRH of the MSM community in Nepal, employing five broad strategies, including behavior change communication (BCC), local advocacy and networking, social and community mobilization, links to services and products, and capacity building. The BCC has included group education meetings, distribution of materials, referrals for STI treatment and counseling, and condom distribution and demonstrations. The advocacy and networking activities addressed gender-related barriers to HIV prevention by seeking to raise awareness of the legal and social rights of MSM, improve social acceptance of this population, and inform and educate the MSM community. Meetings were held with various stakeholders, including NGOs, police, journalists, lawyers, and media. The Society coordinated events and special days as well as media campaigns. Film and documentaries were used to inform MSM on various issues such as sexual orientation.

FHI conducted an evaluation of the components of the Blue Diamond Society program that they started supporting in 2002, namely: behavior change communication, legal advocacy and networking, social and community mobilization, and linkages to services and products. The evaluation showed significantly increased knowledge and safer sex behaviors among MSM who were exposed to the interventions. Although evidence of police brutality persisted, the program appeared to increase awareness of the MSM community and the need to respect their rights.

74 Baek et al., 2007.

75 Hossain et al., 2004; Alam, Rob, and Khan, 2004.

views, and client registers. The intervention resulted in increases in male clients seeking services at the intervention clinics from 131 to 337 per month. Most, however, still came for general health issues. The number of male RTI/STI clients increased from one to more than five per month at intervention sites. Men were able to attend services during regular clinic hours. Adding RH services for men did not have an adverse affect on the number of female clients seeking services. Finally, the intervention resulted in increased knowledge among service providers about male reproductive health issues and RTIs/STIs. The study found that female service providers can successfully provide services to men.

Involving Men in Sexual and Reproductive Health[76]

Country: Ecuador

Implementing organizations: APROFE (Association for the Benefit of the Ecuadorian Family)

This initiative was undertaken as part of APROFE's efforts to increase the number of male clients receiving the organization's services. The initiative started in the mid-1990s and coincided with APROFE's efforts to become more financially sustainable, to improve quality of care, and to increase focus on gender equality throughout the organization. After an initial unsuccessful attempt at establishing male clinics, the Involving Men initiative sought to attract men to clinics attended by women. Providers encouraged clients to bring their partners and the organization used mass media to encourage men and couples to use APROFE's services. Hours in some clinics were extended to 7:00 pm and Saturday morning to accommodate work schedules. An evaluation was conducted by the Harvard School of Public Health through analysis of APROFE's documents, interviews with providers at all levels in four clinics, 28 semi-structured individual interviews, and four focus group discussions. From 1999 to 2000, the evaluation revealed an increase in the number of male clients who accompanied their partners, from an average 545 to 1,121 per month. The number of male clients who came alone also increased. For example, service statistics for urology visits registered an increase of almost 2,000 men in 2001. The gender issues raised by this intervention included the need to protect privacy of male clients and the need to get women's consent for the parts of the visits in which they wanted their partners to participate.

76 Shepard, 2004.

HIV/AIDS/STI CASE STUDY
INTERVENTION:

Tuelimishane ("Let's Educate Each Other")

COUNTRY: **Tanzania**
TYPE OF INTERVENTION: **Community theater and peer support**
IMPLEMENTING ORGANIZATIONS: **Tuelimishane Project**

Gender-Related Barriers to RH

In Dar es Salaam the links between HIV, violence, and infidelity are influenced by gender norms, expectations, and relationship structures that characterize youth sexual relationships, including transactional sex. Research has shown the link between transactional sex, HIV, and intimate partner violence (see more on IPV in chapter 5).

In Dar es Salaam, transactional sex is a survival strategy for some women. And in cases of infidelity or gender-based violence, women may be unlikely to stand up to their partners for fear of losing financial support.

Objective

The objective of the intervention was to reduce HIV-risk behaviors and reported violence by young men.

Strategy

The program was designed based on formative research among young men and women regarding the context of sexual relationships among youth at risk for HIV, including gender norms and roles, partner violence, and sexual behavior. The theme of transactional sex and the roles of young men and women in the practice also emerged in the formative research.

The intervention was composed of two main components: community theater and peer support groups. The community theater groups developed three skits, each focusing on a different theme (sexual communication, infidelity, and conflict resolution.) There were a total of 21 public performances in locations where young men frequently hang out. The performances communicated information regarding violence, sexual negotiation, sexual responsibility, and HIV risk, and engaged the audience in discussion surrounding the main theme. Low-literacy print comics were also distributed.

Peer support groups of 10-12 young men were formed to create a safe place to discuss topics related to social norms, gender, HIV/AIDS, infidelity, sexual communication, and conflict resolution. The support groups developed key messages that were used in the drama intervention, and then reinforced those messages. In addition to the same-sex peer groups, mixed-sex and mixed-age groups were formed to encourage dialogue across a broader audience and to give young men the opportunity to hear different perspectives related to sexual behavior and gender-based violence.

Evaluation Design: Pretest-posttest control group design

The evaluation consisted of four phases: formative, baseline survey, implementation, and post-intervention research. Forty men and 20 women (ages 16-24 years) were interviewed and 14 focus groups were conducted during the formative phase. A community mapping exercise identified social venues for youth, transportation routes, and other community features that could affect the intervention. Baseline surveys were conducted in the intervention and control sites, with 503 and 448 respondents, respectively.

Table 4.2

Reproductive Health Outcomes

VARIABLE	CONTROL	INTERVENTION
Did *not* use condom during last sex with primary partner	78 (56.9%) N=137	91 (44.8%) N=203
Condom use reported less than half the time with partners in past 6 months	70 (55.1%) N=127	60 (36.4%) N = 165
Proportion of men who agree or strongly agree with statement that violence vs. women could be justified if:		
She does not complete household work	53 (20.6%) N = 257	25 (8.3%) N = 301
A woman disobeys her partner	61 (23.7%) N = 257	29 (9.7%) N = 300
He suspects she is unfaithful	32 (12.4%) N = 258	17 (5.6%) N = 302
He learns she is unfaithful	56 (21.7%) N = 258	26 (8.6%) N = 301
She asks him to use condoms	26 (10.2%) N = 256	13 (4.3%) N = 301

Source: Mbwambo and Maman, 2007.

Table 4.3

Gender Outcomes

SIGNIFICANT GENDER OUTCOMES	OF THOSE WHO AGREED/STRONGLY AGREED AT BASELINE, PROPORTION OF MEN WHO DISAGREED/STRONGLY DISAGREED AT ENDLINE	
	CONTROL	INTERVENTION
Men should have the final say in all family matters	34 (19.0%) N=179	104 (51.2%) N=203
There is nothing a woman can do if her partner wants to have other girlfriends	43 (47.3%) N=91	81 (80.2%) N=101
A wife should tolerate being beaten to keep the family together	59 (46.5%) N=127	72 (61.0%) N=118
A woman needs her husband's permission to work	31 (14.4%) N=215	68 (30.4%) N=224
It's a woman's job to take care of her home and cook for her family.	37 (17.5%) N=212	94 (42.3%) N=222

Source: Mbwambo and Maman, 2007.

The baseline surveys recorded information regarding demographics, gender roles and norms, attitudes toward and experiences of violence, HIV risk behaviors, and use of physical and sexual violence. The post-intervention assessment interviewed a total of 315 men in the intervention community (62.6%) and 266 men in the control community (59.4%). The post-intervention and baseline survey were identical in the control community, with an added section on intervention exposure for men in the intervention site. Female partners of 20 men were interviewed as part of the post-intervention assessment.

Reproductive Health Outcomes

Two of the six variables measuring HIV-risk behaviors were found to be significant. Men in the intervention community were significantly more likely to have used a condom during their last sexual experience and in the past six months.

While there were no significant differences regarding reported use of violence, the study did find improvement in attitudes, with men in the intervention village significantly less likely to report that violence against women is justified under various scenarios.

Young men in the intervention community were significantly more likely to have favorably changed their attitudes regarding gender norms. In an interview, one 20-year old female partner said, "Yes, for example, our communication has become much better than the way it used to be; now he shows that he understands me and he agrees with most of the things which I advise him."

Limitations

It was difficult to keep men engaged in the peer support component of the intervention, perhaps because in urban settings like Dar es Salaam many of the men migrate. In rural settings, where young men are less mobile, a 12-month program may be more successful in keeping men engaged.

Conclusions

This community-based communication intervention was designed to reduce rates of HIV-risk behaviors and reported use of violence by young men. The evaluation showed some evidence that men had changed their behaviors related to condom use for HIV prevention. Though there were no significant changes in use of violence, results showed significant changes in norms and attitudes regarding violence among men in the intervention community.

Youth who participated in the drama group portrayed stories that happened within their own community. The participatory nature of the community drama intervention demonstrated that solutions to combating HIV/AIDS are available from within the community itself. Youth were able to develop a deeper understanding of HIV/AIDS and capacity to communicate about these issues with other community members.

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HIV/AIDS/STI CASE STUDY

INTERVENTION:

Stepping Stones

COUNTRY: **South Africa**

TYPE OF INTERVENTION: **HIV prevention**

IMPLEMENTING ORGANIZATIONS: **Medical Research Council**

Gender-Related Barriers to RH

In South Africa, gender norms influence male and female power dynamics, resulting in gender-inequitable intimate relationships. Norms limit women's agency in many areas, including restricting their ability to negotiate sex and to demand condom use from their partners. This is particularly true of partners of migrant laborers who are most at risk of HIV and others STIs. Because educational and economic opportunities for women are limited, some women use transactional and commercial sex work as a survival strategy, and research has shown the link between these behaviors and increased HIV risk.

Objective

Stepping Stones is a gender-transformative HIV-prevention program that aims to improve sexual health through building stronger, more gender-equitable relationships with better communication between partners.

Strategy

The Stepping Stones intervention is implemented using participatory learning approaches in single-sex peer groups. The evaluation was implemented from 2003 –2005. Eleven same-sex project staff members, slightly older than the participants, were trained for three weeks prior to implementation. They facilitated the sessions (described below), employing adult education methods including role play, spider diagrams, and similar exercises.

The program contains 13 sessions, each three-hours long, and three peer group meetings. The issues covered in the 13 sessions include reflecting on love, sexual health joys and problems, body mapping, menstruation, contraception and conception (including infertility), sexual problems, unwanted pregnancy, HIV/STIs, safe sex, gender-based violence, motivations for sexual behavior, and dealing with grief and loss. The intervention relied on same-sex peer groups "as this format gives the best opportunity for frank discussion and a supportive environment for exploring behaviour change."[77] The male and female groups were conducted in parallel sessions and came together in three meetings to present exercises and promote dialogue. During these three sessions, groups present exercises they have been working on that promote dialogue and communication.

The second intervention (the control arm) was a single two- to three-hour session with exercises about HIV and safer sex practices drawn from the Stepping Stones curriculum.

Efforts were made to gain community support for the project by involving important stakeholders and holding community meetings. The project had an active community advisory board composed of members from Departments of Health and Education, from municipalities, local traditional leaders, the National Association for People with HIV/AIDS, the University of Transkei (UNITRA), and young people approximately the same age as study participants.

Evaluation Design: Cluster randomized-controlled trial

The evaluation was completed in 70 clusters (each cluster was usually a village) at least 10 kilometers apart. Study participants included 1360 men and 1416 women, ages 15–26 years. Study villages were assigned to receive either the complete Stepping Stones intervention or the single 2-3 hour session control. Participants were interviewed prior to the implementation and gave blood for an HIV and Herpes test. Participants were re-interviewed and re-tested 12 and 24 months after the first interview.

Qualitative research was completed in two of the clusters with 10 women and 11 men. Each participant was interviewed prior to and after participating in Stepping Stones.

Reproductive Health Outcomes

Women in the intervention arm had 15 percent fewer new HIV infections than those in the control arm [incidence rate ratio = 0.85 (95% CI: 0.60, 1.20)] and 31 percent fewer Herpes infections [incidence rate ratio =

77 Jewkes et al., 2006: 5.

0.69 (95% CI: 0.47, 1.03)]. Neither was significant at the 5% level.

Findings did, however, show significant improvement in a number of reported risk behaviors in men, with men reporting fewer partners and higher condom use, as well as less transactional sex, perpetration of intimate partner violence, and substance use. The same behavior changes were not found in women, and there was actually an increase in transactional sex. This finding could be linked to possible under-reporting of sexual activity by women at baseline.

Gender Outcomes

Qualitative data suggest that the intervention improved couple communication and increased men's and women's awareness that violence against women was wrong.

Limitations

The scope of the Stepping Stones intervention for the randomized control trial, including the age ranges included, was limited by resources available for the study and the evaluation. A large proportion of the participants did not attend all the sessions and, therefore, the full impact of the intervention may have been underestimated. Another limitation is that an overly optimistic assumption about the reduction in HIV infections limits the statistical analysis due to a small sample size.

Replication

The Stepping Stones intervention was initially developed for use in Uganda. Over the last 10 years the intervention has been used in 40 countries, adapted for at least 17 settings, and translated into at least 13 languages. Stepping Stones has developed an adaptation guide, to provide guidance to organizations adapting the program for the first time or for organizations wishing to make changes to an existing Stepping Stones curriculum.

Conclusions

Evaluation of the Stepping Stones program suggests that the intervention reduced new HIV and other STI infections among women. The intervention showed significant improvement in reducing risk behaviors in men. The program has been widely replicated throughout the world, and translated into multiple languages.

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HIV/AIDS/STI CASE STUDY

INTERVENTION:

Program H

COUNTRY: **Brazil**

TYPE OF INTERVENTION: **HIV/AIDS prevention**

IMPLEMENTING ORGANIZATIONS: **Instituto Promundo**

COSTS: **$35,856.97 (group education and lifestyle marketing campaign n = 258); and $21,060.28 (group education only n = 250). Cost analysis for replications of Program H has shown intervention costs to range from $25,000 - $50,000.**

Gender-Related Barriers to RH

In Latin America there exist many traditional beliefs on masculinity, including that men have more and stronger sexual urges than women, men have the right to decide when and where to have sex, sexual and reproductive health issues are women's concerns, men have the right to outside partners or relationships, and men have the right to dominate women. These traditional macho beliefs promote inequitable intimate relationships and sustain and support risky behaviors among men who have internalized such norms. Women are often unable to negotiate safe sexual practices with their partners. Additionally, women are unlikely to carry out risk-reducing or protective behaviors, such as carrying condoms with them, for fear of gaining a reputation of being promiscuous.

Objective

The study examined the effectiveness of interventions designed to improve young men's (ages 14–25) attitudes toward gender norms and to reduce HIV/STI risk.

Strategy

The intervention focused on helping young men to question traditional norms related to masculinity and to discuss inequitable gender-related views and the advantages of more gender-equitable behaviors. It used group education activities that encouraged reflection on what it means to "be a man."

Intervention activities included two main components: a field-tested curriculum used in same-sex groups and a lifestyle social marketing campaign. One intervention site, Bangu, received both the group education and lifestyle social marketing campaign, and the second site, Maré, received only the group education component.

The group education component contained: 1) a 20-minute no-word cartoon video highlighting one man's experiences from childhood to early adulthood; and 2) 70 activities (role plays, brainstorming exercises, discussion sessions, and individual reflection) covering five themes (sexuality and reproductive health, fatherhood and care-giving, from violence to peaceful coexistence, reasons and emotions [including communication skills, substance abuse, and mental health], and preventing and living with HIV/AIDS). Weekly two-hour sessions were held over a period of six months. Five male facilitators were trained on the rationale for the intervention; intervention materials; study objective, design, and methodology; timeline for group activities; and logistics.

The social marketing campaign (a behavior change communication campaign) promoted a more gender-equitable lifestyle and HIV/STI/violence prevention at the community level, reinforcing the messages given in the group education sessions. Peer promoters, young men recruited from the community, helped to implement the campaign. They identified sources of information and cultural outlets in the community. They also developed intervention messages using radio spots, billboards, posters, postcards, and dances, about how "cool and hip" it was to be a gender-equitable man. Additionally, the campaign presented condom use and negotiation as elements of a gender-equitable lifestyle, aiming to increase the availability of a new condom brand (Hora H) through strategic distribution, including bars, community dances, and parties.

Evaluation Design: Quasi-experimental control design

The Gender-Equitable Men (GEM) Scale was used to determine men's attitudes toward gender norms at baseline (n = 780) and post-intervention in three sites (two intervention and one control/delayed.) Multivariate logistic regression analyses for correlated data were used, controlling for age, family income, and education.

Reproductive Health Outcomes

Findings indicate that improvements in gender norm scale scores were associated with changes in at least one key HIV/STI risk outcome (e.g., STI symptoms, condom use). For both intervention sites, positive changes in attitudes toward inequitable gender norms over one year was significantly associated with decreased reports of STI symptoms ($p < .001$). In the intervention sites of Bangu and Maré, young men were approximately four times and eight times less likely to report STI symptoms over time, respectively. A significant association was not found for condom use, but a trend in the

expected direction was seen in one intervention village.

Gender Outcomes

At six months, agreement with inequitable gender norms significantly decreased in both intervention sites (10 out of 17 items improved in Bangu and 13 out of 17 items improved in Maré). These positive changes were sustained at the one-year follow-up period. Only one out of 17 items improved in the control area.

Limitations

Similar to other interventions involving young men, Program H struggled with attendance issues. Nearly 30 percent of the participants attended the majority of the sessions, while more than 50 percent of the participants attended less than half. Work was the number one reason given for missing a session. Among participants who attended the majority of the sessions and those who attended less than half, there were no significant differences in work status, age group, education level, number of sexual partners, and attitudes toward gender at baseline. Monitoring data showed that some groups had higher than average participation rates, and some facilitators were more successful in generating interest and consistent participation.

Replication

Program H has been replicated in several places throughout Brazil and the world. An evaluation of *Yaari Dosti* (Program H replicated in Mumbai, India, see page 33) showed similar gender outcomes, with significantly more men supporting gender-equitable norms.

Two additional programs, Program M and Program D, have been developed utilizing the same strategies as Program H to promote young women's health and reduce homophobia, respectively.

Conclusions

The young men in the study, from three low-income communities (*favelas*) in Rio de Janeiro, started the study reporting substantial risk of HIV and STIs. Support for inequitable gender norms and roles was significantly associated with HIV risk. The program resulted in significantly smaller percentages of young men supporting inequitable gender norms. Significant improvements were also found in HIV/AIDS outcomes, including STI symptoms and condom use, particularly in the area with the combination of group discussions and social marketing. Decrease in support for inequitable gender norms was associated with decreased reports of STI symptoms.

The positive changes in attitudes toward gender norms were equally significant for both groups of young men exposed to either the combination intervention or education activities alone. This implies that the group education component was likely most successful in addressing gender-related attitudes. However, findings show changes were often greater for young men exposed to the combined intervention. This highlights the importance of both interpersonal and community-level communication strategies.

Evaluation of Program H illustrates the link between gender-inequitable attitudes and HIV/STI risk behaviors and outcomes. It also shows that group education programs focusing on gender-equitable relationships and BCC campaigns combating inequitable gender norms can lead to more gender-equitable relationships and improved HIV/STI outcomes.

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5 Harmful Practices: Barriers to Reproductive Health

Although the 2004 "So What?" report did not include a chapter devoted to harmful practices, this chapter has been added in this publication for two reasons: first, because of the substantial role of such practices in undermining RH, especially among young women; and second, because some of the most innovative, gender-transformative work in the reproductive and sexual health field focuses on the reduction of harmful practices. Interventions are classified here by three types of harmful practices: early marriage and childbearing (EM&C); female genital mutilation/cutting (FGM/C); and gender-based violence, specifically, intimate partner violence/sexual violence (IPV/SV).

PROGRAM	COUNTRY
EM&C:	
Behane Hewan	Ethiopia
Building Life Skills to Improve Adolescent Girls' Reproductive and Sexual Health	India
CASE STUDY: Delaying Age at Marriage in Rural Maharashtra	India
FGM/C:	
Navrongo FGM/C Experiment	Ghana
Awash FGM/C Elimination Project	Ethiopia, Kenya
Five Dimensional Approach for the Eradication of FGM/C	Ethiopia
CASE STUDY: Tostan Community-based Education Program	Senegal
Gender-Based Violence:	
Soul City	South Africa
Through Our Eyes	Liberia
One Man Can Campaign	South Africa
CASE STUDY: Intervention with Microfinance for AIDS and Gender Equity (IMAGE)	South Africa

I. Early Marriage and Childbearing

Early marriage and childbearing (EM&C) is associated with a wide range of negative social and health consequences. It is an abuse of girls' human rights, robbing them of educational and economic opportunities as well as the chance simply to be children. In some settings, marriages are arranged in infancy and there is variation in the age at which co-habitation begins. In other settings, both the husband and the wife are married in their teenage years. Often, however, female brides are much younger than their husbands, and they are unready for sex, especially with an older stranger. In these situations, sexual initiation after an early marriage often amounts to socially sanctioned rape, in some cases legal, and in others (where marriages take place before the statutory minimum age) technically illegal but virtually never prosecuted.

Early marriage almost always leads to early childbearing.[78] About 15 million young women between 15 and 19 years of age give birth every year, accounting for over 10 percent of the births worldwide. Most of these young mothers are married.[79] Early childbearing has been shown to contribute to mortality and morbidity during pregnancy, labor, and delivery, and increases the risk of premature births.[80] It also contributes to rapid population growth. In countries where contraceptive use is at least moderately high, increasing the number of years between generations by increasing the age at which women begin having children may have a greater impact in reducing population growth than further reducing fertility rates.[81]

EM&C Interventions

The three EM&C interventions reviewed are broad in focus. All employed gender transfor-

78 Adhikari, 2003.

79 ICRW, 2004.

80 UNICEF, 2001.

81 Bongaarts, 1994; Caldwell and Caldwell, 2003.

mative approaches and sought to influence attitudes and behaviors of a range of community stakeholders. One of them, **Delaying Age at Marriage In Rural Maharashtra**, is one of the case studies (see p. 52). It is a life skills education project with unmarried adolescent girls on a variety of topics.

Table 5.1 lists the gender strategies used to reduce early marriage and childbearing in the projects reviewed.

Table 5.1

Strategies Used to Reduce Early Marriage and Childbearing (EM&C)

Strategies
Encourage boys and girls to examine notions of gender
Include messages about risks of early marriage and childbearing
Increase skills of providers to reach young women and men
Sensitize communities about EM&C
Institute life skills for unmarried adolescent girls (nutrition, self-esteem, and age at marriage)

Behane Hewan[82]

Country: Ethiopia

Implementing organizations: Ethiopian Ministry of Youth and Sport, with the Amhara Regional Youth Bureau, and UNFPA, with technical assistance from the Population Council

This pilot program in a village in rural Ethiopia sought to sensitize communities to the risks and disadvantages associated with child marriage, promote education to prevent early marriage among adolescents, and provide support for girls who were already married. The interventions included social mobilization of adolescent girls who formed groups led by female mentors, with encouragement to stay in school, nonformal education and livelihood programs for out-of-school girls, community dialogue on early marriage and health issues affecting girls, and fiscal incentives to families who did not marry off their daughters during the project period.

Using a quasi-experimental case control design, the Behane Hewan program evaluation focused on four areas of interest: education, social networks and participation, marital status, and RH. The evaluation results showed significant impacts in all four areas:

- Girls in the intervention village were three times as likely to be in school as girls in the control village;
- Knowledge and communication on HIV, STIs, and FP increased in the intervention village, compared with the control village;
- Younger adolescents (ages 10-14) were 90 percent less likely to be married than control group girls of the same age;
- Not a single girl ages 10-14 in the intervention area was married during the year between the two surveys (although marriages in this village accelerated after the age of 15 years, probably because the expectation that girls should marry during adolescence persisted); and
- Use of contraception among girls, which was at comparable levels in the two sites at the beginning of the project, was three times higher in the intervention village at the end of the project.

Building Life Skills to Improve Adolescent Girls' Reproductive and Sexual Health Project[83]

Country: India

Implementing organizations: ICRW with Swaasthya

This intervention was carried out by ICRW with Swaasthya in two urban slums in Delhi. The program provided life skills education for unmarried adolescent girls, focusing on girls' age at marriage, self-esteem, and nutritional needs. The project in the first site, Tigri, ran from 1998-2001, followed by a sustainability study ending in 2005; a replication at the second site, Naglamachi, ran from 2003-2006. While the target participants for the program were unmarried girls, Swaasthya also included a component to encourage adults to be more supportive of adolescent girls and sensitive to their needs.

The Building Life Skills Project was evaluated using baseline and endline surveys without control groups. In one site, the evaluation found that exposure to skills-building modules, social support, and one-on-one interaction with a Swaasthya fieldworker was associated with high knowledge of sexual and reproductive health among the unmarried girls and young

82 Erulkar and Muthengi, 2009.

83 Pande et al., 2006.

women involved in the project, a strong perception of support from mothers and other gatekeepers, and a positive perspective on life. In the second, more socially conservative site, the findings were weaker. The sustainability analysis in the first site showed that some outcomes, such as changes in knowledge, were largely sustained, but that the program interventions were not continued by Swaasthya fieldworkers after outside support was withdrawn. Knowledge of sexual and reproductive health also decreased, suggesting that consistent input is needed to maintain knowledge among this target group.

II. Female Genital Mutilation/ Cutting (FGM/C)

The practice of FGM/C affects between 100 million and 140 million women and girls worldwide, most of whom live on the African continent. In some settings, the cutting is much more extensive than in others. The practice of FGM/C tends to be associated with particular ethnic groups more than with nations or religions, socio-economic status, or educational levels.[84] In Kenya, for example, almost all women of reproductive age among the Somali, Kisii, and Maasai ethnic groups have undergone some type of FGM/C.[85] Forms of FGM/C range from infibulation, the most severe, in which all external genitalia is removed and the vaginal opening is stitched and narrowed, leaving a small hole for urine and menstrual flow, to less extreme cutting in which the clitoris or clitoral hood is nicked or removed.[86] FGM/C can lead to immediate complications, such as hemorrhaging and infection. The more severe forms can lead to long-term effects, such as poor maternal and newborn health outcomes, prolonged labor, and socially debilitating conditions such as malodorous urine retention or painful and difficult sexual relations with resulting problems between couples.[87]

In the last two decades, FGM/C has gained international recognition as a health and human rights issue and funding for intervention projects and research has increased. The most promising approaches include community-based solutions and addressing rights as well as the social, legal, economic, and health dimensions of FGM/C. Several donor organizations have reached consensus about the most effective approach to FGM/C interventions, as articulated in "Toward a Common Framework for the Abandonment of FGM/C".[88]

FGM/C Interventions

The four FGM/C projects reviewed are all set in Africa, and all four approaches are gender transformative to some extent. The projects combine FGM/C interventions with interventions on other topics and all have emphasized community involvement, taking into account community attitudes regarding gender roles. The case study presented here is **Tostan's Community-Based Education Program**. This Senegalese NGO project seeks to transform cultural norms rather than just behavior (see p. 54). Tostan, plus two of the other interventions — by Navrongo and CARE — have been extensively evaluated, while IntraHealth's intervention in Ethiopia had a much more limited evaluation.

Table 5.2 lists the gender strategies used in the projects to reduce FGM/C that were reviewed.

Navrongo FGM/C Experiment[89]

Country: Ghana

Implementing organizations: Navrongo Health Research Center (NHRC)

This project employed a mixed gender strategy—transformative in attempting to influence cultural expectations regarding girls and women, but also accommodating gender expectations by training girls in domestic tasks as they would be trained as part of the rituals surrounding FGM/C. The objective of the project was to accelerate abandonment of FGM/C in six villages of the Kassena-Nanka district of Northern Ghana. The project employed a strong community engagement and mobilization component, using an approach known locally as *alagube* ("connoting the process by

84 Chege et al, 2004; see also PRB, 2008.

85 Kenya DHS, 2003.

86 WHO, 2008.

87 See H. Jones et al., 1999; L. Morison et al., 2001; WHO, 2006; PRB, 2008.

88 UNICEF, 2007.

89 Feldman-Jacobs and Ryniak et al., 2006.

which people solve a common problem by pooling their individual and community social resources").[90] The target audience (women and adolescent girls) was involved in one of three sets of activities: 1) FGM/C-related education alone; 2) livelihood and development activities alone (such as learning how to do handicrafts or about micro-lending); and 3) a combination of FGM/C education and livelihood and development activities. In both the education and livelihood and development sessions, women and girls met in large groups (70 participants) twice monthly for two-hour sessions.

The project used a "4-cell experiment" design, with each cell, or community, receiving one of four interventions: 1) No intervention or control group; 2) education activities; 3) livelihood and development activities; 4) combination of education and livelihood and development activities. A baseline survey covered 3,221 respondents; follow-up surveys were undertaken each year between 1999 – 2003 to monitor and evaluate outcomes. Cox Proportional Hazard regression models were used to analyze the survey data and measure the impact of the interventions on girls' likelihood of being cut. The results of the analysis indicate impressive reductions in FGM/C in the experimental groups: one year of the FGM/C education strategy was associated with a 93 percent decrease in the risk of being cut; one year of the combination education plus livelihood was associated with a 94 percent decrease in the risk, compared to the control group. However, substantial reductions of FGM/C in the comparison area plus the reliability of self-reporting on a practice that is against the law in that country, raise questions about the validity of the responses.

Table 5.2

Strategies Used to Reduce Female Genital Mutilation/Cutting (FGM/C)

Promote model for change: girls right to education; women's union to demand rights; strengthening women's position in the family
Influence cultural expectations regarding girls and women
Train girls in domestic tasks they would learn as part of FGM/C rituals
Promote dialogue between women and men on gender and FGM/C health-related issues

Awash FGM/C Elimination Project[91]

Country: Kenya and Ethiopia

Implementing organizations: CARE with local organizations and Population Council

This project sought to empower women to attend and participate in meetings to discuss health-related issues with their male partners. Set in six villages in Ethiopia and two refugee camps in Kenya, the project focused on behavior change communication (BCC) education and advocacy, with an emphasis on creating dialogue between women and men on FGM/C and other topics related to health and gender, and strengthening spousal communication regarding family planning. A variety of communication channels were used: a) meetings with community groups, women's groups, health education groups, and schools; b) performances by popular theatre groups; c) evening video sessions that showed recorded discussions by religious leaders speaking out on FGM/C issues; and d) mass media activities. CARE believed that the feasibility of these projects depended on FGM/C being linked with a broader set of RH issues rather than as a stand-alone intervention, thus reducing the danger of it being seen as an agenda imposed by outsiders.

The Population Council/FRONTIERS conducted an operations research study that compared two Awash interventions, each with a control group. Using a quasi-experimental design, the intervention sites were purposively selected to correspond to Awash FGM/C Elimination project areas and nearby sites were selected for comparison purposes. The actual intervention, which began with the introduction of expanded (in Kenya) and new (in Ethiopia) FGM/C abandonment activities, occurred over a 21-month period from January 2001 through June 2002 (in Kenya) and October 2002 (in Ethiopia). The study assessed the effectiveness of BCC and advocacy activities versus no interventions in Ethiopia, while in Kenya the comparison was between BCC strategies alone and the combination of BCC and advocacy activities.

The interventions were more successful in Ethiopia than Kenya. In all knowledge and atti-

90 Feldman-Jacobs and Ryniak et al., 2006.

91 Care, 2005.

tude indicators assessed, the intervention site in Ethiopia showed more positive change than Kenya, and it is not clear if the advocacy strategy added much value to the intervention in Kenya. Moreover, in Kenya the comparison site performed better on all attitude and intended behavior indicators. The evaluators attributed this unexpected result to a failure to implement the advocacy strategy effectively as well as to pre-existing socio-economic differences in the intervention and control populations. In both countries the study designs were not adhered to; project interventions as well as influences from outside the project affected the outcomes of interest. They also cited contamination in the study design in both Kenya and Ethiopia due to population movements into and out of the intervention and comparison areas.

In both countries, there was active public debate on the merits of continuing the practice, and some uncut girls, men, women, and families publicly stated that they did not want to continue the practice. In both countries, traditional leaders began to address the issue of protection of those wishing to remain uncut, an area of adjudication never-before addressed. In Ethiopia, 70 elders made open declarations that their villages would henceforth not cut their daughters.

Five-Dimensional Approach for the Eradication of Female Genital Mutilation/Cutting[92]

Country: Ethiopia

Implementing organizations: IntraHealth International

The objective of this multi-pronged project was to both increase knowledge about FGM/C and to change behavior. It encouraged women's empowerment while acknowledging their lack of power by helping them to voice their concerns about FGM/C to influential men. Abandonment of FGM/C was addressed through five perspectives: health, gender, law/human rights, religion, and information. IntraHealth emphasized community empowerment and mobilization along with advocacy to encourage long-term sustainability. Undertaken from 2003-2005, the project was introduced across eight sites in regions with higher than average prevalence of FGM/C (in one site it was as high as 99 percent). While the project was designed to include all community members with a stake in the practice of FGM/C, specific groups were identified and targeted through tailored interventions. More than 4,200 community members, both men and women, participated in the project's training, information, education, and communication community mobilization activities, and many more were reached through related national and local media programs, including broadcasts on television and radio, and printed materials in local languages. Interventions included national and regional workshops, training of trainers, community leadership training and community mobilization, Public Declarations, and a religious leaders' forum.

As a result of one IntraHealth workshop, teachers, media, and religious leaders joined together to make a public declaration that they would work to stop gender inequities and oppression and the practice of FGM/C. The project also formed associations of non-circumcised girls and mothers of non-circumcised girls as well as a community network to protect girls from FGM/C and report any occurrence to the regional gender bureau and police station. The qualitative evaluation conducted by IntraHealth included focus group discussions with community leaders and suggested a change in attitudes regarding marriage to non-circumcised girls. However, there was no substantiation of attitudinal or behavior change. Plans to do a quantitative evaluation were disrupted by calls for a national election, which occupied many of the community leaders.

III. Gender-Based Violence

Gender-based violence, including intimate partner violence (IPV) and sexual violence (SV), are worldwide public health problems associated with a wide range of negative physical, psychological, social, and economic consequences for abused women themselves and for children whose mothers are exposed to violence.[93] The reported prevalence of IPV/SV varies considerably across settings. A multi-country WHO study reported rates as

92 Feldman-Jacobs and Ryniak et al., 2006.

93 Garcia-Moreno et al., 2005; Heise and Garcia-Moreno, 2002; Heise, Ellsberg, and Gottemoeller, 2002; Heise, Pitanguy, and Germain, 1994.

high as 71 percent in rural Ethiopia and between 21 and 47 percent in most countries.[94] In analyses of data from the Demographic and Health Surveys (DHS) conducted between 1995 and 2004 in 12 countries, prevalence of domestic violence ranged from 18 to 53 percent.[95]

Gender-Based Violence Interventions

The gender-based violence (GBV) interventions featured here focused on intimate partner violence (IPV), physical violence perpetrated by men against their female partners, as well as sexual violence (SV). Although psychological violence is also a common form of IPV/SV, none of the interventions directly addressed it, perhaps because it tends to be more subjectively defined and, therefore, difficult to measure. Like many of the EM&C and FGM/C interventions described above, the projects with documented success in addressing IPV/SV also adopted multi-sectoral, multi-dimensional approaches to reducing harmful practices. All of the evaluated interventions that were found on IPV/SV were gender transformative in nature as they sought to change a harmful behavior rooted in gender inequality. They all were situated in Africa, particularly in South Africa, where rates of IPV/SV are among the highest in the world.[96]

Only one of the four interventions discussed in this GBV section focuses primarily on engaging men: the One Man Can Campaign in South Africa. The objective of this project is to stop IPV/SV, promote healthy relations, and prevent HIV/AIDS. (Another example from South Africa, "Men as Partners," is described in the chapter on HIV/AIDS; and "Visions," a nonformal education program for youth in Egypt described in the youth chapter, also includes the topic of IPV/SV.) Soul City and IMAGE (case study, p. x) had the most rigorous evaluations.

Table 5.3 lists the gender strategies employed in the projects reviewed to reduce IPV/SV.

94 Garcia-Moreno et al., 2005.

95 Kishor and Johnson, 2004.

96 Mathews et al., 2004.

97 Usdin et al., 2005.

Table 5.3

Strategies Used to Reduce Intimate Partner Violence/Sexual Violence

Strategies Used to Reduce Intimate Partner Violence/Sexual Violence
Engage men to stop violence against women through participatory workshops and community interventions
Institute microfinance-based poverty alleviation programs and participatory trainings
Address individual, community, and socio-political levels – 'edutainment'
Amplify voices from within the community through participatory community engagement in producing video tapes on IPV/SV and health issues
Create action kits to engage men in stopping violence against women

Soul City[97]

Country: South Africa

Implementing organizations: South African Soul City Institute for Health and Development Communication (a multi-media health promotion project) working with the National Network on Violence Against Women

This project began with the premise that behavior change interventions aimed solely at individuals have limited impact. Soul City, therefore, sought to influence women and men at multiple mutually-reinforcing levels — individual and community as well as socio-political environment — through prime-time radio and television dramas and print material. This method has been dubbed "edutainment," where social issues are integrated into entertainment formats such as television and radio to reach marginalized rural communities in particular.

Domestic violence was the major focus in Soul City's fourth television and radio series, aired between July and December 1999. The intervention sought to create an enabling environment for behavior change by advocating for the implementation of the 1998 Domestic Violence Act (DVA). The series provided role models for the use of the DVA and a helpline was established to provide more information. The series also promoted interpersonal and community dialogue and encouraged collective efficacy and action to shift social norms, increase supportive behavior, and link people to sources of support. At the individual level, the intervention aimed to influence knowledge, awareness, attitudes, self-efficacy, intention to change, and practices.

The evaluation of Soul City was multifaceted, consisting of several inter-related studies, triangulated to improve validity of the results. These included national-level pre/post surveys and a qualitative impact assessment using 29 focus groups and 32 in-depth interviews. The evaluation showed an impact on attitudes, help-seeking behaviors, and participation in community action, though not in the actual incidence of IPV/SV.[98] There was a shift in knowledge regarding domestic violence, with 41 percent of respondents gaining knowledge about the project's helpline. Attitudinal shifts following the intervention include a 10 percent increase in respondents disagreeing that IPV/SV is a private affair and a 22 percent shift in perceptions of social norms regarding IPV/SV. Differences between male and female respondents on these outcomes were not reported.

The evaluation concluded that 1) the intervention played a decisive role in implementation of the Domestic Violence Act, and 2) a strong association existed between exposure to the intervention and a number of factors indicative of and necessary to bring about social change.

Through Our Eyes[99]

Country: Liberia

Implementing organizations: The American Refugee Committee (ARC) and Communication for Change

This is a unique behavior change project set in Liberian refugee camps and launched in 2006 by Liberian refugees in Guinea with support from the American Refugee Committee (ARC) and its partner, Communication for Change. By producing video tapes on the subjects of IPV/SV and health issues, which are played back to the community, it aims to amplify voices from within the community through participatory community engagement. The Liberia-based team has produced more than 30 videos and conducted dozens of playback sessions about such highly sensitive subjects as rape, forced marriage, teenage prostitution, unintended pregnancy, STIs, and equal rights for women and girls. Recent videos have focused on gender roles and women's empowerment (e.g. "Making Family Decisions," "Women are Roosters Too," "Women Freedom in Society," "*Nennie Nyan Daa Porlie Gehye:* Women Can Do It"), seeking to promote more nuanced and sustainable aspects of gender transformation that focus on shifting social and cultural norms. The intervention is being replicated in Asia and elsewhere in Africa.

The evaluation of Through Our Eyes demonstrates a unique way to evaluate a project with little resources and considerable community involvement. It was conducted through focus group discussions during each video playback session. The findings suggest an increase in women's use of reproductive health services in target areas, and a reduction in stigma associated with discussing sexual violence and other matters related to women's health and rights. They also suggest that the women felt more confident in articulating their concerns about IPV/SV and reproductive health, and pride in their new skills in making videotapes. (A series of formal participatory evaluations are being planned.)

One Man Can (OMC) Campaign[100]

Country: South Africa

Implementing organizations: Sonke Gender Justice

The One Man Can Campaign, a partnership on HIV and gender violence in southern Africa, is a flagship initiative of the South African NGO Sonke Gender Justice (Sonke). Begun in 2006, it encourages and supports men and boys to take action to stop IPV/SV and to promote healthy, equitable relationships between men and women. OMC has been implemented in all of South Africa's nine provinces as well as in several other southern African countries (in the latter, by partner organizations). By July 2007, through the implementation of 10 OMC projects, Sonke had trained 465 people in six provinces to implement OMC activities; had conducted two 4-day workshops for more than 2,000 people in six provinces; and had reached tens of thousands of people through community OMC partnerships.

98 Impact on actual incidence of IPV/SV is problematic to measure in the context of an intervention project, in any case, because such interventions typically encourage women who have kept their abuse secret to openly discuss their situations.

99 Information from www.c4c.org/eyes.html

100 Peacock, 2008.

The OMC project interventions were developed based on results from formative research that included literature reviews, surveys, and focus group discussions with survivors of violence, faith-based leaders, and teachers and coaches. The surveys asked boys and men how they understood the problem of men's violence against women and what they would be willing to do about it.

Based on the findings, Sonke developed a kit to provide men with resources to act on their concerns about domestic and sexual violence. This Action Kit includes such materials as stickers, clothing, posters, music, video clips, and fact sheets, and provides specific information and strategies on how men can support a survivor, use the law to demand justice, educate children early and often, challenge other men to take action, make schools safer for girls and boys, and raise awareness in churches, mosques, or synagogues. Sonke implements OMC workshops with groups of men in communities across South Africa and has provided training on the OMC Campaign to a broad range of key stakeholders including government departments at the national and provincial levels, traditional healers, faith-based leaders, the police, youth service organizations, in- and out-of-school youth, teachers, and other CBOs and NGOs. Groups of men and boys attend workshops and develop community teams to put the training into action.

Phone surveys with a random sample of program participants and routine data collection from government sources and NGOs were completed to evaluate a number of behavioral outcomes. Results showed positive results, with 91 percent of participants who had witnessed domestic violence reporting it to authorities (police, community structure, NGOs). Sixty-one percent of respondents also reported that they had increased their condom use after attending a workshop.

Pre/post tests in connection with specific workshops suggested dramatic attitudinal changes. For example, pre/post test results from a workshop with members of a traditional court showed that before the workshop, 100 percent of the male respondents believed that they had the right, as men, to decide when to have sex with their female partners. This dropped to 25 percent after the workshop. In another case, 63 percent of participants from a local tribal authority said they believed that, under some circumstances, it is acceptable for men to beat their female partners. Post-workshop, 83 percent of respondents disagreed with this statement. Similarly, before the workshop, 96 percent of the participants believed that they should not interfere in other people's relationships even in cases of violence. After the workshop, all participants said they believed that they should interfere.

HARMFUL PRACTICES CASE STUDY
INTERVENTION:

Delaying Age at Marriage in Rural Maharashtra

COUNTRY: **India**
TYPE OF INTERVENTION: **Life skills program**
IMPLEMENTING ORGANIZATIONS: **ICRW with Institute of Health Management, Pachod (IHMP)**

Gender-Related Barriers to RH

In rural Maharashtra, there are few alternatives to marriage for young girls. Parents are reluctant to send girls to school because of safety concerns, and outside employment opportunities for women are very limited. In order to ensure a daughter will be taken care of in the future, parents are anxious to find a suitable husband. Her consent is often not taken, and she is often married to a much older man. This marriage arrangement creates significant power imbalances between the girl and her husband, leaving her vulnerable to many harmful outcomes. For example, she may be unable to negotiate contraceptive use or she and her husband may not have access to appropriate information about family planning. Thus, early marriage often leads to early child bearing. The age difference also means that girls are at greater risk of HIV from their husbands, who may be more sexually experienced.

Objective

The intervention study sought to test the effectiveness of a life skills program in increasing girls' self-esteem and literacy and delaying age at marriage in Maharashtra.

Strategy

The program specifically addressed gender-related barriers by trying to improve the social status of adolescent girls through increasing their skills related to gender, legal literacy, and team building. The life skills training approach recognizes that early marriage and poor sexual and reproductive health are closely linked with girls' low self-esteem, social vulnerability, and limited life options. The program was implemented in multiple year-long phases, with one-hour education sessions held each weekday evening. This case study focuses on the first implementation year completed in 1998 – 1999. It targeted unmarried adolescent girls ages 12 – 18, focusing on out-of-school and working girls.

The sessions concentrated on improving the girls' skills and knowledge in the following areas: Social Issues and Institutions, Local Bodies (i.e. local government and civil society structures), Life Skills, Child Health and Nutrition, and Health. One example of an activity in the life skills course is the education practicum, in which girls in the community conduct an informal education course, such as teaching literacy skills to non-participating girls.

Parents were engaged throughout the development of the program and implementation of the intervention. IHMP organized 10 focus group discussions with mothers and their unmarried daughters in order to develop the program's content. Once IHMP had developed the curriculum, parents were given the opportunity to learn about it, give feedback, and participate in monthly meetings.

Already established village development committees collaborated with IHMP to recruit and hire teachers for the life skills program. The teachers were required to have at least seven years of formal education (the same level required for the village-based *anganwadi*, workers in the State-operated Integrated Child Development Services) so the program could be replicated throughout the country if successful.

Evaluation Design: Quasi-Experimental pretest-posttest control group design

The study compared 17 intervention and 18 control villages, with a total of 1,146 participants. Two noncontiguous primary health centers (PHC) were randomly assigned to the intervention and control group. Each PHC was broken down into smaller geographical units, each with a population of 1,000 – 1,500, with 17 and 18 units making up the intervention and control groups respectively. The girls were grouped according to their level of participation in the program, and ranged from not attending to fully attending. Teachers tracked the participants for one year following completion of the life skills course, noting who married within that year.

Table 5.4

Reproductive Health Outcomes

ATTENDANCE	# OF GIRLS	% MARRIED < 18 YRS	ADJUSTED OR+
Complete	166	9.1	1 (reference)
Partial	243	22.6	2.42*
None	737	29.3	2.58*

N=1146; *p<0.05; +Adjusted for girls' age, current schooling status, education, SES, family type, mother's education, parents' occupation

Source: ICRW, *Delaying Age at Marriage in Rural Maharashtra.*

Reproductive Health Outcomes

Comparing only the girls who participated fully in the life skills program and a randomly selected group from the control area, logistic regression analysis indicates that the control group was four times more likely to marry before 18 than the group who fully participated.

From the study sample, nine percent of the girls who completed the course were married before the age of 18 years, compared to almost 30 percent of the girls who never attended. Logistic regression shows that, controlling for background characteristics, girls who never attended the course were more than two-and-a-half times as likely to get married before age 18 compared to girls who completed the course.

These findings show that the program significantly delayed marriage of both program participants and nonparticipants in the intervention areas as a whole. The median age at marriage rose from 16 to 17 years from 1997–2001, and the proportion of marriages to girls younger than 18 dropped from 81 percent to 62 percent. There was no significant change in the control group.

Gender Outcomes

Qualitative interviews suggested that after attending the life skills course, girls acted more confidently and autonomously. They influenced household decisions, including decisions regarding their own marriage, spoke without hesitation or fear, demonstrated more self-discipline, and were more independent in daily activities. A pre- and post-test of the life skills course showed that while the intervention and control group had similar pre-test scores, only the intervention group exhibited significant changes, with correct answers increasing by 1.5 to 3.0 times.

Scale-up

By the end of the study, the state government of Maharashtra had adapted and scaled up IHMP's life skills model for rural Maharashtra.

Conclusions

The evaluation suggests that the life skills program provided the girls with skills and knowledge that increased their confidence and helped them to become more involved in household decisions, including decisions regarding their own marriage. Inclusion of parents in developing program content and implementation helped to achieve broad community support, evidenced by delayed marriages occurring within the whole intervention area, not just among program participants.

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HARMFUL PRACTICES CASE STUDY
INTERVENTION:

Tostan Community-Based Education Program

COUNTRY: **Senegal**
TYPE OF INTERVENTION: **Community engagement and education program**
IMPLEMENTING ORGANIZATIONS: **Tostan; evaluation by Population Council.**

Gender-Related Barriers to RH

Female genital cutting (FGC)[101] is a common practice throughout Senegal. The practice of FGC is perpetuated by the belief that it is a rite of passage to womanhood and necessary for suitable marriage prospects. Because of these factors, mothers often believe they are acting in their daughters' best interests. Because it is culturally expected for women to undergo FGC, it may be difficult for individuals to stand up to this social norm.

Objective

Tostan's goal was to help communities, especially women, improve living and health conditions, and to mobilize villages to hold public declarations supporting the abandonment of harmful practices, particularly FGC and child marriage.

Strategy

Tostan seeks to empower people to make informed decisions for the benefit of their personal and community development. The educational program includes modules on human rights, problem solving, environmental hygiene, and women's health. Through participatory educational methods for communication of technical information, discussion of human rights issues, and development of strategies for social transformation, the NGO hopes to improve the confidence and self-determination of women.

Implementation of the program typically follows six phases over the course of 18-24 months. In the first, a village sets up a committee to adapt and manage the program. In the second phase, about 30 participants in each village receive training and education courses three times a week for two hours each covering hygiene, women's health, human rights, and problem-solving. Training emphasizes enabling participants to analyze their own situation and find the best solution. In the third and fourth phases, trainees share what they are learning with others, and the group begins to organize public discussions around issues identified by the trainees. Participants serve as discussion leaders and facilitate a process of community consensus-building in renouncing FGC. In the fifth phase, community members reach out and spread educational activities to neighboring villages. Finally, a group of villages organizes a public declaration to indicate their collective intention to renounce harmful practices

Table 5.5

Prevalence of FGC Among Daughters of Participants

	BASELINE	POST-INTERVENTION	ENDLINE
Participants in intervention area	87% n = 550	84% n=340	79%* n=353
Non-participants in intervention area		85% n=213	78%* n=199
Comparison Group	93% n = 272	--	89% n = 232

* Statistically significant at $p<0.05$

Evaluation Design: Quasi-experimental case-control design

A quasi-experimental control design was used to evaluate differences between men and women in 20 intervention and 20 control villages. At baseline, 576 women, 373 men, and 895 daughters were surveyed in the intervention villages. In the control villages, 199 women, 184 men, and 396 daughters were surveyed.

In the intervention villages, a survey was administered to both participants and non-participants (immediately before the intervention at baseline, immediately after the intervention, and two years after the intervention/endline). Those living in the control villages were interviewed twice, at baseline and endline. In addition, qualitative data were collected to gauge the community mobilization process and people's perceptions, attitudes, and behaviors.

Reproductive Health Outcomes

The prevalence of FGC among daughters at baseline was 87 percent and 93 percent for the intervention and control groups, respectively. By the endline, FGC prevalence among daughters of women in the intervention group had significantly declined. No significant change could be seen in the comparison group (see table. 5.5).

The proportion of women who thought FGC was necessary significantly declined in the intervention group. A decrease was also

101 While USAID and many NGOs and donors refer to this practice as female genital mutilation/cutting or FGM/C, Tostan prefers to use what it considers the non-pejorative term of FGC, female genital cutting.

Table 5.6

Proportion of Women Who Thought FGC Was a Necessity

	BASELINE	POST-INTERVENTION	ENDLINE
Participants	70% n = 550	21%	15%
Non-participants		33%	29%
Comparison Group	88% n = 272	--	61%

found in the control group; however, the difference in this change was less than in the intervention group (see table above).

Awareness of at least two consequences of FGC significantly increased among men (from 11 to 83 percent) and women (from 7 to 83 percent) immediately after participating in the program, although it declined somewhat (to 66 percent for men and 70 percent for women) by the time of the endline survey.

Among the majority of women participating in the program who disapproved of FGC at the endline, 85 percent said that they had changed their mind after the Tostan program and 10 percent said their disapproval dated back several years.

In addition to FGC, the evaluation showed a wide range of positive RH outcomes including:

- Significant declines in women's personal experience of violence during the last 12 months in both the intervention and comparison group (the intervention group declined significantly more than the comparison group);
- Significant increase in knowledge of contraceptive methods by men and women in the intervention group;
- Significant increase in awareness of STIs at endline by women participants and nonparticipants in the intervention villages (no increase was observed in the comparison group), and a significant increase in men who knew at least two kinds of STIs compared to the comparison group.

Gender Outcomes

After the intervention, there was a significant increase among women in the intervention groups who agreed with the statement that "girls ought to go to school" and agreed that women's unions had a role in demanding rights. Levels were sustained through to the endline. The comparison group also revealed similar significant trends.

Partner approval of contraceptive use, as perceived by the women, improved significantly in the intervention group. These levels were maintained at endline. Discussion with partners about family planning was higher among the participants (30 percent) than among the non-participants (17 percent).

Limitations

The evaluation showed improvements in a number of the measured RH outcomes in both the intervention and the comparison villages. For example, awareness of gender-based violence reached the same level of improvement in the comparison villages as in the intervention villages. This could be a result of changing social factors in the community, as well as contamination because Tostan radio programs were broadcast throughout the region.

Conclusions

Knowledge about FGC issues among both men and women increased significantly during the study period. Those who participated in the education program increased their knowledge more than others living within the villages. Most disapproved of FGC and declared that they had no intention of cutting their daughters in the future. The same tendency was observed in the comparison group, but to a lesser extent, suggesting that there is a widespread shift in attitude, which this program may have accelerated in the intervention villages.

Levels of awareness of family planning, pregnancy surveillance, child health, and STI/HIV issues increased after the program, and comparisons show a statistically significant increase by the intervention group over the comparison group for all but one health indicator.

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HARMFUL PRACTICES CASE STUDY

INTERVENTION:

Intervention with Microfinance for AIDS and Gender Equity (IMAGE)

COUNTRY: **South Africa**

TYPE OF INTERVENTION: **Cross-sectoral**

IMPLEMENTING ORGANIZATIONS: **Small Enterprise Foundation (SEF)**

Gender-Related Barriers to RH

Intimate partner violence/sexual violence (IPV/SV) is highly prevalent across sub-Saharan Africa. Women living in poverty are more likely to suffer from violence. Evidence points to a link between violence and HIV/AIDS status. In the Limpopo Province, acceptance by women of their husband's extra-marital affairs is commonplace. Women often tolerate these behaviors from their husbands because they are the main income earners in the family and, therefore, have a position of authority in the household. Additionally, men and women may have internalized norms that perpetuate male control and acceptance of violence.

Objective

The IMAGE project, implemented from 2001 – 2005, sought to increase women's empowerment through micro-lending, gender awareness, and HIV training, and to decrease women's experience of IPV/SV.

Strategy

Women (ages 18 and older) who lived in the poorest households in each village were selected as participants using SEF's participatory wealth-ranking criteria. The intervention included two strategies: a micro-lending program and a gender-focused training component called "Sisters for Life."

Microfinance Program. The IMAGE micro-lending program followed the Grameen model, and supported women's new and existing business ventures. In this model, groups of five women acted as each other's benefactor, and all women in the group had to repay their loans in order to move up to the next credit level. Women met every two weeks to repay their loans, apply for credit, and discuss their business plans.

Sisters for Life Program. The gender awareness and HIV-training component was implemented in two phases alongside the microfinance program. Phase one consisted of 10 one-hour sessions on gender roles, cultural beliefs, relationships, communication, domestic violence, and HIV infection, with the goal of strengthening communication skills, critical thinking, and leadership. In phase two, women who were identified by their loan centers as "natural leaders" received additional training on leadership and community mobilization to lead initiatives in their own families and communities. Based on participatory learning and action (PLA) principles, phase two was an open-ended program that encouraged broad community mobilization to engage men and boys.

Evaluation Design: Cluster randomized-control trial

During the recruitment period of the evaluation, 430 loan recipients and 430 matched control participants were enrolled. The multi-level evaluation was designed to measure changes at the individual, household, and community level. Matched villages were randomly assigned to receive the intervention either at the beginning or the end of the evaluation period. Participatory wealth ranking was used to form matched experimental and control groups based on age and poverty level. Reproductive health data were collected, including sexual behavior and HIV status. Gender outcomes investigated included economic and social benefits, intra-household communication, decision-making, and gender relations.

Nine empowerment indicators relevant to South Africa were used. Seven focus group discussions supplemented the quantitative data.

Researchers measured women's experience of IPV/SV during the past year, as well as two secondary outcomes, including experience of controlling behavior from partners and attitudes toward the acceptability of IPV/SV.

Reproductive Health Outcomes

Results showed that experience of IPV/SV in the past year decreased by half in the intervention villages. An analysis of trends showed a consistent decrease in IPV/SV over time for all four intervention villages, whereas IPV/SV remained constant or increased in the control villages. The study also showed that, compared to the control group, at endline women in the intervention group reported less controlling behavior from their partners and less accepting attitudes toward violence. For the intervention group, there was not a substantial decrease from baseline to endline in experiencing controlling behavior (see table 5.7).

Gender Outcomes

The intervention measured a number of gender outcomes, including effects on economic well-being and empowerment. Participants in the intervention group reported increased assets, expenditures, and membership in savings groups.

Participation in the intervention was associated with greater self-confidence and financial confidence, more progressive attitudes toward gender norms, increased autonomy in decisionmaking, greater partner appreciation of their household contribution, improved household communication, better partner relationships, and higher levels of participation in social groups and collective action (see table 5.8).

Table 5.7

RH Outcomes

	BASELINE		FOLLOW-UP (2 YEARS AFTER BASELINE)	
	INTERVENTION (%)	CONTROL (%)	INTERVENTION (%)	CONTROL (%)
INTIMATE PARTNER VIOLENCE				
Experience of past year IPV/SV	11.4	9.0	5.9	12.01
Progressive attitudes to IPV/SV	…	…	52.4	35.5
Experienced controlling behavior by partner	34.7	22.5	33.7	41.7

Source: Kim et al., 2007: 1974-1802.

Table 5.8

Gender Outcomes

	BASELINE	FOLLOW-UP
	INTERVENTION GROUP	
Empowerment		
Greater financial confidence	45.5	72.0
Challenging gender norms	37.4	61.2
Autonomy in decisionmaking	27.7	57.1
Taking part in collective action	41.0	75.7
Economic well-being		
Estimated household asset value > 2000 rand	48.2	58.2
Savings group membership	24.5	36.2

Limitations

Research has shown that women often underreport experiencing IPV/SV due to its sensitive and stigmatized nature. Willingness to disclose often increases as awareness increases of IPV/SV definitions and its prevalence. This reporting bias may have underestimated the impact of the intervention on IPV/SV.

Scale-up

The IMAGE project is currently being scaled-up in partnership with AngloPlatinum Mines in 150 villages.

Conclusions

The evaluation found women's risk of physical or sexual violence was reduced by more than half following the intervention, and improvements were shown in all nine dimensions of women's empowerment measured in the study. The research team attributes these results to women's enhanced ability to challenge the acceptability of violence, their expectation of better treatment from male partners, their willingness to leave abusive relationships, and heightened public awareness about intimate partner violence.

This intervention is noteworthy for combining development and health interventions to achieve reductions in IPV/SV. Achieving a strong partnership between the microfinance institute and HIV/AIDS prevention organization was key to the successful implementation of this cross-sectoral intervention.

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6 Meeting the Needs of Youth

Nearly half of the world's population is below the age of 25, including an estimated 1.2 billion adolescents ages 10-19, and most of those young people live in developing countries.[102] Adolescence is a time of transition from childhood to adulthood and, as such, is a critical time to provide young people with the knowledge and skills they need to ensure a lifetime of good sexual and reproductive health. Adolescents, and particularly adolescent girls, face a range of reproductive health risks once they become sexually active, including STIs, HIV/AIDS, and unintended pregnancy. Pregnancy is the leading cause of death for young women ages 15 to 19 worldwide, with complications of childbirth and unsafe abortion leading the list.[103] In 2007, an estimated 5.4 million young people (ages 15-24) were infected with HIV. Prevalence was highest in sub-Saharan Africa, where 90 percent of HIV-positive children live; young women in the region have rates that are even higher than those of young men.[104]

PROGRAM	COUNTRY
African Youth Alliance	Ghana, Tanzania, Uganda
Guria Adolescent Health Project	Georgia
Transitions to Adulthood - Adolescent Livelihoods Training	India
Transitions to Adulthood - Tap and Reposition Youth	Kenya
New Visions	Egypt
CASE STUDY: Ishraq	Egypt
CASE STUDY: First-time Parents	India

Gender and sexual norms are established early[105] and dictate such things as when and with whom to have sex, and whether to use protection. Gender norms related to sex can have detrimental effects on men as well as women, particularly for STIs and HIV and for risk of violence.[106]

Waiting to have sex, known as "delaying sexual debut," can reduce the number of sexual partners and, therefore, reduce the risk of contracting HIV.[107] Opinions vary on what are the appropriate programs for adolescents, ranging from teaching abstinence-only until marriage to providing comprehensive sex education (including means of protection from pregnancy and disease). Evidence has been available for quite some time that in countries with strong youth-friendly sexual and reproductive health services, the incidences of teenage pregnancy, abortion, and STIs are consistently much lower than in countries where these services are not available.[108]

Interventions

The seven interventions highlighted here focused on addressing gender norms, providing information, and building skills related to SRH. Readers should note that several of the interventions in other chapters of this publication (particularly in Chapter 4, Reducing HIV/AIDS) are relevant to young people, risky behaviors, and negative health outcomes.

All seven interventions undertook gender transformative approaches, in whole or in part. Four sought to improve adolescent reproductive health by promoting gender equitable norms. The two projects selected as case studies were **Ishraq (enlightenment)** in Egypt and the **First-time Parents** in India. Ishraq focused on development of life skills and opportunities for girls, while the **First-time Parents** sought to reach

102 UN Population Division, 2008.

103 WHO, 2004.

104 See Children and HIV and AIDS at www.unicef.org/aids/. See also UNAIDS, 2007.

105 Eggleston, Jackson, and Hardee, 1999; Blakemore, 2003

106 See Pulerwitz, Barker, and Nascimento, 2006.

107 Pettifor et al., 2004 , in Gay et al., 2005.

108 Grunseit, 1997.

young married women with RH information and services, empowering them to address their own needs (see p. X).

Table 6.1 lists the strategies employed by these programs to meet the needs of youth.

The African Youth Alliance (AYA)[109]

Country: Uganda, Tanzania, Ghana, and Botswana

Implementing organizations: PATH, Pathfinder International, and UNFPA with funding by the Bill and Melinda Gates Foundation; Evaluation by JSI.

The AYA project was designed to be an "innovative, collaborative and comprehensive prevention program" for improving adolescent (ages 10-24) sexual and reproductive health in four African counties.[110] The intervention had six components: policy and advocacy coordination; institutional capacity building; coordination and dissemination; BCC, including life planning skills; youth friendly services; and integration of adolescent sexual and reproductive health with livelihood skills training. There were three cross-cutting themes: gender; partnerships; and active participation of youth. AYA program materials note that, "Gender-sensitive approaches are applied at different levels to challenge gender biases that exist at multiple levels and maintain unequal status, access, and life experience for males and females."[111]

John Snow, Inc. (JSI) evaluated the AYA project in three of the four countries (Uganda, Tanzania, and Ghana) using a post-intervention analysis to ascertain the impact of exposure to AYA's comprehensive integrated program on sexual and reproductive health behavior among youth. The evaluation compared knowledge, attitudes, and behavioral outcomes between intervention and control sites and youth who were and were not exposed to the AYA intervention. The evaluation did not measure any gender outcomes. The analysis used two analytic techniques for measuring impact using data collected at one point in time (cross-sectional data): propensity score matching and instrumental variable regression. The evaluation found that AYA positively impacted a number of variables, including contraceptive and condom use, partner reduction, and several self-efficacy and knowledge antecedents to behavior change. Areas in which there was little evidence of impact included delay of sexual debut and abstinence among females and males, and partner reduction among males. The impact of AYA was greater on young women than on young men. The evaluation concluded that AYA program approaches need to be refined to better reach young men.

Table 6.1

Strategies to Meet the Needs of Youth
Employ comprehensive approach addressing policy, community and individual levels
Address structural issues and underlying factors affecting poor RH, including gender inequity
Address notions of gender through community theater
Empower rural, out-of-school girls and work with young males to promote life skills, including RH and gender equity
Improve women's economic prospects through livelihoods and microcredit (integrated with RH)
Empower young married women with RH information and services
Perform gender analysis throughout project development and implementation

Guria Adolescent Health Project (GAHP)[112]

Country: Georgia

Implementing organizations: CARE

This project was implemented in the Guria region of Georgia as part of a wider effort by USAID and CARE to strengthen underlying causes of poor family planning/reproductive health (FP/RH) in order to yield sustainable health outcomes. The Guria project used an inter-generational approach to "influence social, cultural and gender norms and inequalities [to] improve promotion of reproductive health rights and responsibilities of adults and adolescents."[113] This meant working with parents on how to involve adolescents in designing and implementing a program on sexual and reproductive health for young people.

109 African Youth Alliance, 2008; see also Williams et al., 2007.

110 See www.jsi.com/Managed/Docs/Publications/Evaluation/aya_evaluation_uganda.pdf, accessed online Dec. 1, 2009.

111 AYA, 2008.

112 CARE, 2005; CARE 2007.

113 CARE, 2007, p. iii.

Components of the project included the use of youth and adult change agents; promotion of health education and social marketing; and implementation of micro-grants and youth-friendly services.

This project was evaluated using baseline and endline surveys as well as through qualitative methods and document review. The evaluation found impressive changes in knowledge, attitudes, and behaviors in support of access to family planning information and services. The percentage of young women and men aware that it is possible to prevent unwanted pregnancy nearly doubled from 50 percent to 93 percent. Knowledge of contraception also improved, with young people knowing about more methods and more effective methods. The evaluation also found more support for adolescent rights, including protection of girls from kidnapping. The project promoted increased discussion of gender topics, most notably masculinity.

Transitions to Adulthood—Adolescent Livelihoods Training[114]

Country: India

Implementing organizations: Population Council and CARE/India

This project integrated a livelihoods component into an existing reproductive health project that had been serving adolescent girls and boys in the slums of Allahabad, India for years.The aim was to expand girls' decisionmaking power through building and strengthening social networks and developing financial and income-generating capabilities. The livelihoods approach sought to provide skills to transform the ways girls perceive themselves and are perceived within their communities. Peer educators recruited adolescent girls to participate in the program. Girls in the experimental and control areas received information on RH; in the experimental areas girls also received vocational counseling, information on savings accounts, and follow-up support from a peer educator.

The evaluation, conducted by the Population Council and the Centre for Operations Research and Training (CORT), used a pre- and post-test design, with baseline surveys of adolescents and one of their parents. It found that, as a result of the intervention, girls in the experimental areas were more likely to be members of a group and to know where unmarried women could safely congregate. These girls also scored higher on measures of social skills and self-esteem and knowledge of reproductive health. The project did not have an appreciable effect on gender role attitudes, girls' mobility, girls' expectations for work, or how the girls used their time.

The evaluation of the livelihoods component noted that, while such a short-term project can raise awareness and change attitudes, it cannot be expected to change the structure of opportunities available for girls. It concluded that, in order to reduce deeply entrenched gender disparities that exist and enhance girls' ability to have a greater voice in influencing their lives, future programs should include more contact with the girls and stronger efforts to develop group cohesion and to improve the communication, negotiation, and decision-making skills of adolescent girls. Since this evaluation, CARE-India has incorporated the livelihoods approach into its ongoing adolescent programs in India.

Transitions to Adulthood—Tap and Reposition Youth (TRY)[115]

Country: Kenya

Implementing organizations: Population Council with K-Rep Development Agency (KDA).

This savings and microcredit project, which also focused on gender attitudes, targeted out-of-school adolescent girls and young women in low-income and slum areas of Nairobi, Kenya. The objective was to improve adolescents' livelihood options as a way to reduce vulnerabilities to adverse social and reproductive health outcomes. The TRY model included group-based micro-finance, such as integrated savings, credit, business support, and mentoring. The project was implemented first as a pilot project (1998–2000) and was then scaled-up and evaluated from 2001–2004.

The evaluation was a quasi-experimental, pre- and post-test design, with surveys conducted at baseline and at the conclusion of the project. In total, 326 participants and their

114 Sebastian, Grant, and Mensch, 2005.

115 Erulkar and Chong, 2005.

matched controls were interviewed at baseline, and 222 pairs were interviewed again at endline. Compared to the control group, TRY participants had significantly higher levels of income and household assets. TRY participants who saved, compared to control group savers, had significantly higher savings. TRY participants also shifted to more equitable gender attitudes. Their RH knowledge was not significantly higher, although the TRY participants had somewhat greater ability to refuse sex and insist on condom use. At endline, TRY participants and controls held similar views on five of the eight issues, while TRY girls were significantly more liberal on three issues: that wives should be able to refuse sex, that marriage is not the best option for an unschooled girl, and that it is not necessary to have a husband in order to be happy. A score was calculated using responses to the gender attitude statements, with a maximum possible score of eight. At baseline, the aggregate gender score for controls was significantly greater than the TRY girls. At endline, however, TRY girls had marginally greater gender attitude scores at the level of $p<0.1$, suggesting the project may have had an impact on participants' gender attitudes.

The intervention faced challenges in meeting the diverse needs of different groups of adolescent girls. A significant number of participants, particularly younger adolescents, dropped out of the program. The experience from TRY suggests that rigorous micro-finance models may be an appropriate intervention to improve young girls' economic opportunities and reproductive health outcomes for older and less vulnerable girls. For this subset of girls, the model appeared to be effective in improving girls' status on a range of economic indicators.

New Visions[116]

Country: Egypt

Implementing organizations: CEDPA and 216 local organizations

In a survey carried out by CEDPA, 36 percent of young Egyptian males ages 12–20 could not name one mode of transmission for HIV/AIDS. According to a national survey, one out of three married women have been abused, and more than half of young boys thought a man was justified in beating his wife in certain circumstances. In response to this data, New Visions was designed to encourage the development of life skills and to increase gender sensitivity and RH knowledge among boys and young men ages 12-20 in order to ultimately improve outcomes for girls and women.

The New Visions course consisted of 64 sessions, each 1 ½ to 2-hours long, over a six-month period, facilitated by young college graduates. The curriculum contained messages related to gender equity, partnership with women, responsibilities to self, family and community, and civil and human rights. Skills development included anger management, planning, negotiation, communication, and decisionmaking. The evaluation compared pre- and post-test responses of 1,477 New Visions participants. Outcome measures consisted of 12 scales based on the subjects' reported knowledge, attitudes, and behaviors in: gender-equity attitudes, gender roles attitudes, gender-based violence attitudes, domestic violence attitudes, female genital mutilation/cutting attitudes, RH knowledge, HIV knowledge, male roles and MCH/FP attitudes, substance-related behavior, self-confidence, decisionmaking, and environmental behaviors.

Results showed that exposure to the program was a highly statistically significant predictor of better RH knowledge and attitudes outcome scores. There were significant changes in knowledge of a source of family planning and knowledge about HIV. At endline, only 11 percent of boys could not name one mode of HIV transmission, compared with 36 percent at baseline. Significant positive shifts were recorded in attitudes toward male-female interaction, female genital mutilation, and gender-based violence. Respondents' views on shared responsibility between men and women in family decisionmaking, community service, political participation, and household duties all improved; participants were more likely than at baseline to support equitable treatment for boys and girls regarding attire, work, and age of marriage. By engaging young men, who are often the gatekeepers to improving young girls' health, the intervention was successful in improving RH and gender outcomes for both girls and boys.

116 CEDPA, 2005.

YOUTH CASE STUDY
INTERVENTION:

Ishraq ("Enlightenment")

COUNTRY: **Egypt**
TYPE OF INTERVENTION: **Nonformal education**
IMPLEMENTING ORGANIZATIONS: **Save the Children, Population Council, the Egyptian-NGO CARITAS, and CEDPA**

Gender-Related Barriers to RH

Adolescent girls in Upper Egypt face many barriers to leading healthy and productive lives, including discrimination and social isolation. Twenty-six percent of girls ages 13–19 in rural Upper Egypt have received two years or less of schooling. Community norms limit adolescent girls' mobility and decisionmaking. Girls do not have access to safe meeting places outside the home and remain closely supervised until a husband is chosen for them. Early arranged marriages often lead to early childbearing and successive pregnancies, perpetuating the cycle of isolation, illiteracy, and poverty into the next generation.

Objective

The Ishraq project aims to improve the life opportunities of rural out-of-school girls, 13-15 years of age, in four villages in Minya Governorate. The project's objectives are to improve literacy, recreational opportunities, livelihood skills, health practices, and mobility; to influence policies and social norms regarding girls' life opportunities; and to promote support for girls' education.

Strategy

The three-year pilot initiative was carried out from 2001 – 2004. Prior to implementing the Ishraq intervention, the project identified community stakeholders and the necessary community structure in which to implement the project. Women "promoters" or intermediaries were identified who would help the girls gain access to public spaces. Village committees were formed, composed of a broad range of stakeholders, who helped to support recruitment and program activities.

To recruit adolescent girls to the program, Ishraq followed four strategies: word of mouth, public announcements, parents' meetings, and home visits by promoters. The home visits played a critical role in increasing parents' understanding of and comfort level with the program and, thus, allowing their daughters to participate.

The Ishraq project consisted of four main components:

1) Twice-weekly literacy classes for 24 months that utilized the Caritas *Learn to be Free* curriculum as well as a core curriculum of Arabic and mathematics. The course also helped to prepare girls to sit for the national education entrance exam;

2) CEDPA's *New Horizons* life skills program that presented reproductive health information and basic life skills—girls attended two 90-minute sessions each week for 12 months;

3) A sports and physical activity curriculum developed by Population Council to encourage fun in a safe environment, develop social networks, and improve girls' self-confidence. This was implemented in two phases, with the first introducing girls to traditional games (three months) and the second phase teaching table tennis and one team sport (10 months). The girls attended two 90-minute sessions each week;

4) A home skills and livelihoods training program instructed girls on basic domestic skills as well as a choice of vocational skills development, including electrical appliance management and repair, hairdressing (the most popular option), and sweets production.

Evaluation Design: Quasi-experimental design

The evaluation compared the Ishraq participants with a matched control group of adolescent girls.

A household census was used to identify eligible girls ages 13 to 15. A baseline survey was administered using a structured, individual questionnaire before the program was implemented. A mid-point survey was completed of girls who had joined the program at a later date, and an endline survey was completed of all baseline and midpoint respondents. In total there were 587 respondents.

In addition, focus group discussions and unstructured interviews were used to monitor the changes taking place in girls, the promoters, and families.

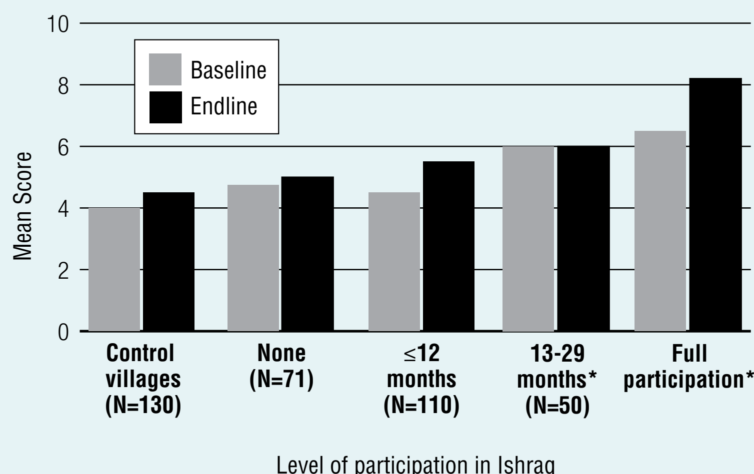
Reproductive Health Outcomes

One clear impact was a decline in support for FGM/C among girls who had participated in the program for a year. Evaluation results showed a significant decline (from 71% to 18%) in percent of Ishraq girls who intend to circumcise their daughters in the future compared with the control group. One percent of program participants compared with 76 percent of nonparticipants said they believed FGM/C was necessary. Girls who lived in the intervention villages but did not participate in the program showed a greater, though statistically insignificant, decline in support for FGM/C than the control village. This suggests that knowledge and attitudes may be shifting through peer networks.

Differences in attitudes toward violence at endline were statistically significant: 64 percent of program participants compared

Figure 6.1

Mean Scores on the Gender Role Attitudes Index, Baseline and Endline Surveys



* Significant at p=0.001

Source: Brady et al., 2007.

to 93 percent of the control group believed that a girl should be beaten if she disobeys her brother.

The proportion of girls preferring to marry before the age of 18 dropped substantially among all groups, intervention and control. The longer the exposure to Ishraq, the greater the decline in the proportion of girls preferring marriage before age 18. Paired comparisons did not show significant results.

Gender Outcomes

The evaluation included questions on attitudes toward gender roles. Results show that respondents participating in the program for more than one year developed more gender-equitable attitudes.

Limitations

The final evaluation of the project was carried out four months after its completion. A long-term assessment may be more successful in capturing the full impact of the intervention, as girls reach important transitions in their lives, including marriage and childbearing, and become decisionmakers in their households.

Conclusions

The Ishraq program integrated various approaches to improve the health and well-being of adolescent girls in rural Upper Egypt. One key contribution of the intervention study is to show how addressing harmful gender norms, which often dictate how a girl is to behave and the opportunities available to her, can lead to positive health and gender outcomes. The findings indicate that the project was successful in program areas and among program participants in obtaining space in which girls could safely meet, increasing literacy, increasing support among girls for later age at marriage and for a say in choosing their husbands, reducing support for FGM/C, and increasing feelings of self-confidence. Through participation in Ishraq activities, parents adopted increasingly progressive views related to girls' roles, rights, and capabilities.

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YOUTH CASE STUDY

INTERVENTION:

First-time Parents

COUNTRY: **India**

TYPE OF INTERVENTION: **Counseling, support, and peer groups**

IMPLEMENTING ORGANIZATIONS: **Population Council in partnership with the Child in Need Institute of West Bengal and the Deepak Charitable Trust in Gujarat**

Gender-Related Barriers to RH

Recently married adolescent girls in India face one of the most vulnerable periods of their lives, including increased restrictions on their mobility and decision-making capabilities and social isolation. They are often not empowered enough to make decisions for themselves that will lead to positive outcomes. These girls are also often under pressure to conceive soon after marriage, even though the risks of early childbearing are well known. While these young married girls are now sexually active, they are often unable to negotiate sex with their husbands.

Objective

This project aimed to develop and test an integrated package of health and social interventions to improve young married women's reproductive and sexual health knowledge and practices, and to expand their ability to act in their own interests.

Strategy

The intervention, carried out from January 2003 – December 2004, focused on young women who were newly married, pregnant, or first-time postpartum in Diamond Harbour Block in West Bengal and Vadodara Block in Gujarat. Husbands of these young women, senior family members, and health care providers were also included. The intervention consisted of three components: information provision; healthcare service adjustments; and group formation.

Female and male outreach workers provided RH information to 2,305 young married women and 1,481 of their husbands through home visits. Husbands were reached by male outreach workers and by participation in discussions in neighborhood meetings. Senior family members were reached in a more ad hoc manner when opportunities arose.

Topics included prevention of reproductive tract infections; contraception; sex as a voluntary, safe, and pleasurable experience; planning for delivery of the first birth; care during pregnancy and postpartum; breastfeeding; ways for husbands to support wives during pregnancy, childbirth, and the postpartum period; and the importance of communication, respect, and joint decisionmaking between husband and wife.

The project worked closely with health care providers to educate them on the special needs of young, newly married couples and first-time parents. The project supplied safe delivery kits and refresher-training courses for traditional birth attendants and provided transportation for couples to health services.

The project also formed groups of 8-12 young women who met for 2-3 hours each month. The meetings gave girls the opportunity to interact with peers and mentors, exposing the young women to new ideas and increasing their self-confidence to communicate and act in their own interests. The girls identified topics to focus on, including legal literacy, vocational skills, pregnancy and postpartum care, gender dynamics within and outside the family, relationship issues, and nutrition.

Evaluation Design: Quasi-experimental study design

Pre- and post-intervention surveys were administered to young women in both the intervention and control sites. In total, 2,862 and 4,555 women were interviewed at baseline and endline, respectively. Data were collected on topics such as young women's agency and social networks, reproductive health knowledge and practices, and partner support and communication.

Reproductive Health Outcomes

The intervention had significant, positive effects on girls' autonomy, RH knowledge and practice, and couple relationships.

RH knowledge and practices improved significantly among program participants in both intervention sites. After controlling for potentially confounding effects, young women who were exposed to the interven-

tion in Diamond Harbour were significantly more likely to have had comprehensive antenatal check-ups. The intervention group saw a 62 percent increase in those who made delivery preparations, as opposed to only a 40 percent increase in the control group. In the experimental group, the proportion that had a postpartum check-up increased by 40 percent, while there was only minimal increase in the proportion seeking postpartum care among controls. Women exposed to the intervention were also significantly more likely to have breastfed their babies immediately after birth and fed their babies colostrum when compared to the control. In Vadodara, participation had a significant, positive net effect on routine postpartum check-ups and use of contraceptives for delaying the first birth.

In both sites, young women who participated in the intervention were more likely to have discussed contraceptive use and timing of first pregnancy with their husbands, although the net effect was statistically significant only in Vadodara.

Gender Outcomes

The intervention had significant effects on partner communication. Young married women from both sites who participated in the intervention had significantly greater say in household decision-making than young married women in control villages. They were also more likely to discuss contraceptive use and timing of first pregnancy with their husbands. Young women in Diamond Harbour were more likely than women in the control villages to express their opinion when they disagreed with their husbands. In some sites, young married women who were exposed to the intervention had more mobility and were more likely to adhere to more equitable gender norm attitudes.

Limitations

The study faced numerous limitations to its research design. First, there were a number of differences between the intervention and control villages (e.g. programmatic activities and socio-demographic characteristics of young married girls) that limit their comparability. Comparison of background characteristics also show that self-selection into intervention activities did occur. Additionally, many of the young women were lost at follow-up due to their frequent movement between natal and marital homes.

Conclusions

Young married girls face many gender barriers that limit their capacity to act in ways and make decisions that are in their own interest. The First-time Parents project sought to address these barriers by empowering women with knowledge, reducing their social isolation, and making healthcare services more youth-friendly. The intervention was successful in producing positive reproductive health and gender outcomes, including health practices and spousal communication.

References

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7 Conclusions

In the past five years there has been a clear increase in the evidence that integrating gender does improve reproductive health outcomes. Many of these programs also improve gender outcomes. Thanks to early pioneers[117] whose efforts articulated the links between gender and development, donors have set gender equality and gender mainstreaming as core principles of their programming.[118] Attention to gender issues in development assistance has been the policy of USAID since 1982.[119] In 2007, the UN adopted a system-wide policy for gender mainstreaming and that same year the World Health Assembly adopted Resolution WHO 60.25 for integrating gender analysis and actions at all levels of health policies and programs in member states.[120]

The *Programme of Action* of the 1994 International Conference on Population and Development (ICPD) called for a gender perspective to be "adopted in all processes of policy formulation and implementation and in the delivery of services, especially in sexual and reproductive health, including family planning."[121] Many of the strategies highlighted in the ICPD *Programme of Action* are clearly evident in the programs described in this report.

Today, women and men are reaping the benefits of gender-integrated programming and stronger evaluations are measuring the effects. This update of the 2004 *"So What?"* report makes an important contribution to the growing body of literature on gender-based approaches to policy and programming. The evidence presented here suggests that incorporating gender strategies contributes to reducing unintended pregnancy, improving maternal health, reducing HIV/AIDS and other STIs, eliminating harmful practices, and meeting the needs of youth – all broadly included under the term "reproductive health." As stated earlier, the interventions reviewed here were of two broad types: those that *accommodate* existing gender differences and inequities to achieve RH goals; and those that seek to *transform* gender norms and ameliorate gender inequities to overcome RH barriers. Significantly, a majority of the interventions in this review employ transformative approaches and this must be counted as a big step forward.

Indeed, substantial progress has been made and several of the recommendations made in 2004 can now be listed as achievements, notably:

1) Gender and Measures of Outcomes. There has been progress in the last five years and this review found several projects that do integrate gender perspectives and promote gender equality. Moreover, gender equality and gender-equitable outcomes are measured more often than they were five years ago. Many organizations are funding and implementing innovative gender-integrated programs, and some are also prioritizing strong evaluations of gender-integrated programs. For example, USAID has long supported operations research projects, which has included evaluation of gender-integrated programming. Operations research, along with other program evaluations, has moved the field forward in terms of documenting and measuring what difference a gender perspective can make in improving RH as well as gender equity outcomes. The authors did find examples of additional programs that seemed innovative but were lacking in evaluation, thus the impact they may be generating is not known and they were not included in this review.

2) Added Value. While it is still difficult to isolate the effects of a gender-equitable project on RH/HIV/AIDS, several of the projects reviewed

117 See 1948 Universal Declaration of Human Rights; see also Overholt et al., 1985; Longwe, 1991; and Moser, 1993.

118 Pfannanschmidt et al., 1996; UN, 2002; WHO, 2002; Sida, 2005.

119 USAID, 1982.

120 See www.who.int/gender/mainstreaming/investing/en/index3.html.

121 UN, 1999.

were quite convincing in demonstrating the "added value" of a gender component. In these projects, control or comparison groups represent the basic RH services to which the gender component was added. One could argue that much of what was done in the intervention sites really addressed quality of care as much as gender, but the overlap between these two concepts at the operational level should not be seen as invalidating the test of a gender-integrated intervention. Similarly, Chapter 5 (Harmful Practices) documents reproductive health outcomes of interventions that involved gender as their central theme—for example, interventions to stop FGM/C. Again, because of the use of control groups, the extent to which the adoption of a gender perspective in program design contributed to positive gender outcomes is clear. A number of interventions across the chapters, and particularly those related to HIV/ AIDS and youth, focused on changing gender norms related to masculinity, behavior related to sex, and health-seeking. The strong evaluation designs used in most of these programs strengthen the conclusion that adopting a gender-transformative approach contributed to positive RH and gender outcomes.

3) Rigorous Evaluations. While there are many ethical, logistical, and financial reasons that not all evaluations can be randomized controlled trials (RCTs)—the gold standard of evaluations—the projects reported here demonstrate creativity and innovation in the use of other rigorous evaluation techniques. The development of approaches such as the use of participatory learning methods with youth or the efforts to involve men in maternity care should not be jettisoned just because of the difficulty of isolating the gender component in an evaluation. Qualitative evaluations should not be disregarded due to their inability to quantify change; their conclusions lend powerful insight to the processes of change.

4) Beyond HIV/AIDS. While gender concerns have received more attention in HIV/AIDS/STI prevention work due to the well-documented link between inequitable gender relations and the spread of HIV/AIDS and STIs, the role of gender in the various other RH areas included in this report is increasingly demonstrated.

122 Boender et al., 2004: 65.

Allowing for double-counting of interventions that address multiple RH areas, 18 of the programs reviewed focus on improved outcomes related to harmful practices; 16 addressed HIV/ AIDS and other STIs; 13 addressed unintended pregnancy; 12 were directed at youth; and 7 addressed maternal health. Most of the programs related to youth also have objectives to improve HIV/AIDS/STI outcomes. Clearly, the importance of gender is being acknowledged across many facets of RH and health.

One conclusion from the 2004 report remains true: "Achieving a change in gender relations is a long-term process that may not be reflected in a relatively short-term intervention."[122] The importance of long-term investments in transforming inequitable gender norms that may compromise RH cannot be over-emphasized. Such long-term investments will facilitate dealing with the root causes of inequity rather than only the symptoms of it. Gender norms are learned and reinforced over many years; undoing those norms takes time. The need for evaluations to likewise measure impact over longer spans of time persists.

New Findings

Many projects related to each RH issue (unintended pregnancy, maternal health, etc.) sought to change underlying beliefs and attitudes that shape norms related to power dynamics between women and men, including sexual dynamics. These programs, working with men and women of all ages, have had success in improving gender- equitable views. Some programs have been successful in changing behavior, most commonly condom use, but also, in some cases, reducing gender-based violence. Addressing gender norms is time-intensive and requires examination of both male and female norms.

All of the 40 programs reviewed here achieved positive reproductive health outcomes, though some were much more limited than the implementers had hoped for, often because the research designs were "contaminated". As in the 2004 review, there is always the possibility of reporting bias by participants, but given the increased rigor of many of the evaluations reviewed for the present report, the authors believe this bias has been reduced.

As before, changes are more likely to be seen in knowledge and attitudes than in reproductive

health behaviors. Some of the most common RH outcomes measured include knowledge and use of contraceptives (11 interventions each), knowledge of HIV/AIDS transmission and prevention, condom use, and use of HIV/AIDS and pregnancy care services (see Table 1.3 on page 10). Thirty of the 40 interventions reviewed for the present report measured gender impact; all of these reported positive changes on a range of gender outcomes. The most frequently measured gender outcomes were attitudes regarding gender equity and women's rights and partner communication about FP and other RH issues (nine and 11 evaluations, respectively; see Table 1.4). Most of the other gender outcomes that were measured reflected various dimensions of women's empowerment; for example, self-confidence or self-esteem, community participation and social networks, mobility, decision-making power, and practical skills. Three evaluations used empowerment scales to measure impact on gender outcomes.

Based on this review, the key findings from this analysis of 40 projects with evaluation outcomes are that:

- **Gender-integrated strategies are stronger and better evaluated than five years ago.** The analysis found that the strategies used to integrate gender were grounded in deeper theoretical and practical knowledge of the effects of gender on RH. The most promising strategies for improving RH outcomes include those that seek to directly confront harmful or inequitable gender norms (e.g. IMAGE, Program H, Stepping Stones), increase community awareness and dialogue around gender and RH (e.g. Soul City, Through our Eyes, Somos Diferentes Somos Iguales), or increase couple communication (e.g. First-time Parents Project). In the current analysis, the evaluation methodologies were much more likely to use experimental and quasi-experimental designs. No evaluation in 2004 used randomized control trials; five evaluations herein used this "gold standard" methodology.

  Evaluating gender outcomes is necessary to understanding further the mechanisms and the degree to which intervention strategies affect behavior and attitudes. Continued evaluation rigor will further inform and enrich program development and, ultimately, RH outcomes.

- **Incorporating gender into a range of strategies leads to a better understanding of RH issues.** Each chapter of this review focused on the gender strategies used to address the various RH issues. Looking at the programs in each chapter as a whole, it is clear that careful incorporation of gender into program strategies leads to a better understanding of the RH issue at hand. This is clear in HIV/AIDS programming: inequitable gender relations in the ability to negotiate safe sex and expectations of intimate relationships fuel transmission of HIV. Strategies to meet the needs of youth focus on establishing strong foundations for young women and men to grow into adulthood with good reproductive health, and understanding the gender roles that guide their behavior leads to more effective programs. Programs for youth work to strengthen communication and negotiation skills. Programs for young women also provide livelihood skills and establish community networks for this group, especially important because young women are often isolated. Examining harmful practices, one can see that they are clearly rooted in gender roles, and that any effort to mitigate these practices needs to encompass the social constructions of gender that have legitimated those practices over time.

  If any areas seem to be lagging behind, they would be the areas involving unintended pregnancy and maternal mortality. The unintended pregnancy interventions appeared to incorporate gender in less ambitious and accommodating ways compared to other RH areas. In addition, fewer interventions were found here than in the 2004 review of reducing unintended pregnancy. Maternal health had the fewest number of evaluated interventions of any of the RH topics. Nonetheless, evidence exists that the healthy timing and spacing of pregnancy can be improved by incorporating gender in programs, with the result of healthier mothers and families.

- **Formative research is critical.** As noted in many of the interventions reviewed, formative research is critical for designing gender interventions. Programs to integrate gender benefit greatly from initial formative research to determine specific social and gender dynamics in project areas. This type

of groundwork can help determine which groups should be included in specific interventions. Formative research can also help ensure that the project is meeting local needs and that it is being implemented with an understanding of the local context.

- **Programs that integrate gender can benefit from working at multiple levels.** The 40 projects reviewed include work with individuals, couples, families, community leaders, providers, and policymakers, among other groups. Many of the projects also link individual-level interventions with community-level interventions, such as mass media or social marketing campaigns.

  Gender-integrated components of reproductive health programming are often embedded in participatory or community empowerment initiatives. This theme is common in many of the projects, including Through Our Eyes, Stepping Stones, Program H, AYA, and mothers2mothers. Some of these programs seek to empower both women and communities. The various programs have involved married women, men, youth, parents, and community leaders. Some programs worked not only with the health sector, but also in the areas of agriculture, education, and economic development. Because changing norms is a community process, projects will benefit from careful consideration of the multiple levels at which gender norms operate and inclusion of a community involvement or mobilization component.

- **Projects that integrate gender need to focus on costs, scale up, and identifying policy and systemic changes required to "mainstream" gender.** Notably absent from many of the projects reviewed here is adequate attention to the costs of the projects and the feasibility of scaling up the interventions. Given the time-intensive nature of some of the interventions, particularly for those that seek to examine and change personal views about gender norms, considerations for scale up are critical. Moreover, few of the projects included discussion about national or sectoral policies that might exacerbate gender inequality or, conversely, enhance gender equality.

Future Directions

This publication makes a critically important contribution to the continuing quest for conclusive evidence that incorporating gender components to programs improves RH outcomes. While the reviewers might wish for more conclusive data and more in-depth descriptions of what makes a program gender transformative, there can be no doubt that the field has come a long way in the last five years.

Many challenges remain, not the least of which is that more investment still needs to be made in monitoring and evaluation if we are to prove beyond a shadow of doubt that integrating gender yields improvements in RH outcomes. Donors should be encouraged to focus their funding efforts on gender integration interventions and evaluations, and, in turn, to encourage implementing organizations to measure gender impact.

Given the evidence presented here, we recommend that development experts focus particularly on:

- Scaling up and replicating the programs that have been proven to work;
- Focusing on transformative approaches in interventions, particularly in those that seek to reduce unintended pregnancy;
- Undertaking cost-effectiveness research to shed light on how to achieve these improvements in RH in a manner that is affordable and feasible for both donors and governments;
- Institutionalizing these achievements through policy change; and
- Conducting sustainability analyses to learn how long these changes last, and what follow-up may be needed over time to ensure that the positive impacts of interventions to improve gender-equity are maintained and passed on to future generations.

It is the fervent hope of the authors that more program planners, policymakers, and funders will insist on incorporating gender into RH programs. The way forward, focusing on well-evaluated projects that address policy, systems, and cost issues, scaling up gender integration, and addressing sustainability of equitable gender relations over time, will make important contributions to health and lives of women, men, and families.

Appendix: Quick Reference Guide

The following tables summarize the objectives, strategies, reproductive health outcomes, and gender outcomes of the interventions included in this report. The tables, like this report, are organized by RH issue area (unintended pregnancy, maternal health, STIs/HIV/AIDS, harmful practices, and youth). Table A.2 identifies interventions by evaluation methodologies.

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PROGRAM NAME	ORGANIZATION	OBJECTIVES	STRATEGIES	RH OUTCOMES	GENDER OUTCOMES	COUNTRIES	PAGE NUMBER
REDUCING UNINTENDED PREGNANCY							
Cultivating Men's Interest in FP	Project Concern International, Institute for Reproductive Health (Georgetown University)	Increase men's involvement in FP decision-making and practice	Integration of FP messages into water and sanitation program	Greater contraceptive knowledge by women and men; greater fertility knowledge by women and men	Greater partner communication regarding family planning and communication	El Salvador	14
Male Motivation Campaign	Johns Hopkins Bloomberg School of Public Health CCP, Guinean Ministry of Health	Increase access and demand for health care services; improve quality of care; improve coordination among health care providers and services	Community outreach to religious leaders; social mobilization through advocacy and multimedia interventions	Greater contraceptive knowledge; greater family planning use	Increased partner communication about family planning	Guinea	13
PRACHAR I & II	Pathfinder International, local NGOs	Improve the health and welfare of young mothers and their children by changing traditional customs of early childbearing	Nonformal education; parent and community involvement; provision of contraceptives	Lengthened first birth interval; improved knowledge, attitudes toward, and use of contraception; increased knowledge of risks of early childbearing; fewer teenage pregnancies	None	India	16
PROCOSI	PROCOSI, Population Council	Assess the impact and cost of incorporating a gender perspective in reproductive health service delivery	Institutionalize a gender perspective in RH service delivery	Increased client satisfaction with providers and care; decline in unmet need for contraceptives	Increased partner communication about FP and sexual relations	Bolivia	20
Reproductive Health Awareness	KAANIB Foundation	Improve men's involvement in RH matters	Education sessions on RH and partner communication	Greater knowledge of women's fertile period; increased knowledge and practice of self breast and testicular exams; greater contraceptive knowledge	Great partner communication around family planning	Philippines	15

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Table A.1

PROGRAM NAME	ORGANIZATION	OBJECTIVES	STRATEGIES	RH OUTCOMES	GENDER OUTCOMES	COUNTRIES	PAGE NUMBER
REWARD	Nepal Red Cross Society, Centre for Research on Environment, Health and Population Activities, CEDPA	Strengthen women's capabilities for informed decision-making to prevent unintended pregnancy and improve reproductive health	Expand access to and delivery of quality, gender-sensitive FP and health information; promote an enabling environment that strengthens women's informed RH decision-making	Increased contraceptive prevalence rate; increased registration for ANC	None	Nepal	17
Together for a Happy Family	Jordanian National Population Committee, Johns Hopkins Bloomberg School of Public Health CCP	Enlist men's support in making informed decisions with their wives toward using family planning	National multimedia campaign to involve men in family planning	Greater contraceptive use by men; greater contraceptive knowledge	Increased spousal communication about FP reported by men	Jordan	14
Women's Empowerment Model to Train Midwives and Doctors	Family Health Alliance	Address maternal mortality in Afghanistan by preventing unwanted pregnancies and promoting birth spacing through the expansion of family planning services	Empowerment strategies and training of female health providers	Greater provider knowledge of family planning and STI detection and transmission; improved clinical skills	None	Afghanistan	18
IMPROVING MATERNAL HEALTH							
FEMME Project	CARE Peru, Peruvian Ministry of Health	Improve access, use, and quality of emergency obstetric care (EMOC) for pregnant women	Multi-component strategy to standardize handling of cases and encourage women's right-based approach to obstetric care through organization changes	Increase in meeting women's EMOC needs; reduced case-fatality rate	None	Peru	23

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PROGRAM NAME	ORGANIZATION	OBJECTIVES	STRATEGIES	RH OUTCOMES	GENDER OUTCOMES	COUNTRIES	PAGE NUMBER
Involving Men in Maternity Care (South Africa)	Reproductive Health Research Unit (RHRU) University of the Witwatersrand, KwaZulu Natal Department of Health, Population Council	Expand antenatal and post-partum care program to improve RH; increase the use of appropriate post-partum family planning	Clinic-based: strengthen existing antenatal package and service monitoring; train health providers	Greater knowledge of dual protection provided by condoms; increased assistance by men during an emergency situation	Increased partner communication on STIs, sexual relations, immunization, and breastfeeding	South Africa	25
Men in Maternity (India)	Employee's State Insurance Corporation, Population Council	Investigate the feasibility, acceptability and cost of a model of maternity care that encourages husbands' participation in antenatal and postpartum care	Individual/couple/group counseling, STI screening, and syndromic management	Greater contraceptive knowledge for women and men; greater FP use; greater knowledge of warnings signs in pregnancy; increase in screening of pregnant women for syphilis	Greater inter-spousal communication on baby's health; increased joint decisionmaking on family health and FP	India	24
Social Mobilization or Government Services	Foundation for Research in Health Systems, ICRW	Examine the effectiveness and cost of addressing 'supply' versus 'demand' constraints to improve RH for young married women	Social mobilization through community-based organizations; strengthening government services through training for service providers	Greater knowledge of maternal health, contraceptive side effects, and abortion; increased use of services	Improved community support for young women's health needs	India	27
REDUCING HIV/AIDS AND OTHER STIS							
Integration of RH Services for Men in Health and Family Welfare Centers	NIPORT and Directorate of Family Planning, FRONTIERS/ Population Council	Integrate male reproductive health services within the existing government female-focused health care delivery system	Community outreach and mobilization; training for service providers	Increased clinic visits by men; increased clinic visits by women	None	Bangladesh	36
Involving Men in Sexual and Reproductive Health	Association for the Benefit of the Ecuadorian Family (APROFE)	Increase the number of male clients seeking and receiving RH/ STI services	Encourage female users to involve male partners; radio campaigns; adjust clinic hours to men's schedules	Increased clinic visits by men	None	Ecuador	37

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PROGRAM NAME	ORGANIZATION	OBJECTIVES	STRATEGIES	RH OUTCOMES	GENDER OUTCOMES	COUNTRIES	PAGE NUMBER
Men as Partners	EngenderHealth	Increase information and services to improve men's RH; promote male engagement to challenge gender norms	Multiple macro- and micro-level strategies including workshops, media, and advocacy	Improvement in knowledge about RH; improved attitudes toward IPV and decision-making	Increased gender-equitable attitudes regarding women's rights	South Africa	33
mothers2 mothers	mothers2mothers	Provide education and psychosocial support to HIV-positive pregnant women and new mothers; help them to access health care services for PMTCT and postpartum care	Peer education and mentoring	Increased exclusive breastfeeding; greater knowledge of MTCT transmission; greater receipt and ingestion of nevirapine; greater CD4 testing; greater contraception use	Greater psychosocial well-being	South Africa	36
Play Safe	Reproductive Health Initiative for Youth in Asia (EU/UNFPA)	Promote healthy behaviors about sex, drug use, and gender relations among middle-class male youth	Peer education and outreach (pilot project)	Greater knowledge of HIV/AIDS; reduction in frequency of commercial sex; greater condom use; greater use of reproductive health services	None	Cambodia	34
Program H	Instituto Promundo	Improve young men's attitudes toward gender norms; reduce HIV/STI risk	A validated curriculum for group education; lifestyle social marketing campaign	Increased understanding of association between gender and HIV/AIDS; reduced STI symptoms	Increased support of gender-equitable norms; support for gender-equity in GEM Scale	Brazil	42
Somos Diferentes, Somos Iguales	Puntos de Encuentro	Empower young men and women to prevent HIV infection in Nicaragua	Mass media: Sexto Sentido television series	Greater knowledge and use of RH services; greater knowledge of HIV/AIDS transmission and prevention; greater condom use with partners	Reduced stigmatizing and gender-inequitable attitudes; higher gender index values; increased self-efficacy	Nicaragua	32
Stepping Stones	Medical Research Council	Improve sexual health by building stronger, more gender-equitable relationships with better communication between partners	Participatory learning approaches in single-sex peer groups	Lower STI symptoms; greater condom use in last 12 months; fewer partners; lower perpetuation of IPV/SV	Improved partner communication; changes in attitudes regarding acceptability of IPV/SV	South Africa	40

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PROGRAM NAME	ORGANIZATION	OBJECTIVES	STRATEGIES	RH OUTCOMES	GENDER OUTCOMES	COUNTRIES	PAGE NUMBER
Tuelimishane	Tuelimishane Project	Reduce HIV risk behaviors and violence by young men through gender-focused, community-based interventions, including drama and peer support	Community theater and peer support groups to promote dialog on gender and HIV	Positive shift in attitudes toward violence against women; decreased HIV risk behaviors; increased use of condoms at last sex with primary partner	Positive changes in attitudes toward norms regarding gender roles and IPV	Tanzania	38
Yaari Dosti	Instituto Promundo, CORO, Horizons/ Population Council	Examine the effectiveness of interventions designed to improve young men's attitudes toward gender norms and to reduce HIV/STI risk	A validated curriculum and lifestyle social marketing campaign (an adaptation of Program H)	Increased understanding of association between gender norms and HIV/AIDS; increased condom use with all partners; reduction in self-reported IPV	Increased support of gender-equitable norms; improvements in partner communication	India	33
HARMFUL PRACTICES							
EARLY MARRIAGE AND CHILDBEARING							
Behane Hewan	Ethiopian Ministry of Youth and Sport, Amhara Regional Youth Bureau, UNFPA, Population Council	Sensitize communities to the risks and disadvantages of child marriage; promote education to prevent early marriage	Social mobilization of adolescent girls; nonformal education and livelihood programs for out-of-school girls; community dialogue on early marriage; fiscal incentives to families	Increased knowledge and communication on HIV, STIs, and FP; reduced likelihood that younger adolescents were married; increased contraceptive use	Increased school attendance for girls	Ethiopia	45
Building Life Skills to Improve Adolescent Girls' R&SH	Swaasthya, ICRW	Improve the social and health status of adolescent girls; promote self-development and increase self-confidence and self-esteem; delay age at marriage	A one-year life skills training course; information, education, and communication campaign	Greater S/RH knowledge; improved menstrual hygiene	Improved perceived self-determination	India	45
Delaying Age at Marriage in Rural Maharashtra	Institute of Health Management Pachod, ICRW	Increase girls' self-esteem and literacy; delay age at marriage	A one-year life skills training course; parent and community involvement	Increased age at marriage; improved S/RH knowledge	Improved cognitive and practical skills; increased willingness to act autonomously	India	52

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Table A.1

PROGRAM NAME	ORGANIZATION	OBJECTIVES	STRATEGIES	RH OUTCOMES	GENDER OUTCOMES	COUNTRIES	PAGE NUMBER
FEMALE GENITAL MUTILATION/CUTTING							
Awash FGM/C Elimination Project	CARE Ethiopia, local NGOs, Population Council	Empower women for greater participation in community and to discuss FGM/C with partners	BCC and educational activities to break the silence surrounding FGM/C; meetings with community groups; performances	Increased knowledge regarding consequences of FGM/C; greater contraceptive knowledge; greater family planning use	Spousal communication regarding family planning; increased public discussion of FGM/C	Ethiopia, Kenya, Sudan	47
Five Dimensional Approach for the Eradication of FGM/C	IntraHealth International	Increase knowledge about FGM/C and change behavior	Improve women's empowerment and initiate community dialog through the perspectives of health, gender, law/rights, religion, and information	Change in attitudes regarding FGM/C; increased community action against FGM/C	Teachers, media, and religious leaders made public declarations against FGM/C	Ethiopia	48
Navrongo FGM/C Experiment	Navrongo Health Research Center	Accelerate abandonment of FGM/C in the Kassena-Nanka district of Northern Ghana	Community involvement, FGM/C education, livelihood and development activities for young girls	Decreased FGM/C incidence	None	Ghana	46
Tostan Community-based Education Program	Tostan, GTZ, Population Council	Provide information to support a strategy to improve women's health and abandonment of FGC	Basic education program including hygiene, problem solving, women's health, and human rights	Improved knowledge of contraception, STIs, prenatal care, and violence; decreased incidence of violence; greater awareness of FGC consequences; decreased FGC incidence	Improved attitudes toward girls' schooling; improved attitudes toward role of women's unions to demand rights	Senegal	54
GENDER-BASED VIOLENCE							
IMAGE	Small Enterprise Foundation	Increase women's empowerment through micro-lending, gender awareness, and HIV training	Micro-finance through women's groups and gender-focused training	Decreased IPV/SV; more progressive attitudes toward IPV/SV; decreased controlling behavior by intimate partner	Increased score on women's empowerment scale; increased progressive attitudes toward gender norms	South Africa	56

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PROGRAM NAME	ORGANIZATION	OBJECTIVES	STRATEGIES	RH OUTCOMES	GENDER OUTCOMES	COUNTRIES	PAGE NUMBER
One Man Can Campaign	Sonke Gender Justice	Male involvement to take action against domestic and sexual violence	BCC campaign and Action Kit to promote the idea that all men have a role to play in ending violence against women	Greater knowledge of HIV/AIDS transmission and prevention; decrease in men's beliefs that violence against women is justified in some circumstances	More gender-equitable beliefs in sex decision-making	South Africa	50
Soul City	Soul City Institute for Health & Development Communication, National Network on Violence Against Women	Address gender norms at the community and individual levels through 'edutainment'	Multi-media health promotion campaign using TV and radio broadcasts incorporating social issues into entertainment formats	Increased knowledge of IPV/SV resources; decreased beliefs that men are justified in beating their partners; increased number of respondents taking action to stop IPV/SV	Women's increased awareness of self-worth and identity	South Africa	49
Through Our Eyes	American Refugee Committee, Communication for Change	Provide participants with a safe environment to share experiences, develop new ideas, and address gender-based violence in their communities	Participatory community engagement with video and community playback sessions	Increased uptake of reproductive health services; increased capacity to make healthy decisions to mitigate consequences of risky sexual behavior	Improved gender relations; women more articulate in discussing IPV/SV and RH	Liberia	50
MEETING THE NEEDS OF YOUTH							
African Youth Alliance Program	UNFPA, PATH, Pathfinder International	Improve adolescent sexual and reproductive health and to prevent transmission of HIV/AIDS	Implementation and scaling up a comprehensive set of integrated ASRH interventions using existing institutions	Increased HIV/AIDS knowledge; increased confidence in negotiating condom use; increased delay of sexual debut; increased contraceptive use	None	Ghana, Tanzania, Uganda	59
First-time Parents Project	Child in Need Institute, Deepak Charitable Trust, Population Council	Develop an integrated package of health and social interventions to improve married young women's S/RH knowledge/practices, and self-determination	Educational home visits; counseling sessions; girls' group formation; training for health care providers	Increased clinic visits for maternal health; greater family planning use; improved partner communication	Increased mobility, social networks developed; increased partner support and communication	India	64

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Table A.1

PROGRAM NAME	ORGANIZATION	OBJECTIVES	STRATEGIES	RH OUTCOMES	GENDER OUTCOMES	COUNTRIES	PAGE NUMBER
Guria Adolescent Health Project	CARE International	Achieve improvements in reproductive health through improving life skills of adolescents; provide youth-friendly information and services; raise community awareness	Health education and social marketing; theater; micro-grants; youth-friendly services	Greater contraceptive knowledge; greater family planning use	Decreased tolerance for kidnapping	Georgia	59
Ishraq	Caritas, Save the Children, Population Council, CEDPA	Improve the life opportunities of rural out-of-school girls by improving literacy and education, livelihoods, health knowledge, and social policies	Nonformal educational sessions; female champions; sports and physical activity; home skills/ livelihoods training	Decline in acceptance of early marriage; decline in girls' favorable attitudes toward FGM/C; improved attitudes toward violence	Increased levels of self-confidence; improved gender attitudes	Egypt	62
New Visions	CEDPA, local NGOs	Develop life skills and increase gender sensitivity and RH knowledge among boys and young men in order to improve outcomes for girls and women	A series of 64 nonformal educational sessions facilitated by peer leaders	Increased positive responses about IPV/ SV and FGC; greater knowledge of family planning sources; greater knowledge of HIV/AIDS transmission	Increased gender-equitable beliefs about gender roles and equitable treatment	Egypt	61
Transitions to Adulthood - Livelihoods Training	CARE India, Population Council	Deliver technical skills and transform the way girls view themselves	Group education; vocational training; financial counseling; peer mentors	Greater RH knowledge	Greater social skills; increased group membership	India	60
Transitions to Adulthood - Tap & Reposition Youth	K-Rep Development Agency, Population Council	Improve livelihood options; reduce unplanned pregnancies; decrease vulnerability to STIs, HIV, and unsafe abortion	Financial empowerment through microcredit, combined with a focus on gender attitudes	Greater ability to negotiate condom use with partner; greater ability to refuse sex	Increased liberal gender attitudes; increased income and household assets	Kenya	60

Table A.2

Evaluation Methodologies, by Category and Program Name

TYPE OF EVALUATION METHODOLOGY	#	MAIN (AND SUB CATEGORIES)	PROGRAM NAME (AND COUNTRY)
Experimental Design (Randomized control trial, 2x2 or 4 cell)	5	HP/IPV/SV (UP, HIV/AIDS/STI)	IMAGE (South Africa)
		MH (Youth)	Involving Men in Maternity Care (South Africa)
		HP/FGM/C (Youth)	Navrongo FGM/C Experiment (Ghana)
		MH (UP, Youth)	Social Mobilization or Government Services (India)
		HIV/AIDS/STI	Stepping Stones (South Africa)
Quasi –Experimental Designs, Including: • Pretest-posttest, cluster sample • Pretest-posttest, control group design • Non-equivalent control group • Quasi-experimental control group • Case-control group	17	HP/FGM/C (Youth)	Awash FGM/C (Ethiopia, Sudan, Kenya)
		HP/EM (Youth)	Behane Hewan (Ethiopia)
		UP (MH)	Cultivating Men's Interest in FP (El Salvador)
		HP/EM (Youth)	Delaying Age at Marriage in Rural Maharashtra (India)
		MH	FEMME Project (Peru)
		Youth (UP, MH)	First Time Parents (India)
		HIV/AIDS/STI (MH)	Integration of RH Services for Men in Health and Family Welfare Centers (Bangladesh)
		Youth (HP/EM)	Ishraq (Egypt)
		MH (UP)	Men in Maternity (India)
		HIV/AIDS/STI (MH)	mothers2mothers (South Africa)
		UP (HP/EM, MH)	PRACHAR I & II (India)
		HIV/AIDS/STI	Program H (Brazil)
		HIV/AIDS/STI	Somos Diferentes, Somos Iguales (Nicaragua)
		HP/FGM/C (UP, MH)	Tostan Community Empowerment Program (Senegal, Burkina Faso)
		Youth (UP, HIV/AIDS/STI)	Transition to Adulthood – Tap and Reposition Youth (Kenya)
		HIV/AIDS/STI (HP/GBV)	Tuelimishane (Tanzania)
		UP (MH)	Reproductive Health Awareness (Philippines)
Non-Experimental Study Design	15	Youth (HIV/AIDS/STI)	Africa Youth Alliance (Ghana, Tanzania, Uganda)
		HP/EM (Youth)	Building Life Skills to Improve Adolescent Girls' Reproductive and Sexual Health (India)
		Youth (UP)	Guria Adolescent Health Project (Georgia)
		HIV/AIDS/STI	Involving Men in Sexual and Reproductive Health (Ecuador)
		UP	Male Motivation Campaign (Guinea)
		HIV/AIDS/STI (HP/GBV)	Men as Partners (South Africa)
		Youth (HIV/AIDS/STI, HP/GBV)	New Visions (Egypt)
		HP/GBV (HIV/AIDS/STI)	One Man Can Campaign (South Africa)
		UP	PROCOSI (Bolivia)
		UP (MH)	REWARD (Nepal)
		HP/GBV	Soul City (South Africa)
		UP	Together for a Happy Family (Jordan)
		Youth	Transitions to Adulthood – Livelihoods Training (India)
		UP (MH)	Women's Empowerment Model to Train for Midwives and Doctors (Afghanistan)
		HIV/AIDS/STI (HP/GBV)	Yaari Dosti (India)
Qualitative	3	HP/FGM/C	Five Dimensional Approach for the Eradication of FGM/C (Ethiopia)
		HIV/AIDS/STI (HP/GBV, Youth)	Play Safe (Cambodia)
		HP/GBV	Through Our Eyes (Liberia)

Table A.3

Selected Reproductive Health Outcomes of Interventions Highlighted in this Report

OUTCOMES RELATED TO:	PAGE NUMBER
Healthy Timing, Spacing, and Limiting of Pregnancies	
Greater contraceptive knowledge	
Awash FGM/C	47
Behane Hewan	45
Tostan Community Empowerment Program	54
Cultivating Men's Interest in Family Planning	14
Guria Adolescent Health Project	59
Involving Men in Maternity Care (South Africa)	25
Male Motivation Campaign	13
Men in Maternity (India)	24
Reproductive Health Awareness	15
Social Mobilization or Government Services	27
Together for a Happy Family	14
Greater contraceptive use	
African Youth Alliance Program	59
Awash FGM/C	47
Behane Hewan	45
First-time Parents Project	64
Guria Adolescent Project	59
Male Motivation Campaign	13
Men in Maternity (India)	24
mothers2mothers	36
PRACHAR I & II	16
REWARD	17
Together for a Happy Family	14
Greater awareness of fertility	
Cultivating Men's Interest in Family Planning	14
Reproductive Health Awareness	15
Maternal Mortality and Safe Motherhood	
Increase in use of skilled pregnancy care	
First-time Parents Project	64
REWARD	17
Social Mobilization or Government Services	27
Increase in joint decision-making with partner about contraception	
Men as Partners	33
Men in Maternity (India)	24
Reduced case fatality rate	
FEMME Project	23
Increase in client satisfaction with providers and care	
PROCOSI	20
Decline in unmet need for contraceptives	
PROCOSI	20
Increase in screening of pregnant women for Syphilis	
Men in Maternity (India)	24
Increase in women's emergency obstetric care needs being met	
FEMME Project	23
Greater knowledge of warnings signs in pregnancy	
Men in Maternity (India)	24
Improved provider clinical skills & knowledge of FP methods & STI care	
Women's Empowerment Model to Train Midwives and Doctors	18
Increase in awareness of prenatal care	
Tostan Community-based Education Program	54

Table A.3

Selected Reproductive Health Outcomes of Interventions Highlighted in this Report

OUTCOMES RELATED TO:	PAGE NUMBER
HIV/AIDS and Other STIs	
Greater knowledge of HIV/AIDS transmission and prevention	
African Youth Alliance Program	59
Behane Hewan	45
Men as Partners	33
New Visions	61
One Man Can	50
Play Safe	34
Somos Diferentes, Somos Iguales	32
Greater condom use:	
At last sex:	
Program H	42
Tuelimishane	38
Yaari Dosti	33
With primary partner:	
Play Safe	34
Somos Diferentes, Somos Iguales	32
Stepping Stones	40
Yaari Dosti	33
Increase in visits to centers that provide HIV/AIDS and STI services	
Integration of RH Services for Men in Health and Family Welfare Centers	36
Involving Men in Sexual and Reproductive Health	37
Play Safe	34
Social Mobilization or Government Services	27
Somos Diferentes, Somos Iguales	32
Lower reported STI symptoms	
Program H	42
Stepping Stones	40
Greater knowledge of STI symptoms	
Tostan Community-based Education Program	54
Increased exclusive breastfeeding	
mothers2mothers	36
Greater receipt & ingestion of Nevirapine	
mothers2mothers	36
Greater CD4 testing	
mothers2mothers	36
Harmful Practices (early marriage, intimate partner violence, & female genital mutilation/cutting)	
Decrease in belief that IPV/SV is justified under some circumstances	
One Man Can Campaign	50
Soul City	49
Stepping Stones	40
Greater knowledge of IPV/SV resources	
Somos Diferentes, Somos Iguales	32
Soul City	49
Decrease in incidence of violence	
Tostan Community-based Education Program	54
Stepping Stones	40
Yaari Dosti	33
Increased community action and protest against harmful practices	
Five Dimensional Approach for the Eradication of FGM/C	48
Soul City	49

Table A.3

Selected Reproductive Health Outcomes of Interventions Highlighted in this Report

OUTCOMES RELATED TO:	PAGE NUMBER
Attitudes toward IPV/SV	
IMAGE	56
Men as Partners	33
New Visions	61
Tuelimishane	38
Decrease in risk of IPV/SV	
IMAGE	56
Decrease in controlling behavior by intimate partner	
IMAGE	56
Increased uptake of RH services	
Through Our Eyes	50
Greater knowledge of harmful consequences of FGM/C and advantages of not cutting girls	
Awash FGM/C	47
Tostan Community-based Education Program	54
Ishraq	62
Attitudes toward FGM/C	
Five Dimensional Approach for the Eradication of FGM/C in Ethiopia	48
New Visions	61
Increase in number of men who marry uncircumcised girls	
Five Dimensional Approach for the Eradication of FGM/C in Ethiopia	48
Decrease in FGM/C incidence	
Tostan Community-based Education Program	54
Navrongo FGM/C Experiment	46
Increase in age at marriage	
Delaying Age at Marriage in Rural Maharashtra	52
Increase in interval between marriage and first birth	
PRACHAR I & II	16
Greater knowledge of risks of early childbearing	
PRACHAR I & II	16
Fewer adolescent pregnancies	
PRACHAR I & II	16
Fewer adolescent marriages	
Behane Hewan	45
Youth Reproductive Health	
Greater sexual and reproductive health knowledge	
Building Life Skills to Improve Adolescent Girls' R&SH	45
Delaying Age at Marriage in Rural Maharashtra	52
Transitions to Adulthood - Livelihoods Training	60
Increase in decision-making ability related to:	
Condom use:	
African Youth Alliance Program	59
Transitions to Adulthood - Tap and Reposition Youth	60
Sex:	
Transitions to Adulthood - Tap and Reposition Youth	60
Increase in age at sexual debut	
African Youth Alliance Program	59

Table A.4

Selected Gender Outcomes of Interventions Highlighted in this Report

OUTCOMES RELATED TO:	PAGE NUMBER
Increased gender-equitable attitudes and beliefs	
IMAGE	56
Men as Partners	33
New Visions	61
One Man Can Campaign	50
Program H	42
Tap and Reposition Youth	60
Tostan Community-based Education Program	54
Tuelimishane	38
Yaari Dosti	33
Increased partner communication about reproductive health or family planning	
Awash FGM/C	47
Cultivating Men's Interest in Family Planning	14
First-time Parents Project	64
Involving Men in Maternity Care (South Africa)	25
Men in Maternity (India)	24
Male Motivation Campaign	13
PROCOSI	20
Reproductive Health Awareness	15
Stepping Stones	40
Together for a Happy Family	14
Yaari Dosti	33
Women's increased self-confidence, self-esteem, or self-determination	
Building Life Skills to Improve Adolescent Girls' R&SH	45
Ishraq	62
mothers2mothers	36
Somos Diferentes, Somos Iguales	32
Soul City	49
Women's increased participation in the community and development of social networks	
Behane Hewan	45
First-time Parents Project	64
Transitions to Adulthood - Livelihoods Training	60
Increased support (emotional, instrumental, family planning, or general support) from partners or community	
First-time Parents Project	64
Social Mobilization or Government Services	27
Higher scores on an empowerment scale for women	
IMAGE	56
Ishraq	62
Somos Diferentes, Somos Iguales	32
Increased life and social skills	
Delaying Age at Marriage in Rural Maharashtra	52
Transitions to Adulthood - Livelihoods Training	60
Women's increased decision-making power	
Through Our Eyes	50
Higher formal educational participation for women or girls	
Behane Hewan	45
Women's increased mobility	
First-time Parents Project	64
Improved gender relations within the community	
Through Our Eyes	50
Women more articulate in discussing IPV/SV and RH	
Through Our Eyes	50
Decreased tolerance for kidnapping of girls	
Guria Adolescent Health Project	59

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Conclusions

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Glossary

4-Cell Design. Study designs that involve four treatment arms are called *factorial designs, 4-cell designs, or 2x2 designs.* These designs aims to test two different interventions (each alone and combined) against a control, which receives no intervention. The following diagram illustrates this study design for two interventions (A and B):

Group 1	**A & B**	**A only**	Group 2
Group 3	**B only**	**Control (Neither A or B)**	Group 4

Antiretroviral Therapy (ART). Antiretroviral drugs are medications for the treatment of infection by HIV. Different classes of antiretroviral drugs act at different stages of the HIV life cycle. These drugs are also known as ARVs. In people who have been infected with HIV, ART can lengthen and improve their quality of life.

Baseline. Baseline refers to the period prior to (or at the introduction of) an intervention. Data is gathered at this point to compare with performance after the intervention to determine what change has taken place.

Chi Square Test. A statistical test that measures whether the distribution of observed data systematically differs from what we would expect if the data were distributed evenly, with no difference between the comparison groups.

Cluster Randomized Control Trial. In this type of RCT, clusters, such as communities, hospitals, or other groups of people, are randomized, and all consenting persons in the group are enrolled.

Community-Based Survey. A survey where the participants are selected from a pre-defined community. Community-based research often involves more interaction with the community, such as the use of peers or members of the community to recruit or conduct the survey, or community input into the research questions and design of the survey.

Contamination. Contamination occurs when there is communication about the intervention between groups of participants (usually treatment and control). This can lead to a diffusion of treatment, because, consciously or subconsciously, the control group receives part or all of the intervention. Contamination can also occur if the intervention is not fully implemented.

Control Group. When an intervention is randomly assigned in an experimental study design, the control group does not receive the intervention. The control group is supposed to be comparable to the intervention group, which receives the intervention. If entire groups or communities are randomly assigned, it is referred to as a 'control area'.

Correlated Data. When data are correlated, there is a relationship between two or more sources of data. This means that they tend to vary, be associated, or occur together in a way not expected on the basis of chance alone. For example, if a group of participants in a study respond in a predictable manner, there is a correlation among that group. This is often the case among participants who are selected through one health facility.

Cost Effectiveness Analysis. This form of analysis seeks to determine the costs and effectiveness of surveillance and response strategies and activities. It can be used to compare similar or alternative strategies and activities to determine the relative degree to which they will obtain the desired objectives or outcomes. The preferred strategy or action is one that has the least cost to produce a given level of effectiveness, or provides the greatest effectiveness for a given level of cost.

Cox Proportional Hazard. This is a form of statistical analysis. It is a survival analysis measuring the proportional difference in the length of time to an event between two populations.

Endline. Endline refers to the period after an intervention is completed. Data gathered at this point is usually compared with performance before the intervention to determine what change has taken place.

Equality. Gender equality is equal treatment of women and men in laws and policies and equal access to resources and services within families, communities, and society at large.

Equity. Gender equity connotes fairness and justice in the distribution of opportunities, responsibilities, and benefits available to men and women, and the strategies and processes used to achieve gender equality. Equity is the means, equality is the result.

Evaluation. The use of social science research procedures to systematically investigate the effectiveness of social intervention programs that are designed to improve social conditions.

Experimental. Experimental studies control the allocation of treatment (intervention) to subjects (participants). The distinguishing feature of experimental studies in evaluation is randomization. In evaluation research, participants or groups are randomly assigned to either an intervention group or a control group. Randomly assigning the groups helps ensure that the intervention and control groups are comparable to each other so that any differences at endline can be attributed to the intervention.

Female Genital Mutilation/Cutting. Often referred to as a harmful traditional practice, this involves the cutting or alteration of the female genitalia for social rather than medical reasons.

Focus Group Discussion. Focus groups are a form of qualitative data collection. Focus groups usually consist of 8-10 people who are similar in background. They may be randomly or purposively selected to participate. Conversation is guided by a facilitator. Focus groups tend to weed out extreme or false views, and uncover underlying group norms.

Follow-up. This is often used interchangeably with the term *endline.* In some cases, however, follow-up refers to data collection that occurs some period of time after endline. In these cases, endline is the data collection point at the end of the intervention, and follow-up occurs later to see what changes are sustained over time without the intervention.

Formative Research. Formative research takes place before or during the design of the intervention itself. The results of formative research guide the design of the program to make it most effective and acceptable to the target population. Formative research is often done as a needs assessment, pretesting to ensure the intervention can be implemented, or collection of qualitative data such as focus groups.

Gender. This term refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women.

Gender-based Violence. A term used to distinguish violence that targets individuals or groups of indicivduals on the basis of their gender from other forms of violence; may result in physical sexual or psychological harm. Terms such as **Intimate Partner Violence**, **Sexual Violence**, and **Domestic Violence** are used to describe gender-based violence in its various forms.

Gender Norms. Societal messages that dictate what is appropriate or expected behavior for males and females.

Highly Active Antiretroviral Therapy (HAART). A combination of several (usually three or four) antiretroviral drugs is known as Highly Active Antiretroviral Therapy. HAART is often more effective than using one antiretroviral drug alone. See *antiretroviral therapy*.

Incidence. The rate of new cases of a disease or event in a population. While prevalence is the measure of all cases at one point in time, incidence measures the number of new cases during a time period.

Intrapartum. Occurring during or pertaining to labour and/or delivery.

Matched Control. When randomization is not possible, individual cases may be matched with individual controls that have similar characteristics, such as age. By carefully selecting matches for the intervention cases or groups, the intervention and comparison groups should be similar.

Maternal Morbidity. This refers to a diseased state, illness, or departure from health as a result of pregnancy, termination of pregnancy, labour and delivery, or from any cause related to or aggravated by the pregnancy or its management.

Maternal Mortality. A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental causes. The *Maternal Mortality Ratio* is the number of maternal deaths out of 100,000 live births in a given year.

Monitoring Data. Data that come from the regular observation, surveillance, or checking of changes in a condition or situation, or changes in activities. Health facilities often use systematic collection of data on specified indicators to provide management with indications of the extent of progress and achievement of objectives.

Non-Equivalent Control Group. In quasi-experimental study designs, in which treatment and comparison groups are not randomly assigned, the group that does not receive the intervention is called a non-equivalent control group. The term 'comparison group' is also used.

Non-Experimental. Non-experimental study designs do not involve randomization or comparison groups. These designs are not able to determine the effect or impact of an intervention, but may be helpful to determine reasons why a problem exists or why a program was successful. Non-experimental evaluation designs include post-test only, pretest-posttest without comparison groups, observational studies, or studies using only qualitative data.

Pilot Project. Pilot projects, similar to formative research, are designed to inform about the success of an intervention prior to launching a full-scale intervention. Pilot projects are usually a shorter version of the intervention or include a smaller population. Pilots can help to inform whether the population understands, responds, or uses the intervention in the anticipated manner. The results of a pilot study are used to refine the intervention before the full-scale program.

Postpartum. Of, occurring, or referring to the period after childbirth.

Prenatal. Occurring or existing before birth, or preceding birth. It refers to both the care of the woman during pregnancy and the growth and development of the fetus. It is also known as *antenatal*.

Pretest-Posttest. This is a study design in which both the experimental (intervention) and control groups receive an initial measurement observation (known as baseline or pretest). The experimental group then receives the intervention, but the control group does not. After the intervention, a second set of measurement observations is made (known as endline or posttest).

Prevalence. The amount of a given disease in a population at a certain time. Prevalence is the measure of all cases at a point in time, while incidence is the measure of new cases during a time period.

Process Variable. An indicator or measurement that is used as part of an evaluation to gauge the implementation or monitor the intervention or program. The variable focuses on the process of the intervention, which is the set of activities conducted to achieve the results. Process variables often focus on the quality, access, or reach of a program.

Qualitative Data. Qualitative data include virtually any type of information that cannot be captured in a numerical format. In social research, it most often refers to open-ended, in-depth interviews with individuals or focus group discussions, but can also include observations or the results of activities such as word associations or free listing. Qualitative data cannot be quantified, but lend insight to processes, feelings, and experiences.

Quantitative Data. Data that are collected in a numerical, quantifiable way. Statistical methods of analysis can be applied. Quantitative data can be measurements, counts, ratings, scores, or classifications to which numerical values can be applied.

Quasi-Experimental. In many field research situations, it is simply not possible or feasible to meet the random assignment criteria of a true experimental study design. Quasi-experimental studies do not meet the randomization criteria, but are strong study designs that help the researchers to control some of the outside influences that could interfere with the quality or accuracy of the data. Examples of quasi-experimental designs include time series studies, pretest-posttest with non-equivalent control groups, and separate sample pretest-posttest.

Randomized Control Trial. A randomized controlled trial (RCT) is a planned experiment designed to asses the efficacy of an intervention in human beings by comparing the intervention to a control condition. The allocation to intervention or control is determined purely by chance through randomization. An RCT is the gold standard for determining causality in research.

Regression Analysis. Regression analysis is a statistical method for describing a "response" or "outcome" variable as a simple function of "explanatory" or "predictor" variables. In a *simple linear regression*, one predictor variable is used to predict a response. In *multiple linear regression*, two or more predictor variables are used to predict the response. This allows for control of additional background characteristics. *Logistic regression* analysis is used when the outcome is a binary or dichotomous variable. Logistic regression can be simple, using one predictor, or multiple, using two or more predictors.

Sample Size. Number of clusters/households/individuals that a survey sets out to include, i.e. interview. The aim of *sample size calculation* is to have a large enough sample in each group to estimate a population mean or difference in means (or proportions) within a narrow interval. Statistical calculations can determine how large a study sample needs to be in order to have confidence in the results of the statistical analysis.

Sex. Refers to the biological and physiological characteristics that define men and women.

Statistically Significant. A result that tells us only that any observed difference between groups is unlikely to be due to chance. Statistical significance is usually measured at the 0.05 level, which means the observed difference would occur by chance less than five percent of the time.

Student's T Test. This is a statistical hypothesis test that is used when the distribution of values in a population is assumed to be a normal distribution (bell curve) but the standard deviation is unknown. The Student's T Test is a simple statistical tool that is frequently used to compare a mean (average) measure between two populations.

Syndromic Management. This is one of several biomedical approaches to the treatment of sexually transmitted infections, or STIs. In syndromic management, a clinician (such as a nurse) bases treatment not on clinical tests for disease, but on the symptoms or effects that the individual is experiencing. Treatment is then offered for all diseases that could cause that symptom, or syndrome. In treating STIs, this enables clinicians to offer treatment faster than waiting for test results or in locations where clinical testing is unavailable.

Transactional Sex. Sexual behavior that results in women or men receiving money or goods in exchange for sex; usually differentiated from commercial sex or prostitution.

Triangulation. Using two or more methods or sources of data to investigate something. It is preferable that the methods and sources have different strengths and weaknesses so that the strengths of one can help counterbalance the weaknesses of the others.

Validity. The degree to which a measurement or finding actually measures or detects what it is supposed to measure. Validity refers to the accuracy or truthfulness of a study's conclusions.

THE INTERAGENCY GENDER WORKING GROUP (IGWG), established in 1997, is a network comprising non-governmental organizations (NGOs), the United States Agency for International Development (USAID), cooperating agencies (CAs), and the USAID Bureau for Global Health (GH). The IGWG promotes gender equity with population, health, and nutrition (PHN) programs with the goal of improving reproductive health/HIV/AIDS outcomes and fostering sustainable development. For more information, go to **www. igwg.org**.

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