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STRUCTURAL INTERVENTIONS THAT EMPOWER THROUGH ECONOMIC OPPORTUNITIES, EDUCATION, AND COLLECTIVE ACTION



*Evidence-based Strategies to Transform
Gender Norms, Roles, and Power
Dynamics for Better Health*

Photo by Arundati Muralidharan

Recognizing the influence of gender-based inequality on health outcomes, international organizations have advocated integrating a gender perspective into health programs.¹ To recommend evidence-based strategies to accomplish this, the Gender, Policy and Measurement (GPM) program—funded by the Asia bureau of USAID—conducted a systematic review of published and unpublished literature documenting gender-aware programs. GPM wished to identify strategies that health programs had used either to accommodate (work around) or transform areas of gender inequality, and whose influence on key health outcomes had been measured. This review yielded 146 gender-integrated interventions conducted in low- and middle-income countries (LMICs) worldwide—34 of them in India—that had been evaluated for their impact on

- Reproductive, maternal, neonatal, and child health, plus adolescent health
- HIV and AIDS
- Gender-based violence (GBV)
- Tuberculosis
- Universal health coverage

Five gender strategies that have been demonstrated to improve health emerged from the systematic review. This brief highlights one of them: structural interventions that empower people who are marginalized because of their gender identities—women and girls, men who have sex with men, and transgender people—through economic opportunities, education, and collective action (Blankenship et al., 2006). (The other strategy briefs are available at: www.healthpolicyproject.com?zp=382.)

To read the full report—*Transforming Gender Norms, Roles, and Power Dynamics for Better Health: Findings from a Systematic Review of Gender-integrated Health Programs in Low- and Middle-Income Countries*—please visit www.healthpolicyproject.com?zp=381.

Creating the Conditions for Change

Building economic opportunities, expanding access to education, and promoting collective action—each a type of structural intervention—create the conditions for change by reducing barriers and enabling people to make healthy choices. These interventions improve health outcomes by focusing on the social determinants of health. They shape supportive structures within families, communities, and health systems that can encourage and sustain health benefits. By helping to change power dynamics at the community level, they can enable greater gender equity in decision making and access to resources. They can empower women and girls by improving their education, mobility, and financial agency: the capacity to make and act on decisions independently. And they can enhance women’s and girls’ self-efficacy and self-confidence. Because they challenge gender norms, they can lead to more gender-equitable knowledge, attitudes, and behavior.

Economic opportunities

When women acquire skills and opportunities to earn a living and retain control of their earnings, their decision-making abilities and sense of agency increase. Most economic empowerment programs focus on income generation, often in conjunction with support from microcredit schemes. Livelihood training—teaching

women the basics of saving money and managing a business—is also a component of some structural programs. Many economic empowerment programs include mentoring and/or social support. This kind of economic empowerment may lead to a broad range of improved health outcomes.

Education

These interventions create pathways for girls and women to enroll or re-enroll in school or vocational training programs. They eliminate barriers to formal education and/or create a supportive environment. Economic incentives, literacy and vocational training, and community campaigns to promote education are common elements of interventions that seek to improve health through education.

Collective action

Interventions that empower disadvantaged groups through collective action help participants gain the leverage and skills necessary to be successful advocates for their rights (e.g., to health education, a livelihood, and safety) and to combat stigma. For women specifically, this strategy corrects power imbalances by providing social support and increasing their knowledge and communication and negotiation abilities. Women’s social status often rises as a result.

Learning from Case Studies

Structural interventions work best when they target specific barriers to or opportunities for gender equality. Those that emerged in the literature scan were often implemented in combination with strategies to challenge inequitable gender norms, such as critical reflection, women’s empowerment, and social and behavior change communication. Structural interventions go further, however, to address socioeconomic and other power inequalities that influence health. They were most commonly used to improve the health situations of adolescent girls, young women, and female sex workers. The review found that out of 21 programs that made structural interventions, five were implemented in India.

Financial interventions empower women and increase their knowledge of sexual and reproductive health

Microfinance programs, which provide women with small loans to run their own businesses, increase women’s self-confidence and access to resources. Such programs can change existing power dynamics and equip women to make or negotiate healthier choices. Although this approach was not used in India, evidence of its effectiveness was documented elsewhere—most commonly in sub-Saharan Africa.

Five gender-based strategies that improve health

Strategies that transform gender inequality

- Challenge gender norms
- Create the conditions for change through structural interventions
- Promote equitable relationships and decision making

Strategies that accommodate gender inequality

- Improve health systems to work around barriers grounded in gender norms
- Engage communities in behavior change for gender equity

The Tap and Reposition Youth project, in Kenya, used a modified, group-based microfinance model to extend savings incentives, credit, business support, and mentoring to out-of-school adolescent girls and young women in Nairobi. By overcoming such common gender-specific barriers to good adolescent health, such as a lack of social support and resources, the program increased the participants' decision-making ability around sex and condom use and improved attitudes toward women's right to refuse sex (Erulkar et al., 2005). Microfinance aside, other programs used livelihood training, often in conjunction with social support, to enable women to run successful businesses. In India, one intervention combined these strategies to integrate adolescent livelihood activities into a reproductive health program for urban slum dwellers. To extend the girls' use of their newly acquired livelihood skills, the project created a savings mechanism for them. By addressing barriers to and increasing women's mobility and participation in social networks, the program led to improvements in women's sexual and reproductive health knowledge (Sebastian et al., 2005).

Vocational training reduces sexual violence and improves adolescent reproductive health.

Health interventions that integrate vocational training can address gender-specific barriers to employment and income-generating potential by equipping women and girls with job skills and challenging the norms of their domestic and productive roles. These programs can be informal or linked to formal educational settings.

Economic incentives support education and delay marriage

Girls' education is often interrupted or cut short due to families' financial constraints, social norms that devalue girls' education, or norms of early marriage. To ease these barriers and promote norms favoring girls' education, many programs use conditional cash transfers or other material incentives. Although GPM did not find evidence of this approach in India, evidence from other LMICs demonstrates how it can be used to improve the health and well-being of adolescent girls.

The Berhane Hewan project in Ethiopia offered school supplies (exercise books, pencils, and pens) to girls to encourage school attendance or re-enrollment. The project also conducted community conversations on topics related to preventing early marriages and empowered girls through livelihood training. If girls completed the program successfully, when they graduated, they and their families received an additional incentive: a goat. The project led to increases in contraceptive use and knowledge of HIV

and sexual and reproductive health, and a delay in girls' marriages (Gage, 2009).

Informal educational opportunities improve adolescent health, including healthy timing and spacing of pregnancy

The Better Life Options Program, in India, conducted literacy classes with adolescent girls, facilitated linkages with formal education, and engaged stakeholders such as parents. By empowering the girls and sensitizing their families and communities to their unique needs, the project sought to transform the girls' environment. This intervention achieved gains in the healthy timing and spacing of pregnancy and improved adolescent, maternal, neonatal, and child health (CEDPA, 2001).

Education and empowerment through collective action reduce HIV and other sexually transmitted infections and prevent gender-based violence

These interventions help populations with limited agency and social status as a result of gender norms, such as adolescent girls and female sex workers, to advocate their rights and adopt healthy behaviors. They use such strategies as mobilizing communities for advocacy; working with powerful stakeholders; organizing women to enhance their ability to advocate successfully; and providing access to healthcare, education, and economic and other social support. The Sonagachi and Avahan projects, which worked with female sex workers in India to reduce their vulnerability to HIV, led to improvements in outcomes related to HIV and other sexually transmitted infections and GBV. Through Avahan, female sex workers increased their leverage by forming community-based organizations to advocate collectively for their rights. It also promoted community mobilization and advocacy to reduce stigma, violence, and barriers to safety and to improve relations between female sex workers and the police. Notably, Avahan reduced HIV prevalence in some of its intervention sites.

Measuring Improvements in Health and Gender Equality

GPM developed a scale to rate the strength of evidence for each intervention—"effective," "promising," or "unclear"—based on the combined ratings of an intervention's impact on health outcomes and rigor of evaluation design.²

All of the economic empowerment and education programs in India and 95 percent of those in other LMICs were found to be effective or promising in their impact on outcomes across nearly all of the health areas examined.

(The exception was tuberculosis, for which no education programs were reviewed.) GPM found only two collective action interventions in India, but both were effective in improving HIV and GBV outcomes. Nearly all of the effective and promising structural interventions were implemented in combination with strategies to challenge gender norms, either at the community level or through personal empowerment or critical reflection on gender norms. Therefore, the effectiveness of a gender program cannot be attributed to the use of a single gender strategy, but rather in the layering of multiple gender strategies that complement and reinforce one another.

Structural interventions also led to many gender outcomes in India and other LMICs. Some of these are increased expression of gender-equitable attitudes and beliefs, including improved attitudes toward intimate partner and sexual violence; women's increased community participation, mobility, decision-making power, and participation in formal education; women's improved self-confidence, self-esteem, and/or self-determination; reports of increased communication between partners; increased partner/community support; and increased incidence of action against violence. Structural interventions in LMICs other than India showed evidence of increased control by women over their wages or other income.³

Recommendations

By integrating evidence-based strategies that address economic opportunities, education, and collective action into health programming, interventions can improve health outcomes by breaking down gender-specific barriers that prevent healthy and health-seeking behavior. To achieve this, health program planners should

- **Implement integrated women's empowerment and livelihoods programs and promote girls' education** to improve adolescent health, HIV, and GBV outcomes. These approaches should engage men, boys, and communities in the process.
- **Use collective action and advocacy** to address stigma, discrimination, and violence against marginalized groups, such as female sex workers. This strategy has been shown to be highly effective in preventing HIV transmission.

- Identify factors outside of the health sector that impact health. **Explore opportunities for cross-cutting action** in development sectors such as education and commerce to improve health and other socioeconomic outcomes.
- **Explore the long-term impact of structural interventions.** Sustained evaluations are needed to understand long-term impacts and because health impacts may not be immediately apparent. (Structural interventions affect distal factors, so it takes longer to see their impact on proximal factors and health outcomes.)

Notes

1. World Health Organization. 2014. "Why Gender and Health?" Available at <http://www.who.int/gender/genderandhealth/en/>.
2. Effectiveness ratings for each intervention are available in the Program Overview document. For an explanation of the effectiveness rating scale, refer to the full report: *Transforming Gender Norms, Roles, and Power Dynamics for Better Health*.
3. For a complete list of health and gender outcomes, refer to *Transforming Gender Norms, Roles, and Power Dynamics for Better Health: Gender-Integrated Programs Reference Document*.

References

- Blankenship, K.M., S.R. Friedman, S. Dworkin, and J.E. Mantell. 2006. "Structural Interventions: Concepts, Challenges and Opportunities for Research." *Journal of Urban Health* 83(1): 59–72.
- Centre for Development and Population Activities (CEDPA). 2001. *Adolescent Girls in India Choose a Better Future: An Impact Assessment*. Washington, DC: CEDPA.
- Erulkar, A.S., and E. Chong. 2005. *Evaluation of a Savings & Micro-Credit Program for Vulnerable Young Women in Nairobi*. Nairobi, Kenya: Population Council.
- Gage, A.J., ed. 2009. *Coverage and Effects of Child Marriage Prevention Activities in Amhara Region, Ethiopia: Findings from a 2007 Study*. Chapel Hill, North Carolina: University of North Carolina at Chapel Hill, Carolina Population Center, MEASURE Evaluation.
- Sebastian, M.P., M. Grant, and B. Mensch. 2005. *Integrating Adolescent Livelihood Activities within a Reproductive Health Programme for Urban Slum Dwellers in India*. New Delhi, India: Population Council.

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