A Manual for Integrating Gender Into Reproductive Health and HIV Programs:

FROM COMMITMENT TO ACTION (2nd Edition)

August 2009

USAID
FROM THE AMERICAN PEOPLE

IGWG

This Manual update was prepared with support from the BRIDGE Project (No. GPO-A-00-03-00004-00), funded by the U.S. Agency for International Development (USAID), and implemented by the Population Reference Bureau (PRB) on behalf of the Interagency Gender Working Group (IGWG), a network comprising USAID Cooperating Agencies (CAs), non-governmental organizations, (NGOs) and the USAID Bureau for Global Health.

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).

Copyright August 2009, Population Reference Bureau. All rights reserved.

A MANUAL for INTEGRATING GENDER Into REPRODUCTIVE HEALTH and HIV PROGRAMS:

FROM COMMITMENT TO ACTION (2nd Edition)

AUGUST 2009

By
Deborah Caro of Cultural Practice, LLC,
For the Interagency Gender Working Group

ACKNOWLEDGMENTS

The development of the original Gender Manual, published in 2003, involved many people over several years—too many to acknowledge here. This update would not be possible without the many hours and great diversity of ideas contributed by those individuals, particularly the other original authors: Jane Schueller, Maryce Ramsey, and Wendy Voet.

Special thanks to USAID's Michal Avni and Patty Alleman, gender advisors in the Office of Population and Reproductive Health of the Global Health Bureau, for their commitment and support in making this publication a reality; to Sandra Jordan and Lora Wentzel, also of that office, and to Diana Prieto, gender advisor in USAID's Office of HIV/AIDS, for their invaluable review and suggestions. I am grateful also to Charlotte Feldman-Jacobs and Karin Ringheim of the Population Reference Bureau (PRB) for their considerable editing, support, and encouragement in moving this revised Gender Manual forward. And, of course, thanks to all those who field-tested this Manual over the years and whose feedback has made this a better resource.

Deborah Caro
August 2009

TABLE OF CONTENTS

Acknowledgments ii

List of Acronyms iv

Preface v

Brief Overview of Chapters vi

CHAPTER 1: INTRODUCTION 1

CHAPTER 2: RATIONALE FOR GENDER INTEGRATION AND MAINSTREAMING 3

CHAPTER 3: THE GENDER INTEGRATION CONTINUUM 9

CHAPTER 4: THE GENDER ANALYSIS FRAMEWORK 19

CHAPTER 5: A PROCESS FOR GENDER INTEGRATION THROUGHOUT THE PROGRAM CYCLE 33

- Step 1. Assessment 35
- Step 2. Strategic Planning 44
- Step 3. Design 50
- Step 4. Monitoring 55
- Step 5. Evaluation 60

References 67

APPENDICES

Appendix I — Additional Definitions 70

Appendix II — The Interagency Gender Working Group (IGWG) 72

Appendix III — Gender Resources and References 74

LIST OF ACRONYMS

AIIH & PH	All India Institute of Hygiene and Public Health
APS	Annual Program Statement
BLP	Better Life Options Project (India)
CA	Cooperating Agency (nongovernmental organizations and consulting firms that implement USAID funded programs)
CBD	Community-Based Distribution
CEDPA	The Centre for Development and Population Activities
CIDA	Canadian International Development Agency
CSW	Commercial Sex Worker
DFID	Department for International Development (Great Britain)
DG	Democracy and Governance
DMSC	Durbar Mahila Samanwaya Committee (Bombay, India)
FGM/C	Female Genital Mutilation/Cutting
FHI	Family Health International
FWCW	1995 UN Fourth World Conference on Women (Beijing, China)
GO	Governmental Organization
HIV/AIDS	Human Immunodeficiency Virus/Autoimmune Deficiency Syndrome
ICPD	U.N. International Conference on Population and Development (Cairo, Egypt, 1994, and all subsequent ratifications)
IEC	Information, Education, and Communication
IGWG	Interagency Gender Working Group
INTRAH	Innovative Technologies for Healthcare Delivery
JHPIEGO	JHPIEGO Corporation, an affiliate of Johns Hopkins University
MOH	Ministry of Health
NGO	Nongovernmental Organization
NORAD	Norwegian Agency for Development
OECD/DAC	Organization for Economic Cooperation and Development/ Development Assistance Committee
OVC	Orphans and other vulnerable children
PHN	Population, Health, and Nutrition
PLWHA	People Living with HIV/AIDS
PMTCT	Preventing mother to child transmission of HIV
PRB	Population Reference Bureau
RFA	Request for Applications
RFP	Request for Proposals
RFTOP	Request for Task Order Proposal
RH	Reproductive Health, incorporating in this Manual Maternal Health, Family Planning, and HIV and AIDS
SIDA	Swedish International Development Cooperation Agency
STI	Sexually Transmitted Infection
SRH	Sexual and Reproductive Health
TA	Technical Assistance
TAG	Technical Advisory Group
TBA	Traditional Birth Attendant
UN	United Nations
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

PREFACE

The Interagency Gender Working Group (IGWG), (www.igwg.org), established in 1997, is a network of organizations, including the USAID Bureau for Global Health, USAID-funded cooperating agencies (CAs), health and women's advocacy groups, non-governmental organizations (NGOs), and individuals. The IGWG promotes gender equity within programs to improve reproductive and maternal health, and HIV/AIDS outcomes and to foster sustainable development.

The IGWG's specific objectives are to:

- Raise awareness and commitment to synergies between gender equity and reproductive health (RH), and HIV/AIDS outcomes;
- Collect empirical data and best practices on gender issues and the interface with RH;
- Advance best practices and influence the field;
- Develop operational tools for the integration of gender approaches into population, health, and nutrition (PHN) programming; and
- Provide technical leadership and assistance.

The major activities of the IGWG are gender capacity-building, advocacy, and the development of operational tools (see a complete listing of IGWG products, services, and contacts in Appendix 3 or at www.igwg.org). This Manual is a companion to the *Guide for Incorporating Gender Considerations in USAID's Family Planning and Reproductive Health RFAs and RFPs*, developed chiefly for USAID program managers. The Manual complements the Guide by orienting program designers, managers, and technical staff on how to integrate gender issues into program design, implementation, and evaluation. The Manual promotes greater understanding of how gender relations and identities affect the capacity of individuals and groups to make informed choices about their sexual and reproductive health, and to negotiate and obtain better RH outcomes. Users of the Manual will learn how to harness an increased awareness of gender considerations for the design, implementation, and evaluation of more effective programs.

This 2009 edition incorporates updated tools and approaches to gender integration in USAID programs. The IGWG offers the Manual as a tool to be used, adapted, and improved through its application in the hope that users of the Manual will move from a commitment to integrating gender considerations in the design of programs to concrete actions to promote gender equity in programs and policies. Feedback on the Manual and suggestions for strengthening it are welcome, and should be addressed to igwg@prb.org.

BRIEF OVERVIEW OF CHAPTERS

CHAPTER 1 **Introduction** describes the purpose and use of the Manual and intended audiences.

CHAPTER 2 **Rationale for Gender Integration and Mainstreaming** explores the background and the benefits of addressing gender issues in programming and policy formulation, and defines some key gender terms and concepts used throughout the document.

CHAPTER 3 **The Gender Continuum** describes a tool for identifying and assessing the extent to which gender has been appropriately and effectively integrated into programs. It will help program managers more fully understand how gender differences and unequal power relations are treated in the context of health program design and implementation, and with what results.

CHAPTER 4 **The Gender Analysis Framework** presents a tool for collecting, synthesizing, and analyzing context-specific information on gender relations and identities that can assist program designers and evaluators responsible for conducting a gender assessment or synthesizing information from existing research and analyses.

CHAPTER 5 **Gender Integration Throughout the Program Cycle** provides a series of guiding questions and methodological tips. Case studies of actual projects illustrate gender integration at each stage of project development and demonstrate the link between key elements of a gender-integrated approach and project actions. The five steps to gender integration in the programming cycle are:

- STEP 1: Assessment: Collect data on gender relations, roles, and identities that pertain to the achievement of program outcomes and analyze data for gender-based constraints and opportunities that may affect, impede or facilitate program objectives.
- STEP 2: Strategic Planning: Develop or revise program objectives for their attention to gender considerations; restate them so that they strengthen the synergy between gender and health goals; identify participants, clients, and stakeholders.
- STEP 3: Design: Identify and decide on key program strategies and activities to address gender-based constraints and opportunities.
- STEP 4: Monitoring: develop and monitor indicators that measure health and gender-specific outcomes.
- STEP 5: Evaluation: Measure progress and impact of program and policies on health and gender equity. Make recommendations to adjust design and activities based on monitoring and evaluation results; strengthen aspects of the program that contribute to more equitable health and gender outcomes, and rework aspects that do not.

CHAPTER 1: INTRODUCTION

Since this Manual was first published in 2003, there has been an encouraging increase in attention to gender equity goals in reproductive health (RH)[1] and HIV/AIDS programming, promoting respect for the fundamental needs and rights of individuals and communities. There has also been improved understanding of how to undertake a gender analysis that can help programs and policies be more responsive to the social, economic, cultural, and political realities that constrain or enhance reproductive health.

Purpose of the Manual

The primary purpose of this revised Manual is to offer organizations an updated resource on how to integrate a gender equity[2] approach into the design and implementation of RH programs. Such an approach aims to maximize access and quality, support individual decisionmaking about reproductive health, increase sustainability, and put into practice commitments the U.S. government has made to international agreements.

Use of the Manual

This Manual aims to help program implementers:

- Improve the quality of RH services;
- More effectively meet the needs of program participants;
- Improve program sustainability;
- Better inform and empower clients;
- Improve couple communication;
- Improve utilization of services; and
- Broaden development impacts and enhance synergies across sectors.[3]

In addition, international and national health specialists can use this Manual when shaping programs responsive to RFAs and RFPs. Programs that use gender integration approaches have a strategic advantage in meeting the gender requirements of USAID and PEPFAR, and in contributing to the Millennium Development Goals.

1 For simplification purposes, the term reproductive health (RH) will be used throughout the document but should be understood to incorporate sexual health as well as family planning (FP), HIV/AIDS, and maternal health (MH).

2 The terms "gender equity" and "gender equality" are often used interchangeably, although there are differences. Gender equality means equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities and society at large. 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. Because this Manual primarily addresses gender programming rather than changes to laws and policies, the term "gender equity" will be used throughout.

3 For further information about the impact of gender-integrated programs on RH, see E. Rottach, S.R. Schuler, and K. Hardee, *Gender Perspectives Improve RH Outcomes: New Evidence*, Washington, DC: PRB for USAID's IGWG, forthcoming.

The Manual is intended as a user-friendly reference, to be used at any stage of the program cycle, from program design to program evaluation. However, it will be most effective if used to guide program decisions throughout the life of project development, implementation, and evaluation.

As a tool for strategic program planning rather than for training, the Manual provides practical steps for gender integration, and is not intended as a comprehensive guide to addressing gender issues. It complements gender and reproductive health training materials by offering direction on integrating gender into newly designed or ongoing project cycles, programs, and policy analyses.

Intended Audiences

The primary audiences for this Manual include RH program managers and technical staff of USAID and its implementing partners, as well as governmental organizations (GOs), and international and local nongovernmental organizations (NGOs).

CHAPTER 2: RATIONALE FOR GENDER INTEGRATION AND MAINSTREAMING

2

Why Use This Manual?

The evidence is strong that gender equity contributes to the achievement of specific RH outcomes,[4] including:

- Reduced unmet need for contraception;
- Reduced unwanted and unintended fertility;
- Reduced HIV transmission and improved access to care and treatment;
- Prevention of mother to child transmission of HIV;
- Reduced violence against women;
- Decreased maternal mortality.

Moreover, the U.S. Government (USG) has committed to mainstreaming gender concerns in its programs, upholding its support of international agreements, including the 1994 United Nations International Conference on Population and Development (ICPD), the 1995 Fourth World Conference on Women (Beijing), and the development of policies to implement these agreements.

The Beijing Platform for Action defines gender mainstreaming as:

> "…the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality."[5]

The Millennium Development Goals

While the ICPD, Beijing, and other international agreements provided a vision of gender equity, they were not specific in articulating how progress would be measured. In 2000, the Millennium Declaration for the first time established goals and measurable indicators and targets to be achieved within a specified timeframe. The Millennium Declaration commits signatory countries, including the United States, "to promote gender equality and the empowerment of women as effective ways to combat poverty, hunger, and disease and to stimulate development that is truly sustainable."[6]

Gender equity is not only a cross-cutting objective in all eight Millennium Development Goals (MDGs), it is also the specific focus of MDG 3, Promote Gender Equality and Women's Empowerment.

4 J. Cleland et al., "Family Planning: The Unfinished Agenda," in *The Lancet*, 2006.

5 Platform for Action, UN Fourth World Conference on Women (Beijing: UN, 1995).

6 World Bank, Gender and Development Group, *Gender Equality and the Millennium Development Goals* (Washington, D.C.: World Bank, 2003); see also www.un.org/millenniumgoals/.

MDG 3 calls for nations to "Achieve parity in:

- the ratio of girls and boys in primary, secondary and tertiary education;
- the ratio of literate females 15-24 years to males of the same age;
- the share of women in wage employment in the non-agricultural sector; as well as
- the proportion of seats held by women in national parliaments by 2015."

MDG 3 both contributes to and is reinforced by the achievement of the remaining seven goals (see box below) and the targets most relevant to gender equity.

MDG 1 Eradicate Extreme Hunger and Poverty: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day and the proportion of people who suffer from hunger; and achieve full and productive employment and decent work for all, including women and young people.

MDG 2 Achieve Universal Primary Education: Ensure everywhere, boys and girls alike will complete a full course of primary schooling.

MDG 3 Promote Gender Equality and Women's Empowerment: See description above.

MDG 4 Reduce Child Mortality: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

MDG 5 Improve Maternal Health: Reduce the Maternal Mortality Ratio by three-quarters, between 1990 and 2015, and achieve universal access to reproductive health by 2015.

MDG 6 Combat HIV/AIDS, Malaria, and Other Diseases: Have halted by 2015 and begun to reverse the spread of HIV/AIDS, the incidence of malaria and other major diseases, and achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.

MDG 7 Ensure Environmental Sustainability: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation and achieve by 2010, a significant reduction in the rate of loss to biodiversity.

MDG 8 Develop a Global Partnership for Development: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system and address the special needs of the least developed countries.

The USG, along with other national, international, and private donors, has committed to helping developing countries meet their 2015 targets in the interest of international development as well as gender equity.

Through the MDGs and earlier agreements, such as the ICPD and the Beijing Conference, the United States has declared it will:

- Promote women's empowerment and gender equity;
- Focus on meeting the reproductive and sexual health needs of youth;
- Involve women in leadership, planning, decisionmaking, implementation, and evaluation.
- Promote the constructive engagement of men and boys to improve the health of women and girls and men themselves.

USAID and Gender

In 1996, USAID issued its first Gender Plan of Action, which recognized that "through attention to gender issues, our development assistance programs will be more equitable, more effective and – ultimately – more sustainable."[7]

Since then, the evidence has only grown more compelling that reducing gender inequities can result in dramatic development impacts in other sectors. Improving access to education for girls, for example, contributes to improved child, maternal, and family health as well as to reduced fertility, increased incomes, and productivity. RH programs that address the differential opportunities, constraints, contributions, and benefits that women and men face will improve health outcomes by more effectively increasing access to services, improving communication, strengthening negotiation and advocacy skills, and widening participation and input into decisionmaking.

USAID policy mandates integrating gender considerations into RH programs.[8] As stated in the Automated Directive System (ADS), USAID requires program managers to incorporate gender considerations into the design of new contracts, grants, and cooperative agreements and calls for staff to:

- Conduct appropriate gender analyses in the entire range of technical issues that are considered in the development of all projects and activities;
- Integrate gender considerations into the statement of work (SOW) for competitive contract solicitations (Requests for Proposals-RFPs) and program descriptions (Requests for Applications-RFAs); and integrate gender issues into all technical evaluations (for RFPs and RFTOPs) and selection criteria (for RFAs and APSs);
- Mainstream gender considerations into the design, implementation, and monitoring and evaluation of USAID program and policy support activities;
- Include gender indicators and sex-disaggregated data collection into the program monitoring and evaluation plan.

7 Statement by J. Brian Atwood, Administrator, USAID; Accessed online May 1, 2009 at http://www.usaid.gov/policy/ads/200/gplana96.pdf.

8 The USAID Automated Directive System (ADS) is the operating policy for USAID programs and policy work. 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.

USG and Gender

In Spring 2009, the United States Government (USG) announced its commitment to promoting better health around the world through the Global Health Initiative,[9] benefitting women, families, and communities. In addition to funding for global HIV/AIDS, malaria, and tuberculosis, there will be increased focus on child and maternal health, family planning, neglected tropical diseases, and health system strengthening, thereby

- Preventing millions of new HIV infections;
- Reducing mortality of mothers and children under five, saving millions of lives;
- Averting millions of unintended pregnancies; and
- Eliminating some neglected tropical diseases.

The President's Emergency Plan for AIDS Relief (PEPFAR)[10] is a key component of the Global Health Initiative. Launched in 2003, PEPFAR demonstrated the USG's commitment to gender equality while establishing a comprehensive, integrated, strategy to combat the global spread of HIV and AIDS. In 2008, PEPFAR's re-authorization strengthened the program's mandate to integrate gender in all technical areas in prevention, treatment, and care. Through five gender strategies tailored to meet the unique gender-specific needs and challenges of different beneficiary groups, PEPFAR's aim has been to:

- Increase gender equity in HIV/AIDS activities by promoting proactive and innovative strategies to ensure that men and women, girls and boys, have equitable access to prevention, care, and treatment services; to address barriers selectively faced by women and men in accessing programs and in enjoying program benefits; to mitigate the burden of care on women and girls; and to encourage men's uptake of services .
- Reduce violence and coercion by supporting efforts to change social norms that perpetuate violence against women; by developing screening, couples counseling and partner notification strategies; by working with health providers, other institutions and communities to provide a range of support services and referrals for survivors, including the provision of post-exposure prophylaxis (PEP); and by strengthening policy and legal frameworks that outlaw gender-based violence.
- Address men's norms and behaviors by constructively engaging men in advancing gender equity, preventing violence, and promoting sexual and reproductive health for themselves and their partners, including couples testing and counseling; involving men in prevention of mother-to-child transmission; behavior change programs addressing alcohol and substance abuse, cross-generational sex, and multiple concurrent partnerships; and working with the armed services and communities on responsible male behavior.
- Increase women's legal rights and protection by eliminating discriminatory policies, laws, and legal practices that deny women enforceable legal rights and protections, by promoting equal rights to inheritance, land, property and other productive assets; and by increasing awareness among judicial, legal and health sectors, community leaders and traditional authorities on the legal rights related to HIV/AIDS.

9 From the U.S. State Department fact sheet on "The U.S. Commitment to Development," July 7, 2009. Accessed on August 1, 2009 at http://www.state.gov/e/eeb/rls/fs/2009/113995.htm.

10 The 5-year strategy for the second phase of PEPFAR is forthcoming and will be accessible at www.pepfar.gov.

- Increase women's access to income and productive resources by strengthening their access to vocational training, education, microfinance and credit so as improve their ability to access services, support themselves and their children, and avoid coercive and high risk activities that increase vulnerability to HIV.

Gender Inequity Contributes to Poor Health Outcomes

Gender equity and health objectives are mutually reinforcing. Gender inequity is a major obstacle to reaching better family planning, maternal and reproductive health outcomes, and to preventing and treating HIV/AIDS. Women's control over financial resources and power are fundamental to their capacity to access and use health information, make informed decisions about their health and fertility, and to negotiate and insist on safe sex practices. Conversely, when women or men are unable to make critical decisions about their reproductive and sexual health, there are high social and economic costs for them as individuals, and for their families, communities, and countries.[11]

Many reproductive health problems are directly linked to gender inequity, including maternal mortality, unintended pregnancies, the feminization of the HIV pandemic, and gender-based violence.

A high maternal mortality ratio is one of the strongest indicators of gender inequity and discrimination against women. Extensive research has shown that poverty and the disempowerment of women — low status, lack of power, lack of access to information, limited mobility, lack of decisionmaking and choice, early age of marriage and violence — all contribute to maternal mortality and morbidity.[12]

Women's lack of access to family planning or lack of decision-making ability regarding how often and when to have children often results in high fertility and unintended pregnancies. Women's mobility and access to financial resources is limited in many parts of the world, restricting their access to and use RH services. Decisions about pregnancy and family size are often strongly influenced or independently determined by men or other family members.[13]

The increasing feminization of the HIV pandemic is also largely attributable to unequal gender power relations which impede women's capacity to negotiate safer sex practices. In addition, traditional norms of masculinity enable men to engage in sexually risky behaviors with negative health consequences for themselves and their partners.[14]

And finally, gender-based violence is a direct result of unequal gender power relations, and undermines women's reproductive as well as physical and psychological health. A WHO study of intimate partner violence in ten countries found that violence had a significant negative impact on health during pregnancy and was associated with increased risk of HIV. In addition, women who experienced intimate partner violence also reported more recurring health problems than women who did not experience violence.[15]

11 Swedish Ministry of Foreign Affairs, 2004.

12 Gill, K., R. Pande, and A. Malhotra, "Women Deliver for Development," *The Lancet* 370, no. 9595 (2007):1347 – 1357.

13 R. Smith et al., *Family Planning Saves Lives*, 2009.

14 Barker et al., 2007.

15 Garcia-Moreno et al., 2005.

The flip side of this "gender inequity breeds poor health" coin is that gender-integrated RH and HIV programs enhance positive reproductive and sexual health outcomes for women and men. Research evidence exists that programs that consider gender in response to SRH and HIV problems can increasingly demonstrate value added.[16] Moreover, a review of programs that have constructively engaged men has identified many that were effective in helping men to reduce behaviors that put themselves and their partners at risk.[17] Program managers can use this Manual to replicate and expand upon these successes, and to lay the foundation for documenting the impact of the process.

Gender Definitions and Working Concepts

Understanding the distinction between the terms sex and gender is important for conducting an appropriate analysis of gender relations, roles, and identities in conjunction with the design of gender-integrated RH and HIV/AIDS programs. The definitions below clarify some of the terminology commonly used in programs that focus on gender. Additional definitions used in this manual or related to gender integration are provided in Appendix I.

Sex refers to the biological and physiological characteristics that define men and women (WHO).

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

Gender identity refers to one's sense of oneself as a man, a woman or transgender[18] (American Psychological Association-APA).

Sexual identity, sexual preference, and sexual orientation refer to an enduring pattern of emotional, romantic, and/or sexual attractions to men, women, or both sexes, and a person's sense of identity based on those attractions, related behaviors, and membership in a community of others who share those attractions (APA).[19]

16 Rottach, Schuler, and Hardee, forthcoming.

17 Barker et al., 2007.

18 According to the APA, the term transgender is "used to describe people whose gender identity or gender expression differs from that usually associated with their birth sex."

19 In March, 2009, Robert Wood, the acting Department Spokesman for the Bureau of Public Affairs, U.S. Department of State, publically endorsed the UN Statement on "Human Rights, Sexual Orientation, and Gender Identity: "The United States supports the UN Statement on "Human Rights, Sexual Orientation, and Gender Identity," and is pleased to join the other 66 UN member states who have declared their support of this Statement that condemns human rights violations based on sexual orientation and gender identity wherever they occur." See www.state.gov/r/pa/prs/ps/2009/03/120509.htm

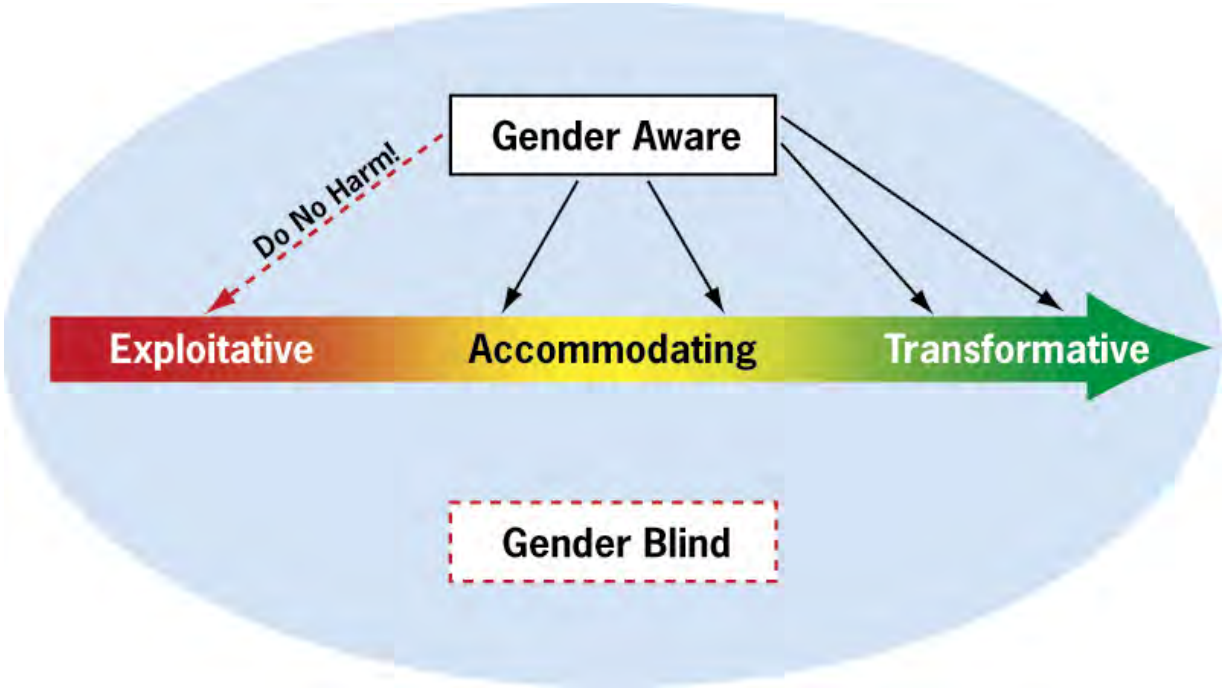
CHAPTER 3: THE GENDER INTEGRATION CONTINUUM

3

To guide various projects on how to integrate gender, the IGWG has developed a conceptual framework known as the *Gender Integration Continuum*. This framework[20] categorizes approaches by how they treat gender norms and inequities in the design, implementation, and evaluation of program/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 prerequisite for all gender-integrated interventions is to be gender aware.

FIGURE 1. The Gender Integration Continuum



20 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; G.R. Gupta, D. Whelan, and K. 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.

In the gender integration continuum graphic (see page 9), 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 broken, 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.

The gender integration continuum is a tool for designers and implementers to use in planning how to integrate gender into their programs/policies. Under no circumstances should programs take advantage of existing gender inequalities in pursuit of health outcomes ("do no harm!"), which is why, when printed in color, the area surrounding "gender exploitative" is red, and the arrow is broken.

Gender aware programs/policies are expected to be designed with gender accommodating or transformative intentions, or at other points along that end of the continuum. Programs/policies may have multiple components that fall at various points along the continuum, which is why there are multiple arrows in the graphic. The ultimate goal of development programs/policies is to achieve health outcomes while transforming gender norms toward greater equality; therefore, the area around "gender transformative" is green ("proceed forward"), and the arrow extends indefinitely toward greater equality.

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. It is an unacceptable approach for integrating gender.

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. However, in situations where gender inequities are deeply entrenched and pervasive in a society, 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 and traditional leaders.

Program/policy planners should keep in mind that a particular project may not fall neatly under one type of approach, and may include, for example, both accommodating and transformative elements. It is also important to note that 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.

Most importantly, program/policy planners and managers should follow 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.

Gender Continuum Concepts

Gender Blind refers to little or no recognition of local gender differences, norms, and relations in program/policy design, implementation, and evaluation.

Gender Aware refers to explicit recognition of local gender differences, norms, and relations and their importance to health outcomes in program/policy design, implementation and evaluation. This recognition derives from analysis or assessment of gender differences, norms, and relations in order to address gender equity in health outcomes.

Gender Exploitative refers to approaches to program/policy design, implementation, and evaluation that take advantage of existing gender inequalities, behaviors, and stereotypes in pursuit of health and demographic outcomes. The approach reinforces unequal power in the relations between women and men, and potentially deepens existing inequalities.

Gender Accommodating refers to approaches to project design, implementation, and evaluation that adjust to or compensate for gender differences, norms, and inequities. These approaches respond to the different roles and identities of women and men. They do not deliberately challenge unequal relations of power or address underlying structures that perpetuate gender inequalities.

Gender Transformative refers to approaches that explicitly engage women and men to examine, question, and change institutions and norms that reinforce gender inequalities, and as a result achieve both health and gender equality objectives.

Examples Along the Gender Continuum

The project examples below, while based on one or more actual cases, are fictionalized to demonstrate how projects might fall at various points along the continuum. The projects are categorized according to their perceived intent at design. Sometimes projects are designed with one approach and result in an outcome that differs from the original intent. This is noted in the comments under "explanation of categorization."

Project Description	Category	Explanation of Categorization
Campaign to Increase Male Involvement in Zimbabwe In an effort to increase contraceptive use and male involvement in Zimbabwe, a family planning project initiated a communication campaign promoting the importance of men's participation in family planning decisionmaking. Messages relied on sports images and metaphors, such as "Play the game right; once you are in control, it's easy to be a winner;" and "It is your choice." The campaign increased the use of contraceptive methods. When evaluating impact, the project asked male respondents whether ideally they, their partners, or both members of the couple should be responsible for making family planning decisions. The evaluation found that while men were more likely to believe that they should take an active role in family planning as a result of the campaign, they did not necessarily see this as a topic for joint decisionmaking. Men interpreted the campaign as promoting the notion that family planning decisions should be made by men alone.	Exploitative	The project's intention was to convey to men that FP is a topic about which they should be concerned. However, the messages used emphasized those aspects of masculinity that speak to men's power: winning in sports, being in control, and making decisions. Men came away from the campaign with the unintended message that they should be in control of FP decisions, which further limited women's participation in FP/RH decisionmaking and couple communication, and undermined the objective of increasing men's role as supportive partners.

Project Description	Category	Explanation of Categorization
A Female Genital Mutilation/Cutting (FGM/C) intervention in Kenya sought to encourage abandonment of the practice. Project staff realized that simply enacting a law prohibiting the practice would not address the cultural and social motivations supporting the practice within the community, and would likely result in driving the practice underground. A medical anthropologist, hired to conduct qualitative research with women, men, and religious leaders, conveyed to project leaders the symbolic nature of the ritual to the community. Together with community members, the project staff designed a ritual for girls that maintained meaningful cultural elements, such as a week-long seclusion, life-skills education, dance and storytelling, and gift-giving. The new ritual retained the celebratory nature while eliminating the cutting. The new rite-of-passage ritual has been accepted by the entire community.	Transformative	The project engaged women and men, girls and boys, in a process of critical reflection, leading to an understanding that the long-accepted cultural practice of FGM/C violated the rights of girls to health and bodily integrity. By working with communities to identify an alternative, culturally acceptable ritual, the project staff were also able to incorporate RH information to enable young girls to make more informed decisions. By challenging gender norms and eliminating a harmful cultural practice, the project ultimately aimed for a transformative impact on participant communities.

Project Description	Category	Explanation of Categorization
Cultural Resources and Maternal Health in Mali In order to reduce maternal morbidity and mortality, this Mali project used indigenous knowledge and cultural resources in an attempt to increase and improve couple communication and health-seeking behavior during pregnancy. Research showed that one of the most important obstacles to women's maternal health care-seeking behavior was their lack of communication with other household members, particularly husbands, about pregnancy and the need for care. Women said they were unable to initiate conversations with their husbands to solicit their consent and financial support (as head of household) for maternal health services. In designing a health campaign, the project staff recruited a traditional musical story teller (a *griot*) to compose a song that would educate the community about the importance of maternal health care. The campaign also used a traditional article of women's clothing (the *pendelu*) as a symbol of pregnancy and couple communication. As a result of this campaign, the level of communication between wives and husbands concerning maternal health increased dramatically. More positive attitudes and behaviors related to pregnancy emerged at the household level, including husbands' support for reduced workloads and improved nutrition for their wives, and approval for seeking medical attention and maternal health services.	Transformative	This project was designed to address women's lack of power to communicate with their husbands about pregnancy, and to increase their access to and use of maternal health services. Employing culturally appropriate and significant symbols and messages, the project succeeded in improving couple communication, men's willingness to assume responsibility during pregnancy for tasks that were typically performed by women, and men's encouragement for their wives to seek medical attention. While the design and intent of the project were transformative, unless the project demonstrated that the project actually increased decisionmaking on the part of women, the outcome would be accommodating rather than transformative.

Project Description	Category	Explanation of Categorization
Condom Social Marketing in Bolivia The goal of a social marketing campaign in Bolivia was to increase condom sales. The campaign television spot featured a young man who said very proudly that he used a different color condom with each of his several girl friends. The intended message was that he used condoms whenever he had sex, a "safe sex" message.	Exploitative	The TV spot capitalized on social and cultural values supporting men's virility, sexual conquest, and control. It reinforced the expectation/stereotype that "macho" men have multiple female sexual partners and undercut the notion that joint communication and decisionmaking, negotiation, and mutual respect are important for safe sex behaviors. It also contradicted other health efforts to promote safe sex practices through partner reduction.

Project Description	Category	Explanation of Categorization
Youth Roles in Care and Support for Persons Living with HIV/AIDS (PLWHA) In Zambia, a project aiming to involve young people in the care and support of PLWHA conducted formative research to assess the interest of young people in being caregivers, and to explore the gender dimensions of care. Young people were asked what care-giving tasks male and female youth feel more comfortable and able to carry out, and asked PLWHA what tasks they would prefer to have carried out by male or female youth. Based on this research, the project developed youth care and support activities for PLWHA which incorporated tasks preferred by young women and young men.	Accommodating	The program was successful in engaging both young women and young men in providing care and support with which PLWHA are comfortable. This project divided tasks according to the existing gendered division of labor, but also according to the desires of PLWHA. The program accommodated existing gendered divisions of labor, but missed an opportunity to engage young men for the first time in a care-giving role, creating the potential for a more transformative outcome.

Project Description	Category	Explanation of Categorization
HIV/AIDS Prevention in Thailand This project provided education, negotiation skills, and free condoms to female commercial sex workers (CSW) in Thailand. Although knowledge and skills among CSWs increased, actual condom use remained low. After further discussions with the CSWs, project managers realized that CSWs weren't successful in using condoms because they did not have the power to insist on condom use with their clients. The project then shifted its approach and enlisted brothel owners, who had the power and authority to insist on condom use, as proponents of a "100% condom-use policy." Since the vast majority of brothels in the project region participated in the project, the project resulted in a significant increase in safe sex practices.	Accommodating	This project accommodated to the lack of power that female sex workers had over their clients and instead used the power of male brothel owners to demand 100 percent condom use on their premises. While the approach did not challenge the power differentials between sex workers and brothel owners, it did force more protective health behavior on the male clients.
Mass Media to Reach Youth on RH in Nicaragua A Nicaraguan NGO produced a popular TV soap opera (*telenovela*) to introduce a range of social and health issues (e.g., pregnancy, HIV prevention, gender-based violence, and discrimination against the physically disabled) into public debate. Since the soap opera was particularly popular with youth, it presented the opportunity to address and challenge traditional gender roles. One storyline followed a young couple as they fell in love, and through their discussions about intimacy, contraception, and STIs. The male character in the couple was sensitive and caring toward his female partner, and they engaged in open communication about sexuality and family planning. In another episode, the young woman was raped. The telenovela then dealt with the aftermath of sexual violence, including women's legal rights in Nicaragua and the effect of rape on intimacy. Using mass media, this program presented alternative gender role models and raised awareness and public discussion about gender and RH.	Transformative to certain segments of the population	This project had a transformative intention—to model non-conventional equitable gender roles for young men and women as a way of promoting more open communication about sex, rights, and gender-based violence. The evaluation of the project revealed that as a communication medium, soap operas reach primarily younger and older women, and older men, but not young men. Therefore, the transformative messages were not communicated to the half of the intended audience who were young men. Based on the evaluation, the project revised its communication strategy, reaching out to young men in soccer clubs.

Project Description	Category	Explanation of Categorization
Female Condom Promotion in South Africa A pilot program was designed to increase the acceptability and use of the female condom in South Africa. Historically, female condoms have been promoted to women. Acknowledging that men, in the African context, dictate the terms of heterosexual encounters, the program decided to try an innovative approach: the promotion of the female condom to men by male peer promoters. This involved (1) male promoters demonstrating to men the use of the female condom; (2) explaining to men that self-protection and sexual pleasure are completely compatible with the use of the female condom, especially when compared to currently available barrier alternatives, and (3) giving female condoms to the men to use with their female partners. Staff based their programmatic approach on research showing that men are preponderantly concerned with retaining control over the means of protection against HIV and STIs, while they remain ambivalent about female-controlled methods. They wanted their women to be protected from STIs, including HIV, but the threat of infection was seen as ensuring that women remained faithful.	Exploitative	This program had an explicit intention of empowering men to use a technology that was developed so that women would have more control over decisions about contraception and protection from STIs and HIV. It exploited men's greater power over decisions about sexuality and reproduction to achieve a health outcome, and reinforced men's control over the means of protection as well as the norm that allows men to have multiple partners while women are expected to remain faithful. While some may interpret this project as accommodating rather than exploitative, since it engaged men around the use of a method ostensibly controlled by women, the program was grounded in research that men's interest in any method was likely to be based on maintaining control over their partners' sexuality.

Using the Gender Continuum Case Studies as a Training Tool

The Gender Continuum was actually developed as a training tool and this Manual can be easily adapted to such use. Trainers might ask participants to place the case studies at different points along the continuum, depending on the assumptions they make in interpreting the initial intention of the project and how the design contributed to particular outcomes. Below are some suggested questions for some of the case studies, to stimulate discussion.

Case: Youth Roles in Care and Support for PLWHA in Zambia

- How would you categorize this project if boys and girls had been given opportunities to choose roles regardless of whether they conformed to normative gender roles?

Case: Cultural Resources and Maternal Health in Mali

- Is it possible to have a gender transformative design that does not have a positive health impact?

Case: HIV/AIDS Prevention in Thailand

- How might you categorize this project if you discovered that the brothel owners were women, or that the sex workers were men?
- How might you categorize the project if you found out that despite positive changes in safe sex practices, the involvement of brothel owners in condom promotion did nothing to lessen client violence against sex workers?

CHAPTER 4: THE GENDER ANALYSIS FRAMEWORK

4

Gender analysis is the process of identifying gender inequities and their implications for programs and development. By examining the social construction of identities, roles, and social, economic, and political relations, a gender analysis helps us to understand the differential distribution of power and resources based on gender in societies. Gender analysis reveals information that is necessary for making informed decisions about family planning, reproductive and sexual health, HIV, and safe motherhood programming, and should, whenever possible, be an integral part of the broad range of technical analyses conducted in preparing the strategic plan.

Gender analysis involves the collection and interpretation of data to examine gender differences, and the impact of these differences on the lives and health of all youths and adults, whatever their sexual orientation. Gender experts have developed a number of tools to guide the analysis. Some are sector-specific and others are more general. (For an illustrative list of tools, see Appendix III.)

A gender analysis framework prompts users to ask:

- What are the different constraints and opportunities faced by women and men, boys and girls, according to gender?
- How do gender relations (in different domains of activity) affect outcomes and the achievement of sustainable results?
- How will proposed results affect the relative status of men and women?

Gender analysis approaches and tools focus on specific aspects of social and cultural relations in a given context. These specific "slices" of social and cultural relations are often referred to as "domains". Some of the most frequently analyzed domains include: access to resources; knowledge, beliefs and perceptions (norms); practices and participation (roles); rights and status; and, related to all of these, power.

FIGURE 2. Domains of Social and Cultural Relations

Access to Resources: This domain refers to one's ability to use financial and other resources/assets. The capacity to access resources is fundamental to being a fully active and productive (socially, economically, and politically) participant in society. Resources and assets include:

- Natural and productive resources[21]
- Information
- Education
- Income
- Services
- Employment
- Benefits

An individual may have access to resources but limited ability to make autonomous decisions about their use. For instance, an adolescent girl may work and earn income that she hands over to adults in her household who decide how most, if not all, of her income is used. The girl has access to employment but she does not control the disposal of her income. (Control in this framework is considered under "power.") This is an important point, for example, in assessing whether livelihood options for adolescent girls enable them to retain control over economic resources they generate.

Knowledge, Beliefs, and Perceptions: As a consequence of having access to different types of knowledge, men and women have diverse beliefs, perceive situations differently, and conform to social norms that are gender-specific.

This domain includes:

- Types of knowledge that men and women are privy to—who knows what. based on their experiences and what's seen as appropriate for each to know;
- Beliefs (ideology) guide what is deemed proper or normative behavior for men and women, boys and girls, and defines how they conduct their daily lives; and
- Perceptions that guide how people interpret aspects of their lives differently depending on their gender identity.

Knowledge in some cultures may be proprietary, e.g., known only to men or only to women, limiting the ability of individuals to understand and participate in the full range of social experience. For example, only mothers (not fathers) may be socialized to understand the need for adults to be caring and nurturing of children. Fathers may believe that children only depend on them for financial support and discipline, and not for emotional support. Gender constraints prohibit both mothers and fathers from engaging fully with their children.[22]

Gender-based perceptions or attitudes lead to differential interpretations of information. For instance, adolescent girls who do not perceive themselves as independent may lack the confidence to assume responsibility for a business or to think about saving for the future.

Practices and Participation: This refers to peoples' behaviors and actions in life – what they actually do – and how this varies by gender. The domain encompasses:

- The freedom of movement or autonomy to enable participation;
- The types of activities and practices, e.g., meetings, training courses, the political process, and health and social services;

21 Productive resources relate to the four factors of production: land, labor, capital, and entrepreneurial skills.

22 G. Barker, D. Doğruöz, and D. Rogow, "And How Will You Remember Me, My Child? Redefining Fatherhood in Turkey" in *Quality/Calidad/Qualité* 19, New York: Population Council, 2009.

- The way that people engage in development activities, actively or passively, or by accepting or seeking out services;
- The allocation and availability of time to participate.

Women and girls may have less freedom of movement, e.g., ability to leave the home unchaperoned. Passive participants may attend a meeting and be aware of information being transmitted, but not voice an opinion or play a leadership role. Active participation involves voicing opinions and otherwise contributing to the group process. The ability to participate in any activity is constrained by time. Adolescent girls in developing countries have been found to carry a heavier workload and enjoy less leisure time than boys, regardless of whether they are enrolled in school or not.[23]

Legal Rights and Status: Rights include the capacity to exercise one's vote, run for office, be an active legislator, and to enter into legal contracts. This domain refers to how people of different genders are regarded and treated by both the customary and formal legal codes and judicial systems. Gender-based differences in legal rights and status may particularly affect gay, lesbian, bisexual, and transgendered individuals.

This domain includes rights to:

- Inherit and own property
- Legal documents (such as identity cards, property titles, and voter registration)
- Reproductive choice
- Life-saving maternal healthcare
- Representation
- Due process

Gender differences occur in recognizing the existence of rights within the written or applied law, as well as in how such rights can be implemented or enforced. For example, adolescent girls may be unlikely to know the legal age at marriage or how to prevent parents from marrying them off below the legal age.

Power: This refers to the capacity to control resources and to make autonomous and independent decisions free of coercion. Gender norms influence the extent to which individuals can freely decide, influence, control, enforce, engage in collective actions, and exercise decisions about:

- Acquiring and disposing of resources;
- Choosing what to believe;
- One's own body;
- Reproductive choice;
- Children;
- Occupation;
- Affairs of the household, community, municipality, and the State;
- Voting, running for office, and legislating;
- Entering into legal contracts;
- Moving about and associating with others.

23 C. Lloyd, M. Grant, and A. Ritchie, "Gender Differences in Time Use Among Adolescents in Developing Countries: Implications for Rising School Enrollment Rates" in *Journal of Research on Adolescence* 18, no.1 (2008): 99–120.

A gender analysis systematically examines the four domains of access to resources; knowledge, beliefs, and perceptions; practices and participation; and rights and status, and the relative power, control, and decision-making authority based on gender. Gender analyses seek to reveal the gender-based constraints that inhibit (and sometimes gender-based opportunities that facilitate) the achievement of a particular program objective.

Gender constraints and opportunities need to be investigated in specific contexts, as they vary over time and across different organizational and institutional contexts:

- Partnership or primary relationship
- Household
- Community
- Civil society and governmental organizations/institutions

Gender relations are linked to a host of other specific power relations that are at work in a specific context – such as differences in power based on race, class, ethnicity, residence (urban vs rural), and age. In some cases, these factors may exert more influence on the balance of power than gender alone, but in combination, they may exacerbate gender inequity, e.g., for poor, rural low-caste adolescent women.

Although gender patterns may appear remarkably similar across contexts, it is helpful to understand the specific relations (and ongoing changes and contradictions in these relations) across time, in different organizational contexts, and in different sociocultural contexts.

Tools for Organizing, Analyzing, and Planning

Table 4.1 on the next page can be used to organize data collection and synthesis for a gender analysis based on primary or secondary data sources.

- **1st column**- What are the key gender issues in each of the 4 domains and in terms of power? Place information in the appropriate domain. Go through the information and assess which of the findings on gender relations within different domains might impact either negatively (gender-based constraints) or positively (gender-based opportunities) on the health, attitude, and behavior outcomes, achievement of the project's objectives, or on the relative status of men and women.
- **2nd column**- What additional information is needed to help the program understand the gender barriers or constraints? Often sources lack complete information on key gender issues relevant to a particular project, program, or policy under consideration. Barriers to program implementation encountered at an earlier stage of the project may not have been adequately addressed or explained by the available gender information. Note any missing information, what the source might be, and what type of expertise or methodology may be required to generate and analyze the information. Collection of additional data may become an activity under the project or program.
- **3rd column** – What are the gender-based constraints? Record the constraints, noting that information pertaining to one domain can sometimes contribute to an identified constraint in another domain. For instance, restrictions on women's capacity to realize their legal rights may be constrained by their access to information. Similarly, men's capacity to assume greater responsibility

for the care of their children may be limited by beliefs about their proper roles as men and by their unwillingness to be deemed "unmanly." Prioritize constraints that may have a significant bearing on reaching the project's objectives or on relations of power between men and women, especially when resources are limited.

- **4th column** – What are the gender-based opportunities? Record the information identified in different domains that may facilitate reaching program objectives, improve the balance of power in gender relations, or have a positive impact on health and equity outcomes. For instance, the role of men in maintaining roads in their communities may be an opportunity to discuss and overcome constraints to transporting women to healthcare facilities more rapidly if they experience complications during labor and delivery.

TABLE 4.1. A FRAMEWORK FOR GENDER ANALYSIS (DATA COLLECTION AND ANALYSIS)

DATA COLLECTION AND SYNTHESIS-Step 1 What are the key gender relations related to each domain and to power?	DATA COLLECTION AND SYNTHESIS-Step 2 What additional information is needed about gender relations?	ANALYSIS-Step 1 What are the gender-based constraints to reaching program objectives?	ANALYSIS-Step 2 What are the gender-based opportunities for reaching program objectives?
Consider these relations in different contexts ~ individual, partners, family and communities, health care and other institutions, policies			
Access to Resources[24]:			
Knowledge, Beliefs, Perceptions:			
Practices & Participation:			
Legal Rights and Status:			
Power, Control, and Decisionmaking:			

24 While many gender analysis frameworks treat access and control of resources as a single domain, this framework intentionally separates them in order to emphasize that access to or use of assets (resources) is not the same as having control or decision-making authority over the resources. This framework locates control over resources as a dimension of power.

Table 4.2 below illustrates how the information in the Gender Analysis Framework is used to address gender issues in project and program design and monitoring and evaluation. After gender-based constraints and opportunities are prioritized (step 1), develop objectives or sub-objectives to overcome the barriers or to take advantage of gender-based opportunities. Agree on objectives or subobjectives (results), and the types of activities or strategies that may be effective in reaching them. Gender indicators should be measures of the removal or mitigation of the constraints and the utilization of opportunities. Gender indicators are distinct from indicators that measure health outcomes or results. See Chapter 5 for a full presentation of how to integrate gender in the project or program cycle.

TABLE 4.2: STRATEGIC PLANNING—INTEGRATION OF GENDER INTO THE PROJECT CYCLE (SUB-OBJECTIVES, ACTIVITIES, INDICATORS)

Step 2. Proposed sub-objectives to address gender-based opportunities or constraints	Step 3. Development of proposed activities to address gender-based opportunities or constraints	Steps 4 and 5. Indicators for monitoring and evaluation

An Illustrative Case Study

The following illustrative case study may be useful in practicing the application of the Gender Analysis Framework.

Case Study: Preventing Mother to Child Transmission (PMTCT) of HIV Programming in Country Zed[25]

As in many countries, Country Zed continues to find it difficult to facilitate women's access to PMTCT services. These services include testing to determine HIV status; access to drugs to prevent HIV-positive mothers from transmitting the disease to their children; information on exclusive infant feeding options; health care for infants; family planning; and care and treatment for the woman's own health.

Program Goals: Reduce the number of babies born with HIV and improve the health and survival of mothers living with HIV.

Program Objectives:

- Expand access to a full range of PMTCT interventions;
- Fight the stigma associated with HIV, and encourage and support disclosure.

Proposed Strategy: The program has decided to pursue one of two strategies to increase women's willingness to test, seek results, and, if positive, follow through on preventive prophylaxis, infant feeding recommendations, and taking care of the mother's own health. The strategies are 1) Train peer counselors to provide education and psychosocial support to HIV-positive pregnant women, and follow-up after delivery; or 2) Involve men in couples counseling.

Your Task: You have been brought in as a gender expert to help guide program staff through a decision to adopt one of these two strategies or another approach. After reading the information below, use the Gender Analysis Framework to identify the most critical gender-based constraints and opportunities that may either prevent or facilitate uptake of prenatal VCT, treatment, and post-natal follow-up.

Available Background Information: The most recent Demographic and Health Survey (DHS) for Country Zed reported high utilization (90 percent) of antenatal care by pregnant women, but only 47 percent delivered at a health facility. Most women completed at least some primary schooling. More than half of the women reported having a partner or husband. Only 40 percent had access to piped water or electricity. More than half reported no independent income.

Data from the WHO Multi-Country Study on Domestic Violence report that for Country Zed, 41-56 percent of ever-partnered women, ages 15-49, had ever experienced physical or sexual violence from an intimate partner; 17-25 percent had experienced severe physical violence, and of these, 1/3 to 1/2 had experienced severe physical violence within the past year.

Some recent poster campaigns with slogans such as *"Test for the Health of the Next Generation,"* picture a pregnant woman holding a newborn baby. Although antenatal care (ANC) use is high, recent

25 This case study is a composite drawn from several sources and countries including: Baek et al. 2007 *Key Findings from an Evaluation of the Mothers2 Mothers Program in Kwazulu-Natal, South Africa*, Washington, DC: Population Council and Horizons Trust; accessed online July 1, 2009 at www.who.int/pmnch/topics/maternal/mothers2mothers/en/index.html; and Burke et al., *Male Participation in PMTCT in Tanzania*, 2004.

focus groups show that women have limited knowledge of specific PMTCT interventions or availability of these services at the local health clinic. When asked about the importance and availability of specific medicines and recommended exclusive infant feeding practices, women expressed uncertainty about the effect of these recommendations on their pregnancy and the health of the infant. A number of women expressed the belief that women who are HIV-positive should not have any more children. Regarding testing, women were more interested in knowing their HIV status for the purpose of protecting themselves from infection in case the result was negative, or for seeking care if HIV positive. It is significant that only 11 percent identified concern about infecting their child as a primary reason to learn their HIV status.

Gender Norms

Women are expected to seek permission from their male partners before testing. They believe that testing without a partner's permission will increase conflict. Men feel free to make their own decisions about whether to test or not and rarely disclose their HIV status to their partners. However, men are reluctant to use testing sites close to their own communities, fearing lack of confidentiality. Men also believe that by the time a woman is pregnant, it is too late for themselves and their partners to be tested. They argue that a woman who is positive should not have any more children. If a man is positive, however, he is unlikely to disclose, and will still desire more children. Men say that access to anti-retrovirals (ARVs) to prevent transmission would be a great incentive for them to agree to testing for themselves and their partners, even if ARVs were only provided to mothers and babies.

Both men and women in the community report that health information is supposed to be brought into the family by the man. Women are not regarded as reliable sources of information. Men are viewed as the decisionmakers in the family. Men regard health care providers as legitimate sources of information, yet they generally do not accompany their partners to family planning, antenatal or postnatal care services and would not be expected to attend the labor or birth of their child. Birth, delivery, and care of infants are seen as exclusively the responsibility of women, although men are increasing their involvement in childrearing responsibilities once children become toddlers or older.

Responding to Local Beliefs

Many people in the community believe that if one parent is HIV positive, both parents and all children born will be HIV positive as well. HIV-related stigma in the community remains high and is directed at the person who first tests and discloses his or her status. Because of antenatal testing, more women than men know their HIV status. It has not been uncommon for women who reveal their HIV positive status to be abandoned, and many women fear being abused by their male partners.

Women do discuss health and relationship issues with other women in the community, and find other women an important source of social support and practical information, especially as related to women's and children's health. However, this information is not directly brought in to the household. Health care providers in the public sector have limited time to be able to provide much information and counseling to their clients. Overburdened by the migration of health care staff as well as by absences due to their own and family illnesses, midwives and nurses are stretched too thin to provide even a minimum standard of clinical care.

TABLE 4.3: ILLUSTRATIVE CASE STUDY: DATA COLLECTION AND ANALYSIS

Based on your program goal (to reduce the number of babies born with HIV and improve the health of HIV-positive mothers) and your program objectives (to increase PMTCT interventions and fight stigma) answer the following questions:

Step #1. Assessment What are the key gender relations related to each domain (related to a, b, c, d, e below) that affect women and girls, and men and boys?	**#2. Assessment** What other information about gender relations is needed? (Collecting and analyzing data could become an activity in #3)	**#3 Assessment** What are the *gender-based constraints* to reaching program objectives?	**#4 Assessment** What are the *gender-based opportunities* to reaching program objectives?
Be sure to consider these relations in different contexts ~ individual, partners, family and communities, health care and other institutions, policies			
a. Access to Resources • 50% of women have access to income • Women's access to information in the household comes through their male partners. • Women gain information from other women but do not share it within the home.	• Do women without incomes have access to other types of resources (assets)? • What happens to women's access to financial and other resources when they are abandoned by their partners? • Do women and men have access to health services? • Are there fees and transport costs affecting access to services for women who do not have access to income?		
b. Knowledge, beliefs, perceptions (some of which are norms): • Women are expected to seek partner's permission before testing (belief) • Women and men have limited knowledge of PMTCT but for different reasons (women, because of limited access and men because it is connected to pregnancy and childbirth which is the purview of women (knowledge)	• What do men actually know about PMTCT?	• Women's fear of abuse or abandonment deter them from agreeing to be tested or from picking up their results. • Women and men have limited access to information	• Peers are a source of information. • Men's perception that availability of ARVs is a good reason to be tested and to encourage partner to get tested for herself and the baby. • Women's concerns for their own health motivate them to get tested and treated. • Although women's peers are a source of information, the information they provide is not viewed as reliable as information provided by men.

Step #1. Assessment	#2. Assessment	#3 Assessment	#4 Assessment
• Knowledge brought into the household by women is not regarded by either men or women as reliable (belief) • Messages about testing that stress benefits to women resonate more with women (perception) • Men believe testing during pregnancy is too late (belief) • Men are supposed to make decisions (belief) • More women know their HIV status than men (knowledge) • Men view male healthcare providers and community leaders as legitimate sources of information (belief) • Men believe that HIV-positive women should not have any more children (belief) • Men and women believe that if one partner is HIV+ then the other is also and their children will be too (belief) • Men perceive that access to ARVs is an incentive to get tested themselves and have their partners test, even if the ARVs are only provided to the baby and/or the mother (perception) • Women believe they will be abused if they reveal their positive HIV status to a partner. • Women doubt the reliability of recommendations about their own and their infants' care (perception)		• The access of women and men to information is limited by the belief that information is only reliable if it comes from men. • Men's belief about pregnancy as being too late for testing may limit their support for partner testing or to follow through on care. • Violence and the threat of violence prevent women from testing and from revealing their status to partners.	• Men may be more open to information and counseling from male health care providers. • Information on the availability and how to access ARVs may encourage more men and women to agree to testing.

Step #1. Assessment	#2. Assessment	#3 Assessment	#4 Assessment
c. Practices, roles & participation • Women are solely responsible for babies • Men participate in care of children (toddlers and older) • Men do not accompany their partners to antenatal, RH, or FP care, or remain with them during delivery • Many men abandon female partners who disclose positive HIV status • Women healthcare providers are over-burdened by dual role as caregivers in health facilities and households • Women test more than men, generally through ante-natal care • Men who know they are HIV positive rarely disclose to partners because they want to have more children • Women in community discuss information about HIV and PMTCT among themselves	• What are the actual practices of men and women with regard to testing? • Do men take older children to health services? • Are men present in the community or do they migrate or work away from home? • What distinguishes women who agree to testing from those who don't? • What distinguishes men who disclose to their partners from those who don't?	• Information is controlled by men but they do not attend ante-natal health services or speak to women who dispense information. • The dual burden of female healthcare workers limits their ability to provide information and counseling	
d. Legal rights and status	• Are there legal (formal or customary) restrictions to a woman signing an informed consent form without her partner's consent? • Do abandoned or widowed women have property or inheritance rights? • Who actually makes what types of decisions in the household and under what circumstances? • Do women with income have control over that income?		

Step #1. Assessment	#2. Assessment	#3 Assessment	#4 Assessment
e. Power and decision-making • Men control access to information in the household • Men make their own decisions about testing • About 50% of women have ever suffered violence from a partner and about 10% have experienced severe violence in the last year	• Who actually makes what types of decisions in the household and under what circumstances? • Do women with income have control over that income?	• Violence prevents women's access to VCT and ability to make decisions.	

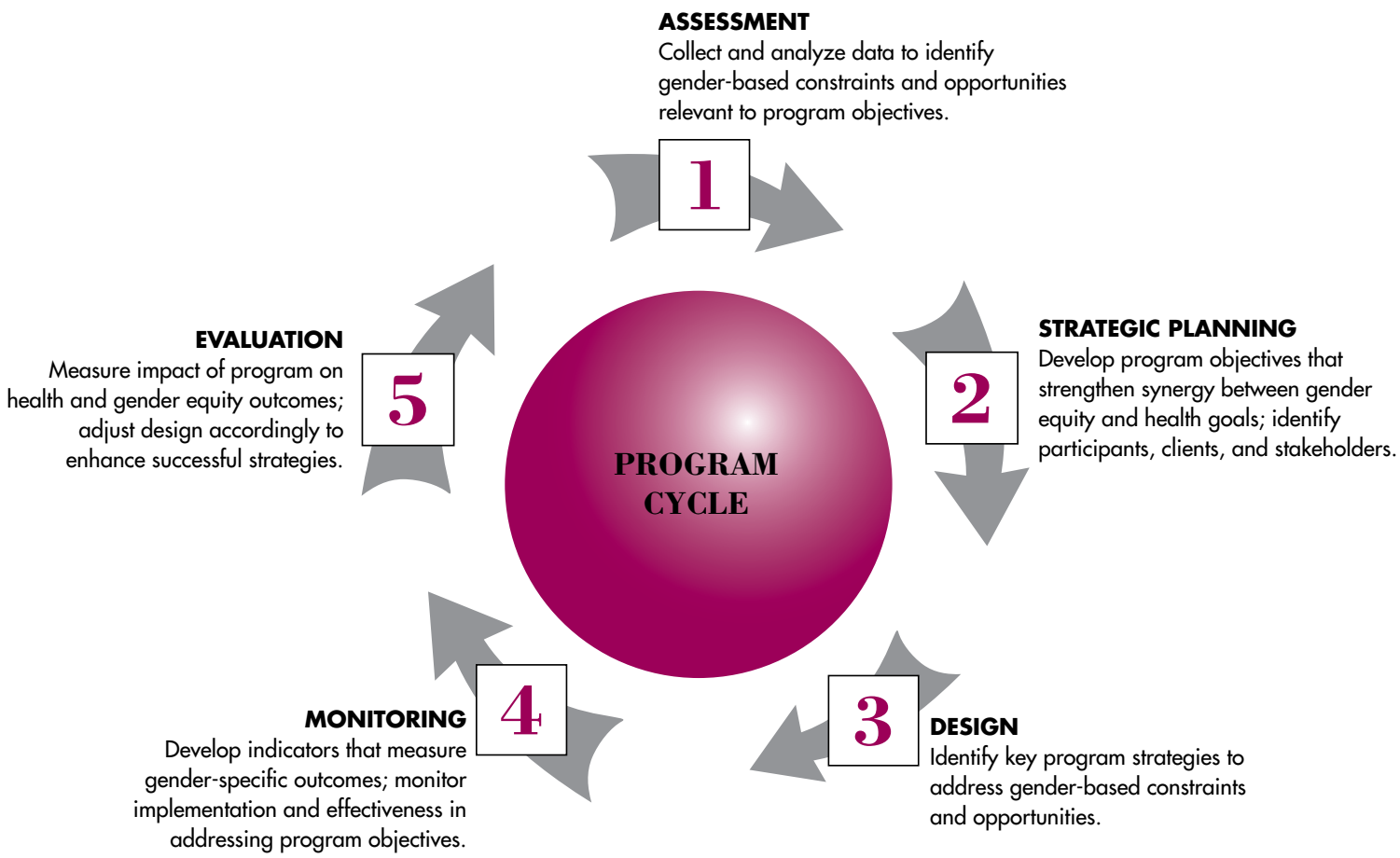
TABLE 4.4. CASE STUDY: INTEGRATING GENDER ANALYSIS INTO THE PROGRAM CYCLE (OBJECTIVES, ACTIVITIES, INDICATORS)

#1: Critical Constraints and Opportunities	#2: What gender-integrated *objectives* can be included in the strategic plan to address gender-based opportunities or constraints?	# 3. What proposed *activities* can be designed to address gender-based opportunities or constraints?	# 4 & 5. What *indicators* for monitoring and evaluation will show if the gender-based opportunity has been maximized or the gender-based constraint removed?
• Women and men have limited access to information. • Access to information limited by belief that information is only reliable if it comes from men. • Men's incorrect belief that by the time of pregnancy, it is late for their partners to be tested for HIV or for follow-up on care. • Men may be open to information on counseling from male health care providers • Information on the availability and how to access ARVs may encourage more men and women to agree to testing.	• Make channels of information about PMTCT more accessible to men and women. • Increase support among women and men for women as well as men to be able to introduce health information into household.	• Use both men and women peer educators to convey information about the value of HIV testing, antenatal treatment and post-natal care, and to recommend infant feeding practices. • Use both male and female peer educators, as well as male leaders in the community, to develop messages and foster critical reflection and skills-building that support women's ability to introduce health information within the household, and to promote sharing of health decisions between women and men. • Develop messages that emphasize health benefits of knowing one's HIV status for both mothers and babies. • Link exclusive breastfeeding or alternative infant feeding options to non-HIV-related life circumstances (i.e. general benefits of exclusive infant breastfeeding for all babies; proper alternative feeding methods for women who work or travel).	• # of men and # of women who have been exposed to health messages from peer educators. • # of men and # of women who regard health information they receive as reliable • # of men and # of women who believe that women are reliable sources for information introduced into the household. • # of women who report having introduced health information into household • # of men who report their female partner introduced information into the household • # of men and # of women who know benefits of testing, PMTCT and infant feeding practices.

#1: Critical Constraints and Opportunities	#2: What gender-integrated *objectives* can be included in the strategic plan to address gender-based opportunities or constraints?	# 3. What proposed *activities* can be designed to address gender-based opportunities or constraints?	# 4 & 5. What *indicators* for monitoring and evaluation will show if the gender-based opportunity has been maximized or the gender-based constraint removed?
• Violence and the threat of violence prevent women from testing and from revealing status to partners. • Violence prevents women from accessing VCT and impedes their ability to make decisions.	• Increase men and women's knowledge of how GBV increases vulnerability of women and men to HIV. • Increase men and women's capacity to prevent violence.	• Develop educational strategies and training modules for men. • Develop materials that reflect SRH issues that are of interest to men and women. • Develop interactive methods that allow men to realize consequences of violence for their partners themselves. • Develop approaches that make women aware of where to seek help for GBV.	• % of men who believe that it is never right to hit a woman. • % of men and women who believe that women have the right to decide to be tested. • % of men and women who feel they can discuss their HIV status with their partner without fear of violence.

CHAPTER 5: A PROCESS FOR GENDER INTEGRATION THROUGHOUT THE PROGRAM CYCLE

Strategic Steps to a Gender-Integrated Program

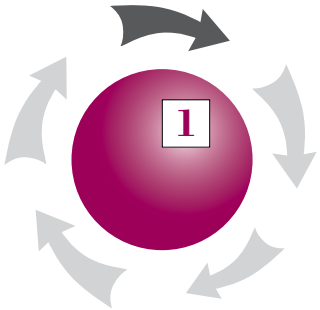


Adapted from Measure Evaluation

Incorporating a gender perspective in programs involves a series of steps that are both sequential and iterative. A program design that is gender-integrated is flexible and receptive to feedback on progress and problems, as well as responsive to changes in interpersonal relationships, resources, and access to information. This chapter provides examples from actual programs that have successfully integrated a gender perspective or gender elements into design, implementation, and monitoring and evaluation. Case material is used to illustrate how these programs answered gender-related questions at different steps in the program cycle. The various elements of a gender-integrated approach that are present in each case study are also highlighted. Each case is illustrative only and not intended to be an exhaustive treatment or analysis of program outcomes.

Steps to Gender-Integrated Programs

1. **Assessment** (Gender Analysis): *Part I:* Collect data on gender relations, roles, and identities in relation to the health needs or problems to be addressed by the program. *Part II:* Analyze information to identify gender-based constraints and opportunities that may affect achievement of health objectives or the relative status of women and men.
2. **Strategic Planning:** Examine program objectives for their attention to gender constraints and opportunities; restate objectives so that they strengthen the synergy between gender and health goals; identify participants, clients, and stakeholders.
3. **Design** program approaches, interventions, and activities to support achievement of health and gender equity objectives.
4. **Monitoring:** Develop indicators to measure gender-specific outcomes, especially the alleviation of gender-based constraints and application of opportunities; Collect baseline data on impact indicators and regularly monitor process indicators.
5. **Evaluation:** Collect end-line data and analyze differences between baseline and endline to assess the effectiveness of program elements designed to address gender issues. Re-examine gender analysis, identify any constraints not anticipated at the beginning, and adjust design and activities based on monitoring and evaluation results.



STEP 1, ASSESSMENT, Part I: Collect data on gender relations, roles, and identities that pertain to the achievement of program outcomes.

The previous chapter introduced the Gender Analysis Framework. This section reviews gender assessment as the initial step in a process for integrating gender into projects and programs. Part 1 of the assessment phase presents critical questions to consider when designing a gender analysis data collection process. Part 2 focuses on the implications of the information collected for project design.

Focus Data Collection on Program Objectives

The starting point of gender analysis research is to collect sex-disaggregated data linked to the program's objectives. What kind of information does the program team need to collect to understand how gender roles and identities are defined within a particular society and how they vary across age, class, and ethnicity? For a program focused on RH policy, relevant data would include:

- Who is involved in community and local government and how do different groups and individuals within the locality (data disaggregated by sex) participate in regional and national policymaking?
- What issues are discussed in public fora and who is able to bring these issues forward? What roles do men and women, adolescent boys and girls play in these public arenas?
- How is information communicated from public fora to groups and individuals who are not present? Who has access to different media? (data disaggregated by sex)

Information is often available through national census and surveys and in published and unpublished research reports. The DHS have included, in a number of countries, modules on men, gender relations, domestic violence, and HIV, and are an important source of information wherever available. Occasionally it is necessary to conduct primary data collection using survey or participatory research techniques.[26] Data collected from both quantitative and qualitative methods, and at a variety of levels (individual, household, community, regional, and national) provide a firmer informational base for making decisions on how to most effectively integrate gender considerations into programs.

Who Is Included in Data-Gathering Efforts?

How the program implementers involve various stakeholders and participants in the data collection process will affect the quality of the information gathered and have implications for program planning. There are several methods for the collection and analysis of information on gender roles, decisionmaking, and control over resources. For the most part they are variations on quantitative and qualitative research methods (e.g., surveys, rapid appraisal methods, focus groups) that include specific questions on men's and women's activities, roles, assets, decisionmaking, and responsibilities (see references in Appendix 3, under "Gender Integration and Mainstreaming Manuals" for additional information on methods).

26 While participant needs and stakeholder interests are best discerned through direct participation of individuals and groups, the program staff can draw important conclusions about key gender differences by analyzing sex-disaggregated micro- and macro-economic data and national statistics on social development. Information about labor force participation and segmentation, incomes, poverty rates, educational attainment, health status, legal status, judicial access, and political participation of women relative to men, to name a few, provide national level indicators of gender inequalities to be addressed by the project team in the development of objectives and activities.

Use of participatory research methods increases the involvement of the different participants and stakeholders in the research process. The active engagement of participants provides an opportunity for them to express their needs and aspirations, participate in the analysis of the causes of their health problems and concerns, and play a role in developing sustainable solutions.

Focus groups and other participatory methods are effective for ascertaining the range of local beliefs, attitudes, interests, and priorities, especially as they vary across gender, socioeconomic status, age groups, and ethnicity. Focus groups are useful for getting feedback on client satisfaction, efficacy of IEC campaigns, and acceptability of new contraceptive methods.

Focus Groups

The project team is responsible for ensuring that focus groups are constructed and the questions asked in an ethical manner that will elicit diverse perspectives from the participants, including those who are disempowered within the particular sociocultural context under study. Attention to gender issues is not limited to inclusion of men and women in information gathering efforts. Unless couple dynamics are under investigation, this typically requires conducting focus groups separately based on sex. Age groupings, language, caste or class, and ethnicity are also important considerations. Focus groups that include young and old, and people of different ethnic backgrounds may only yield information from representatives of the most powerful groups. For example, in same sex groupings, a young girl might not feel that it is appropriate to provide a viewpoint that differs from that expressed by an older woman.

Survey Instruments

A survey that is constructed to elicit information from male and female participants—including their priorities and interests; how they spend their time; their personal networks; their material, social, and knowledge resources—will provide the program staff with a more accurate picture of the social dynamics in a region. Surveys should include both men and women (young and old), questions on autonomy, mobility, control over resources, and political participation, and take into account the literacy levels and language of different respondents

Quality of the Information Collected

Before beginning data collection, it is helpful to consider whether there are social factors that constrain the participation of individuals or groups in research. For example:

- Will women's limited mobility outside of the household restrict their participation in focus groups?
- Will the need for a husband's consent for a woman to participate in an interview affect the confidentiality of the information?
- Will women agree to participate in research when only male community leaders authorized permission to conduct the research? Will men participate if the data collectors are primarily women and the topics are sensitive?
- Are there potential negative consequences for research participants? Questionnaires and interview guides that involve sensitive material should be reviewed by an institutional ethical review committee. Participants should sign or agree to an informed consent that outlines the purpose of the research and details any potential benefits or consequences of participating in the research.
- Will men be able to participate given seasonal work responsibilities?

The quality of the information collected has a direct impact on program design and outcomes. These issues might not come to light during stakeholder analyses and needs assessments unless appropriate questions have been asked of both men and women. For instance:

- Women may be reluctant to seek treatment for sexually transmitted infections (STIs) or to share a diagnosis with male partners if they fear physical violence or other reprisals.
- Men may refuse to use health services for prevention and treatment of STIs if the services principally cater to women's reproductive needs.

It is important that questions elicit context-specific information that respondents are unlikely to volunteer spontaneously. The phrasing of the questions, terminologies, categories, and the settings for gatherings also affect the quality of information about gender relations. It may be necessary, for example, to ask directly about specific tasks or time expenditure to get information about women's work. Quality information on gender issues is most likely to emerge when researchers consider the types of situations in which women and men are able to express themselves freely.

- Will they respond more comfortably to a questionnaire, in focus groups, or to participatory or qualitative methods?
- Are men and women more willing to respond to questions as individuals or in groups?
- Does it make a difference whether the survey interviewer or focus group facilitator is a man or a woman (of a particular age, class, or ethnicity)?
- Should discussions be in public places or in the home?
- Does the language used in the interviews or surveys affect the responses of men and women differently?
- Under what circumstances might women and men be interviewed together?

The answers to these questions will vary. (See "Gender and Reproductive Health Manuals" in Appendix 3 for references about research methods and gender).

ILLUSTRATIVE CASE STUDY FOR STEP 1, ASSESSMENT PART I (DATA COLLECTION): MATERNAL HEALTH PROGRAM IN TANZANIA[27]

IMPLEMENTING ORGANIZATIONS

Several USAID cooperating agencies—PCS/CCP, JHPIEGO, INTRAH, and EngenderHealth—are working to improve maternal and reproductive health care in 16 districts in Tanzania. The specific initiatives include: antenatal care with a focus on preventing and treating malaria and syphilis in pregnancy, postabortion care, family planning, and long-term and permanent family planning methods.

PROBLEM TO BE ADDRESSED

In order to improve quality, project staff conducted research on clients' perception of quality of care.

OBJECTIVES

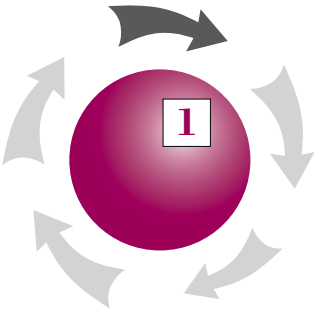
- To develop a quality improvement and recognition program in 16 districts in Tanzania;
- To ascertain the different criteria of quality services defined by providers and community members (clients and non-clients).

Note: Unlike other case studies presented in this chapter, the Maternal Health Program in Tanzania was not designed originally to address gender issues. The case is an example of a program that has taken some initial steps in midcourse to collect and analyze information on gender differences in attitudes and preferences related to health care services. The program staff expect to use the findings to better understand and respond to gender-based constraints to the use of services.

27 Personal communication with Wendy Voet, JHPIEGO, 2003.

ILLUSTRATIVE CASE STUDY FOR STEP I, ASSESSMENT PART 1: MATERNAL HEALTH PROGRAM IN TANZANIA

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
Should men and women be interviewed together or separately?	Focus group discussions (FGD) were used to collect data from the community. There was some initial concern that the men might dominate the discussion in mixed groups.	• Groups were segregated by sex to ensure inclusion of different perspectives. • Women were separated by age so that older women did not overshadow younger women's opinions. • The project created a relatively unstructured and open-ended forum to encourage women to communicate diverse perspectives.
Does it make a difference whether survey interviewers or focus group facilitators are men or women (of a particular age, class, or ethnicity)?	Assessment teams were composed so that women would interview women and men would interview men. The researchers believed that participants would feel more comfortable discussing sensitive topics with facilitators of the same sex.	• As men and women both expressed clear preferences for privacy in gender-specific terms, the use of same-sex interviewers for groups helped to create a more relaxed and open exchange of ideas.
What kinds of questions are most effective for eliciting gender differences?	Men and women were asked the same set of questions without explicitly probing into gender differences. Facilitators, however, asked each group questions about who controlled significant resources and who made major decisions with regard to seeking health care.	Men and women focused on different aspects of care in their responses, e.g.: • Women highlighted privacy as a critical element of quality, especially in examining rooms; • Men cited the sex and age of the provider as a key element of quality for STI services. They felt embarrassed if they were seen by an older female nurse rather than by a younger male; • Women also revealed that the decision to deliver in a hospital, especially in an emergency, is made by both a woman's husband and her mother. They indicated that the mother has the final say because the husband is likely to make the decision based on cost rather than gravity of his spouse's condition. A mother is more apt to focus on her daughter's health.



STEP 1, ASSESSMENT, Part II: **Analyze data for gender-based constraints and opportunities that may affect, impede, or facilitate program objectives.**

Diverse Sources and Types of Information

Information collected from a variety of sources and through different methods reveals different aspects of gender-based beliefs and practices. Qualitative research will assist the program staff to interpret the meaning of quantitative data and trends from the participants' perspectives and to probe more deeply into the social, economic, and political structures that sustain or challenge existing ideas and patterns of behavior. For example, researchers may be able to answer the following questions:

- What does information in previous or new research reveal about gender relations and the relative status of women and men?
- Are there differences between men and women that are significant for program outcomes and how will gender-based constraints and opportunities affect achievement of program results?

For instance:

- Will restrictions on women's mobility and limited literacy affect their ability to participate as health educators and to access RH services?
- Will men's seasonal absence from the community affect community support for program activities?
- Do limited resources for schooling of girls increase their vulnerability to unintended pregnancy, STIs, and violence?
- Have changes in agricultural production affected the time women have available to tend gardens that provide important nutrients for the household?
- Do adolescent boys participate in social clubs that provide opportunities to engage them in peer counseling activities; are there comparable groups for girls?

ILLUSTRATIVE CASE STUDY FOR STEP 1, ASSESSMENT PART 2: TOSTAN—ENDING FEMALE GENITAL CUTTING IN SENEGAL [28]

IMPLEMENTING ORGANIZATION

Tostan is a Senegal-based NGO whose mission is to empower African communities to bring about sustainable development and positive social transformation based on respect for human rights. It promotes an integrated approach to learning through community-based education. The organization aims to promote participatory learning that is accessible to and controlled by women learners in rural communities. It has continued to revise its Community Empowerment Program in response to feedback from the community over the last 15 years.

PROBLEM TO BE ADDRESSED

In Senegal, female genital cutting (FGC) is practiced by some ethnic groups as part of girls' initiation rites. The practice, although intended by parents and communities to prepare girls for marriage and motherhood, violates the rights of girls to bodily integrity, and often leads to serious health complications, including bleeding and hemorrhaging, infection, pain, difficulty urinating, stress, shock, complications during sex and childbirth, and even death.

OBJECTIVES

The objectives of Tostan's educational program are to:

- Reduce illiteracy in Senegal;
- Promote self-development through the use of adapted educational materials;
- Offer a model basic education program;
- Promote reproductive health.

The program emphasizes problem-solving skills applied to various social and economic challenges that impact women and their communities in their daily lives. Basic to this approach is a philosophy that allows participants to understand and examine local practices in a non-judgmental way; to receive new, especially technical, information in an understandable way, and to work as a group to process information and decide about future actions. The project does not tell the villagers what to decide or to do, but presents relevant information through familiar cultural expressions such as stories, songs, drama, and games.

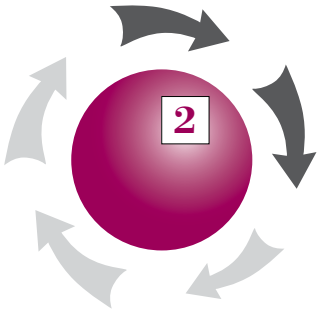
In 1994, Tostan used this methodology to develop a new module on RH issues, including FGC. Because FGC is linked to a girl's opportunity to marry, it was essential to involve inter-marrying groups in a collective decision to abandon the practice. Tostan's module included the story of an eight-year-old girl who dies as a consequence of FGC. This part of the curriculum initiated a nationwide movement against the practice, engaging parents, religious leaders, and politicians, particularly in villages participating in public declarations against FGC. Several evaluations of the project in the last decade have concluded that the project has resulted in positive changes in women's status, increased access to health services, and positive knowledge and attitude changes toward FGC. The UNICEF evaluation even showed a decrease in prevalence in the Tostan villages.

28 Information taken from Tostan, *Breaking through in Senegal: The Process that Ended Female Genital Cutting in 31 Villages* (New York: Population Council and Tostan, 1999); and from C. Feldman-Jacobs, S. Ryniak et al., 2006. See also the Tostan evaluation by UNICEF, *Long-Term Evaluation of the Tostan Programme in Senegal: Kolda, Thies and Fatick Regions, 2008.*

ILLUSTRATIVE CASE STUDY FOR STEP 1, ASSESSMENT PART 2:
TOSTAN—ENDING FEMALE GENITAL CUTTING IN SENEGAL

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
What does information in previous or new research reveal about gender relations and the relative status of women and men?	After performing the socio-drama, women were asked a series of questions to assess the specific implications and consequences of practicing FGC: • Why do you think girls are cut? Do you think it is a necessary practice? Why or why not? • Would you have your daughter cut? Why or why not? • What health dangers are related to FGC? Have you heard of women who had these problems? • What are the taboos related to women who are not cut? • What does Islam say about FGC? Is it an obligation prescribed in the Koran? • Do you think that FGC can have a negative effect on the life of a woman? Why or why not? • Do you think FGC violates any of the articles of the Human Rights Convention that were discussed in the Tostan module? Tostan facilitators were instructed not to be judgmental when posing these questions to the women and to ask the women if they wanted to discuss the issue with health agents, religious leaders, and community leaders. The information the women assembled in response became the basis for a dramatic set of decisions within the community.	• Initially the women were reluctant to discuss the socio-drama but by the third performance, they concluded that they practice FGC because it is part of a tradition expected of them by men and religious leaders. • They discussed it and decided that their human rights training had taught them that they also had a right to an opinion about the practice. They decided to talk to other women and their husbands about the negative health consequences of FGC. In the process they discovered that many people in the community supported stopping the practice. • The women also decided to speak to an Imam to inquire whether the Koran required FGC. The Imam responded that it did not and that he personally was against the practice. This information, in addition to that about health problems, was sufficient to convince the women's husbands and other women who had not participated in the Tostan program. • Finally, the village chief also lent his support by saying that life changes and traditions change. • The Bambara village where this series of data collection, analysis, and attitudinal change took place also made the firm decision to stop the practice of FGC.

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
What does information in previous or new research reveal about gender relations and the relative status of women and men?	The Bambara women who had used information to change the opinions and decisions in their communities also decided to speak to journalists about their decision. The publication of their story led to an assessment of gender issues at high levels of the Senegalese government.	• On November 20, 1997, in response to Bambara women speaking out in the media, the President of Senegal declared that human rights must include women's rights and that respect for women's rights was essential to progress in the country. • A group of women legislators immediately proposed a series of legislative reforms to support gender equality in tax law, social protection, labor laws, and the family code. • On February 3, 1998, the President proposed a law against FGC. • On February 15, 1998, people in 13 villages signed a declaration stating they would no longer practice FGC. By summer of 2008, more than 3,000 villages in Senegal had publicly declared for the abandonment of FGC.



STEP 2, STRATEGIC PLANNING: Develop or revise program objectives for their attention to gender considerations; restate them so that they strengthen the synergy between gender and health goals; identify participants, clients, and stakeholders.

Develop or Revise Objectives

Gender integration in the design of activities begins with the identification of participants and stakeholders, their needs, concerns, and interests. To thoroughly assess participants' needs and priorities, gather information from a cross-section of potential participants and interest groups, including men and women of different ages, ethnic groups, and socioeconomic status. Social and economic differences among these groups are likely to affect their capacity to access and use information and services. For instance, if health information is not adequately tailored to the different interests and literacy levels of women, men, or adolescent boys and girls, they may not use the health services. Program managers and technical staff can benefit by asking themselves:

- Who are the direct participants of the program? Have they participated in setting the objectives and designing the activities of the program?
- Have other stakeholders who might be advocates for or opponents of the program been consulted?
- Has the program staff considered how differences in the sex, age, socioeconomic status, and ethnicity of participants and stakeholders might affect their ability to voice opinions, make decisions, or access information and services?
- What are the different roles and responsibilities women and men have that will affect program outcomes and allocation of its benefits? Do women and men control different types and levels of resources? Do they have diverse needs, desires, interests, and abilities to make and express decisions and opinions?
- Are there elements of the program that might be affected by local gender relations, roles, or identities?
- What are the social, legal or cultural taboos or obstacles that might prevent women or men (or adolescent girls or boys) from participating in the project?

Develop Intermediate Results or Sub-Objectives

At the beginning of program design, consider developing intermediate results or sub-objectives to specifically address gender-based opportunities and constraints to achieving strategic objectives. For instance:

- If women's time is a constraint to seeking antenatal care, consider an intermediate objective that addresses gender-based constraints to access. The objective might be to develop or strengthen satellite services near places women frequent, such as services located close to their places of employment or in mobile units that visit markets and communities.
- If outreach to men and adolescent boys is key to supporting adolescent girls' access to reproductive health information and services (including advice on delay of sexual activity and access

to family planning), an intermediate objective might be "increased participation by men and adolescent boys in FP, RH, MH and HIV/AIDS educational activities."

- If policies present gender-based constraints, such as requiring spousal consent for certain forms of contraception or testing for STIs, an intermediate objective could be to eliminate such constraints by promoting changes in the legislative and regulatory framework and in training health care providers.
- If gender-based violence or fear of abandonment affect a woman's decision to get tested for HIV or to use other reproductive health services, gender-based constraints affecting health seeking behavior and decisionmaking may need to be addressed in conjunction with other health education and outreach activities.
- If traditional norms around masculinity contribute to behaviors that put men and their partners at risk, programs may need to develop sub-objectives to address the underlying gender beliefs in combination with developing other types of educational messages and incentives to change behavior.

Assess Feasibility

As time and resources are often limited, program staff—with active involvement of participants and their communities—should examine the feasibility of achieving objectives in light of available financial, human, and technical resources.

Assessing What is a Feasible Objective:

- What intermediate steps that address gender differences will enhance program effectiveness and contribute to a more equitable distribution of its benefits?
- Which gender-based constraints and opportunities identified in the preceding gender analysis are priorities to address in the program because of either their magnitude or importance for achieving desired health and gender equity objectives?
- What is the institutional capacity of the implementing organizations to address gender issues? What types of organizations have the gender and technical skills and knowledge to assist the program to achieve gender-equity results?
- What program resources are available and who controls them? What is the likelihood that resources can be allocated to address gender-based constraints through intermediate objectives and activities? Who needs to be influenced and how?
- What tasks (formal and informal) are essential to accomplish these results? Which tasks do women perform and which do men perform? Is a gendered division of labor among the program staff, service providers or government personnel likely to affect the project's ability to achieve gender equity in its program?
- How supportive is the enabling environment (policies, champions, and advocacy partners) for achieving the gender and reproductive health or HIV outcomes? Is support likely from the government or civil society organizations? What other challenges might arise?

ILLUSTRATIVE CASE STUDY FOR STEP 2, STRATEGIC PLANNING: REPROSALUD IN PERU [29]

IMPLEMENTING ORGANIZATION

Movimiento Manuela Ramos, a Peruvian NGO, was awarded a co-operative agreement in 1995 by the U.S. Agency for International Development (USAID) to implement the Reproductive Health in the Community Project, known as ReproSalud.[1]

PROBLEM TO BE ADDRESSED

Despite notable increases at the national level in contraceptive prevalence and the use of reproductive health services and declines in fertility, people in rural areas of Peru have been at the margins of these changes. Conventional approaches to service delivery do not adequately address the social, cultural, gender, and other structural barriers faced by poor rural women and men. Their lack of access to information and care impedes their ability to make informed RH choices. The ReproSalud project was designed to address the most critical of these structural barriers, including gender inequality, differing cultural concepts of health on the part of clients and providers, ethnic and class prejudices, and poverty.

OBJECTIVES

Through an innovative, inter-sectoral design, ReproSalud aimed to:

- Improve women's reproductive health in rural and peri-urban Peru;
- Simultaneously address women's practical needs and strategic gender interests.

The project contributes to these goals by:

- Increasing women's utilization of RH preventive practices and services;
- Actively involving women in identifying, prioritizing, and resolving their own RH problems and in determining and negotiating the conditions in which RH services are delivered;
- Ensuring that the public health system incorporates women's perspectives into health care delivery and institutionalizes women's participation in the design and implementation of Ministry of Health (MOH) services so that health services are better able to respond to women's needs.

RESULTS

A mid-term evaluation in 2002 found that in comparison with non-participant communities, residents of ReproSalud communities were: 92 percent more likely to know how at least one modern method of contraception works; 27 percent more likely to have their last delivery attended by a health professional; 15 percent more likely to have had four pre-natal visits; 18 percent more likely to seek treatment for RTIs; 15 percent more likely to use a family planning method, and 18 percent less likely to have unmet need for family planning. ReproSalud also had a positive influence on gender indicators such as how they will spend the money they earn, refusing to submit to forced sex; go to the authorities if beaten by their spouse, decide jointly with

29 Information for this section taken from: A. Alberti et al., *Strengthening ReproSalud's Monitoring and Evaluation Strategies* (Washington, DC: POPTECH Project, 1998); Anna-Britt Coe, *Health, Rights, and Realities: An Analysis of the ReproSalud Project* (Takoma Park, MD: Center for Health and Gender Equity, 2001); S, Galdos and B. Feringa, "Two Years on the Ground: ReproSalud through Women's Eyes," a report presented to USAID/Peru, 1999; J. Bruce and D. Rogow, *Alone You Are Nobody, Together We Float: The Manuela Ramos Movement* (New York: Population Council, 2000) (www.popcouncil.org); B. Shepherd, D. Ferrando, and A. Beltran, "Midterm Evaluation of the ReproSalud Project for USAID,"LTG Associates March 2002; and C.Yon, "Involving Men in a Project based on Women's Empowerment," 2003.

their spouse on such issues as children's education, sexual relations, contraception, and number of children. There were also improvements in attitudes among men who participated in at least one educational module: a 55 percent increase in the number who agreed that their partners should give birth in a health facility; a more than doubling of the percentage of men with STIs who went to a health clinic and who used condoms to protect themselves and their partners; and a 50 percent decrease in the percentage of men who believed they were entitled to demand sex from a partner when she did not want it.

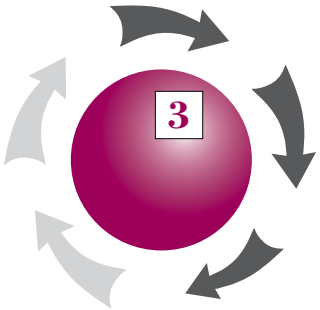
ILLUSTRATIVE CASE STUDY FOR STEP 2, STRATEGIC PLANNING: REPROSALUD IN PERU

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
Who are the direct participants of the project?	Participants of the project were women in rural and peri-urban areas of Peru. The project was designed to engage and mobilize community-based organizations; to identify, prioritize, and develop resolutions to RH problems. Women participated in the design, implementation, and evaluation of subprojects through several mechanisms.	• Women's groups competed with one another through developing skits about their most pressing RH concerns. Since the project emphasized forming partnerships with women's groups, the project team selected the groups that, through their skits, demonstrated cohesiveness and ability to work together. • Once selected, representatives of the community-based organizations participated in a 3-4 day self-diagnostic process whereby they explored issues affecting women at different ages. After exchanging information about health beliefs and practices with the project coordinators, participants prioritized their RH concerns and selected the most critical issues as the focus for community education activities.

ILLUSTRATIVE CASE STUDY FOR STEP 2, STRATEGIC PLANNING: REPROSALUD IN PERU

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
Have potential participants been involved in setting the objectives and designing the activities?	Participants were not involved in the initial design of the project, but during the early stages of project implementation during consultations, the women told project coordinators of their desire to involve their male partners. Women wanted to alter the attitudes and behaviors of men that they identified as barriers to women's improved health.	ReproSalud decided that it was essential to involve men so they would not be a barrier to women's participation in the project. Discussions with women also revealed that men were responsible for many of women's reproductive health problems.
Are there other stakeholders who might be advocates or opponents of the program? Have they been consulted?	The women persuaded project implementers that if they redesigned the project to give men access to the same information as women, they would all be more effective in reaching out to local authorities.	

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
Which gender-based constraints and opportunities identified through gender analysis and consultations with participants are priorities to address in the program because of either their magnitude or their importance for achieving desired health and gender equity/equality objectives?	In order to reach the goal of the project of improving SRH and gender equity, the project developed two new objectives: • To raise men's awareness about gender equity and women's rights; • To increase men's knowledge to prevent and deal with sexual and reproductive health problems.	• Introducing new objectives and adjusting project strategies, methodologies, and materials to men's concerns and interests improved communication between men and women and enhanced the capacity of both groups to recognize the effects of individual decisions on each other and their families. • Sharing of information promoted a respect for women's and men's reproductive rights and helped to alter power imbalances in relationships. • Involving men on women's terms enlisted men as strong allies in gaining the support of local and regional governmental officials and in persuading health services providers to respond more sensitively to women's SRH needs.



STEP 3, DESIGN: Identify and decide on key program strategies and activities to address gender-based constraints and opportunities.

Determining Strategies for Desired Results

Once the data has been analyzed and has yielded information about gender-based constraints and opportunities, the program team can gain insight into which strategies would achieve the desired program objectives and results. In choosing among different options, the team should consider both feasibility and likely effectiveness for achieving both health and gender equity objectives—choosing a gender accommodating or gender transformative approach (see Chapter 3 of this Manual).

- What activities and services will the program have to implement to ensure that gender constraints will be mitigated or eliminated, and opportunities will be successfully utilized?
- How will activities and services ensure equitable participation by women and men (boys and girls)?
- In what ways will program activities benefit women and men?
- What strategies will help ensure that activities benefit women and men equitably or will challenge and alter institutionalized inequities in benefits?
- How will the program ensure that women and men have equitable access to and control over information, health resources (training, outreach, products), and services?
- What strategies will the program employ to address discriminatory laws, policies, regulations, and institutions?
- What strategies will the program develop to address social and cultural preferences?

Analysis reveals how gender-based opportunities or constraints provide the basis for program design. For example:

- How can social and sports clubs be used to engage adolescent boys in creating more equitable gender relations with their partners to reduce gender-based violence, unwanted pregnancies, and HIV transmission?
- How can partners and in-laws be encouraged to permit married adolescents greater autonomy and mobility to participate in health education and livelihood development activities?
- What time-saving approaches (including a more equitable allocation of tasks between men and women) or new technologies can be introduced to allow women time for community involvement, e.g., to serve on a health facility oversight committee monitoring problems with quality and access?
- How can women's ability and authority to make decisions to improve access to maternal healthcare in their communities be increased?
- How can projects reduce the gender-based economic constraints that increase the vulnerability of adolescent girls to HIV transmission?

The answers to these types of questions should guide program and activity design.

ILLUSTRATIVE CASE STUDY FOR STEP 3, DESIGN: SAFE MOTHERHOOD THROUGH COMMUNITY MOBILIZATION[30]

IMPLEMENTING ORGANIZATION

The Population Council in New York partnered with the M.V. Foundation, an Indian NGO that focuses on children's rights. The project site was in Rangareddy District in the State of Andhra Pradesh, India, and included 38 villages with a total population of approximately 40,000 people.

PROBLEM TO BE ADDRESSED

The intervention sought to lower the high incidence of maternal mortality and morbidity by impacting the low utilization of maternal health services. Related gender-focused problems included men's lack of interest in maternal health and restricted capacity of women to make decisions about their own antenatal care and delivery.

OBJECTIVES

The project aimed to raise awareness of safe pregnancy and delivery practices in order to reduce maternal mortality and morbidity by:

- Raising awareness of the importance of good nutrition, antenatal care, and delivery in health facilities;
- Supporting greater oversight and involvement of communities in supervising health services to make them more accountable to women's needs;
- Addressing gender-based and health system constraints to women's ability to act on their rights to deliver with a skilled birth attendant (SBA) and to access life-saving care in the event of complications during pregnancy, delivery and post-partum.

The following strategies and activities were used to meet these objectives:

- Mobilization of community members (leaders, men ,women, and adolescent boys and girls) to demand quality pregnancy-related services;
- Awareness-raising among husbands and senior family members, especially mothers-in-law to ensure delivery care by an SBA, and the need for emergency funds and plans in the case of complications;
- Outreach by health workers to all pregnant women through home visits.

RESULTS

The 18-month project demonstrated convincing improvements in health-seeking behavior and gender relations, including:

- An increase in women with three or more antenatal visits (from 61 percent to 72 percent) and who sought their first visit in the first trimester (from 45 percent to 55 percent);
- An increase in women who decided to deliver in a health-care facility (from 67 to 79 percent) and who identified a hospital to go to in case of emergency (from 35 to 49 percent);
- An increase of more than 50 percent in the number of women who saved money to meet delivery expenses and who discussed birth-related plans with close family members.

30 This case study is based on a report by Dipa Sinha, "Empowering Communities to Make Pregnancy Safer: An Intervention in Rural Andhra Pradesh," Health and Population Innovation Fellowship Programme, Working Paper, No. 5 (New Delhi: Population Council, 2008). Accessed online July 1, 2009 at www.popcouncil.org/pdfs/wp/India_HPIF/005.pdf

As for gender-related changes, by the end of the intervention, 50 percent more women reported their household and agricultural workload decreased during pregnancy, and the percentage of women who had access to more food and more nutritious food nearly doubled. Also, the percentage of men who assisted their partners with household work during pregnancy nearly doubled.

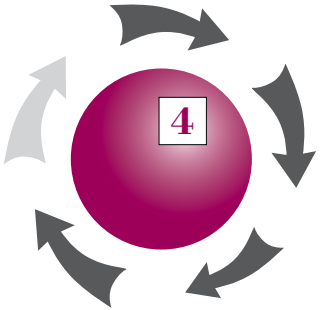
ILLUSTRATIVE CASE STUDY FOR STEP 3, DESIGN: "SAFE MOTHERHOOD THROUGH COMMUNITY MOBILIZATION"

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
What activities and services will the project implement to ensure that gender needs and concerns are addressed?	At the community level: • To respond to the finding that pregnancy and childbirth were considered a normal event in the life of a woman and the community had no role to play, the project developed several activities through organized groups as agents of change, community government (*gram panchayats*) and youth committees. • Distributed posters, and conducted cultural programs and street plays on the rights of women to maternal health.	• Trained youth committees and *gram panchayats* on how to oversee quality and functioning of health services, and informed them on the number of deliveries occurring at home rather than in health facilities • Committees collected data on the number of maternal deaths, complications, and antenatal care. • *Gram panchayats* held regular monthly meetings with mothers' committees, youth, ward members, healthcare workers and school representatives to discuss performance of healthcare facilities using data in a non-confrontational way. • Within a short period of time, local leaders took over the direction of meetings from project facilitators. • Leaders of youth committees raised awareness among other youth about maternal health and women's rights, as well as about the responsibilities of public health providers.

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
How will activities and services ensure equitable participation by women and men, girls and boys?	Youth committees only had young men as members. The project wanted to also involve young women in the youth committee activities.	• Community organizers helped youth groups to set up committees of girls and young women. Young male committee members helped to increase girls' and young women's participation by guaranteeing to their parents that the activities would take place in a safe environment. • Girls and young women's committees were formed in 20 villages. Young women were encouraged to participate actively in youth committees along with men and to join them in applying pressure to health center staff to be more accountable for maternal health outcomes.
What kinds of strategies will help the project to ensure that activities benefit women and men equitably or address institutionalized inequities?	• *Gram panchayat* meetings delegated leaders to seek out higher level medical authorities when problems could not be addressed locally. • Youth committees sponsored volunteer community action to clean up and improve health center infrastructure. • *Gram panchayat* committees and youth committees provided oversight that ensured regular attendance and quality of care by healthcare providers at all levels.	• Community leaders reported that as a direct result of their interactions about problems faced by health providers and women, government officials demonstrated a greater willingness to address problems. For example, complaints about unnecessary referrals to district hospitals pressured the medical director to improve conditions at the health center so that women, including those with complications, could deliver closer to home. • Women also viewed health care providers as more responsive to the needs of pregnant and post-partum women.

ILLUSTRATIVE CASE STUDY FOR STEP 3, DESIGN: "SAFE MOTHERHOOD THROUGH COMMUNITY MOBILIZATION"

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
What strategies will the project employ to address discriminatory laws, policies, regulations (formal and customary), and institutions?	At the family level: • To address the attitudes among men and senior family members that pregnancy-related messages were only relevant to women, the project initiated meetings for men away from home to give them a space to discuss maternal health issues, including ways to support their wives. • Members of the *gram panchayat* and youth committees also attended men's meetings and provided a link between partners of pregnant women and the health services.	• Initially men were supportive of their partners going to antenatal care and purchased needed medicines, but were unwilling to assume a more proactive or supportive role in their households and were embarrassed to discuss pregnancy-related issues with community organizers or healthcare providers. Men's group discussions focused on ways to support their wives, availability of services and the need to plan for emergencies, and issues related to domestic violence, harassment, and alcoholism. • As a result of men's group meetings, men were more willing to assist their partners in some domestic tasks, although they still feared stigma from other men, relatives and neighbors. Many were able to serve as role models for new members of the groups.



STEP 4, MONITORING:
Develop and monitor indicators that measure gender-specific outcomes; evaluate the effectiveness of program elements designed to address gender issues.

Tracking Progress and Impact

Performance indicators disaggregated by sex are necessary for monitoring progress, health outcomes, and impact of programs on men and women, as well as for assessing if the program is contributing to greater gender equity. One way to formulate gender indicators is in direct relationship to the gender-based constraints and opportunities identified from the gender analysis and project design. Gender indicators measure whether a gender-based constraint has been mitigated or removed, or the impact of taking advantage of a gender-based opportunity. For instance, if women's lack of access to money prevents them from using health services because of users fees or transport costs, the indicator should measure whether the fees have been removed, transport has been subsidized, or women have been enabled to access services through free mobile clinics. An indicator that measures removal of a gender-based constraint can be compared to a simultaneous change in health indicators, such as an increase in the use of health services. Even when both gender and health indicators move together in a positive direction, one cannot establish a causal or attributional relationship between them without having invested in careful baseline and endline data collection and evaluation.

Routine monitoring of outcomes will indicate whether a program is meeting its aims and objectives. To ascertain why the program is meeting its objectives or why it is not, it is necessary to evaluate progress and impact of the specific program elements. Tracking the benefits and costs of gender mainstreaming is essential to building the body of knowledge about how gender disparities affect development outcomes, and how gender-sensitive development programs can promote gender equity.

Gender indicators are most useful for demonstrating changes in gender relations and impacts when they are developed during activity planning and tracked throughout implementation. Sex-disaggregated data and gender impact indicators provide feedback to implementing agencies and stakeholders on progress, problems, and unanticipated outcomes. They also provide the analytical basis for making informed adjustments to programs during implementation and for the design of future activities. Gender analysis in the planning process helps to define what indicators are required to track differential impacts of activities. Some issues to consider when selecting indicators:

- Are indicators disaggregated by sex, ethnic group, age, and socioeconomic status?
- Are baseline data collected on women and men of different ages, socioeconomic status, and ethnicity?
- Are there specific indicators to measure changes in gender relations, access to services and resources, and power?
- Does the project have a systematized way for collecting and analyzing the information on a regular basis?
- Does the project have policies about what to do when monitoring and evaluation data reveal gender inequities?
- How do gender-specific objectives link to impact on RH?

A project monitoring and evaluation (M&E) plan specifies the indicators and the terms for their analysis and interpretation. By developing gender-specific indicators or disaggregating most indicators by sex, the M&E plan can help to point out gender differences in program implementation and impact. But these quantitative indicators only highlight differences; without further analysis, they do not explain why or how differential outcomes occur, and may contribute little to an understanding of the importance of gender in a program without a plan for interpreting the results. For instance, sex-disaggregated data of the number and sex of people using a clinic will not explain if:

- The services offered are more attuned to the needs of men or women;
- Men and women are treated differently by health care providers; or
- The location of the clinic limits who has access.

Further analysis and possibly qualitative research will be needed to uncover the reasons for such differences. It is through the careful collection and analysis of gender-specific quantitative and qualitative data that the information can be meaningfully incorporated into management decisions and reporting. This is best accomplished through consultative and participatory involvement of participants and stakeholders in the analysis of M&E data. Their involvement will help counteract gender and institutional biases in deciding what to measure and how to use monitoring information to increase participants' control over program activities and results.

Examples of Indicators that Measure Gender-Specific Outcomes[31]

- In Clinics—Change in provider attitude toward choice of FP; change in bias toward women; change in clinic protocols regarding provision of a full range of methods; change in gender/age mix for each service provided at clinic;
- In Cases of Gender-Based Violence—Change in provider awareness of signs of violence; change in referral systems; change in community attitudes; change in police attitudes and behaviors;
- In Policy Process—Change in number of women or women's groups participating in the policy process; change in attitude of policymakers/those involved in policy process toward women or women-centered NGOs; change in attitudes of community leaders, representatives of the private sector, and special interest groups involved in policy process;
- In Research—Change in the way gender is included in research protocols; evidence of more sophisticated modeling of gender and other variables;
- In Men's Participation—Change in knowledge among men regarding family planning, maternal health, HIV/AIDS; changes in partners' attitudes about FP.

31 These examples are from N. Yinger et al., *A Framework to Identify Gender Indicators for Reproductive Health and Nutrition Programming* (Washington, DC: PRB for USAID's IGWG, 2002). This IGWG paper is an excellent resource for developing gender integrated monitoring and evaluation plans.

ILLUSTRATIVE CASE STUDY FOR STEP 4, MONITORING : "LINKAGES BETWEEN DEMOCRACY AND GOVERNANCE (DG) AND REPRODUCTIVE HEALTH (RH) IN PLATEAU STATE, NIGERIA" [32]

IMPLEMENTING ORGANIZATION

The Centre for Development and Population Activities (CEDPA) implemented the USAID-funded Enabling Change for Women's Reproductive Health (ENABLE) project in Nigeria and four other countries. In Nigeria, the Nigerian Institute of Social and Economic Research (NISER) collaborated with CEDPA and local partner, the Church of Christ in Nigeria (COCIN).

PROBLEM TO BE ADDRESSED

Unequal gender relations contribute to higher HIV risks for women, especially young women, and to low levels of use of family planning and maternal health services in many countries. The program recognized that 1) women and men lead multidimensional lives that involve complex sets of social, political, and economic relations; and 2) in order to achieve greater reproductive health impacts, women must be empowered to be more effectual agents in other dimensions of their lives.

OBJECTIVES

The ENABLE Project was designed to address gender-based constraints that prevent women from making informed and autonomous reproductive health decisions. The premise in Nigeria was that expansion of women's participation in politics and governance would increase their control, decisionmaking, and power in other domains of their lives, including reproductive health. To test this, the study used a four-cell quasi-experimental design to compare four communities in which three received interventions: RH only; Democracy and Governance (DG) only; combined RH and DG; and a control community. RH communities received multi-faceted activities including seminars, home visits, talks in churches and communities about HIV/AIDS; condom distribution; creation of an HIV/AIDS unit in the Health Services Department; care and support for orphans and People Living with HIV/AIDS (PLWHA); training of church pastors in HIV/AIDS counseling; FP, immunizations, breastfeeding promotion and safe motherhood. Activities in DG communities included: advocacy visits to community leaders (women, religious, governmental, etc.); rallies; civic education, promoting joint decisionmaking between partners; training on conflict management, leadership, political participation, social mobilization, and accountability; and formation of coalitions and supervisory groups. RH/DG combined communities received all of the above.

RESULTS

Following the interventions, in 2002-3, women in a sample of each type of community were compared on empowerment indicators and use of and intention to use contraception. Empowerment was measured by four indices: a) mobility—the conditions, frequency, and autonomy of women to move about for different types of activities; b) household decisionmaking—women's preferences for who should make decisions about work outside the home, food preparation, and purchase of household items; c) sexual empowerment—whether or not a woman can refuse to have sexual relations with her male partner for a number of reasons (e.g., if he has an STI or is having

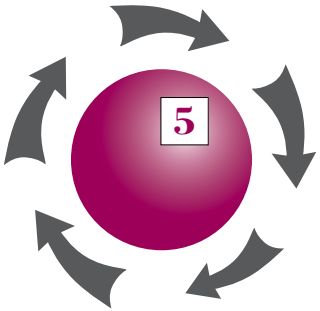
32 The information for this case study is from K. Oyediran and C. Teller, "Linkages between Women's Participation in Democratic Activities and Reproductive Health Behaviours: A Case Study of Plateau State, Nigeria" (Washington, DC: CEDPA, August 2003). Accessed on July 1, 2009 at www.jhuccp.org/igwg/presentations/Wednesday/Plen5/Linkages.pdf.

sex with other women, or if the woman has recently given birth, or is not in the mood); d) gender-based violence—whether or not a woman believes it is justified for her husband to beat her. The study found that women in communities receiving the combined DG/RH interventions scored highest on all of the empowerment and RH indicators.

ILLUSTRATIVE CASE STUDY FOR STEP 4, MONITORING: LINKAGES BETWEEN DEMOCRACY AND REPRODUCTIVE HEALTH IN PLATEAU STATE, NIGERIA"

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
Are baseline data collected on women and men of different ages, socioeconomic status, and ethnicity?	Increasing concern about the rise in HIV prevalence rates and the minimal use of modern family planning methods, led the project to test whether unequal gender relations played a key role in limiting women's access to information and services. The program tested the impact of activities that increased women's participation in decisionmaking within the household and the community in combination with access to RH information and services on enhancing reproductive health outcomes.	The evaluation used a cross-sectional four-cell quasi-experimental design to measure the comparative impact of Democracy and Governance (DG), RH, and combined interventions. • Women in four Local Government Areas (LGAs), each with a different set of interventions, were compared. • In addition to demographic data, the study collected information on the respondents' sexual activity, fertility preferences, husband's socioeconomic background, and on women's work, decisionmaking, and political participation.

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
Are there specific indicators to measure changes in gender relations, access to services and resources, and power?	Based on the information collected in the survey questionnaire, the study coordinators constructed four scales to measure women's empowerment: 1) mobility 2) household decisionmaking; 3) sexual empowerment; and 4) gender-based violence. These were correlated with a fifth scale that measured household socioeconomic status.	• Women in DG/RH combined communities were more likely to register high mobility (80%) as compared with women in RH only (73%), DG only (58%), and control group (58%). • Women in the combined DG/RH communities were more likely to make autonomous decisions than women in other intervention communities. The DG-only communities had the highest percentage of women who said they made decisions jointly with their partners. • Women in DG/RH and DG-only communities also rated highest on the sexual empowerment index, with 83% (DG/RH) and 74% (DG) considering themselves to be empowered. Women in the RH only (66%) and the control communities (60%) were less sexually empowered and presumably less able to negotiate safe sex practices.
Are there specific indicators to measure changes in gender relations, access to services and resources, and power?	Attitudes toward gender-based violence were not an explicit focus of project activities and messages, although GBV was one of the indicators used to measure empowerment. Therefore, this indicator did not directly measure the impact of program interventions.	• Control communities had the highest percentage of women stating that it was not justified for a husband to beat his wife (58%) compared to 38% in DG/RH, 23% in RH only, and 33% in DG only communities. Project implementers hypothesize that these attitudes preceded the program and were not significantly impacted by them.
How do gender-specific objectives link to impact on reproductive health?	Participation in both DG and RH activities achieved impacts greater than those achieved by RH or DG interventions alone.	• The percentage of women in DG/RH (12%) who used modern family planning methods was twice that of women in RH only (6%) communities. • Intention to use a form of modern contraception in the future was highest in the DG/RH (53%) communities followed by DG only (46%); RH only (43%); and control (40%).



STEP 5, EVALUATION: Measure progress and impact of program and policies on health and gender equity. Make recommendations to adjust design and activities based on monitoring and evaluation results; strengthen aspects of the program that contribute to more equitable health and gender outcomes, and rework aspects that do not.

Redesigning Program Elements

Evaluation involves comparing outcomes at two or more points in time (typically baseline and endline) to ascertain change. In evaluating a gender analysis, some key questions include:

- Has the program reduced power differences in relations between men and women? For instance, is decisionmaking more equitable; do men and women have more equal opportunities; has women's mobility outside the home increased; has men's use of violence against women decreased? Have men become more concerned with and involved in attending to the healthcare of themselves, their children, and their partner?
- Has stigma and discrimination against people who do not follow traditional gender norms and behaviors been reduced?
- Has the removal of gender-based constraints contributed to improved health outcomes?
- Are institutions and organizations more supportive of gender equity and less discriminatory?
- Have identified changes contributed to increasing access to healthcare and information, as well as to changes in health seeking behavior and outcomes.

Evaluation can also help to identity what did not work well and why. A second round of gender analysis can reveal important dimensions of gender relations that were overlooked or missed initially. For instance, a program focused on ensuring that key health messages were attuned to the different needs and concerns of men and women might have overlooked the different media and interpersonal contexts through which men and women generally receive information. Therefore, effective messages may never have arrived at their intended audiences.

If the program is not achieving its intended results, activities may need to be redesigned in order to more effectively address gender inequalities and to increase the prospects for achieving desired program outcomes. For instance:

- If adolescent boys' attitudes about sexuality and responsibility for teenage pregnancy do not demonstrate a significant change after providing sex education at soccer practice, the project might reassess its assumption about reaching boys through athletic clubs.
- If that still seems like an appropriate venue, perhaps it is necessary to analyze the effectiveness of educational materials for the intended audience. Are the messages at odds with social norms and concepts about virility and sexual power that are intrinsic to boys' gender identity?
- Are the social clubs effective vehicles for changing social norms? Are there other social groups that have greater influence on social norms than boys' clubs?

- Might it be more effective to engage older men and women who shape boys' concepts about sexuality?

As in the initial gender analysis, it is particularly important to involve program participants in analyzing why the project is not achieving its intended results. Often there are important factors that participants are aware of that are not obvious to program staff. Joint engagement in analysis and problem-solving helps to creatively address both hidden and overt gender-based constraints, as this last case study illustrates.

ILLUSTRATIVE CASE STUDY FOR STEP 5, EVALUATION: SONAGACHI—STI/HIV PREVENTION IN INDIA (SHIP)[33]

IMPLEMENTING ORGANIZATION

The program was initiated by the All India Institute of Hygiene and Public Health (AIIH&PH), with support from the National AIDS Control Organization of India (NACO), the Ministry of Health and Family Welfare of West Bengal, and WHO. The project has generated a large coalition of NGOs, including the sex workers' own organization, the Durbar Manila Samanwaya Committee (DMSC).

PROBLEM TO BE ADDRESSED

At the time of the project's initiation, the prevalence of HIV among commercial sex workers (CSWs) was small but growing, and STIs were becoming increasingly prevalent. The original design of the program focused on raising awareness of HIV/AIDS, condom use, and clinical services. Over time, through a process of peer education, community mobilization, policy change, and economic and political empowerment, the Sonagachi Program has played a significant role in a powerful process of social change and significant improvements in health outcomes. The HIV prevalence among CSWs in India at the time of the project was almost 50 percent in all major cities except Calcutta, where it was just below 10 percent. There is strong evidence that the Sonagachi Project contributed to this highly significant difference in HIV prevalence.

OBJECTIVES

Originally, in 1992, the principal objectives were to reduce STI/HIV transmission, lower prevalence of STIs, and increase condom use among CSWs and their clients in the Sonagachi area of Calcutta. With increased participation of the sex workers in the design and implementation of the project, the program added other objectives, such as reducing violence perpetrated by clients, brothel owners, police, and hoodlums; increasing literacy; and generating income from alternative sources. The project has increasingly focused on preventing under-aged girls from becoming sex workers.

RESULTS

When made aware that sex workers routinely adopted safe sex practices with their short-term customers but were more reluctant to do so with their long-term partners, Sonagachi staff prioritized a focus

33 The information for this case study is drawn from "Sonagachi: A Sex Worker Project in a Red Light District of Calcutta, India" (UNAIDS, 2000) accessed online at: www.unaids.org; DMSC-TAAH Research Group, Crossing Sectors: Dialogue on Intersectoral Action: Meeting Community Needs for HIV Prevention and More: Intersectoral Action for Health in the Sonagachi Red-Light Area of Kolkata. WHO, Commission on Social Determinants of Health, Geneva, 2008; and Basu et al., 2004.

on the relationships between the workers and their long-term partners. Other results included the creation of businesses where CSWs marketed condoms, leading to a rise in condom use; of a successful credit union; and of a training program for police. The success of the project in decreasing STI/HIV transmission and gender-based violence is attributed to the salience of messages on the importance of also incorporating safe sex practices into long-term relationships; building social capital as a means of increasing political influence; confronting stigma and discrimination with economic, social, and political empowerment; and working in partnership with local government and other power-brokers.

ILLUSTRATIVE CASE STUDY FOR STEP 5, EVALUATION: SONAGACHI—STI/HIV PREVENTION IN INDIA (SHIP)

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
Does the program adequately respond to the specific gender needs of the participants and clients?	Baseline and follow-up surveys indicated that many gender-based challenges contributed to the vulnerability and increased health risks faced by Sonagachi CSWs: 85 percent were illiterate, more than 45 percent had children, 70 percent had entered the trade due to poverty or family disputes, and 27 percent said that their clients insisted on group sex, putting them at additional risk for both violence and disease. In 1992, more than 90 percent had never used condoms.[34] Young CSWs presented particular problems that had not been identified at the beginning of the program. They were less able to negotiate safe sex practices, were more vulnerable to HIV infection, and were often the pretext for police raids.	• Sex workers were engaged as peer counselors and joined forces with the DMSC, which served as an advocacy group for participants. One third of peer educators subsequently left the sex trade. • Participants requested literacy training, initially to be more effective as peer counselors, but subsequently as a way to more effectively defend their rights. The incidence of syphilis is lower for those CSWs who are literate. • Workers also identified a need for loans and used them to start businesses and to market condoms. Condom sales increased dramatically. • The DMSC and its membership successfully lobbied for the rights of sex workers to establish their own credit union. USHA was established in 1995 and by 2004 held $850,000 in assets and more than 8,000 sex worker members had accounts. The success of the credit union has provided its members with sufficient financial stability to allow them to negotiate better working conditions which has also contributed to their improved health status . • To reduce trafficking among young girls, DMSC set up a system to monitor brothels, and arranged to send young CSWs to boarding school.

34 To put these results to a test under more rigorous conditions, an operational research study was conducted by the University of California in the Cooch District of West Bengal, with a sufficient distance between intervention and control sites to avoid significant influence. After 16 months, the intervention sites showed significantly greater percentages of CSWs reporting consistent use of condoms as compared to the control sites (Basu et al., 2004).

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
Are there any gender-based obstacles to achieving the objectives of the program that were not adequately addressed by the original design of the program?	Sex workers, and even some of the staff, were victims of abuse and violence by various stakeholders, including clients, brothel owners, pimps, other criminals who profited from the trade, and police. This climate of violence had an impact on achieving the original objectives of the project. For instance, staff noted that after police raids, condom use declined and the incidence of STIs rose among clinic users. Sex workers also suffered from gender-based discrimination and stigma that limited their access to health services; left them powerless to negotiate the terms of their work, to negotiate safe sex practices. In order to effectively address the root causes of sex workers' disempowerment and discrimination, the project redefined the problems the CSWs faced from technical/behavioral to problems based on lack of rights and social justice. The approach was also reformulated from one based on changing individual risky health behaviors to one focusing on structural changes and empowerment, improving occupational health in order to address not only individual behavior but also working conditions and environmental risks.	• Peer education focused on both sex workers and madams. • AIIH&PH developed a training program for police. • DMSC organized CSWs to demonstrate against police raids and against unethical and illegal testing for HIV/AIDS. • The program established services for the clients of sex workers, including clinics and awareness programs. Gonorrhea decreased from 13 percent in 1992 to less than 4 percent in 1998. • To increase the power of CSWs to negotiate clients' use of condoms and health services, clinic referral tickets were developed for clients. Condom use increased from less than 3 percent to more than 90 percent between 1992 and 1998. • Regular clients (babus) were engaged to escort sex workers to and from work to protect them from thugs who prey on them outside of establishments. • Hundreds of sex workers received legal training. In addition to a dramatically lower HIV prevalence among Sonagachi participants, as compared to CSWs in other cities (correlated with a high rate of condom use), the gender impacts include large decreases in sex trafficking, violence, coercion, and police raids against sex workers. As a result of peer education and strong social cohesion, CSWs had increased choice and power to make decisions. Greater economic security allowed sex workers to refuse customers at times in order to take care of their own health. Accumulation of savings also gave them greater control over their working environment.

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
		The factors contributing to these outcomes were: 1) having access to key power brokers facilitated through AIIHPH; 2) construction of alliances based on the strong social capital of the coalition of organizations that grew out of the project (DMSC); and 3) development and strategic use of alliances with governmental and other nongovernmental organizations, especially with local government.
Do staff members have the appropriate set of skills to address gender issues and the needs of the clients?	Several staff initially had to overcome their discomfort with working in the context of the sex workers' world. They had to confront both their prejudices about the sex workers and fears for their safety from street criminals.	• The program invested in capacity building for both the staff and the sex workers. In coalition with the DMSC and other organizations involved in the program, staff were sensitized to the difficult situations faced by the sex workers and became more responsive to their needs. • Over time, management of the project evolved into a coalition of partners called the "Conglomerate" which ensures a distribution of responsibility across different stakeholders, and encourages a diversity of ideas and strategic thinking. • Shared responsibility has created a climate of volunteerism that has allowed the program to contain costs, expand coverage, and put increasing amounts of control in the hands of the participants. • Since 1992, the project has placed control over health care in the hands of the community. The project treated CSWs respectfully and ethically, encouraging them to express and address their needs.

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED	HOW THE PROJECT WORKED
Are the indicators used for monitoring and evaluation adequately capturing the impacts of the program?	At the beginning of the program, the primary impact measures were biomedical, focusing on the effectiveness of STI control. The program had difficulty capturing behavioral changes, especially with regard to male clients. In addition, the indicators were not adequately assessing changes in levels of empowerment among the women sex workers, or the involvement of the community.	• Use of STI clinics by program clients is measured by the number of those presenting referral cards given to them by CSWs. • Empowerment is measured in part by the number of times sex workers successfully negotiated with landlords, police, and others to support their adoption of healthier practices. While not clients, these gatekeepers are positioned to affect the safely and vulnerability of CSWs. • Specific contexts were identified where CSWs' power to protect themselves needed strengthening. For instance, condom use is lowest with their long-term clients (*babus*), upon whom CSWs are often dependent for support and for legitimizing their children so they can attend school. Pimps and madams, who side with resistant clients, remain obstacles to condom use. The work environment militates against negotiating with intransigent clients. Sex workers often share rooms with other workers and are reluctant to be assertive in the presence of others.

REFERENCES

Alkire, S. "Concepts and Measures of Agency." *Oxford Poverty and Human Development Initiative, Working Paper Series*, nd. . Accessed online May 1, 2009 at www.ophi.org.uk/pubs/Alkire_Agency_WP9.pdf.

American Psychological Association, Accessed online May 1, 2009 at www.apa.org/topics/sorientation.html#whatis.

Baek, C., V. Mathambo, S. Mkhize, I. Friedman, L. Apicella, and N. Rutenberg. *Key Findings from an Evaluation of the Mothers2mothers Program in KwaZulu-Natal, South Africa. Horizons Final Report.* Washington, DC: Population Council, 2007.

Barker, G., D. Dogruoz, and D. Rogow. "And How Will You Remember Me, My Child? Redefining Fatherhood in Turkey." *Quality/Calidad/Qualite* 19. New York: Population Council, 2009.

Barker, G., C. Ricardo, and M. Nacimento. *Engaging Men and Boys in Changing Gender-based Inequity in Health: Experience from Program Interventions.* Geneva: WHO, 2007. Accessed online May 1, 2009 at http://www.who.int/gender/documents/Engaging_men_boys.pdf

Basu, I., S. Jana, M.J. Rotheram-Borus, D. Sweneman, S. Lee, P. Newman, and R. Weiss. "HIV Prevention Among Sex Workers in India." *Journal of Acquired Immune Deficiency Syndrome* 36, no. 3 (July 2004).

Beetham, G. and J. Demetriades. "Feminist Research Methodologies and Development: Overview and Practical Application." *Gender and Development* 15, no. 2 (July 2007).

Bennett, L. Unequal Citizens: Gender, Caste, and Ethnic Exclusion in Nepal, Kathmandu. Nepal: DFID and The World Bank, 2005. Accessed online May 1, 2009 at http://siteresources.worldbank.org/INTRANETSOCIALDEVELOPMENT/Resources/Bennett.rev.pdf.

Bruce, Judith, and Debbie Rogow. Alone You Are Nobody, Together We Float: The Manuela Ramos Movement. New York: Population Council, 2000.

Burke, M., M. Rajabu, A. Ramadhani, and J. Burke. "Male Participation in Prevention of Mother to Child Transmission Prevention Programs in Tanzania," at Social Research Conference and the HIV Educators' Conference, Sydney, Australia, 2004.

The Center for Reproductive Rights. *Bringing Rights to Bear Anew: 2008 Update.* New York: Center for Reproductive Rights, 2008.

Cleland, J., S. Bernstein, A. Ezeh, A. Faundes, A. Glasier, and J. Innis. "Family Planning: The Unfinished Agenda." *The Lancet* 368, no. 9549 (2006): 1810-1827.

Coe, Anna-Britt. *Health, Rights, and Realities: An Analysis of the ReproSalud Project.* Takoma Park, MD: Center for Health and Gender Equity, April 2001.

Durbar Mahila Samanwaya Committee (DMSC) and Theory and Action for Health (TAAH) Research Team. "Meeting Community Needs for HIV Prevention and More: Intersectoral Action for Health in the Sonagachi Red-light District Area of Kolkata," nd (circa 2008). Geneva: WHO. Accessed online May 1, 2009 at www.who.int/social_determinants/resources/isa_sonagachi_ind.pdf.

Esplen, Emily. *Engaging Men in Gender Equality: Positive Strategies and Approaches: Overview and Annotated Bibliography.* Brighton: Institute of Development Studies, October 2006.

Feldman-Jacobs, C. and S. Ryniak et al. *Abandoning Female Genital Mutilation/Cutting: An In-Depth Look at Promising Practices.* Washington, DC: PRB for the IGWG, 2006.

Garcia-Moreno, C., H. A. Jansen, M. Ellsberg, L. Heise, C. Watts. *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women.* Geneva: WHO, 2005.

ICRW and Promundo. *Engaging Men and Boys to Achieve Gender Equality: How Can We Build on What We Have Learned?* Washington D.C.: ICRW and Promundo, 2007. www.icrw.org/docs/Engaging_Men_and_Boys_to_Achieve_Gender_Equality.pdf

Kabeer, Naila. *Gender Mainstreaming in Poverty Eradication and the MDGs.* Ottawa: CIDA, 2003.

Lloyd, C., M. Grant, and A. Ritchie. "Gender Differences in Time Use Among Adolescents in Developing Countries: Implications for Rising School Enrollment Rates." *Journal of Research on Adolescence*18, no.1 (2008): 99-120.

Open Society Institute. *Strategies for Change: Breaking Barriers to HIV Prevention, Treatment, and Care for Women.* New York: Open Society Institute, 2008.

Oyediran, Kola and Charles Teller. *Linkages between Women's Participation in Democratic Activities and Reproductive Health Behaviors: A Case Study of Plateau State, Nigeria.* Washington, DC: CEDPA, August 2002.

Population Council. *Power in Sexual Relationships: An Opening Dialogue among Reproductive Health Professionals.* New York: Population Council, 2001.

Samilius, L. and E. Wagberg. *Sexual Orientation and Gender Identity Issues In Development.* Stockholm: SIDA, 2005.

Shepherd, B., D. Ferrando, and A. Beltran. "Midterm Evaluation of the ReproSalud Project for USAID," by LTG Associates, March 2002.

SIDA. "Integrating Gender Equality into Development Co-operation – Drawing Lessons from the Recent Evaluations by Sida and the European Commission." Sida/UTV Working Paper 2004:2 (November 2003).

Smith, R., L. Ashford, J. Gribble, and D. Clifton. *Family Planning Saves Lives.* Washington, DC: PRB, 2009.

Swedish Gender Mainstreaming Support Committee. *Gender Mainstreaming Manual: A Book of Practical Methods.* Stockholm: 2007. Swedish Ministry of Foreign Affairs. Power and Privileges—on Gender Discrimination and Poverty. 2004.

Sweetman, Caroline. *Men's Involvement in Gender and Development Policy and Practice.* Oxfam Working Paper, 2001. http://publications.oxfam.org.uk/oxfam/display.asp?isb=085598466X

UNDP. *Empowered and Equal: Gender Equity Strategy 2008-11.* New York: UNDP, 2008.

UNFPA. *State of the World Population 2008, Reaching Common Ground: Culture, Gender, and Human Rights.* New York: United Nations Fund for Population Activities.

UNICEF, *Long-term Evaluation of the TOSTAN Programme in Senegal: Kolda, Thiès, and Fatick Regions*. New York: UNICEF Section of Statistics and Monitoring, Division of Policy and Practice, 2008.

World Bank. *Gender and Agriculture Sourcebook*. Washington, DC: The World Bank, 2009.

World Bank. *Gender Equality as Smart Economics*. Washington, DC: The World Bank, June 2007.

World Bank Institute. *Empowerment in Practice: Analysis and Implementation, A World Bank Learning Module*. Washington, DC: World Bank, May 2007.

Yinger, N. et al. *A Framework to Identify Gender Indicators for Reproductive Health and Nutrition Programming*. Washington, DC: PRB for the IGWG, 2002.

Yon, Carmen. "Involving Men in a Project based on Women's Empowerment." A 2003 PowerPoint Presentation. Accessed online July 1, 2009 at www.jhuccp.org/igwg/presentations/Tuesday/Plen3/InvolvingMen.pdf

APPENDIX I. ADDITIONAL DEFINITIONS

Constructive men's engagement (CME) promotes gender equity; increases men's support for women's sexual and reproductive health and children's well being; and advances the reproductive health of both men and women. Men can be constructively engaged as clients, supportive partners, and as agents of change. (IGWG)

Gender-based violence (GBV) is used to distinguish violence that targets individuals or groups of individuals on the basis of their gender from other forms of violence. It includes any act which results in, or is likely to result in, physical, sexual or psychological harm. GBV includes violent acts such as rape, torture, mutilation, sexual slavery, forced impregnation and murder. It also defines threats of these acts as a form of violence. (United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Reproductive health (RH) is a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." (Fourth World Conference on Women (FWCW) Platform for Action, 1995, paragraph 94; International Conference on Population and Development (ICPD) Programme of Action, 1994, paragraph 7.2).

Reproductive rights "embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents." Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant." (ICPD Programme of Action, 1994, paragraphs 7.2 and 7.3)

Sexual health encompasses behaviours essential to countering sexually transmitted diseases (STDs), including HIV/AIDS. Sexual health aims at the enhancement of life and personal relations, and sexual health services should not consist merely of counselling and care related to reproduction and sexually transmitted diseases. (FWCW Platform for Action, paragraph 94; ICPD Programme of Action, paragraph 7.2)

Sexual rights include "the human right of women to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence". (FWCW Platform for Action, paragraph 96)

Violence against Women (VAW) refers to "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Accordingly, violence against women encompasses but is not limited to the following:

(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; (c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

Other acts of violence against women include violation of the human rights of women in situations of armed conflict, in particular murder, systematic rape, sexual slavery and forced pregnancy. Acts of violence against women also include forced sterilization and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection." (FWCW Platform for Action, 1995, paragraphs 113,115)

Women's empowerment is a social process whereby women acquire power individually and collectively. It enhances women's capacity to act independently (self-determination), control assets and make choices and decisions about all aspects of one's life (adapted from Kabeer 2001). Women's empowerment is the process by which unequal power relations are transformed and women gain greater equality with men. At the government level, this includes the extension of all fundamental social, economic and political rights to women. On the individual level, this includes processes by which women gain inner power to express and defend their rights and gain greater self-esteem and control over their own lives and personal and social relationships. Male participation and acceptance of changed roles are essential for women's empowerment (UNFPA).

APPENDIX II. THE INTERAGENCY GENDER WORK GROUP (IGWG)

The Interagency Gender Working Group (IGWG), established in 1997, is a network of organizations, including the USAID Bureau for Global Health, USAID-funded Cooperating Agencies (CAs), health and women's advocacy groups, and individuals. The IGWG promotes gender equity[35] within programs to improve reproductive and sexual health/HIV/AIDS outcomes and foster sustainable development.

The IGWG's specific objectives are to:

- Raise awareness and commitment to synergies between gender equity and RH outcomes;
- Collect empirical data and best practices on gender and RH;
- Advance best practices and reach the field;
- Develop operational tools for the integration of gender approaches into population, health, and nutrition (PHN) programming; and
- Provide technical leadership and assistance.[36]

IGWG Publications (at www.igwg.org/publications.aspx):

Addressing Cross-Generational Sex: A Desk Review of Research and Programs, 2007.

Addressing Gender-Based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis, 2004.

Addressing Gender-Based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers (Second Edition), 2008.

Cross-Generational Sex: Risks and Opportunities, 2008.

Do Empowered Mothers Foster Gender Equity and Better Reproductive Health in the Next Generation? A Qualitative Analysis from Rural Bangladesh, 2005.

Exploring Gender Perspectives in Population and Health Programs: Workshop Findings and Recommendations, 2002.

A Framework to Identify Gender Indicators for Reproductive Health and Nutrition Programming, 2002.

Gender-Based Violence and Reproductive Health & HIV/AIDS: Summary of a Technical Update, 2002.

35 See footnote on page 1 for further discussion of the concepts of gender equity and gender equality.

36 These objectives are very similar to those described in the IGWG's *Guide for Incorporating Gender Considerations in USAID's Family Planning and Reproductive Health RFAs and RFPS*, Washington D.C.: USAID2000. The current Manual and the RFA/RFP guide are intended to complement each other.

Gender Perspectives Improve Reproductive Health Outcomes: New Evidence, forthcoming.

Guide for Incorporating Gender Considerations in USAID's Family Planning and Reproductive Health RFAs and RFPs, 2000 (2009 edition forthcoming).

How to Integrate Gender into HIV/AIDS Programs: Using Lessons Learned from USAID and Partner Organizations, 2004.

Involving Men in Sexual and Reproductive Health: An Orientation Guide, 2002.

Involving Men to Address Gender Inequities: Three Case Studies, 2003.

A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action, 2003

New Insights on Preventing Child Marriage: A Global Analysis of Factors and Programs, 2007.

Reaching Men to Improve Reproductive Health for All: An Implementation Guide, 2004.

Research Gaps Related to Gender Issues and Population, Health, and Nutrition Programs: Summary of an Analysis, 2000.

The "So What?" Report: A Look at Whether Integrating a Gender Focus Into Programs Makes a Difference to Outcomes, 2004.

Strengthening Regional Work on Gender-Based Violence; a Meeting of Activists, Practitioners and Researchers from the Horn, East and Southern Africa, Kampala, Uganda, 2006.

A Summary of the "So What?" Report: A Look at Whether Integrating a Gender Focus into Programs Makes a Difference to Outcomes, 2005.

Publications may be ordered by emailing ***prborders@prb.org****.*

APPENDIX III: GENDER RESOURCES AND REFERENCES

Gender and Development Websites

Beijing Plus Ten: www.unrisd.org/ (Search for "Policy Report on Gender and Development 10 Years after Beijing")

BRIDGE, a searchable database of gender and development materials and online resources, www.bridge.ids.ac.uk/

Canadian International Development Agency (CIDA), www.acdi-cida.gc.ca.

Gender Equality Group, OECD, Development Assistance Committee (DAC): DAC Guiding Principles for Aid Effectiveness, Gender Equality and Women's Empowerment, 2008, www.oecd.org/dac/gender

United Nations Development Program (UNDP), www.undp.org/gender

USAID Office of Wome n in Development, www.usaid.gov

Gender Analysis Frameworks (available on the Web)

Cambodia-Canada Legislative Support Project. *The Key Steps of Gender Analysis of Legislation*, Feb. 2003.

CARE. Gender Analysis Framework (Revised). CARE BANGLADESH, March 2005.

CIDA. *Gender Analysis*. Ottawa: Canadian International Development Agency, 2007.

DANIDA. *Country Gender Analysis*. Copenhagen: Denmark Ministry of Foreign Affairs, 2008.

Department for International Development Cooperation (DFID), Finland. *Navigating Gender: A Framework and a Tool for Participatory Development*. Helsinki: Ministry of Foreign Affairs, 2001.

FAO, *Socio-economic and Gender Analysis (SEAGA) Program* at www.fao.org/sd/seaga/default.htm.

Hunt, Julie. "Introduction to Gender Analysis Concepts and Steps," in *Development Bulletin* 64 (2003):100-106.

International Labor Organization. *ILO Online Gender Learning and Information Module*, at www.ilo.org.

Kols, Adrienne. *A Gender Guide to Reproductive Health Publications: Producing Gender-Sensitive Publications for Health Professionals*. Edited by Ruwaida Salem and Tara Sullivan. Baltimore: JHUCCP INFO Project, November 2007.

Leong T.G. and C. Lang. *Vibrant Communities Gender and Poverty Project, Gender Analysis Tools*. Ontario: Tamarack, 2004 at www.crvawc.ca.

Meinzen-Dick, R., L. Pandofelli, S. Dohrn, and J. Athens. "Gender and Collective Action: A Conceptual Framework for Analysis," Paper presented at the International Research Workshop on Gender and Collective Action, October 2005.

University of Liverpool and the London School of Hygiene and Tropical Medicine. *Guidelines for the Analysis of Gender and Health*.

Warren, Hannah. "Using Gender-analysis Frameworks: Theoretical and Practical Reflections," in *Gender and Development* 15, no. 2 (July 2007). www.genderanddevelopment.org.

Gender Integration and Mainstreaming Manuals

Economic and Social Commission for Asia and the Pacific. *Putting Gender Mainstreaming into Practice.* New York: United Nations, 2003. www.unescap.org.

European Commission (EC), Employment, Social Affairs and Equal Opportunities Director General. *Manual for Gender Mainstreaming, Social Inclusion, and Social Protection Policies.* Brussels: EC, 2008.

European Commission Employment, Social Affairs and Equal Opportunities Director General. *Manual for Gender Mainstreaming of Employment Policies.* Brussels: EC, July 2007.

Government of Sweden, Gender Mainstreaming Support Committee. *Gender Mainstreaming Manual.* Stockholm, 2007.

Ministry of Community, Aboriginal and Women's Services. *Guide to Best Practices in Gender Analysis.* British Columbia, Canada: Ministry of Community, Aboriginal and Women's Services, 2003.

Pact Tanzania. *Gender Mentoring: A Guide for Strengthening Equality in Communities.* Dar es Salaam: Pact, nd.

United Nations Development Programme, *Gender Mainstreaming Programme and Project Entry Points: Learning and Information Pack.* New York: United Nations, January 2001.

Wassenaar, Nicolien. *Incorporating Gender into your NGO.* Amsterdam: Networklearning.org, May 2006.

Gender and Reproductive Health and HIV/AIDS Manuals

Commission on Social Determinants of Health. *Achieving Health Equity: From Root Causes to Fair Outcomes.* Interim Statement. Copenhagen: WHO Regional Office for Europe, 2007.

Commonwealth Secretariat. *Gender Mainstreaming in the Health Sector: Experiences in Commonwealth Countries.* London: Commonwealth Secretariat, 2005.

Eckman, A., with B. Huntley and A. Bhuyan. *How to Integrate Gender into HIV/AIDS Programs: Using Lessons Learned from USAID and Partner Organizations.* Washington, D.C.: IGWG, Policy Project, and USAID, 2004.

Gilson, L., J. Doherty, R. Loewenson, and V. Francis. *Challenging Inequity Through Health Systems.* Final Report, Knowledge Network on Health Systems. London: London School of Hygiene and Tropical Medicine, Equinet, and Centre for Health Policy, June 2007.

Health Evidence Network. *What is the Evidence on Effectiveness of Empowerment to Improve Health?* Copenhagen: WHO Europe, February 2006.

Hope, Ruth. *Gender Equality and HIV Pandemic.* Gender Equality Series-Technical Series Paper No. 2/07. Fairfax, VA: MIDEGO, 2007.

International Planned Parenthood Federation/Western Hemisphere Region. *Manual to Evaluate Quality of Care from a Gender Perspective.* New York: IPPF/WHR, January 2000.

IPAS and HD Networks. *Gender or Sex: Who Cares? Skills-Building Resource Pack on Gender and Reproductive Health for Adolescents and Youth Workers.* Chapel Hill, NC: IPAS, 2001.

Johns Hopkins University/Center for Communications Programs. *Gender Guide for Health Communication Programs,* 2003.

Kleintjes, S., B. Prince, A. Cloet, and A. Davids. *Gender Mainstreaming in HIV/AIDS: Seminar Proceedings,.* New York: UNAIDS, HSRC, Dalhousie University, 2005.

PAHO, Gender and Health Unit. *Annotated Bibliography on Gender Mainstreaming and Analysis Resources for Health Programmers.* Washington D.C.: Pan-American Health Organization, August 2003.

Rao Gupta, G., D. Whelan, and K. Allendorf. *Integrating Gender into HIV/AIDS Programmes.* Washington, DC and Geneva: ICRW and WHO, 2003.

Sen, Gita and Piroska Ostlin. *Unequal, Unfair, Ineffective and Inefficient, Gender Inequity in Health: Why It Exists and How We Can Change It.* Final Report to the WHO Commission on Social Determinants of Health. Stockholm: Karolinska Institute, 2007.

UNAIDS. Operational Guide on Gender and HIV/AIDS: A Rights-based Approach. Amsterdam: UNAIDS, 2005.

UNIFEM. *Transforming the National AIDS Response: Mainstreaming Gender Equality and Women's Human Rights into the 'Three Ones" – Executive Summary.* New York: UNIFEM, 2006.

Welbourn, Alice. Stepping Stones: *A Training Package on HIV AIDS, Communication and Relationship Skills.* London, UK: ACTIONAID, 1995. Available from TALC Publications, or://www.talcuk.org/stratshope/order.html. See also Stepping Stones at www.steppingstonesfeedback.org.

World Health Organization. *Addressing Violence Against Women in HIV Testing and Counseling: A Meeting Report.* Geneva: World Health Organization, January 2006.

World Health Organization. *Transforming Healthy Systems: Gender and Rights in Reproductive Health. A Training Manual.* Geneva: WHO, 2001.

Other Gender Planning Manuals (multisectoral)

Development Assistance Committee, OECD. *Gender Equality in Sector Wide Approaches: A Reference Guide.* Brussels: OECD, June 2002.

Grown, C., G.R. Gupta, and A. Kes. *Taking Action: Achieving Gender Equality and Empowering Women.* London and Sterling, VA: Earthscan and the Millennium Project, 2005.

UK Gender and Development Network. *Women's Rights and Gender Equality, in the New Aid Environment and Civil Society Organizations: A Research Project of the UK Gender and Development Network.* London: UK Gender and Development Network, January 2008.

United Nationals Development Programme (UNDP). *Innovative Approaches to Promoting Women's Economic Empowerment.* New York: UNDP, November 2008.

Gender in Monitoring and Evaluation Resources

Alsop, Ruth and Nina Heinsohn. *Measuring Empowerment in Practice: Structuring Analysis and Framing Indicators.* World Bank Policy Research Working Paper. Washington, DC: The World Bank, February 2005.

NORAD. *Lessons from Evaluations of Women and Gender Equality in Development Cooperation.* Oslo: NORAD, 2006.

Approaches to Integrating Gender Concerns in Advocacy and Policy

Brown, E., B.N. Collison, and N.L. Rogers-Currie. *Youth and the Global HIV/AIDS Crisis: A Toolkit for Action.* United Nations Association in Canada, May 2002.

Derbyshire, Helen. *Gender Manual: A Practical Guide for Development Policy Makers and Practitioners.* London: DFID, April 2002

Goetz, Anne-Marie. *Gender and Accountability: Challenges for Reform in Developing States.* Boston: Boston Consortium on Gender, Security, and Human Rights, Tufts University; April, 2006.

Liverpool School of Tropical Medicine. *Gender Inequalities and Health Sector Reform. Policy Briefing for Health Sector Reform, Number 2.* Liverpool: LSTM, 2000.

UNDP. *Taking Gender Equality Seriously: Making Progress, Meeting New Challenges.* New York: UNDP, 2006.

UN-Habitat. *Mechanism for Gendering Land Tools: A framework for Delivery of Women's Security of Tenure.* Nairobi, Kenya: UN-Habitat and Global Land Tools Network, June 30, 2006.

UNIFEM. *Who Answers to Women? Gender and Accountability, Progress of the World's Women 2008/2009.* New York: UNIFEM, 2009.

The World Bank. *Engendering Development — Through Gender Equality in Rights, Resources, and Voice.* Washington, DC: World Bank, 2001.

Training Manuals

de Bruyn, Maria. *Gender or Sex: Who Cares? Skills-building Resource Pack on Gender and Reproductive Health for Adolescents and Youth Workers.* Chapel Hill: IPAS, 2002.

EngenderHealth. *Men's Reproductive Health Curriculum: Counseling and Communicating with Men, Vol. 2.* New York: EngenderHealth, 2008.

EngenderHealth. *Men's Reproductive Health Curriculum. Introduction to Men's Reproductive Health Services Revised Edition –Participant's Handbook.* New York: EngenderHealth, 2008.

EngenderHealth. *Men's Reproductive Health Curriculum. Introduction to Men's Reproductive Health Services—Revised Edition: Trainer's Resource Book.* New York: EngenderHealth, 2008.

EngenderHealth. *Men's Reproductive Health Curriculum: Management of Men's Reproductive Health Problems, Participant's Handbook, Vol. 3.* New York: EngenderHealth, 2008.

EngenderHealth. *Men's Reproductive Health Curriculum: Management of Men's Reproductive Health Problems, Trainer's Resource Book, Vol. 3.* New York: EngenderHealth, 2008.

EngenderHealth. *Men's Reproductive Health Curriculum: Trainer's Resource Book to Accompany Counseling and Communicating With Men.* New York: EngenderHealth, 2008.

FES and CRTDA. *Building Capacities on Gender Mainstreaming: A Training Module.* Collective for Research and Training on Development-Action, March 2005.

Medical Women's International Association. *Training Manual for Gender Mainstreaming in Health.* British Columbia, Canada: Medical Women's International Association, 2002.

National AIDS Control Council and the Policy Project. *HIV/AIDS and Gender Training: A Toolkit for Policy and Senior Level Decision Makers.* Nairobi, Kenya: Policy Project, 2004.

SAT. *Mainstreaming Gender in HIV and AIDS Work, SAT Training and Practice Manuals, Number 2.* Harare, Zimbabwe: SAT, 2004.

United Nations. *Facilitators Manual Competence Development Programme on Gender Mainstreaming.* NY: United Nations, 2002.