

**A Manual for**  

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**Integrating Gender Into**  

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**Reproductive Health**  

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**and HIV Programs:**

**FROM COMMITMENT TO ACTION**



**IGWG**

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**A**

**MANUAL for INTEGRATING  
GENDER Into REPRODUCTIVE HEALTH  
and HIV PROGRAMS:  
FROM COMMITMENT TO ACTION**

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Prepared on Behalf of  
the Gender Manual Task Force  
for the Interagency Gender Working Group  
of the USAID Bureau for Global Health

**By Deborah Caro (Cultural Practice, LLC),  
With Jane Schueller (FHI),  
Maryce Ramsey (Formerly With CEDPA),  
and Wendy Voet (JHPIEGO)**

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Julia Ernst, CRLP  
Rebecca Firestone, formerly of CHANGE  
Jill Gay, Independent Consultant  
Rupsa Malik, CHANGE

### **Reviewers**

Maria de Bruyn, Ipas  
Jill Gay, Independent Consultant  
Jodi Jacobson, Anna-Britt Coe, and Avni Amin, CHANGE  
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## LIST OF ACRONYMS

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<b>AIIH &amp; PH</b>	All India Institute of Hygiene and Public Health	<b>INTRAH/Prime</b>	Innovative Technologies for Healthcare Delivery/PRIME II Project
<b>CA</b>	Cooperating Agency (nongovernmental organizations and consulting firms that implement USAID funded programs)	<b>JHPIEGO</b>	JHPIEGO Corporation, an affiliate of Johns Hopkins University
<b>CBD</b>	Community-Based Distribution	<b>MOH</b>	Ministry of Health
<b>CCP</b>	Center for Communication Programs, Johns Hopkins University	<b>NACO</b>	National AIDS Control Organization of India
<b>CEDPA</b>	The Centre for Development and Population Activities	<b>NGO</b>	Nongovernmental Organization
<b>CHANGE</b>	Center for Health and Gender Equity	<b>NORAD</b>	Norwegian Agency for Development
<b>CIDA</b>	Canadian International Development Agency	<b>OECD/DAC</b>	Organization for Economic Cooperation and Development/Development Assistance Committee
<b>CRLP</b>	Center for Reproductive Law and Policy	<b>OVC</b>	Orphans and Other Vulnerable Children
<b>CSW</b>	Commercial Sex Worker	<b>PHN</b>	Population, Health, and Nutrition
<b>DFID</b>	Department for International Development (Great Britain)	<b>PLHA</b>	People Living with HIV/AIDS
<b>DG</b>	Democracy and Governance	<b>PROWID</b>	Promoting Women in Development, a project of the International Center for Research on Women
<b>DMSC</b>	Durbar Mahila Samanwaya Committee (Bombay, India)	<b>RFA</b>	Request for Applications
<b>FGC</b>	Female Genital Cutting	<b>RFP</b>	Request for Proposals
<b>FWCW</b>	1995 UN Fourth World Conference on Women (Beijing, China)	<b>RH</b>	Reproductive Health
<b>FWFP</b>	The Federation for Women and Family Planning, Poland	<b>SIDA</b>	Swedish International Development Cooperation Agency
<b>GO</b>	Governmental Organization	<b>STI</b>	Sexually Transmitted Infection
<b>HIV/AIDS</b>	Human Immunodeficiency Virus/Autoimmune Deficiency Syndrome	<b>TA</b>	Technical Assistance
<b>ICPD</b>	1994 UN International Conference on Population and Development (Cairo, Egypt)	<b>TAG</b>	Technical Advisory Group
<b>IEC</b>	Information, Education, and Communication	<b>TBA</b>	Traditional Birth Attendant
<b>IGWG</b>	Interagency Gender Working Group	<b>UN</b>	United Nations
		<b>USAID</b>	United States Agency for International Development
		<b>WHO</b>	World Health Organization

## PREFACE

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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/equality<sup>1</sup> within programs to improve reproductive 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 reproductive health (RH) and HIV/AIDS outcomes;
- Collect empirical data and best practices on gender and RH/HIV/AIDS;
- Advance best practices and reach the field;
- Develop operational tools for the integration of gender approaches into population, health, and nutrition (PHN) programming;
- Provide technical leadership and assistance.<sup>2</sup>

A major focus of the IGWG has been on gender education, advocacy, and the development of operational tools (see a complete listing of IGWG products, services, and contact information in Appendix 3). This Gender Integration Manual was developed as a companion to the *Guide for Incorporating Gender Considerations in USAID's Family Planning and Reproductive Health RFPs and RFAs*. The Guide was developed chiefly for USAID program managers and designers of new programs. The Manual complements the Guide by orienting program managers and technical staff on how to integrate gender concerns into program design, implementation, and evaluation. The Manual promotes greater understanding of how gender relations and identities affect individuals' and groups' capacity to negotiate and obtain better RH/HIV/AIDS decisions and 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 that strengthen the ability of participants to make informed choices about their sexual relations and reproductive health.

The IGWG authors view the Manual as a tool to be used, adapted, and improved through its application. It is the hope of the authors that users of the Manual will move from a commitment to integrating gender considerations in the design of programs to concrete actions throughout implementation.<sup>3</sup> Feedback on the Manual and suggestions for strengthening it are welcome.

<sup>1</sup> See page 11 for further discussion of the concepts of gender equity and gender equality.

<sup>2</sup> These objectives are very similar to those described in the IGWG *Guide for Incorporating Gender Considerations in USAID's Family Planning and Reproductive Health RFAs and RFPs* (Washington, DC: PRB for USAID, 2000).

<sup>3</sup> See disclaimer on the inside of the front cover.

## BRIEF OVERVIEW OF CHAPTERS

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**CHAPTER I** describes the background of the Manual as well as how and when to use it. This chapter also defines a few key gender terms and concepts used throughout the document.

**CHAPTER II** outlines the guiding principles that should be incorporated into all gender-integrated programs. These guiding principles provide the underlying pillars of gender-equitable and sustainable RH/HIV/AIDS programs.

**CHAPTER III** reviews and describes each of the concrete strategies for implementing the principles in Chapter 2. These are elements that are common to a number of projects analyzed by the authors of the Manual. Ideally these elements together form the building blocks of a gender-integrated program, and organizations may want to work toward this ideal as budget, time, and personnel resources allow. There is an exercise at the end of this chapter that organizations can use to assess the extent to which they have incorporated the guiding principles and elements into their programs.

**CHAPTER IV** describes a process for integrating gender concerns into each stage of the program cycle. It 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 six steps to gender integration in the programming cycle are:

- STEP 1: Examine 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 2: Collect data on gender relations, roles, and identities that pertain to the achievement of program outcomes.
- STEP 3: Analyze data for gender differences that may affect achievement of program objectives.
- STEP 4: Design program elements and activities that address gender issues.
- STEP 5: Develop and monitor indicators that measure gender-specific outcomes; evaluate the effectiveness of program elements designed to address gender issues.
- STEP 6: Adjust design and activities based on monitoring and evaluation results; strengthen aspects of the program that are successful and rework aspects that are not.

At the end of Chapter 4, there is a matrix that organizations can use to work through the steps presented.

# INTRODUCTION

## Why Use This Manual?

Increasing attention to gender equity/equality goals in reproductive health (RH) and HIV/AIDS programs promotes respect for the fundamental needs and rights of individuals and communities. Gender integration makes programs and policies responsive to the social, economic, cultural, and political realities that constrain or enhance reproductive health and satisfaction. By guiding organizations on how to integrate a gender equity/equality approach into RH/HIV/AIDS programs, this Manual will help program implementers to:

- Improve the quality of RH/HIV/AIDS services;
- More effectively meet the needs of program participants;
- Make programs sustainable;
- Better inform and empower clients;
- Improve couple communications;
- Improve utilization of services;
- Broaden development impacts and enhance synergies across sectors.<sup>4</sup>

Concern for gender disparities and enhanced gender equity/equality also contributes to specific RH/HIV outcomes, such as:

- Improved contraceptive prevalence;
- Reduced HIV transmission;

- Reduced fertility;
- Reduced violence against women;
- Decreased maternal mortality.<sup>5</sup>

In addition, USAID has recognized the value of gender integration in its programs by incorporating gender integration into policy directives and through the commitments to promoting gender equity the U.S. Government has made by signing international agreements.

## 1. USAID directives require integrating gender considerations into RH/HIV/AIDS programs.<sup>6</sup>

USAID policy, as stated in the Automated Directive System (ADS), requires integration of gender considerations into Agency programs. The ADS 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 a given Strategic Plan.
- 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 develop gender-related evaluation criteria for ranking the responses submitted by bidders and applicants.

<sup>4</sup> RH/HIV/AIDS efforts that do not address gender biases jeopardize the health results projects hope to achieve and may further exacerbate gender inequities. Nearly every reference presented in the Manual supports the idea that addressing gender issues will improve RH/HIV/AIDS programs. Additional impact data will help to document how equitable programs improve participants' reproductive health and well-being. For a preliminary survey of the literature that documents the RH impact of gender-integrated programs, see the soon to be published IGWG report by Carol Boender, Sidney Schuler et al., *The "So What?" Report: A Look at Whether Integrating Gender Into Reproductive Health Programs Makes a Difference to Outcomes* (Washington, DC: PRB for IGWG, forthcoming).

<sup>5</sup> Ibid.

<sup>6</sup> 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 integrating gender considerations into policies, programs, and activities. For required technical analyses for strategic plans, including gender, see ADS 201.3.8.4; for gender integration in activity design see ADS 201.3.12.6 and for activity approval 201.3.12.15; for reflecting gender in performance indicators see ADS 203.3.4.3; and for incorporating gender in evaluation criteria for competitive solicitations—RFPs—see 302.5.14 and in program statements for Requests for Applications—RFAs—see 303.5.5b.

- Mainstream gender considerations into the design, implementation, and monitoring and evaluation of USAID program and policy support activities.
- Include gender indicators in the Program Monitoring Plan (PMP).

## **2. The United States has made commitments to address gender issues.**

By signing the agreements<sup>7</sup> of the United Nations International Conference on Population and Development (ICPD) in Cairo, the Fourth World Conference on Women (FWCW) in Beijing, and their five-year reviews, the United States declared it would, among other things:

- Promote women's empowerment and gender equity/equality;
- Put aside demographic targets to focus on the needs and rights of women, youth, and men;
- Promote a comprehensive reproductive health and rights approach; and
- Involve women in leadership, planning, decisionmaking, implementation, and evaluation.

### **Purpose of the Manual**

The primary purpose of this Manual is to assist in the design and implementation of RH/HIV/AIDS programs that integrate approaches to achieving gender equity/equality. RH/HIV/AIDS programs that integrate gender equity/equality objectives maximize access and quality, support individual decisionmaking and reproductive choice,

increase sustainability, and put into practice U.S. international commitments and USAID policies.

Secondly, international and national health specialists can use this Manual when shaping responses to RFPs and RFAs. As discussed in the Preface, the former Program Implementation Subcommittee of the IGWG also released an RFP/RFA Guide and this Manual complements it. Programs that use approaches like the one described in this Manual will have a strategic advantage.

### **Intended Audience**

The primary audience for this Manual is in-country RH and HIV/AIDS program managers and technical staff of USAID cooperating agencies (CAs), governmental organizations (GOs), non-governmental organizations (NGOs), and other implementers, both current and prospective. The secondary audience for this Manual is U.S.-based CAs and PHN program managers and USAID Missions overseas.

The Manual is a tool to help readers incorporate gender considerations into their program cycle in order to achieve more equitable and sustainable RH/HIV/AIDS outcomes. The Manual, intended as a strategic planning guide, provides information on guiding principles, strategies, and practical steps for gender integration, but does not pretend to address all possible gender concerns and issues. It was developed as a program planning tool rather than a training tool. It complements other gender and reproductive health training materials by providing direction for how best to integrate gender into newly designed or ongoing projects and programs.

<sup>7</sup> More recently, the United States Government has signed on to the Millennium Development Goals, that include a goal of gender equality: "GOAL: 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 (Secretary General of the United Nations, *Road Map towards the Implementation of the United Nations Millennium Declaration*. New York: UN, September 6, 2001: p. 24.)

## How To Use This Manual

This document is designed as a reference manual. It can 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 a project.

The Manual is organized to be user-friendly. Some users may wish to refer to Chapters 2 and 3 to understand the guiding principles and program elements that are intrinsic to gender-integrated programming. Others may want to skip to the step-by-step approach outlined in Chapter 4 that is illustrated with case study material and demonstrates how the elements and principles are incorporated into real programs.

Users can adapt this Manual to meet the specific priorities, scope, resources and constraints of their own activities, as all programs are different and have distinct needs. Although the Manual describes key elements of successful gender-integrated projects, the step-by-step approach followed in Chapter 4 allows program managers to incorporate the elements individually or together to achieve the most effective design and implementation of programs. Case studies in Chapter 4 illustrate how the gender elements are incorporated in different ways and at different stages of the programming cycle.

## Rationale for Gender Integration and Mainstreaming in RH Programs

The Programme of Action of the 1994 International Conference on Population and Development (ICPD) and the Beijing Declaration and the Platform for Action of the 1995 Fourth World Conference on Women (FWCW) call for gender equality and gender mainstreaming, the empowerment of women, and the comprehensive fulfillment

of women's reproductive rights and health. Gender equality is expressly included as a goal in the 1996 Organization for Economic Co-operation and Development /Development Assistance Committee (OECD/DAC) strategy statement, "Shaping the 21st Century: The Contribution of Development Cooperation." U.S. commitment to the international development goals (including gender equality and women's rights) was reaffirmed at the July 2000 Okinawa summit of the Group of Eight industrialized countries. The United States' continued commitment in 2003 to gender equality is highlighted by specific requirements in the proposed law to establish a comprehensive, integrated, five-year strategy to combat the global spread of HIV and AIDS (H.R. 1298). The strategy calls for addressing such gender issues as empowerment of women, reduction of gender-based violence, increased involvement of men as responsible partners, and increased access of women to economic opportunities.<sup>8</sup>

In upholding its support of international agreements and the development of policies to implement these agreements, the U.S. government has committed to mainstreaming gender concerns in its programs. 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."**<sup>9</sup>

<sup>8</sup> House Rule 1298 available at <http://thomas.loc.gov/cgi-bin/bdquery>.

<sup>9</sup> Platform for Action, UN Fourth World Conference on Women (Beijing: UN, 1995).

**Gender equality** permits women and men equal enjoyment of human rights, socially valued goods, opportunities, resources, and the benefits from development results. The fact that gender categories change over time means that development programming can have an impact on gender inequality, either increasing or decreasing it.<sup>10</sup>

**Gender equity** is the process of being fair to women and men. To ensure fairness, measures must be available to compensate for historical and social disadvantages that prevent women and men from operating on a level playing field. Gender equity strategies are used to eventually attain gender equality. Equity is the means; equality is the result.<sup>11</sup>

**Gender integration** means taking into account both the differences and the inequalities between women and men in program planning, implementation, and evaluation. The roles of women and men and their relative power affect who does what in carrying out an activity, and who benefits. Taking into account the inequalities and designing programs to reduce them should contribute not only to more effective development programs but also to greater social equity/equality. Experience has shown that sustainable changes are not realized through activities focused on either women or men alone.

Attention to gender inequities, for example, improving access to education for girls, can result in dramatic development impacts in other sectors by reducing fertility, improving health, and increasing incomes and productivity. RH/HIV/AIDS programs that address differential opportunities, constraints, and contributions of women and men will improve health outcomes by more effectively increasing access to services, improving communication, strengthening negotiation and advocacy skills, widening participation, and strengthening

decisionmaking of diverse populations.

Although the ultimate goal is gender equality, there are many steps along the way that involve the more immediately attainable objective of integrating gender concerns into the different program elements to make development more equitable. In the Manual the paired term of equity/equality is used in recognition of both the goal and the process.

<sup>10</sup> OECD DAC, DAC Guidelines for Gender Equality and Women's Empowerment in Development Cooperation (Paris, 1998): p. 13.

<sup>11</sup> Canadian International Development Agency, *Guide to Gender-Sensitive Indicators* (Ottawa: CIDA, 1996).

Understanding the distinction between the terms sex and gender<sup>12</sup> is important for conducting the appropriate analyses of gender relations, roles, and identities in conjunction with the design of gender-

integrated RH programs. The terms defined below and those found in Appendix 1 clarify some of the terminology commonly used in programs that focus on gender.

**Sex** refers to the biological differences between women and men. Sex differences are concerned with women and men's physiology.

**Gender** refers to the economic, social, political, and cultural attributes and opportunities associated with being female and male. The social definitions of what it means to be female or male vary among cultures and change over time.<sup>13</sup> Gender is a socio-cultural expression of particular characteristics and roles that are associated with certain groups of people with reference to their sex and sexuality.

**Reproductive health**<sup>14</sup> "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. 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."<sup>15</sup>

<sup>12</sup> A recent report by the National Institutes of Health in the U.S. recommended that a clear distinction be made in the use of the terms sex and gender. The report noted that the interchangeable use of the terms causes confusion among the scientific community, policymakers, and the general public. It recommends that the term sex should be used as a "classification, generally male or female, according to the reproductive organs and functions that derive from the chromosomal complement." It states that gender is a term that should refer to "a person's self-representation, as male or female [or some third category], or how that person is responded to by social institutions on the basis of the person's gender presentation."

<sup>13</sup> DAC Guidelines for Gender Equality and Women's Empowerment in Development Cooperation (Paris: OECD, 1998).

<sup>14</sup> USAID Policy on Family Planning and Reproductive Health: USAID's Office of Population and Reproductive Health provides assistance for family planning and related reproductive health activities, which may include linking family planning with maternity services, HIV/AIDS and STD information and services, eliminating female genital cutting, and post-abortion care. Any reference to reproductive health, reproductive health care and reproductive health services in this Guide refers to such activities. USAID funds are prohibited from being used to pay for the performance of abortion as a method of family planning or to motivate or coerce a person to practice abortion.

USAID has defined family planning and reproductive health in Appendix IV of its Guidance on the Definition and Use of the Child Survival and Health Program Funds, dated May 1, 2002. Primary elements include: expanding access to and use of family planning information and services; supporting the purchase and supply of contraceptives and related materials; enhancing quality of family planning information and services; increasing demand for family planning information and services; expanding options for fertility regulation and the organization of family planning information and services; integrating family planning information and services into other health activities; and assisting individuals and couples who are having difficulty conceiving children. The word *choice*, as used in the Manual, refers *exclusively to an individual's capacity to exercise options with regard to the elements contained within USAID's definition of Reproductive Health*.

<sup>15</sup> Platform for Action, UN Fourth World Conference on Women (Beijing: UN, 1995): paragraph 94.



## GUIDING PRINCIPLES FOR A GENDER-INTEGRATED PROGRAM

According to the ICPD Programme of Action, “Reproductive health care programs should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services...”<sup>16</sup> Given this mandate, a successful gender-integrated RH program promotes the empowerment of women and supports gender equity/equality goals to enhance RH/HIV/AIDS outcomes for all.

An equitable approach to RH/HIV/AIDS services and programs focuses on the different needs of women, men, adolescents, and communities. In order to eliminate gender disparities women and men must actively participate in reproductive and sexual decision-making. Moreover, it is critical that adolescent boys and girls be involved and their concerns addressed if sustainable and equitable reproductive health outcomes are to be achieved.

Based on the experience of a number of programs around the world, five principles are fundamental to RH/HIV/AIDS programs that integrate gender: 1) working through community partnerships; 2) supporting diversity and respect; 3) fostering gender accountability; 4) promoting human rights, including reproductive rights; and 5) empowering women, men, youth, and communities. Described below, these guiding principles support access to high-quality services, individual choice, and sustainability of programs.

### Working Through Local Partnerships

Successful RH/HIV/AIDS programs recognize the value and strengths of partnering with local communities. They acknowledge that the capacity and expertise to design, implement, and evaluate

good RH/HIV/AIDS programs lie at the local level. As such, they seek to build mutually beneficial relationships with all of those in the community who have a vested interest in improving the RH/HIV/AIDS outcomes for women, men, and youth. Partnering early and at all stages of the program cycle increases local ownership and control, enhancing program sustainability.

### Supporting Diversity and Respect

While culture, religion, ethnicity, and class set the context for shaping gender roles, it is often only the negative aspects and outcomes of these factors that are emphasized in programs. By focusing on culture as a resource for change, RH/HIV/AIDS programs can more effectively advance gender equity/equality in partnership with local communities. Quality RH/HIV/AIDS programs acknowledge, respect, and build on the cultural, religious, ethnic, class, and racial diversity of their clients, communities, staff, partners, and donors. The *ReproSalud*, *Tostan*, and *Sonagachi* case studies in Chapter 4 illustrate how RH/HIV/AIDS programs can work within dynamic cultural contexts in close partnership with local communities to achieve gender equity.

### Fostering Accountability

Programs that achieve sustainable and equitable RH outcomes hold those involved accountable for the achievement of gender equity/equality goals throughout implementation, just as they are held accountable for other RH results. Such goals can include, but are not limited to, reducing gender disparities that affect women’s

<sup>16</sup> ICPD, VII, 7.

and men's health; increasing women's decisionmaking power; eliminating discriminatory policies, and reducing gender-based violence.

Accountability helps to modify behavior and holds staff responsible for gender integration. This includes all staff: the receptionist who greets clients respectfully; the provider who holistically addresses a client's needs; the donor who genuinely holds its program implementers accountable for gender equity/equality results; the program manager who values gender equity/equality goals enough to incorporate these goals into the hiring and training of staff; the policy and financial decisionmakers who demonstrate accountability through the allocation of funds; and the researchers who take up the challenge of measuring the impact of gender on services, programs, and on broader development goals. Holding everyone in an organization accountable for promoting gender equity/equality enhances the stature of these objectives within programs, demonstrates institutional commitment, creates a supportive environment, and, most importantly, improves RH/HIV/AIDS outcomes.

### **Promoting Respect for the Rights of Individuals and Groups**

For RH/HIV/AIDS programs to be successful, they must recognize and embrace the complementary goals of gender equity/equality, human rights, and reproductive rights (see Appendix 2). Gender-integrated RH/HIV/AIDS programs support the right to adequate

health care and the right to reproductive self-determination in the face of unequal power relations that form the basis for the denial of women's reproductive rights. Equitable RH/HIV/AIDS programs promote, monitor, implement, and enforce human rights norms relevant to reproductive health. In addition, a human and reproductive rights approach informs a gender-integrated approach to policy formulation and reform, research, program interventions, and service delivery. Partners and countries that approach reproductive health from a rights perspective bring new attention and energy to addressing public health problems by directly engaging clients in decisions about their health-care.

### **Empowering Women, Men, Youth, and Communities**

Central to a good RH/HIV/AIDS program is the idea that participants and communities have the skills, knowledge, and power to make informed RH/HIV/AIDS decisions. Empowerment is "the sustained ability of individuals and organizations to freely, knowledgeably, and autonomously decide how best to serve their strategic self-interest and the interest of their societies in an effort to improve their quality of life."<sup>17</sup> Through collaborative work with women, men, youth, and their communities, RH/HIV/AIDS programs that integrate gender provide an enabling environment for individual and group empowerment.

<sup>17</sup> CEDPA, *Gender, Reproductive Health, and Advocacy* (Washington, DC: CEDPA, 2000). The concepts discussed in this section are taken from several CEDPA publications, including *Gender and Development* (1999) and *Advocacy* (1999).

**Women’s empowerment:** Improving the status of women also enhances their decisionmaking capacity at all levels, especially as it relates to their sexuality and reproductive health. Experience and research show that RH/HIV/AIDS programs are most effective when they take steps to improve the status of women.<sup>18</sup> Programmatic efforts that empower women provide an enabling environment for broadened, linked services that account for the social, political, psychological, economic, and sexual dimensions of women’s health and well-being.

**Men’s participation:** Gender roles often constrain men as well as women. Because the actions and behaviors of men affect both their own health and that of their partners and children, gender-equitable RH/HIV/AIDS programs help men to understand this impact. While promoting women’s RH decisionmaking, such programs also work to increase men’s support of women’s RH and children’s well-being, and address the distinct reproductive needs of men. Gender-integrated RH/HIV/AIDS programs take into account men’s perspectives in program design, help men to feel welcome at clinics, provide a wider range of information and services to both women and men, and portray men positively. Most importantly, programs involving men aim to promote gender equality in all spheres of life.<sup>19</sup>

**Empowering youth:** Strategically and deliberately investing in the well-being of young people (both girls and boys) can result in powerful positive individual and social behavior change, especially with regard to RH/HIV/AIDS issues such as delaying the age of sexual initiation and increasing condom and contraceptive use. Effective programs incorporate the visions, perceptions, and needs of the diverse populations of youth and “actively seek the involvement of youth in the planning, implementation and evaluation of development activities that have a direct impact on their daily lives.”<sup>20</sup>

**Empowering communities:** As already mentioned, community ownership is key to sustainable development. Additionally, communities are empowered through enabling environments that promote positive change (including improved RH behaviors and outcomes) and through deliberate, participatory processes that involve local institutions, local leaders, community groups, and individual members of the community. For sustained change to take place, an enabling environment in the home and within the broader community must also support individual agency and choice.

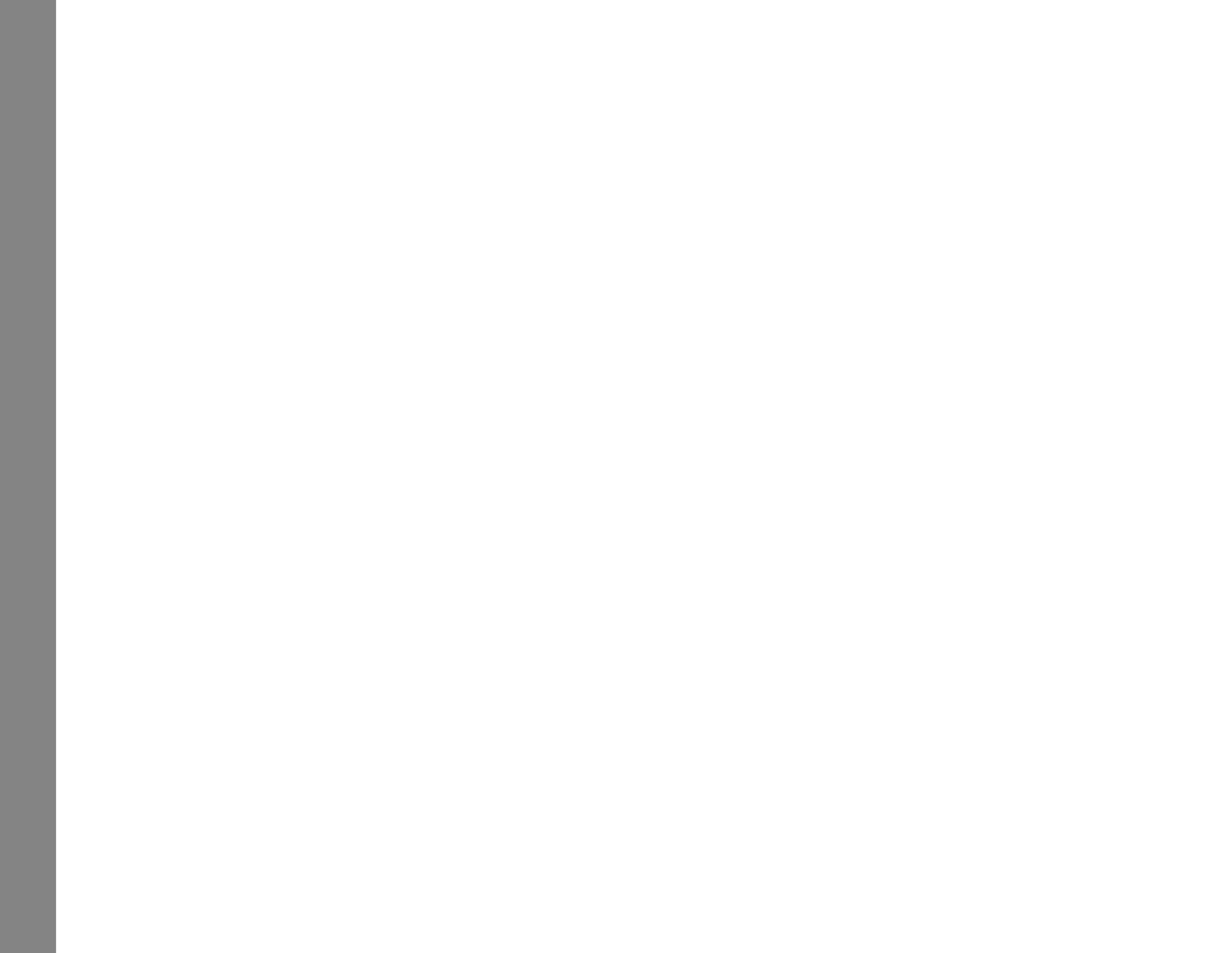
The guiding principles presented in this chapter provide the underlying pillars of equitable programs. The elements presented in the next chapter represent the concrete strategies for implementing the princi-

ples. Case studies in Chapter 4 illustrate the principles and some of the different gender elements.

<sup>18</sup> ICPD, 1994.

<sup>19</sup> UNDP, 1994.

<sup>20</sup> CEDPA, *Adolescent Girls in India Choose a Better Future: An Impact Assessment* (Washington, DC: CEDPA, 2001).



## ELEMENTS OF A GENDER-INTEGRATED PROGRAM

A review of programs that successfully integrate gender demonstrates that it is important not only to be aware of the guiding principles as outlined in the previous chapter but also to translate these principles into program elements. The elements that appear in this chapter were common to gender-integrated projects reviewed in preparation of the Manual.

### ELEMENTS OF A GENDER-INTEGRATED PROGRAM

- **Specific gender equity/equality objectives and indicators for measuring success**
- **Equitable participation and involvement at all levels**
- **Fostering equitable relationships**
- **Advocacy**
- **Coalition building**
- **Multisectoral linkages**
- **Community support for informed individual choice**
- **Institutional commitment to gender integration**

Incorporating these principles into the design, implementation, and evaluation of programs will help managers and technical staff to develop and track measurable results and will maximize the impact of all program results.

### **Gender Equity/Equality Objectives and Indicators for Measuring Success**

RH programs that enhance gender equity/equality are more effective at sustaining positive health outcomes. While it is not always necessary to define separate gender objectives, RH programs will benefit from making a commitment to equity/equality by addressing gender roles and identities in intermediate results and activities. Most RH objectives are linked to specific gender results, which enhance the importance, impact, and sustainability of the program. For example, a specific objective for an HIV/AIDS program may be to increase the use of female and male condoms by 50 percent in three years. The RH program is more likely to attain and sustain its health outcomes if it defines a supporting gender objective, such as increased capacity of women to negotiate safer sex with their partner or increased capacity of men to share decisionmaking with women. Most programs that integrate gender try to develop, track, and evaluate gender results and their impact on other program results (see Step 1 in Chapter 4).

### **Gender equity/equality objectives and indicators for measuring success promote:**

- Measurement of equitable participation and results;
- Sustainability of RH/HIV/AIDS outcomes; and
- Reduction of gender-based barriers to accessing and using services.

## **Equitable Participation and Involvement at All Levels**

Gender-integrated programs emphasize the equitable participation of women and other under-represented groups (e.g., ethnic minorities, adolescents, commercial sex workers, and people with different sexual orientations) in program design, decisionmaking, and priority setting. In many places, men, as well as women, are disempowered by racial, ethnic, and economic discrimination. Often these factors that disempower men and women also have a negative impact on power relations between women and men. Gender-integrated programs attempt to address the many factors that discriminate against women, men, and youth. Projects that put women and other marginalized groups at the center of the program can stimulate interaction between a variety of constituencies and stakeholders, such as intended participants, government officials, women's health and rights NGOs, and community groups. Participatory program design and implementation processes tie interventions to community concerns and establish a sense of local ownership. Fostering a participatory dialogue on reproductive health in a context of gender equity/equality promotes shared responsibility and accountability among community members (see Step 3 in Chapter 4 for an example of community participation).

### **Equitable participation promotes:**

- Listening to women and other marginalized groups and involving them in decisionmaking about their reproductive health;
- Broad social inclusion of a variety of constituencies and stakeholders;
- A sense of shared responsibility and ownership of the project by its participants;
- Flexibility and responsiveness on the part of project staff to participants' knowledge, interest, and concerns.

## **Fostering Equitable Relationships**

Unequal power relationships between sex partners, among members of a community, and between clients and providers often obstruct women and men's access to high quality RH/HIV/AIDS services. The ICPD Programme of Action and the women's health movement have shown us that a set of enabling economic and social conditions are necessary for achieving good reproductive health; a focus on relationships is one strategy for creating enabling conditions. How people relate to one another can be instructive in determining how women and men define their health needs and how they act on those needs. Looking at relationships and thinking about how to foster equitable partnerships can be a more empowering approach to RH/HIV/AIDS programs.

It is as important to examine gender relationships between service providers and their supervisors as those between providers and clients. The review of gender-integrated programs revealed that, in collaboration with program beneficiaries, such programs seek to define the skills and information needed by the client to express his/her health concerns and needs to a provider. These programs also work with providers to identify the skills they need to facilitate more open relationships with clients and the conditions necessary to create a positive environment for clients (see Steps 1 and 3 in Chapter 4 for examples of renegotiating power in relationships).

### **Fostering equitable relationships promotes:**

- Better communication and more equitable decisionmaking between sexual partners;
- Improved communication between clients and health care providers;
- Better working conditions for health care providers regardless of their position and level of training;
- Improved quality and increased use of services.

## Advocacy

Gender-integrated programs incorporate processes that enable women, youth, and men, across all segments of society, to advocate for their rights. Such programs produce an environment that is conducive to making changes in individual behavior, community norms, and regional and national policies. Advocacy activities help participants to assess and renegotiate their relationships with service providers as well as build organizational and negotiation skills to advocate for their needs to policymakers. Clients and providers may need skills training to advocate for high quality services, to build relationships with health organizations, and to organize community members to renegotiate gender relationships that negatively affect health behavior (see Steps 1, 3, 4, and 6 in Chapter 4 for examples of advocacy approaches).

### Advocacy activities help to:

- Empower women, youth, and men in negotiations with service providers and policymakers;
- Inform beneficiaries about their rights;
- Develop organizational, public speaking, and lobbying skills in participants;
- Strengthen participants' capacity to articulate and promote their rights in public arenas;
- Promote dialogue among a broad spectrum of stakeholders and decisionmakers.

## Coalition Building

Coalition building takes advocacy to the next level. Through coalitions, diverse groups, especially those historically excluded from political participation, join together through a participatory process to systematically pursue a targeted set of actions in support of a specific objective. The efforts of coalitions are strategic and directed at decisionmakers in support of specific programmatic or policy change. Coalition building is an effective way to represent and give voice to women and other disempowered or marginalized populations, allowing them to participate directly in the political process. The challenging process of building consensus among diverse groups demands an open exchange of ideas, gender equitable relations among participants, and a focus on common objectives. Ultimately, the aim of the process is to strengthen the position of under-represented groups, such as ethnic minorities, and young men and women, in the political arena to advocate for their reproductive health care interests in public and private (see Steps 1, 3 and 4 in Chapter 4 for examples of projects that support coalition building).

### Coalition building promotes:

- Linkages among different groups in civil society around common interests;
- A process for building consensus among groups and communicating their common interests to policymakers;
- Socially responsive and responsible policies and programs.

## Multisectoral Linkages

A multisectoral approach promotes synergy<sup>21</sup> between different sectors, often combining health services with interventions that address women's economic empowerment, literacy, political participation, and mobility. Through a multisectoral approach, many barriers can be addressed to confront women's disempowerment and the complex factors that lead to poor reproductive health. In order to create conditions for change, a gender-integrated project needs to have a good contextual understanding of the environment in which it intends to operate. It also needs to assess the critical constraints in a particular situation, understand who can best address these constraints, and determine how to build effective linkages (see Steps 1, 3, 5, and 6 in Chapter 4 for examples of projects with multisectoral linkages).<sup>22</sup>

### Multisectoral linkages promote:

- Attention to the context and environment in which the project operates;
- Attention to the multidimensional aspects of power dynamics that prevent women's access to resources and services;
- Synergy between different kinds of interventions, such as between health care and education, and income generation.

## Community Support for Informed Individual Choice

Gender relations extend beyond the nuclear household into many social contexts, such as the extended family, community groups, and beyond the community to relationships with health services, employers, and political leaders. Projects that integrate gender enable individuals to negotiate new information and behaviors relative to existing norms within different social settings. Project experience demonstrates that individual women with support from social organizations (e.g., community, religious, political, and family groups) are more likely to adopt changes in their individual RH/HIV/AIDS strategies than are people who are not actively engaged in women's organizations. Similar findings are beginning to emerge on the importance of organizations for supporting changes in adolescents' and men's attitudes and behavior. Advocacy through social groups and their leaders can provide an enabling context for changes in values and norms that allow individuals to make new decisions about their behavior.

Projects that promote community support for individual reproductive choice and decisionmaking begin with women and men's own concepts of their bodies, sexuality, health, and priorities. Projects with a gender focus introduce new knowledge as an alternative view, offering different explanations and solutions to self-identified problems. While the objective is to help people adopt positive health

<sup>21</sup> Synergy refers to the positive effects that combined action of two or more types of interventions may have on one another. For instance, activities that increase income in the household may also improve the health of household members by removing an economic barrier to accessing healthcare. In turn better health of household members may increase income by decreasing the number of days of work lost to illness.

<sup>22</sup> For a discussion of the gender and reproductive health impact of multisectoral approaches, see I. Syed Hashemi, Sidney Schuler, and Ann P. Riley, "Rural Credit Programs and Women's Empowerment in Bangladesh," *World Development* 24, no. 1 (1996) 45-63.

practices, this approach recognizes the importance of influencing social norms and providing social support for individual behavior change. Through dialogue among health care educators and group members, the group is able to assess and formulate new visions and approaches to RH and gender relations that allow individuals to make independent and informed choices and changes in their lives (see Steps 1, 3, and 6 in Chapter 4 for examples of community support for individual choice).

### **Community support for informed individual choice promotes:**

- New approaches to IEC/behavior change that respect participants' beliefs, while providing them with alternative knowledge for understanding their bodies and reproductive processes;
- Recognition that communities are heterogeneous, and that individuals and groups within communities hold diverse views;
- Support to individuals to negotiate new information and behaviors against existing norms within a community setting.

### **Institutional Commitment to Gender Integration**

An institutional commitment to gender equity/equality ensures that gender integration in programs receives high priority at all levels of program administration. Gender-integrated programs address gender imbalances within the program's institutional structure, leadership, and management. Management pays attention to gender equity/equality issues with regard to staff composition, professional advancement, salaries, and employment benefits, and works to insure that other policies and the general institutional culture support equal opportunity, participation, and decisionmaking.<sup>23</sup>

### **Institutional commitment to gender integration translates into:**

- Equitable policies that support equal opportunities of women and men for advancement and compensation for comparable work;
- Shared responsibility and leadership among all staff for developing and implementing gender-equitable programs;
- A work environment free of discrimination and respectful of diverse working and management styles;
- Investment in gender analysis, planning, and training expertise;
- Inclusion of gender integration criteria in job performance evaluations.

<sup>23</sup> For a guide to how to conduct an institutional gender audit, see Patricia Morris, *The Gender Audit: A Process for Organizational Self-Assessment and Action Planning* (Washington, DC: InterAction, 2001).

## EXERCISE # 1

Organizations could try this exercise to see where they stand on integrating the guiding principles and program elements into their programs. This is a good starting point for discussions on how institutions can do this.

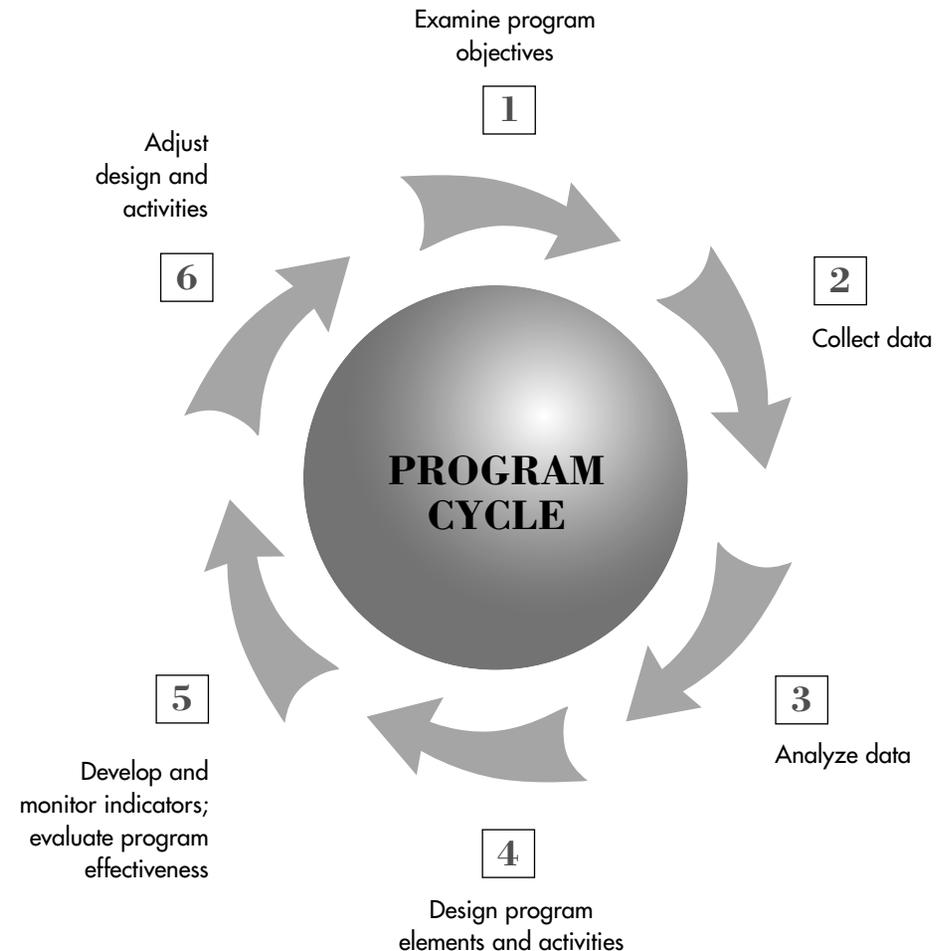
### IDENTIFICATION OF GUIDING PRINCIPLES AND ELEMENTS OF A GENDER-INTEGRATED PROGRAM

Principles	Present in this project (give an example)	Absent in this project
<ol style="list-style-type: none"> <li>1. Working through local partnerships</li> <li>2. Supporting diversity and respect</li> <li>3. Fostering accountability</li> <li>4. Promoting respect for the rights of individuals and groups</li> <li>5. Empowering women, men, youth, and communities</li> </ol>		
Elements	Present in this project (give an example)	Absent in this project
<ol style="list-style-type: none"> <li>1. Specific gender equity/equality objectives and indicators for measuring success</li> <li>2. Equitable participation and involvement at all levels</li> <li>3. Fostering equitable relationships</li> <li>4. Advocacy</li> <li>5. Coalition building</li> <li>6. Multisectoral linkages</li> <li>7. Community support for informed individual choice</li> <li>8. Institutional commitment to gender integration</li> </ol>		

## A PROCESS FOR GENDER INTEGRATION THROUGHOUT THE PROGRAM CYCLE

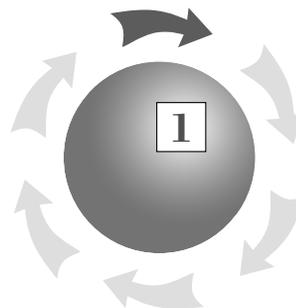
Incorporating a gender perspective in programs involves a series of steps that are both sequential and iterative. A program design that is gender-integrated is flexible and receptive to feedback on progress and problems, as well as responsive to changes in interpersonal relationships, resources, and 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 sample gender-based questions under different steps in the program cycle. The various elements of a gender-integrated approach present in each case study are also highlighted. Each case is presented as an illustration only and is not meant to be an exhaustive treatment or analysis of program outcomes. At the end of the chapter there is a matrix that can be used to work through the different steps for gender integration.

**While this chapter highlights specific questions and actions to integrate gender into programs, these steps are intended as an integral part of overall program design and implementation, not as separate activities.**



## STEPS TO GENDER-INTEGRATED PROGRAMS

- 1. Examine 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;**
- 2. Collect data on gender relations, roles, and identities that pertain to the achievement of program outcomes;**
- 3. Analyze data for gender differences that may affect achievement of program objectives;**
- 4. Design program elements and activities to address gender issues;**
- 5. Develop and monitor indicators that measure gender-specific outcomes; evaluate the effectiveness of program elements designed to address gender issues;**
- 6. Adjust design and activities based on monitoring and evaluation results; strengthen successful aspects of the program and rework aspects that are not.**



**STEP 1: Examine 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.**

### **Examine Objectives**

Examine overall objectives of the program in light of the gender relations, roles, and identities of the project's participants. Are there aspects of the goals and objectives that will be affected by local gender relations, roles, or identities? Gender integration in the design of activities begins with the identification of participants and stakeholders.

To thoroughly assess participants' needs and priorities, gather information from a wide 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 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?
- Are there other stakeholders who might be advocates or opponents of the program? Have they been consulted?
- Has the program staff considered how differences in participants' and stakeholders' sex, age, socioeconomic status, and ethnicity 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 Objectives

When designing programs, consider developing intermediate objectives that specifically address gender-based 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 aim to develop or strengthen satellite services near places women frequent in the course of conducting other activities, 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 the delay of sexual activity and access to family planning), it may be necessary to set an intermediate objective of "increased participation by men and adolescent boys in RH 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 health care provider training.

## 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?
- What resources are needed to accomplish these steps? What types of organizations have the gender and technical skills and knowledge to assist the program to achieve gender-equitable results?
- Who controls program resources? 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 accomplishing the 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 greater gender equity/equality in its program?

## ILLUSTRATIVE CASE STUDY FOR STEP 1: “REPROSALUD, PERU”<sup>24</sup>

### IMPLEMENTING ORGANIZATION

In September 1995, *Movimiento Manuela Ramos*, a Peruvian feminist NGO, was awarded a cooperative agreement by the U.S. Agency for International Development (USAID) to implement the Reproductive Health in the Community Project, known as ReproSalud.

### PROBLEM TO BE ADDRESSED

Despite notable national increases in the use of reproductive health services and contraceptive prevalence 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 conceptions of health and physiology on the part of clients and providers, ethnic and class prejudices, and poverty.

### OBJECTIVES

Through an innovative, intersectoral design, ReproSalud aims 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:

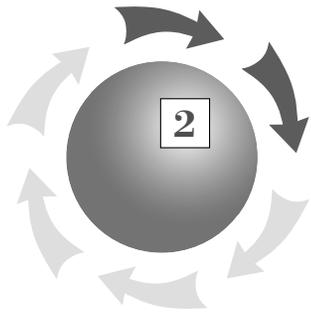
- Increasing women’s utilization of RH/HIV/AIDS preventive practices and services;
- Actively involving women in identifying, prioritizing, and resolving their own RH problems and in determining and negotiating the conditions in which RH/HIV/AIDS services are delivered;
- Ensuring that the public health 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.

<sup>24</sup> Information for this section taken from: Amalia Alberti, Deborah Caro 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); Susana Galdos and Barbara Feringa, “Two Years on the Ground: ReproSalud through Women’s Eyes,” a report presented to USAID/Peru, 1999; Judith Bruce and Debbie Rogow, *Alone You Are Nobody, Together We Float: The Manuela Ramos Movement* (New York: Population Council, 2000) ([www.popcouncil.org](http://www.popcouncil.org)).

## ILLUSTRATIVE CASE STUDY FOR STEP 1: “REPROSALUD, PERU”

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED
<i>Who are the direct participants of the project?</i>	The direct participants of the project are 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 solutions to RH/HIV/AIDS problems. Women participate in the design, implementation, and evaluation of subprojects through several participatory mechanisms.
<i>Have potential participants been involved in setting the objectives and designing the activities?</i>	The project engaged women as key partners and sought their ideas from the beginning in discussions about ways to influence other stakeholders, including local health providers, and local authorities in improving services. The original design of the project was based on the assumption that once women identified and learned about options to address their primary RH/HIV/AIDS concerns, they would inform community and regional leaders to elicit their support for discussions with regional health authorities about ways to improve the quality of services.
<i>Are there other stakeholders who might be advocates or opponents of the program? Have they been consulted?</i>	In the initial stages of these consultations, the women told project coordinators of their desire to involve their male partners early in the educational process. They persuaded project designers that if the men acquired the same information as women, they would all be more effective in reaching out to local authorities.
<i>Has staff considered how gender, age, socioeconomic status, and ethnic differences affect participants' ability to voice opinions, make decisions, or access information and services?</i>	From the beginning, the ReproSalud team exchanged ideas with the participants about biomedical information and local beliefs and practices from the perspective of culture, gender, and age. The project supplemented information gathered through dialogue in the self-diagnostic exercises, with a number of anthropological studies in different regions of Peru to better understand variations in beliefs and practices. Both the participants and the project team benefited from increased understanding of the terms that women used to refer to their physiology and health problems. From these interactions, they were able to develop a common language to improve communication between health educators and participants, as well as between health care providers and clients. One study compared health care providers' and clients' concepts of quality of care. It aimed to: <ul style="list-style-type: none"> <li>• Identify the conceptual models of quality held by different groups of women and providers;</li> <li>• Identify points of divergence and convergence of the different conceptual models to find strategies that would address the needs of women yet fit within the confines of national health policies;</li> <li>• Analyze the decisionmaking process in health care facilities to gain a better understanding of constraints and opportunities within the facilities;</li> <li>• Understand how local variations in needs and priorities from women's perspectives compare to national priorities;</li> <li>• Make suggestions for regional priorities.</li> </ul>

HOW THE PROJECT WORKED	PROGRAM ELEMENT
<ul style="list-style-type: none"> <li>• Women’s groups in rural and peri-urban areas competed through skits about their most pressing RH concerns. As 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.</li> <li>• 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.</li> </ul>	<p><b>Gender-equitable participation</b></p> <p><b>Advocacy</b></p> <p><b>Fostering equitable relationships</b></p> <p><b>Specific gender objectives and indicators for measuring success</b></p>
<ul style="list-style-type: none"> <li>• By partnering with women from the start and listening to their concerns, the project followed the participants’ suggestion to organize regional coordinating committees, composed of women, men, and community and regional leaders, in order to discuss with health officials how to make health services more responsive to local needs and desires. The coalitions were more effective than women alone in influencing health providers to change.</li> </ul>	<p><b>Gender-equitable participation</b></p> <p><b>Coalition building</b></p> <p><b>Advocacy</b></p> <p><b>Fostering equitable relationships</b></p>
<ul style="list-style-type: none"> <li>• Women wanted to alter men’s attitudes and behaviors they identified as barriers to women’s improved health.</li> <li>• Sharing of information promoted a respect for women’s and men’s reproductive rights and helped to alter power imbalances in relationships.</li> <li>• 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 RH needs.</li> </ul>	<p><b>Fostering equitable relationships</b></p> <p><b>Coalition building</b></p>
<ul style="list-style-type: none"> <li>• The studies demonstrated that bridging the conceptual models of the users and providers is a challenge, but there are points of convergence from which to start. The information on different beliefs provides a basis for dialogue and translation across the different systems. Additionally, bringing many of these differences to consciousness allows the women and health care providers to work on differences rather than simply react to the intransigence of the other.</li> <li>• The project discovered that health care providers and women had different ideas about quality. Project coordinators found that they had incomplete information about what quality meant to the different stakeholders; therefore, they undertook a study to understand what quality of care meant to both the service providers and users.</li> </ul>	<p><b>Fostering equitable relationships</b></p> <p><b>Specific gender objectives and indicators for measuring success</b></p>



## **STEP 2: Collect data on gender relations, roles, and identities that pertain to the achievement of program outcomes.**

### **Focus Data Collection Around 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 RH/HIV/AIDS policy program, relevant data focused on project objectives would include:

- Who is involved in community and local government and how do different groups and individuals (data disaggregated by sex) within the locality participate in regional and national policymaking?
- What are the issues that are discussed in public fora and who is able to bring them 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. Occasionally it is necessary to conduct primary data collection using survey or participatory research techniques.<sup>25</sup> 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 different stakeholders and participants in the data collection process will affect the quality of the information gathered and will have implications for program planning. There are several gender analysis 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 "Other Gender Planning Manuals," for additional information on methods).

<sup>25</sup> 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.

## 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,

as well as a firmer base for program planning. Staff should include both men and women (young and old) in the survey and design the survey to draw out factors related to gender, such as decisionmaking, control over resources, and political participation. Questions should take into account the literacy levels and language of different respondents.

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 the people conducting the focus groups construct the groups and ask questions in a way that will elicit diverse perspectives from the participants, even 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.

Consider:

- Whether to interview men and women in single sex or mixed groups;
- If heterogeneous or homogeneous groupings by age will affect the answers of different participants;

- If the language used will affect participation if some participants are not fluent in that language.

In some situations focus groups that include both men and women, young and old, and people of different ethnic backgrounds may only yield information from representatives of the most powerful groups. In some cultural contexts, for instance, women may not feel comfortable disagreeing publicly with men. Similarly, in some sex groupings, a young girl might not feel that it is appropriate to challenge a view expressed by her mother. If women or older people are not fully literate in a national language, they may not speak up.

## Consider the 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 participated in authorizing permission to conduct the research?
- Are there potential negative consequences for research participants?

By gaining informed consent from participants prior to conducting a research program, implementers are more likely early on to identify and address gender-based constraints to involving participants in the research.

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 are likely to be reluctant to seek out diagnoses for STIs or to share information with male partners if they are at risk of physical violence or other reprisals.
- Men may refuse to use health services for prevention and treatment of sexually transmitted infections if the services principally cater to women's reproductive needs.

It is important to develop questions to 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. Therefore, it may be necessary to ask directly about specific tasks or time expenditure to get information about women's work. Likewise, outsiders who draw conclusions from observations of local activities may be predisposed by their own culture and experience to see what men in the village do and know, but overlook the range of women's work and knowledge. Researchers can limit these types of omissions and distortions by probing into the biases, assumptions, and stereotypes that they may hold unconsciously. 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 men or women (of a particular age, class, or ethnicity) carry out a survey or facilitate focus groups?
- Should discussions be in public places or in the home?
- Does the language used in the interviews or surveys differently affect the responses of men and women?
- Should women and men be interviewed together or separately?

The answers to these questions will vary with the age, ethnicity, and economic circumstances of the respondents (see "Gender and Reproductive Health Manuals" in Appendix 3 for references about research methods and gender).

## ILLUSTRATIVE CASE STUDY FOR STEP 2: “MATERNAL HEALTH PROGRAM IN TANZANIA”<sup>26</sup>

### IMPLEMENTING ORGANIZATION

Several USAID cooperating agencies—JHU/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 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 has 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).

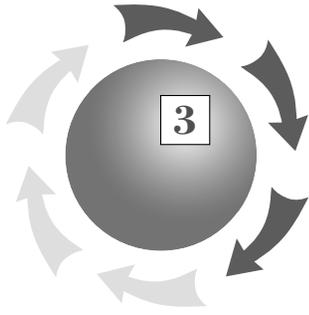
NOTE: Unlike the other case studies presented in this chapter, the Maternal Health Program originally was not designed to address gender issues. The case is an example of a program that has taken some initial steps in midcourse to collect and analyze information on gender differences in attitudes and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

<sup>26</sup> Information from personal communication with Wendy Voet, JHPIEGO.

## ILLUSTRATIVE CASE STUDY FOR STEP 2: “MATERNAL HEALTH PROGRAM IN TANZANIA”

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED
<i>Should men and women be interviewed together or separately?</i>	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.
<i>Does it make a difference whether men or women (of a particular age, class, or ethnicity) carry out a survey or facilitate focus groups?</i>	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.
<i>What kinds of questions are most effective for eliciting gender differences?</i>	Men and women were asked the same set of questions without being probed about gender differences. Facilitators, however, asked each group questions about who controlled significant resources and made major decisions with regard to seeking health care.

HOW THE PROJECT WORKED	PROGRAM ELEMENT
<ul style="list-style-type: none"> <li>• Groups were segregated by sex to ensure inclusion of different perspectives.</li> <li>• Women were separated by age so that older women did not overshadow younger women's opinions.</li> <li>• The project created a relatively unstructured and open-ended forum to encourage women to communicate diverse perspectives.</li> </ul>	<p><b>Gender-equitable participation</b></p>
<ul style="list-style-type: none"> <li>• 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.</li> </ul>	<p><b>Fostering equitable relationships</b></p>
<p>Men and women focused on different aspects of care in their responses, e.g.:</p> <ul style="list-style-type: none"> <li>• Women highlighted privacy as a critical element of quality, especially in examining rooms;</li> <li>• Men cited the gender 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;</li> <li>• 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, while a mother is more apt to focus on her daughter's health.</li> </ul>	<p><b>Specific gender objectives and indicators for measuring success</b></p>



### **STEP 3: Analyze data for gender differences that may affect achievement of program objectives.**

By analyzing the collected data, project planners will be better able to design activities that address gender-based constraints

to achieving program objectives, and that incorporate local resources and beliefs.

#### **Diverse Sources 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 these patterns 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 for engaging them in peer counseling activities and are there comparable groups for girls?

### IMPLEMENTING ORGANIZATION

Tostan is a Senegal-based NGO that promotes an integrated approach to learning through a program consisting of eight participatory community-based educational modules. The module topics range from income generation, literacy, and human rights to reproductive health and child survival. The goal of the organization is to promote participatory learning in a way that is accessible to and controlled by women learners in rural communities.

### PROBLEM TO BE ADDRESSED

In Senegal, female genital cutting (FGC) is part of girls' initiation rites practiced by some ethnic groups. The practice, which is intended to prepare girls for their gender roles as men's partners and as mothers, often produces serious health complications for women, such as bleeding and hemorrhaging, infection, pain, difficulty urinating, stress, shock, and complications during sex and childbirth.

### 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 and how they can be applied to the different social and economic problems that women and their communities face 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 a way that they can understand; 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. The project presents relevant information through familiar cultural forms such as through stories, songs, drama, and games.

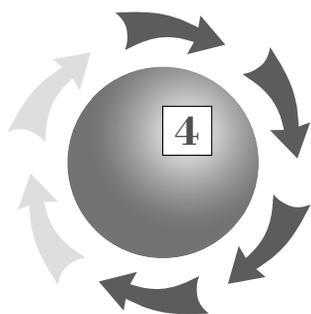
In 1994, Tostan used this methodology to develop a new module on RH issues, including FGC that is practiced by some ethnic groups in Senegal. Tostan, along with other health and rights organizations, believes that the practice contributes to serious health problems throughout women's life cycle and often causes death among recently circumcised girls. As part of the new curriculum, Tostan included a socio-drama about an eight-year-old girl who dies as a consequence of FGC. This part of the curriculum initiated a nationwide movement at the local and national levels to eliminate the practice. The process engages women, men, religious leaders, and politicians.

<sup>27</sup> 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); (nd) *Senegalese Women Remake Their Culture*. <http://www.tostan.com/article3.html>

**ILLUSTRATIVE CASE STUDY FOR STEP 3: “TOSTAN—ENDING FEMALE GENITAL CUTTING”**

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED
<p><i>What does information in previous or new research reveal about gender relations and the relative status of women and men?</i></p>	<p>After performing the socio-drama, women were asked a series of questions to assess the specific implications and consequences of practicing FGC or not. The information the women assembled in response became the basis for a dramatic set of decisions within the community. Some of the questions the women posed to stakeholders were:</p> <ul style="list-style-type: none"> <li>• Why do you think girls are cut? Do you think it is a necessary practice? Why or why not?</li> <li>• Would you have your daughter cut? Why or why not?</li> <li>• What health dangers are related to FGC? Have you heard of women who had these problems?</li> <li>• What are the taboos related to the woman who is not cut? Do you believe these taboos?</li> <li>• What does Islam say about FGC? Is it an obligation prescribed in the Koran?</li> <li>• Do you think that FGC can have a negative effect on the life of a woman? Why or why not?</li> <li>• Do you think FGC violates any of the articles of the Human Rights Convention that were discussed in the module?</li> </ul> <p>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.</p>
<p><i>What does information in previous or new research reveal about gender relations and the relative status of women and men?</i></p>	<p>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, including the presidency.</p>

HOW THE PROJECT WORKED	PROGRAM ELEMENT
<ul style="list-style-type: none"> <li>• Initially the women were reluctant to discuss the socio-drama but by the third time they performed it, they concluded that they practice FGC because it is part of a tradition expected of them by men and religious leaders.</li> <li>• 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.</li> <li>• 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.</li> <li>• Finally, the village chief also lent his support by saying that life changes and traditions change.</li> <li>• 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.</li> </ul>	<p><b>Gender-equitable participation</b></p> <p><b>Fostering equitable relationships</b></p> <p><b>Coalition building</b></p> <p><b>Multisectoral linkages</b></p> <p><b>Social support for informed individual choice</b></p>
<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• On February 3, 1998, the President proposed a law against FGC.</li> <li>• On February 15, 1998, 13 villages signed a declaration stating that they would no longer practice FGC. These villages also named a commission to monitor compliance with the declaration.</li> </ul>	<p><b>Specific gender equity/equality objective(s)</b></p> <p><b>Advocacy</b></p>



## **STEP 4: Design program elements and activities to address gender issues.**

### **Determining Strategies for Desired Results**

Once the data has been analyzed and has yielded information about gender differences, the program team can then use this information to gain insight into the program objectives and to determine which strategies would achieve the desired results.

- What activities and services will the program have to implement to ensure that gender specific needs and concerns will be addressed?
- How will activities and services ensure equitable participation by women and men and girls and boys?
- In what ways will program activities benefit women and men?
- What kinds of strategies will help the program to ensure that activities benefit women and men equitably or will address institutionalized inequities?

- 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:

- Is it possible to work through social clubs to reach adolescent boys?
- Are there timesaving approaches or new technologies that might assist women to continue cultivation of garden produce or will their involvement in cash cropping provide them with sufficient monetary resources to purchase the products they no longer grow?
- Are there ways to increase women's ability and authority to make decisions for communities even when men are absent?

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

**IMPLEMENTING ORGANIZATION**

The Federation for Women and Family Planning (FWFP) was founded in 1992 as a coalition of nine NGOs that promote and defend the reproductive health and rights of women in Poland.<sup>29</sup>

**PROBLEM TO BE ADDRESSED**

Unofficial statistics indicate that only 12 percent of Poles use modern forms of family planning. Few published sources on reproductive health, a paucity of RH services that disseminate accurate information, and the high cost of contraceptives are some of the factors that contribute to low contraceptive prevalence. The little information that is disseminated by the media and in textbooks is often negative, misleading, or inaccurate and reinforces gender stereotypes and prejudices. In addition, the Polish Doctors Council recommended that doctors only offer information and access to contraceptives if specifically asked.

**OBJECTIVES**

In response to the need to improve information on reproductive health, rights, and services, the FWFP designed a two-year project to involve women in the process of lobbying and advocacy to equip them with the tools for policy change. The USAID-funded PROWID (Promoting Women in Development) project provided the FWFP with two years of funding to design a communications and advocacy program. The program’s goal was to improve reproductive health care services for women, to increase their reproductive rights by raising the awareness and influence of the public and policymakers, and, ultimately, to create a common agenda. Specific activities included:

- Development of a national network of women’s reproductive health and rights advocates;
- Promotion of international standards on reproductive health and rights for health care providers and policymakers;
- Design of a media campaign on the status of women’s reproductive health and rights.

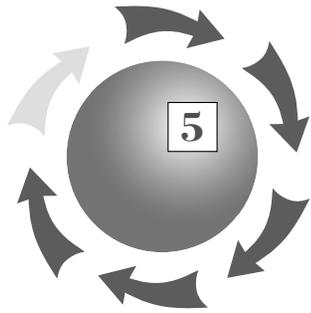
<sup>28</sup> This case study is based on the situation in Poland in 1998 and is taken from "The Federation for Women and Family Planning End of Project Report" for the ICRW/CEDPA PROWID (Promoting Women in Development) Project; also see Federation for Women and Family Planning, *Advocacy for Women’s Reproductive Health and Rights: Developing a Grassroots Strategy in Poland* (Washington, DC: PROWID/ICRW, 1999).

<sup>29</sup> USAID support did not include advocacy or support of abortion rights and these were not objectives of the program described here.

**ILLUSTRATIVE CASE STUDY FOR STEP 4: “ADVOCACY FOR WOMEN’S REPRODUCTIVE HEALTH AND RIGHTS, POLAND”**

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED
<p><i>What activities and services will the project have to implement to ensure that gender needs and concerns will be addressed?</i></p>	<p>In an ongoing effort to involve women in lobbying and advocacy, FWFP:</p> <ul style="list-style-type: none"> <li>• Disseminated a report on reproductive health status in Poland to scientists, parliamentarians, women’s organizations and journalists;</li> <li>• Formed a 10-member Advocacy Council of politicians, scientists, and health policymakers to create policy messages, identify target audiences, and advise on advocacy strategies;</li> <li>• Held workshops for policymakers and health care providers;</li> <li>• Widely disseminated information, bulletins and fact sheets.</li> </ul>
<p><i>How will activities and services ensure equitable participation by women and men (boys and girls)?</i></p>	<p>A fact sheet on male responsibility in parenting, family planning, and reproductive behavior was distributed to stimulate men’s interest in domains that were previously seen as pertaining only to women.</p>
<p><i>What kinds of strategies will help the project to ensure that activities benefit women and men equitably or will address institutionalized inequities?</i></p>	<p>FWFP distributed:</p> <ul style="list-style-type: none"> <li>• 2000 copies of a fact sheet on sterilization that addressed gender stereotypes and promoted legalization of sterilization as a voluntary method of contraception in Poland.</li> <li>• A fact sheet on sex education—including information on international commitments and standards for sex education, gender perspectives, and male responsibility—to schools, parliamentarians, and other high-level politicians.</li> </ul>
<p><i>What strategies will the project employ to address discriminatory laws, policies, regulations, and institutions?</i></p>	<p>Advocacy and information campaigns were aimed at initiating legislative processes for reproductive rights or to stop attempts to limit those rights. The FWFP successfully influenced health practitioners, the media, nongovernmental organizations, academics, local policy-makers, and community groups.</p> <p>They were less successful with national legislative policymakers who voted to withdraw sex education courses from public schools (although vetoed by the President) and exclude reproductive health policies from the national health program.</p>

HOW THE PROJECT WORKED	PROGRAM ELEMENT
<ul style="list-style-type: none"> <li>• Formed a network of 220 health advocates and 9 local support groups to promote international health standards;</li> <li>• Developed fact sheets for advocacy activities (6,000 bulletins for providers and 10,000 sex education fact sheets for schools were distributed);</li> <li>• Service improved at 3 Warsaw and 5 regional clinics whose doctors had attended FWFP workshops (improvements included breast exams and information and distribution of contraceptives);</li> <li>• Reports from clients that trained doctors respected patients' rights to information, choice, privacy, continuity of service, and confidentiality.</li> </ul>	<p><b>Specific gender equity/equality objective(s)</b></p>
<ul style="list-style-type: none"> <li>• Realization that there is a need for additional outreach to men. Women in Poland bear major responsibility for family planning; therefore, future strategies will aim to foster shared responsibility between partners and active involvement of both in responsible sexual behavior. Involving men in outreach activities will increase access to information and health services, particularly outside of Warsaw.</li> </ul>	<p><b>Fostering equitable relationships</b></p>
<ul style="list-style-type: none"> <li>• The fact sheet stimulated requests for additional information and interviews by the press.</li> <li>• During debates on sex education in Polish schools, supportive parliamentarians and the President of Poland used the fact sheet.</li> </ul>	<p><b>Advocacy</b></p> <p><b>Multisectoral linkages</b></p> <p><b>Coalition building</b></p>
<p>Especially in a potentially unsupportive political environment, the FWFP learned that:</p> <ul style="list-style-type: none"> <li>• Advocacy groups must set priorities and develop multiple tools for influencing policymakers;</li> <li>• Well-researched and objective fact sheets are essential to countering misinformation;</li> <li>• Knowledge of legislative processes is fundamental to promoting reproductive rights through policy change. By having advocates elected to public office, the FWFP was able to wield more influence and overcome bureaucratic roadblocks.</li> </ul>	<p><b>Fostering equitable relationships</b></p> <p><b>Gender-equitable participation</b></p>



**STEP 5: Develop and monitor indicators that measure gender-specific outcomes; evaluate the effectiveness of program elements designed to address gender issues.**

### Tracking Progress and Impact

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 and recording the benefits and costs of gender mainstreaming are essential to building the body of knowledge about how gender disparities affect development outcomes, and how development programs hinder or promote gender equality.

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 (i.e., gender impact indicators), improve-

ments in gender equity/equality, and the critical points in the monitoring process at which sex-disaggregated data are useful for effective management. 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 (M & E) 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 sex disaggregating most indicators, the M&E plan can help to point out gender differences in program implementation and impact. Quantitative indicators only highlight differences, without further analysis; they do not explain why or how differential outcomes occur. Sex-disaggregated indicators may contribute little to an understanding of the importance of gender in a program without a plan for interpreting the sex differences revealed by the indicators. For instance, sex-disaggregated data of the number and sex of people using a clinic will not explain the significance of the differences. Further analysis is needed to ascertain if those differences are because:

- 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.

Answers to these questions require careful analysis of the indicator data. But it is only through the careful collection and analysis of gen-

der-specific quantitative and qualitative data that the information can be meaningfully incorporated into management decisions and reporting. It is as important to involve participants and stakeholders in the analysis of M&E data as it is to involve them earlier in the programming cycle. Their involvement through consultative and participatory approaches will help eliminate 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<sup>30</sup>

- IN CLINICS—Change in provider attitude toward choice of FP, change in bias toward women, change in clinic protocols regarding provision of 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 having 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; more sophisticated modeling of gender and other variables;
- IN MEN'S PARTICIPATION—Change in knowledge among men regarding FP/RH/HIV/AIDS; changes in partners' attitudes about FP.

<sup>30</sup> These examples are adapted from Nancy Yinger et al., *A Framework to Identify Gender Indicators for Reproductive Health and Nutrition Programming* (Washington, DC: PRB for IGWG, 2002). This IGWG paper is an excellent resource for developing gender-integrated monitoring and evaluation plans.

## ILLUSTRATIVE CASE STUDY FOR STEP 5: “LINKAGES BETWEEN DEMOCRACY AND GOVERNANCE (DG) AND REPRODUCTIVE HEALTH (RH) IN PLATEAU STATE, NIGERIA”<sup>31</sup>

### IMPLEMENTING ORGANIZATION

The Centre for Development and Population Activities (CEDPA) is a U.S.-based private voluntary organization that implements the USAID-funded Enabling Change for Women’s Reproductive Health (ENABLE) project in five countries.

### PROBLEM TO BE ADDRESSED

There is increasing evidence that unequal gender relations contribute to higher risk of HIV transmission for women, as well as to low levels of use by women of family planning and maternal health services in many countries. The ENABLE Project was designed to address gender-based constraints that prevent women from making informed and autonomous reproductive health decisions. 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 in Nigeria sought to improve women’s reproductive health by creating an enabling environment<sup>32</sup> that was supportive of “women’s informed and autonomous decisionmaking.” The premise of the program 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. RH activities consisted of: seminars and home visits with RH messages; condom distribution; creation of an HIV/AIDS unit in the Health Services Department; HIV/AIDS talks in church councils; care and support for orphans and People Living with HIV/AIDS (PLHA); training of church pastors and their spouses in HIV/AIDS counseling; talks in communities and churches on HIV/AIDS and STI prevention, FP, immunizations, breastfeeding promotion, and safe motherhood. Activities in DG and DG/RH-combined communities included: advocacy visits to community leaders (women, religious, governmental, etc); rallies; civic education, advocacy of joint decisionmaking between partners; training

<sup>31</sup> The information for this case study is taken from Kola Oyediran and Charles Teller, *Linkages between Women’s Participation in Democratic Activities and Reproductive Health Behaviours: A Case Study of Plateau State, Nigeria* (Washington D.C.: CEDPA, August 2003).

<sup>32</sup> CEDPA states that “an enabling environment for women’s empowerment includes expanded rights and opportunities encompassing, but not limited to, full political participation, access to basic services especially health care and education, economic self-reliance, property ownership and inheritance rights, and the elimination of gender-based discrimination and exploitation (Oyediran and Teller 2003:p.5).”

on conflict management, leadership, political participation, social mobilization, and accountability; and formation of coalitions and supervisory groups.

### **IMPACT ASSESSMENT**

The impact assessment was designed to test the objective and the premise that increased political participation strengthens women's reproductive health decisionmaking. Between December 2002 and January 2003, CEDPA, along with its local partner, COCIN,<sup>33</sup> conducted a study to determine if there is a relationship between key reproductive health behaviors and participation in DG activities. The study used a quasi-experimental design to compare four types

of communities: no intervention (control); RH interventions only; DG interventions only; and combined RH and DG interventions. Women in a sample of each of these communities were compared on empowerment indicators,<sup>34</sup> use of and intention to use contraception, and socio-economic characteristics. Regressions were run to measure the effects of socioeconomic characteristics, sexual empowerment (one of the empowerment indices), mobility, and gender-based violence on the women's intention to use a modern family planning method and on exposure to community-based distribution of contraceptives and DG activities. The study concluded that, according to the bivariate findings, women in RH/DG communities scored higher on all of the empowerment and RH indicators.

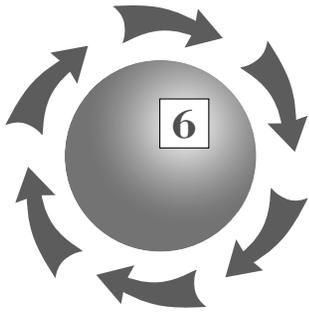
<sup>33</sup> Church of Christ in Nigeria.

<sup>34</sup> Empowerment was measured by four scales or indices: a) mobility-- measured the conditions, frequency, and autonomy of women to move about for different types of activities; b) household decision-making--determined 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 (if he has a STI or he is having sex with other women, or if the woman is tired, has recently given birth, or is not in the mood); d) gender-based violence – whether or not woman believes it is justified for her husband to beat her (Oyediran and Teller 2003, p.16).

**ILLUSTRATIVE CASE STUDY FOR STEP 5: “LINKAGES BETWEEN DEMOCRACY AND REPRODUCTIVE HEALTH IN PLATEAU STATE, NIGERIA”**

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED
<p><i>Are baseline data collected on women and men of different ages, socioeconomic status, and ethnicity?</i></p>	<p>Increasing concern about the rise in HIV prevalence rates and the minimal use of modern family planning methods, led USAID/Nigeria through the CEDPA ENABLE Project to test the supposition that unequal gender relations played a key role in limiting women’s access to information and services. The program proposed to test 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.</p>
<p><i>Are there specific indicators to measure changes in gender relations, access to services and resources, and power?</i></p>	<p>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. The mobility index was measured by high, medium, and low based on questions that probed conditions, frequency, and whether mobility was independent or accompanied outside of the household. Household decisionmaking about purchase of household goods, health care, visits to family members, food preparation, and women’s work outside the home was measured by whether it was autonomous, joint with partner, or by someone else. The sexual empowerment index was based on whether women could refuse sex with her partner and under what circumstances.</p>
<p><i>Are there specific indicators to measure changes in gender relations, access to services and resources, and power?</i></p>	<p>Attitudes towards 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.</p>
<p><i>How do gender-specific objectives link to impact on reproductive health?</i></p>	<p>Bivariate findings show that overall women in communities with both DG and RH activities had superior scores on empowerment and RH indicators in comparison with women who were in RH or DG only communities or in communities with no activities at all. The study indicated that participation in both DG and RH activities achieves impacts greater than those achieved by family planning interventions alone.</p>

HOW THE PROJECT WORKED	PROGRAM ELEMENT
<p>In lieu of baseline data, the evaluation used a cross-sectional four-cell quasi-experimental design to measure the comparative impact of DG, RH, and combined interventions.</p> <ul style="list-style-type: none"> <li>• Women in four Local Government Areas (LGAs), each with a different set of interventions, were compared: 1) DG and RH activities; 2) RH only activities; 3) DG only activities; and 4) No activities. 2000 women were interviewed in four LGAs.</li> <li>• In addition to standard demographic and household characteristics, the study collected information on the respondents' ethnic and religious background, reproduction, contraceptive use and attitudes, marriage and sexual activity, fertility preferences, husband's socioeconomic background, and on women's work, decisionmaking, and political participation. The study was conducted by the Nigerian Institute of Social and Economic Research (NISER) in collaboration with CEDPA and COCIN.</li> </ul>	<p><b>Multisectoral linkages</b></p>
<ul style="list-style-type: none"> <li>• 80% of women in DG and RH communities registered high mobility as compared with women in RH only (73%), DG only (58%), and control group (58%).</li> <li>• Similarly, the women in the combined DG and RH communities were more likely to make autonomous decisions than women in other types of communities. The DG only communities had the highest percentage of women who said they made decisions jointly with their partners.</li> <li>• Women in DG/RH and DG only communities also rated highest on the sexual empowerment index, with 83% (RH&amp;DG) 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.</li> </ul>	<p><b>Equitable participation</b></p> <p><b>Fostering equitable relationships</b></p>
<ul style="list-style-type: none"> <li>• With regard to gender-based violence, the 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 it.</li> </ul>	<p><b>Fostering equitable relationships</b></p>
<ul style="list-style-type: none"> <li>• The percentage of women in DG/RH (12%) who use modern family planning methods was twice that of women in RH only (6%) communities.</li> <li>• Intention to use a form of modern contraception in the future was much higher in the DG/RH (53%) communities than in any of the other communities: RH only (43%); DG only (46%); and control (40%).</li> <li>• Higher educational levels correlated positively with higher rates of contraceptive use (13% for women with secondary education or above compared with 7% for those with less than a secondary education)</li> <li>• Other factors associated with current use of FP methods were: current age, religious affiliation, place of residence, exposure to radio, household socioeconomic status, mobility, contact with CBDs, exposure to DG activities, and husband's educational level.</li> </ul>	<p><b>Multisectoral linkages</b></p>



**STEP 6: Adjust design and activities based on monitoring and evaluation results; strengthen aspects of the program that are successful and rework aspects that are not.**

### Redesigning Program Elements

The redesign of program elements to address gender issues might entail additional data collection and analysis to identify any factors that were overlooked during the design phase. Based on new findings, steps 3 and 4 might be repeated. Monitoring information often prompts project managers to reassess assumptions if it indicates that the program is not achieving its intended results. If these assumptions prove to be unfounded, particular 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 sex education at soccer practice, the project might reassess its assumption about reaching boys through athletic clubs.
- If that still seems like a sound assumption, 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?

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. For instance, the sex worker participants in the Sonagachi project made the staff aware that while they routinely adopted safe sex practices with their short-term customers, they were more reluctant to do so with their long-term partners. As a result of this input, and unlike most other projects that focused on commercial sex workers, Sonagachi prioritized a focus on the relationships between the workers and their *long-term partners*. The success of the Sonagachi project in decreasing STI transmission and gender-based violence is attributable to the inclusion of messages about the importance of incorporating safe sex practices into long-term relationships as well as with short-term clients.

## ILLUSTRATIVE CASE STUDY FOR STEP 6: “SONAGACHI—STI/HIV/AIDS PREVENTION IN INDIA (SHIP)”<sup>35</sup>

### IMPLEMENTING ORGANIZATION

The program was initiated by the All India Institute of Hygiene and Public Health (AIIPH), with support from the National AIDS Control Organization of India (NACO), the Ministry of Health and Family Welfare of West Bengal, and WHO. It has also received funding from DFID (the UK’s Department for International Development) and NORAD (the Norwegian Agency for Development Cooperation). The project has grown into a large coalition of NGOs, including the Health and Eco-Defense Society, the Human Development and Research Institute, Sramajibi Mahila Sangha, Socio-legal Aid Research and Training Centre, and the sex workers’ own organization, the Durbar Manila Samanwaya Committee (DMSC).

### PROBLEM TO BE ADDRESSED

The program addresses the increasing prevalence of STIs and a small but growing prevalence of HIV among commercial sex workers. The original design of the program focused on raising awareness of HIV/AIDS, condom use, and clinical services.

### OBJECTIVES

The objectives of the program have evolved over time. Originally, in 1992, the principal objective was to reduce STI/HIV transmission and to lower prevalence of STIs and increase condom use among commercial sex workers 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 has added other objectives and activities, 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 sex workers from entering the trade.

<sup>35</sup> 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](http://www.unaids.org). Use of the term CSW does not imply USAID support of prostitution. The case study is featured because commercial sex workers are one of the most at risk populations (MARPs) that the Office of HIV/AIDS works with in many countries to stem the transmission of the infection to the general population. The Sonagachi case is a well known case with very positive results, especially for some of the most vulnerable and poorest victims of the epidemic.

**ILLUSTRATIVE CASE STUDY FOR STEP 6: “SONAGACHI—STI/HIV/AIDS PREVENTION IN INDIA (SHIP)”**

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED
<p><i>Does the program adequately respond to the specific gender needs of the participants and clients?</i></p>	<p>Both a baseline survey and a follow-up survey two years later indicated that the Sonagachi commercial sex workers (CSWs) faced many gender-based challenges that contributed to their vulnerability and increased health risks. 85% of those surveyed were illiterate, over 45% had children, 70% had entered the trade due to poverty or family disputes, and 27% said that their clients insisted on group sex, putting them at additional risk for both violence and disease. In 1992, 90.6% had never used condoms.</p> <p>Young commercial sex workers 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.</p>
<p><i>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?</i></p>	<p>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.</p>

HOW THE PROJECT WORKED	PROGRAM ELEMENT
<ul style="list-style-type: none"> <li>• The program engaged sex workers as peer counselors and joined forces with the DMSC that served as an advocacy group for participants. One third of peer educators subsequently left the sex trade.</li> <li>• 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.</li> <li>• Workers also identified a need for loans and used them to start businesses and to market condoms. Condom sales increased from 213,056 in 1997 to 443,805 in 1999.</li> <li>• DMSC set up a system to monitor brothels for young CSWs and arranged to send them to boarding school. This seems to have reduced trafficking in young girls.</li> </ul>	<p><b>Multisectoral linkages</b></p> <p><b>Fostering equitable participation</b></p> <p><b>Community support for informed individual choice</b></p>
<ul style="list-style-type: none"> <li>• Peer education focused on both sex workers and madams.</li> <li>• AIH&amp;PH developed a training program for police.</li> <li>• DMSC organized CSWs to demonstrate against police raids and against unethical and illegal testing for HIV/AIDS.</li> <li>• The program established services for sex workers' clients, including clinics and awareness programs. Gonorrhea decreased from 13.2% in 1992 to 3.9% in 1998.</li> <li>• To increase CSWs' power to negotiate clients' use of condoms and health services, the program developed clinic referral tickets for clients. Condom use by clients increased from 2.7% in 1992 to 90.3% in 1998.</li> <li>• The program engaged regular clients (<i>babus</i>) to escort sex workers to and from work to protect them from thugs who prey on them outside of establishments.</li> <li>• Hundreds of sex workers have received legal training.</li> </ul>	<p><b>Advocacy</b></p> <p><b>Coalition building</b></p> <p><b>Community support for informed individual choice</b></p>

ILLUSTRATIVE QUESTIONS	HOW THE PROJECT RESPONDED
<p><i>Do staff members have the appropriate set of skills to address gender issues and the needs of the clients?</i></p>	<p>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 own safety from street criminals.</p>
<p><i>Are the indicators used for monitoring and evaluation adequately capturing the impacts of the program?</i></p>	<p>At the beginning of the program, the primary impact measures were biomedical ones, focusing on the effectiveness of STI control. The program had difficulty capturing behavioral changes, especially with regard to male clients. In addition, there was a feeling that the indicators were not adequately capturing changes in levels of empowerment among the women sex workers, or the involvement of the community.</p>

HOW THE PROJECT WORKED	PROGRAM ELEMENT
<ul style="list-style-type: none"> <li>• The program invested in capacity building through training for both the staff and the sex workers. In coalition with the DMSC and other organizations involved in the program, staff was sensitized to the difficult situations faced by the sex workers and became more responsive to their needs.</li> <li>• Over time, management of the project has 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.</li> <li>• 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.</li> <li>• Since 1992, the project has placed control over health care in the hands of the community by investing in capacity building for staff and CSWs. The project treated CSWs respectfully and ethically, encouraging them to express and address their needs.</li> </ul>	<p><b>Institutional commitment to gender integration</b></p> <p><b>Coalition building</b></p>
<p>New indicators were added to measure new objectives developed over the course of the program:</p> <ul style="list-style-type: none"> <li>• Referral cards to STI clinics that CSWs gave to their clients were used to measure how many clinic users are clients of program participants.</li> <li>• Empowerment was 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 these men are not clients, they are gatekeepers who are positioned to either facilitate or impede the vulnerability and protection of CSWs.</li> <li>• Use of these indicators has pointed to specific contexts where CSWs' power to protect themselves needs strengthening. For instance, condom use is lowest with long-term participants (<i>babus</i>). CSWs are often dependent on <i>babus</i> 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.</li> </ul>	<p><b>Fostering equitable relationships</b></p>

## EXERCISE #2

This matrix may be useful for working through the steps for integrating gender into programs in this chapter. The first column refers to results of doing steps 1 and 6. The second and third columns refer to data collection and analysis in steps 2 and 3. The interventions in the fourth column are the activities and program elements identified by working through step 4. Column five refers to the indicators developed in step 5. Return to column one for step 6 when program objectives are adjusted based on monitoring and evaluation results. Add as many rows as needed for your specific program. In working through the matrix, attention should be paid to whether the objectives and indicators address the gender-based constraints and opportunities that have been identified as critical to achieving the RH/HIV/AIDS outcomes of the program.

### INTEGRATING GENDER THROUGHOUT THE PROGRAM CYCLE

<b>Steps 1 and 6</b> Project objectives, intermediate objectives, and results	<b>Step 2</b> Types of data to be collected—what do we need to know about whom?	<b>Step 3</b> Gender-based constraints to/opportunities for achieving objectives and results	<b>Step 4</b> Interventions that address gender-based constraints/opportunities	<b>Step 5</b> Indicators to measure gender (removal of constraints or building on opportunities) and health impacts of interventions

## APPENDIX 1:

### Concepts and Terminology

**Gender** refers to the economic, social, political, and cultural attributes and opportunities associated with being female and male. The social definitions of what it means to be female or male vary among cultures and change over time.<sup>36</sup> Gender is a sociocultural expression of particular characteristics and roles that are associated with certain groups of people with reference to their sex and sexuality.

**Gender analysis** refers to the methodologies that identify and interpret the socioeconomic consequences of gender inequities, differences, and relations for achieving development objectives. Gender analysis provides contextual understanding of the environment in which development policies, programs, and projects operate. It examines disparities in the roles, activities, needs, constraints, opportunities, and power associated with being male and female in a given context, and looks at how these attributes affect and are affected by interventions and policies.

Examining women's and men's differential access to and control over resources (land, labor, capital, produce, tools, knowledge, institutions, social networks) is an essential component of the analysis, as is the comparative participation of women and men in the exercise of power and decisionmaking. Collection of sex-disaggregated quantitative and qualitative data provides an empirical foundation for assessing the potential impact of gender relations on the program and the relative benefits to women and men.

An examination of gender inequities, differences, and relations is an integral part of socio-economic analysis and cannot be isolated from the broader social context. Even within a single culture or nation, neither women nor men form a homogeneous group. Other

social factors like class, race, ethnicity, income, education, religion, and geographic location interact with gender and influence how important gender roles and gender relations may be for a particular program.

Various gender analysis tools have been proposed by development agencies to guide the collection and analysis of the information necessary for gender mainstreaming (see references to additional manuals in Appendix 4). The precise questions shaping a particular analysis depend on the sector and on the agency goals for gender and women in development. USAID policy calls for attention to gender to improve the status of women and enhance development results.

**Gender discrimination** is the inequitable treatment, including unfair treatment or unequal treatment, of a person or a group of people based upon gender. Gender discrimination is a violation of human rights, including the right to fair and equal treatment by governments through government programs, policies, and laws.

**Gender equality** permits women and men equal enjoyment of human rights, socially valued goods, opportunities, resources, and the benefits from development results. The fact that gender roles and identities change over time means that development programming can have an impact on gender inequality, either increasing or decreasing it.

**Gender equity** is the process of being fair to women and men. To ensure fairness, measures must be available to compensate for historical and social disadvantages that prevent women and men from operating on a level playing field. Gender equity strategies are used to eventually attain gender equality. Equity is the means; equality is the result of more equitable policies, programs, institutions, and distribution of resources.<sup>37</sup>

<sup>36</sup> DAC Guidelines for Gender Equality and Women's Empowerment in Development Co-operation, 1998 (Paris: OECD, 1998).

<sup>37</sup> CIDA, A Project-level Handbook: The Why and How of Gender-Impact Indicators (Ottawa: CIDA, 1996).

**Gender integration** means taking into account both the differences and the inequalities between women and men in program planning, implementation, and assessment. The roles and power relationships between women and men affect who does what in carrying out an activity and who benefits. Taking into account the inequalities and designing programs to reduce them should contribute not only to more effective development programs but also to greater social equity/equality. Experience has shown that sustainable changes are not realized through activities focused on either women or men alone.

**Gender mainstreaming** is the term used in the Platform for Action, adopted by the 1995 Fourth World Conference on Women in Beijing, to designate the methods and institutional arrangements for achieving gender equality. Gender mainstreaming goes beyond accounting for gender considerations in programs. Rather than regarding gender issues as special interests to be taken up separately, gender mainstreaming is an approach that treats gender considerations as core factors to be incorporated throughout policy formulation, planning, evaluation, and decisionmaking procedures.

Mainstreaming implies that attention to equality between women and men should pervade all development policies, strategies, and interventions. Mainstreaming does not simply mean ensuring that women participate in a development agenda that has already been decided upon. It aims to ensure that women as well as men are involved in setting goals and in planning so that development meets the priorities and needs of both women and men. Mainstreaming thus involves giving attention to equality in relation to analyses, policies, planning processes, and institutional practices that set the over-

all conditions for development. Mainstreaming requires that analyses be carried out on the potential impact on women and men of development interventions in all areas of societal development. Such analysis should be carried out *before* the important decisions on goals, strategies, and resource allocations are made.<sup>38</sup>

**Gender perspective** is a theoretical and methodological approach that permits us to recognize and analyze identities, viewpoints, and relations, especially between women and women, women and men, and men and men.<sup>39</sup>

**Gender roles and identities** vary among cultures and change over time. Women and men often differ in the activities they undertake, in access to and control of resources, in participation in decisionmaking, and in the power they have to manage their lives. The social positions ascribed to women and men are defined relative to one another. In most societies, women have less access than men do to resources, opportunities, and decisionmaking. The social, political, and economic institutions of a society – family, schools, industries, religious organizations, and governments – are also gendered. They tend to incorporate and reinforce the unequal gender relations and values of a society. However, gender roles and identities have the capacity to undergo significant change.

**Access to and control over resources** refer to the ways in which resources are allocated differently between women and men. **Access** is defined as the opportunity or ability to make use of the resource. **Control** is the power to decide how the resource is used. It is the ability to make decisions about and the capacity to derive benefits from resources. Women often have access but no control.<sup>40</sup>

<sup>38</sup> SIDA, *A Handbook for Mainstreaming a Gender Perspective in the Health Sector* (Stockholm: SIDA, 1997).

<sup>39</sup> Susan Paulson, Maria Elena Gisbert, and Mery Quinton, *A Guide for Rethinking Differences and Rights in Sexual and Reproductive Health: A Training Manual for Health Care Providers* (Research Triangle Park: Family Health International, Women Studies Project of Family Health International through a Cooperative Agreement with USAID, 1999).

<sup>40</sup> Adapted from Oxfam, *A Guide to Gender-Analysis Frameworks* (Oxford: Oxfam, 1999).

**Human rights**<sup>41</sup> are universal, indivisible, interdependent, interrelated, and inalienable rights recognized under international law. Human rights include civil, cultural, economic, political, and social rights, including the right to development as expressed in numerous international treaties and other documents, like the Beijing Platform for Action. All governments are legally bound to a core set of human rights founded upon universal principles of human dignity, freedom, and equality, which are applicable to all individuals. All human rights, and especially those encompassing reproductive rights, should be taken into account throughout any development program. A gender perspective in public health orients RH/HIV/AIDS programs toward rights-based approaches. These rights-based approaches draw from provisions in international human rights and other covenants that safeguard the respect, dignity, equality and self-esteem of all human beings.

**Masculinity and femininity**, like gender, are socially defined constructs influenced by myriad forces including history, culture, religion, and economics. Studies confirm the existence of normative models of masculinity and femininity accepted by men and women that determine unequal relationships between genders. Common models of masculinity that emphasize male superiority increasingly elicit a range of negative reactions among men, such as tension, discomfort, conflict, and repudiation.<sup>42</sup>

**Men and gender equality:** Achieving gender equality requires supporting alternative models of masculinity that are not necessarily in opposition to models of femininity and that allow men to behave in ways that foster equality between men and women. These models could include showing emotions and sharing reproductive responsibilities, namely contraception, child care, and financial welfare.<sup>43</sup>

**Reproductive rights** are human rights encompassing a number of separate human rights, including certain civil, political, economic, social, and cultural rights.<sup>44</sup>

**Sex** refers to the biological differences between women and men. Sex differences are concerned with women's and men's physiology.

**Women's rights** are the human rights of women. At the UN Fourth World Conference on Women in Beijing, China, in 1995, the international community recognized the broad conceptual notion of women's rights as human rights explicitly for the first time. Women's rights emerged through the recognition that 1) individuals have rights vis-à-vis nations under international law (a concept applicable to all human rights); 2) women are capable of having legal rights; and 3) women and men have equal rights. Women's rights include equality between women and men generally, and also rights particularly relevant to women, such as reproductive rights.<sup>45</sup>

<sup>41</sup> Human Rights have been delineated through numerous international human rights instruments, such as the United Nations Charter (1945), Universal Declaration of Human Rights (1948), International Covenant on Economic, Social and Cultural Rights (1966), International Covenant on Civil and Political Rights (1966), Convention on the Elimination of All Forms of Discrimination Against Women (1979), Nairobi Forward-Looking Strategies for the Advancement of Women (1985), Vienna Declaration and Programme of Action of the World Conference on Human Rights (1993), Programme of Action of the International Conference on Population and Development (1994), and Beijing Declaration and Platform of Action of the United Nations Fourth World Conference on Women (1995), and other international documents.

<sup>42</sup> José Olavarría and Teresa Valdés, *Literature Review for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms* (New York and Oaxaca: AVSC and IPPF/WHO, 1998).

<sup>43</sup> Olavarría and Valdés, 1998.

<sup>44</sup> U.S. Government policy does not support advocacy for abortion rights.

<sup>45</sup> Felice D. Gaer, "And Never the Twain Shall Meet. The Struggle to Establish Women's Rights as International Human Rights," in *The International Human Rights of Women: Instruments of Change* (Chicago: American Bar Association, 1998).

## APPENDIX 2:

### The USAID Bureau for Global Health (GH) Interagency Gender Working Group

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/equality<sup>46</sup> within programs to improve RH/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/HIV outcomes;
- Collect empirical data and identify best practices on gender issues and the interface with RH/HIV;
- 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.<sup>47</sup>

### IGWG Organizational Structure

The IGWG has 60-80 active members and maintains a listserv with over 350 subscribers. A major focus of the group has been on gender education, advocacy, and the development of operational tools. A Technical Advisory Group (TAG) serves as the strategic planning and advisory body of the IGWG. The TAG members ensure that the work of the IGWG addresses issues and needs as they arise in the

RH field. Specifically, the TAG has identified priority technical areas: gender-based violence, youth and gender, HIV/AIDS and gender, and a continued focus on male involvement and dual protection.

Discrete task forces and small grants carry out IGWG activities in the technical areas recommended by the TAG. Dissemination and training are integrated as ongoing activities of the IGWG. Technical assistance (TA) to the field is based on specific country requests.

The cooperative and participatory nature that has characterized the IGWG since its inception continues to be a priority. The participation of a wide range of USAID CAs, as well as non-USAID-funded agencies, on the Task Forces is strongly encouraged. In addition, technical updates will be offered to the USAID and non-USAID community on a variety of pertinent issues. The first, on gender-based violence, was held in May 2002.

### Current Task Forces and Contact Information (from the IGWG website <http://www.igwg.org>):

#### Gender, Access, and Quality Task Force

CONTACT: Karen Hardee, The Futures Group International, [k.hardee@tfgi.com](mailto:k.hardee@tfgi.com)

Examines the linkage among gender, access, and quality of care through: 1) understanding current thinking and practices in the field regarding the integration of a gender perspective into RH/HIV/AIDS programs at different program levels, and 2) proposing a programmatic framework for integrating gender perspectives.

<sup>46</sup> See page 11 for further discussion of the concepts of gender equity and gender equality.

<sup>47</sup> 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.: PRB for IGWG, 2000). The current Manual and the RFA/RFP guide are intended as complementary companion documents.

### **Research/Evidence-Based Examples Task Force**

CONTACT: Sid Schuler, Academy for Educational Development, [sschuler@aed.org](mailto:sschuler@aed.org), and Karen Hardee, The Futures Group International, [k.hardee@tfgi.com](mailto:k.hardee@tfgi.com)

Assesses how gender-integrated programming contributes to achieving reproductive health outcomes and population, health, and nutrition (PHN) results.

Assesses how gender-integrated programming contributes to achieving reproductive health outcomes and PHN results. Forthcoming: Carol Boender et al., *The “So What” Report: A Look at Whether Integrating a Gender Focus Into Programs Makes a Difference to Outcomes*.

### **Gender and HIV/AIDS Task Force**

CONTACT: Mary Kincaid, The Futures Group International, [m.kincaid@tfgi.com](mailto:m.kincaid@tfgi.com)

Assesses the gender issues, activities, and priorities that have been identified within USAID’s HIV/AIDS programs, around three themes: adolescents, dual protection, FP/HIV/AIDS integration. The findings and the recommendations from participatory regional workshops will guide USAID’s work on gender and HIV/AIDS.

### **Best Practices on Male Involvement Task Force**

A global conference, organized by the former Men and RH Subcommittee, was held in September 2003. Its objectives were to increase knowledge, commitment, and capacity to work with men on RH/HIV/AIDS issues from a gender-equity perspective. For more information about male involvement and RH, please go to [www.rho.org/html/menrh\\_igwg.html](http://www.rho.org/html/menrh_igwg.html).

### **To Subscribe to the IGWG Listserv**

The IGWG also maintains a listserv for its members. Members receive e-mails relating to the IGWG's progress, information, and updates on products and services. The listserv also includes interesting news items, along with information about relevant conferences, workshops, and presentations. To learn more about the IGWG listserv contact: Haruna Kashiwase, IGWG Listserv Moderator, Population Reference Bureau, [hkashiwase@prb.org](mailto:hkashiwase@prb.org).

Phone: 202.483.1100.

For more information on the IGWG, contact [IGWG@usaid.gov](mailto:IGWG@usaid.gov).

## APPENDIX 3:

### Gender Resources and References

#### WEBSITES

##### Gender and Development

Analytical Tools for Human Development  
[www.undp.org/hdro/](http://www.undp.org/hdro/)

Beijing: [www.un.org/womenwatch/confer/beijing5/](http://www.un.org/womenwatch/confer/beijing5/)

BRIDGE online resources,  
[www.ids.ac.uk/bridge/reports\\_gend\\_CEP.html](http://www.ids.ac.uk/bridge/reports_gend_CEP.html)

Canada and development:  
[www.acdi-cida.gc.ca/equality](http://www.acdi-cida.gc.ca/equality)

Gender Equity Group, OECD, Development Assistance Committee:  
[www.oecd.org/dac/gender/index.htm](http://www.oecd.org/dac/gender/index.htm)

United Nations Development Program:  
[www.undp.org/gender](http://www.undp.org/gender)

USAID Office of Women in Development, [www.usaid.gov](http://www.usaid.gov); then click on gender; or [www.genderreach.com](http://www.genderreach.com) and [www.genderreach.com/links/genderlinks.htm](http://www.genderreach.com/links/genderlinks.htm)

##### Gender and Reproductive Health

ICPD: [www.unfpa.org/icpd/index.htm](http://www.unfpa.org/icpd/index.htm)

IGWG: [www.igwg.org](http://www.igwg.org)

MANAGER'S ELECTRONIC RESOURCE CENTER: Managing Reproductive Health Services with a Gender Perspective, <http://erc.msh.org/mainpage.cfm?file=2.2.8.htm&language=English&module=chs>

#### PRINTED SOURCES

##### USAID IGWG Publications ([www.igwg.org](http://www.igwg.org))

*Exploring Gender Perspectives in Population and Health Programs: Workshop Findings and Recommendations*, based on workshops held in 1999.

*A Framework to Identify Gender Indicators for Reproductive Health and Nutrition Programming*, for incorporating gender into the design and evaluation of PHN programs.

*Gender and Reproductive Health Training Curriculum* includes modules for integrating gender considerations into different aspects of health programming.

*Gender-Based Violence and Reproductive Health & HIV/AIDS: Summary of a Technical Update*, based on a day-long technical update held May 1, 2002.

*Guide for Incorporating Gender Considerations in USAID's Family Planning and Reproductive Health RFAs and RFPs*, a tool for the design of USAID reproductive health programs in accordance with the ADS gender guidelines.

*Helping Involve Men (HIM)*, a CD-ROM on research and programmatic literature on men's participation in reproductive health.

*Involving Men in Sexual and Reproductive Health*: an orientation guide CD-ROM.

*Involving Men to Address Gender Inequities: Three Case Studies*, highlights innovative interventions for involving men in reproductive health programs.

*Research Gaps Related to Gender Issues and Population, Health, and Nutrition Programs: An Analysis*, the fundamentals of gender and reproductive health research based on the principles of the Cairo ICPD and Beijing International Women's Conferences (A Summary of an Analysis also available).

## Gender Integration and Mainstreaming Manuals

The Centre for Development and Population Activities, *Gender Equity: Concepts and Tools for Development* (Washington, DC: CEDPA, 1996). Accessed online at [www.cedpa.org](http://www.cedpa.org).

Morris, Patricia, *The Gender Audit: A Process for Organizational Self-Assessment and Action Planning* (Washington, DC: InterAction, 1999).

Save the Children, *Best Practices in Gender Relations Analysis. From Analysis to Action: Integrating Gender into Programs* (Washington, DC: Save the Children, 1996).

United Nations Development Programme, *Gender Mainstreaming Programme and Project Entry Points: Learning and Information Pack* (New York: United Nations, January 2001). Accessed online at <http://learning.undp.org>.

## Gender and Reproductive Health Manuals

Davison, Peter, Roger Davis, and Andrew Safer, *Healthy Relationships Violence Prevention Curriculum* (Halifax, Nova Scotia: Men for Change, 1997). Accessed online at [www.m4c.ns.ca/](http://www.m4c.ns.ca/)

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Paulson, Susan, Maria Elena Gisbert, and Mery Quitón, *Guide for Rethinking Differences and Rights in Sexual and Reproductive Health: A Training Manual for Health Care Providers* (Research Triangle Park, NC: Women Studies Project of Family Health International through a Cooperative Agreement with USAID, 1999).

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Sorenskin, Freya, Kelly Stewart, Laura Duberstein Lindberg, Marta Pernas, and Sean Williams, *Involving Males in Preventing Teen Pregnancy; A Guide for Program Planners* (Washington, DC: The Urban Institute). Accessed online at [www.urban.org/family/invmales.html](http://www.urban.org/family/invmales.html).

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World Health Organization, *Transforming Healthy Systems: Gender and Rights in Reproductive Health* (A Training Manual for Health Managers) (Geneva: WHO, 2000). Accessed online at <http://who.int/reproductive-health/>.

## Other Gender Planning Manuals (multisectoral)

Chambers, R., "Participatory Rural Appraisal (PRA): Challenges, Potentials and Paradigm," *World Development* 22, no.10 (1994): 1437-1454.

Connell, D., "Participatory Development: An Approach Sensitive to Class and Gender," *Development in Practice* 7, no. 3 (1997): 248-259.

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Canadian International Development Agency, *Guide to Gender-Impact Indicators* (Ottawa: CIDA, 1995).

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

**For additional copies contact:  
Population Reference Bureau  
1875 Connecticut Ave., NW, Suite 520  
Washington, DC 20009-5728  
[www.prb.org](http://www.prb.org)  
Phone: (202) 483-1100  
email: [prborders@prb.org](mailto:prborders@prb.org)**

