A Framework To Identify Gender Indicators For Reproductive Health and Nutrition Programming

Prepared Under the Auspices of the Interagency Gender Working Group, Subcommittee on Research and Indicators

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I. Introduction

The importance of including gender in population, health, and nutrition (PHN) programming has gained acceptance in the last decade and was given a significant boost after the Interagency Gender Working Group (IGWG)[1] was established in 1997. The IGWG's Subcommittee on Research and Indicators took upon itself the task of articulating the role of gender in PHN programming and of explicitly including gender in monitoring and evaluation activities. The subcommittee members, drawing on their years of experience working on PHN and gender issues in developing countries, developed a framework for incorporating gender into the design and evaluation of PHN programs and provided a large set of examples (see Annex) as a tool for PHN program planners.

This paper introduces that framework. The focus is at the level of interventions, not changes in behavior or health status at the population level, such as would be measured in a Demographic and Health Survey. MEASURE Evaluation[2] provides resources on a wide range of population and health indicators, including their gender implications; MEASURE DHS+[3], in both the core survey questionnaire and the gender module, provides data at the population level. It is not the intention of the authors of this paper to provide a comprehensive or definitive list of gender indicators or to discuss how to make the standard PHN indicators more gender sensitive.[4] Rather, this paper offers a way of thinking about gender that makes it relevant for PHN programming and evaluation. It is one step along the path to understanding and measuring the role of gender in the PHN sector.

The four specific objectives of this paper are:

- To articulate a rationale for including gender in PHN programming;
- To define gender and several aspects of gender in ways that make it easier to include in PHN programming;
- To suggest a framework for identifying and addressing gender-related constraints to achieving PHN objectives, using a detailed set of illustrative examples; and
- To identify some generally applicable gender themes, including obstacles, indicators, and monitoring of changes.

1 The Interagency Gender Working Group, established in 1997, is a network of nongovernmental organizations (NGOs), the U.S. Agency for International Development (USAID), cooperating agencies (CAs), and the Bureau for Global Health of USAID. The IGWG promotes gender equity with population, health, and nutrition programs with the goal of improving reproductive health/HIV/AIDS outcomes and fostering sustainable development.

2 J.T. Bertrand and G. Escudero, *Compendium of Indicators for Evaluating Reproductive Health Programs* (Chapel Hill, NC: Carolina Population Center, MEASURE Evaluation, University of North Carolina, 2002).

3 See the DHS+ website for more details (www.measuredhs.com).

4 One relatively simple step toward making all indicators more gender sensitive is to disaggregate them by sex. Significant differences between boys and girls or men and women on a range of development indicators can highlight the need for modifying interventions to redress gender inequities.

II. Rationale for Including Gender-Related Indicators in Population, Health, and Nutrition Programming

Women in development (WID) is often considered a separate development sector, one in which WID objectives are specified, WID projects are developed, and WID indicators are used to measure success. Critical as this approach has been to highlighting the importance of women to development, it does not sufficiently reflect the reality that the sociocultural underpinnings of gender roles and attitudes can contribute to or undermine success in other development sectors.

Gender is not just about women. It is about the sociocultural roles assigned to men and women, and the dynamics between them. While women, in general, are more disadvantaged by these roles in terms of their opportunities to benefit from reproductive health (RH) and other development programming, men may also face gender-related barriers to their reproductive health and functioning. For example, notions of masculinity that equate virility with the number of children fathered may make it difficult for a husband to reach a decision with his wife to limit their family size. Such role definitions may make it unlikely that a man will use a condom even in situations in which sex may entail a high risk of contracting sexually transmitted infections (STIs). In addition, men must be included in many of the sociocultural changes that would help women realize improved RH, such as access to financial resources, unrestricted mobility, and enhanced decisionmaking.

This paper addresses the relationship between gender and reproductive health. The mandate from the 1994 International Conference on Population and Development (ICPD) was to design programs from the clients' perspectives: to help women and men understand reproductive health more fully, define their own reproductive health objectives and family size preferences, and obtain information and services to achieve those objectives. At every step along the way, gender-related obstacles could prevent people from understanding and achieving good reproductive health. For example, women have relatively lower literacy and lack access to mass media, so women may have less knowledge about reproductive health, including family planning and where to get services. Gender-related dynamics between a man and a woman might make it difficult for a woman who wants to avoid a pregnancy to negotiate contraceptive use. Women may have fewer opportunities to participate in health-related decisionmaking and research, thus limiting the full range of perspectives brought to bear in each of these settings.

On the other hand, some gender-related aspects of society might also provide positive starting points for developing PHN programs. For example, in many societies women have traditional ways of communicating and passing information from one generation to the next that can be used as vehicles for change. In Kenya, where some communities have practiced female genital cutting as a rite of passage, communities are now holding "circumcision with words" ceremonies that continue the positive traditional discussions between women and girls without the harmful cutting.[5] At times, traditional views on masculinity can offer opportunities. Where societies dictate that it is men's role to protect the health of their wives and children, interventions can build on that belief to provide men with better information on how to fulfill their role.[6]

Strategic PHN project design begins with a careful assessment of health status and the full range

[5] Asha Mohamud, Nancy Ali, and Nancy Yinger, *Female Genital Mutilation, Programs to Date: What Works and What Doesn't* (Geneva: WHO, 1999).

[6] Case studies that examine such male roles will be published later this year in an IGWG/Population Reference Bureau publication, titled *Involving Men to Challenge Gender Inequities in Reproductive Health: Three Case Studies.*

of constraints and opportunities in a particular society that might undermine or support the project's objectives. Gender clearly falls within that range. Strategic project design also includes a well-articulated monitoring and evaluation (M&E) plan to track the extent to which project objectives are being achieved. When an initial project assessment identifies gender as a constraint, activities to address those gender-related constraints need to be included in the intervention and its M&E. The next section provides some ideas on how to define gender so that it is a focused concept that can usefully be included in PHN programming.

III. Defining Gender

To incorporate gender into PHN projects, program planners and evaluators must define it in clear and practical terms—or operationalize it—in ways that make it useful to a project's design without losing sight of the project's health-related objectives. To make gender a distinct and useful concept, it must be differentiated from other kinds of development obstacles, such as poverty, or such service-related obstacles as poorly trained staff, inadequate logistics, and insufficient resources.

The gender literature offers a variety of definitions of gender that, at the most general level, highlight the different social and economic roles society assigns to women and men. For example, the Organization for Economic Cooperation and Development defines gender as follows: "Gender refers to the economic, social, political, and cultural attributes and opportunities associated with being male and female. The social definitions of what it means to be male or female vary among cultures and over time."[7]

It is not too difficult to apply this somewhat abstract definition to PHN programming. The gender literature sheds light on four major aspects of gender as guides to gender-sensitive programming:

- **Participation:** Participation from a gender perspective reflects the differential involvement women and men have at various phases of project design and implementation, including (1) participation in project activities or as recipients of project benefits; (2) involvement in decision-making and control of project activities and resources; and (3) participation at the national or regional policy level in decisions about social and economic development priorities and policies.[8]
- **Equity and equality:** Gender equity describes development processes that are fair to women and men. To ensure fairness, activities need to be undertaken to compensate for or redress historical and social disadvantages that prevent women and men from otherwise operating on a level playing field and taking advantage of the benefits of socioeconomic development. Gender equity strategies are used to attain gender equality, which is defined as equal enjoyment by women and men of socially valued goods, opportunities, resources, and rewards. Equity is the means; equality is the result.[9]
- **Empowerment:** Empowerment focuses attention on the degree of control individuals are able to exert over their own lives and environments and over the lives of others in their care,

[7] Development Assistance Committee (DAC), *DAC Source Book on Concepts and Approaches Linked to Gender Equality* (Paris: OECD, 1998).

[8] P. Oakley, "The Concept of Participation in Development," *Landscape and Urban Planning* 20, no. 1/3 (1991) 114-22; DAC, 1998.

[9] RHA Subgroup, Program Implementation Subcommittee, IGWG, *Guide for Incorporating Gender Considerations in USAID's Family Planning and Reproductive Health RFAs and RFPs* (October 2000); CIDA, *Guide to Gender-Sensitive Indicators* (Ottawa: CIDA, 1996); Swedish International Development Cooperation Agency, *Handbook for Mainstreaming a Gender Perspective in the Health Sector* (Stockholm: SIDA, 1997).

such as their children. Generally, women are less empowered than men at the household and community levels and beyond. Efforts to operationalize women's empowerment need to gather data on women's participation in decisionmaking within the household, women's control of income and assets, spousal/partner relations, and attitudes that reflect self-efficacy, self-worth, and rejection of rigid gender-based roles.[10]

- **Human rights:** A gender perspective on human rights focuses on reproductive rights such as the right to control one's sexuality; the right of couples and individuals to decide freely and responsibly about the number and spacing of children, and to have the information and means to achieve this right; the right to obtain the highest standard of sexual and reproductive health; and the right to make decisions free from discrimination, coercion, or violence. These rights are recognized in legal documents and international treaties and accords.[11]

These four aspects of gender are not mutually exclusive; interventions that contribute to women's empowerment may also facilitate their participation in a PHN intervention, which in turn might address basic human rights. But, each category has a different emphasis that may make it more or less complementary to different kinds of PHN programming. For example:

- A PHN training strategy might explicitly choose to address **participation** by designing programs that deal with the time constraints faced by female primary care providers in attending training programs far from home, including more women in the development of training protocols and curricula, and by reviewing the admissions criteria for medical schools to make sure they are not biased against women.
- Policy programs might choose to emphasize **human rights** aspects of reproductive rights, as mentioned above, because one of the roles of government is (or should be) to guarantee human rights.
- A service delivery program could choose to contribute to **empowerment** by working with service providers to understand women's difficulties in asking questions about their bodies and issues related to sex, and developing counseling approaches to improve communications; by working with the community to change norms concerning restricted mobility of women; and by instituting economic development initiatives that enable women to earn money and control resources.
- A service delivery program could address **equity** by working with the community and/or other nongovernment organizations (NGOs) to establish a revolving loan fund or micro-credit program to give women more autonomous access to financial resources or by working with men to encourage couple dialogue and joint decisionmaking.

One concern PHN program planners may have is that gender is a large and amorphous concept and that PHN activities, complex in and of themselves, cannot and should not be expected to solve a country's gender problems. But it is clear from the literature—and from the many field experiences now incorporating gender into programs and projects—that gender, like PHN, can be divided into components from which to develop interventions that support the achievement of PHN objectives.

[10] Sunita Kishor, *A Framework for Understanding the Role of Gender and Women's Status in Health and Population Outcomes* (Calverton, MD: Macro International, 1999); DAC, 1998.

[11] United Nations, *Platform for Action From the UN Fourth World Conference of Women* (Beijing: UN,1995); International Planned Parenthood Federation, Western Hemisphere Region, *Manual to Evaluate Quality of Care From a Gender Perspective* (New York: IPPF/WHR, 2000); KULU-Women and Development, *Monitoring Women's Sexual and Reproductive Health and Rights: Results From a Workshop in Copenhagen, Denmark, January-February 2000* (Copenhagen: KULU-Women and Development, 2000).

IV. A Framework for Incorporating Gender Into PHN Programming

The framework suggested in this paper and illustrated by examples in the Annex uses a three-step process to incorporate gender into PHN programming:

(1) Identify the gender-related obstacles to and opportunities for achieving a particular PHN objective in a particular setting;

(2) Include or modify activities aimed at reducing those gender-related obstacles; and

(3) Add indicators to M&E plans to measure the success of the activities designed to lower gender-related obstacles.

Gender-related indicators in this context are process indicators; they measure success in reducing gender-related obstacles as part of the process of achieving a PHN objective. Gender-related indicators are additions to, not replacements for, indicators that measure changes in health status. The framework does not address indicators to measure changes in gender status, such as changes in one of the four aspects listed earlier for the population as a whole. This framework is for an important but different evaluation task.

The Annex provides detailed examples of the kinds of gender-related obstacles related to family planning, sexually transmitted infections (STIs), safe motherhood (SM), post-abortion care (PAC), and nutrition that might appear. These are only examples, based on the authors' collective experience in PHN and gender in a range of countries. They are not universally applicable. For example, in some countries women face significant restraints on their freedom to travel on their own, while in others women are free to move about without restriction. Thus, if the framework were to be used to design and evaluate a specific project, the first step would be to conduct a context-specific assessment of the gender-related obstacles to achieving the project's objectives. The four aspects of gender defined in Section III provide some guidance on what to look for. For example, is the participation of women and men in designing and accessing project benefits balanced? Can women decide on their own whether or not to participate in project activities?[12]

Once the assessment is complete, the project designers would explicitly include activities to address specific gender-related obstacles and incorporate measurement of the project's success at doing so. The examples in the Annex provide a rich set of possibilities to stimulate the process of identifying what might be applicable in any given setting.

Table 1 highlights one example from the Annex.

[12] For more information on gender assessment tools, see B. Thomas-Slayter et al., *A Manual for Socio-Economic and Gender Analysis: Responding to the Development Challenge* (Worcester, MA: ECO-GEN-Clark University, 1995); C. March et al., *A Guide to Gender-Analysis Frameworks* (Oxford: Oxfam, 1999); V. Gianotten et al., *Assessing the Gender Impact of Development Projects* (London: Intermediate Technology Development Group Publishing, 1994); T. Keays et al., eds., *UNDP Learning and Information Pack—Gender Mainstreaming, accessed online* at www.undp.org/gender/capacity/gm_info_module.html, in June 2000; and *Gender Analysis as a Method for Gender-based Social Analysis, accessed online* at www.worldbank.org/gender/assessment/gamethod.html, on May 23, 2002.

TABLE 1

Objective	Gender-related obstacle to achieving the objective	Activities that address the obstacles	Indicators to measure success of the gender-related activities	Data sources
Reduce unintended pregnancy	Women cannot successfully negotiate FP use because it is culturally inappropriate to discuss sexual issues with providers or partners	Training of service providers to address issues of sexuality in counseling sessions with both men and women; Information, Education, and Communication (IEC) and participatory interventions to help clients discuss sensitive issues or communicate with their partners	Change in providers' counseling content, style, and ability; change in individuals' attitudes and behaviors	Pre- and post-training observations; attitudinal surveys (exit interviews) at clinic, qualitative interviews with women and men

The PHN objectives listed in the Annex are based on the ICPD Program of Action. So, for example, programs aimed at reducing unintended pregnancy respond to women's and men's own childbearing preferences. If a woman wants to avoid a pregnancy but finds it difficult to discuss sexual issues with her partner or her health provider because of prevailing gender norms, she may be unable to obtain and use appropriate contraception. Thus, she would be at risk for an unintended pregnancy. This gender-related obstacle contributes to making the PHN objective— reducing unintended pregnancy—difficult to achieve. Of course, the gender-related obstacle in Table 1 is only one possible example among many gender-related issues that might make this objective difficult to achieve. Moreover, there are many obstacles not related to gender that a project would need to address. Race/ethnicity, poverty, and poor quality of care often compound gender issues and contribute to poor health status.

Explicitly including gender-related activities need not take a project in radically new directions. Some of the activities that would help to alleviate gender-related obstacles are simply modifications of activities that a well-designed, high-quality project would probably include anyway. For example, a project to reduce unintended pregnancy might focus on better client-provider interaction through improved training in counseling skills. If the content of that training were expanded to include gender, the project might be better able to help women avoid unwanted pregnancies. For other activities, particularly broader-based efforts to address community gender norms, the key is to work collaboratively with projects in other sectors.

By focusing on gender-related obstacles, one might falsely infer that gender should be addressed only in order to alleviate its negative impact on health status. Such an approach would fail to recognize the positive synergy that could be achieved in both the PHN and gender sectors of development if the two were integrated. Reproductive health programs can contribute to change in an array of gender issues. Table 2 highlights how some of the same process and output indicators that measure changes in gender-related obstacles to PHN programs could also be used to assess changes in one of the four gender aspects defined above.

TABLE 2

Gender aspect	Illustrative indicators
Participation	Number of women participants in RH policy process; Number of agencies adopting diversity guidelines and policies; Number of women's advocacy groups included in research decisionmaking process.
Empowerment	Changes in women's and men's knowledge of RH and HIV/AIDS/STIs; Number of RH courses and educational events; Changes in men's and women's attitudes toward violence against women; Increased community awareness about medical needs during pregnancy.
Equity	Percent of microcredit funds used for FP/RH services; Options for transport to service delivery points; Time needed for transportation to services; Cost of transportation; Assessment of RH care commodities used, at what cost, and by whom; Decrease in restrictions on services and information; Increase in male STI clients' satisfaction with services, hours, and location.
Human Rights	Changes in policymakers' knowledge of and attitudes toward human rights approaches; Increase in number of state-level RH rights enforcement mechanisms and assessment of whether revised service delivery protocols include human rights language; Existence of patients' bills of rights.

V. Identifying Commonly Experienced Obstacles and Indicators

The Annex does not include an exhaustive list of gender/PHN indicators but rather draws on the experiences of the authors and highlights approaches to incorporating gender into PHN M&E plans. However, certain gender-related obstacles appear repeatedly in the examples, making it possible to construct a more general list of obstacles that might need to be addressed. This general list may be useful in constructing a "Gender-Related Obstacles" grid for a particular project or program.

Such a grid might include the following obstacles:

- Lack of awareness among policymakers or service providers of the definition of gender or its importance to achieving PHN objectives;
- Lack of dialogue between providers and clients on RH issues due to cultural constraints;
- Provider bias toward clients based on such client characteristics as sex, age, and marital or economic status;
- Cultural bias against certain family planning methods or health services;
- Differential access to education between girls and boys;
- Differential access to sources of health knowledge between men and women;
- Differential participation in decisionmaking at the household and community levels between men and women;
- Differential access to household resources between men and women;
- Cultural constraints on discussing RH issues with spouse or partner;
- Lack of time to access services, due to multiple responsibilities in the household; and
- Restrictions on women's mobility (not relevant in all countries).

The final list for any particular project or program would need to be tailored to specific settings and objectives. In much the same way, measurement of the indicators would need to be program-specific and more detailed. The examples in the Annex are ideas and suggestions drawn from the authors' understanding of PHN, gender, and project monitoring and evaluation; the examples have not been tested in real project or research environments, nor are they specified in the detail necessary to be immediately translated into monitoring and evaluation research.

Additional work is needed both to deepen the empirical base for understanding which aspects of gender can make the most significant contributions to improved RH status and which aspects of RH programming are most likely to contribute to gender equality, and to develop carefully specified and measurable indicators.[13] A wide array of M&E techniques exists, ranging from population-based sample surveys that help establish baseline values for relevant indicators and measure change over time to participatory techniques that allow the beneficiaries to contribute to the definition of program success. Box 1 highlights the components of a good indicator.

MEASURE Evaluation provides a wealth of resources to assist with the development of well-specified monitoring and evaluation plans.[14]

Monitoring changes in gender-related obstacles at the project level is only part of the picture. In order for the project to be sustainable, changes both in health status and in gender attitudes and behavior must occur at the population level. MEASURE DHS+ has developed modules on women's empowerment and violence, and has included several key

[13] The Empowerment of Women Research Program at John Snow, Inc., and the POLICY Project at the Futures Group International, with the support of the USAID Interagency Gender Working Group, are currently reviewing evidence on the relationship between gender-sensitive programming and reproductive health outcomes. The resulting report will include findings from qualitative and quantitative evaluations, and focus on such RH outcomes as partner communication, sexual negotiation, and changing community norms.

[14] See the MEASURE *Evaluation* website at www.cpc.unc.edu/measure/

questions in the core Demographic and Health Survey (DHS) questionnaire that contribute to the measurement of many of these issues at the population level. Sunita Kishor, who has developed a framework that links gender and RH,[15] identifies 11 key issues for which DHS data are available, either in the core questionnaire or in the empowerment and violence modules (those marked with an asterisk are indicators available in MEASURE DHS+ core questionnaire):

1. Educational status and media exposure;*
2. Employment status;*
3. Control over earnings;*
4. Freedom of movement;
5. Control over money and assets;
6. Attitudes about gender roles;
7. Attitudes about the right to refuse sex;*
8. Spousal equality and communication;
9. Freedom from violence and coercion;
10. Attitudes that reflect a sense of self-efficacy, self-worth, and entitlement; and*
11. Control of household and reproductive decisionmaking.*

The most comprehensive method for including gender in PHN programming would be to include both project- and program-level process indicators as described here and population-level impact or outcome indicators.

[15] Sunita Kishor, *A Framework for Understanding the Role of Gender and Women's Status in Health and Population Outcomes* (Calverton, MD: Macro International, 1999).

[16] World Health Organization, *Selecting Reproductive Health Indicators: A Guide for District Managers, Field Testing Version* (Geneva: WHO, 1997).

[17] Canadian International Development Agency (CIDA), *Guide to Gender-Sensitive Indicators* (Ottawa: CIDA, 1996).

BOX 1

The World Health Organization defines a good indicator as being:[16]

- **Ethical**—Data must respect people's rights to confidentiality, freedom of choice in supplying information, and informed consent regarding the nature and implications of the data required.
- **Useful**—The indicator acts as a marker of progress toward improved reproductive health status or as a measure of progress toward specified process goals.
- **Scientifically robust**—The indicator should be a valid, specific, sensitive, and reliable reflection of what it purports to measure.
- **Representative**—The indicator must adequately encompass all the issues or population groups it is expected to cover.
- **Understandable**—The indicator should be simple to define and its value easy to interpret.
- **Accessible**—It uses data that are already available or are relatively easy to acquire by feasible methods that have been validated in field trials.

In addition, the Canadian International Development Agency (CIDA) recommends that good indicators have the following characteristics:[17]

- **Participatory**—The indicator has been developed in a participatory fashion.
- **Relevant**—The indicator has been formulated at a level the user can understand and is relevant to the users' needs.
- **Sex-disaggregated**—Data are collected so that analysis can be conducted separately for males and females, if appropriate.
- **Qualitative or quantitative**—Data are either quantitative or qualitative, as appropriate to the objectives of the project.

VI. Conclusion

While much of the discussion in this paper addresses gender-related issues as obstacles to achieving PHN objectives, it must be understood first and foremost that improvements in gender dynamics offer an opportunity to improve health and well-being. Thus, PHN programs can, and indeed should, reinforce the explicit inclusion of gender-related activities in project design, implementation, and M&E. Again, the entire gender domain need not be addressed in order to make progress.

If designers and implementers of PHN programs understand the aspects of gender, they can explicitly and actively work to address the gender-related concerns most directly relevant to their programs. The programs themselves will benefit because gender-related barriers will be lowered, making the health objectives more achievable. Program recipients will benefit on two fronts: intended PHN services will be provided more effectively, and there will be a concomitant improvement in at least one of the four gender aspects: participation, equity and equality, empowerment, and human rights. Ultimately, society will benefit from sustainable improvements in well-being.

Finally, because this framework is offered as a tool for discussion and not as a definitive list of indicators, the authors welcome any feedback on how it could be improved, additional examples to include, and ways in which it has been useful. For more information or to provide feedback, please contact IGWG@usaid.gov.

References

Abdullah, Rashidah, *A Framework on Indicators for Action on Women's Health Needs and Rights After Beijing* (Kuala Lumpur, Malaysia: Asian-Pacific Resource and Research Centre for Women, 2000).

Advisory Committee on Voluntary Foreign Aid (ACVFA), *New Agenda for Gender Equality* (Washington, DC: ACVFA, 2000).

Bertrand, J.T., and G. Escudero, *Compendium of Indicators for Evaluating Reproductive Health Programs.* Carolina Population Center, MEASURE Evaluation (Chapel Hill, NC: University of North Carolina, 2002).

Canadian International Development Agency (CIDA), *Guide to Gender-Sensitive Indicators* (Ottawa: CIDA, 1996).

Center for Health Education, Training, and Nutrition Awareness (CHETNA), *A Manual on Gender Sensitive Indicators* (Ahmedabad, India: CHETNA, 1999).

Development Assistance Committee (DAC), *DAC Source Book on Concepts and Approaches Linked to Gender Equality* (Paris: Organization for Economic Co-operation and Development [OECD], 1998).

Gianotten, V., V. Groverman, E. Van Wilsum, and L. Zuidberg, *Assessing the Gender Impact of Development Projects* (London: Intermediate Technology Development Group Publishing, 1994).

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

Keays, T., M. McEvoy, S. Murison, M. Jennings, and F. Karim, eds., *UNDP Learning and Information Pack—Gender Mainstreaming* (New York: Gender and Development Programme, United Nations Development Programme [GIDP/UNDP], June 2000), accessed online at www.undp.org/gender/capacity/gm_info_module.html.

Kishor, Sunita, *A Framework for Understanding the Role of Gender and Women's Status in Health and Population Outcomes* (Calverton, MD: Macro International, 1999).

KULU-Women and Development, *Monitoring Women's Sexual and Reproductive Health and Rights: Results from Workshop in Copenhagen, Denmark, January-February 2000* (Copenhagen: KULU-Women and Development, 2000).

March, C., I. Smyth, and M. Mukhopadhyay, *A Guide to Gender-Analysis Frameworks* (Oxford: Oxfam, 1999).

Mohamud, Asha, Nancy Ali, and Nancy Yinger, *Female Genital Mutilation, Programmes to Date: What Works and What Doesn't* (Geneva: WHO, 1999).

Oakley, P., "The Concept of Participation in Development," *Landscape and Urban Planning* 20, no. 1/3 (1991): 114-22.

Reinharz, Shulamit, *Feminist Methods in Social Research* (New York: Oxford University Press, 1992).

RHA Subgroup, Program Implementation Subcommittee, IGWG, *Guide for Incorporating Gender Considerations in USAID's Family Planning and Reproductive Health RFAs and RFPs* (Washington, DC: IGWG, 2000).

Swedish International Development Cooperation Agency (SIDA), *Handbook for Mainstreaming a Gender Perspective in the Health Sector* (Stockholm: SIDA, 1997).

Thomas-Slayter, B., R. Polestico, A. Esser, O. Taylor, and E. Mutua, *A Manual for Socio-Economic and Gender Analysis: Responding to the Development Challenge* (Worcester, MA: ECO-GEN-Clark University, 1995).

United Nations, *Platform for Action from the UN Fourth World Conference of Women* (Beijing:UN, 1995).

United Nations Population Fund (UNFPA), *Indicators for Population and Reproductive Health Programs* (New York: UNFPA, 1998).

U.S. Agency for International Development (USAID), *Through a Gender Lens: Resources for Population, Health and Nutrition Projects* (Washington, DC: USAID, 1997).

World Bank, *Gender Analysis as a Method for Gender-Based Social Analysis*, accessed online at www.worldbank.org/gender/assessment/gamethod.html, on May 23, 2002.

World Health Organization (WHO), *Reproductive Health Indicators for Global Monitoring: Report of an Interagency Technical Meeting, 9–11 April 1997* (Geneva: WHO, 1997).

_____ *Selecting Reproductive Health Indicators: A Guide for District Managers, Field Testing Version* (Geneva: WHO, 1997).

For a selected list of relevant websites, links, and resources on gender issues, refer to the website of the U.S. Agency for International Development's Interagency Gender Working Group: www.igwg.org.

ANNEX
Illustrative Examples* of Gender Indicators

The table in this Annex uses the ICPD Program of Action as a starting point for identifying PHN objectives and, while not an exhaustive list of gender/PHN indicators, it draws on the experiences of the authors and highlights approaches to incorporating gender into PHN M&E plans.

* Examples for family planning (FP), safe motherhood (SM), sexually transmitted infections (STIs), postabortion care (PAC), and nutrition objectives

PHN Sector	Objectives of activity	Gender-related obstacles to achieving objective	Activities that address the obstacles	Indicators to measure success of activities designed to reduce gender-related obstacles	Data sources
FP	Reduce unintended pregnancy	Differential access to sources of high-quality reproductive health information due to lower literacy among women	Provide IEC materials for low and non-literate women; provide mass media IEC messages, particularly radio	Reproductive health knowledge among intended beneficiaries	Pre- and post-tests in the community on reproductive health knowledge
FP	Reduce unintended pregnancy	Differential access to sources of high quality reproductive health information and care due to restricted mobility	Develop participatory interventions to address community norms about women traveling to seek RH info and services	Client volume at clinic (number of patients and/or visits); qualitative assessment of impact on mobility of women (do women visit neighbors? go to market?)	Clinic records; pre- and post-intervention qualitative interviews
FP	Reduce unintended pregnancy	Women cannot negotiate FP use successfully because it is culturally inappropriate to discuss sexual issues with providers or partners	Train service providers to address issues of sexuality in counseling sessions with both men and women; IEC and participatory interventions to help clients discuss sensitive issues and/or communicate with their partners.	Providers' counseling content, style, and ability; assessment of changes in clients' attitudes; perception of ability to talk with partners	Pre- and post-training observations and attitudinal surveys (exit interviews) at clinic; qualitative interviews; DHS and other surveys
FP	Reduce unintended pregnancy	Women cannot negotiate FP use successfully due to misperceptions about partner's attitude toward FP	Train and implement couples counseling; model good couple communication (for example, through use of community theater)	Providers' counseling content, style, and ability; assessment of changes in clients' attitudes	Pre- and post-training clinic observations and attitudinal surveys; qualitative interviews.
FP	Reduce unintended pregnancy	Women cannot negotiate FP use successfully because partner has lack of or misinformation about FP or does not approve of FP	Disseminate high-quality information using innovative approaches to reach men and women; encourage innovative behavior change; develop youth peer counseling and education programs for males on female RH rights	Men's knowledge about FP/RH rights; partners' attitudes about FP; relevant materials developed; number of training-of-trainers (TOT) sessions held; number of peer counselors trained; knowledge, attitudes, and skills among male peer educators and counselors on women's RH rights; knowledge, attitudes, and practices among young men about rights, violence, gender roles, RH behaviors, age at first sexual experience or marriage, good parenting	Pre- and post-test of knowledge; pre- and post-intervention assessment of partners' attitudes; project records; pre- and post-training assessment; observations at several points in time; tailored survey or qualitative assessments

PHN Sector	Objectives of activity	Gender-related obstacles to achieving objective	Activities that address the obstacles	Indicators to measure success of activities designed to reduce gender-related obstacles	Data sources
FP	Reduce unintended pregnancy	Women cannot successfully negotiate FP use due to fear of violence and/or actual violence	Disseminate high-quality information at the community level about women's RH rights and the benefits of FP; train to increase provider awareness of the signs of violence, and referrals for counseling; develop outreach activities to enhance community awareness of domestic violence and possible interventions; provide training for policymakers and the judiciary on domestic violence	Men's knowledge about FP/RH; provider awareness of signs of violence; referral systems; community attitudes; police attitudes and behaviors	Pre- and post-test of knowledge; pre- and post-training assessment of provider and police awareness; clinic observations; pre- and post-intervention changes in perception of women
FP	Reduce unintended pregnancy	Women cannot acquire FP supplies and/or services due to differential access to household resources for transportation and/or commodities	Collaborate with microcredit schemes; support community-based transportation efforts; subsidize pricing schemes based on gender-analysis research on access to resources	Percent of microcredit funds used for FP/RH services; options for transportation; time needed for transportation to services; cost of transportation; assessment of RH care—commodities used, at what cost, and by whom	Survey; clinic and pharmacy records
FP	Reduce unintended pregnancy	Women cannot acquire FP supplies and/or services due to provider-based provision that woman needs permission of husband/partner/ male (or parents in the case of unmarried girls) to receive FP	Change existing protocols and regulations at clinic; train providers about new protocols and regulations and the impact of these changes for women	Protocols and regulations; extent of enforcement of new protocols and regulations	Official clinic documents; clinic observation and exit interviews with women
FP	Reduce unintended pregnancy	Women cannot acquire FP supplies and/or services due to multiple role responsibilities, including child care, household duties, etc.	Improve clinic hours, set according to women's definition of "convenient"; provide child care, perhaps using a community-based child care cooperative (CBCCC)	Clinic hours; existence of CBCCC; number of women who use CBCCC	Surveys of women who use clinic regarding convenience; observation-based assessment of CBCCC use
FP	Reduce unintended pregnancy	Women cannot acquire FP supplies and/or services because of sociodemographic status that leads to differential access to services and commodities (widows, single versus married women)	Change existing protocols and regulations at clinic (if it is written policy); train providers about new protocols and regulations; introduce universal RH rights through community-based activities	Protocol and regulation changes that occur (if written policy) and extent of enforcement of new protocols and regulations; attitudes of providers, women, and community	Official clinic documents; clinic observation and exit interviews with women; qualitative interviews; interviews in community (survey and qualitative)

PHN Sector	Objectives of activity	Gender-related obstacles to achieving objective	Activities that address the obstacles	Indicators to measure success of activities designed to reduce gender-related obstacles	Data sources
FP	Provide and encourage use of full range of FP choices, as appropriate, for women and men	Provider bias rooted in gender and sociocultural attitudes (e.g., providers will give condoms to unmarried boys but not girls); will not support use of vasectomy when appropriate	Use participatory intervention to help providers understand the sociocultural reasons behind the specific bias and/or the attitudes toward a full range of methods	Provider attitude toward choice of FP; change in bias toward women and men and specific methods; clinic protocols regarding provision of full range of methods	Pre- and post-training assessments of providers; exit interviews with clients (women) and/or interviews in their homes; written clinic documentation and protocols
FP	Provide and encourage use of full range of FP choices, as appropriate, for women and men	User bias rooted in gender attitudes (e.g., condoms are for sex with commercial sex workers, or vasectomies emasculate men)	Use participatory intervention to make providers aware of user bias and reasons for bias; provide high-quality FP information; improve the quality and accessibility of vasectomy services through provider training and IEC	User attitudes toward FP; reduction in user bias; knowledge of and attitudes toward vasectomy by service providers and men and women; demand for vasectomies; level of technical skill to provide no-scalpel vasectomy	Pre- and post-activity assessment of users; exit interviews with clients and/or interviews in their homes; pre- and post-training survey; clinic records; observation
FP	Foster high quality client-provider interaction	Providers offer poor quality counseling due to bias rooted in gender or sociocultural attitudes	Train providers in gender-sensitive counseling skills; make providers aware of gender bias and reasons for bias.	Counseling activities of provider; reduction in bias toward women and specific FP methods	Pre- and post-activity assessment of providers and information given to clients; exit interviews with clients and/or interviews in their homes; clinic assessments
FP	Provide FP in the context of integrated RH services throughout life cycle	Gender bias of provider does not allow all clients to receive the benefits of integrated RH services (e.g., unmarried adolescents)	Train providers; reorient services and information to address needs of adolescents, widows, etc.	Decline in restrictions on services and information; access of adolescents to services	Pre- and post-activity community-based survey or quality assessment; pre- and post-activity exit interviews with clients; clinic observation
FP	Provide FP in the context of integrated RH services throughout life cycle	Users are reluctant to utilize full range of services due to sex of provider	Train providers to be sensitive to gender issues; if possible, staff clinic to provide clients with the choice of male or female providers	Age and sex mix of clients; client satisfaction with services	Pre- and post-activity exit interviews with clients; clinic observation
FP	Provide FP services in a financially sustainable manner	Fee structure does not take into account gender-related differential access to resources and therefore may not be sustainable	Revise fee structure based on gender and age analysis to decide who needs subsidization (e.g., adolescent girls with no income or employment)	Gender and age mix for each service provided at clinic	Clinic records; pre- and post-activity assessment of clinic use and financial accounting

PHN Sector	Objectives of activity	Gender-related obstacles to achieving objective	Activities that address the obstacles	Indicators to measure success of activities designed to reduce gender-related obstacles	Data sources
FP	Conduct gender-sensitive, high-quality research that contributes to improved reproductive health status	Allocation of resources and setting of research priorities is typically controlled by male decisionmakers and does not include women's health advocacy groups	Train women's advocacy groups and research decisionmakers on the importance of including women and other disenfranchised groups in the research decision-making process; create network of research decisionmakers and women's health advocacy groups	Number of women's advocacy groups included in research decisionmaking process; funds allocated for research involving women's and gender health-related concerns	Count of advocacy groups included in research decisionmaking process; assessment of funds directed toward FP, RH, and gender research
FP	Conduct gender-sensitive, high-quality medical research that contributes to improved reproductive health status (e.g., new contraceptive methods for women and men)	The research process emphasizes narrowly defined health impacts, so qualitative aspects of changes in gender-related variables are not given credibility in the research community; nonthreatening life effects	Fund research that combines quantitative and qualitative methodologies; establish review boards to assist with more holistic approaches to RH research that include gender	Changes in how gender is included in research protocols; more sophisticated modeling of gender and other variables	Text assessments; project documents
FP	Conduct gender-sensitive, high-quality research that contributes to improved reproductive health status	Gender concepts poorly specified and operationalized; distinctions among gender, poverty, quality of care not carefully delineated	Provide gender training for people setting research agendas and researchers; train researchers on multivariate techniques to understand relative importance of gender variables	Changes in how gender is included in research protocols; more sophisticated modeling of gender and other variables	Text assessments; project documents
FP	Pre-service training curriculum incorporates state-of-the-art technical approaches	Content of training materials does not explicitly address the gender-related obstacles women face in accessing and using FP/RH services; staff in training institutions not aware of their own gender biases	Adapt curriculum; analyze gender and content of training materials and curricula; conduct participatory activities with medical and nursing school staff to help them understand the importance of gender norms and biases	Curricula and training materials; trainer knowledge and attitudes	Text review; pre- and post-intervention assessments
FP	High-quality training in FP/RH is available as needed to improve performance	Primary care providers, many of whom are women, are not included in pre- and in-service training or training is offered at times or places inconvenient to them given their multiple roles	Develop training plans to explicitly expand the number of women participants; design programs at convenient times and places; review eligibility requirements for participating in training for gender bias	Number of women trainees; change in venues or times to be convenient for trainees; training plans and strategies that include a gender analysis	Program documents and reports

PHN Sector	Objectives of activity	Gender-related obstacles to achieving objective	Activities that address the obstacles	Indicators to measure success of activities designed to reduce gender-related obstacles	Data sources
FP	RH/FP policies reflect a human rights approach	Policymakers may not include women's sexual and RH rights in their thinking about or understanding of human rights	Disseminate human rights literature, including the concept of reproductive rights as human rights; train policymakers on rights and how to guarantee them (e.g., using international conventions); disseminate examples of patients' bills of rights	Policymakers' knowledge of and attitude toward human rights approach; assessment of whether State-level RH rights enforcement mechanisms are in place and whether revised service delivery protocols include human rights language; existence of patients' bills of rights	Survey of attitude; text reviews
FP	Gender-sensitive and Cairo-appropriate FP/RH policies at community and national levels are in place	Women's voices are not heard in the policy process	Encourage community mobilization on policy process; create dialogue between women's groups and policymakers; conduct IEC campaigns and meetings to provide forums on issues; establish guidelines for getting women into the policy process	Number of media events that specifically address issue; actions taken by women on specific policy issues, to make opinions known in policy process; dialogue continuing over time	Counts of media events; panel interviews with policymakers; content analysis; qualitative interviews with women
FP	Gender-sensitive and Cairo-appropriate FP/RH policies at community and national levels are in place	Key individuals and organizations advocating for gender-sensitive policies are disenfranchised by policies and policy processes	Encourage community education and mobilization about policy process; develop guidelines for diversity of participants in drafting and finalizing policies	Number of women participants in policy process; number of agencies adopting diversity guidelines and policies	Count or survey of individuals involved in policy process; text assessment of policy guidelines
FP	Gender-sensitive and Cairo-appropriate FP/RH policies at community and national levels are in place	Those in the policymaking process are unaware of gender issues and their importance	Provide gender training for everyone involved in the policy process (policymakers, legislators, etc.)	Attitudes, understanding, and knowledge of gender issues	Pre- and post-training assessment of policymakers
FP	Gender-sensitive and Cairo-appropriate FP/RH policies at community and national levels are in place	FP/RH information provided to legislators and key policymakers does not include gender issues	Provide everyone in the policymaking process with high-quality information on gender issues that create obstacles to use of services	Information and material provided to participants in the policy process changed to include information on gender and RH	Text assessments of policy-targeted IEC materials

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FP	Gender-sensitive and Cairo-appropriate FP/RH policies at community and national levels are in place	Sociocultural barriers negatively influence attitudes of policymakers (e.g., denying sexual and RH rights of unmarried, adolescent, or widowed, individuals)	Provide legislators and key policymakers with high-quality information about FP/RH needs of these distinct groups; develop participatory activities with policymakers to examine gender and sexuality norms and their role in RH	Development and distribution of IEC materials; laws and policies; number of events or activities held; attitudes	Number of legislators or policymakers voting for a change in policy; community or national policy documents; pre- and post-activity assessments
FP	If gender-sensitive, Cairo-appropriate FP/RH policies exist, they are enforced	No coordination with women's groups, so the full range of gender issues is not included	Create network linking women's groups and government	Existence of network; number of meetings of network	Project reports; meeting minutes
FP	If gender-sensitive, Cairo-appropriate FP/RH policies exist, they are enforced	Providers do not support gender-sensitive policies (e.g., informed choice, couples counseling, and elimination of female genital cutting [FGC])	Conduct IEC campaign on benefits of policies; disseminate information that supports policies; conduct formative research on why policies are not enforced; create interventions designed for specific audiences; increase policy communication	Change in support for and compliance with policies	Pre- and post-intervention assessments of provider support for gender-sensitive policies and programs
FP	If gender-sensitive, Cairo-appropriate FP/RH policies exist, they are enforced	No allocation of government funds for FP/RH programs because health and gender issues are not a high priority for policymakers	Provide policymakers with case studies showing benefits of health and gender programs; train policymakers on same issues	Policymakers' attitudes toward funding FP/RH programs; funds allocated for FP/RH programs	Pre- and post-intervention survey of policymaker attitudes; assessment of expenditures on FP/RH programs
FP	Establish mechanisms to ensure policy participation of NGOs, community leaders, representatives of the private sector, and special interest groups	Sociocultural barriers to women's involvement in policy process because they are not perceived by policymakers to be capable of participating	Prepare case studies showing benefits of participatory policy processes in general and of including women in particular; train policymakers on benefits of women's involvement	Number of women or women's groups participating in the policy process; attitudes of policymakers toward women leaders and women's groups	Project reports; pre- and post-assessment of policymaker attitudes
FP	Establish mechanisms to ensure policy participation of NGOs, community leaders, representatives of the private sector, and special interest groups	Women's groups are not known or invited into policy process due to underfunding, lack of knowledge about process, size, disenfranchisement	Provide information on relevant women's groups to policymakers; build capacity for women's groups that should be included in the process	Number of women's groups involved in policy process; number of capacity-building training and events held	Counts of groups involved in policy process; counts of training and events held

PHN Sector	Objectives of activity	Gender-related obstacles to achieving objective	Activities that address the obstacles	Indicators to measure success of activities designed to reduce gender-related obstacles	Data sources
HIV/ AIDS/ STIs	Reduce incidence of HIV/AIDS and STIs	Women fail to understand normal and abnormal reproductive events or functions in their bodies; differential and/or incomplete knowledge and/or education about what are normal and abnormal RH-related body functions	Offer community IEC on reproductive functions, both normal RH events and occurrences and abnormal RH symptoms; train providers to better counsel women on RH topics; provide women- and girl-targeted instruction and education at clinics on RH issues	Community knowledge of RH and HIV/AIDS/ STIs; counseling skills of providers; number of RH educational courses and events	Pre- and post-intervention survey of community knowledge; clinic observation; survey of clinic services and educational programs
HIV/ AIDS/ STIs	Reduce incidence of HIV/AIDS and STIs	Women are not empowered to refuse sexual relations with their partner or to insist on condom use	Train providers in and implement couples counseling; model good couple communication (e.g., through community theater)	Providers' counseling content, style, and ability; individuals' attitudes	Pre- and post-training observations at clinics; attitudinal surveys (exit interviews) at clinics; qualitative interviews in the community
HIV/ AIDS/ STIs	Reduce incidence of HIV/AIDS and STIs	Women are unable to take advantage of available services because of differential access to resources and information and restricted mobility	Train and sensitize providers in HIV/ AIDS/STIs; share information with and counsel men and women; provide affordable male and female condoms; enlist women with STIs as peer counselors; integrate STI services into MCH/FP services and centers	Providers' attitudes; condom use, both male and female; existence of programs to bring women with STIs into the counseling system; number of facilities that offer both MCH/FP and STI services	Attitudinal survey of providers; assessment of counseling options in community; clinic surveys
HIV/ AIDS/ STIs	Reduce incidence of HIV/AIDS and STIs	Stigma against women with STIs on the part of providers and community	Train and sensitize providers and other clinic personnel in confidentiality issues and HIV/AIDS/STIs; provide information on where women can receive HIV/AIDS/ STI services and counseling; form support groups for women with STIs	Providers' attitudes; counseling content, style, and ability; information given out at clinics concerning STI services; number of support groups and networks	Pre- and post-training attitudinal surveys of providers; pre- and post-training observations and attitudinal surveys (exit interviews); survey of community regarding support groups and services available
HIV/ AIDS/ STIs	Reduce incidence of HIV/AIDS and STIs	Stigma against men who have sex with men (MSM) who seek services and/or those with STIs	Create special service delivery sites where MSM feel comfortable seeking services; train clinic staff and providers on and increase use of confidentiality measures	Providers' attitudes; counseling content, style, and ability; clinic use among target population	Pre- and post-training attitudinal surveys of providers; pre- and post-training clinic observation and attitudinal surveys of target clients (exit interviews)

PHN Sector	Objectives of activity	Gender-related obstacles to achieving objective	Activities that address the obstacles	Indicators to measure success of activities designed to reduce gender-related obstacles	Data sources
HIV/ AIDS/ STIs	Reduce incidence of HIV/AIDS and STIs	Stigma against female commercial sex workers	Train and sensitize providers and other clinic personnel in HIV/AIDS/STIs; train providers in RH needs specific to commercial sex workers	Providers' attitudes; counseling content, style, and ability	Pre- and post-training attitudinal surveys of providers; pre- and post-training clinic observation and attitudinal surveys (exit interviews)
HIV/ AIDS/ STIs	Reduce incidence of HIV/AIDS and STIs	Men are unable to take advantage of available services because service bias favors women	Train providers; change service locations and hours to be suited to male clients' needs	Location and hours of service delivery point (SDP); satisfaction of male clients with services, hours, and location	Clinic records; observations; client exit interviews
HIV/ AIDS/ STIs	Reduce incidence of HIV/AIDS and STIs	Men do not take responsibility for spreading STIs with their female partners	Provide behavior change communications (BCC) programs on STIs to help men understand their role in supporting women's health; provide specific counseling sessions for men with STIs	Number of BCC activities and materials developed, pretested, and disseminated; men's knowledge and attitudes about their sexual behavior related to women's RH; increase in condom use; increase in demand for STI counseling services	Project records; pre- and post-intervention survey; qualitative assessments; community survey on sexual practices; survey of clinic records

PHN Sector	Objectives of activity	Gender-related obstacles to achieving objective	Activities that address the obstacles	Indicators to measure success of activities designed to reduce gender-related obstacles	Data sources
PAC	Post-abortion care (PAC) policies are in place and implemented	Bias against PAC patients causes insufficient resource allocation toward PAC services	Communicate research, analysis, and policy briefs to policymakers about the need for PAC	Policymakers' attitudes toward funding PAC programs; funds allocated for PAC services and programs	Pre- and post-intervention surveys of policymakers' attitudes; budget
PAC	High-quality PAC widely available and utilized	Men and community are not aware of or sensitive to PAC complications	Provide outreach to partners (if the woman wants it) in PAC and counseling, including FP	Attitudes toward abortion and support for the woman; partners' participation	In-depth interviews; pre- and post-intervention surveys; clinic records
PAC	High-quality PAC widely available and utilized	Transportation and access to necessary PAC services not available due to differential allocation of household resources	Provide IEC in community on importance of services; create or expand community transportation cooperative; subsidize pricing schemes for services	Community awareness of when PAC is needed; number of transportation options; assessment of services being utilized	Pre- and post-intervention surveys; surveys of transportation possibilities in community; clinic records
PAC	High-quality PAC widely available and utilized	Bias against PAC patients leads providers to treat these women punitively	Establish protocols for high-quality PAC; train providers in protocol; create implementation plan for protocol in clinics; sensitize providers regarding PAC	Existence of PAC protocol and implementation plan; number of providers trained in protocol and sensitized to PAC issues	Program protocol and documents; attitudinal and knowledge-based surveys of providers
PAC	High-quality PAC widely available and utilized	Client fears of punitive treatment from legal system lead to delay in accessing services	Provide IEC in community on availability of services; sensitize providers regarding PAC; support dialogue between providers and community to discuss fears and changes in services; establish dialogue with religious and/or legal policymakers about differences between PAC and abortion	Number of patients reporting for PAC; community awareness of need to access PAC services	Pre- and post-intervention attitudinal surveys of community; clinic surveys

PHN Sector	Objectives of activity	Gender-related obstacles to achieving objective	Activities that address the obstacles	Indicators to measure success of activities designed to reduce gender-related obstacles	Data sources
SM	Broad-based support for safe motherhood policies	Community does not value pregnancy and/or maternity services	Provide community-wide IEC on importance of pregnancy (specifically of mother) and on essential obstetric care (EOC)	Community support for safe pregnancy and EOC	Pre- and post-intervention attitudinal surveys in community on importance of pregnancy and EOC
SM	Policy support for making high-quality obstetric care (OC) available	Policymakers and health structure do not invest enough in women's health services	Communicate research, analysis, and policy briefs to policymakers on the need for affordable service options	Policies and protocols	Text review of program protocols and documents
SM	Funding for high-quality OC available	Lack of policy support for funding for women's health services	Provide high-quality information on the need for OC and cost-effective interventions to legislators, key policymakers, and others in the budgetary process and health care system	Financial resources earmarked for OC services	Government budget
SM	High-quality OC widely available and used	Because it is culturally inappropriate to discuss sexual issues with men, women may not be able to communicate symptoms or problems with provider	Train to increase providers' communication skills with women	Providers' counseling content, style, and ability	Pre- and post-training surveys
SM	Knowledge of healthy pregnancy and childbirth shared by women and men	Differential access to information: women are excluded from modern media and men are excluded from traditional sphere	Provide community-based IEC on healthy pregnancy and delivery	Knowledge of healthy pregnancy	Pre- and post-intervention surveys; interviews
SM	High-quality emergency obstetric care (EMOC) widely available and used	Differential access to household resources for transportation during pregnancy-related emergencies	Provide IEC on need for proper medical care during pregnancy; collaborate with microcredit schemes to increase income for women; develop community transportation plans	Increased community awareness about medical needs during pregnancy; assessment of microcredit schemes, including percent change in funds used for EMOC; number of options for transportation	Pre- and post-tests of knowledge within the community; clinic records; surveys of transportation possibilities
SM	Knowledge of healthy pregnancy and childbirth shared by women and men	Cultural norms do not support reduced workload during pregnancy	Provide IEC on healthy pregnancy; create community work cooperative to swap more physically demanding tasks for less demanding ones during critical periods of pregnancy	Increased community knowledge of pregnancy risks associated with work; existence of work-swap cooperative	Pre- and post-surveys of pregnancy risk knowledge and actions; project records of cooperative

PHN Sector	Objectives of activity	Gender-related obstacles to achieving objective	Activities that address the obstacles	Indicators to measure success of activities designed to reduce gender-related obstacles	Data sources
SM	High-quality OC widely available and used	Health services focused on outcome of the child rather than on the health of the mother	Train to increase provider awareness of pre- and post-natal medical needs of mother	Assessment of delivery system to identify ways of improving the health of newly delivered mothers; changes in obstetric practices, based on assessment	Pre- and post-intervention assessments
SM	Knowledge of healthy pregnancy and childbirth shared by women and men	Cultural beliefs and practices about women's bodies contribute to adverse outcomes (e.g., FGC and certain beliefs about food and dietary restrictions)	Conduct participatory and ethnographic research on beliefs and practices; implement community-based communication campaigns to develop more health practices	Better understanding of pregnancy; improved practices	Qualitative research

PHN Sector	Objectives of activity	Gender-related obstacles to achieving objective	Activities that address the obstacles	Indicators to measure success of activities designed to reduce gender-related obstacles	Data sources
Nutrition	Improved knowledge of available nutrient-rich foods	Women's differential access to sources of nutrition knowledge (e.g., restricted mobility, resources, or time to travel to service site)	Address mobility norms and provide transportation; reorient and organize flow of clinic services to reduce time; build skills of clients, particularly women, to identify problems in service delivery and suggest options to resolve the same, management and service delivery (see below); build women's skills in taking increasing responsibility for food distribution or growth monitoring; identify acceptable compensation packages for women as they take on more responsibilities	Change in mobility norms; number of women attending; reduction in overall time clients spend at clinic; client perceptions of clinic efficiency; changes in types and extent of active client participation (e.g., in making management decisions, solving operational problems, mobilizing resources, or providing services); women's satisfaction with compensation	Log system (for women's roles in service centers); observations; client records; center records, including child's growth chart and frequency of attendance, and food distribution reports; interviews (one-on-one or in groups of clients and service providers)
Nutrition	Improved knowledge of available nutrient-rich foods	Men's differential access to sources of nutrition knowledge, because men are not traditionally assigned or assume responsibility for care and feeding of family members	Make educational sessions more men-friendly; raise awareness of men's contributions to ensuring family nutrition that may not be formally acknowledged (e.g., earning income and resource allocation); support community-based behavior change interventions on men's roles in food-related choice in the household	Number of men attending health and nutrition education sessions; men's and women's perceptions of men's roles; increase in time men spend caring for or feeding children (and a reduction in women's time)	Interviews (one-on-one or in groups of clients and service providers); group discussions; attendance records; time allocation reports; center and household observations

PHN Sector	Objectives of activity	Gender-related obstacles to achieving objective	Activities that address the obstacles	Indicators to measure success of activities designed to reduce gender-related obstacles	Data sources
Nutrition	Increased consumption of food, particularly nutrient-rich foods, by young children	Gender-related food taboos (e.g., girls cannot eat eggs); social norms that dictate the order in which family members eat; feeding choices that are affected by the social value parents place on girls or boys; caregivers (principally female relatives) have multiple tasks and little time to prepare foods for, care for, or feed young children (all time- and labor-intensive) in ways that are best for those children; children, especially girls, caring for children create opportunity costs for each child	Conduct formative research on feeding practices; provide IEC on children's nutritional needs (focus on norms); provide skill-building in feeding and other caring practices; provide greater economic and physical access to technologies that increase food availability and add nutrient value (e.g., nutrient-rich varieties) and reduce time and labor (e.g., solar dryers, oilseed presses); work with income-generating project staff to improve economic opportunities, reduce time and labor, and achieve nutritional objectives; provide day care or other communal services that free time for women and other caregivers, while meeting children's health, nutrition, and other development needs	Reduction in adherence to food taboos; better understanding of girls' and boys' nutritional needs; improvement in age-appropriate feeding practices and reduction in gender differentials in feeding practices; sex-disaggregated dietary intake (e.g., change in calorie consumption as a percent of minimal requirements by sex and age); percent of women's and percent of men's income spent on food; number and type of child-care providers (e.g., cooperatives and rotating household-based care (HH)	Interviews, particularly focus groups (re: taboos); HH observations (of feeding practices); dietary intake questionnaires (e.g., 24-hour food recalls)
Nutrition	Increased consumption of food, particularly nutrient-rich foods, by adolescents	Gender-related food taboos; social norms that dictate the order in which family members eat; access to high-quality food affected by social and economic roles (e.g., boys in fields or school all day do not have access to sufficient and/or high-quality food)	Conduct formative research on feeding practices; provide IEC on nutritional needs (focus on physiological differences between boys and girls); involve adolescents in community theater to model good intrafamily food distribution; provide school-based or workplace canteens; provide training programs for street vendors to improve nutritional quality of food and increase their production and income earnings (while maintaining affordability of their products)	Reduction in adherence to food taboos; better understanding of girls' and boys' nutritional needs; change in attitudes toward intrafamily food distribution; higher-quality food available; sex-disaggregated dietary intake; percent of food budget spent on boys versus girls	Dietary intake questionnaires (e.g., 24-hour food recalls)

PHN Sector	Objectives of activity	Gender-related obstacles to achieving objective	Activities that address the obstacles	Indicators to measure success of activities designed to reduce gender-related obstacles	Data sources
Nutrition	Increased consumption of food, particularly nutrient-rich foods, by adolescents	Gender-related food taboos; social norms that dictate the order in which family members eat; access to high-quality food affected by social and economic roles (e.g., boys in fields or school all day do not have access to sufficient and/or high-quality food)	Conduct formative research on feeding practices; provide IEC on nutritional needs (focus on physiological differences between boys and girls); involve adolescents in community theater to model good intrafamily food distribution; provide school-based or workplace canteens; provide training programs for street vendors to improve nutritional quality of food and increase their production and income earnings (while maintaining affordability of their products)	Reduction in adherence to food taboos; better understanding of girls' and boys' nutritional needs; change in attitudes toward intrafamily food distribution; higher-quality food available; sex-disaggregated dietary intake; percent of food budget spent on boys versus girls	Dietary intake questionnaires (e.g., 24-hour food recalls)
Nutrition	Increased consumption of food, particularly nutrient-rich foods by adults, especially women (including elderly)	Gender-related food taboos; social norms that dictate the order in which family members eat; access to high-quality food affected by social and economic roles (e.g., men in fields all day do not have access to sufficient and/or high-quality food)	Conduct formative research on feeding practices; provide IEC on nutritional needs (focus on physiological differences between men and women); use community theater to model good intrafamily food distribution; provide workplace canteens; provide training programs for street vendors to improve nutritional quality of food and increase their production and income earnings (while maintaining affordability of their products)	Reduction in adherence to food taboos; better understanding of women and men's nutritional needs; change in attitudes toward intrafamily food distribution; higher-quality food available; sex-disaggregated dietary intake; percent of food budget spent on women versus men	Dietary intake questionnaires (e.g., 24-hour food recalls)
Nutrition	Improved access to vitamin A and iron supplements	Women cannot get to distribution points; differential access to financial resources; lack of awareness by care providers (including health professionals and parents) that boys need iron supplements; boys will not go to maternal and child health (MCH) clinics	Reorient services to meet client needs; collaborate with income-generation programs to stress nutritional needs; provide IEC on boys' nutritional needs; promote community-based behavior change interventions on men's knowledge of women's need for supplements	Client perceptions of clinic services; increase in money spent on supplements; increased knowledge and use of supplements by boys; more HH resources available for supplementation	

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