



# THE GENDER INTEGRATION CONTINUUM

USER'S GUIDE  
SCENARIOS BANK



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# User's Guide Scenarios Bank

## AGRICULTURE

### *Agriculture Scenario #1*

An agribusiness project in a rural area focused initially on providing loans to farmers to finance land reclamation. Working with the local government units (LGU), the USAID contractor advertised the launch of the land reclamation phase via posters in front of the LGU building and announcements after Friday worship in the mosques. To qualify for a low-interest bank loan under the project, a farmer must:

- Have a title showing land ownership.
- Meet the bank's general conditions for obtaining a loan.
- Enroll in a two-week evening training workshop in a local council building from 5:00 p.m. to 7:00 p.m.

After the deadline passed, the project director noted only 5 percent of loan applicants were women. To increase women's participation in the project, the director issued an extension for women's loan applications. He also waived the first two conditions (land title and general conditions) for female applicants, if a male relative could show land title of ownership in his name and would co-sign the loan for the woman. Finally, the project held a meeting with the local women's organization to announce the project, the new conditions for women, and the addition of free child care during the evening training workshop. The project director was surprised that after all he had done to increase women's participation; only 10 percent of the final applications were from women. A midterm evaluation noted that women felt the project was "a man's project"—and they did not want to take a loan that required a male co-signer because that gave him too much control over the enterprise.

### *Agriculture Scenario #2*

A project to promote the adoption of horticulture crops by small, essentially subsistence farm households, and the formation of a marketing cooperative created a substantial increase in average household income. The male heads of household are the "farmers" and the principal participants in the cooperative. At the same time, their wives and children are increasingly involved ("unpaid family labor") in planting, weeding, and harvesting of the labor-intensive vegetable production. New sources of employment also have opened up for young women in vegetable packing and processing.

While family income and well-being have improved, schooling among adolescent girls has decreased. Girls leave school both for employment and because adolescent girls are required to care for younger siblings while their mothers work in the household plots. After a midterm evaluation noted these unexpected consequences, the project team worked with the local community to help launch a daycare program at the school so that adolescent girls could attend school and still be responsible for their siblings.

## EDUCATION

### *Education Scenario #1*

This project in Mongolia was intended to both develop distance education and to assist mainly Gobi women in getting information to help them survive socioeconomic shocks, while changing attitudes and developing skills for self-reliance and income generation. During the transition to a market-based economy, state-run enterprises folded, and women suffered from higher levels of unemployment than did men. Reductions in social services (daycare, schools, and health programs) changed the sex-based labor patterns. Women, with fewer options for wage labor, were increasingly responsible for heavier workloads and more household production—from making their own clothes to finding inputs for livestock care. Access to information was limited by paper shortages restricting newspaper production and the increasing scarcity of functioning radios. Rural women—particularly single, female heads of households—were identified as the most vulnerable group in Mongolian society.

Donors provided resources to rejuvenate the newspapers and supply radios. A needs analysis identified interest in obtaining more information on livestock rearing, processing of animal products, family health care, literacy training, using available raw materials to earn money, and business development skills. Provincial and district committees were formed and included many stakeholders including local officials, women's groups, and school teachers to coordinate implementation. Print and radio-based educational materials were developed and supplies (radios and batteries, pens and paper) were distributed by local volunteer tutors to women learners selected by local committees to participate. The volunteer tutors traveled to herding communities, reaching a total of 15,000 women in 62 districts. Weekly radio programs were broadcast both from the capital and from local stations, with the latter including locally relevant information. Information centers were set up in provincial and district centers with copies of the materials.

The project overcame many of constraints to open information and distance learning, establishing a decentralized model in a previously highly centralized system. Women and their families learned new skills and learning groups were created, with many anecdotal accounts of increased confidence among women.

### *Education Scenario #2*

Community awareness campaigns encouraged parents in rural villages to enroll their daughters in school. A mass media campaign helped bring national awareness of the issue, and the program included a gender sensitivity training for ministry officials. As a result of these efforts, girls' participation rates soared, reducing the gender gap between girls' and boys' enrollment from 10 percent to six percent. In the classrooms, the increased numbers of students created a severe shortage of chairs, most of which were occupied by boys, leaving girls to sit on the floor. Girls rarely answered questions in class since this would require them to stand, thereby enabling boys sitting on the floor to look up their skirts, which made the girls very uncomfortable. Teachers praised the girls' behaviors by calling them "neat," "quiet," and "dainty," while boys were praised for being "curious" and "strong."

### *Education Scenario #3*

Given the shortage of qualified teachers in secondary schools, the ministry instituted a program to recruit recent female graduates as teachers. The program aimed to provide educated female role models for students to increase the demand for secondary school among young girls. To attract qualified applicants, the program offered special supply kits and other monetary incentives. Gender sensitivity training was offered to incoming and current teachers. Customary protocols at individual schools resulted in the assignment of these new female teachers to the largest and lowest status classes (for example, primary level), and the new teachers found they had few opportunities to attend workshops or trainings. While many of the older, male teachers had attended the gender sensitivity training, the daily inequalities and treatment faced by women in the schools were not addressed or discussed.

### *Education Scenario #4*

Recognizing that educational achievement is affected by poor health and malnutrition, the government instituted an innovative program of cash transfers. Cash transfers were provided to poor rural households on the condition that their children attend school and their family visits local health centers regularly. All financial transfers were channeled to mothers, as they were more likely to spend the extra income on basic household goods than were fathers. By the end of the program's second year, children from participating households received on average 0.64 more years of schooling than other children, secondary school enrollment rates increased as much as 14 percent for girls and 8 percent for boys, and the probability that husbands made decisions alone about the health and education of their families decreased significantly.

### *Education Scenario #5*

An education project was designed to decrease children's risk of HIV infection. A baseline assessment was conducted to identify teacher and student knowledge and attitudes regarding gender dynamics, gender violence, and HIV/AIDS. A student prevention program was designed in which groups of boys and girls discussed issues related to gender roles, human rights, relationships, reproductive health, and interpersonal communication skills. Through participatory activities, girls and boys explored gender roles, role-played positive behaviors, and learned how to make informed reproductive health decisions that respect the rights of others and themselves. The post-project survey found that the percentage of students who thought school was equally important for girls and boys rose from 38 percent to 60 percent. Teachers' awareness of the sexual harassment of girls increased from 30 percent to 80 percent. Students' belief that they had the right not to be hurt or mistreated increased from 57 percent to 70 percent.

## ENVIRONMENT

### *Environment Scenario #1*

Forest resources are a key component in rural Nepal family livelihoods. Fuel wood, fodder, leaf litter, and timber, as well as edible products make important contributions to the household economy. The Nepalese government initiated a community forest program in 1978 and expanded community forestry development under new legislation in 1995 with users' committees given authority to manage the forest resources by establishing rules and penalizing offenders. Both men and women are eligible to serve on the user committees, but women tend to be underrepresented or wholly absent, in part a reflection of more general gender patterns of women's exclusion from most public settings.

A development program in a mountainous community in rural Nepal was designed to address deforestation. In this community, men are responsible for the family's income, while women contribute to productive and reproductive needs within the home. In this area, forests have been cut down rapidly and sold by men for economic gain, resulting in severe soil erosion and diminished sources of firewood. As a result, women have been forced to spend more time searching for firewood, and the community's overall economic well-being suffered. The intervention focused on reforestation efforts and alternative means of income generation. The program trained community women to produce and sell handicrafts.

While this program was successful in reducing deforestation, and women were successful in bringing new sources of cash to the home, program staff noticed a significant increase in domestic violence.

## FAMILY PLANNING/REPRODUCTIVE HEALTH/HIV/GENDER-BASED VIOLENCE (FP/RH/HIV/GBV)

### *FP/RH/HIV/GBV Scenario #1*

Staff in an HIV clinic in Chile carried out a situation assessment to better understand the reproductive health priorities of HIV-positive women at their clinic. One of the primary issues HIV-positive women expressed was their desire to control their fertility so that they could choose whether and when they wanted to become pregnant. However, women reported that a major barrier continues to be the ability to use either condoms or other forms of birth control that might be discovered by their partners, as many of their partners are opposed to either. Male partners may even take the suggestion of using such methods as a sign of infidelity and grounds to beat a woman, they said. Based on the information they collected, clinic staff decided to offer only Depo-Provera shots (longer-acting injectables) to all women, and de-emphasize (and reduce their supplies of) any other types of sexually transmitted infection or pregnancy prevention methods.

### *FP/RH/HIV/GBV Scenario #2*

In rural Egypt, women tend to follow strict cultural rules related to modesty and seclusion that substantially restrict their physical mobility outside the home. This, coupled with limited control over resources and decisionmaking, has affected women's ability to access family planning services. To address these challenges, the local health district has trained female

community health workers to bring reproductive health services to women's door steps. Women are visited by health workers who provide counseling, information, and access to certain methods of contraception.

### *FP/RH/HIV/GBV Scenario #3*

A community-based intervention in South Africa combined a microfinance program with a gender and HIV curriculum. Its goals were to reduce HIV vulnerability and gender-based violence (GBV), promote women's empowerment, improve family well-being, and raise awareness about HIV. In the project, groups of five women guaranteed each other's loans, meeting every two weeks to discuss business plans, repay loans, and apply for additional credit. In addition, the groups took part in a participatory learning and action program with sessions on relationships, communication, cultural beliefs, GBV, HIV prevention, critical thinking, and leadership. The microfinance groups elected leaders to participate in additional training on community mobilization. These leaders went on to organize dozens of community events to raise awareness on GBV and HIV.

### *FP/RH/HIV/GBV Scenario #4*

In Country Q and elsewhere, family planning clinics will offer female clients a choice of "hidden" contraceptive methods, such as Depo-Provera shots, Norplant, or an IUD, if the woman expresses fears that her husband does not support her use of contraception even though she expresses her desire to limit or space births. Some women may fear violence if their partner finds oral contraceptive pills in the house, or if they suggest use of a condom. Clinicians will assure women that the IUD or Norplant is basically invisible, and that her partner is very unlikely to realize that she is receiving Depo-Provera shots at well-baby clinic visits.

### *FP/RH/HIV/GBV Scenario #5*

During regular business hours, public sector family planning clinics in an urban Uganda are often busy, with many clients congregating and waiting to be seen by providers. To take advantage of this captive audience, the clinic developed short videos that run on a continuous loop, providing details about available contraceptive methods. The information shared includes basic details on how the methods are administered, health advantages, and possible side effects.

## **HEALTH POLICY**

### *Health Policy Scenario #1*

After decentralizing its social sector programs, observers in Country Q noted that municipal strategic planning processes were proceeding with no participation from women. In response, a USAID project decided to conduct gender workshops for women and men before the start of the planning process in target municipalities, to create a public space for women's voices and to challenge norms about women's participation in public policy. The intervention in each municipality started with workshops for women only, to build their confidence, help them practice speaking in public about issues of concern to the community, and explore their concerns about gender and power in their relationships at the household and community

levels. These workshops were followed by gender workshops for both women and men together, in which they mutually explored gender relations and norms, and how these were affecting the full participation of women and men in political processes and social and economic development. Several women participants reported that, although their husbands beat them badly when they returned from the first gender workshop, the women returned for the second workshop anyway because the sessions were changing their views of the worth of women and what they could do in their lives.

### *Health Policy Scenario #2*

To reduce winter flooding and improve the sewage system, with anticipated health benefits for the population, an international donor paid for construction of a modern highway to replace the overcrowded, old main road into a densely populated city. Although the new highway had to cut through neighborhoods, schools, markets, and parks, it greatly improved the flow of car and truck traffic into and out of the city and was praised by local authorities. One year after its completion, a social assessment identified that the transmission of water-borne illnesses had declined due to improved water and sewage functions, but the project had unanticipated impacts:

- Thirteen children were killed on the highway trying to cross to the other side.
- Families caring for their elders who live on the other side were having more difficulty.
- Women who used to sell their products in the market on the other side were having difficulties getting to the market and have seen their incomes decline.
- The local women's organization, on one side of the highway, reported a dramatic decline in attendance at their educational events by women located on the other side.

The donor agency responded with a follow-on project. It started with a participatory community assessment and worked with the women's organization, local women leaders, and local authorities to identify a solution. The project built a wide footbridge over the highway. It also established a rotating loan fund for small, social development initiatives, to be managed by a local social development committee. The loan trust requires a minimum of 60 percent of the committee's voting members be women.

### *Health Policy Scenario #3*

A local council and an NGO teamed up to build a public library in a mid-size, highly dispersed town with a third of the population living in nearby neighborhoods not easily accessible by local transport. From the outset, the library was established to work with young people—both males and females—as part of the community's efforts to improve secondary education. After great deliberations and efforts, a local philanthropist living abroad agreed to donate land at the lively center of town, facing the local cafes and billiard halls that attract young and middle-aged men. A stipulation of the donation was that the philanthropist's male cousin who is an expert librarian would manage the library. The library charged a small, annual membership fee, limited the number of borrowed books to three at a time, and required that the books be returned or renewed after one week. After young women visiting the library complained about being harassed by the men smoking and playing billiards across the street,



the librarian opened a new, rear entrance for women, and designated a section of the library for women's use only.

#### *Health Policy Scenario #4*

An NGO in rural Bangladesh is formally committed to responding to gender inequalities in its programs and policies. Its anti-poverty programs offer credit and income-generating skills and inputs, with 70 percent of members and 85 percent of borrowers being women. The organization also strives to employ women and to pursue progressive and countercultural social goals through women's workforce participation. It instituted the following policies to enhance the retention of female staff and their effectiveness as development workers:

- Adapting the organizational culture to formal and informal behavioral norms that support the participation of women (for example, that women ride bicycles and motorcycles, wear nontraditional clothing, and live and work with male colleagues in rural offices away from immediate families).
- Increasing women's presence in the organization and their participation in decisionmaking (recruiting more women, adopting "fast-track" promotion policies for women, providing special training in management skills).
- Facilitating their physical adjustment to the demands of the workplace and their role within it (addressing issues of mobility and safety, organizing essential health care and maternity leave, allowing 2 days per month "desk leave" for menstruation).

Despite these efforts, female development agents still experience some problems: high degrees of mobility for young women and accommodations away from the family with non-kin men raised questions about their personal integrity, potentially subjecting female workers to hostility and fear for their safety. All staff are required to sign a "movement register" when they leave the office, a security measure considered important in an environment where some female development workers are targeted for abuse and attack. This measure is resented by female staff who claim that their movements are more strictly controlled than those of their male colleagues. When the NGO arranged for female staff to supervise closely clustered villages to minimize travel distances, the new policy created resentment on the part of some male staff.

Women's reluctance to ride bicycles is thought to account for high dropout rates; and riding motorcycles is seen to provide protection for women staff since the speed and noise shield them from verbal and other attacks. Despite these difficulties, some village women have expressed admiration for female field workers and see motorcycle riding as a way of improving women's status. Many female workers reported feeling pride and accomplishment in their freedom of movement and skill.

#### *Health Policy Scenario #5*

Country Q's parental leave policies prohibit the employment of women for a minimum of 16 weeks before and after childbirth, and provide a state-subsidized income substitute. Legislation enables mothers and fathers alike to take a job-protected, paid leave of absence for up to two years to care for each child. Benefits consist of one flat rate for single mothers

or married mothers whose husband has little or no income. Fathers have the right to paid paternal leave as long as the mother does not take it and remains employed.

Since these laws passed, nearly all women (95 percent to 98 percent) who are entitled to parental leave benefits take them and most draw benefits for the entire period. However, only 1 of those taking parental leave are fathers. For men, parental leave tends to constitute a transitory phase in their formal careers, frequently connected with a change of jobs. For women, parental leave usually marks the beginning of a longer period of absence from the labor market for child care.

#### *Health Policy Scenario #6*

A study found that a requirement for overseas training for medical career progression created an obstacle for female doctors who were not able to leave husbands and family at that period in their lives. In the survey, female doctors described an assumption in the upper ranks of the medical establishment that women did not want, or were not able, to advance their careers because of family responsibilities, which resulted in pervasive discrimination against women in promotions and scholarship awards for overseas study. The study found that nearly half of the graduates were not taking postgraduate training, mainly because of the pressures of family responsibilities. These graduates also believed they were discriminated against through common stereotypes of female doctors as “inefficient” and lacking motivation because they were more likely to work part time or to take career breaks. The study also identified that adequate housing and security were the primary concerns for women doctors moving to rural areas, not salary incentives. Ultimately, female graduates had a high “rate of exit” from medicine.

#### *Health Policy Scenario #7*

Seclusion of girls and women is considered a sign of female respectability; respectability also requires that women travel in the company of a male family member. At the same time, women serve as community-level paramedical staff, in recognition of their frequently greater acceptability to local clients and their ties to the community. Anecdotal evidence suggests that the cultural expectation of female respectability constrains the full range of community outreach activities and supervisory performance expected from trained community midwives. For example, female supervisors are required to return home before nightfall. Recently, the government enacted very directive measures to address the problems of getting health staff to work in rural areas. In the face of cultural difficulties in recruiting women, they established a system of compulsory health service for women.

#### *Health Policy Scenario #8*

In Country Q, community-based NGOs sought to gain inheritance and property rights for women. To do so, these groups carried out an analysis to identify which processes—at the level of cultural norms, implementation and decisionmaking structures, and written laws—presented barriers to women accessing their rights, and developed an advocacy strategy based on this analysis. In particular, the analysis identified key barriers such as cultural norms that “women who love don’t talk about money and property” and structural barriers where local land boards were physically distant to women and also institutionally unfriendly (very male dominated). The advocacy strategy thus decided to focus on lobbying traditional

decisionmaking structures led by traditional male authorities, such as councils of elders, to increase their awareness and support for women's property rights, and have them in turn issue decrees to support women's rights as well as to raise the issue of women's inheritance and property rights with local land boards. In the first six months after the advocacy was initiated, 20 women were able to reclaim their property.

#### *Health Policy #9*

A project in Region Q sought to strengthen the organizational capacity of networks for people living with HIV (PLHIV). To help foster organizational development, the project supported the construction of a detailed, user-friendly manual with concrete step-by-step guidance on how to carry out a self-assessment of organizational strengths and weaknesses, and resource materials and activities to strengthen any areas identified as challenges. PLHIV regional network members led development of its manual, and serve as a technical assistance resource to country level organizations as they seek to strengthen networks of PLHIV.

#### *Health Policy #10*

Health Workers for Change addresses gender biases in health workers' personal, organization, and professional lives through reflective- and action-oriented training using participatory methods developed under the leadership of the Women's Health Project in Country Q. These courses address gender relations as well as race, class, and other axes of discrimination. Health workers go through a process of value clarification and self-reflection about how their organization and work mirrors their society more broadly. They are encouraged to put themselves in the shoes of others and, thus, develop empathy for the role of other actors in the health systems. Actions devised through the training arise from analyzing health workers' own context and experience base. Within their organizations, health workers that participated in the program were able to make changes within their direct power and influence, but were not able to make wide-ranging institutional changes that were much more difficult to implement.

#### *Health Policy Scenario # 11*

In Country Q, a community health worker program relied exclusively on female staff members in ways that reinforced the beliefs that only women can provide maternal health advice. The program also failed to challenge prevailing beliefs that excused men from taking responsibility for child care, failed to sanction forms of male sexuality that increased STI risk among their wives, and failed to question norms around domestic violence that inhibited women from talking to male health workers in their homes.

#### *Health Policy Scenario # 12*

A program in Country Q provided support to community-based female health workers. They were allowed to assume broader roles than the simple health care tasks they were originally charged with and thus became trusted confidants and respected advocates for their fellow community members. Their work was explicitly and frequently recognized by professional health care workers and strengthened by the formation of their own peer support group. Functioning referral systems supported them. They were acknowledged by

their communities of origin. Managers were sympathetic to their concerns and responded by listening and providing infrastructural support when possible. Lastly, these workers received continuous training and regular supervision. The strategic support the female community-based workers received greatly sustained their work and permitted the flexibility to adapt their work to suit community needs.

### *Health Policy Scenario # 13*

In Country Q, female community-based volunteers were very successful in making contraceptive methods widely available throughout the country. While their work was highly regarded by village leaders as well as the general population, it was perceived as an extension of their roles as caregivers. Women's work as FP volunteers did not significantly increase their decisionmaking roles within their households or access to education or paid work.

### *Health Policy Scenario # 14*

In Country Q, a new strategy sought to reform traditional gender norms that constrained health workers' efforts in service delivery and assuming tasks for which they were trained, but prevented from performing by doctors. The strategy entailed subtly redefining the meaning of purdah (seclusion) for female staff and the communities in which they worked. Purdah was reinterpreted as:

"an emphasis on the external and physical criteria of seclusion to an internalized, moral code of conduct. Observance of inner purdah does not require physical seclusion; rather it manifests itself through politeness in interpersonal behavior, religious orthodoxy, modesty in dress and language, and, above all, through strictly professional behavior and attitudes toward men. As long as this moral code of conduct is followed, the health workers argued, purdah was not broken."

After gaining the initial approval of village elites, female health workers were able to expand their duties to providing medicines and injections. Gradually, they became known as "little doctors" linked to "big doctors" through effective referral systems. When male senior staff visited them for supervision in the field, they treated their female colleagues with respect rather than reprimanding them in public. Overtime, female health workers assumed increasingly influential and respected roles in the villages where they worked, often giving advice to villagers regarding important decisions or resolving local disputes.

## **KEY POPULATIONS**

### *Key Populations Scenario #1*

Project managers in Country Q have seen an uptick in arrests of men who have sex with men (MSM) in public spaces. In response, they prepare personal safety workshops for MSM. In the workshops, the facilitators tell the MSM participants, "If you're worried about your safety, try being less 'obvious,'" and they ask participants to come up with strategies to look and act more masculine.

### *Key Populations Scenario #2*

A project in Country Q develops support groups for transgender people to talk about the violence they face. Through partners, the project offers gender-affirming services (such as hormone therapy) as well as HIV prevention, care, and treatment. It also provides referrals and accompaniment to legal assistance for individuals who have been discriminated against or who have experienced violence.

### *Key Populations Scenario #3*

A program that provides HIV services to female sex workers in drop-in centers recently launched an outreach campaign with the message that “sex workers take care of themselves because they are the backbone of their families and communities.” The drop-in center provides space for the children of sex workers, and the first question on the new client form is, “What services do your children need?”

### *Key Populations Scenario #4*

A program to support people who inject drugs (PWID) offers clean needles, HIV testing, and condoms to PWID. Its outreach workers are all men, as a situation analysis showed that 95 percent of PWID are men. Outreach workers wear shirts with an image of two men running across a finish line and a message that says, “You are a valuable member of society.”

### *Key Populations Scenario #5*

Men who have sex with men (MSM) face such severe stigma and discrimination in health settings that they find it difficult to access sexual health services, including sexually transmitted infection (STI) and HIV counseling, testing, and treatment. An organization working on HIV prevention and mitigation established a pilot program to work with MSM. The group focused on *kothis*—biological males who adopt feminine behaviors and attributes, including normatively feminine sexual roles. The project established a place where they could meet and support one another, providing information on health care and other resources, training local health care providers on how to provide services to *kothis* in a sensitive manner, and organizing medical visits at the meeting space itself. In focusing on *kothis*, staff decided not to work with penetrators whose numbers are much larger and who do not publicly acknowledge having sex with men. They also made the decision to focus only on sex workers and on sexual activity occurring in public spaces.

## **MALE HEALTH**

### *Male Health Scenario #1*

To increase contraceptive use and male involvement, a family planning project initiated a communication campaign promoting the importance of men’s participation in family planning decisionmaking. Messages relied on sports images and metaphors, such as “Play the game right, once you are in control, it’s easy to be a winner” and “It is your choice.” The campaign increased the use of contraceptive methods. When evaluating impact, the project asked male respondents who should ideally be responsible for making family planning decisions—they, their partners, or both members of the couple. The evaluation found that: “Whereas men

were far more likely to believe that they should take an active role in family planning matters after the campaign, they did not necessarily accept the concepts of joint decisionmaking. Men apparently misinterpreted the campaign messages to mean that family planning decisions should be made by men alone."

### *Male Health Scenario #2*

A reproductive health project in an indigenous community wants to encourage men to become involved in family planning and be more supportive of their wife's or partner's choices. Gender based violence is an issue in this community, and women sometimes fear that their use of contraception will result in their partner becoming violent towards them. Project planners are also concerned about increasing rates of sexually transmitted infections (STI) in the area, as the men have been migrating to a nearby mining town for work, returning with infections, and spreading these to their partners in the village.

The project introduces a pilot effort to address these issues. They decide to offer an STI clinic one day each week for men in the local women's clinic. Some of the project designers think that by bringing men into the women's clinic for services, men will become more comfortable in the clinic, start to feel a sense of belonging there, and so be more likely to accompany their partners to the clinic for services, where they can be brought into discussions on family planning, safe motherhood, domestic violence, and other related issues.

### *Male Health Scenario #3*

A participatory, group intervention was piloted in Mumbai with young men ages 16 to 24. Data indicate that almost half of new HIV infections in India occur in young men under age of 30. Other data suggest most boys are socialized into a sense of masculinity characterized by male dominance in sexual and other relationships—and that these norms may promote poor sexual health and risk-taking for young men and their partners. Adapting an intervention (Program H) from Brazil, a behavior change intervention sought to stimulate critical thinking about gender norms. Exposure to the program resulted in a decline in reported violence against any sexual partner and increased condom use. A social marketing campaign is also underway, with the tag line "Real men have the right attitude."

## **MATERNAL, NEWBORN, AND CHILD HEALTH (MNCH)**

### *MNCH Scenario #1*

To decrease markedly high rates of maternal mortality in Country Q, a US-based organization initiated a project to reduce disease and death associated with postpartum hemorrhage, particularly among young mothers. The project included community-level interventions to raise awareness among traditional birth attendants, young women, and mothers-in-law about the markers for postpartum hemorrhaging that should trigger an emergency response. During the project's midterm evaluation, community members reported that recognizing the warning signs of distress was not enough to prompt action for mothers who delivered at home. The decision to seek medical care for a new mother in distress was influenced by many factors, including the availability of household resources, the power distribution in the household, and the relative status of the new mother in the household vis-à-vis her in-laws.

The organization subsequently amended the project to establish a community fund to cover the costs of emergency transportation for women experiencing postpartum hemorrhage and other forms of distress.

### *MNCH Scenario #2*

In Country Q, a donor project works to strengthen and create more efficient systems, structures, and interventions to reduce maternal mortality in three rural communities. Project interventions focus on the four major causes of maternal mortality and address conditions that lead women to delay seeking life-saving treatment for emergency obstetric complications. The project trains facility- and community-based health workers, including traditional birth attendants, in improved maternal health care practices. One of the interventions includes sensitizing male traditional village leaders in this Muslim region, in recognition of their influence over community norms and behaviors. The leaders are encouraged to promote quick action from household members and neighbors when someone suspects that a laboring woman is having emergency obstetric complications, emphasizing that the baby's life may be at stake.

### *MNCH Scenario #3*

A child survival project in Country Q, aiming to reduce disease and death rates among children and women of reproductive age, focused on using indigenous knowledge and cultural resources to increase and improve communication and health-seeking behavior during pregnancy. Research showed that one of the most important obstacles to women's maternal health care-seeking behaviors was the absence of discussion about pregnancy between husbands and wives, as well as with other household members. The women in this area felt that they could not take advantage of maternal services because they could not initiate conversations with their husbands nor solicit their consent and financial support, as the heads of household. The project staff asked a griot to compose a song that educated people about maternal health care, along with promoting the *pendelu*—a traditional article of women's clothing—as a symbol of pregnancy and couple communication. This campaign dramatically increased the level of communication between wives and husbands concerning maternal health. Additionally, the campaign resulted in more positive attitudes and behaviors related to pregnancy at a household level, including husbands supporting their wives by reducing their workloads, improving their nutrition, and urging them to seek medical attention and maternal health services.

### *MNCH Scenario #4*

A group of HIV-positive mothers of small children organized to become advocates for prevention of mother-to-child transmission of HIV (PMTCT) and for HIV-positive mothers. The group encourages women to attend prenatal clinics, where they can access PMTCT services if they are positive. The group also educates positive mothers in their communities in life skills, PMTCT, infant care, and human rights. They use song, dance, and drama, as well as appearances on television and radio where they share their experiences as positive mothers and call for a reduction in stigma and discrimination. The peer educators also increase women's access to income by training positive mothers in personal financial management and income generation by tailoring, farming, and selling handicrafts. Finally, the group partners with HIV-positive men's networks to encourage men to value fatherhood and to become involved in PMTCT.

### *MNCH Scenario #5*

The Government of India began integrating HIV into the National Rural Health Mission in April 2008. They issued a circular to district Reproductive and Child Health (RCH) officers asking whether they were willing to work on HIV and to report cases of HIV-positive women who came for antenatal care (ANC). One intervention developed subsequently is working to improve quality of antenatal care for HIV-positive women by addressing gender and quality of care issues. For example, special spousal counseling exists for women in ANC who test positive for HIV. The husband is encouraged to come in for a variety of tests, and the program reports his HIV status to him first. They also put HIV-positive women in contact with a lawyers' network and NGOs in the area working with people living with HIV. The program also introduces the woman and the healthcare worker to the specific obstetrician who will attend her labor and birth. This doctor gives the woman her fourth and extra ANC checkup in the third trimester and registers her name on the books to receive Nevirapine prophylaxis when she goes into labor to prevent mother to child transmission.

### *MNCH Scenario #6*

A multi-pronged program to improve maternal and child health in several Delhi slums works on diarrheal case management, increasing institutional births, and increasing immunization, among other things. They conduct community outreach through the formation of women's groups focused on health, and have also provided some limited access to credit. While women of reproductive age and children are the target of the program, it also reaches out to men as decisionmakers. The program runs local TV ads for services, encouraging men to support their partners in taking children for prevention and treatment, using messages directed at men and women. The program reaches out to religious leaders and men at mosques on the need to take their wives for services.

## **MICROENTERPRISE**

### *Microenterprise Scenario #1*

A USAID project to increase competitiveness of small and medium enterprises supported a small, women-owned, traditional handicrafts company in a provincial town. The products, sold in stores in the capital city and in tourist areas, were based on the traditional embroidery done by the women in the region. The company bought the embroidered pieces from the women in the community, who did the embroidery in their homes. The USAID project assisted the company in design, quality control, business management, and marketing channels. The company developed more formal relationships with the women embroiderers, requesting particular designs, sizes, quality, and paid them accordingly. Both the company and the embroiderers were earning more income, as product sales increased in response to the improved quality of the products.

At the same time, community leaders in the town noted an increase in the percentage of men in the community who left, for months at a time, to seek construction jobs or other work in neighboring countries. This trend meant more women were de facto heads of household for at least part of the year. Interestingly, some men in the community, who stayed behind, started to learn embroidery and work alongside their wives or partners.



## WATER, SANITATION, AND HEALTH (WASH)

### *WASH Scenario #1*

Government data showed high incidence rates of diarrhea and other intestinal infections among school-aged children in several rural provinces in their country. In response to this public health problem, and in an effort to increase the number of days children spent in the classroom (and decrease the number they spent at home being sick), several communities were selected for a behavior change campaign. The campaign aimed to raise awareness of hand washing as a highly effective means of reducing such illnesses and introduced a simple protocol for hand-washing by all household members. The campaign targeted women with messages encouraging them to be “good mothers” and “take proper care of their families” by strictly enforcing the hand-washing protocol for everyone in their homes. Some messages implied that if a child is sick, it means the mother was not “doing her job well.” Follow-up studies showed the messages were effective, with a high rate of adoption of the new hand-washing protocol and a subsequent reduction in intestinal diseases among school-aged children.

### *WASH Scenario #2*

The Central American Hand Washing Institute aimed to reduce disease and death among children under age five through a communication campaign promoting proper hand washing with soap to prevent diarrheal disease. Four soap companies launched hand-washing promotion campaigns that included radio and television advertisements; posters and fliers; school, municipal, and health center programs; distribution of soap samples; promotional events; and print advertisements. The basic approach was to present a mother as the caretaker of the family and to describe or illustrate the three critical times for hand washing: before cooking or preparing food; before feeding a child or eating; and after defecation, cleaning a baby, or changing a diaper. They also emphasized essential aspects of hand-washing technique: use water and soap, rub one’s hands together at least three times, and dry them hygienically.

### *WASH Scenario #3*

A WASH program in a rural area of country Z increased the number of water sources in a community, and decreased the average distance and amount of time that community members had to travel to the water source. A final project evaluation found, as expected, that women were the main beneficiaries of these changes. Given that obtaining household water was a women’s role, women experienced the greatest reductions in time burden. The final evaluation also found a surprising result: Women in several focus group discussions reported that the increased access to water sources had decreased household conflict, including violent conflict and beatings from their husbands. The women explained that previously the longer distances they traveled to water sources would sometimes require them to be out after dark; in these cases, their husbands would often accuse women of infidelity, and at times beat them. Now that women spend less time away from home and are returning before dark, they do not face the same conflict and accusations from their husbands.

## YOUTH RELATED

### *Youth Scenario #1:*

A project for youth at risk of participating in gangs created an activity and training center to provide attractive alternatives to life in the streets for adolescents. The center was open to both young men and women, although the primary focus was intended to be young men who were presumed to be the greatest threat to the community. To the distress of the operator, young women were the center's principal clientele. The young women, who were not attending school because they had become pregnant, often arrived with their babies and toddlers. The center offered them an alternative to the isolation of their homes, a chance to let the children play with others, and stimulating classes and access to computers. The center director noted that the presence of young children deterred young men from going to the center. In response, the director established a schedule of times when children were allowed to come to the center with either their mother or father (or both) and other times when no children were allowed. Classes were offered during the "no children" hours, under the assumption that without children present more young men would show up and there would be fewer distractions for class participants (both women and men). Class offerings included sessions on job skills training, parenting, healthy gender relations, and conflict management.

### *Youth Scenario #2*

A project sought to involve young people in the care and support of people living with HIV (PLWH). This project carried out formative research to assess young people's interest and to explore the gender dimensions of care. The assessment explored what care-giving tasks male and female youth feel more comfortable and able to provide, as well as what tasks PLWH themselves would prefer a male or female youth provide. Based on this research, the project adopted an approach that incorporates preferred tasks for young women and young men.

### *Youth Scenario #3*

Health project staff were concerned about rising STI and pregnancy rates among youth. Unable to convince the predominantly Roman Catholic public school system to incorporate a reproductive health and HIV curriculum in the high schools, the program staff decided to instead recruit volunteer peer educators to conduct "charlas," informal discussion groups. Peer educators ran after-school neighborhood youth charlas in mixed-sex groups to discuss issues related to dating, relationships, reproductive health, contraception (including condoms), and STI/HIV testing. They also provided information on where contraceptives (including condoms) and STI/HIV testing could be obtained.

#### *Youth Scenario #4*

An NGO produced a popular television soap opera (a “telenovela”) to introduce a range of social and health issues into public debate, such as pregnancy prevention, HIV, gender-based violence, and discrimination against the physically disabled. Since the soap opera was particularly popular with youth, it presented the opportunity to address and challenge traditional gender roles. A storyline in the telenovela followed a young couple as they fell in love, and through their discussions about intimacy, contraception, and STIs. The male character in the couple was sensitive and caring towards his female partner, and they engaged in open communication about sexuality and family planning. In another episode, the young woman was raped. The telenovela then dealt with the aftermath of sexual violence, including its effects on intimacy and women’s legal rights. Using mass media, this program presented alternative gender role models, and raised awareness and public discussion about gender and reproductive health.

#### *Youth Scenario #5*

A program in Country N challenges traditional expectations of boys’ and girls’ roles. It works with 10-to-14-year-old boys and girls, bringing them together at Child Clubs for participatory workshops one hour per week, for 8 weeks. Sessions explore young people’s hopes, dreams, and ideas about gender equality, power, and fairness. They identify small actions that brothers can take to promote respect and empower girls in their homes. Results of the initial program show boys are making small changes in their own behavior—helping their sisters and mothers with household chores, advocating for their sisters’ education and against early marriage, and encouraging family members, friends, and neighbors to do the same. Compared with those who did not participate, more girls in the program-intervention group state that their brothers and other boys in their communities are making small changes toward gender equality. Parents also report that their sons now help their daughters with schoolwork and chores, and that their households are more peaceful as a result.

