

the
‘SO WHAT?’
report

**A Look at Whether
Integrating a Gender
Focus Into Programs
Makes a Difference
to Outcomes**

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INTERAGENCY GENDER WORKING GROUP TASK FORCE REPORT

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Note

In 2001, the Interagency Gender Working Group (IGWG) established a task force to answer the question, “What difference does it make if we integrate gender concerns into reproductive health programs?” Officially named the Task Force on Evidence that Gender Integration Makes a Difference to Reproductive Health Outcomes, it quickly became known as the “So What?” Task Force and this resulting paper became known as the “So What” Report.

Since that time Task Force members have reviewed nearly 400 interventions (25 of which are highlighted herein) from reproductive health programs that address maternal morbidity and mortality, unintended pregnancy, STIs/HIV, and quality of care. This paper is the result of that review and it serves many useful purposes. First of all, it is an invaluable compendium of activities and studies that take a gender-based approach to reproductive health and HIV/AIDS policy and programming. Secondly, while not an exhaustive study of relevant program evaluations, operations research, and clinical trials, this paper provides examples of the range of activities that can help answer the question of whether promoting gender equity in reproductive health and HIV/AIDS program interventions improves health outcomes. And finally, it provides a base upon which to add additional pieces of evidence of the relationship between gender equity promotion, on the one hand, and reproductive health and HIV/AIDS prevention, on the other.

But most importantly, we now have no doubt that the information available to date points toward the fact that integrating a gender component into reproductive health (RH) programs does appear to make a difference to outcomes—both in stronger health results and in gender equity. Furthermore, it is clear to us what the next step must be: the focus must now be on *evaluations* of such programs. As documented in this paper, evaluations of reproductive health programs that promote gender equity are few in number, limited in scope, and short-term. To get even stronger evidence to answer the question of “So What?”, reproductive health and gender experts, program planners and funders will need to pick up the gauntlet in improving the quality of evaluations.

—Members of the “So What” Task Force

Executive Summary

Improving reproductive health and promoting gender equity are key components of the Programme of Action (POA) from the Cairo International Conference on Population and Development (ICPD) in 1994. As the tenth anniversary of the ICPD approaches, it is time to take stock of the progress made toward implementing the POA. *Does taking a gender-based approach to policy and programming as proposed in the POA have an effect on reproductive health outcomes?* This question, posed to the USAID Interagency Gender Working Group (IGWG), formed the basis for a review of the evidence that integrating gender into reproductive health programs makes a difference to outcomes—both reproductive health outcomes and gender outcomes.

This review focuses on four components of reproductive health programs, including interventions to:

- Reduce unintended pregnancy and abortion,
- Reduce maternal morbidity and mortality,
- Control STIs/HIV/AIDS, and
- Improve quality of care.

The review notes gender-related barriers to each component of reproductive health and the strategies undertaken by programs to address the barriers. Out of nearly 400 interventions reviewed, 25 are included here as examples of reproductive health programs that integrate gender to either accommodate gender differences or transform gender norms to promote equity. The review also notes some interventions that exploit gender inequalities to pursue reproductive health goals.

The interventions selected for inclusion in this paper were limited to those that have been evaluated—those that established criteria for assessment that were clearly related to the aims of the intervention and proceeded according to the evaluation design, whether quantitative, qualitative, or both. However, the evaluations presented in this paper are of vary-

ing quality and thoroughness—the authors found very few interventions that had undergone scientifically rigorous impact evaluations. Yet, the examples collected in this paper comprise the strongest evidence available to date on this topic. The evidence reviewed suggests that integrating gender into reproductive health programs appears to have a positive impact on achieving reproductive health outcomes.

Strategies to Integrate Gender into Reproductive Health Interventions

Programs have used a variety of strategies to integrate gender into reproductive health interventions.

Reducing Unintended Pregnancies

To reduce unintended pregnancy, interventions that *accommodate gender differences* have ranged from community-based distribution (CBD) of contraceptives to clinics that offer childcare for women while they are seeking services. These strategies work to overcome practical obstacles imposed by gender inequality, such as seclusion within the home, limited time due to an unequal burden of work, and little access to cash to pay for health services.

Interventions that seek to *transform gender norms* operate on the assumption that for an individual to make behavioral changes, she or he must have practical skills in long-term planning, problem solving and decisionmaking, and a sense of self-efficacy. Participatory techniques of community work that encourage reflection and discussion are important to this approach. Some of these interventions hold women's empowerment as an explicit goal for improving women's lives.

Some interventions offer training in various topics in addition to reproductive health, such as literacy, employment skills, legal rights, parenting, child health, and social mobilization. Other interventions seek to empower women by

improving couple communication or to increase men's responsibility for family planning by reaching them in non-health care settings, for example through agricultural extension.

Reducing Maternal Morbidity and Mortality

Initiatives in safe motherhood have included interventions to prevent the delays that can lead to maternal death. Counseling interventions that *accommodate gender differences* have sought to raise women's awareness of the importance of gaining permission from family elders and husbands to seek health care in advance of labor. Other programs have educated men about recognizing and responding to

pregnancy and postpartum. Programs have reached out to men through peer educators, home visits from field workers tailored to men's schedules, workshops for men held on days when men are not working, and men's clubs and mother-in-law clubs, where mothers are motivated to encourage their sons to give higher priority to their wives' health care.

Reducing STIs/HIV/AIDS

Some strategies to *accommodate gender differences* in STI programs address the lack of control over the conditions that many sex workers face—strategies such as educating brothel owners or enacting laws to enforce condom use among clients. Many interventions to *transform gender relations* have sought to stimulate dialogue on the relationship between gender norms and sexual behavior, rather than just providing information on condom use and risk behaviors alone. Additional behavior change communication (BCC) strategies incorporate negotiation and communication skills training for women to increase their assertiveness in partner communication about topics related to sex, STIs/HIV/AIDS, and dual protection/dual method use. Many programs aim to challenge the acceptance of norms related to male promiscuity, infidelity, and control of sexual relationships, and/or norms that promote female isolation and ignorance. Peer educators have also addressed such sensitive topics as virginity and women's fear of sexual and physical abuse, economic abandonment, or increased infidelity in retaliation for asking partners to use condoms.

To help women avoid transactional sex, education programs have offered vocational training in income-generating activities. One project has been particularly successful at working with sex workers and communities to reduce stigma and to teach these women—who are typically powerless in relation to brothel owners, clients, and police—how to protect themselves from STIs/HIV and violence.

Programs for adolescents have aimed to challenge attitudes and norms that increase STI/HIV vulnerability through age-appropriate publications for young people and discussions with peer educators on risk and the social contexts that shape risk.

The evidence reviewed suggests that integrating gender into reproductive health programs appears to have a positive impact on achieving reproductive health outcomes.

danger signs and have encouraged men to pay greater attention to the needs of pregnant women. To improve maternal nutrition, women with limited access to cash have been taught how to introduce low-cost, high-nutrient foods into their diets.

Strategies to *transform gender relations* include those that increase women's access to and control of resources where men dominate financial decisionmaking in the home and undervalue their wives' health care. Interventions have included establishing credit and savings groups with women and creating emergency loan funds supplied through women's cooperative agricultural production or market activities. Women have been encouraged to get involved in advocacy activities, such as contacting government officials to request improved access to programs in their remote villages.

Some programs have aimed to re-negotiate power relationships surrounding maternal health decisionmaking, including getting male partners, extended families, and community members to appreciate their roles in and give more priority to women's health care during

Improving Quality of Care

Most interventions that have addressed gender barriers to quality of care *accommodate gender differences* rather than challenge gender relations. Examples include increasing women's access to female providers, coaching women to be more assertive with providers, adding child-care for clients, reducing waiting time, making services more male-friendly, introducing couples' counseling, and allowing women to choose a female family member to accompany them through labor and delivery.

Conclusions

This review generated eight main conclusions:

1. Evaluations of reproductive health programs that promote gender equity are few and limited in scope.
 - a. Relatively few programs that seek to transform gender relations to promote equity have undergone systematic evaluation.
 - b. Gender impact is rarely measured.
2. It is difficult to isolate the effects of a gender perspective in programming.
3. Evaluations are typically short-term, while changing gender relations is a long-term process.
4. The strongest evidence comes from evaluations comparing the same interventions with and without the addition of a gender component.

5. Among interventions promoting gender equity, there are more initiatives with demonstrated results in STI/HIV prevention than in other health areas.
6. Many programs seeking to transform gender relations combine it with a community participation or community empowerment strategy.
7. The 25 interventions reviewed that integrate gender reported positive reproductive health and HIV outcomes.
8. Among the 20 interventions that measured gender impact, gender outcomes were positive.

Based on these conclusions, the authors' recommendations for future directions in gender integration in reproductive health programming are twofold: 1) stronger integration of gender in designing program interventions, and 2) more rigorous evaluation of interventions that integrate gender.

Programs must have the dual goals of ensuring good reproductive health outcomes and promoting gender equity to be truly successful and to reach the objectives set out at the 1994 ICPD. Ten years after Cairo, it is time to recognize the benefits of promoting gender equity in all reproductive health programs.

Introduction

“A gender perspective should be adopted in all processes of policy formulation and implementation and in the delivery of services, especially in sexual and reproductive health, including family planning.”¹

Background

The 1994 International Conference on Population and Development (ICPD) in Cairo marked a paradigmatic shift in national population policies and donor population assistance strategies worldwide. In response to critiques that the prevailing agenda was too centered on demographic change, the focus on fertility reduction was replaced by a human rights and life-cycle approach to reproductive health.² The *Programme of Action* (POA) set forth at the ICPD calls for the broadening of services beyond the provision of contraceptives and emphasizes individual needs rather than top-down family planning programs.

Gender-equity concerns are a pillar of the POA. Gender equity may be defined as equivalence in life outcomes for women and men, recognizing their different needs and interests, and requiring a redistribution of power and resources.³ The POA identifies gender-based inequities as barriers to reproductive health, and gender equality as critical to successful health and development work. It advocates a set of actions for governments and international collaborators to take toward women’s social and economic empowerment and men’s responsibility in population and reproductive health policies and programs, including:

- Incorporating reproductive rights education into both formal and informal education processes;
- Ensuring that women and men have equal access to information, education and services needed to achieve good reproductive health and to exercise their reproductive responsibilities, especially through non-

formal education and community-based activities;

- Ensuring that women have equal participation and equitable representation in the leadership, planning, decisionmaking, management, implementation, organization, and evaluation of services;
- Educating and enabling men to share more equally in all areas of family and household responsibilities, including, among others, responsible parenthood, domestic tasks, and reproductive behavior, and to accept major responsibility for the prevention of sexually transmitted infections (STIs);
- Supporting measures to protect women, youth and children from abuse, including sexual abuse, exploitation, trafficking, and violence;
- Stopping the practice of female genital cutting and protecting women and girls from all similar unnecessary and dangerous practices; and
- Developing integrated approaches to the special health, education, and social needs of girls and young women, and enforcing laws to ensure that marriage is entered into only with the free and full consent of the intending spouses.⁴

1. United Nations, 1999.

2. United Nations, 1994. The ICPD Programme of Action specifically refers to a human rights approach to reproductive health. USAID has defined family planning and reproductive health in Appendix IV of its Guidance on the Definition and Use of the Child Survival and Health Program Funds, dated May 1, 2002. Primary elements include: expanding access to and use of family planning information and services; supporting the purchase and supply of contraceptives and related materials; enhancing quality of family planning information and services; increasing demand for family planning information and services; expanding options for fertility regulation and the organization of family planning information and services; integrating family planning information and services into other health activities; and assisting individuals and couples who are having difficulty conceiving children.

3. Reeves and Baden, 2000.

4. United Nations Department of Public Information, 1995.

The primary arguments for pursuing these strategies have been based on equity and human rights concerns. Gender equity is an important development objective⁵ and should be a goal of reproductive health and HIV/AIDS programs. However, there has not been an adequate assessment of the direct evidence that integrating a gender perspective in reproductive health programming makes a positive difference to program outcomes. While the links between empowerment of women and health and population outcomes seem apparent to many, a compilation of the evidence substantiating such links could further strengthen the argument that gender must be taken into account in policies and programs, as well as provide substantive guidance for program design.

Objective

To address this gap in evidence, the Interagency Gender Working Group (IGWG) established a task force in 2001 to answer the question, “What difference does it make if we integrate gender concerns into reproductive health programs?” This paper, produced by that task force, assembles evidence from programs addressing four reproductive health issues: maternal morbidity and mortality, unintended pregnancy, STIs/HIV, and quality of care.

Methodology

The authors identified documents for this review through literature searches and by contacting experts in the reproductive health field from various organizations. Both published and unpublished documents (primarily journal articles and evaluation reports) were included. Databases of reproductive health, development, and academic literature, including POPLINE, the Development Experience Clearinghouse, and Expanded Academic, were searched extensively, as were journals such as *Studies in Family Planning*, *Reproductive Health Matters*, *International Family Planning Perspectives*, and *Population and Development Review*.

Practitioners from organizations worldwide were contacted to locate any appropriate pro-

gram evaluation documents, and to draw on their knowledge of other programs, organizations, and people working on gender and reproductive health. Of 166 individuals and organizations contacted, 66 were able to offer information about relevant interventions or suggest other key informants. The authors then reviewed around 400 reproductive health and HIV/AIDS programs, cross-sectoral development programs with reproductive health components, clinical trials, and operations research projects. If program results were not available in peer-reviewed journals, evaluation reports from the implementing organizations were requested.

Criteria for Inclusion in This Review

Three main questions were asked before any given intervention was included in this publication:

Does it integrate gender; has it been evaluated; and does it have measured reproductive health outcomes?

1. Does the intervention integrate gender?

In this paper, the term *gender integration* refers to strategies applied in program assessment, design, implementation, and evaluation to take gender norms into account and to compensate for gender-based inequalities. In the household and the community, women’s and men’s roles and relative power shape the division of labor, the allocation of responsibilities, and behavior affecting reproductive health and health service utilization.⁶ Power relations between men and women also shape the division of labor within the structure of health service delivery systems and create inequalities in access to the benefits provided through such systems. Although gender equity is an important objective in itself, it is not necessary for a reproductive health intervention to include equity in its stated goals in order for it to integrate gender. Reproductive health may remain the primary objective, and programmers may choose to identify and address gender inequities primarily because they are hindrances to improved health.

In some cases, strategies to overcome gender barriers to reproductive health are incorporated into initiatives without being labeled as such. For example, where women relate to non-kin primarily via the husband, are isolated within the home, or are considered men’s prop-

5. See World Bank, 2001.

6. Caro et al., 2003.

erty, encouraging women to use contraception or attend reproductive health clinics may be seen as a challenge to patriarchal control. Strategies to address these barriers may include community-based distribution, changes in service hours, special training of female providers, child-care provision within clinics, or fee waivers. These initiatives may be guided by an access and quality of care framework, rather than an explicit gender perspective.

In the same vein, it was not necessary for an intervention's evaluation to measure changes in gender relations in order to be included in this review. Measuring the gender impact of health and development programs and policies is a relatively new but quickly advancing science, and we include gender outcomes when they have been reported. Some gender indicators are best described as proxy measurements of changing gender relations. For example, greater partner communication does not necessarily mean that equity in decisionmaking about reproductive health between partners has increased. In contexts where reproductive health has tacitly been a women's domain of knowledge and action, as partner communication improves, men may continue to acknowledge women's expertise but offer greater support for their health. Alternatively, men may begin to stretch their sphere of control to include reproductive health decisions, and the increasing communication episodes may be in the form of directives from men to women.⁷

Types of Gender Integration Strategies

To distinguish among gender integration strategies, interventions are divided into three types:

1. Interventions that *exploit gender inequalities* in the pursuit of reproductive health and demographic goals. The situation of women may worsen, for example, when the use of male opinion leaders or aggressive imagery in marketing slogans aimed at men reinforces male dominance of decision-making authority and resources.

2. Interventions that *accommodate gender differences*. Interventions that accommodate gender inequities make it easier for women to fulfill the duties ascribed to them by their gender roles, without attempting to reduce gender inequality.⁸ They may include community-based distribution, changes in service hours,

special training of female providers, child-care provision within clinics, or fee waivers. One advantage to accommodating inequitable gender norms is that women are likely to experience some health benefits more quickly than with approaches that seek to change gender systems.

Some of the strategies discussed in this paper are ones that exploit gender inequalities or accommodate gender differences. The main focus of our review, however, is on the third type of gender integration strategy:

3. Interventions that seek to *transform gender relations* to promote equity. Changes toward more equitable gender relations may only develop slowly, but such changes are more likely to bring long-term and sustainable benefits to women.

Programs and policies may transform gender relations through:

- Encouraging critical awareness of gender roles and norms;
- Promoting the position of women relative to men;
- Challenging the imbalance of power, distribution of resources, and allocation of duties between women and men; or
- Addressing the unequal power relationships between women and service providers.

In addition, some innovative programs may accommodate gender norms in order to achieve short-term results while simultaneously initiating efforts to change gender norms in the long-term. These programs may be the most comprehensive approach to integrating gender in reproductive health programming. See Chapter 2 for a discussion of how programs using one service delivery approach—community-based distribution of contraceptives—can exploit gender norms, accommodate gender differences, or transform gender norms.

Gender Integration Through Male Involvement

Efforts to involve men in reproductive health constitute a special case of potentially gender-integrated programs, and several are included

7. In most cases, evaluation reports reviewed here did not analyze the quality of changes in partner communication about reproductive health and family planning. Nevertheless, data on couple communication have been included because greater communication has the potential to foster more equitable decision-making patterns.

8. Schuler, 1999.

in this review. Male involvement is critical to promoting gender equity in the context of reproductive health and other development programs, yet alone does not guarantee the promotion of gender equity.

Men have generally been more involved in reproductive health than the health and development field has given them credit for.⁹ A focus on women may have dismissed and even undermined male roles, such as the practice of *coitus interruptus*, periodic abstinence, or postpartum abstinence as methods of child spacing.¹⁰ Maternal and child health centers have in essence institutionalized the mother-child dyad, effectively precluding the involvement of fathers.

Men play important roles in regulating women's access to health services.¹¹ An important rationale for involving men in traditional family planning has been the widespread understanding that men want more children than women and dislike contraception.¹² Programs can challenge or uphold men's "gate-keeping" authority—the ability or inclination to control women's mobility, social contacts, or access to health services and other resources. Targeting men "as a means for reaching and altering their wives' reproductive behavior," as researchers in Ghana have urged,¹³ may be effective in a program sense, but reflects little concern with gender equity and may even risk reinforcing male prerogative. In Zimbabwe, one program increased men's knowledge of and communication about family planning methods, but increased men's belief that the husband alone should decide whether to practice family planning.¹⁴

Some reproductive health program designers have interpreted the call for male involvement as a call to provide services to men. In an era of scarce resources, it is unwise to set up men's reproductive health essentially in competition with women's. In developing countries, the existence of few alternatives to health care

9. Greene and Biddlecom, 2000.

10. Rogow and Horowitz, 1995; Miller et al., 1998; Helzner, 1996; Bledsoe, 1990; van de Walle and van de Walle, 1993.

11. Robey et al., 1998; Goldberg and Toros, 1994.

12. Bankole and Singh, 1998; Mason and Taj, 1987; Coombs and Chang, 1981.

13. Ezeh, 1993:173.

14. Kuseka and Silberman, 1990; Piotrow et al., 1992; Kim et al., 1996.

Table 1.1

Number of Interventions Reporting Selected Reproductive Health Outcomes*

| REPRODUCTIVE HEALTH OUTCOMES | NUMBER OF INTERVENTIONS |
|---|-------------------------|
| Unintended Pregnancy | |
| Greater family planning use | 6 |
| Greater contraceptive knowledge | 5 |
| Fewer child deaths | 2 |
| Lower fertility | 1 |
| Fewer teenage pregnancies | 1 |
| Increase in age at marriage | 1 |
| Greater receptivity to family planning information | 1 |
| Maternal morbidity/mortality | |
| Increase in use of skilled pregnancy care | 4 |
| Greater knowledge of warning signs in pregnancy | 3 |
| Better nutrition | 2 |
| Men's improved knowledge of wives' antenatal care | 1 |
| Better post-abortion recovery | 1 |
| Fewer obstetrical complications | 1 |
| Lower maternal mortality | 1 |
| STIs/HIV/AIDS | |
| Greater knowledge of HIV/AIDS transmission and prevention | 10 |
| Greater condom use | 6 |
| Lower STIs | 3 |
| Greater knowledge of STI symptoms | 2 |
| Quality of Care | |
| Increased clinic visits | 2 |
| Improved client-provider interaction | 1 |

*Some interventions addressed more than one reproductive health outcome, so that some of the 25 interventions meeting the review criteria are listed more than once.

services provided by family planning clinics accentuate the tradeoffs.

Few programs have attempted to improve reproductive health outcomes by involving men in ways that promote gender equity. Of these, even fewer have been evaluated in ways that clarify how reducing gender inequities supports good reproductive health. Increasing men's concern for women's health is an important aspect of many of these interventions, along with countering attitudes about men and women that support male control of reproduction and sexuality. Research in Jamaica suggests that gender norms regarding sex and

Table 1.2

Number of Interventions Reporting Selected Gender Outcomes*

| GENDER OUTCOMES | NUMBER OF INTERVENTIONS |
|--|-------------------------|
| Increased equitable gender attitudes and awareness of rights | 9 |
| Women's increased self-confidence or self-esteem | 4 |
| Women's increased participation or leadership roles in the community | 4 |
| Increased partner communication about reproductive health or family planning | 4 |
| Increased support (emotional, instrumental, family planning, or general support) from partners | 3 |
| Women's increased willingness to protest or seek help for domestic violence | 2 |
| Women's increased decision-making power | 2 |
| Higher formal education for women or girls | 2 |
| Higher scores on empowerment scale for women | 1 |
| Women's increased mobility | 1 |
| Improved sexual negotiation skills | 1 |
| Increased women earning income | 1 |
| Higher levels of women's literacy | 1 |
| Women's increased assertiveness in client-provider interactions | 1 |

*Some interventions addressed more than one gender outcome, so that some of the 25 interventions meeting the review criteria are listed more than once.

reproduction are reinforced and accepted by children early in life.¹⁵ Most societies accept and reinforce the notion of an aggressive, uncontrollable male sexuality,¹⁶ while recognizing the public health challenges of, for example, the widespread patronage of prostitutes (e.g., in Thailand).¹⁷ The male involvement initiatives reviewed in this paper demonstrate how some projects have addressed these barriers.

2. Does the intervention have measured reproductive health outcomes?

How should the success of interventions that integrate gender be measured? Should we be assessing the gender impact of reproductive health strategies, the health impact of gender strategies, the gender impact of gender strategies in reproductive health, or all of these? The most methodologically rigorous evaluations rely on well-studied indices in reproductive health and family planning; for example, contraceptive prevalence and STI/HIV rates. However, many

evaluations use a wider range of indicators, such as couple communication and age at marriage, as well as indicators of gender outcomes, including equitable gender attitudes and women's decision-making power. The authors have limited this review to programs with measured outcomes in reproductive health/family planning, although the gender outcomes of those programs are included as well, when they are available.

3. Has the intervention been evaluated?

The interventions selected for inclusion in this paper were limited to those that have been evaluated—those that established criteria for assessment that were clearly related to the aims of the intervention and proceeded according to the evaluation design, whether quantitative, qualitative, or both. However, the evaluations presented in this paper are of varying quality and thoroughness. The authors found very few interventions that met the first two criteria and that had also undergone scientifically rigorous impact evaluations that were thorough, detailed, and attentive to confounding factors. Optimally, an evidence-based assessment of the relationship between gender integration and outcomes relies on data collection and analysis that meets the highest standards. Yet, the examples collected in this paper comprise the strongest evidence available to date on this topic.

Overview

Of the 400 interventions reviewed, 25 met the above criteria and are described within this paper. The following chapters are organized by reproductive health issue—maternal morbidity and mortality, unintended pregnancy, STIs/HIV/AIDS, and quality of care. However, many interventions described here have documented effects in more than one of these areas. These initiatives have been placed in chapters according to the most significant outcome they documented. The various reproductive health and gender outcomes measured in the 25 interventions are listed in Tables 1.1 and 1.2. The Appendix gives more information about which

15. Eggleston et al., 1999.

16. Ramos and Gogna, 1997; Fordham, 1995.

17. See Knodel et al., 1996.

interventions applied each indicator, and provides quick reference tables to summarize the evaluation methods used. The tables in the Appendix can also be used to identify interventions that crosscut areas of reproductive health.

This review is not exhaustive. It is likely that there are additional reproductive health interventions that integrate gender that the authors were unable to uncover. Furthermore, there are several programs in the process of being evaluated that would be included here if results were available at press time, including the Tostan project in Senegal (www.tostan.org),

Family Health International's *Rethinking Differences and Rights in Sexual and Reproductive Health: A Training Manual for Health Care Providers in Bolivia* (www.fhi.org), Project H in Brazil (www.promundo.org.br), and CEDPA's ENABLE Project and New Horizons program in Egypt (www.cedpa.org). These evaluations will yield important evidence to help answer the question posed in this review — “What do we know about the relationship between gender integration and outcomes in reproductive health and gender?”

Unintended Pregnancy

Background

The ICPD *Programme of Action* set a goal of providing universal access to a full range of safe and reliable family planning methods and to related RH services by 2015. Fertility has declined in many countries worldwide as family planning programs have met the needs of couples and individuals for contraceptives to reduce fertility. In the developing world as a whole, the total fertility rate (TFR), or the average number of births per woman, has fallen from 5.7 births per woman in 1970 to 3.5 today, excluding China.¹⁸ Still, one-third of births (32 percent) in the developing world are ill-timed or unwanted, as documented in the latest estimates from Demographic and Health Surveys for 51 developing countries.¹⁹

Many unintended pregnancies end in abortion.²⁰ Of the 35 million abortions that occur annually in developing countries, 19 million are in countries where abortion is illegal and generally unsafe. According to WHO, every year, 78,000 women die of complications of abortion performed by unqualified people or in unhygienic conditions, or both.²¹ Many abortions occur for lack of good contraceptive availability and services.²²

Unintended pregnancy affects the well-being of women, children, and families. Unintended pregnancies carried to term are more likely to involve complications.²³ Women with unintended pregnancies may be subject to increased physical abuse by their partners during pregnancy.²⁴ Women in a qualitative study in Egypt said that an unintended pregnancy negatively affected their ability to look after their own health and also resulted in financial burdens, more household work, less personal time and less time with other children, and less time for social interaction with others.²⁵ A study of women in Indonesia found that having an unintended pregnancy negatively affected women's psychological well-being.²⁶ Long-term

studies suggest that children who result from unplanned pregnancies face poorer mental and physical health and less occupational success.²⁷

Unintended pregnancy results from many factors, among them lack of access to contraception. Among the 24 percent of women in the Indonesia study mentioned above, more than half of the women (56 percent) were not using contraception when they got pregnant. About 114 million women — over one in six — in the developing world have an unmet need for contraception, often for lack of access to a choice of modern methods. In 1999, only 57 percent of couples in 88 developing countries had reasonable access to five modern contraceptive methods (pill, IUD, condom, and male and female sterilization).²⁸

Gender-Related Barriers to Reducing Unintended Pregnancy

Numerous gender-related barriers contribute to unintended pregnancy, some at the institutional and policy level, and others at the levels of the family and community. Family planning policies and programs have historically been designed by men for women, based on the common view that fertility control is women's domain. As a result, women have often been treated as targets of family planning programs rather than beneficiaries of reproductive health care. The gender stereotype that women are primarily responsible for family matters, including family planning, is one reason that

18. United Nations, 2000.

19. Westoff, 2001.

20. USAID funds are prohibited from being used to pay for the performance of abortion as a method of family planning or to motivate or coerce a person to practice abortion.

21. WHO, 1998.

22. Henshaw et al., 1999.

23. Institute of Medicine, 1988.

24. Goodwin et al., 2000.

25. Kader and Maklouf, 1998.

26. Hardee et al., 2003.

27. David, 1992.

28. Ross and Stover, 2001.

programs have been slow to involve men and address gender-based inequities.

The balance of power between men and women in the household also has implications for contraceptive use and reducing unintended pregnancies. The view that women alone are responsible for obtaining contraceptive methods may extend to financial responsibility, meaning that women without their own sources of income may not be able to seek fee-based family planning services.²⁹ Women are also sometimes blamed for unplanned pregnancies.³⁰ Yet men often play important roles in regulating women's access to health services through control of finances, women's mobility, means of transportation, and health care decisions.³¹ In settings as diverse as Zambia and Bolivia, some women would rather have abortions than risk repeated conflicts with their husbands over contraceptive use.³²

Women also face unequal power relations with family planning providers. Family planning clinicians often assume an authoritarian role and expect patients to be passive.³³ The imbalance in this relationship is exacerbated by disparities in social status and education between clients and providers, which are likely to be greater when the client is female.³⁴ Female clients may remain silent and have unanswered questions or concerns that affect the success of their family planning use.³⁵ The eight-country Women's Studies Project, conducted by Family Health International (FHI), found that "women are generally satisfied with family planning services but want more female providers, more emotional support, help with side effects, and more information on contraceptive methods."³⁶

Still, women often recognize the benefits of family planning even when they are poorly treated at family planning clinics.³⁷ The FHI Women's Studies Project revealed that most

women and men are convinced that practicing family planning and having smaller families provide economic and health benefits and that family planning offers freedom from unplanned pregnancy and can improve partner relations and family well-being.³⁸ Even in China, which has had a strong family planning program with strict fertility targets, women appreciate the benefits of family planning, if not the way the family planning program is administered.³⁹

Gender norms may dictate that women—particularly young women—appear ignorant about sexual matters, and men alone make decisions about family planning use.⁴⁰ Women who visit clinics for contraceptives may be stigmatized as promiscuous or too independent, especially where women's physical mobility outside the home is limited due to norms of *purdah* or other forms of seclusion.⁴¹ Some women may have to use contraception secretly when their husbands disapprove.⁴² This is especially true for women who live with the threat of physical abuse from their partners.

Gender Integration and Community-Based Distribution

There is debate in the family planning field about the gender implications of certain strategies used in various socio-cultural contexts to provide family planning services. Community-based distribution of contraceptives (CBD) is a good example of the complexity of gender issues and the differences in outcomes of programs that accommodate gender differences versus those that strive for gender equity. CBD describes a variety of strategies used to make family planning (and sometimes primary health care) services more accessible by providing them at various community locations, often at the homes of individual clients, rather than through fixed clinics. As the word "distribution" implies, the primary focus in most CBD programs is on creating easy access to "supply methods" of contraception (condoms, oral contraceptives, and sometimes spermicidal foaming tablets) and, in some cases, basic medicines. In addition, CBD programs may seek to influence individual behavior and change reproductive norms in communities.

CBD strategies are often designed to overcome practical obstacles imposed by gender inequality—such as restrictions on women's

29. Schuler et al., 2002b.

30. Hoang et al., 2002.

31. Robey et al., 1998; Goldberg and Toros, 1994.

32. Biddlecom and Papohunda, 1998; Schuler et al., 1994.

33. DiMatteo, 1994.

34. Upadhyay, 2001.

35. Schuler et al., 1985; Schuler and Hossain, 1998.

36. Barnett and Stein, 1998: xiii.

37. Schuler and Hossain, 1998.

38. Barnett and Stein, 1998.

39. Xie et al., 2000.

40. Bezmalinovic et al., 1997; Population Council, 2000.

41. Schuler et al., 1994.

42. Castle et al., 1999.

movement in public, little access to money, and limited decision-making power—without confronting the issue of inequality *per se*. CBD programs bring contraceptives to women in their homes, greatly reducing the social and economic costs of using contraception. In addition, the programs have provided a source of employment and substantial social and material rewards to the distributors themselves, as documented in Bangladesh,⁴³ as well as generated a quick way to meet goals for contraceptive use and lower fertility rates. Yet, from a broader perspective, even as it creates employment for some women, the strategy may reinforce women's isolation within the family because it does not draw women out into the public sphere nor link them to resources outside the home.⁴⁴ In reinforcing gender-based social inequities, CBD programs may help to perpetuate women's social and economic exclusion.

Perhaps the best documented CBD program is in Bangladesh. This program's success in reducing fertility rates is attributed to home visits by female family planning workers.⁴⁵ As in many such programs designed without explicit gender equity goals, the Bangladesh CBD program construed family planning as a natural extension of women's traditional roles, offering something from which families could benefit without men having to bear the cost.⁴⁶ Much of the literature on female CBD workers has emphasized their positive contributions in increasing and maintaining the use of contraception, and some writers associate door-to-door family planning with women's empowerment.⁴⁷ Indeed, these workers introduced a radical idea—that women could control their own reproduction. In addition, they helped women to overcome practical constraints related to their gender roles; they accompanied women to health facilities to receive clinical contraceptive methods such as sterilization and, in some cases, cared for their children and brought them medicines and food if they had to stay over night.⁴⁸ But it was mainly in earlier phases of the program (the 1970's and 1980's) that the door-to-door strategy brought new ideas and created new opportunities for women. Family planning has since become a norm in Bangladeshi society, and women are gradually entering the public sphere to avail themselves of microcredit, employment, education, and other opportunities. Yet,

the door-to-door family planning program continued to bring women contraceptives and, implied, some argue, that they should stay home and use them.⁴⁹

Arguably, much has been accomplished in Bangladesh by accommodating existing gender roles. The rapid reproductive revolution is significant not only for economic and health reasons, but also because it gives women the potential to control their own lives in unprecedented ways. But in its focus on increasing contraceptive use rather than on a broader reproductive health agenda, the family planning program and its door-to-door, woman-to-woman service delivery strategy may have missed opportunities to promote gender equity in the context of reproductive health.

The Navrongo Community Health and Family Planning Project in Ghana is a more recent example of how gender factors have been integrated into the design of a CBD program. In this region, the fact that men have virtually "complete" control over women has been an obstacle to availing women of contraception.⁵⁰ Research in the program sites has described men's rights to beat their wives, violence as a social duty, and fertility regulation as "conjugal refusal" because of men's strong sense of sexual ownership of women.⁵¹ The Navrongo strategy, at least initially, was to convince the community that in delivering family planning services to women, the project would be fully accountable to traditional male authority figures and sensitive to men's concerns.⁵² Working through the council of elders, the project appeared to have reinforced women's subordinate position and the expectation of working with community leaders (men) to increase contraceptive use (by women). The program experienced some success in terms of elevated contraceptive use—modest increases in contraceptive use in project areas but not in a comparison area⁵³—but at a high social cost.

43. Simmons et al., 1992; Population Council, 1999b.

44. Schuler, 1999; Schuler et al., 1995, 1996.

45. Cleland and Phillips, 1994.

46. Schuler et al., 1995, 1996.

47. Simmons, 1996; Simmons et al., 1992.

48. Simmons et al., 1988, 1992; Mita and Simmons, 1995; Schuler, 1999.

49. Schuler, 1999; Schuler and Hossain, 1998; Schuler et al., 1995, 1996.

50. Binka et al., 1995; Nazzar et al., 1995.

51. Adongo et al., 1997.

52. Schuler, 1999.

As the program developed, domestic violence increased.⁵⁴

Both the programs discussed above have seen recent changes that respond to the need for women's empowerment in the long-term. Navrongo organizers have begun to encourage women's involvement in social institutions traditionally monopolized or dominated by men. New initiatives being organized include micro-lending to groups of women and an initiative to prevent female genital cutting.⁵⁵ These additions to the program may mitigate men's control in the community yet fall short of promoting women's rights as reproductive health and contraceptive decisionmakers.

In Bangladesh, the 1997 Health and Population Sector Strategy reoriented health and population goals to include stakeholder involvement, a focus on meeting individuals' needs rather than demographics, improved quality of care, and a wide range of reproductive health services. The strategy makes a commitment to take gender issues into account in implementation and ensure equal stakeholder participation from men and women. Door-to-door contraceptive distribution is gradually being phased out in favor of "community clinics" where the former door-to-door workers will be based. Emerging evidence suggests that communities are responding favorably to the new strategy, that restrictions on women's mobility are relaxing and their use of clinic-based health services is becoming a norm.⁵⁶ It is too early to detect the effects of the new delivery strategy—which works to transform gender relations—on contraceptive use and fertility.

Interventions That Have Addressed Gender Barriers Related to Unintended Pregnancy

Interventions That Accommodate Gender Differences

In addition to CBD, family planning programs have developed a variety of strategies that accommodate gender differences to circumvent barriers to contraceptive use. One common

strategy is to offer free or low-cost services to women who do not have access to, or control of, household cash for health care expenditures. Some clinics also offer childcare to clients during their visits, making it easier for women to use services. Although the Colombian IPPF-affiliate Profamilia (which provides 70 percent of family planning services in the country) advocates for the fundamental rights of women, it involves men also by providing them with RH services, particularly through all-male clinics.⁵⁷

Interventions That Transform Gender Relations

Nine interventions that aim to transform gender relations and that have been systematically evaluated are presented here. Many of the programs are in settings where women have little autonomy in their daily lives and little assertiveness in their relationships with husbands and health care providers. For an individual to make behavioral changes, she or he must have practical skills in long-term thinking, problem solving, and decisionmaking, and a sense of self-efficacy. Many program strategies presented here involve building on these capacities in women and girls and on the belief that they are capable of making important decisions about themselves and their health. Participatory techniques of community work that encourage reflection and discussion are important to this approach, and programs with long-term, on-going groups of participants are more likely to report positive impact. Some of these interventions hold women's empowerment as an explicit goal and/or educate women in reproductive and human rights.

Successful interventions also respond to women's requests for particular services or activities, such as involving men or linking contraceptive distribution to community organizations, and offer training in more than reproductive health, in areas such as literacy, employment skills, legal rights, parenting, child health, and social mobilization. Other elements of the programs presented here include strengthening women's voice in community planning, bringing issues to government officials and donor organizations, and educating men on the importance of women's reproductive health and family planning. There is an

53. Population Council, 1999a.

54. Bawah et al., 1999.

55. Bawah et al., 1999.

56. Bates et al., 2003; Schuler et al., 2002a.

57. Ojeda, 1998.

increasing call for education programs for youth, including family life education and sex education programs to address gender issues,⁵⁸ but few programs have incorporated these to date. The adolescent initiatives in this chapter

demonstrate their effectiveness in contexts of low education levels for girls, high adolescent pregnancy, and/or preferential allocation of health care and food resources to boys.

58. Eggleston et al., 1999.

INTERVENTION:

Stimulating Dialogue Through Radio Shows

COUNTRY: **Zambia**

TYPE OF INTERVENTION: **Cross-sectoral program with reproductive health component**

IMPLEMENTING ORGANIZATIONS: **Panos Southern Africa, ZNBC Bemba, and 13 rural women's clubs**

Gender-Related Barriers to RH

According to respondents from the evaluation described here, women in the group of villages where this intervention took place, 600 km north of Lusaka alongside the Lusaka to Dar es Salaam railway, had been unaware of their rights. Their potential contributions to community development had been overlooked and their opinions about reproductive health matters went unheard. "Before, women didn't even know that they had the right to speak about certain things," said one respondent. Respondents also said they were too busy with household duties to seek out health information at clinics.

Objective and Strategy

The objectives of the program were to enable women's clubs to bring material and social benefits to their communities; to empower women at the household, community, and national levels; and to stimulate debate on development issues. From November 1998 to May 2001, women's clubs met weekly to discuss development issues of importance to them. These discussions were recorded and sent to a radio producer in Lusaka who sought responses to the issues raised from relevant development experts. The tape and the responses were edited into a radio program in the Bemba language and broadcast weekly on the national station ZNBC. Topics covered family planning, HIV/AIDS and the use of condoms, living with AIDS, abortions, locally grown foods and nutrition, women in politics, and other subjects. In response, some experts donated equipment and labor to meet community needs, and commitments fulfilled in the program villages included clinic construction, a solar panel for electricity for one clinic, an increase in supply of medicines, and other support for educational and governmental infrastructure.

Evaluation Design: Qualitative

The intervention was evaluated through an unreported number of group discussions and interviews with women's clubs, community members, and project staff members in September 2001. A survey of 328 residents of the outskirts of Lusaka and two different Bemba-speaking parts of the country found that 51 percent of respondents were regular listeners. Of these, 59 percent said they had learned significant lessons from the programs.

RH Outcomes

Respondents frequently mentioned the impact of a radio program on family planning created by the women's club in Mununga village. This program appears to have improved people's receptivity to information on birth spacing. One respondent said, "When the health workers were going round the villages trying to educate people, a lot of people were not interested, they didn't think it was important, but when it started coming from their fellow women, from the clubs, a lot of people now have gotten interested and have started following." A program from the women's club in Tazama on HIV/AIDS prevention and condoms was also frequently reported to have stimulated a great deal of discussion within communities and NGOs. Nutrition and food preparation was another topic from the club in Salamo that impacted respondents, who said that the information about nutritious crops such as soybeans and sunflower seeds was valuable for them.

Gender Outcomes

Based on respondents' frequent comments about the increasing respect men have for women's ideas, the evaluation team concluded that the intervention had a positive impact on gender relations. One man said, "Even in our homes, men

are now saying that what the women are saying is what the men should also follow." A few men complained that women in the radio programs were blaming the men for everything, but more people valued women's opinions as expressed on the air and gained a new sense of women's capacities. An elderly male village leader said, "There are some women who think even better than men, and they can come up with ideas that are brilliant... When they speak about issues they come out very, very strongly, and that makes the people of this area very proud." Women from clubs reported feeling more confident to share their views, articulate issues, and work with government officials on development. In the home, too, the radio programs seem to have changed gender relations. A male member of a Parent Teachers' Association said, "Women talk about real life issues, such as how people are supposed to live in the home in harmony, and it has worked wonders, where some people have actually changed attitudes after listening to the women doing the counseling in the program."

Conclusion

A more thorough evaluation might have been able to specify the degree of change in contraceptive use, reproductive health service utilization, and dietary patterns as a result of the program. Yet, the qualitative data demonstrates that both men and women consider the radio programs to be authoritative sources of information and have noted attitude and behavior changes regarding women's roles.

References

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INTERVENTION:

Autodiagnosis Through the ReproSalud Project

COUNTRY: Peru

TYPE OF INTERVENTION: Reproductive health program

IMPLEMENTING ORGANIZATIONS: Movimiento Manuela Ramos, funded by USAID and the Monitoring, Evaluation, and Design Support (MEDS) Project

Gender-Related Barriers to RH

Reproductive health status among Peruvian women is among the lowest in Latin America, with high rates of unwanted pregnancies and births; complications from unsafe, induced abortion, high-risk pregnancies and births; and high rates of sexually transmitted infections (STIs) and reproductive tract infections (RTIs). In 1998, widespread news coverage about the testimonies of women allegedly sterilized without their consent brought to light serious violations of reproductive rights and choice. Research in Peru has documented socio-cultural barriers that distance communities from formal health services, as well as gender barriers in the home and community that limit reproductive health. Client-provider relations reflect mistrust between communities and reproductive health services, misunderstanding and disrespect for clients' cultural beliefs, and a lack of gender-sensitivity in client-provider interactions. The gap created by gender, ethnic, and class differences, and exacerbated by geographic and infrastructure barriers, isolates many indigenous and poor communities in Peru and prevents many women from using reproductive health and family planning services. Those who do use these services often are not assertive as clients and may not use the services effectively.

Objective and Strategy

Since 1995, Movimiento Manuela Ramos, a Peruvian feminist NGO, has been implementing ReproSalud, an innovative project funded by USAID that works with community-based women's groups to identify women's RH needs and to ensure that the public health system is responsive to those needs. Launched in 1995, ReproSalud seeks to increase women's reproductive health knowledge and self-confidence, to reduce the social distance between health providers and their intended clients, and to advocate for improved reproductive health and family planning services from the clients' perspectives.

Table 2.1

RH Results, Mid-point of ReproSalud Project

| VARIABLE | INTERVENTION SITES (%) | | CONTROL SITES (%) | |
|--|------------------------|------------------------|-----------------------|------------------------|
| | BASELINE (N=2,132) | MID-POINT (N=1,852) | BASELINE (N=1,967) | MID-POINT (N=1,598) |
| WOMEN | | | | |
| in union using contraception | 58.4* | 71.8* | 60.6* | 64.6* |
| in union who know how at least one method works | 13.5* | 55.5* | 14.9* | 31.9* |
| who practice the rhythm method and know fertile days of cycle | 22.5* | 28.3* | 24.0 | 24.1 |
| who know that breastfeeding decreases likelihood of becoming pregnant | 34.0* | 56.3* | 30.9* | 46.9* |
| who say that services of closest health facility are good | 45.5* | 56.2* | 52.8* | 69.7* |
| with a pregnancy within last two years who attended four or more prenatal visits | 55.6* | 83.1* | 62.2* | 81.0* |
| with birth within last two years that was attended by health personnel | 36.1* | 48.0* | 40.9 | 42.7 |
| in union who know at least one danger sign of pregnancy and postpartum | 19.4* | 46.0* | 13.2* | 40.0* |
| in union who would go to a health facility in case of danger signs | 42.6* | 71.6* | 36.8* | 62.2* |
| who spent money on their health in last year | 49.5 | 50.0 | 45.7 | 45.2 |
| who attended a health facility for reproductive health or family planning services | 26.3* | 42.2* | 22.5* | 39.7* |
| who attended health facility for vaginal discharge | 50.6* | 61.4* | 51.4* | 58.4* |
| who know how "white menses" (vaginal discharge) is spread | 4.9* | 19.0* | 4.7* | 11.4* |
| who have heard about Pap tests or breast exams | 63.2* | 81.4* | 59.6* | 71.8* |
| who take care of themselves in order to feel well | 56.8* | 65.1* | 65.2* | 56.4* |

*p<0.05

Source: Ferrando et al., 2002.

The ReproSalud project first holds workshops with women in communities to analyze their reproductive health problems, consider their priorities, and develop solutions through participatory research techniques, such as socio-dramas, story-telling, body-mapping, and "problem trees." "Problem trees" involve discussing a prob-

lem (the tree's trunk), its consequences (the branches and leaves), and its causes (the roots). This analysis leads to the development of project activities to address the root causes. Initiated in nine provinces (predominantly low literacy, rural mountainous areas), the program has reached 123,000 women and 66,000 men. The most common

Table 2.2

Gender Results, Mid-point of ReproSalud Project

| VARIABLE | INTERVENTION SITES (%) | | CONTROL SITES (%) | |
|--|------------------------|-----------|-------------------|-----------|
| | BASELINE | MID-POINT | BASELINE | MID |
| POINT | | | | |
| WOMEN | (N=2,132) | (N=1,852) | (N=1,967) | (N=1,598) |
| who say that their work is as important as their partners | 51.4* | 57.8* | 48.4* | 55.2* |
| who say that girls and boys should study to the same level | 86.7* | 91.9* | 94.5* | 89.6* |
| in union who jointly make decision with partner about sex, family planning, and number of children | 23.7* | 32.9* | 22.6* | 27.8* |
| in union who do one or work household chores jointly with partner | 23.2* | 46.7* | 18.6* | 37.9* |
| in union who jointly decide with partner how much education children should get | 57.4* | 64.0* | 57.8 | 58.0 |
| in union who have spoken with partner about number of desired children | 67.8* | 72.6* | 69.3* | 74.0* |
| in union who have spoken with partner about family planning in last 12 months | 15.2* | 20.3* | 11.4* | 14.1* |
| in union whose partner helps when children are sick | 38.7* | 44.7* | 30.0* | 35.3* |
| who know where to seek help if partner beats them | 45.6* | 65.6* | 44.8* | 59.5* |
| who say that women can use contraception even if partner opposes | 68.9* | 64.4* | 65.0* | 60.4* |
| who would seek help from the police if partner beat them | 14.3* | 38.4* | 15.7* | 37.2* |
| who decide how to spend the money they earn | 31.6* | 36.1* | 29.8 | 27.8 |
| who don't have sex out of sense of obligation | 50.6* | 64.0* | 55.4* | 58.7* |
| MEN... | (N=1,649) | (N=1,691) | (N=1,543) | (N=1,502) |
| who say that their partner's work is as important as theirs | 52.1* | 69.8* | 55.9* | 68.3* |
| who say that girls and boys should study to the same level | 89.1 | 91.4 | 91.6 | 90.9 |

*p<0.05

Source: Ferrando et al., 2002.

problems selected by women are too many children, suffering during childbirth, domestic violence, and "white menses" (vaginal discharge). The first cycle of project activities usually involves educational activities in reproductive health to address the selected problems. Due to the lack of control that many women have over factors that influence their health and health care, participating women often ask that their husbands be educated in reproductive health as well. In some cases, the women's groups established relationships with local health authorities and

signed *convenios* (agreements), in which the health service agrees to respond to women's priorities and acknowledge their rights as clients, and the women agree to support the public health services and take action to increase utilization of the facility by others in their community.

Evaluation Design: Pre- and Post-Intervention Control Group

The evaluation team conducted a baseline survey in 1997-1999 and a mid-point evaluation between 2000 and 2001 in 70 interven-

tion communities and 25 control communities. Households were randomly sampled for the baseline with a total of 4,099 women and 3,192 men. The same houses were revisited for the mid-point survey, and 67.7 percent of the baseline sample was interviewed a second time. When new occupants were in the home, the residents there were interviewed, replacing some of the 32.3 percent that had moved, for a total of 3,450 women and 3,193 men.

Reproductive Health Outcomes

In intervention communities, women experienced significant increases in 14 out of 15 indicators of reproductive health knowledge and practices (see Table 2.1). For women in control communities, 12 of these 15 indicators increased significantly between baseline and mid-point. The improvements in intervention communities were greater than improvements in control communities for the majority of indicators.

Gender Outcomes

In intervention communities, women and men displayed significant increases in gender-equitable attitudes and practices in 14 out of 15 indicators, presented in Table 2.2. Control communities showed significant increases in 12 of these 15 indicators. The impact overall was greater on women than on men.

Conclusions

The period of operation of this project coincided with a time of stronger investment in the health sector by the Ministry of Health and donor agencies, which may have made it difficult to isolate the effects of the project. However, the greater improvements in reproductive health and gender that were experienced in the intervention communities suggest that the project has had effects beyond the impact of the national health system investments.

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INTERVENTION:

Training-of-Trainers in Health and Empowerment

COUNTRY: **Mexico**

TYPE OF INTERVENTION: **Reproductive health program**

IMPLEMENTING ORGANIZATIONS: **IMIFAP, supported by Glaxo/SmithKline**

Gender-Related Barriers to RH

Women in the southern state of Oaxaca, Mexico, are especially disadvantaged by the widespread poverty of the region. The state has one of the highest fertility rates in Mexico, and 32 percent of births are to adolescent mothers.⁵⁹ Women are largely relegated to passive roles inside the home and, as a result, do not always take the initiative to care for their own health and well-being. In preliminary research, investigators found that women tend to talk little about sexuality, and many are reluctant to ask partners to use a condom for fear of being beaten and/or accused of being unfaithful.

Objective and Strategy

IMIFAP, a Mexican NGO, designed a project to increase the psychosocial skills of Oaxacan women in a way that will enable them to adopt healthy behaviors for themselves, their families, and their communities. The goals were to improve the knowledge, beliefs, intentions, and behavior of women with respect to health, nutrition, hygiene, sanitation, sexuality, reproductive health, and empowerment. The team created a women's workshop based on these topics, to be conducted in a total of 120 hours in four modules. An additional workshop of two modules covers the health, rights, and empowerment of children. These participatory workshops—called “*Si Yo Estoy Bien, Mi Familia También*” (If I'm okay, my family is, too)—

not only provided women with health information but also measured items on an empowerment scale. The workshops encouraged reflection and discussion; helped to develop self-esteem, decision-making skills, assertive communication styles, and planning for goals; and raised awareness of human rights. In a training-of-trainers framework, 25 community health promoters, 510 rural health assistants (including some representatives of IMSS Solidaridad, the government health program for rural communities), and 3,700 volunteers eventually reached 37,750 women in at least 140 rural communities. Facilitators encouraged women to take action to improve their health on both individual and group levels.

Evaluation Design: Pre- and Post-Intervention Control Group

A survey of 94 questions was used for baseline evaluation in February 1999. Respondents were 419 married and single women between the ages of 12 and 20 years who had participated in the program, and 120 who had not. Final evaluation took place in February 2001 with 606 women in the experimental group and 280 in the control group. The control group was drawn from 35 communities where the intervention had not taken place. Surveys included an empowerment scale based on the following reported actions: using contraceptives even if partner disagrees; asking for information

about contraceptive methods in the rural medical unit; expressing disagreement to partner; talking to partner about how to spend household money and how many children to have; talking with daughters about menstruation, how to take care of themselves, and how babies are born; talking to sons about how babies are born; working outside the house; and going outside the house without partner's permission. Married women were asked if they carried out these actions; single women were asked if they intended to carry them out in the future.

RH Outcomes

There were no significant differences between control and intervention sites before implementation, so these results were omitted from the evaluation report. At the post-test, the intervention group was significantly more likely to have heard of the pill and the IUD and to know how to use them. Results also indicated that women in the experimental group had better knowledge of STIs, such as knowing that they could get an STI if their partner did not use condoms, and were significantly more likely to use condoms (see Table 2.3). Although figures were not listed in the report, knowledge of the purpose of a Pap test, the proportion of women who had had a Pap test, and knowledge and practice of good nutrition

59. INEGI, 1995.

were reported to be significantly higher in the experimental group as well. Finally, good hygiene practices, such as the existence of ventilation in the latrine, were more common in the experimental group.

Gender Outcomes

Single women in the experimental group scored significantly higher on the empowerment scale than single women in the control group (scores of 74 versus 62 percent). Married women in the experimental group scored somewhat higher on the empowerment scale than controls, but the difference was not significant (scores of 73 versus 70 percent). See Table 2.4.

Conclusion

Building on their success with this series of workshops, IMIFAP plans to design education modules targeted to men on health, gender, empowerment, domestic violence, sexuality, and HIV/AIDS, and a micro-finance program for women and men that includes training in gender, economics, risk taking, and self-efficacy.

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Table 2.3

Post-Intervention RH Outcomes of IMIFAP Program

| | INTERVENTION GROUP (%) (N=606) | CONTROL GROUP (%) (N=280) |
|---|-----------------------------------|------------------------------|
| Has heard of contraceptive pill | 76.6 | 67.3 |
| Knows how to use the pill | 48.0 | 35.9 |
| Has heard of the IUD | 56.9 | 31.5 |
| Knows how to use the IUD | 37.8 | 25.1 |
| Knows that she could get an STI due to lack of hygiene | 52.0 | 42.0 |
| Knows that she could get an STI if partner does not use condoms | 6.0 | 1.0 |
| Married women who use a condom | 6.0 | 1.0 |
| Knows that pregnant women should eat more | 71.0 | 54.0 |
| Has a family garden | 28.0 | 12.0 |

Source: IMIFAP, 2003.

Table 2.4

Average Post-Intervention Scores on Empowerment Scale from IMIFAP Program

| | INTERVENTION GROUP (%) (N=606) | CONTROL GROUP (%) (N=280) |
|---------------|-----------------------------------|------------------------------|
| Married women | 73 | 70 |
| Single women | 74 | 62 |

Source: IMIFAP, 2003

online at www.imifap.org.mx, on July 1, 2003.

Susan Pick, "Si Yo Estoy Bien, Mi Familia También (If I Am OK, My Family Is

Too)" (paper presented at the 2002 PsychoSocial Workshop, Atlanta, Georgia, May 7, 2002).

INTERVENTION:

Program for Adolescent Mothers

COUNTRY: **Jamaica**

TYPE OF INTERVENTION: **Reproductive health program**

IMPLEMENTING ORGANIZATIONS: **The Women's Centre of Jamaica Foundation (WCJF), supported over the course of the program by Pathfinder International, International Planned Parenthood Federation, the Jamaican government, the United Nations Children's Fund, the United Nations Population Fund, USAID, AVSC International (now EngenderHealth), and Christian Children's Fund of Canada. "Baby-fathers" evaluation conducted by Youth.now, the Futures Group International.**

Gender-Related Barriers to RH

In 1993, 45 percent of all Jamaican women aged 15 to 24 had been pregnant before the age of 19. Due to negative social attitudes, teen mothers usually drop out of school and are at a high risk of repeat pregnancy and its associated health risks during the teen years. Low levels of education limit employment opportunities and increase women's reliance on men for economic support. Yet, partners' support of adolescent mothers is often erratic, a pattern that may be repeated by male children who receive little parenting from their fathers. The existence of a law that penalizes men who impregnate young women under age 16 may be one factor limiting the visibility of male partners in young mothers' lives.

Objective and Strategy

The WCJF started the Program for Adolescent Mothers in 1978 with the objective of helping teenage mothers complete their education, prevent a second pregnancy in their adolescent years, and raise their employment potential so that they have a viable alternative to depending on men for support. By 1994, 48 percent of Jamaican mothers under the age of 16 were enrolled in the program. In seven centers and six outreach stations across the island, teenage mothers spend three to six months in the program before returning to school. During this time, girls receive academic instruction to avoid interrupting their secondary education and vocational training in crafts, fish farming, vegetable gardening, and other skills. Life skills education topics include reproductive health, family planning, STIs/HIV, child health, parenting, women's legal rights, and decision-making. Girls are also given counseling

for building self-respect. In 1990, program workers began outreach with "baby-fathers"—the partners of young women who are enrolled in the program. To promote their active involvement in parenting, "baby-fathers" were encouraged to attend the centers and participate in discussions with staff and counseling.

Evaluation Design: Post-Intervention Control Group/Post-Intervention Experimental Group Only

WCJF and the Population Council conducted an evaluation of the program in 1988-1989. A total of 88 program graduates under age 17 and a comparison group of 111 adolescent mothers who did not participate in the program were interviewed. In addition, 11 former participants responded in two focus group sessions. The Futures Group, under the Youth.now Project, also undertook a tracer study of "baby-fathers" who may have been exposed to center activities between 1990-1994. Conducted in 2002, this study was limited to fathers of male children in order to explore how the program affected father-son relationships and reproductive health knowledge and attitudes in the next generation of men. There were 31 cases in which the mother, father, and child could all be interviewed, for a total of 93 interviews (there was no comparison group for the tracer study).

RH Outcomes

Participants were found to be more effective in family planning use compared to teenage mothers not enrolled in the program, evidenced by a 14.6 percent rate of repeat pregnancy among participants and a 38.7 percent rate among non-participants (see Table 2.5). Among "baby-

fathers," 39 percent used condoms every time they had sex (see Table 2.6).

Gender Outcomes

Fifty-five percent of girls in the program returned to regular schools, compared to 15 percent of nonparticipant mothers (see Table 2.7). Focus group discussions showed that participants felt a high level of self-efficacy and responsibility in controlling their fertility, improvements in self-confidence, and increases in equitable attitudes about relationships with men. Support from partners was likely only if the couple had been in a serious relationship before the young woman became pregnant and if the partner was confident that the child was his biological offspring. Most fathers (54 percent) felt that they were doing a better parenting job than their fathers had done with them, and many felt that a separate program for men could help them communicate with their sons about reproductive health, sexuality, and personal development.

Conclusions

In writing about the Women's Centre of Jamaica Foundation's program for adolescent mothers, Pamela McNeil said:

"The dawning of empowerment for young women is delicately balanced among self-knowledge, reproductive rights, quality education and economic freedom. If we really believe that reproductive rights are human rights, then we must recognize the synergy that links reproductive rights and education to the empowerment of young women. This has been demonstrated time and time again in all the evaluations of the WCJF over several years."⁶⁰

The success the program has experienced with young women does not extend

to their partners, however, whose participation continues to be stymied by the fear of prosecution for impregnating a minor. Nonetheless, a 1993 cost-benefit analysis estimated that each dollar invested in the Program for Adolescent Mothers resulted in a savings of US\$6.7 to society.

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Pamela McNeil, *Preventing Second Adolescent Pregnancies by Supporting Young Mothers; FOCUS on Young Adults Project Highlights, 1999*, accessed online at <http://www.pathfind.org/pf/pubs/focus/Project%20Highlights/JamaciaWCentre.htm>, June 26, 2003.

60. McNeil, 1999.

Table 2.5

Rate of Repeat Teenage Pregnancy Among WCJF Participants

| | PROGRAM PARTICIPANTS (%) (N=88) | NON-PARTICIPANTS (%) (N=111) |
|---|---------------------------------|------------------------------|
| Respondents having a second teenage pregnancy | 14.6 | 38.7 |

Barnett, et al. 1996.

Table 2.6

Condom Use Among Baby-Fathers in WCJF Evaluation

| | "BABY-FATHER" PARTICIPANTS (%) (N=31) |
|---------------------|---------------------------------------|
| Always uses condoms | 39 |

Source: Gayle, 2002.

Table 2.7

Rate of Return to School Among WCJF Participants

| | PROGRAM PARTICIPANTS (%) (N=88) | NON-PARTICIPANTS (%) (N=111) |
|----------------------------|---------------------------------|------------------------------|
| Returned to regular school | 55 | 15 |

Barnett, et al. 1996.

INTERVENTION:

Better Life Options Program (BLP)

COUNTRY: India

TYPE OF INTERVENTION: Cross-sectoral program with reproductive health component

IMPLEMENTING ORGANIZATIONS: CEDPA with Prerana in peri-urban Delhi, Bharatiya Grameen Mahila Sangh (BGMS) in rural Madhya Pradesh, and Gujarat State Crime Prevention Trust in rural Gujarat. Evaluation funded by the Bill and Melinda Gates Foundation.

Gender Barriers to RH

Many girls in India have few options other than early marriage and pregnancy. Compared to boys, they are less likely to go to school and, therefore, to receive the benefits of school-based clinics and skills for attaining employment. Within the family, girls receive less health care, education, and nutrition than boys, and the onset of puberty decreases a girl's physical mobility and autonomy in decision-making. Adolescent marriages and pregnancies are common. According to the National Family Health Survey of 1998-1999, only 38.6 percent of married adolescents were involved in decisions about their own health care, and 86 percent needed permission from their husbands or other family members to go to the market.

Objective and Strategy

Since 1989, the Better Life Options Program (BLP) has used an empowerment model to train low-income adolescent girls aged 12 to 20, both married and single, in family life education, literacy and vocational skills, and general and reproductive health. Local organizations in three sites tailor the program design to fit local contexts, stressing leadership, social mobilization through advocacy, and community involvement. In the peri-urban slums of Delhi, Prerana offers six-month trainings at a community center. In Indore, Madhya Pradesh, BGMS organizes eight-month trainings at a village center, a more advanced four-month residential program, and collectives for girls to work together on community issues. The program in rural Gujarat, through the Gujarat State Crime Prevention Trust, implements ten-month trainings. By 1999, the program had reached over 10,000 adolescent girls in India.

Evaluation Design: Post-Intervention Control Group

In 1999, CEDPA began an evaluation of the BLP. The evaluation team restricted the sample to alumnae girls who had attended the program from 1996-1999 and a control group selected at random from villages and slums in areas comparable to those in which the program operated. All married former participants that could be located were included in the study, along with a random sample of unmarried former participants. Altogether, the study sample comprised 1,693 girls (858 control and 835 program alumnae). Local interviewers administered questionnaire surveys to respondents including questions on reproductive health, HIV/AIDS, self-esteem, menstruation, pregnancy, lacta-

tion, childcare during diarrhea, nutrition, immunization, and other topics.

RH Outcomes

The average age at marriage among program graduates was 18.0, compared to 17.6 among controls. Married respondents were more likely than controls to discuss family planning with their husbands (55 percent more likely) and to use contraception if they had gone through the program. Married program graduates were more likely to receive professional obstetrical care, including at least three prenatal visits, tetanus toxoid immunization, postnatal care, and delivery in a health institution. High nutrient foods were consumed significantly more often by graduates than by non-graduates (fig-

Table 2.8

Reproductive Health Behaviors Among Married BLP Alumnae and Controls

| | BLP ALUMNAE (%) (N=835) | CONTROL GROUP (%) (N=858) |
|--|-------------------------|---------------------------|
| Married at 18 or older* | 52 | 35 |
| Received at least three antenatal care visits | 91 | 64 |
| Received tetanus toxoid immunization | 91 | 62 |
| Delivered in health institution* | 50 | 36 |
| Received postnatal care | 57 | 39 |
| Currently uses contraception* | 36 | 27 |
| Completed children's immunizations | 63 | 32 |
| Treats children with oral rehydration solution | 42 | 12 |
| | BLP ALUMNAE (%) (N=835) | CONTROL GROUP (%) (N=858) |
| Average number of children** | 1.73 | 1.98 |
| Average age at marriage** | 18.0 | 17.6 |

All differences are statistically significant unless noted; significance level not reported.

*Difference becomes non-significant after controlling for girls education.

**Difference not statistically significant.

Source: CEDPA, 2001.

Table 2.9

Selected Gender Outcomes of Better Life Options Program

| | BLP ALUMNAE (%) (N=835) | CONTROL GROUP (%) (N=858) |
|--|----------------------------|------------------------------|
| Decides autonomously: | | |
| To go to market | 52 | 27 |
| To spend what is earned | 42 | 12 |
| When to marry | 25 | 7 |
| To continue education | 62 | 39 |
| Uses public transportation | 58 | 25 |
| Literate | 95 | 68 |
| Completed secondary education | 66 | 46 |
| Learned a vocational skill | 99 | 22 |
| Employed or self-employed | 35 | 8 |
| Traveled alone to health center in past six months | 59 | 20 |
| Traveled alone outside village in past six months | 68 | 21 |
| Had a say in selecting husband | 55 | 34 |
| Members of village level groups or clubs | 47 | 2 |

Note: All differences are statistically significant.
Source: CEDPA, 2001.

ures not reported). Overall, graduates had fewer children (average 1.73 versus 1.98) and fewer child deaths (40 percent higher probability in control group), in part due to their greater likelihood of completing their children's immunizations (63 versus 32 percent) and treating them with oral-rehydration solution during diarrhea episodes (42 versus 12 percent). There were no differences in the number of diarrhea episodes experienced by children (figures not reported). Finally, program alumnae were 65 percent more likely to be aware of HIV/AIDS and 17 percent more likely to know about its prevention. The authors of the evaluation state that the majority of these differences were significant even after controlling for girls' education, literacy status, parents' education, and marital status, but the results are not reported for all variables. Table

2.8 shows the reproductive health outcomes for which figures are presented in the evaluation report.

Gender Outcomes

Compared to the control group, girls graduating from the program were more likely to be literate; to have completed secondary school; to be studying at the time of the investigation (25 percent more likely); to have learned a vocational skill; to have a savings account (figures not reported); to be employed; and to have control over how to spend the money they earned. Graduates also were more comfortable speaking in front of elders (50 percent more likely), expressing their ideas, and making friends (figures not reported). They had more control over decisions that affected them, such as health care, meal planning (figures not

reported), continuing education, husband selection, and age of marriage. Program participants were more likely to use public transportation; travel alone to the market, health center, or outside the village; follow the national news (figures not reported); and be members of village level groups or clubs. A greater proportion of girls in the program believed that men should help with housework and women should work outside the home (figures not reported); that women should initiate discussions about child spacing with their husbands (51 percent more); that infertility is not usually the woman's fault (50 percent more); and that education is as important for girls as it is for boys (34 percent more). The authors of the evaluation state that the majority of these differences were significant even after controlling for girls' education, literacy status, parents' education, and marital status, but the results are not reported for all variables. Table 2.9 shows the gender outcomes for which figures are presented in the evaluation report.

Conclusions

The Better Life Options Program has had a powerful impact on the lives of adolescent participants, even when self-selection biases are statistically reduced. The program's success demonstrates that women's empowerment in community and family life and their increasing ability to achieve reproductive health occur simultaneously.

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INTERVENTION:

Husbands and Postabortion Care

COUNTRY: **Egypt**

TYPE OF INTERVENTION: **Operations research study**

IMPLEMENTING ORGANIZATIONS: **The Population Council's Asia and Near East Operations Research and Technical Assistance Project in Cairo, and the Egyptian Fertility Care Society, with support from USAID**

Gender-Related Barriers to RH

One in five admissions to the obstetrics/gynecology ward in public-sector hospitals in Egypt is for postabortion (spontaneous or induced) care. After returning home, many of these women resume their domestic duties before having had time to fully recover. Women who suffer from postabortion complications face pressures from husbands and in-laws to become pregnant again soon after a miscarriage, in order to prove their fertility. A preliminary 1997 study showed that, without an adequate recovery period before the next pregnancy, women are more likely to experience obstetrical complications.⁶¹

Objective and Strategy

The study's hypotheses were that counseling husbands on postabortion care would positively affect the physical and psychological recovery of their wives and contraceptive use at one month after discharge. Investigators oriented physicians in six hospitals in Menia Governorate in southern Egypt and trained them in counseling husbands of postabortion women. When a consenting postabortion care patient was ready to be discharged from the hospital, her attending physician spoke to her husband privately in a short conversation about the following topics: the woman's need for rest and adequate nutrition; postabortion warning signs indicating need for care; the possibility of a return to fertility within two weeks; the need for family planning to avoid unwanted pregnancies and ensure an adequate recovery; and, in the case of spontaneous abortions, the cause of the miscarriage. The number of patients agreeing to participate over the two months of the study was 366.

Evaluation Design: Post-Intervention Control Group

A post-test-only control group design was used with a sample size of 293 couples—136 in the intervention group and 157 in the control group. Thirty days after a woman's discharge from the hospital (and thus 30 days from the intervention), she responded to a survey. A "weakness index" indicated her physical health based on symptoms such as fatigue, shortness of breath, or headaches. A woman's emotional health was assessed through the Psychological Distress Index, which presented a list of emotional symptoms such as sleep difficulty, loss of appetite, and

anxiety. Women also responded to surveys measuring three facets of husbands' support (instrumental support, emotional support, and family planning support).

RH Outcomes

Good physical recovery of postabortion women was associated with high emotional support from husbands (odds ratio, 1.7) and husband counseling (odds ratio, 1.3). Husband counseling had less effect on good emotional recovery of women than did a low education level, high emotional support from the husband, and a pregnancy that was planned. Husband counseling did have a positive effect on

Table 2.10

Logistic Regression Analysis Results for Good Recovery and Contraceptive Use

| VARIABLES ASSOCIATED WITH GOOD PHYSICAL RECOVERY OF WOMAN | ADJUSTED ODDS RATIO (N=293) | 90% CONFIDENCE INTERVAL |
|--|-----------------------------|-------------------------|
| High emotional support from husband | 1.7 | 1.1,2.6 |
| Husband counseled | 1.3 | 0.8,2.0 |
| High instrumental support from husband | 1.1 | 0.7,1.7 |
| Complications during recovery | 0.2 | 0.1,0.3 |
| VARIABLES ASSOCIATED WITH GOOD EMOTIONAL RECOVERY OF WOMEN | | |
| Low education level of woman | 2.5 | 1.4,4.3 |
| High emotional support from husband | 2.0 | 1.3,3.0 |
| Index pregnancy planned | 1.7 | 1.1,2.6 |
| Husband counseled | 1.0 | 0.6,1.4 |
| Complications during recovery | 0.4 | 0.2,0.7 |
| VARIABLES ASSOCIATED WITH CONTRACEPTIVE USE OR INTENTION TO USE | | |
| High family planning support from husband | 5.9 | 3.5,10.0 |
| Husband counseled (at smaller hospitals) | 3.8 | 1.5,9.4 |
| Previous use of family planning | 3.5 | 1.7,5.6 |
| Number of living children 3 or more | 2.5 | 1.4,5.0 |
| Husband counseled | 0.6 | 0.3,1.2 |
| Index pregnancy planned | 0.4 | 0.2,0.7 |

Source: Abdel-Tawab, et al., 1999.

61. Huntington et al., 1997.

contraceptive use at smaller hospitals, where training of physicians had been more thorough (odds ratio, 3.8), although family planning support by husband had the greatest effect on contraceptive use (odds ratio, 5.9). See Table 2.10 for other variables associated with good recovery and contraceptive use.

Gender Outcomes

Husbands in both the intervention and the control group were more likely to provide emotional or family planning support to their wives than instrumental support, such as getting to appointments (see Figure 2.1).

Logistic regression analysis revealed that counseled husbands (compared to the control group) were 1.5 times more likely to provide higher than average instrumental support to their wives, 1.3 times more likely to provide emotional support, and 1.6 times more likely to provide family planning support. Table 2.11 shows other variables associated with high support from husbands.

Conclusion

Overall the results of this trial intervention show that counseling husbands in postabortion care and contraception has a positive impact on the support that husbands provide to women postabortion, on women's postabortion recovery, and, when counselors have been thoroughly trained as they were at the smaller hospital sites, on contraceptive use.

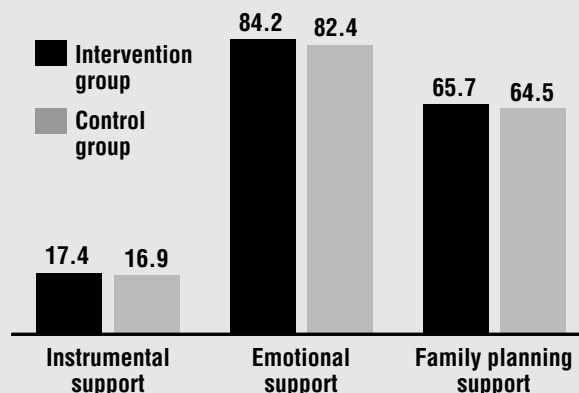
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D. Huntington, L. Nawar, and D. Abdel-Hady, "Women's Perceptions of Abortion in Egypt," *Reproductive Health Matters* 9(1997): 101-107.

Figure 2.1

Results of Husband Support Survey



Source: Abdel-Tawab, et al., 1999.

Table 2.11

Logistic Regression Analysis for High Husband Support

| | ADJUSTED ODDS RATIO (N=293) | 90% CONFIDENCE INTERVAL |
|---|-----------------------------|-------------------------|
| INSTRUMENTAL SUPPORT | | |
| Nuclear household composition | 2.6 | 1.7,4.0 |
| Complications during recovery | 1.8 | 1.1,3.2 |
| Husband's education secondary level or higher | 1.7 | 1.0,2.5 |
| Husband counseled | 1.5 | 0.9,2.4 |
| Husband counseled (at smaller hospitals) | 0.5 | 0.2,0.9 |
| EMOTIONAL SUPPORT | | |
| Index pregnancy planned | 2.8 | 1.8,5.0 |
| Number of living children 3 or more | 2.0 | 1.2,3.3 |
| Husband and wife blood relatives | 1.9 | 1.2,2.9 |
| Husband counseled | 1.3 | 0.8,1.9 |
| FAMILY PLANNING SUPPORT | | |
| No desire for more children | 5.0 | 2.5,10.0 |
| Husband's education secondary level or higher | 2.5 | 1.4,5.0 |
| Number of living children 3 or more | 2.5 | 1.4,5.0 |
| Smaller hospital | 1.7 | 1.1,2.7 |
| Husband counseled | 1.6 | 1.1,2.6 |

Source: Abdel-Tawab, et al., 1999.

INTERVENTION:

Father's Role in Postpartum Family Planning

COUNTRY: Turkey

TYPE OF INTERVENTION: Operations research study

IMPLEMENTING ORGANIZATIONS: Istanbul Medical School Woman and Child Health Research and Training Unit, supported by EngenderHealth's Men as Partners Initiative, the Mellon Foundation, the Population Council's Middle East Research Awards Program, and the Robert H. Ebert Program on Critical Issues in Reproductive Health.

Gender-Related Barriers to RH

Men's roles in reproductive health are limited in Turkey. In a preliminary study by the Istanbul Medical School at Capa, women clients said they expect their husbands to provide financial and emotional support, but that men's responsibilities in

laboring outside the home excuse them from participating in household and parenting chores. Although women desire open and communicative relationships with their husbands, and men say they do not want to recreate the distant relationships their fathers had within the family, the study found that young couples rarely speak to each other about reproductive health. At the clinic, men are seen accompanying their wives but generally wait outside the examination area until consultations are finished. Clinics in Istanbul rarely reach out to men, in spite of men's reported willingness to learn more about reproductive health and how to help their wives with tasks traditionally considered women's responsibility. As one man said, "I don't know what [my wife] is feeling. Nobody taught me. I didn't get any information."⁶²

vention aimed to reach first-time parents in particular and took place between 1992-1994. Two intervention groups were formed, one for couples and one for mothers only. Each group attended four antenatal group education sessions, occurring weekly and lasting one hour and a half. Topics included pregnancy, childbirth, infant care, postpartum health, and family planning. Participants (both partners in a couple or mothers alone) were also sent an informational booklet answering common questions and concerns of new parents and a number for telephone counseling services, functioning during business hours. Telephone educators were able to answer questions and consult with clinic doctors if necessary.

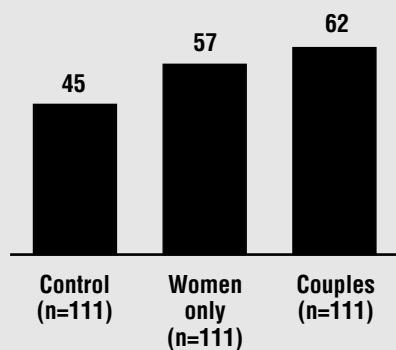
Evaluation Design: Post-Intervention Control Group

Project staff randomized 333 primigravida women (women expecting their first labor and delivery) into three groups. In the first group, mothers and their partners were invited to participate; in the second group, only mothers were invited; and the third

62. Turan et al., 2002.

Figure 2.2

Use of Modern Contraceptives Among Control Group, Women Only Group, and Couples Group



Source: Turan et al., 2002.

Objective and Strategy

To respond to the potential for greater men's involvement in postpartum health, the Woman and Child Health Unit at the Istanbul Medical School Hospital designed an intervention to increase exclusive breastfeeding, postpartum checkups, and family planning. The inter-

group received no special intervention outside of the regular services of the family health clinic. Participants were contacted for follow-up interviews four months after their deliveries.

RH Outcomes

The use of modern contraceptives was significantly higher in the intervention groups (Figure 2.2), and multivariate analysis showed that contraceptive use in the couples group was significantly higher than in the other two groups. Infant checkups and women's postpartum checkups were slightly more common in the intervention groups as compared to the control group. Male attendance at information sessions was poor (26 percent of men had attended at least one session), which respondents said was due to the difficulty men have in getting excused from work.

Gender Outcomes

Among the three study groups, there were no significant differences in responses to the question of who made household decisions in infant feeding, infant health, postpartum women's health, and family planning. However, the inter-

Table 2.12

Partner Communication Outcomes in Male Involvement Initiative in Turkey

| PERCENTAGE OF RESPONDENTS WHO SPOKE TO PARTNER ABOUT POSTPARTUM ISSUES AFTER HAVING.... | WOMEN | MEN |
|---|---------------------|-----------|
| Attended at least one session (%) | 70 (n not reported) | 77 (n=22) |
| Read the question-and-answer booklet (%) | 63 (n=132) | 79 (n=88) |

Source: Turan et al., 2002.

vention stimulated conversation between partners in 70 percent of women and 77 percent of men who attended at least one session, and 63 percent of women and 79 percent of men who read the question-and-answer booklet (Table 2.12).

Conclusion

A follow-up project is testing an intervention that is similar to the one reported here but tailored more specifically for men. Men have separate educational sessions at a community center rather than at the hospital (which is oriented to women), and sessions take place on Sunday afternoons when men are most likely to be available.

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INTERVENTION:

Reaching Men Through Agricultural Extension

COUNTRY: Honduras

TYPE OF INTERVENTION: Operations research study

IMPLEMENTING ORGANIZATIONS: CARE/Honduras and the Population Council INOPAL/III

Gender-Related Barriers to RH

A preliminary study with agriculturalists in rural communities in four Honduran states showed that only 42 percent of women believed their partners would support them in the decision to plan their families. Only about 50 percent of women who said that they did not want another child for at least two years were using a family planning method.

Objective and Strategy

CARE and the Population Council chose to test strategies for improving men's participation in reproductive health decisionmaking. They hypothesized that exposure to materials and organized discussions about reproductive health would result in greater reproductive health knowledge among men, greater practice of family planning among couples, and greater couple communication about reproductive health. CARE, in conjunction with the Ministry of Natural

Resources, was already operating the Community Agroforestry Project (PACO) in several villages in Yoro, Santa Barbara, Copan, and Lempira states. These villages were divided into three sectors, two of which would receive interventions. The third sector was a control area (but was later dropped from the analysis, as explained below).

In Sector A, PACO extensionists trained community volunteers to provide reproductive health education during meetings with farmers and cooperative members (who are men). A manual entitled "La Cartilla" provided instructions in participatory activities and discussion questions for groups in responsible fatherhood, reproductive health, family planning, sexually transmitted infections, and safe motherhood and lactation. In Sector B, a booklet called "Family Management Plan" was distributed. This booklet, based on one called "Farm Management Plan" (which is used in agri-

cultural extension and targeted to rural couples), leads couples through a decision-making process about family size and birth spacing in relation to their resources and goals. It includes the following themes: household resources, childcare, maternal/paternal health, prenatal care, postnatal care, nutrition, and couple communication. Interventions lasted from May 1996 to August 1997.

Evaluation Design: Pre- and Post-Intervention Experimental Group Only

The original design called for comparing the pre- and post-intervention results in each of the intervention areas to results in a control area. However, contamination occurred across all areas, and the evaluation team combined the data in the two intervention areas and excluded the control group from the analysis. A baseline survey took place in March 1996, with a sample of 127 women and 131 men. The final survey took place in October 1997 with 299 women and 300 men.

Subgroups of family planning users answered additional questions, which included 44 women and 35 men in the baseline and 133 women and 149 men in the final survey.

RH Outcomes

Post-intervention, both men and women were significantly more likely to have heard of the IUD, pills, and female sterilization. Women were more likely to know about condoms, and men had a greater increase in knowledge of vasectomy. Knowledge of what a woman should do to prevent cervical cancer increased among men and women combined (from 62.7 to 82.5 percent). A greater proportion of respondents knew that hemorrhaging (28.7 versus 44.2 percent) and stomach pains (21.7 versus 59.9 percent) were warning signs during pregnancy. Among men, recognition of penile discharge and

Table 2.13

Family Planning Outcomes of Male Involvement Initiative in Honduras

| INDICATOR | WOMEN (%) | | MEN (%) | | TOTAL (%) | |
|------------------------------|------------------|-----------------|------------------|-----------------|------------------|-----------------|
| | BASELINE (N=127) | ENDLINE (N=299) | BASELINE (N=131) | ENDLINE (N=300) | BASELINE (N=426) | ENDLINE (N=431) |
| Knowledge of: | | | | | | |
| IUD | 23.6* | 43.5* | 11.5* | 32.7* | 17.4* | 38.1* |
| Condom | 53.5* | 75.9* | 74.0 | 80.3 | 64.0* | 78.1* |
| Pill | 72.4* | 90.3* | 70.2* | 84.0* | 71.3* | 87.1* |
| Female sterilization | 32.3* | 53.8* | 20.6* | 40.0* | 26.4* | 46.9* |
| Vasectomy | 9.4 | 14.7 | 6.9* | 14.3* | 8.1* | 14.5* |
| Injection | 11.0 | 13.0 | 9.2 | 11.0 | 10.1 | 12.0 |
| Ovrette | 0.8 | 1.3 | 0.8 | 1.7 | 0.8 | 1.5 |
| Billings | 1.6 | 1.7 | 3.1 | 3.0 | 2.3 | 2.3 |
| Rhythm | 26.8 | 18.7 | 30.5 | 13.3 | 28.7 | 26.0 |
| Using family planning method | 36.7* | 55.0* | 28.8* | 58.2* | 32.8 | 56.6 |

*p<0.05

Source: Lundgren et al., 1998.

Table 2.14

Knowledge of What to Do If a Woman Has Warning Signs During Pregnancy, Baseline and Endline Surveys

| WHAT SHOULD A WOMAN WITH WARNING SIGNS DO? | WOMEN (%) | | MEN (%) | | TOTAL (%) | |
|--|------------------|-----------------|------------------|-----------------|------------------|-----------------|
| | BASELINE (N=127) | ENDLINE (N=299) | BASELINE (N=131) | ENDLINE (N=300) | BASELINE (N=426) | ENDLINE (N=431) |
| Go to a health center | 25.2* | 55.9* | 60.5* | 75.7* | 43.0* | 85.8* |
| Go to a midwife | 0.0* | 18.1* | 0.0* | 30.0* | 0.0 | 24.0 |
| Go to the hospital | 26.0* | 35.1* | 19.1* | 57.0* | 22.5* | 46.1* |
| Go to a doctor | 42.5* | 47.5* | 28.2* | 63.3* | 35.3* | 55.4* |
| Go to a pharmacy | 6.3* | 0.7* | 8.4* | 0.3* | 7.4* | 0.5* |
| Does not know | 1.6 | 3.3 | 4.6* | 0.0* | 3.1 | 1.7 |

*p<0.05

Source: Lundgren et al., 1998.

Table 2.15

Couple Communication and Support Outcomes of Male Involvement Initiative in Honduras

| COUPLE COMMUNICATION AND SUPPORT | WOMEN (%) | | MEN (%) | | TOTAL (%) | |
|---|------------------|-----------------|------------------|-----------------|------------------|-----------------|
| | BASELINE (N=127) | ENDLINE (N=299) | BASELINE (N=131) | ENDLINE (N=300) | BASELINE (N=426) | ENDLINE (N=431) |
| Has spoken with partner about family planning in the last 15 days | 36.2 | 45.8 | 41.2* | 51.7* | 38.8* | 48.7* |
| Has spoken with partner about STIs/HIV in the last 15 days | 35.4* | 60.2* | 55.0 | 47.7 | 45.3 | 53.9 |
| Man gave woman support in method selection | 88.0 | 88.6 | 92.1 | 96.8 | 89.8 | 92.7 |
| Type of support given from man to woman in family planning use: | (n=44) | (n=133) | (n=35) | (n=149) | (n=79) | (n=282) |
| Money | 29.5 | 42.1 | 17.1* | 35.6* | 24.1* | 38.7* |
| Go to classes | 6.8 | 17.4 | 40.0 | 24.2 | 21.5 | 21.0 |
| Accompany during appointment | 27.3 | 31.8 | 28.6 | 34.2 | 27.8 | 33.1 |
| Moral support | 36.4 | 52.3 | 85.7* | 57.7* | 58.2 | 55.2 |

*p<0.05

Source: Lundgren et al., 1998.

pain when urinating as STI symptoms increased significantly (from 13.5 to 48.5 percent and 16.2 to 53.0 percent, respectively). Men and women combined showed an increase in the knowledge that condom use can prevent STIs (35.7 to 62.0 percent). Other outcomes are listed in Tables 2.13 and 2.15.

Gender Outcomes

Women experienced an increase in recent communication with partners about STIs/HIV (35.4 to 60.2 percent). The percentage of respondents who reported that they spoke to their partners about family planning in the prior 15 days rose from 38.8 to 48.7 percent. As for support given by men to women for family planning (limited to family planning users), the percentage of respondents who said that

the male partner had given money for family planning rose from 24.1 to 38.7 percent. Other types of support—going to classes and appointments and moral support—did not show significant increases. In fact, figures dropped for men reporting on giving moral support and going to classes. Authors commented that going to classes was not stressed in the intervention materials, and they speculate that men's conception of moral support may have grown more specific as a result of the intervention, leading some men to understand that they, in fact, were not providing moral support.⁶³

Conclusion

The authors of the evaluation concluded that two of the three hypothesized outcomes did occur—an increase in men's reproductive health knowledge and in couple family planning use. They ascribe the lack of a greater impact on couple communication and support to the pre-existence of high levels of support from men for reproductive health and family planning (which were not sufficiently analyzed in the preliminary study). Yet, the intervention had an important impact on knowledge and behavior of both men and women, and CARE plans to implement similar interventions in other areas.

References

R. Henriquez, E. Arias, C. Hernandez, and J.R. Garcia, *Incorporation of Family Planning in CARE Programs in Western Honduras*. Final Report (Tegucigalpa: CARE / Honduras, 1994).

Rebecka Lundgren, Irma Mendoza, Dolores Maria Valmana, and Judy Canahuati, *Strategies to Involve Men in Reproductive Health Care: From Farm Management to Family Management* (New York: The Population Council, 1998).

63. Rebecka Lundgren, personal communication.

INTERVENTION:

Mayan-Language Educators in Gender and Family Planning

COUNTRY: Guatemala

TYPE OF INTERVENTION: Reproductive health program

IMPLEMENTING ORGANIZATIONS: The Asociación Guatemalteca de Educación Sexual y Desarrollo Humano (AGES) and the Population Council/INOPAL III Project

Gender-Related Barriers to RH

The evaluation for this program does not discuss gender-related barriers to reproductive health within rural areas of Guatemala where the program took place. However, program designers likely identified factors related to gender, since gender was included as a topic in the program curriculum. Evaluation authors did identify the lack of qualified indigenous health educators and a negative attitude toward family planning (despite awareness of the benefits of child spacing) as constraints to the increased use of family planning.

Objective and Strategy

AGES designed the program to test the effectiveness of a Mayan-language course in reproductive health, targeted to rural indigenous men and women, in reaching qualified teachers of the course and impacting the behavior of course students. In 1996, AGES certified teachers from the National Bilingual Education Program (funded by USAID) to teach 10-hour, three module courses in birth spacing; pregnancy, birth, and gender; and mother and child care. Modules included chapters in decision-making about one's own body, domestic violence, family planning methods, STIs, and self-care and child care. Soon after training, teachers formed groups in three departments (Chimaltenango, Quetzaltenango, and San Marcos) where three Mayan languages are spoken (Mam, Quiche, and Kakchiquel). Teachers and students together determined the composition of the groups (male, female, or both), the frequency and duration of sessions, and meeting locations. Teachers soon became contraceptive distributors, as students requested supplies and AGES was eager to support distribution activities.

RH Outcomes of AGES Project

| FOLLOWING INTERVENTION, RESPONDENT... | | RESPONDENTS (%) (N=1,001) |
|---------------------------------------|------------------|------------------------------|
| Sought FP services for first time | | 40 |
| Talked with partner about FP | | 85 |
| CONTRACEPTIVE PREVALENCE RATE | PRE-INTERVENTION | POST-INTERVENTION |
| CPR in project area (%) | 8 | 11 |

Source: Cospin and Vernon, 1997.

Evaluation Design: Post-Intervention Experimental Group Only/Qualitative

A post-intervention survey between November 1996 and January 1997 gathered information from 1,001 students of the course, three-quarters of whom were women.

RH Outcomes

Forty percent of those interviewed said that after the course they had sought family planning from service providers for the first time and 85 percent talked with their partners about birth spacing (Table 2.16). Asked what was the most important thing they had learned in the course, 22 percent of respondents mentioned contraceptive methods, birth spacing, or family planning. In the areas of the intervention, the contraceptive prevalence rate (CPR) rose three percentage points over the course of the program. Because the CPR was only eight percent previously, this represents almost a 40 percent increase in use of modern methods among women married or in union.

Gender Outcomes

Among those who attended the module on pregnancy, gender, and violence, 68 percent reported receiving "greater support from their partners" after the course.

Five percent of respondents mentioned a gender or violence topic as the most important thing they had learned in the course.

Conclusion

This intervention provided high-quality, face-to-face messages about reproductive health and gender relations to poor members of isolated rural communities. The impact measured by the evaluation occurred in just seven months of the program's operation.

References

Gloria Cospin and Ricardo Vernon, *Reproductive Health Education in Indigenous Areas Through Bilingual Teachers in Guatemala* (Guatemala City: Asociación Guatemalteca de Educación Sexual y Desarrollo Humano and the Population Council/INOPAL III Project, 1997).

Maternal Mortality and Morbidity

Background

Reducing maternal mortality, the death of women from pregnancy and delivery-related causes, is a major goal of the ICPD *Programme of Action* and the Safe Motherhood Initiative.⁶⁴ The ICPD target was to reduce levels of maternal mortality measured in 1990 by one half by the year 2000. However, maternal mortality levels remain high.

Each year, over half a million women die from pregnancy-related causes. Most of these maternal deaths take place in the developing world and most are unnecessary. Of the women who are pregnant each year, an estimated 40 percent experience pregnancy-related health problems, with 15 percent suffering from serious or long-term complications. An estimated 300 million women today suffer from disabilities, such as anemia, uterine prolapse (the protrusion of the uterus out of the vagina), fistulae (holes in the birth canal that allow leakage from the bladder or rectum into the vagina), pelvic inflammatory disease, or infertility, as a result of having experienced pregnancy and delivery complications.⁶⁵

The death of a mother has broad familial and social implications. It is not uncommon for women in Africa, when about to give birth, to bid their older children farewell, telling them, “I am going to the sea to fetch a new baby, but

the journey is long and dangerous and I may not return.”⁶⁶ Tragically, when a mother dies, her children are also more likely to die.⁶⁷ A pregnant teenager is at greater risk for pregnancy-related death—up to five times more likely for mothers under age 15.⁶⁸ Children of mothers who survive but are poorly cared for suffer as well. At least 30 to 40 percent of infant deaths are the result of poor care during pregnancy and delivery.⁶⁹ Poor maternal health and nutrition contribute to low birth weight in 20 million babies each year—almost 20 percent of all births.⁷⁰

Maternal mortality has clearly delineated biomedical causes and solutions.⁷¹ Hemorrhage, obstructed labor, induced abortion, sepsis (infection) and hypertensive disorders are the five major direct medical causes of poor maternal health, accounting for approximately 80 percent of all maternal deaths.⁷² Unsafe induced abortions account for 13 percent of maternal deaths around the world, but up to 33 percent in some countries.⁷³ Indirect medical causes (such as anemia, malaria, viral hepatitis and tuberculosis) account for approximately 20 percent of maternal mortality.⁷⁴

Maternal malnutrition is associated with an increased risk of maternal death, spontaneous abortion, infection, anemia, compromised immune function, lethargy and weakness, and lower productivity.⁷⁵ Nutrient deficiencies that pre-exist pregnancy may be exacerbated by childbearing.

Poor utilization rates of clinical services and trained personnel also contribute to poor maternal health. The percentage of women who receive no antenatal care is 37 percent in Africa, 35 percent in Asia, and 27 percent in Latin America and the Caribbean. Each year, 60 million women give birth with the help of an untrained traditional birth attendant or family member, or with no help at all. The majority of women in developing countries receive no postpartum care.⁷⁶

64. The Safe Motherhood Inter-Agency Group (IAG) launched the Safe Motherhood Initiative in 1987. For more on this initiative, see www.safemotherhood.org.

65. Starrs, 1998; Fortney and Smith, 1996; Stewart et al., 1997.

66. Brundtland, 1999.

67. Strong, 1992.

68. United Nations Dept. of International Economics and Social Affairs, 1991.

69. World Health Organization, 1996.

70. Bellamy, 1998.

71. Gay et al., 2002.

72. World Health Organization, 1997.

73. Starrs, 1998.

74. World Health Organization, 1997.

75. Huffman et al., 2001; Mackey, 2000.

76. World Health Organization, 1997.

Yet, there is a large body of research and program experiences that “demonstrates that pregnancy and childbirth need not put most women at significant risk.”⁷⁷ Health care policies and programs can be improved to reduce maternal morbidity and mortality. Community involvement in locally based safe motherhood interventions is essential to their success. Life-saving interventions, such as referral to medical centers, antibiotics, and surgery, must be made available to all women, especially those in rural areas who may lack money for health care and transportation, or who may simply lack the permission of their husbands to leave the village to seek care.

Gender-Related Barriers to Reducing Maternal Mortality and Morbidity

Gender norms and the status of women play a large role in shaping dangers associated with motherhood. Women’s overall status, particularly when it comes to economics, legal rights, education, and decisionmaking, can affect their access to maternal health care and influence maternal health outcomes. Women’s lack of decision-making power can limit their access to health care and negatively affect maternal health outcomes.⁷⁸ Many women’s limited access to education translates into a poor understanding of basic health care concepts—including understanding the danger signs in pregnancy. Women who have had few experiences playing a role outside the home may be very uncomfortable in the public sphere, including clinic and hospital settings, where they may be unable to question or express their concerns to health care providers.

Men in many societies are more likely than women to control household expenditures and decisionmaking in the family. When a man is the principal wage earner in a household, his health may be valued more than a woman’s, since a missed day of work for the man due to illness means missed income.⁷⁹ Thus, families may be reluctant to use resources for prenatal, intrapartum, postpartum, and post-abortion care. Other women who know they need to consume more calories during pregnancy or seek treatment when danger signs arise may nonetheless feel it is wrong to divert resources from the rest of the family⁸⁰ or may be scolded

by husbands or mothers-in-law for doing so.⁸¹ Although men may be the principal decision-makers about seeking health services, they may communicate little with their wives about their health during pregnancy and the postpartum period and may remain ignorant as to whether their wives had ever experienced complications during labor and delivery.⁸²

Gender norms surrounding childbearing vary within societies and cultures. During labor, women may desire to demonstrate their strength or they may be expected to suffer through laboring or birthing with little or no aid.⁸³ Even though many studies have demonstrated the beneficial impact of labor companions on clinical outcomes,⁸⁴ physicians and other obstetric service providers may be reluctant to allow family members and other support people to participate in a laboring woman’s care.⁸⁵

Interventions That Address Gender-Related Barriers to Reduce Maternal Mortality and Morbidity

Accommodating Gender Differences

Initiatives in safe motherhood have included interventions to prevent the four delays that can lead to maternal death: delays in recognizing danger signs, in deciding to seek care, in reaching care, and in receiving care at health facilities.⁸⁶ For example, in Pakistan, many women require permission from family elders and husbands to seek health care. A counseling intervention was successful in raising women’s awareness of the importance of gaining this permission in advance, before labor.⁸⁷ Other programs have educated men about recognizing and responding to danger signs.⁸⁸ A Safe Motherhood initiative in Nigeria encouraged

77. Ransom and Yinger, 2002.

78. Atkinson and Farias, 1995; Nachbar, 1997; Vissandjee et al., 1997; World Health Organization, 1995; Roth and Mbizvo, 2001.

79. Schuler et al., 2002a.

80. Hoang et al., 2002.

81. Raju and Leonard, 2000.

82. Raju and Leonard, 2000.

83. Bradby, 1999; Sargent, 1988.

84. Zhang et al., 1996; Hodnett, 2001; Sosa et al., 1980.

85. Jessop et al., 2000: 54.

86. Ransom and Yinger, 2002.

87. Fikree et al., 1999.

88. Adewuyi, 1999; Jessop et al., 2000: 57-62.

men to pay greater attention to the needs of pregnant women and to be active decisionmakers in seeking care.⁸⁹ Few strategies to involve men have been tested, however.⁹⁰ Gender issues in maternal nutrition have also been addressed by teaching women with limited access to cash how to introduce low-cost, high-nutrient foods into their diets.⁹¹

Transforming Gender Relations

Three interventions in maternal mortality/morbidity that attempt to transform gender relations and that have been methodologically evaluated are presented below. Many of the strategies to integrate gender described in the last chapter are also present in the interventions included here.

Strategies in this chapter include those that increase women's access to and control of resources where men dominate financial decisionmaking in the home and undervalue their wives' health care. Numerous studies have shown a positive correlation between women's individual contributions to the household income and household spending on health care.⁹² The extent to which increased spending on health care is allotted to women's obstetrical care remains unknown, but some increase is likely. Two of the examples cited employed credit and savings groups and emergency loan funds, supplied through women's cooperative agricultural production or market activities, to increase women's financial ability to care for themselves during the childbearing year.

Some programs have aimed to re-negotiate the balance of power between women and health care providers; for example, through staff training in gender or through increasing women's options during labor. Others have attempted to bridge the gap between government health officials, who often reside in capital cities, and women in remote areas who have identified their reproductive health needs. Two of the programs presented here were in part effective because community-based women's groups identified reproductive health issues

important to them and wrote letters to government officials requesting improved access to services in their remote villages.

Getting male partners, extended families, and community members to appreciate their roles in and give more priority to women's health care during pregnancy and the postpartum period has been a successful tactic in many programs. Maternal health programs can give men information about pregnancy and birth, and point out specific roles that they and often only they can fill, including providing household help during pregnancy or making plans involving transportation,⁹³ as demonstrated in one of the studies below. Other interventions in men's involvement have not been evaluated. In some areas of Bolivia, the MotherCare project invited men to participate in discussions of the process of pregnancy, labor and delivery and to brainstorm about steps they could take to assist their partners and family members. Men's concerns about recognizing danger signs were met with education programs.⁹⁴ In India, programs have reached out to men through peer educators, home visits from field workers tailored to men's schedules, workshops for men held on Sundays (when men are not working), and men's clubs and mother-in-law clubs, where mothers are motivated to encourage their sons to give higher priority to their wives' health care.⁹⁵

In sum, the strategies used in maternal health initiatives reviewed here include community-based women's groups, economic empowerment of women, reaching men through male outreach workers, and advocacy for increased access to clinics, physicians, and government services. The most effective programs have maintained women's groups for several months, allowing them to develop their priorities and activities.

89. Bello Gummi et al., 1997.

90. Becker, 1996.

91. Johnson-Welch, 1999.

92. Quisumbing and Maluccio, 1999; Thomas, 1997; Grasmuck and Espinal, 2000.

93. Ormel, 1999; Roth, 1998.

94. Kaune and Seoane, 1998.

95. Raju and Leonard, 2000.

INTERVENTION:

Warmi Project in Rural Bolivia

COUNTRY: **Bolivia**

TYPE OF INTERVENTION: **Reproductive health program**

IMPLEMENTING ORGANIZATIONS: **Save the Children/Bolivia, with the Ministry of Health La Paz Health Unit, AYUFAM, the Center for Interdisciplinary Community Studies, and the San Gabriel Foundation, supported by USAID, John Snow, Inc./MotherCare Project, and Save the Children/Westport**

Gender-Related Barriers to RH

Women in Inquisivi, the rural province where the Warmi Project took place, are bound by a tight family structure and rigid gender roles. Women's decision-making power is very limited both in the community and in the family; a woman only holds a village council position if she is a widow of a former member and a landowner; and women are unlikely to speak during community meetings or vote on local issues. In many cases, husbands forbid their wives to participate in mixed groups. The dominance of men in the home includes their control of financial decisionmaking, and Warmi Project staff witnessed several cases of men deciding that the costs of transport to the hospital, which could take 3-7 hours for a woman with pregnancy or labor complications, were too great. In addition, domestic violence is considered a normal part of life and not a problem unless it is continuous or results in serious injury or death.

With little experience working in groups to solve problems, many women may feel alone and powerless to address RH problems. Bolivia has one of the highest rates of maternal and infant mortality in the hemisphere. The geographic barriers of mountainous regions and the cultural barriers between rural indigenous people like those in Inquisivi and urban mestizo service providers seriously restrict access to formal health care.

Objective and Strategy

Save the Children/Bolivia's goal was to determine how a community-based approach could improve maternal and neonatal health in a very remote setting. A three-year project beginning in 1990, the Warmi Project formed groups of indigenous women to help them identify problems and actions toward solutions in their communities. A group approach served to give women practice in speaking in group

Table 3.1

Selected Statistically Significant Findings From Warmi Project

| | BASELINE (1990) (%) (N=151) | FINAL (1993) (%) (N=136) | BASELINE (1990) (%) (N=75) | FINAL (1993) (%) (N=31) |
|--|---|--------------------------------|---|-------------------------------|
| | GROUP OF WOMEN NOT EXPERIENCING MORTALITY | | GROUP OF WOMEN EXPERIENCING MORTALITY | |
| Birth | | | | |
| Birth at home | 96 | 84 | * | * |
| Promoter helped at the birth | 0 | 6 | * | * |
| Birth on old and dirty bed | 33 | 2 | * | * |
| Birth on bed with clean cover/blanket | 31 | 53 | * | * |
| Birth on clean plastic | 3 | 19 | * | * |
| Existence of trained midwives in the community | 65 | 83 | * | * |
| Pregnancy | | | | |
| Diagnosed urinary infection during pregnancy | 9 | 27 | 7 | 39 |
| Prenatal care done by auxiliary | 9 | 25 | 7 | 23 |
| Believe that prenatal care is useful | 60 | 87 | * | * |
| Received tetanus toxoid vaccine during pregnancy | 53 | 61 | * | * |
| Received ferrous sulfate during pregnancy | 17 | 51 | 15 | 45 |
| Newborn and Postpartum | | | | |
| Used razor to cut cord | 8 | 22 | * | * |
| Washed cutting instrument with water | 17 | 33 | * | * |
| Used alcohol to disinfect cord ties | 30 | 44 | * | * |
| No disinfectant of cord ties | 58 | 39 | * | * |
| Resuscitated baby | 3 | 13 | * | * |
| Breastfed immediately after birth | 25 | 50 | * | * |
| Mother was washed after birth | 47 | 69 | * | * |

*Figures for indicators with no statistically significant differences were not reported.
Source: Howard-Grabman et al., 1994.

discussions, inform them about their rights, build self-esteem, and develop leadership skills. Groups of 10 to 30 women met at least once a month, and often weekly, in 50 communities. Four sessions were devoted to autodiagnosis of maternal and neonatal health problems, supplemented by women's investigation of the situation in their communities through interviews with other residents about reproductive health. Obstacles to improved

maternal and neonatal health included the lack of economic resources for transport to the hospital in the case of obstetrical emergencies, poor nutrition, the lack of trained personnel to attend births, little awareness of prenatal care, and uninvolved husbands who did not think of their wives' needs.

The women's groups then planned and implemented actions that were feasible under local conditions, with support

from Save the Children and the Bolivian Ministry of Health. Some groups decided to increase their access to economic resources for emergency transport to the hospital and simultaneously improve nutrition by selling vegetable seeds from family gardens. The money earned was put into a community fund for emergency loans. Other groups established emergency loan funds through selling mosquito nets or other products. Realizing the need for increased health services in their communities, some groups wrote letters to the Ministry of Health requesting better services. Other actions included literacy classes, training midwives (who do not traditionally play a large role in the area), training staff at the District Referral Hospital in essential obstetrical care and indigenous beliefs about childbirth, establishing regular visits to the area by a family planning provider, producing cards to record women's obstetrical histories, and training women how to use the cards. Women involved husbands in a variety of ways, from orienting them to their maternal health care needs to informing the authorities in the case of a husband with available resources who was unwilling to use them for medical attention during a difficult birth.

Evaluation Design: Pre- and Post-Intervention Experimental Group Only/Qualitative

Save the Children conducted a pre-intervention, retrospective case-control study in November 1990 (with 75 women who experienced cases of perinatal/neonatal mortality and 151 "controls"—women who did not experience a mortality; all respondents in the study lived in intervention communities). This study was repeated in 1993 (with 31 cases of mortality and 136 women who did not experience a mortality) with the participation of the Ministry of Health, the Population Council, San Gabriel Foundation (a Bolivian NGO), Save the Children/Westport, Save the Children/Bolivia, and nine women representatives from project communities. The qualitative portion of the evaluation consisted of interviews and group discussions with several pregnant women, midwives, Ministry of Health staff, husbands, and women's groups. The activities that many women's groups had planned were just

Table 3.2

Gender Outcomes in Warmi Project

| | BASELINE (1990) (%) (N=151) | FINAL (1993) (%) (N=136) | BASELINE (1990) (%) (N=75) | FINAL (1993) (%) (N=31) |
|--|---|--------------------------------|---|-------------------------------|
| | GROUP OF WOMEN NOT EXPERIENCING MORTALITY | | GROUP OF WOMEN EXPERIENCING MORTALITY | |
| Women's Organizations | | | | |
| Existence of women's groups in the community | 30 | 69 | 36 | 71 |
| Mother belongs to women's group | 7 | 57 | 8 | 42 |

Source: Howard-Grabman et al., 1994.

getting underway when the formal evaluation process ended.

RH Outcomes

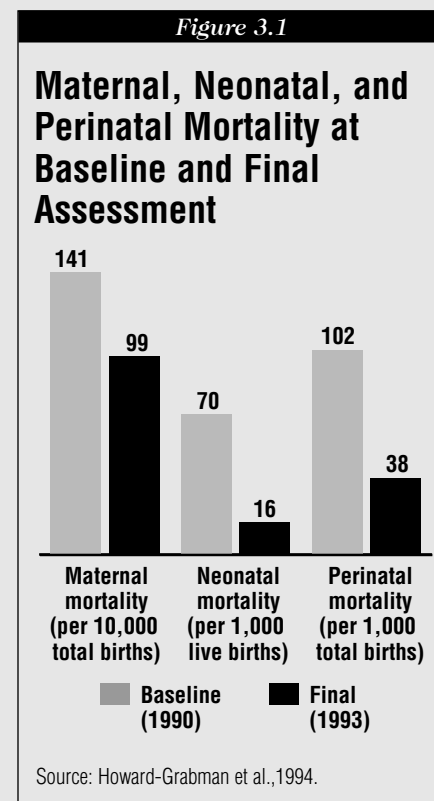
Increases were observed in tetanus toxoid coverage, ferrous sulfate distribution, immediate breastfeeding, consumption of iodized salt, prenatal care visits, postnatal care visits, number of women attended by a trained birth attendant, and many other areas (see Table 3.1). Maternal, neonatal, and perinatal mortality rates fell in the project areas (see Figure 3.1).

Gender Outcomes

Quantitative data showed an increased presence of women's groups and increased women's participation in them (see Table 3.2). Women and authorities responding in interviews most often cited "organization and strengthening of women's groups" as the single intervention that would have the greatest impact on the lives of women and newborns, followed by family planning, literacy trainings, prenatal care, and other interventions.

Conclusions

Giving women opportunities to participate in community planning where gender norms have previously prevented them from doing so can create positive changes even in settings of very low resources. Authors of the project report write, "One of the major qualitative achievements of the Warmi Project was the change in how women are perceived in the community by others and, more importantly, in how women view themselves. One Inquisivi authority stated during the project's final evaluation: 'The women have strengthened



their organizations, now they have voice and vote.' The excitement of seeing women who formerly did not speak, or who spoke only with great difficulty in a group, and who now speak with ease and confidence, is difficult to quantify and impossible to describe."

References

Lisa Howard-Grabman with Guillermo Seoane and Cheri Ann Davenport, *The Warmi Project: A Participatory Approach to Improve Maternal and Neonatal Health: An Implementor's Manual* (Washington, DC: USAID, 1994).

INTERVENTION:

Advocacy and Income Generation With Indian Women

COUNTRY: **India**

TYPE OF INTERVENTION: **Cross-sectoral program with reproductive health component**

IMPLEMENTING ORGANIZATIONS: **Bayalu Seeme Rural Development Society (BSRDS) and World Neighbors/India, funded by the Bill and Melinda Gates Foundation. Portions of the evaluation funded by the Summit Foundation.**

Gender-Related Barriers to RH

Generally, women in the state of Karnataka, India, face a lack of decision-making power in the home and access to resources. Girls are less likely to attend school than boys and child marriage is common. Few women have access to cash or other resources for spending on health care.

Objective and Strategy

In April 1998, the BSRDS, which had previously been engaged in community agricultural projects (predominantly with

men) in several communities of Karnataka, began to integrate a reproductive health component in these villages in order to address the reproductive health needs in these particularly remote and under-served areas. The BSRDS reproductive health worker and a field assistant encouraged and assisted poor rural women to form women's groups. The early activities of these groups included selecting leaders, selecting and receiving training for traditional birth attendants, and initiating a savings and credit group. Groups met every two weeks. After a few

months of these activities, the reproductive health worker helped identify reproductive health and social issues faced by the women. Groups then developed action plans to address what they deemed important. Letter writing was a key part of this effort. Health officials responded to the women's groups and, as they had asked, established gynecology camps and regular visits from a midwife.

Evaluation Design: Post-Intervention Control Group/Qualitative

Between April and May of 2001, an evaluation team administered a survey to around 40 program participants and an equal number of non-participants in each of two project communities, Nellur and Yelenavadgi (survey administered to total of around 160 people in these two project sites). Another community—Khanapur, where the BSRDS had been conducting agricultural projects with groups of men but had not formed women's groups—provided a control site. The sample in this control community consisted of 17 wives of agricultural group members and 23 other women. In addition to the individual survey questions, survey respondents participated in group exercises in which they identified issues relevant to women's status and to reproductive health, and gave their opinions on whether these issues had improved over recent years, and whether improvements were due to program activities or other factors. The evaluation also covered group capacity, organizational capacity, integration, and savings and credit activities of the BSRDS program. Results presented here are relevant to reproductive health and gender.

Table 3.3

Reproductive Health Outcomes in Two BSRDS Project Sites and One Control Site

| INDICATOR | NELLUR (INTERVENTION) (%) | | YELENAVADGI (INTERVENTION) (%) | | KHANAPUR (CONTROL) (%) | |
|--|------------------------------|------------------------------------|-----------------------------------|------------------------------------|--|--|
| | GROUP MEMBERS (N=40) | NON- GROUP MEMBERS (N=40) | GROUP MEMBERS (N=40) | NON- GROUP MEMBERS (N=40) | WIVES OF AG GROUP MEMBERS (N=17) | NON-WIVES OF AG GROUP MEMBERS (N=23) |
| Received antenatal care, more than two visits | 100 | 70 | 88 | 100 | 57 | 46 |
| Received postnatal care, more than two visits | 100 | 52 | 82 | 53 | 43 | 62 |
| Knows about AIDS | 100 | 89 | 100 | 83 | 78 | 40 |
| Knows HIV transmitted through sex | 100 | 71 | 100 | 72 | 78 | 40 |
| Uses condoms | 98 | 60 | 100 | 63 | 56 | 24 |
| Has sex with one partner | 98 | 54 | 100 | 56 | 56 | 24 |
| Knows about STIs | 100 | 79 | 100 | 85 | 72 | 48 |
| Uses modern contraceptives | 78 | 74 | 88 | 78 | 53 | 48 |
| Birth in last 3 years attended by trained TBA, health worker, or doctor | 78 | 74 | 94 | 85 | 0 | 15 |

Note: No statistical comparisons were reported.
Source: McKaig, 2002.

RH Outcomes

Women reported several improvements in RH as a result of program activities. The survey found that participants were more likely to attend more than two antenatal visits, to know about HIV transmission and prevention, to use contraceptives, and to have trained personnel at births occurring in the prior three years than non-participants in the project sites (see Table 3.3). In one project site, Nellur, participants were more likely to attend more than two postnatal visits. Respondents in the control group site had even lower levels of knowledge and practice on most of these measures than non-participants in the project sites, suggesting some spillover of project benefits into the general community. Additionally, 50 percent of funds dispersed in credit activities in Nellur and 26 percent in Yelenavadgi were used for (unspecified) health care concerns.

Gender Outcomes

Issues relevant to women's status that were identified across groups included decisionmaking, property ownership, participation in politics, girl child education, family planning, reproductive health, dowry, right to divorce, violence against women, child marriage, women's mobility, and widow remarriage. With regard to many of these issues, both program participants and non-participants said the situation had improved and the improvements were primarily due to group activities. However, women said that girl child education and participation in politics improved not only because of group activities but also due to the efforts of the government. Survey results found

Table 3.4

Women's Status in Two Communities of BSRDS Project and One Control Site

| INDICATOR | NELLUR (INTERVENTION) (%) | | YELENAVADGI (INTERVENTION) (%) | | KHANAPUR (CONTROL) (%) | |
|----------------------------------|------------------------------|------------------------------------|-----------------------------------|------------------------------------|--|--|
| | GROUP MEMBERS (N=40) | NON- GROUP MEMBERS (N=40) | GROUP MEMBERS (N=40) | NON- GROUP MEMBERS (N=40) | WIVES OF AG GROUP MEMBERS (N=17) | NON-WIVES OF AG GROUP MEMBERS (N=23) |
| | Has right to decisionmaking | 84 | 61 | 91 | 76 | 28 |
| Owns property | 12 | 20 | 7 | 11 | 0 | 0 |
| Participates in politics | 77 | 17 | 63 | 22 | 22 | 4 |
| Willing to protest spousal abuse | 77 | 26 | 86 | 15 | 11 | 0 |
| Right to mobility | 95 | 57 | 93 | 54 | 28 | 28 |
| Participates in public protests | 81 | 26 | 70 | 37 | 11 | 4 |

Note: No statistical comparisons were reported.
Source: McKaig, 2002.

that participants were more likely to say they had the right to make decisions and the right of mobility outside the home, that they participated in politics and public protests, and that they were willing to protest against domestic violence. In the control site, respondents were even less likely to say that they had these rights or participated in politics and protests (Table 3.4). Program participants were less likely to own property than non-participants but more likely than women in the control site. Because baseline indicators were not measured, this difference could indicate that women who did not already own land were more likely to participate in the program, and that participation increased a woman's chances of acquiring land.

Conclusions

The women in this project advocated for their right to access RH services, with the result that access was increased. The program also appears to have empowered women in the household and community spheres in the intervention villages, particularly group members. Yet, the evaluation did not include assessing whether men in the agricultural groups and in the communities where this program operated perceived a change in women's roles.

References

Catharine McKaig, *Evaluating an Integrated Reproductive Health Program: India Case Study* (Oklahoma City, Oklahoma: World Neighbors, 2002).

INTERVENTION:

Pati Sampark (“Contact the Husband”)

COUNTRY: India

TYPE OF INTERVENTION: RH program

IMPLEMENTING ORGANIZATION: Deepak Charitable Trust

Gender-Related Barriers to RH

The area of Nandesari, 20 kilometers north of Vadodara, comprises around 20 villages. The population is primarily Rajput and characterized by conservative and restricted roles for women, which likely limit women’s access to prenatal clinics. Attendance at prenatal clinics by women with signs of high-risk pregnancy is low.

Objective and Strategy

The Deepak Charitable Trust hoped that motivating husbands to support their wives in receiving prenatal care would raise attendance at monthly antenatal clinics in Nandesari. *Pati Sampark* literally means “contact the husband.” In 1995, female outreach workers began identifying pregnant women who were not attending prenatal care. Male outreach workers visited the homes of these women in order to speak with their husbands about the importance of antenatal care and nutrition, in particular tetanus toxoid vaccination, hemoglobin testing, blood pressure checks, proper diet, iron and calcium supplements, and safe childbirth. Men whose wives had the potential for high-risk pregnancies were also given information on high-risk conditions, symptoms, and treatments. Outreach workers provided family planning information to men as well.

Evaluation Design: Post-Intervention Control Group

In 1996, the Deepak Charitable Trust conducted a post-intervention evaluation of Pati Sampark in 10 villages. Respondents included 64 program participants and 49 non-participants (for a total of 113 men), who responded to a survey and in-depth qualitative interviews.

RH Outcomes

Pati Sampark participants were more likely to know about family planning methods, including the condom and the pill, and the value of birth spacing (see Table 3.5). There has also been a small increase in the attendance of women at antenatal clinics in

Table 3.5
Men’s Awareness of Family Planning in Pati Sampark Program

| AWARENESS ABOUT... | MEN IN PATI SAMPARK GROUP (%) (N=64) | MEN NOT IN PATI SAMPARK GROUP (%) (N=49) |
|-----------------------------------|--------------------------------------|--|
| Condom | 82.5 | 53.1 |
| Oral pills | 58.7 | 49.0 |
| Birthspacing | 98.4 | 77.5 |
| Value of 2-3 years between births | 85.9 | 63.3 |

Source: Raju and Leonard, 2000.

Table 3.6
Men’s Awareness of Wives’ Antenatal Care in Pati Sampark Program

| REPORTS KNOWING IF WIFE RECEIVED... | MEN IN PATI SAMPARK GROUP (%) (N=64) | MEN NOT IN PATI SAMPARK GROUP (%) (N=49) |
|-------------------------------------|--------------------------------------|--|
| Hemoglobin | 75.0 | 16.3 |
| Blood pressure test | 84.4 | 30.6 |
| Tetanus toxoid | 98.4 | 55.1 |
| Iron and calcium | 98.4 | 63.3 |

Source: Raju and Leonard, 2000.

the area of Nandesari. Women whose husbands had participated in the program were more likely to attend the clinics on a repeated basis (6 to 7 times) than were women whose husbands did not participate, although these figures were not fully reported.

Gender Outcomes

Men who participated in the Pati Sampark program were much more likely than non-participants to know if their wives had received various antenatal care services, such as hemoglobin tests, blood pressure tests, tetanus toxoid, and iron and calcium supplements (see Table 3.6).

Conclusion

Deepak Charitable Trust staff believe that Pati Sampark has played a role in stimulating the increase in attendance at prenatal

clinics, although they are reluctant to attribute it to the program alone, as there are other programs promoting prenatal care operating in the area.

References

PATH. *Men and Reproductive Health Program Examples—India: Nandesari*, accessed online at http://www.rho.org/html/menrh_progexamples.htm#india-nandesari, on July 1, 2003.

Saraswati Raju and Ann Leonard. *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality* (New Delhi: The Population Council South and East Asia Regional Office, 2000).

Sexually Transmitted Infections (STIs)/HIV/AIDS

Background

In 1999, an estimated 34.3 million people worldwide were living with AIDS. In the same year, 5.4 million people were newly infected, including 2.3 million women. At the end of 1999, an estimated 18.8 million people had died of AIDS worldwide. The numbers are staggering and only continue to grow,⁹⁶ although there are some rays of hope as the incidence of HIV slows somewhat among young people in countries such as Uganda and more recently South Africa and Zambia.⁹⁷ Seventy percent of people living with HIV/AIDS are in Africa, where HIV/AIDS is now the leading cause of death and HIV-positive women outnumber infected men by two million. HIV/AIDS is the fourth most common cause of death worldwide. By the end of 1999, an estimated 13.2 million children, most of them in Africa, had lost their mother or both of their parents to AIDS.⁹⁸

HIV has no cure; nearly all people who are infected with HIV will progress to AIDS within 10 years. Those without access to life prolonging antiretroviral drugs will die as a result of acquiring HIV.

The AIDS pandemic is causing untold suffering in individuals, families, and societies. AIDS is exacerbated by poverty and, in turn, propels many families that face the disease into poverty. Families confronted with AIDS are often forced to sell off assets to pay for health care and funerals. Losing family members who are often in the prime of life further erodes the economic stability of the family. In Zambia, for example, in two-thirds of the families that lost fathers to AIDS, monthly disposable income fell by 80 percent. Remaining family members,

particularly women, have to “make hard choices on the allocation of their time between production, meeting household needs, child care and care of the sick.”⁹⁹

Studies by the International Center for Research on Women (ICRW) have illustrated the critical role of gender and sexuality in influencing sexual interactions and men’s and women’s ability to practice safe behaviors. The studies, many of them included in this chapter, highlighted the importance of increasing women’s access to information and education, skills, services, and social support in order to reduce their vulnerability to HIV/AIDS and to improve their RH outcomes.¹⁰⁰

Gender-Related Barriers to Reducing STIs/HIV/AIDS

The imbalance of power between men and women has been more thoroughly explored in HIV/AIDS and STI research than in other areas of reproductive health. Gender norms have a direct impact on sexual behavior and, therefore, STI risk. Norms may discourage women from displaying knowledge and communicating about sex and related topics. Standards of premarital virginity may limit young women’s access to information about sex, especially when their social interactions outside the family are limited. Where virginity is equated with an intact hymen, adolescents may engage in anal sex to preserve their virginity, a riskier behavior than vaginal sex.¹⁰¹ Promiscuity in men is considered normal in many regions around the world and often includes acceptance of visits to commercial sex workers. Where sex is seen as a wife’s duty, women may face ridicule, violence, or divorce if they refuse sex due to concerns that their husbands may have become infected with STIs acquired from other partners.¹⁰²

Stigma and discrimination are at the heart of the AIDS pandemic, as fear, shame, and

96. UNAIDS, 2000b.

97. Cauvin, 2002; Underwood et al., 2001.

98. UNAIDS, 2000b.

99. Loewenson, 2001.

100. Weiss and Gupta, 1998.

101. Leynaert et al., 1998; Padian et al., 1997.

102. Hoang et al., 2002.

ignorance keep people from practicing prevention and seeking care. Women, due to gender imbalances in many societies, face double stigma and discrimination regarding HIV/AIDS. Many are “blamed” if they or their partner acquire HIV, and some are badly treated or disowned as a result. HIV positive women who have not disclosed their infection and who choose not to have children or not to breast-feed the babies face even further stigma associated with infertility and breastfeeding norms.¹⁰³

The economic disadvantage of women in many societies leads to a lack of sexual negotiation power. Women’s need for economic support from husbands or partners — particularly if they have children — can lead women to remain silent on matters of sex and fidelity in relationships that confer some level of economic security. The fear of economic abandonment by husbands or partners may be greater when extramarital relationships are explicit, resulting in an increased powerlessness to negotiate safe sex just when the risks of STI transmission are the highest. Survival strategies of some women in poverty include formal prostitution and the provision of sex to multiple partners who offer material gifts in return.

Programs are increasingly promoting dual method use (condoms and another method of contraception) or dual protection (using just the condom for the prevention of disease and pregnancy). Gender barriers to negotiating condom use with their partners may hinder women’s ability to engage in dual method use or dual protection.¹⁰⁴

HIV-positive women may be stigmatized in health care settings when they seek reproductive health care. Pregnant HIV-positive women may be denied prenatal or delivery care; some women are pressured to submit to abortion rather than risk having an HIV-positive baby. HIV-positive women may face the same poor treatment in family planning clinics.

Interventions That Have Addressed Gender-Related Barriers to Reducing STIs/HIV/AIDS

Accommodating Gender Differences

The majority of interventions to prevent STI/HIV transmission have been targeted to

high-risk groups, such as commercial sex workers, truck drivers, gay men, and intravenous drug users. Sex workers may have little control over parameters of sexual activity with clients. Strategies to address this problem have included educating brothel owners or enacting laws to enforce condom use among clients. Female condoms and microbicides are woman-controlled and, therefore, increase a sex worker’s chances of protecting herself without having to convince partners to wear a condom.

Transforming Gender Relations

Transforming gender relations is essential for ending the spread of STIs and HIV. Programs for adolescents have aimed to counter attitudes that increase STI/HIV vulnerability through publications for young people and discussions with peer educators on risk and the social contexts that shape risk. In Mexico, *Salud y Género* is attempting to avert the formation of gender-inequitable attitudes, such as the normalization of aggressive male sexuality, by bringing adolescent boys and girls together and involving them in projects and discussions focusing on gender identity.¹⁰⁵ Mexico’s *Gente Joven* program likewise makes a concerted effort to encourage young men to communicate and engage in responsible sexuality, and to counter macho images of men as sexual predators.¹⁰⁶ In Uganda, the Ministry of Information publishes *Straight Talk*, a monthly insert that is distributed with the government newspaper and provides a forum for young people’s opinions and concerns about sex and relationships. Its hope is to “demystify sex, challenge gender stereotypes, and encourage real friendships between boys and girls.”¹⁰⁷ Uganda is the only country in sub-Saharan Africa where the incidence of HIV has declined, although very recent evidence suggests that it is also beginning to decline among young people in South Africa and Zambia.¹⁰⁸

Thirteen programs that transform gender relations and that have been systematically evaluated are presented in this chapter. Some are targeted to groups at high-risk for STIs/HIV;

103. Nyblade et al., 2002.

104. Adeokun et al., 2002; Chikamata et al., 2002.

105. de Keijzer et al., 2003.

106. FOCUS on Young Adults, 1998.

107. Henry, 1995: 32.

108. Cauvin, 2002; Underwood et al., 2001. Evaluations were not available for these programs.

others attempt to reach clients of other reproductive health services or members of selected neighborhoods. The majority take place in urban areas.

Power relations are central to the design of the interventions in this chapter. Many interventions have been successful through the stimulation of dialogue among beneficiaries on the relationship between gender norms and sexual behavior. Operations research at the University of California demonstrates how much more effective this kind of dialogue is than providing information on condom use and risk behaviors alone. Additional behavior change communication strategies in this chapter incorporate negotiation and communication skills training for women to increase their assertiveness in partner communication about topics related to sex, STIs/HIV/AIDS, and dual protection/dual method use. Many of these programs aim to challenge the acceptance of male

promiscuity and infidelity and norms of female chastity and sexual ignorance. Peer educators have also addressed such sensitive topics as virginity, women's fear of sexual and physical abuse, economic abandonment, or increased infidelity in retaliation for asking partners to use condoms.

To help women avoid transactional sex, education programs have offered vocational training in income-generating activities. One strategy discussed here focuses on training sex workers as peer educators in STIs/HIV/AIDS and self-esteem, aiming to increase the knowledge and decisionmaking power of sex workers, who are typically powerless in relation to brothel owners, clients, and police. Another example shows how the strengthening of other women's groups, such as traditional organizations concerned with fertility, can also improve condom use.

INTERVENTION:

Sexual Negotiation Skills Among Inner-City Women

COUNTRY: **United States, low-resource**

TYPE OF INTERVENTION: **Operations research study**

IMPLEMENTING ORGANIZATIONS: **University of California University-wide AIDS Research Program; the AIDS Clinical Research Center, UCSF; and the Center for AIDS Research, University of Alabama**

Gender-Related Barriers to RH

Competing socioeconomic factors and power imbalances experienced by many African-American women in heterosexual relationships increase their risk for HIV infection.

Objective and Strategy

The research team sought to evaluate the efficacy of a community-based HIV sexual risk-reduction intervention for young adult, low-income, heterosexual, African-American women. Women were recruited from the Bayview-Hunter's Point community in San Francisco, California, through street outreach methods and assigned to one of three groups: a five-session social skills intervention group; a single-session HIV education group; or a delayed HIV education control group. The social skills intervention was guided by theories of gender and power and by social cognitive theory. Gender and power theories examine the sexual division of labor, the sexual distribution of power, and gender norms about sexual conduct. Women in the social skills group met for two hours once a week for five weeks, led by two peer health educators. Training included cultural awareness, gender and ethnic pride,

Table 4.1

Odds Ratios for Increases in Condom Use and HIV Knowledge, Social Skills Intervention Group and Single Session HIV Education Group

| VARIABLE | SOCIAL SKILLS INTERVENTION GROUP (N=33) | | SINGLE SESSION HIV EDUCATION GROUP (N=33) | |
|-----------------------|---|-------------------------|---|-------------------------|
| | ADJUSTED ODDS RATIO+ | 95% CONFIDENCE INTERVAL | ADJUSTED ODDS RATIO+ | 95% CONFIDENCE INTERVAL |
| High HIV knowledge | 1.4 | 0.82, 2.36 | 0.9 | 0.54, 1.76 |
| Consistent condom use | 2.1* | 1.03, 4.15 | 1.1 | 0.55, 2.40 |

Note: Delayed HIV education control group is the referent for calculation of odds ratios.
* p<0.05
+Adjusted by baseline variable, length of current relationship, and income level.
Source: DiClemente and Wingood, 1995.

HIV transmission and prevention information, sexual assertiveness and communication, proper condom use, and coping skills. Role-plays allowed participants to practice their skills. The single-session HIV education group received one two-hour session similar to the session on HIV risk-reduction provided as part of the social skills intervention. The delayed HIV education control group did not receive any HIV information until they completed follow-up interviews.

Evaluation Design: Randomized Controlled Trial

The evaluation used structured baseline interviews and three-month follow up interviews, which 100 women completed. Outcomes of interest included consistent condom use, HIV risk-reduction knowledge, sexual self-control, sexual assertiveness, sexual communication, and partner norms supportive of consistent condom use.

RH Outcomes

Compared with the delayed HIV education control group, women in the social skills intervention demonstrated significantly increased consistent condom use and somewhat greater HIV knowledge (Table 4.1). No statistically significant differences in outcome variables were observed between the single-session HIV education group and the control group.

Gender Outcomes

Compared with the delayed HIV education control group, women in the social skills intervention demonstrated significantly greater sexual communication, greater sexual assertiveness, and an increase in partners' adoption of norms supporting consistent condom use (Table 4.2). Again, no statistically significant differences in outcome variables were observed between the single-session HIV education group and the control group.

Conclusions

This intervention compares the effects of a behavior change intervention based on gender theory with the effects of another that does not integrate gender concerns. Women participating in the intervention

Table 4.2

Odds Ratios for Improvements in High Negotiation Skills and Norms, Social Skills Intervention Group and Single Session HIV Education Group

| NEGOTIATION SKILLS AND NORMS | SOCIAL SKILLS INTERVENTION GROUP (N=33) | | SINGLE SESSION HIV EDUCATION GROUP (N=33) | |
|--|---|-------------------------|---|-------------------------|
| | ADJUSTED ODDS RATIO+ | 95% CONFIDENCE INTERVAL | ADJUSTED ODDS RATIO+ | 95% CONFIDENCE INTERVAL |
| High sexual self-control | 1.9* | 1.00, 3.6 | 0.9 | 0.42, 1.74 |
| High sexual communication | 4.1* | 1.67, 10.01 | 0.5 | 0.25, 1.13 |
| High sexual assertiveness | 1.8* | 1.01, 3.27 | 0.8 | 0.43, 1.61 |
| Partner's adoption of norms supporting consistent condom use | 2.1* | 1.08, 3.87 | 1.1 | 0.56, 2.28 |

Note: Delayed HIV education control group is the referent for calculation of odds ratios.
 * p<0.05
 +Adjusted by baseline variable, length of current relationship, and income level.
 Source: DiClemente and Wingood, 1995.

that integrated gender were much more likely to use condoms and practice sexual negotiation skills than women receiving the other intervention. Community-based HIV risk-reduction programs that are gender relevant and culturally integrated and provide social skills training can effectively enhance protective behaviors.

References

Ralph J. DiClemente and Gina M. Wingood, "A Randomized Controlled Trial of an HIV Sexual Risk-Reduction Intervention for Young African-American Women," *Journal of the American Medical Association* 274, no.16 (1995):1271-1276.

INTERVENTION:

Sex Workers in Sonagachi and Beyond

COUNTRY: **India**

TYPE OF INTERVENTION: **RH/HIV/AIDS program**

IMPLEMENTING ORGANIZATIONS: **Initiated by the All India Institute of Hygiene and Public Health (AIIPH&PH), with the National AIDS Control Organization (NACO), the Ministry of Health and Family Welfare of West Bengal, supported by the World Health Organization (WHO), NORAD, and DFID. Other partners: the Health and Eco-Defence Society, the Human Development and Research Institute, Sramajibi Mahila Sangha, Socio-legal Aid Research and Training Centre, and Durbar Mahila Samanwaya Committee (DMSC)**

Gender-Related Barriers to RH

In the oldest red-light district of Calcutta, the sex industry has been shaped by pimps, brothel landladies, politicians, police, local youth, and the mafia. Sex workers themselves are relatively powerless to assert their rights to protect themselves from STIs and HIV. They typically face extreme poverty, low education, and/or family abandonment.

Madams and pimps, who control brothels and access to clients, can demand that sex workers take clients who refuse to use condoms or who are known to carry STIs. *Babus*, men who form long-term relationships with sex workers, may give some economic and emotional support to women, but many are controlling and exploitative.

“One important way in which babus can exert power is the giving of their name to sex workers’ children so the children can be enrolled in school. As they can repudiate this assignment at a later date with the school system, this gives them continuing leverage and power over the women.”¹⁰⁹

Legal support for harassment of sex workers is provided through the Prevention of Immoral Traffic Act, which makes it easy for police to raid brothels looking for young workers and to abuse their authority by harassing, extorting, beating, and raping sex workers.

Objective and Strategy

The objective of the STD/HIV Intervention Programme (SHIP) is to make the sex trade safer for women who are unable to leave the industry. SHIP organizers write,

“Our basic strategy was behavior change communication (BCC), but it was realized

that relative lack of control of women in relation to men, and social and structural barriers put bigger hurdles to behavioral change. The main confronting obstacles are socio-historical, not behavioral.”¹¹⁰

These obstacles include gender inequality, stigma associated with sex work, social and economic vulnerability, and lack of power to stop abuses by various authorities.¹¹¹

After its start in 1992, the program quickly began to respond to the perceived needs of sex workers with the creation of at least 12 free health clinics for sex workers and their families; education and cultural programs for children; and vocational training to provide economic alternatives and economic security for older sex workers who are forced to leave the trade. SHIP designed a six-week training for peer educators and trained more than 200 women to provide STI/HIV education. The small salaries provided by the program have enabled some peer educators to reduce their participation in sex work, and some have chosen to leave the sex trade. Around 20,000 sex workers and *babus* have received trainings from peer educators.

Sex workers’ demand for additional services beyond STI/HIV education has grown over time, and SHIP now offers legal training on how to respond to police officers or landlords who abuse their power (received by some 300 sex workers), literacy classes, and linkages with legal aid and women’s organizations. These activities are meant to increase women’s self-esteem, so that they may feel more confident to negotiate condom use and decline risky sexual behaviors. These activities are also designed to improve women’s practical skills in using

the legal system and seeking alternative employment. Of literacy classes, the organizers say,

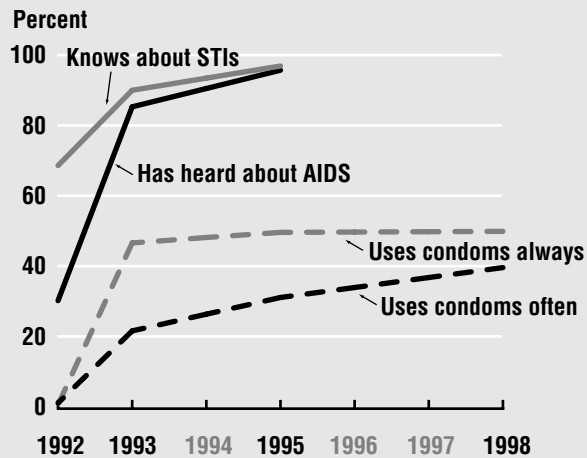
“The prime aim is to build up a meaningful learning process for the specific group of women so that in the course of learning to read and write they may also learn to reflect upon themselves and redefine their role in society.”¹¹²

Recent developments in Sonagachi include the social marketing of condoms through a cooperative enterprise of sex workers, a strategy that both promotes condom use and generates income. Peer educators formed their own organization, the Durbar Mahila Samanwaya Committee (DMSC), and started at least 14 similar programs in other red light districts throughout West Bengal. DMSC’s advocacy work for prostitutes’ rights to protect themselves from violence and STIs has included a demonstration against police raids, attended by around 1,000 sex workers; the organization of national conferences on sex workers and AIDS; and counseling of new arrivals to the sex industry before they begin working. Originally, DMSC members were attempting to send these new arrivals, often young women, back to their homes, but

“[T]he majority simply refused to go, having run away from abusive or difficult circumstances. With the help of the Social Welfare Department, they now have an arrangement whereby most of the girls are sent to boarding schools sponsored by the Social Welfare Department. Over the years, this process appears to have reduced the proportion of bonded sex workers, usually the youngest, entering the brothel, although indicators have not been recorded for this.”¹¹³

Figure 4.1

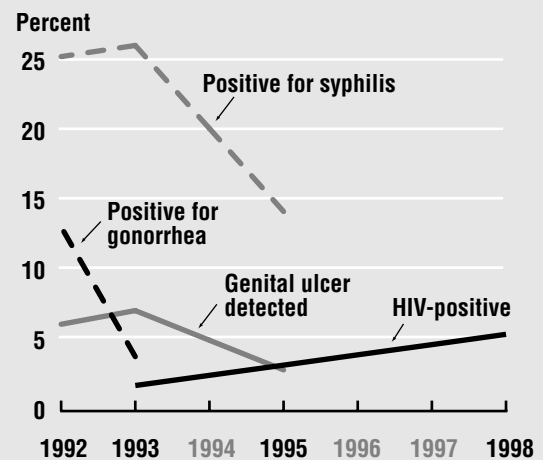
STI/HIV Knowledge and Condom Use Among Sex Workers in Sonagachi District, Calcutta, India



Note: Figures for 1994, 1996, and 1997 were not reported.
Source: UNAIDS, 2000a and AIIIIH&PH, 1997.

Figure 4.2

STI Prevalence Among Sex Workers in Sonagachi District, Calcutta, India, at Four Points in Time



Note: Figures for 1994, 1996, and 1997 were not reported.
Source: UNAIDS, 2000a and AIIIIH&PH, 1997.

Besides connecting young women with social services, DMSC counsels them in STI/HIV prevention.

Evaluation Design: Pre- and Post-Intervention Experimental Group Only

In all stages of evaluation, the sampling method was to randomly select brothels, and then select a random sample of sex workers, stratified by income, within those brothels. A baseline survey took place from April to June 1992 with a random sample of 450 sex workers. The first follow-up survey was conducted in November to December 1993, with 612 sex workers, and a second from July to August 1995 with a sample of 475. Similar surveys were conducted in 1998 and 1999, although sample sizes were not reported. Methods for testing for STIs varied somewhat between surveys, and figures are not available for all STIs for all surveys.

109. UNAIDS, 2000a: 80.
110. AIIIIH&PH, 1997: 9.
111. AIIIIH&PH, 1997: 9.
112. AIIIIH&PH, 1997: 9.
113. UNAIDS, 2000a: 75.
114. UNAIDS, 2000a: 80.
115. UNAIDS, 2000: 76-77.

RH Outcomes

The percent of sex workers who knew about AIDS rose from 30.7 to 85.8 percent between 1992 and 1993 (Figure 4.1). Cases of gonorrhea dropped from 13.2 to 3.9 percent (Figure 4.2). In the 1995 and 1998 evaluations, cases of syphilis and genital ulcers had dropped significantly. The impact of sex workers' organizations on health outcomes is suggested by the finding that syphilis cases are highest among those who have not attended any organizational meetings. HIV cases rose, but the increase was less than that reported for sex workers in most parts of India. Condom use increased over four surveys, including use with *babus*, which rose from 4 percent in 1995 to 30 percent in 1999.¹¹⁴

Gender Outcomes

Gender outcomes have not been adequately monitored. There are plans to measure levels of empowerment and engagement in the community movement by asking how many times the sex worker managed to negotiate with landlords, police and other power brokers, as well as how many sex worker organization meetings or conferences she attended.¹¹⁵

These indicators have not yet been used across time, but organizers note that the project is improving sex workers' self-esteem and humanizing them in the eyes of their clients and other men in the community.

Conclusions

Sonagachi is no longer considered a project but a movement that is spreading to other areas in India, largely through the actions of the DMSC.

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- UNAIDS, *Female Sex Worker HIV Prevention Projects: Lessons Learnt From Papua New Guinea, India and Bangladesh*. UNAIDS Case Study, Best Practice Collection (New York: UNAIDS, 2000).

INTERVENTION:

Empowering Women to Make Safe Contraceptive Method Choices

COUNTRY: **Mexico**

TYPE OF INTERVENTION: **Clinical trial**

IMPLEMENTING ORGANIZATIONS: **The Mexican Instituto Nacional de Salud Pública, the Population Council and the Instituto Mexicano de Seguro Social (IMSS), with EngenderHealth, ICRW, IMIFAP, the Pacific Institute for Women's Health, supported by the Andrew W. Mellon Foundation**

Background

Providers rarely discuss sexual practices and histories with women before inserting IUDs. Fertility reduction policies in some developing countries favor long-acting, provider-dependent contraceptive methods like the IUD, unless it is clearly contraindicated. Nationwide in Mexico, 22 percent of contraceptive users use the IUD, and at IMSS, the largest public-sector provider, more than one-third of clients who come for family planning have an IUD inserted. The IUD does not protect against STIs and can even increase the risk of pelvic inflammatory disease (PID). Laboratory screening for STIs before IUD placement is not routine, and often signs of an STI will not prevent a physician from inserting an IUD and then prescribing treatment for infection.

Gender-Related Barriers to RH

At IMSS Clinic Number 31 in Mexico City, most women are given little information about choice and use of family planning methods. Customary care is for the physician to select an appropriate contraceptive method for clients. Women who ask for pills or condoms are often discouraged from their use; doctors rarely give full explanations of what to expect and how to use the pill, and women are often told

that condoms are not reliable contraceptive methods. A woman will be offered condoms only if clinic staff suspect that she is “promiscuous” and have questioned her about her sexual behavior, often in a patronizing, scolding manner. A man asking for condoms would likely receive them only if he insisted that he had an infection and promised to bring his partner for a visit so that she could receive a more effective contraceptive method.¹¹⁶

Objective and Strategy

An investigative team at IMSS Clinic Number 31 in Mexico City, in collaboration with the Population Council, hypothesized that women might be somewhat better than clinicians at determining whether they are appropriate IUD candidates when given adequate information for decisionmaking. Beginning in March 1997, consenting women seeking contraception were placed into one of two groups, the self-screened (intervention) group or the physician-screened (control) group. Two clinic nurses were trained to conduct one-on-one educational sessions with women in the self-screened group before their consultation with the physician. The nurses described the advantages and disadvantages of condoms, the

pill, and the IUD, demonstrated how to put on a condom, and discussed STI transmission and prevention. Participants were encouraged to ask questions. After the session, but before consultation with the physician and before laboratory results of STI testing were known, clients in the intervention group confidentially recorded the contraceptive method they felt to be most appropriate for themselves. Following regular examination (but also before results of STI testing were available), physicians recommended methods to clients.

Evaluation Design: Randomized Controlled Trial

Women in the physician-screened group received a brief safe-sex talk and were not asked to choose a contraceptive method for themselves. Both groups of women underwent testing for gonorrhea and chlamydia and received the results at a second clinic visit. The contraceptive decisions of clinicians and clients were evaluated against the laboratory results. Of the 2,107 women tested for STIs, 44 women were positive for gonorrhea, chlamydia or both.

116. Coggins and Heimbürger, 2002: 279.

Table 4.3

| RH Outcomes of IUD Screening Intervention | | | |
|--|----------|--------------|---------|
| CHARACTERISTICS | CONTROL | INTERVENTION | P-VALUE |
| All women | (n=1033) | (n=1074) | 0.0000 |
| No IUD (%) | 11.5 | 41.8 | |
| IUD (%) | 88.5 | 58.2 | |
| Infected women | (n=21) | (n=32) | 0.0006 |
| No IUD (%) | 4.8 | 52.2 | |
| IUD (%) | 95.2 | 47.8 | |

Source: Lazcano Ponce et al., 2000.

RH Outcomes

Infected women who received the educational sessions intervention were much less likely to choose an IUD than those in the physician-screened (control) group (see Table 4.3). In the self-screened group, 52 percent of infected women correctly chose not to use the IUD, compared to 5 percent of infected women in the physician-screened group who were screened out of IUD use. Among the intervention group, infected women were significantly less likely to choose the IUD than all women in the intervention group together (48 versus 58 percent). More infected than uninfected women in the intervention group chose condoms as their method of contraception (22 versus

16 percent), although not significantly more.

Gender Outcomes

Gender outcomes were not assessed.

Conclusions

These results underline the capacity of women to apply principles of STI prevention to the unique situations of their own lives. With sensitive topics like sexual practices, clients may be less than candid with health practitioners. Provided with information on risk factors and how various contraceptive methods can increase or decrease risk, women who know themselves to be at risk for STIs can be more successful at selecting the best method

than their physicians. In this study, women were found to be much better than physicians at judging their level of STI risk prior to a laboratory test and the appropriateness of the IUD. Involving clients more in contraceptive choice may help prevent future disease contraction.

References

Christiana Coggins and Angela Heimburger, "Sexual Risk, Sexually Transmitted Infections, and Contraceptive Options: Empowering Women in Mexico with Information and Choice," in *Responding to Cairo: Case Studies of Reproductive Health and Family and Planning*, eds. Nicole Haberland and Diana Measham (New York: The Population Council, 2002).

E.C. Lazcano Ponce, N.L. Sloan, B. Winikoff, A. Langer, C. Coggins, A. Heimburger, C.J. Conde-Glez, and J. Salmeron, "The Power of Information and Contraceptive Choice in a Family Planning Setting in Mexico," *Sexually Transmitted Infections* 76 (2000): 277-281.

INTERVENTION:

Educating Prenatal Clients on STIs/HIV

COUNTRY: Guatemala

TYPE OF INTERVENTION: Operations research study

IMPLEMENTING ORGANIZATIONS: Asociación Guatemalteca para la Prevención y Control del SIDA (AGPCS), DataPro S.A., and ICRW

Gender-Related Barriers to RH

In Guatemala, male promiscuity is considered normal. It is commonly believed that sex is necessary for the mental and physical health of young men, and that men cannot be expected to be faithful to their primary partners. In contrast, women are more likely to report waiting for sexual initiation until they are in a serious relationship and to remain faithful in that relationship. Women often defer to men to make decisions about sexual matters, including family planning. Many women feel helpless to respond to men's promiscuity, due to the prevalence of men's alcohol abuse and violence against women.

Objective and Strategy

AGPCS and DataPro S.A. wanted to place an educational intervention where women would easily have access to it through health services. They targeted prenatal clinic attendees at a large Guatemala City public hospital. A general presentation already existed in the waiting room on HIV/AIDS and STIs. In addition, AGPCS developed a series of four separate, small-group participatory workshops on themes of health and sexuality, self-esteem, partner communication, and communication with adolescent children. A total of 36 large-group presentations reached approximately 1,206 pregnant women waiting to be seen for their prenatal check-up. Over a 14-week period, educators led the small-group workshops on a rotating basis with an average group size of 12, reaching a total of 479 women.

Table 4.4

RH Outcomes of Reaching Prenatal Clients with STI Information

| WOMEN WHO SAID THEY... | PRE-INTERVENTION (%) (N=100) | POST-INTERVENTION (%) (N=50) |
|---|------------------------------|------------------------------|
| View condom use positively | 50 | 82 |
| Would recommend condoms to prevent STIs | 32 | 32 |

Source: Bezmalinovic et al., 1997.

Evaluation Design: Pre- and Post-Intervention Experimental Group Only

The evaluation team interviewed 100 women, randomly selected, before their participation in the general, large-group session. Follow-up interviews took place during women's postpartum periods with 50 of the same women, all of whom had attended at least one small-group workshop.

RH/HIV/AIDS Outcomes

Pre-intervention, around 50 percent of women said they viewed condom use positively; this increased to 82 percent after the educational sessions (Table 4.4). However, there was no change in the percentage of women who said they would recommend condoms to prevent STIs (32 percent).

Gender Outcomes

The authors of the evaluation report a significant difference in the percentage of women responding to the post-intervention questionnaire who indicated they had recently spoken to their partners about the themes included in the workshops, although figures were not reported.

Conclusion

Some women pointed out that during pregnancy their partners might be more willing to discuss the topics of STI and HIV prevention, condom use, and infidelity. Interventions like this one help open lines of communication between partners.

References

Beatrice Bezmalinovic, Wende Skidmore Duflon, Annelise Hirschmann, and Rebecka Lundgren, *Guatemala City Women: Empowering a Vulnerable Group to Prevent HIV Transmission*. Report-in-Brief, Women and AIDS Research Program (Washington, DC: International Center for Research on Women, 1997).

INTERVENTION:

Integrating STI/HIV Prevention Into Family Planning Services

COUNTRY: **Brazil**

TYPE OF INTERVENTION: **Operations research study**

IMPLEMENTING ORGANIZATIONS: **Sociedade Civil Bem-estar Familiar do Brazil (BEMFAM), an International Planned Parenthood Federation affiliate; and ICRW**

Gender-Related Barriers to RH

Although gender roles in Brazil are changing, social and physical contact between women and men is restrained in many circumstances and conversation about sexual matters continues to be uncommon for many couples. Some women face insecure relationships in which men threaten to seek other partners if sex is withheld or conditional. Women sometimes choose to ignore evidence of their partners' unfaithfulness in order to maintain the relationship.

Objective and Strategy

The overall objective of the program was to integrate STI/HIV prevention and control into existing activities of BEMFAM's Salvador clinic in the state of Bahia. Goals included documenting changes in service provision as well as improving women's risk perception and strengthening their ability to negotiate condom use with partners and to talk with them about sexual matters. Of the program's four components—staff training in education, counseling, and STI diagnosis and treatment; a clinic-based discussion group for women; a school-based adolescent project; and a community-based outreach project—the first two were submitted to evaluation.

Program activities began in 1994.

Training for clinic staff included improving their knowledge, skills, comfort level, and confidence in integrating counseling and prevention activities into family planning services. Comprehensive guidelines for STI diagnosis and treatment were also developed. Some staff received additional training in participatory methodology in order to lead women's discussion groups, in which all female clients of the clinic were invited to participate. Each group consisted of 8 to 12 women and lasted for

one hour. Participants read from fictional stories about people's relationships and HIV/AIDS to explore "sexual attitudes and behaviors within their social and cultural contexts, thus helping women to see the roles of men and women as societally and culturally determined rather than inherent."¹¹⁷ Discussion around these stories brought up issues of partner communication, the importance of women's self-care, traditional gender roles, and gender power imbalances. In 1995, there was an average of 60 first-time participants each month; in 1996, there was an average of 36 first-time participants each month.

Evaluation Design: Post-Intervention Experimental Group Only

In December 1996, 41 women responded to an exit interview following their participation in a discussion group. Two months later, 29 of these women were interviewed in-depth, along with 18 clients who had attended a discussion group and returned to the clinic later for condoms. Evaluators also observed 21 medical consultations, five individual counseling sessions, one group discussion for IUD users, one waiting room presentation, and 12 women's discussion groups.

RH/HIV/AIDS Outcomes

The proportion of STI services in relation to all services rose from 8.9 to 9.7 percent in 1996. Based on observations, the interpersonal communication skills of the two physicians on staff improved, yet information provided on STIs in individual consultations remained limited. Condoms were not mentioned as contraceptives in family planning counseling. Many women reported that the discussion groups had a significant impact on their knowledge of STIs and HIV/AIDS. In general, knowledge of HIV/AIDS was greater than knowledge of STIs. Sixty-four percent of women

interviewed in-depth said they used condoms; about half of these women used them at every sexual encounter. Some reported that the discussion group had influenced them to either use the condom for the first time or more consistently (figures not reported).

Gender Outcomes

Many women interviewed in-depth said that the group had facilitated communication with their partners and others about sexuality and reproductive health. Strategies for negotiation included joking, presenting logical arguments, and withholding sex (figures not reported). Providers were not found to incorporate discussion of gender issues in individual consultations.

Conclusions

Many challenges remain for bringing a gender perspective into integrated STI/HIV and family planning services. Women's discussion groups were more successful than individual consultations at dealing with issues of power between sexual partners. The authors of the evaluation concluded, "Autonomy in other areas of sexual decision-making [besides family planning] needs to be explicitly promoted during all interactions with women as a right and responsibility."¹¹⁸

References

Rita Badiani, Cecilia de Mello e Souza, and Julie Becker. *Sexual Health STD/HIV Prevention: An Evaluation of Integrating Clinical and Educational Services in Brazil*. Women and AIDS Research Program Report-in-Brief (Washington, DC: International Center for Research on Women, 1997).

117. Badiani et al., 1997: 2.

118. Badiani et al., 1997: 11.

INTERVENTION:

Peer Education With Factory Workers in Thailand

COUNTRY: **Thailand**

TYPE OF INTERVENTION: **Operations research study**

IMPLEMENTING ORGANIZATIONS: **Chiang Mai University and ICRW**

Gender-Related Barriers to RH

Formative research by investigators at Chiang Mai University and ICRW among young male and female factory workers in Chiang Mai City found a number of gender-related barriers to the adoption of behaviors to reduce STI/HIV risk. Many garment factory workers have migrated from rural areas to find employment and are therefore distant from parents, families, and traditional norms of female-male relationships. In the city, masculinity is associated with sexual prowess and boys prefer girls who are sexually inexperienced. Girls and boys alike report that it is the girl's responsibility to prevent pregnancy, but, unless a boy believes a girl is infected, he will not think it is necessary to wear a condom. The fear of being perceived as socially undesirable prevents many girls from adopting HIV preventive behaviors.

Objective and Strategy

The objective of this intervention was to develop a peer education program for single-sex and mixed-sex groups that explores the effect of gender roles and social norms on sexual behavior, attitudes, relationships, and communication patterns. Program designers aimed to increase the awareness of young (aged 15 to 25), never-married factory workers of factors that influence HIV risk. Investigators planned to test the relative

effects of single-sex versus mixed-sex groups on risk-reduction behaviors of young women. Eighteen peer leaders (12 girls and 6 boys) were trained over the course of 10 weeks, after which they each recruited 10 to 14 participants for their group. In 10 two-hour sessions, leaders led groups through a variety of activities, such as a comic book about an invisible flying condom that silently tells young women ways to negotiate condom use with partners and a romance novel about a young woman who falls in love with an HIV-positive man. The study took place between 1994 and 1996.

Evaluation Design: Pre- and Post-Intervention Experimental Group Only

Study groups included the boys' groups, the girls' groups, and the mixed-sex groups. Pre-intervention, 120 female and 33 male factory workers listened to 11 taped conversations between couples or among groups of boys and girls and then answered a set of questions about risk and risk-reduction behaviors in the conversations. Following the completion of peer education, 97 females and 20 males listened to tapes and answered the survey. Due to the fact that most factories have only female or only male workers, girls and boys in mixed-sex groups were largely unfamiliar with each other. These groups experienced considerable prob-

lems, perhaps a sign that it is too socially prohibitive for young women and men who don't know each other to speak openly about sexual matters. Therefore, rather than comparing mixed-sex groups with single-sex groups, the authors chose to aggregate results into a single intervention group.

RH/HIV/AIDS Outcomes

Attitudes and awareness of risk-reduction behaviors showed considerable change after peer education (see Table 4.5). A higher proportion of respondents could name barriers to enacting risk-reduction behaviors, such as peer pressure (70 percent versus 41 percent) and male promiscuity (75 percent versus 59 percent). Poor communication among youth about sex was identified as a contributor to risk among 29.9 percent of participants before the intervention, who were unable to give reasons why. After the youth groups met, 52.6 percent identified poor communication as a risk factor and gave reasons why.

Gender Outcomes

Due to the difficulties in conducting mixed-sex groups, the authors concluded that mixed-sex groups were less effective than single-sex groups. Aggregating results from all groups, however, showed that the percentage of respondents saying that it was appropriate for a girl to raise the subject of HIV/AIDS with a boy rose

from 29.9 to 42.3 percent, and nearly all of the post-intervention respondents could give reasons in support of their opinion (Table 4.6). At the pre-test, 47.7 percent of respondents said that girls should carry condoms; post-intervention, that percentage rose to 84.6. While the difference between those who perceived problems with the social construction of virginity before (59.8 percent) and after (58.8 percent) the intervention might not appear to be significant, respondents were only able to explain what those problems were in the endline interviews.

Conclusions

Both boys and girls developed their awareness of masculine and feminine gender norms and how they impinge on the practice of safe sex. The authors of the evaluation report write, "The study demonstrated the importance, feasibility, and acceptability of incorporating a gender perspective into interventions for youth."¹¹⁹ As a result of this research, the Northern AIDS Prevention and Care Project has funded the expansion of the program in Chiang Mai to 15 factories with around 1,500 young men and women, the Ministry of Public Health is supporting factories in implementing peer education activities, and the Thai military

119. Cash et al., 1997: 5.

Table 4.5

| RH Outcomes of Peer Education with Factory Workers | | |
|---|------------------------------|-------------------------------|
| BARRIER TO RISK REDUCTION IDENTIFIED BY RESPONDENT | PRE-INTERVENTION (%) (N=153) | POST-INTERVENTION (%) (N=117) |
| Peer pressure | 40.5 | 70.1 |
| Male promiscuity | 58.9 | 75.0 |
| Poor communication among youth | 29.9 | 52.6 |

Source: Cash et al., 1997.

Table 4.6

| Gender Outcomes of Peer Education with Factory Workers | | |
|---|--------------------------|---------------------------|
| RESPONDENT... | PRE-INTERVENTION (N=153) | POST-INTERVENTION (N=117) |
| Said girls should carry condoms | 47.7 | 84.6 |
| Said that women can initiate HIV/AIDS topics with men | 29.9 | 42.3 |
| Perceived problems with the social construction of virginity | 59.8 | 58.8 |

Source: Cash et al., 1997.

is using the peer education materials in their HIV/AIDS program.

References

Kathleen Cash, Jaratbhan Sanguansermisri, Wantana Busayawong, and Porntip Chuamanochan, *AIDS Prevention through Peer Education for*

Northern Thai Single Female and Male Migratory Factory Workers. Women and AIDS Research Program Phase II Research Report Series No.5 (Washington, DC: International Center for Research on Women, 1997).

INTERVENTION:

Talking About Sexuality With Poor Urban Women in Brazil

COUNTRY: **Brazil**

TYPE OF INTERVENTION: **Operations research study**

IMPLEMENTING ORGANIZATIONS: **The Coletivo Feminista Sexualidade e Saúde and ICRW**

Gender-Related Barriers to RH

According to the Ministerio da Saude of Brazil, the female-to-male ratio of HIV/AIDS cases in that country rose from 1 woman to 38 men in 1985 to 1 to 3 in 1995. In 1996, AIDS was the principal cause of death among women aged 15 to 35 years in São Paulo. Poor, monogamous housewives have experienced a large portion of the increase in female cases in the last decade. The behavior of husbands, specifically extramarital affairs with other men and injecting drug use, has been identified as a major factor in the spread of HIV to women. Pre-intervention research found that low-income women in Sao Paulo find it difficult to talk to their partners about sexual matters, condom use, and fidelity and that women who refuse to have sex with their husband risk experiencing domestic violence and infidelity.

Objective and Strategy

The objectives of this study were to implement a series of three educational sessions for low-income women in São Paulo using a pamphlet called “Ousadia! Prazer de Viver” (“Courage! Pleasure for Living”). Based on earlier research, the Coletivo developed this pamphlet to pose questions for group discussion about gender norms governing sexual behavior, condom use, partner communication, fidelity, sexual rights, and non-consensual sex. Facilitators recruited 42 women through community organizations and schools in neighborhoods marked by poverty, violence, and scarce resources. Five groups of 4-12 participants each met for five sessions, one for pre-intervention assessment, three for the intervention, and another for post-intervention assessment. Two groups consisted of women aged 14-21 and three of women aged 21-40. Intervention activities included reading the pamphlet together, discussing questions in the pamphlet, talking about

visual representations of male and female anatomy, and watching a video about virginity. Some activities were modified for the two groups of younger women. The study took place between 1994 and 1996.

Evaluation Design: Pre- and Post-Intervention Experimental Group Only

Nineteen women completed both a pre-intervention and post-intervention questionnaire on their attitudes and knowledge about HIV, contraceptive use, partner fidelity, and gender roles around sexual behavior. Women were also asked how the intervention had affected them.

RH Outcomes

Results showed an increase in the number of contraceptive methods that women had heard of (figures not reported).

Gender Outcomes

The authors stated that, post-intervention, some women who had not done so before had communicated with partners, friends, and children about sex, especially topics of sexual behavior and using a condom to avoid disease. For example, three women had asked their partners to use a condom and two adolescent women said they now carry condoms in their bags. Many women also said they valued the chance to discuss taboo topics in the groups, such as gender roles, first sexual experiences, the role of communication in a relationship, and whether a married woman can refuse to have sex with her husband, and then share information they had learned with other women. Many adult women also said the intervention helped them understand their sexuality (figures not reported).

Conclusions

The authors noted, “It is important to keep in mind that none of the women in the study had ever dis-

cussed HIV/AIDS before, let alone in the context of sexuality and gender relations...The intervention developed and affirmed women’s awareness of their right to pleasure and this awareness can be a powerful stimulant for a woman to take ownership of her body, which is an important first step for HIV prevention. Therefore, it is recommended that sex and sexuality should be fundamental themes in HIV prevention programs for women. Such programs must also be part of broader interventions that address gender inequality, reproductive and sexual rights, and the political and economic context within which poor women risk exposure to HIV.”¹²⁰

References

Regina Rodrigues de Moraes, Rosa Dalva F. Bonciani, and Wilza Vilela, *Sharing Experiences: Empowering and Educating Low-income Women on HIV Prevention in São Paulo, Brazil*. Women and AIDS Research Program Report-in-Brief (Washington, DC: International Center for Research on Women, 1997).

120. Rodrigues de Moraes et al., 1997: 7.

INTERVENTION:

Peer Education Among Adolescent Girls

COUNTRY: **Brazil**

TYPE OF INTERVENTION: **Operations research study**

IMPLEMENTING ORGANIZATIONS: **The Centro da Criança e do Adolescente (Casa de Passagem) and ICRW**

Gender-Related Barriers to RH

Statistics from the Ministerio da Saúde show that the number of young women infected with HIV in Brazil rose steadily throughout the 1990s. The cultural norm that women should remain virgins until marriage has a strong influence on an adolescent girl's self-esteem, her relationship with her mother, her image in the community, and her expectations for the future. This belief shapes how girls communicate with their mothers, what they discuss among themselves, what they reveal about themselves to their community, and their risk factors for STIs/HIV. Many young women and men perceive anal sex as a way to preserve girls' virginity. Negotiating condom use can be difficult for girls due to financial dependence on men, suspicions of infidelity, reduced pleasure associated with condoms, and embarrassment.

Objective and Strategy

This intervention was built on earlier research that sought to understand how low-income female adolescents in Recife perceive their sexuality and to determine the factors that increase their vulnerability to STIs. The goal was to gain a better understanding of the health, sexuality, and AIDS beliefs and behaviors of low-income female adolescents and to test a participatory training program using female adolescent peer educators. Casa de Passagem selected 21 girls who had shown the most enthusiasm during focus groups conducted in preliminary research. After training, peer educators, known as the Adolescent Multipliers of Information (AMIs), developed a curriculum called *The Story of Maria*. The story is comprised of seven vignettes about girls and their partners, covering topics of communication and sexuality, virginity, self-esteem, autonomy, fidelity, and STI/HIV prevention. In teams of two, the AMIs recruited groups of 15-20 girls from their community, who met nine times (three hours each week for nine weeks). A vignette was presented at each meeting for discussion amongst the

participants (called AMIGAs). The study took place between 1994 and 1996.

Evaluation Design: Qualitative

While the intervention was being implemented, the AMIs participated in a weekly process evaluation. During these sessions, the AMIs discussed their experiences from the week before, described any difficulties they had encountered presenting the material, and identified issues or points that needed to be clarified or reinforced. For the final evaluation, investigators conducted several focus groups with AMIs and AMIGAs.

RH/HIV/AIDS Outcomes

Many girls reported that they knew very little about HIV and AIDS before the program and that they had considered information on how to prevent HIV to be essential. The intervention appeared to increase many girls' perceptions of their own vulnerability to infection. One girl said, "I think the most important thing that the [AMI] explained was about AIDS, the virus, because I didn't know that a person could get AIDS from anal sex, too...because there are a lot of girls who have anal sex so they won't get pregnant or lose their virginity." Many girls also noted a change in their attitudes toward sex and sexual decisionmaking. In addition, the girls indicated they are using this information to challenge community attitudes, focusing on confronting people's discriminatory attitudes toward people with HIV.

Gender Outcomes

Focus group data showed a number of changes among the girls participating as peer educators. They were better able to express themselves, and fear of speaking in public was replaced by enthusiasm for communicating their opinions. The AMIs were also more comfortable in talking about subjects previously considered taboo, felt they had increased autonomy, and reported feeling more valued and respected in their communities. Rather than expressing

powerlessness, they started to take more responsibility for their behaviors, including their sexual behaviors. Both AMIs and AMIGAs gave evidence that the intervention challenged their ideas about gender norms:

"The chapter [in The Story of Maria] that I thought was the most interesting was the one about the girl and the unfaithfulness of men, because it was true that the man went out and had sex before he got married because the girl was a virgin. My response was, 'I don't think so. I think this is wrong, it's disrespectful.' Because...a woman has her needs, men say they have them too, but a woman manages to wait, and why can't they?"

Conclusions

The success of this program is based in the development of a curriculum tailored to the circumstances of low-income adolescent girls in Recife. Putting STI/HIV prevention into the larger context of girls' lives not only raised their awareness of STI/HIV transmission and prevention but also provoked them to question the roles of men and women in sexual relationships. One girl said,

"I learned about AIDS, about sexuality, gender, and what I liked most was learning about the rights of women, that women have the right to say no...one can say no when someone touches them. Now that I have all this information, I am stronger, I know what I want in life."

References

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INTERVENTION:

Strengthening Traditional Women's Associations

COUNTRY: **Senegal**

TYPE OF INTERVENTION: **Operations research study**

IMPLEMENTING ORGANIZATIONS: **The Universite Cheikh Anta Diop and ICRW**

Gender-Related Barriers to RH

Senegalese women are less likely than men to be literate or educated, to hold formal sector employment, or to have access to credit. Their lower socioeconomic standing limits their power in sexual decisionmaking with partners. Many women resort to the exchange of sex for economic support but are not registered as sex workers and, therefore, are not eligible to receive free condoms through the health system. Common misconceptions about the cause of AIDS include the notion that it results from women passing evil spirits to extra-marital partners. Women also report fear of asking men to use condoms because their partners may think they are sex workers or having an affair. Laobe women are expected to consent to their husbands' decisions about when and how to have sex. Refusing to have sex with one's husband may be considered evidence of an affair, giving the husband grounds for divorce. Laobe women are specialists in erotic products, which they sell for income and use to enhance the sexual pleasure of male partners. The Laobe believe that these products cannot be used in conjunction with condoms.

Objective and Strategy

Information about sex and fertility is often channeled between women in Senegal through traditional women's associations. This study sought to discover whether these channels could be used to disseminate information about STIs and HIV and to promote condom use. The study team trained two women's groups as community change agents in STI/HIV prevention—the Dimba, a multi-ethnic group for women who have experienced problems with fertility or child death, and women from the Laobe, an ethnic group whose women sell a variety of sexual and erotic products.

Dimba associations from three neighborhoods of Kolda, a city in south-

Table 4.7

Baseline and Endline Results for Kolda (Dimba area)

| VARIABLE | WOMEN | | | | MEN | | | |
|------------------------------|---------------|----------------|---------------|----------------|---------------|----------------|---------------|----------------|
| | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | |
| | INTER. (N=80) | CONTROL (N=80) | INTER. (N=80) | CONTROL (N=80) | INTER. (N=80) | CONTROL (N=80) | INTER. (N=80) | CONTROL (N=80) |
| Knowledge: | | | | | | | | |
| HIV can be transmitted by... | | | | | | | | |
| Sex | 65* | 52* | 68* | 48* | — | — | — | — |
| Blood | 68* | 50* | 71* | 50* | 63* | 73* | 66 | 71 |
| Curse | — | — | — | — | 6* | 13* | 5 | 9 |
| HIV can be asymptomatic | | | | | | | | |
| | 29 | 19 | 49* | 18* | — | — | — | — |
| Mother-child transmission | | | | | | | | |
| | 54* | 37* | 69* | 37* | — | — | — | — |
| Behavior: | | | | | | | | |
| Visited clinic for | | | | | | | | |
| STI | 14 | 20 | 22 | 19 | — | — | — | — |
| Attended HIV discussion | | | | | | | | |
| | 46* | 18* | 52* | 22* | 14* | 5* | 18* | 7* |
| Talked with partner | | | | | | | | |
| | 61* | 31* | 69* | 29* | — | — | — | — |
| Used the condom | | | | | | | | |
| | 28 | 22 | 35* | 23* | — | — | — | — |

Note: Blank cells are due to poor response rate or unreported data; inter.=intervention.
*p<0.05
Source: Niang et al., 1997.

ern Senegal, and Laobe women from two neighborhoods in Kaolack, a city in central Senegal, participated in sessions with facilitators and health care providers to design ceremonies and group discussions that would spread risk-reduction and condom negotiation messages. A public ceremony was subsequently held in each intervention neighborhood. Among the Dimba, the ceremonies included dancing, singing songs incorporating STI/HIV prevention messages, and role-plays to explain the symptoms, transmission, and methods of prevention of HIV/AIDS. The need for male partners to listen to women was emphasized. Laobe women held a ceremony, attended by more than 2,000 people, with erotic dancing, poems, and songs emphasizing the empowerment of

women in sexual negotiation. Topics also included how to eroticize the condom, in part through promoting the idea that they sustain a man's erection.

Both Dimba and Laobe women also formed discussion groups in their neighborhoods to clarify information and ideas about ways that partners can discuss condom use. Men attended some of the sessions in Dimba neighborhoods, with the last session attracting more than 100 men and women. This study took place between 1994 and 1996.

Evaluation Design: Pre- and Post-Intervention Control Group

Evaluators administered a questionnaire both pre- and post-intervention to random samples of 320 residents of two

Table 4.8

Baseline and Endline Results on HIV Knowledge for Kaolack (Laobe area)

| VARIABLE | WOMEN | | | | MEN | | | |
|-------------------------------------|------------------|-------------------|------------------|-------------------|------------------|-------------------|------------------|-------------------|
| | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | |
| | INTER. (N=50) | CONTROL (N=50) | INTER. (N=50) | CONTROL (N=50) | INTER. (N=50) | CONTROL (N=50) | INTER. (N=50) | CONTROL (N=50) |
| HIV can be transmitted by... | | | | | | | | |
| Wind | 15 | 26* | 1 | 24* | — | — | — | — |
| Urine | 20 | 23 | 8 | 25* | — | — | — | — |
| Sex | 46 | 40 | 54 | 38* | 33 | 44* | 34 | 43* |
| Mother-to-child | 21 | 36* | 47 | 33* | — | — | — | — |
| HIV can be prevented by... | | | | | | | | |
| Medicines/ douching | 19 | 33* | 1 | 34* | 16 | 20 | 8 | 19* |
| Traditional belt | — | — | — | — | 12 | 8 | 7 | 16* |
| AIDS exists in | | | | | | | | |
| Kaolack | 40 | 22* | 49 | 22* | 33 | 47* | 37 | 47* |
| Condoms... | | | | | | | | |
| Can make male impotent | 6 | 8 | 1 | 7* | 12 | 2* | 10 | 2* |
| Women can ask husband to use | 25 | 14* | 32 | 11* | 24 | 34* | 26 | 31* |

Note: Blank cells are due to poor response rate or unreported data.

*p<0.05

Source: Niang et al., 1997.

intervention and two control neighborhoods (40 men and 40 women in each site) in Kolda. In Kaolack, pre- and post-intervention samples numbered 200, 25 women and 25 men from each of two intervention neighborhoods and 50 men and 50 women from one control area. Topics included knowledge and beliefs about HIV transmission and prevention, condom use, sexual behavior, health-seeking behavior for STIs, partner communication, and the perceived impact of the intervention.

RH/HIV/AIDS Outcomes

Data indicated that more women increased their knowledge of STIs/HIV in the inter-

vention neighborhoods, including that HIV can be asymptomatic and can be transmitted vertically. At pre-test, there was no significant difference between the groups of women who reported ever using a condom, but at post-test, a greater number of women in the intervention sites said they had used a condom. Among the Laobe (in Kaolack), there was poor response on questions about sexual practices and condom use, and these data were left out of the analysis. However, the survey suggested that the intervention positively impacted Laobe women's knowledge on six of ten facts on HIV transmission and prevention. The impact on men from both

sets of communities was less than that on women (Tables 4.7 and 4.8).

Gender Outcomes

Among the Laobe, analysis suggested that women in intervention sites are more likely to believe that they have the right to ask their husbands to use condoms (see Table 4.8). One woman said, "We now know how to convince our Laobe men who travel far most of the time that they need to use condoms so that they can return to their beautiful wives." Results for this indicator are not reported for the Dimba. In neighborhoods where the Dimba held activities, respondents mentioned in interviews their appreciation of the opportunity to discuss sexual problems with the men of their communities.

Conclusion

This project tapped into pre-existing community resources that were controlled by women—women's institutions and domains of expertise. By choosing these groups as pathways of dissemination for STI/HIV prevention messages, the program gained cultural acceptability and enhanced the power and status of women leaders. This strategy limited the effects on men, at least for those indicators that were measured, but created grounds for a greater recognition of women's rights and knowledge in sexual decisionmaking.

References

Cheikh Niang, Helen Benga, Abibou Diagne Camara, Adjaratou Ndiaye, Rokhaya Nguer, and Yacine Thiam, *An Evaluation of HIV Prevention Interventions Utilizing Traditional Women's Associations in Senegal*. Women and AIDS Research Program, Phase II Research Report Series No. 6 (Washington, DC: International Center for Research on Women, 1997).

INTERVENTION:

Talking About Violence as a Barrier to Condom Use

COUNTRY: **South Africa**

TYPE OF INTERVENTION: **Operations research study**

IMPLEMENTING ORGANIZATIONS: **The University of Natal and ICRW, supported by the Fogarty International Center through a Fogarty Fellowship**

Gender-Related Barriers to RH

Formative research for this program uncovered that many women refrain from discussing condom use with partners because of a fear of violent responses. Even though women said it was normal for casual partners but not steady partners to use a condom, many said that they were more likely to ask their steady partners to use a condom than a casual partner, because they would be able to more accurately predict the risk of a violent reaction with a man that they knew well. Women also feared being abandoned if their fidelity was called into question by asking their partners to use male or female condoms.

Objective and Strategy

The objectives of this study were to test the efficacy of a series of four small-group skills workshops targeted to female and male patients being treated for STI symptoms. The intervention took place at an STI clinic located in a low-income, high-unemployment, high-crime area of KwaMashu, KwaZulu Natal. Ninety-minute workshops were held weekly and based on guided practice and problem solving.

In the first three workshops of the series, single-sex groups discussed female anatomy, male and female condoms, communication between partners, physical and emotional abuse associated with communication about condoms, and HIV prevention and barriers to prevention. The last session brought the men and women together to conduct role-plays about sexual communication, condom negotiation, and related male violence. Men played the parts of women talking to their partners about how it felt to be beaten up, and both men and women shared candidly about experiences in perpetrating or suffering violence related to sexual negotiation. Five such series were held with around 10 women and 10 men each (a total of around 100), with the last session generally ending in applause from participants. The study took place between 1994 and 1996.

Evaluation Design: Pre- and Post-Intervention Control Group

In addition to the five intervention groups, five control groups of 10 women and 10 men each met for one group session, in which they received information that all

STI clinic attendees normally would obtain from staff. Interviews occurred in all groups at baseline and immediately post-intervention. The number of participants completing both pre- and post-test interviews was 151.

RH/HIV/AIDS Outcomes

While risky behaviors were no more common in either group before the intervention (as measured by the Vaginal Episode Equivalent, or VEE¹²¹), afterwards women in the intervention groups engaged in significantly less unprotected penetrative sex than the control groups (VEE scores 14.7 versus 24.12). Men in intervention groups were less likely to engage in unprotected sex post-intervention, but the difference was not statistically significant (VEE

121. One tool used in the interview was the Vaginal Episode Equivalent (VEE), which scores sexual behaviors according to their level of HIV risk. Each unprotected vaginal intercourse scores 1. Unprotected oral sex scores 1/10 of a point, and unprotected anal sex 2 points. The pre-test asked about sexual behavior in the three months prior; the post-test asked about sexual behavior during the period of the intervention (four weeks).

scores 26.28 versus 31.62). None of the control group women used condoms consistently, but following the workshops, 17 percent of women from experimental groups did. Occasional use was reported by 57 percent of intervention group women and 12 percent of control women. Post-intervention, men were significantly more likely to use a condom (11 versus 3 percent consistent use; 56 versus 29 percent occasional use). Importantly, symptoms of STIs were absent from 83 percent of women from experimental groups post-intervention but from only 53 percent of controls, although these differences did not exist at baseline. The decline was much smaller among men's groups (Table 4.9).

Gender Outcomes

There was little difference between reported violence in the experimental and control groups, either before or after the intervention. Unfortunately, the timing of post-intervention interviews was poor; they took place immediately following the final, co-ed session that focused on violence, before participants even had opportunities to alter their behavior.

Table 4.9

Post-intervention Results Among STI Patients in KwaZulu Natal

| | WOMEN (%) | | MEN (%) | |
|--|----------------------------|-----------------------|----------------------------|-----------------------|
| | EXPERIMENTAL GROUPS (N=50) | CONTROL GROUPS (N=50) | EXPERIMENTAL GROUPS (N=50) | CONTROL GROUPS (N=50) |
| Vaginal Episode Equivalent scores | 14.7* | 24.12* | 26.28 | 31.62 |
| Condom use... | | | | |
| Always | 17* | 0* | 11* | 3* |
| Occasionally | 57* | 12* | 56* | 29* |
| Presents STI symptoms | 17* | 47* | 22 | 29 |

*Statistically significant difference (p-value not reported).
Source: Hadden, 1997.

Conclusions

This intervention shows that programs that address women's concerns about violence related to sexual negotiation can be highly effective in reducing risk behaviors and promoting dialogue between men and women. Both men and women received the program well and showed evidence of having reduced their risk behaviors for STI/HIV transmission.

References

Bernadette Hadden, *An HIV/AIDS Prevention Intervention with Female and Male STD Patients in a Peri-Urban Settlement in KwaZulu Natal, South Africa*. Women and AIDS Research Program Report-in-Brief (Washington, DC: International Center for Research on Women, 1997).

Quality of Care Initiatives

Background

Quality of care initiatives are discussed separately because they address all components of reproductive health. Improving quality of care in family planning and reproductive health has grown as a priority over the past decade. Initiatives to improve quality of care in reproductive health have roots in the Bruce-Jain framework¹²² and in continuous quality improvement approaches that adapt total quality management principles for use in health care.¹²³ In both approaches, clients' needs are the central focus of programs. The Bruce-Jain framework structures dimensions of quality from the client's perspective, including choice of methods, correct information, technical competence of providers, good client-provider interaction, continuity of care, and appropriateness and acceptability of care.

Quality improvement approaches take a systems-based view of health service delivery and seek to improve the functioning of health services to meet client needs. The organizational environment must be structured to optimize quality care for clients. Using scientific and statistical methods to identify problems and develop solutions enables managers and staff to continuously improve services provided by their programs. The Maximizing Access and Quality initiative (www.maqweb.org) and performance improvement methods¹²⁴ are also designed to improve the quality of services and care. A number of tools have been developed to assess and improve quality of care (see www.erc.msh.org), including EngenderHealth's COPE (client-oriented, provider-efficient) technique and IPPF/Western Hemisphere Region's Manual to Evaluate Quality of Care from a Gender Perspective.¹²⁵

Initiatives driven by a quality of care perspective can integrate gender issues by introducing improvements to address gender-related barriers to quality of care. For instance, the

Quality Assurance Project (QAP), funded by USAID and implemented by the Center for Human Services (www.qaproject.org), embraces a quality of care framework that is systems-based, client-centered, team-based, and data-driven. In the QAP approach, quality teams are formed at different levels of the health care system and are responsible for monitoring and improving the quality of health services. Quality teams (made up of health care providers, managers, and sometimes community members) undertake a problem-solving analysis of the service delivery as a whole, examining various dimensions of quality: technical performance, effectiveness, efficiency, safety, access, interpersonal relations, continuity, physical aspects, and choice.¹²⁶ In their analyses, teams may identify barriers to quality of care that result from unequal gender relations and norms. Most interventions undertaken to work around these gender-related barriers accommodate gender differences. In some cases, depending on the intervention chosen to solve the quality problem affected by gender, some interventions could potentially transform gender relations to promote equity. For each quality improvement initiative, the quality teams conduct a situation analysis before and after the intervention to document the impact of the improvement.

Although access is often treated separately from quality of care, access is included here as a key component of quality. The authors believe that these aspects of health care are inextricably linked and that quality health services cannot exist if clients face significant obstacles to service utilization. Thus, quality initiatives, especially when addressing gender

122. Bruce, 1990.

123. Hardee and Gould, 1993.

124. Caiola and Sullivan, 2000.

125. IPPF, 2000.

126. Massoud et al., 2001.

issues, must include attention to access barriers.¹²⁷

Gender-Related Barriers to Improving Quality of Care

Gender-related barriers to quality of care are common to various health care settings. In some contexts, women's access to health services is limited due to restrictions on their mobility. Women may also be prevented from visiting health services because they have care-taking responsibilities for children, the elderly, or sick family members and have no one to take care of them in their place. Burdened by reproductive, productive, and community work, and by gender norms that place children's and men's health above women's health, women may not be able to seek care or follow-up in a timely manner nor have the resources needed to do so. Women's shyness vis-à-vis health care providers, especially male providers, may keep women from asking questions during their consultations. Other gender-related barriers include vertical and paternalistic patterns of decisionmaking and communication between health care providers and clients, and masculinity norms that keep men away from health services or limit their involvement in the health care of their partners and/or children.

Interventions That Accommodate Gender Differences

In some settings, health services have undertaken initiatives to make their services more male-friendly, for example, by offering evening hours of operations, allowing the presence of male partners during childbirth, or introducing couple counseling. Some of these initiatives may directly attempt to change the masculinity norms that deter men from clinical services. However, most interventions that have addressed gender barriers to quality of care accommodate gender differences rather than challenge gender relations. For example, a

health center may decide to add a small child-care facility to address the fact that many mothers do not have anyone with whom to leave their children when they visit the health care facility. When trying to improve utilization and follow-up of services such as prenatal care, quality teams have often found that reducing waiting time can greatly increase service utilization by accommodating women's time constraints.

This chapter describes three programs that have improved quality of care from a gender perspective. After community women expressed their preference for female providers, MaxSalud in Peru reinstated a midwife in the clinic and rapidly boosted service utilization. The Smart Patient study in Indonesia coached female family planning clients on assertiveness with clinicians, which increased their likelihood of expressing concerns and asking questions. In Botswana, allowing women to choose a female family member to accompany them through labor and delivery improved obstetrical outcomes. Each of these interventions involved making services more client-centered and responding to women's requests, concerns, questions, and choices.

127. Another IGWG Task Force is assessing the links made by program staff in three countries (India, Kenya, and Guatemala) among access, quality, and gender in reproductive health programs. The report from that task force will be available in winter 2004.

INTERVENTION:

Female Providers at MaxSalud

COUNTRY: Peru

TYPE OF INTERVENTION: Operations research study

IMPLEMENTING ORGANIZATIONS: University Research Co., LLC, in collaboration with the Quality Assurance Project and researchers from the Center for Human Services and Johns Hopkins University/Center for Communication Programs, funded by USAID through the Strengthening Health Institutions Project (SHIP)

Gender-Related Barriers to RH

At a primary health clinic in a peri-urban community in Peru, health managers were alarmed by low utilization rates in 2000 among their mostly female clientele. Taking a rapid problem-solving approach, the managers met with clinic personnel and community-based health promoters to discuss the reasons for low utilization. One of the issues raised by promoters was the fact that the clinic no longer had a female health worker to attend to women's health visits. The certified midwife had been transferred to work at another clinic and replaced with a male gynecologist. According to the promoters, women in the community felt too shy to go to the male doctor for their health problems. Female clients were also feeling the lingering economic effects of the El Niño phenomenon and were busy reconstructing their neighborhoods.

Objective and Strategy

Clinic staff hoped to achieve greater utilization of clinic services by women. Along with a decrease in prices and an aggressive publicity campaign to advertise the new fee schedule, a certified midwife was reinstated as part of the clinic's quality improvement intervention.

Evaluation Design: Pre- and Post-Intervention Experimental Group Only/Qualitative

MaxSalud managers monitor utilization rates for the clinic as part of their health information system. This quantitative data was supplemented with information collected as part of a qualitative study on client perspectives of quality, which included observation of quality team meetings, as well as interviews and focus groups with clients and providers.

RH Outcomes

Service utilization rates rose dramatically after the implementation of improvement interventions. Female clients reported high satisfaction with women's health services and a preference for female providers. Clients found the new fee schedule affordable.

Gender Outcomes

Gender outcomes were not measured.

Conclusion

The sex of health providers, particularly for women's health care, can be a vital aspect of quality from the perspective of clients. Economic barriers can also be an important obstacle to quality of care, especially for women who often bear the

greatest community burden after natural disasters. Community-based promoters can provide an important link between health services and clients. Traditionally, health services have used community-based promoters in top-down transfers of information or in bottom-up mobilization campaigns to increase service utilization. However, community-based promoters can also open up an important dialogue between services and clients by bringing client perspectives of quality to the attention of managers. This dialogue can lead to quality improvement initiatives that address the barriers to quality of care that the community experiences.

References

Diana Santillan, *Using Client Satisfaction Data for Quality Improvement of Health Services in Peru*. QA Case Study Series (Bethesda, MD: Published for USAID by the Quality Assurance Project, 2001).

Diana Santillan and Maria Elena Figueroa, *Implementing a Client Feedback System to Improve NGO Healthcare Services in Peru*. QA Operations Research Results 2(2) (Bethesda, MD: Published for USAID by the Quality Assurance Project, 2001).

INTERVENTION:

Female Relative Support in Labor

COUNTRY: **Botswana**

TYPE OF INTERVENTION: **Clinical trial**

IMPLEMENTING ORGANIZATIONS: **University of Surrey, sponsored by the Government of Botswana**

Gender-Related Barriers to RH

Before the advent of hospital-based birth and accompanying restrictions on gaining entry to labor wards, women in Botswana were well supported by family members during childbirth at home. In addition to a traditional birth attendant, at least one female relative would stay with the woman during her labor and would not leave until the birth was completed. Today, many women in Botswana give birth in the hospital. Usually a woman's mother accompanies her to the hospital but is not permitted to enter the labor wards. In spite of women's desires to have family nearby, health care providers often expect them to endure labor without emotional and physical support.

Objective and Strategy

The goal of this study was to determine the effect of labor support provided by a female relative on obstetric outcomes. Women were allowed to choose a female relative to accompany them through the entirety of their labor and birth in the hospital.

Evaluation Design: Randomized Controlled Trial

This study took place between October 1994 and January 1995 in Gaborone, Botswana. Women admitted to the general labor ward at a primary obstetric referral hospital, Princess Marina Hospital, were screened for eligibility and willingness to participate. Participants in the study were limited to primigravidas (women with their first pregnancies) with uncomplicated obstetrical histories and current labors. The control group and the experimental group each comprised 55 women.

RH Outcomes

Compared to the controls, the experimental group experienced significantly fewer cesarean sections (6 vs. 13 percent), vac-

Table 5.1

Methods of Delivery, Labor Interventions, and Apgar Scores in Clinical Trial of Female Relative Support in Labor

| VARIABLE | EXPERIMENTAL GROUP (%) (N=55) | CONTROL GROUP (%) (N=55) | P-VALUE |
|------------------------------|-------------------------------|--------------------------|---------|
| Spontaneous vaginal delivery | 91 | 71 | 0.03 |
| Vacuum extraction | 4 | 16 | 0.03 |
| Cesarean section | 6 | 13 | 0.03 |
| Analgesia | 53 | 73 | 0.03 |
| Amniotomy | 30 | 54 | 0.01 |
| Oxytocin | 13 | 30 | 0.03 |
| Apgar (1 min) | 8 | 7 | ns |
| Apgar (5 min) | 9 | 9 | ns |

Source: Madi et al., 1999.

uum extractions (4 vs. 16 percent), and amniotomies (30 vs. 54 percent), and received less analgesia (53 vs. 73 percent) and oxytocin (13 vs. 30 percent). There were no significant differences in Apgar scores or perineal trauma (see Table 5.1).

Gender Outcomes

Gender outcomes were not measured.

Conclusion

The study's authors suggest that the presence of a female relative reduced the stress and pain experienced by women in labor, and thereby lowered negative clinical outcomes: "Psychological theory states that in the presence of a companion, laboring women feel empowered and more in control of their labor because they know that someone caring will always be there, and could be called on to help if needed." Increasing the power of laboring women by respecting their wishes to be accompanied by family is a very low cost intervention and, therefore, easily replicable in a variety of settings.

References

B.C. Madi, J. Sandall, R. Bennett, and C. MacLeod, "Effects of Female Relative Support In Labor: A Randomized Controlled Trial," *Birth* 26, no.1(1999):4-8.

INTERVENTION:

Smart Patient Program

COUNTRY: **Indonesia**

TYPE OF INTERVENTION: **Operations research study**

IMPLEMENTING ORGANIZATIONS: **The State Ministry of Population/National Family Planning Coordinating Board in Indonesia (BKKBN) and Johns Hopkins University/Center for Communication Programs, funded by USAID and the Population Council/Frontiers Project**

Gender-Related Barriers to RH

In Indonesia, family planning clients have often reported difficulties in asking questions, expressing concerns, and requesting clarifications from providers. In this study, all the family planning clients were women.

Objective and Strategy

The BKKBN sought to test a strategy for empowering family planning clients to be more assertive in communications with providers and to see how assertiveness coaching affects method continuation at eight months. Sixty-four intervention clinics in two districts of East Java Province (Jombang and Mojokerto) were randomly selected from those that had worked with the BKKBN on a previous project. One-on-one sessions with patient educators just prior to clinic appointments gave women coaching on their right to speak out and skills in asking questions, expressing concerns, and seeking clarification. Clients then wrote down their questions for the provider and practiced saying them aloud to the patient educator, who gave feedback.

Table 5.2

| | EXPERIMENTAL GROUP (N=384) (%) | CONTROL GROUP (N=384) (%) |
|--|-----------------------------------|------------------------------|
| Contraceptive discontinuation rate at 8 months | 8.7 | 16.1 |

Source: Kim et al., 2001.

Contraceptive Discontinuation in Smart Patient Program

| | EXPERIMENTAL GROUP (N=384) (%) | CONTROL GROUP (N=384) (%) |
|--|-----------------------------------|------------------------------|
| Contraceptive discontinuation rate at 8 months | 8.7 | 16.1 |

Source: Kim et al., 2001.

Evaluation Design: Post-Intervention Control Group

Twelve family planning clients (four new and eight continuing), evenly divided between the intervention and control groups, participated at each of the 64 clinics. The total number of participants was 768. Clients in the control group received a leaflet on an unrelated reproductive health topic (HIV/AIDS) and had the opportunity to ask a patient educator questions about the information in the leaflet. Research assistants audiotaped the visits with providers, which allowed analysts to code client-provider interactions for types of questions asked and information offered. Researchers also conducted exit-interviews with clients and made visits to clients' homes eight

months after the intervention to interview them on contraceptive use and reasons for discontinuation. Women in the control group and those in the experimental group were similar demographically and socio-economically and scored comparably on a pre-intervention instrument measuring assertiveness.

RH Outcomes

Experimental group clients had lower rates of contraceptive discontinuation than control group clients at eight months post-intervention, but this did not reach statistical significance (see Table 5.2).

Gender Outcomes

Coded transcripts of appointments with providers and follow-up interviews

showed that women who received patient education asked significantly more questions (6.3 versus 4.9) and expressed more concerns (6.7 versus 5.4), but did not seek clarification significantly more often (1.8 versus 1.5) (see Table 5.3). The client's share of the conversation in both groups was 32 percent of all utterances recorded. In exit interviews, clients valued the legitimization of their right to raise concerns and questions with providers, but 94 percent of intervention group clients wished they had asked the provider more questions. Providers were more likely to give tailored communication (defined as information and advice related to the client's personal needs and circumstances) to clients from the intervention group.

Conclusion

Family planning is often a sensitive topic for discussion between health practitioners and their clients. Social and cultural differences between them may make the situation more difficult. Supporting clients' awareness of their right to understand family planning methods and the impact a method could have in their lives,

Table 5.3

| Gender Outcomes of Smart Patient Program | | | |
|--|----------------------------|-----------------------|---------|
| AVERAGE NUMBER OF... | EXPERIMENTAL GROUP (N=384) | CONTROL GROUP (N=384) | P-VALUE |
| Questions asked | 6.3 | 4.9 | .01 |
| Type of question: | | | |
| Direct question | 5.8 | 4.1 | .01 |
| Assertion question | 0.7 | 0.5 | .05 |
| Embedded question | 0.2 | 0.2 | ns |
| Concerns expressed | 6.7 | 5.4 | .05 |
| Clarifications sought | 1.8 | 1.5 | ns |
| Tailored communication utterances from providers | 24.9 | 21.1 | .01 |

Note: ns = not significant
Source: Kim et al, 2001.

combined with training in how to communicate with a health professional, showed positive results in this program. The training that clients received altered many aspects of the quality of the interactions with their health care providers. The fact that contraceptive discontinuation was unaffected may signal that multiple patient education sessions with educators are required to sustain family planning practice.

References

Y.M. Kim, F. Putjuk, E. Basuki, and A. Kols, *Increasing Client Participation in Family Planning Consultations: An Evaluation of "Smart Patient" Coaching in Indonesia* (paper presented at the American Public Health Association Annual Meeting, Atlanta, October 21-25, 2001).

Conclusion

“Policy-makers and program managers are unlikely to find short cuts to gender-sensitive programs, but by recognizing the links between gender and women’s access to and use of reproductive health services, they may be able to reduce gender discrimination and, over time, modify programs so that they do more to empower women.”¹²⁸

At the ICDP +5 Forum in The Hague, Dr. Nafis Sadik proclaimed that, “We have shown each other and the world that the ICPD Programme of Action is far more than a piece of paper. We have proved that it works.”¹²⁹ The ICPD +5 Forum in The Hague began appraising progress toward implementing the Cairo Programme of Action (POA), of which promoting gender equity has been a key component. This review contributes to the growing body of literature on gender-based approaches to policy and programming in reproductive health.

Three types of gender integration in reproductive health programming have been described: exploiting gender inequalities to pursue reproductive health goals; accommodating existing gender differences and inequities; and seeking to overcome barriers by transforming gender norms and ameliorating gender inequities. The descriptions have included the design of the initiatives as well as their degree of success in achieving reproductive health and equity between women and men. Many of these interventions simultaneously address several reproductive health and HIV/AIDS issues.

Ideally, evaluating the impact of gender integration on reproductive health outcomes would involve operations research designs with experimental and control areas and pre/post measures of the outcomes of interest. Unfortunately, few such studies have been conducted, although some are currently underway. Still, the evidence reviewed is compelling: Integrating gender into reproductive health pro-

grams does appear to have a positive impact on outcomes.

This review has generated eight main conclusions:

1. Evaluations of reproductive health programs that promote gender equity are few in number and limited in scope.

Relatively few programs that seek to transform gender relations to promote equity have undergone systematic evaluation.

Many innovative programs guided by a gender perspective were excluded from this review because they had not been evaluated systematically. This may be because many such programs are recently implemented, innovative, and small-scale, and, therefore, must devote available resources to implementation.

Gender impact is rarely measured.

The programs included in our review did not always measure gender outcomes, perhaps because gender indicators are not well developed and studied, or because donors often do not require monitoring of gender impact.

2. It is difficult to isolate the effects of a gender perspective in programming.

Effective and sustainable programs are designed with a multi-faceted strategy that addresses specific gender barriers to reproductive health within the larger program design. As a result, it is difficult to demonstrate the isolated effects of a gender perspective on reproductive health and HIV outcomes.

¹²⁸. Barnett and Stein, 1998.

¹²⁹. UNFPA, 1999.

3. Evaluations are typically short-term, while changing gender relations is a long-term process.

Programs that challenge gender norms in order to overcome barriers to reproductive health and HIV cannot expect to see strong results in a short period of time. Achieving a change in gender relations is a long-term process that may not be reflected in a relatively short-term intervention. The majority of the programs analyzed have been implemented in the last five or six years. These innovative programs need time to evolve before a strong gender impact can be demanded from them as a measure of success.

4. The strongest evidence comes from evaluations comparing the same interventions with and without the addition of a gender component.

A few evaluations assessed outcomes of reproductive health interventions where a gender component was added only in selected sub-sites or sub-groups. These studies provide the best available evidence that gender integration makes a difference to reproductive health outcomes. In India, the results of adding a reproductive health component that integrated gender to a World Neighbors agricultural intervention in two villages were tested against reproductive health outcomes in another village where the reproductive health component was very limited. In an urban slum neighborhood in the United States, women who attended a series of sessions on STI/HIV risk-reduction from a gender perspective achieved greater improvements in protective behaviors than women who attended a single informational session without the emphasis on gender concerns. And in Turkey, EngenderHealth evaluated the effects of educating couples on obstetrical health and family planning compared to the education of women alone. All of these cases found that sites or groups receiving interventions that integrate gender experienced better reproductive health and gender outcomes for most indicators. However, other differences between intervention components, such as the use of a participatory approach, or a single session versus a series of sessions, makes it difficult to conclude that these outcomes were due to the attention given to gender issues alone.

5. Among interventions promoting gender equity, there are more initiatives with demonstrated results in STI/HIV prevention than in other health areas.

Ten of the programs reviewed focused on STI/HIV reduction, while each of the other health issues had nine or fewer programs. As discussed in the chapter on STIs/HIV, gender concerns have received more attention in STI/HIV prevention work due to the transparent link between inequitable gender relations and the spread of STIs and HIV/AIDS. Sexual behavior is strongly regulated by gender norms, and economic inequities between women and men leave women powerless in transactional sex.

6. Many programs seeking to transform gender relations combine it with a community participation or community empowerment strategy.

Gender-integrated components of reproductive health programming are often embedded in participatory or community empowerment initiatives. These programs may not only be empowering women vis-à-vis men, but also empowering the greater community. Often their goals cross development sectors to include agriculture, education, economic development, and natural resource management.

7. The 25 interventions reviewed that integrate gender reported positive reproductive health and HIV outcomes.

With only a few exceptions, the programs reviewed here achieved positive reproductive health outcomes. However, it is possible that the literature reviewed suffered from a bias against publicizing negative findings. Changes were more likely to be reported in knowledge and attitudes than in reproductive health behavior, and, in some cases, programs had less of an impact on men than on women.

8. Among the 20 interventions that measured gender impact, gender outcomes were positive.

Nearly all interventions using gender indicators reported positive changes in gender relations. Qualitative data showed increases in women's decision-making power and political participation in the community, women's knowledge of legal rights, and societal respect for women. Evidence from quantitative measures demonstrated that programs had stimulated conversations between men and women

about family planning and STIs/HIV and greater mutual support between partners; improved girls' chances of continuing education; increased men's knowledge of women's health care; decreased violent episodes against women; raised women's self-efficacy, self-confidence, assertiveness, and likelihood of discussing sensitive subjects with others; and increased gender equitable attitudes about raising children, the division of labor, and reproductive health matters. In a very small number of cases, gender relations showed no change as a result of intervention activities. Among other factors, this result may be due to delayed impacts that were not measurable at the time of the evaluation and/or a weak investment in a particular aspect of a program, such as women's literacy.

Future Directions

This is a very important review and analysis, which strongly suggests that integrating gender into reproductive health programs appears to have a positive impact on achieving reproductive health outcomes. Perhaps just as important, it provides a much-needed blueprint for further exploration of this causal relationship. The onus is on reproductive health and gender experts to ensure that future interventions are well designed and include a strong monitoring and evaluation component. If we are to be successful in making compelling recommendations for gender integration, we must have the scientific evidence that proves its impact on reproductive health and gender-equity outcomes.

The authors wish to emphasize two specific actions to strengthen the application of gender-based approaches in reproductive health programming:

Stronger integration of gender in designing program interventions. Reproductive health remains the primary objective of most policies and programs. Yet, it is important to understand gender contexts in which development initiatives are situated and to track changes in gender relations that result from interventions not only because gender can create barriers to progress but also because gender equity is a worthy goal in itself. Mainstreaming a gender perspective in development organizations, as mandated by the Beijing Platform for Action

from the Fourth World Conference for Women, involves attention to both women's and men's concerns and relations between them at all stages of planning and operations.¹³⁰ Goals of gender equity should be included in programs and built explicitly into interventions. The IGWG's *A Manual for Integrating Gender Into Reproductive Health and HIV Programs: From Commitment to Action*¹³¹ provides a step-by-step guide to integrating a gender perspective throughout the project cycle.

More rigorous evaluation of interventions that integrate gender. Further efforts in refining evaluation methods and indicators, especially gender indicators, are necessary to generate a solid body of evidence regarding the value of gender integration. Gender indicators are still in the process of being developed and tested. Researchers and program implementers need to be trained in effective use of these measurement tools. Funding for evaluation needs to be allocated, scaled up, and long-term. Sufficient time is needed for programs to show effects. Researchers should keep in mind that (as stated in conclusion 4 above) the strongest evidence comes from evaluations comparing the same interventions with and without the addition of a gender component. The growing body of interventions that incorporate gender may allow researchers and program designers to strengthen monitoring and evaluation of these programs.¹³²

Understanding of gender issues has become much more sophisticated over the past decade. Many programs would benefit from incorporating this knowledge into program design. Programs must have the dual goals of ensuring good reproductive health outcomes and promoting gender equity to be truly successful and to reach the objectives set out at the 1994 ICPD. As we approach Cairo +10, it is time to recognize the benefits of promoting gender equity in all reproductive health programs.

130. United Nations, 2000.

131. Caro et al., 2003

132. See Yinger et al., 2002.

Appendix: Quick Reference Guide

The following tables summarize the evaluation methods, reproductive health outcomes, and gender outcomes of the interventions included in this report. They are meant to provide, at a glance, details about the level of scientific rigor and indicators used in the evaluation studies of the interventions described throughout the subsequent chapters. This report is organized by reproductive health issue area (unintended pregnancy, maternal mortality/morbidity, STIs/HIV/AIDS, and quality of care). However, many initiatives documented effects in more than one of these areas and were placed in chapters according to the most significant outcome they produced. Thus, the following tables are helpful in identifying interventions that cross-cut areas of reproductive health. The page number on which a full description of each intervention can be found is provided in the tables on outcomes.

Table A.1

Evaluation Methods Used in Studies Reviewed

| INTERVENTION | EVALUATION DESIGN | | | | | SAMPLE SIZE |
|---|-------------------|---|--|---|---|-------------|
| | QUALITATIVE | QUANTITATIVE | | | | |
| | | PRE- AND POST-INTERVENTION EXPERIMENTAL GROUP | PRE- AND POST-INTERVENTION CONTROL GROUP | POST-INTERVENTION CONTROL GROUP OR RANDOMIZED CONTROL TRIAL | POST-INTERVENTION EXPERIMENTAL GROUP ONLY | |
| Unintended Pregnancy | | | | | | |
| Egypt-Husbands and Postabortion Care | | | | ● | | 293 |
| Guatemala-Mayan-Language Educators in Gender and Family Planning | | | | | ● | 1001 |
| Honduras-Reaching Men Through Agricultural Extension | | ● | | | | 857 |
| India-Better Life Options Program | | | | ● | | 1693 |
| Jamaica-Program for Adolescent Mothers | ● | | | ● | ● | 303 |
| Mexico-Training-of-Trainers in Health and Empowerment | | | ● | | | 1425 |
| Peru-Autodiagnosis Through the ReproSalud Project | | | ● | | | 14,054 |
| Turkey-Father's Role in Postpartum Family Planning | | | ● | | | 333 |
| Zambia- Stimulating Dialogue Through Radio Shows | ● | | | | | 328 |
| Maternal Morbidity and Mortality | | | | | | |
| Bolivia-Warmi Project in Rural Bolivia | ● | | ● | | | 393 |
| India-Advocacy and Income Generation With Indian Women | ● | | | ● | | 200 |
| India-Pati Sampark: "Contacting the Husband" | | | | ● | | 113 |
| STIs/HIV/AIDS | | | | | | |
| Brazil-Integrating STI/HIV Prevention Into Family Planning Services | | | | | ● | 47 |
| Brazil-Peer Education Among Adolescent Girls | ● | | | | | + |
| Brazil-Talking About Sexuality With Poor Urban Women | ● | ● | | | | 19 |
| Guatemala-Educating Prenatal Clients on STIs/HIV | | ● | | | | 50 |
| India-Sex Workers in Sonagachi and Beyond | | ● | | | | 1537* |
| Mexico-Empowering Women to Make Safe Contraceptive Method Choices | | | | ● | | 2107 |
| Senegal-Strengthening Traditional Women's Associations | ● | | ● | | | 520 |
| South Africa-Talking About Violence as a Barrier to Condom Use | | | ● | | | 151 |
| Thailand-Peer Education With Factory Workers | | ● | | | | 240 |
| U.S.- Sexual Negotiation Skills Among Inner-City Women | | ● | | | | 100 |
| Quality of Care | | | | | | |
| Botswana-Female Relative Support in Labor | | | | ● | | 110 |
| Indonesia-Smart Patient Program | | | | ● | | 768 |
| Peru-Female Providers at MaxSalud | ● | ● | | | ● | — |

Note: Facility or national data are based on monitoring systems; as such, there is no sample size to report.

*Total of sample sizes in first three surveys (1992, 1993, and 1995); +Sample size not reported

Table A.2

Reproductive Health Outcomes of Interventions Highlighted in This Review

| REPRODUCTIVE HEALTH OUTCOMES | INTERVENTIONS | PAGE NUMBER |
|---|---|-------------|
| Unintended Pregnancy | | |
| Greater family planning use | Egypt-Husbands and Postabortion Care | 24 |
| | Guatemala-Mayan-Language Educators in Gender and Family Planning | 30 |
| | India-Advocacy and Income Generation with Indian Women | 36 |
| | India-Better Life Options Program | 22 |
| | Peru-Autodiagnosis Through the ReproSalud Project | 16 |
| | Turkey-Father's Role in Postpartum Family Planning | 26 |
| Lower fertility | India-Better Life Options Program | 22 |
| Fewer teenage pregnancies | Jamaica-Program for Adolescent Mothers | 20 |
| Fewer child deaths | Bolivia-Warmi Project in Rural Bolivia | 34 |
| | India-Better Life Options Program | 22 |
| Increase in age at marriage | India-Better Life Options Program | 22 |
| Greater contraceptive knowledge | Brazil-Talking about Sexuality with Poor Urban Women | 52 |
| | Honduras-Reaching Men Through Agricultural Extension | 28 |
| | India-Pati Sampark: "Contacting the Husband" | 38 |
| | Mexico-Training-of-Trainers in Health and Empowerment | 18 |
| | Peru-Autodiagnosis Through the ReproSalud Project | 16 |
| Greater receptivity to family planning information | Zambia-Stimulating Dialogue Through Radio Shows | 15 |
| Maternal Mortality/Morbidity | | |
| Lower maternal mortality | Bolivia-Warmi Project in Rural Bolivia | 34 |
| Increase in skilled obstetrical care | Bolivia-Warmi Project in Rural Bolivia | 34 |
| | India-Advocacy and Income Generation with Indian Women | 36 |
| | India-Better Life Options Program | 22 |
| | Peru-Autodiagnosis Through the ReproSalud Project | 16 |
| Men's knowledge of wives' antenatal care | India-Pati Sampark: "Contacting the Husband" | 38 |
| Better post-abortion recovery | Egypt-Husbands and Postabortion Care | 24 |
| Fewer obstetrical complications | Botswana-Female Relative Support in Labor | 61 |
| Better nutrition | India-Better Life Options Program | 22 |
| | Mexico-Training-of-Trainers in Health and Empowerment | 18 |
| Greater knowledge of warning signs in pregnancy | Honduras-Reaching Men Through Agricultural Extension | 28 |
| | Mexico-Training-of-Trainers in Health and Empowerment | 18 |
| | Peru-Autodiagnosis Through the ReproSalud Project | 16 |
| STIs/HIV/AIDS | | |
| Lower STIs | India-Sex Workers in Sonagachi and Beyond | 44 |
| | South Africa-Talking about Violence as a Barrier to Condom Use | 56 |
| Greater knowledge of STI symptoms | Honduras-Reaching Men Through Agricultural Extension | 28 |
| | Peru-Autodiagnosis Through the ReproSalud Project | 16 |
| Greater condom use | India-Better Life Options Program | 22 |
| | India-Sex Workers in Sonagachi and Beyond | 44 |
| | Mexico-Training-of-Trainers in Health and Empowerment | 18 |
| | Senegal-Strengthening Traditional Women's Associations | 54 |
| | South Africa-Talking about Violence as a Barrier to Condom Use | 56 |
| | U.S.-Sexual Negotiation Skills among Inner-City Women | 42 |
| Greater knowledge of HIV/AIDS transmission and prevention | Brazil-Integrating STI/HIV Prevention into Family Planning Services | 49 |
| | Brazil-Peer Education among Adolescent Girls | 53 |
| | Guatemala-Educating Prenatal Clients on STIs/HIV | 48 |
| | Honduras-Reaching Men Through Agricultural Extension | 28 |
| | India-Advocacy and Income Generation with Indian Women | 36 |
| | India-Better Life Options Program | 22 |
| | India-Sex Workers in Sonagachi and Beyond | 44 |
| | Mexico-Training-of-Trainers in Health and Empowerment | 18 |
| | Senegal-Strengthening Traditional Women's Associations | 54 |
| Thailand-Peer Education with Factory Workers | 50 | |
| Quality of Care | | |
| Increased clinic visits | Peru-Autodiagnosis Through the ReproSalud Project | 16 |
| | Peru-Female Providers at MaxSalud | 60 |
| Improved client-provider interaction | Indonesia-Smart Patient Program | 62 |

Table A.3

Gender Outcomes of Interventions Highlighted in this Review

| GENDER OUTCOMES | INTERVENTIONS | PAGE NUMBER |
|--|---|-------------|
| Higher scores on empowerment scale | Mexico-Training-of-Trainers in Health and Empowerment | 18 |
| Increase in equitable gender attitudes and awareness of rights | Brazil-Peer Education Among Adolescent Girls | 53 |
| | Brazil-Talking About Sexuality With Poor Urban Women | 52 |
| | India-Advocacy and Income Generation With Indian Women | 36 |
| | India-Better Life Options Program | 22 |
| | Jamaica-Program for Adolescent Mothers | 20 |
| | Peru-Autodiagnosis Through the ReproSalud Project | 16 |
| | Senegal-Strengthening Traditional Women's Associations | 54 |
| | Thailand-Peer Education With Factory Workers | 50 |
| Women's increased mobility | India-Better Life Options Program | 22 |
| Increase in women's willingness to protest or seek help for domestic violence | India-Advocacy and Income Generation With Indian Women | 36 |
| | Peru-Autodiagnosis Through the ReproSalud Project | 16 |
| Women's increase in literacy | India-Better Life Options Program | 22 |
| Greater formal education for women or girls | India-Better Life Options Program | 22 |
| | Jamaica-Program for Adolescent Mothers | 20 |
| Increase in women's participation or leadership roles in the community | Bolivia-Warmi Project in Rural Bolivia | 34 |
| | India-Advocacy and Income Generation With Indian Women | 36 |
| | India-Better Life Options Program | 22 |
| | Zambia-Stimulating Dialogue Through Radio Shows | 15 |
| Women's greater self-confidence or self-esteem | Brazil-Peer Education Among Adolescents | 53 |
| | India-Better Life Options Program | 22 |
| | Jamaica-Program for Adolescent Mothers | 20 |
| | Zambia-Stimulating Dialogue Through Radio Shows | 15 |
| Women's greater decision-making power | India-Better Life Options Program | 22 |
| | Peru-Autodiagnosis Through the ReproSalud Project | 16 |
| Greater partner communication about RH or family planning | Brazil-Integrating STI/HIV Prevention Into Family Planning Services | 49 |
| | Guatemala-Educating Prenatal Clients on STIs/HIV | 48 |
| | Honduras-Reaching Men Through Agricultural Extension | 28 |
| | Peru-Autodiagnosis Through the ReproSalud Project | 16 |
| Increase in women's sexual negotiation skills | U.S.-Sexual Negotiation Skills Among Inner-City Women | 42 |
| Increase in women earning income | India-Better Life Options Program | 22 |
| Greater support (emotional, instrumental, family planning, or general support) from partners | Egypt-Husbands and Postabortion Care | 24 |
| | Guatemala-Mayan-Language Educators in Gender and Family Planning | 30 |
| | Honduras-Reaching Men Through Agricultural Extension | 28 |
| Women's greater assertiveness in client-provider interactions | Indonesia-Smart Patient Program | 62 |

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