A Summary Report of

NEW EVIDENCE

that Gender Perspectives
Improve Reproductive Health Outcomes

USAID
FROM THE AMERICAN PEOPLE

IGWG

A Summary Report of

NEW EVIDENCE

that Gender Perspectives Improve Reproductive Health Outcomes

January 2011

Acknowledgments

Table of Contents

1 Introduction

International initiatives to achieve desired reproductive health (RH) outcomes—such as reducing unintended pregnancy, stopping the spread of HIV/AIDS, and improving maternal health—are increasingly recognizing that these outcomes are affected by gender relations, norms, and roles commonly applied to women and men, and associated inequalities.

Governments worldwide are working to achieve the Millennium Development Goals, including Goal 3: *To promote gender equality and empower women.* Many international donor agencies have embraced the idea that RH policies and programs should support women's empowerment and gender equality,[1] and have included this in their goals and strategies. Bilateral and multilateral organizations, including the U.S. Agency for International Development (USAID), the World Health Organization (WHO), and the United Nations (UN), as well as programs such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Global Health Initiative, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria, all promote gender equality in the policies and projects they implement and fund.

UNFPA's State of the World Population 2008 Report states that, "Gender equality is a human right. In all cultures there are pressures towards and against women's empowerment and gender equality." The 2008 report goes on to advocate culturally sensitive approaches in pursuing international development goals.[2] WHO, in its 2009 report on women and health, highlighted the need to address women's health in all policies.[3] Consistent with this perspective, this summary is based on the premise that RH policies and programs should support socially and culturally sensitive approaches in favor of women's empowerment and gender equality, as contextual factors influencing multiple RH outcomes, and in pursuit of advancing human rights.

> Gender refers to the different roles men and women play in society, and to the relative power they wield. While gender is expressed differently in different societies, in no society do men and women perform equal roles or hold equal positions of power.
>
> Riley, 1997: 1

Background and Objective

In 2004, the Interagency Gender Working Group (IGWG) published *The "So What?" Report: A Look at Whether Integrating a Gender Focus into Programs Makes a Difference to Outcomes*. The report used the term "reproductive health" in its broadest sense, as defined at the 1994 International Conference on Population and Development (ICPD), to include interventions to reduce unintended pregnancy and abortion; reduce maternal morbidity and mortality; and to combat the spread of HIV/AIDS and other sexually transmitted infections (STIs). Until the 2004 *"So What?"* report was published, such evidence had not been brought together in a systematic fashion. The report concluded that "the evidence does suggest that integrating gender into reproductive health programs has a positive impact on achieving reproductive health outcomes." Subsequently, the IGWG, USAID, and WHO collaborated on a summary

---

1   The terms "gender equity" and "gender equality" are often used interchangeably, although there are differences. According to the IGWG, "gender equality" means equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities, and society at large. Gender equity connotes fairness and justice in the distribution of opportunities, responsibilities, and benefits available to men and women, and the strategies and processes used to achieve gender equality. Equity is the means, equality is the result.

2   UNFPA, 2008.

3   WHO, *Women and Health: Today's Evidence Tomorrow's Agenda* (Geneva, 2009).

of the *"So What?"* report. Published in July 2005, the *"So What?"* summary made the lengthy review more accessible to policymakers and program managers.[4]

In 2008, the IGWG undertook a review of more recent RH interventions in developing countries to update the earlier report. This new review, hereafter called the *"New Evidence"* report,[5] assembles the latest data and updates the evidence as to what difference it makes when a gender perspective is incorporated into RH programs. In addition, the authors explored the following two key questions in order to clarify how programs integrating gender have changed since the first review:

- **Are the interventions more strongly focused on transforming inequitable gender relations rather than accommodating them?**
- **Are interventions that incorporate gender using more rigorous approaches in their evaluations?**

The answer to both questions was "yes" and this 2010 summary takes the lessons of the *"New Evidence"* report and presents them in clear and accessible language for policymakers and program managers. As the title suggests, it presents *"New Evidence"* that integrating gender into RH interventions improves outcomes.

Methods

The authors identified documents for the *New Evidence* report through online literature searches and by contacting key informants in the international RH field.[6] The search yielded approximately 200 project documents published since the year 2000, covering a range of RH interventions, cross-sectoral development and life skills programs with RH components, and pilot and operations research projects. In order to be included in this review, interventions had to meet the following criteria:[7]

1. Does the intervention integrate gender?
2. Has the intervention been evaluated?
3. Does the intervention have measured reproductive health outcomes?

Forty studies from developing countries were found to meet all three criteria.[8] All 40 programs used only accommodating or transformative gender approaches, as defined on the next page. (See the full *"New Evidence"* report Appendix for a table of the 40 projects, their objectives, and countries.)

While all 40 projects met the evaluation criteria, the evaluations were of varying quality and thoroughness, employing methods ranging from randomized-control trials (RCT) to post-test-only designs; several relied on qualitative methods exclusively (see Table 1).

Table 1

Methodologies Used in Evaluation of Gender-Integrated Interventions

METHODOLOGY	NUMBER OF STUDIES
Quantitative (primarily)	**37**
Experimental design	5
Quasi-experimental design	17
Non-experimental design	15
Qualitative (exclusively)	**3**

---

4   See *A Summary of the "So What?" Report: A Look at Whether Integrating a Gender Focus Into Programs Makes a Difference to Outcomes* (Washington, DC: PRB for the IGWG, USAID, and WHO, 2005).

5   E. Rottach, S. R. Schuler, and K. Hardee, *Gender Perspectives Improve Reproductive Health Outcomes: New Evidence* (Washington, DC: PRB for the IGWG, 2010).

6   For a more complete explanation of the review methodology, see the full report at Rottach, Schuler, and Hardee 2010, pp. 5,6.

7   These are the same criteria that were used in the 2004 report.

Types of Gender Integration Strategies

In determining whether programs used gender accommodating or gender transformative approaches, the *"New Evidence"* authors drew on the IGWG continuum, which defines the ways that gender is approached in projects (see Figure 1 on page 4).[8] This continuum categorizes approaches by how they treat gender norms and inequities in the design, implementation, and evaluation of programs or policy.

The term **"gender blind"** refers to the absence of any proactive consideration of the larger gender environment and specific gender roles affecting programs/policy beneficiaries. Gender blind programs/policies give no prior consideration to how gender norms and unequal power relations affect the achievement of objectives, or how objectives impact on gender. In contrast, **"gender aware"** programs/policies deliberately examine and address the anticipated gender-related outcomes during both design and implementation. All gender-integrated interventions must be gender aware.

The IGWG emphasizes the following two gender integration principles:

1. First, under no circumstances should programs/policies adopt an exploitative approach since one of the fundamental principles of development is to "do no harm."
2. Second, the overall objective of gender integration is to move toward gender transformative programs/policies, thus gradually challenging existing gender inequities and promoting positive changes in gender roles, norms, and power dynamics.

Gender exploitative approaches, on one end of the continuum, take advantage of rigid gender norms and existing power imbalances to achieve health program objectives. While using a gender exploitative approach may seem expeditious in the short run, it is unlikely to be sustainable and can result in harmful consequences and undermine the program's intended objective.

Gender accommodating approaches, in the middle of the continuum, acknowledge the role of gender norms and inequities and seek to develop actions that adjust to and often compensate for them. While such projects do not actively seek to change the norms and inequities, they seek to limit any harmful impact on gender relations. In situations where gender inequities are deeply entrenched and pervasive in a society, however, gender accommodating approaches often provide a sensible first step to integrating a gender strategy.

Gender transformative approaches, at the other end of the continuum, actively strive to examine, question, and change rigid gender norms and imbalances of power as a means of achieving health objectives, as well as gender-equity objectives. Gender transformative approaches encourage critical awareness among men and women of gender roles and norms; promote the position of women; challenge the unequal distribution of resources and allocation of duties between men and women; and/or address the power relationships between women and others in the community, such as service providers or traditional leaders. Programs and policies may transform gender relations through:

- Encouraging critical awareness of gender roles and norms;
- Empowering women and/or engaging men; or
- Examining, questioning, and changing the imbalance of power, distribution of resources, and allocation of duties between women and men.

A particular project may not fall neatly under one type of approach. While the continuum focuses on gender integration goals in the design or planning of an intervention, it can also be used to monitor and evaluate gender and health outcomes, with the understanding that sometimes programs result in unintended consequences.

The fact that a majority of the interventions in this review were found to employ transformative approaches strongly suggests that the field is evolving toward a deeper understanding of what gender equality entails and a stronger commitment to pursue this equality in health programs.

---

8   The IGWG Gender Integration Continuum draws on a range of efforts that have used a continuum of approaches to understanding gender, especially as they relate to HIV/AIDS. See G.R. Gupta, "Gender, Sexuality and HIV/AIDS: The What, The Why and The How" (Plenary Address at the XIII International AIDS Conference), Durban, South Africa: 2000; G.R. Gupta, D. Whelan, and K. Allendorf, "Integrating Gender into HIV/AIDS Programs: Review Paper for Expert Consultation, 3–5 June 2002," Geneva: World Health Organization, 2002; and WHO, *Guidelines for Integrating Gender into HIV/AIDS Programs: Tool to Improve Responsiveness to Women's Needs* (Geneva, 2009).

WHO and GRAS

The World Health Organization (WHO) has created a slightly different framework for programs seeking to incorporate gender. Known as the WHO gender-responsive assessment scale (GRAS), it describes the continuum by levels, from gender-unequal (level 1), to gender-blind (level 2), gender-sensitive (level 3), gender-specific (level 4), and gender-transformative (level 5) approaches. It also acknowledges that programs and policies may have components that fall at various points along the continuum.

The WHO GRAS describes gender-unequal and gender-blind approaches as undesirable and to be avoided as much as possible, as they can uphold harmful health outcomes by commission or omission.

Such approaches may unintentionally lead to gender-based discrimination. These would correspond to the "gender-exploitative" approaches described in the IGWG framework. The WHO gender-sensitive category is considered the critical turning point in the scale as it represents a level of awareness of gender norms, roles, and relations with no actions to address them. The WHO gender-specific level is similar to the IGWG "gender-accommodating" category, as it acknowledges gender norms, roles, and relations and takes actions to address them. The fifth level—gender-transformative—recognizes differences in gender roles, norms, and access to resources and actively tries to change these in order to promote gender equality.

WHO believes that gender-specific interventions form part of acceptable mainstreaming approaches, and that gender-specific interventions can also be classified in the gender-accommodating category as they may be intentionally directed at addressing gender norms, roles, and relations, and thus promote the health of women (or men depending on the context). Finally, although the term "gender accommodating" may sound negative, such approaches are still used, as they often provide ways of leveling the playing field for women and men.

Source: WHO, *Gender Mainstreaming for Health Managers: A Practical Approach* (Geneva: Department of Gender, Women and Health, WHO, 2010).

FIGURE 1. The IGWG Gender Integration Continuum
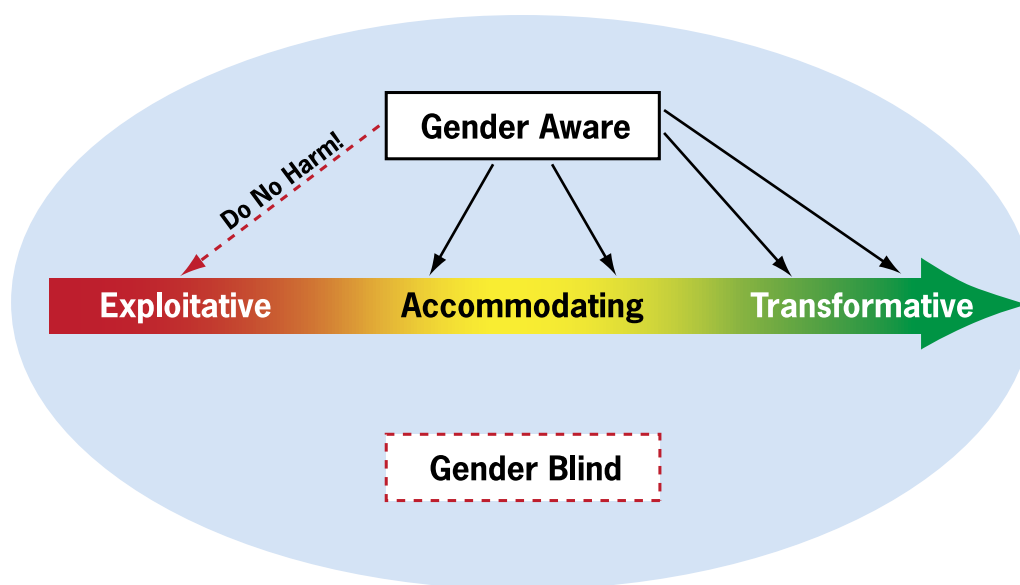
2 Reducing Unintended Pregnancies

Unintended pregnancy is a critical issue throughout the world. Data from 53 countries indicate that one in seven married and one in 13 never-married women have an unmet need for contraception[9] and are thus at risk of unintended pregnancy. Unmet need is highest in sub-Saharan Africa, where one in four married women have an unmet need for contraception.[10]

Numerous gender-related barriers that contribute to unintended pregnancy have been identified, including the fact that family planning (FP) has often been seen as exclusively a woman's domain, and women are often regarded as targets of FP programs rather than beneficiaries of reproductive health (RH) care. Programs have been slow to engage men in taking responsibility for family planning and in addressing gender-based inequities. Men's power over women in the household also has implications for contraceptive use and reducing unintended pregnancies. Women are in a weak position in negotiating the timing and circumstances of sexual intercourse.[11] Women are often blamed for unplanned pregnancies[12] even though men often play important roles in regulating women's access to RH services through control of finances, women's mobility, means of transportation, and health care decisions.[13] Women in some settings would rather undergo abortions than risk repeated conflicts with their male partners over contraceptive use.[14]

Women are disadvantaged by unequal power relations outside the home as well as within it. Gender imbalances in client-provider relationships often are exacerbated by disparities in social status and education, which are likely to be greater when the client is female and the provider is male.[15] This may propel providers to behave in an authoritarian fashion and clients to be submissive and passive.[16] Regardless of the sex of the provider, female clients may fail to ask questions or voice concerns that affect the success of their family planning use.[17] Additionally, gender norms may discourage women, especially young or unmarried women, from appearing to know or acquiring knowledge about sexual matters or suggesting contraceptive use.[18] At the same time, the social construction of masculinity may contribute to male risk-taking in the form of multiple concurrent sexual partners, unprotected sex, and expectations to prove sexual potency.[19]

THE EIGHT INTERVENTIONS ON UNINTENDED PREGNANCY

Male Motivation Campaign (Guinea)

Together for a Happy Family (Jordan)

Cultivating Men's Interest in Family Planning (El Salvador)

Reproductive Health Awareness (Philippines)

PRACHAR (India)

REWARD (Nepal)

Women's Empowerment Model to Train Midwives and Doctors (Afghanistan)

PROCOSI Gender-Sensitive Reproductive Health Program (Bolivia)

---

9   Women who prefer to space or limit births but are not using any form of contraception—either modern or traditional—are considered to have unmet need for family planning.

10 Sedgh et al., 2007. Based on data from Demographic and Health Surveys (DHS).

11 Schuler et al., 1994.

12 Hoang et al., 2002.

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

14 Biddlecom and Fapohunda, 1998; Schuler et al., 1994.

15 Upadhyay, 2001.

16 DiMatteo, 1994; Schuler et al., 1994.

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

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

19 UNFPA, 2008.

Interventions Related to Unintended Pregnancy

Several of the interventions to address unintended pregnancy, as well as the maternal health interventions in the next chapter, countered the traditional practice of only targeting FP services at women; they encourage husbands and other men to take more responsibility in this area. The strategies include enlistment of people who hold power—for example, religious leaders and, in one case, the royal family—to support family planning; influencing husbands to support their wives to use FP services; and providing a male-controlled contraceptive method. Their approaches ranged from accommodating to transformative and sometimes encompassed elements of both.

Other projects encouraged joint decision-making, shared responsibility, and the institutionalization of gender into RH services. Some projects used gender-transformative approaches to address the balance of power between health-care service providers and female clients.

Many of these projects took place in settings where women have little autonomy in their daily lives and little assertiveness in their relationships. In order to make lasting behavior changes, the interventions needed to change attitudes, roles in relationships, or the attitudes or involvement of male partners or community leaders.

The eight interventions incorporating gender strategies to reduce unintended pregnancy achieved several RH outcomes, including:

- Greater contraceptive knowledge and approval;
- Increases in positive attitudes toward contraceptive methods;
- Increased communication between partners or couples about health;
- Longer birth spacing;
- Increased use of long-acting contraceptive methods;
- Increased health-provider knowledge of family planning; and
- Improved quality of care in health facilities.

Programs were better able to achieve increases in *knowledge* about family planning or changes in *attitudes* toward family planning or contraceptive methods than actual increases *in the use* of contraceptives. Knowledge is an important precursor to behavior change, however. Changes in behavior such as increased contraceptive use or longer birth spacing directly contribute not only to reductions in unintended pregnancy, but also healthier mothers, babies, and families over time.

Table 2: Examples of Interventions Targeting Unintended Pregnancy		
PROJECT/INTERVENTIONS	**RH OUTCOMES**	**GENDER OUTCOMES**
Afghanistan: Women's Empowerment Model to Train Midwives and Doctors		
• Trained female health providers and used five empowerment strategies, including decisionmaking power	• Increased trainee knowledge of FP methods, counseling strategies, and STIs/HIV/AIDS (from 53% to 89%)	• Increased trainee understanding re importance of empowering FP clients
Bolivia: PROCOSI Gender-Sensitive Reproductive Health Program		
• Operationalized a gender perspective in health NGOs • Evaluated seven organizational areas, including policies, provider practice, and client satisfaction	• Decreased unmet need for FP among clients; for example, unmet need for limiting & spacing went from 25% to 20% • Improved quality of care, including client satisfaction, counseling, and screening for FP needs	• Increased couple communication about RH • Improved gender equitable views among clients as measured by women's work outside the home and initiation of sexual relations

3 Improving Maternal Health

According to the 2006 *Lancet* maternal survival series, "The risk of a woman dying as a result of pregnancy or childbirth during her lifetime is about one in six in the poorest parts of the world, compared with about one in 30,000 in Northern Europe."[20] This disparity highlights the enormous difficulty of meeting the fifth Millennium Development Goal—reducing maternal mortality by 75 percent between 1990 and 2015.[21] Most maternal deaths occur during labor, child birth, and the immediate postpartum period, with the main medical cause of maternal deaths being obstetric hemorrhage.

The social, economic, and political causes of maternal mortality are many and include gender inequality.[22] For example, women's lack of decision-making power may deny them access to health care, negatively affecting maternal health outcomes.[23] Women's limited access to education can impede their understanding of basic health care concepts such as danger signs in pregnancy. In many settings, women's limited mobility outside the home may make them uncomfortable in institutional settings, such as clinics and hospitals, and women's low confidence and illiteracy can interfere with their communication with health care providers.

Men are often the primary wage earners in formal employment; as a result, their health may be valued more than the health of women, and families may be disinclined to use resources for pregnancy-related care.[24] Pregnant women may be reluctant to consume extra calories or seek care when danger signs arise,[25] or may be scolded by husbands or mothers-in-law for doing so.[26] Men are often primary decisionmakers about their wives' health care, yet they are often ignorant about their wives' health before, after, and even during childbirth.[27]

THE FOUR INTERVENTIONS ON MATERNAL HEALTH
FEMME Project (Peru)
Men in Maternity Care (India)
Involving Men in Maternity Care (South Africa)
Social Mobilization or Government Services (India)

In some societies, gender norms require that women demonstrate their strength by suffering through labor and childbirth with little or no assistance.[28] Facility policies and obstetric service providers may discourage or forbid family members or companions from being present or providing support during labor and birth,[29] despite the many studies that have demonstrated the beneficial impact of labor companions on clinical outcomes.[30]

---

20 Ronsmans and Graham, 2006.

21 A recent *Lancet* article on maternal mortality concluded that, based on new data, "[s]ubstantial, albeit varied, progress has been made towards MDG5." See Hogan et al., *The Lancet* 375, no. 9726 (2010): pp. 1609-1623.

22 Sen, Ostlin, and George, 2007.

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

24 Schuler et al., 2002.

25 Hoang et al., 2002.

26 Raju and Leonard, 2000.

27 Raju and Leonard, 2000.

28 Bradby, 1999; Sargent, 1988.

29 Jessop et al., 2000: 54; Boender et al. 2004: 32.

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

Interventions that Improve Maternal Health

In many developing countries, decisions about ante- and post-natal care typically are made by husbands or mothers-in-law, not by pregnant women or new mothers. The highlighted interventions addressed these power dynamics by focusing on engaging men or older women. The strategy of involving men in maternity care can be gender accommodating in building on men's roles as gatekeepers, or gender-transformative insofar as it encourages men to expand their traditional gender roles.

Often the goal was to improve women's use of services by reaching out to husbands and mothers-in-law, in addition to women. Some projects relied on community-based organizations and youth and women's groups that were already in place to deliver their messages. Other projects aimed to improve the quality of antenatal care services and change attitudes and practices among service providers. While these projects accommodated the existing power structures by targeting power holders, they also incorporated transformative elements through the emphasis on women's rights to a basic standard of care and to be treated respectfully as clients. CARE's FEMME project in Peru, for example, focused on training health care providers and working with political leaders and communities. One way of improving

quality of care has been through issuing guidelines for emergency obstetric care – a simple intervention that has yielded significant results.

The four interventions in the review that incorporated gender strategies in order to improve maternal health realized improvements in several RH outcomes, including:

- Improvements in clinics' use of correct obstetric protocols;
- Reduction in maternal fatalities at health clinics;
- Increased knowledge of family planning;
- Improved knowledge of pregnancy and maternal health danger signs;
- Increases in male engagement in pregnancy-related health-seeking decisions; and
- Increases in utilization of health services for postnatal care, family planning, and reproductive tract or sexually transmitted infections.

Together, these programs illustrate that engaging men in maternal health care is feasible across many cultural and societal contexts. Some have focused on training for providers to improve knowledge and use of clinical protocols for the treatment of obstetric emergencies. Others have gone the route of engaging men in antenatal care visits. By integrating a gender perspective in the relationships, roles, and systems involved in maternal health, the various programs were able to improve women's health and address gender barriers.

Table 3: Examples of Interventions Targeting Maternal Health

PROJECT/INTERVENTIONS	RH OUTCOMES	GENDER OUTCOMES
South Africa: Involving Men in Maternity Care • Improved existing antenatal care services through better information and education programs for couples • Provided couples counseling to engage men in maternal health and induce male partners to attend pre- and post-pregnancy visits	• Increased male assistance to female partners during pregnancy-related emergencies • Increased knowledge of FP	• Increased couple communication by intervention on topics such as STIs, sexual relations, immunizations, and breastfeeding (75 vs 64% of controls, 81 vs 75%, 81 vs 75%, and 87 vs. 83%, respectively).
India: Social Mobilization or Government Services • Instituted interactive health education sessions for married adolescent girls and formed male group forums (social mobilization (SM) arm) • Sensitized government health service providers to the needs of youth and provision of couples counseling	• Demonstrated improvements in girls' knowledge of FP and maternal health • Increased use of health services for postnatal care and sexual health and contraceptive use • Knowledge of need for PNC increased 129% in the SM site	• Increased awareness among male partners of maternal care issues and willingness to seek care during pregnancy and childbirth for their partners

4 Reducing HIV/AIDS and Other STIs

Much has been written about the effect of gender on the HIV/AIDS pandemic.[31] Biological differences and gender inequality contribute to the epidemic by increasing vulnerability to the virus and exacerbating the impact of living with HIV and AIDS.

Gender norms affect both women's and men's sexual behavior and ability to protect against HIV/AIDS. When gender norms, customs, and laws relegate women to a lower status and value than men it makes women particularly vulnerable to HIV. In many countries, researchers have noted that gender issues are at the core of the country's HIV epidemic, which is "fueled by sexual behavior and women often have little or no decision-making power in sexual relations."[32] Recent research has pointed to sexual and physical violence as a "key determinant" of the HIV epidemic.[33] Worldwide, almost half of the people living with HIV or AIDS are women; in sub-Saharan Africa, 60 percent of those living with HIV or AIDS are women.[34]

Gender norms pertaining to men—norms that prescribe early sexual debut, risky sex, and multiple partners—also put them at increased risk.[35] Moreover, men may be reluctant to seek medical information and services because of gender norms that portray health-seeking behavior as weak and not masculine. Failure to access such services negatively impacts men and their partners.

Economic realities can also compound gender inequality and power relations as a risk factor for HIV/AIDS and a barrier to support and treatment. Women may be less likely to access resources and more likely to depend on men for financial survival for themselves and their children. Women, particularly young women, have a range of motivations for seeking out multiple partners, and operate on a continuum of volition that often

THE 10 STI/HIV/AIDS INTERVENTIONS
Somos Diferentes, Somos Iguales (Nicaragua)
Men as Partners (South Africa)
Yaari Dosti (India)
Play Safe (Cambodia)
Mothers2Mothers Program (South Africa)
Integration of RH Services for Men in Health & Family Welfare Centers (Bangladesh)
Involving Men in Sexual and Reproductive Health Services (Ecuador)
Tuelimishane (Tanzania)
Stepping Stones (South Africa)
Program H (Brazil)

makes it difficult to negotiate safer sex, regardless of their motivation.[36] For many women, having more than one partner and engaging in cross-generational or transactional sex are economic survival strategies to support themselves and their dependents.[37]

Moreover, 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 – particu-

---

31   See UNIFEM, 2009.

32   Antwi and Oppong, 2003, p.6.

33   Khobotlo et al., 2009. Note: the authors recognize that gender-based violence is an important contributor to HIV and the interventions that address violence can be found in Chapter 5, Harmful Practices; see especially the IMAGE project, page 15.

34   UNAIDS, 2009.

35   UNAIDS, 2009.

36   Weissman et al., 2006.

37   Hope, 2007.

larly if they have children – can lead to their remaining 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.[38]

Improving Sexual Health for Men Who Have Sex with Men (MSM)

Among sexual minorities, gender relations and power dynamics affect vulnerability to and the impact of HIV/AIDS. Nowhere is this more true than with MSMs—Men who have Sex with Men. Gender-related issues facing MSMs are complex and relate to stigma against same-sex relationships and against individuals whose behavior deviates from "accepted" masculine behavior in many societies. These populations lack power in society, are often socially marginalized and victimized, and have limited legal rights and protection. Unfortunately, while the authors of the *"New Evidence"* report found some promising interventions that incorporated gender strategies to prevent HIV among MSM, no programs met all the requirements of this review. Much work is needed to understand and address the gender dynamics among sexual minorities and societies and the factors that increase vulnerability and magnify impact (see the three intervention descriptions in Rottach, Schuler, and Hardee 2009: pp. 34-36).

In some countries, HIV-positive women face employment discrimination because of their HIV status. Legal frameworks that ensure non-discrimination on the basis of sex can empower women. Conversely, inequality under the law, for example with regard to property and inheritance rights, can increase women's vulnerability to HIV/AIDS. For many women, loss of a husband to HIV/AIDS is followed by loss of property and land, exacerbating the impact of the disease and limiting their ability to protect themselves and their families.[39]

Interventions Related to Reducing STIs/HIV/AIDS

A strong case was made by the 10 interventions in this chapter that addressing gender norms, promoting policies and programs to extend equality in legal rights, and expanding services for women and men can result in improved HIV/AIDS and gender outcomes. Some of the interventions were designed specifically to reach high-risk groups (see box on MSMs), others tar-

geted clients of reproductive health services generally, and still others focused on particular demographic groups, such as young men. Some of the outcomes identified in these projects were intermediary outcomes such as knowledge, risk perceptions, and behavior change regarding condom use. While these are forbearers to reductions in HIV incidence, measuring reductions in HIV incidence requires longer-term interventions and evaluations.

Among the gender-transformative interventions for HIV/AIDS, all addressed gender norms related to HIV and AIDS, including infidelity, communication about sexual matters, stigma, gender-based violence, and risky behavior. These messages were communicated through a variety of channels. Some programs developed peer groups for educational sessions, or delivered their messages through workshops. Others promoted gender-equitable norms through mass social marketing campaigns or television and radio programs. Gender norms in relationships were addressed through couples counseling in health facilities – working with both partners together. Some programs used peer educators to deliver the messages, while others used health professionals, HIV/AIDS specialists, or spokespersons such as celebrities. Most of the programs were successful in stimulating dialogue on the relationship between gender norms and sexual behavior.

Another approach to addressing HIV/AIDS was to include a gender perspective in promoting the use of health services. Looking carefully at when, where, and how men and women use sexual and reproductive health services allowed programs to design services to better meet their needs and encourage use. Sensitizing service providers to the gender-role influences on risky behaviors and health-care seeking patterns helped to improve quality of care. For example, training providers about men's sexual and reproductive health helped to draw more male clients to health centers dominated by women.

Still other programs focused on men and women living with HIV/AIDS, including health care utilization by women, and offering targeted education and psychosocial support ser-

---

38 Boender et al., 2004.

39 Human Rights Watch, 2002.

vices to HIV-positive mothers to reduce the risk of transmission to their infants. Some worked at the service provider level, addressing service-level barriers to the use of services for care and treatment of HIV.

The 10 interventions demonstrate that strategies to reduce HIV/AIDS and other STIs that incorporate gender-equality perspectives are becoming increasingly sophisticated in their approach to addressing gender dynamics. Integrating gender perspectives in HIV/AIDS/STI prevention projects is primarily transformative, focusing on changing the dynamics of interactions between women and men. The projects focused on increasing women's empowerment and on challenging gender norms that affect men's health. Many programs also included components to help men identify and begin to question their gender roles, both the advantages conferred to them and the risks to which these roles expose them and others in their lives.

Together, these 10 interventions incorporating gender strategies within programs for HIV/AIDS and STIs have achieved many reproductive health outcomes, including:

- Reduction in stigmatizing or gender-inequitable attitudes;
- Improvements in partner communication;
- Increased knowledge of HIV-prevention measures;
- Increases in reported condom use during sexual intercourse;
- Reductions in high-risk sexual behaviors such as multiple partners;
- Increases in utilization of health care services;
- Reductions in violence against women; and
- Reductions in substance use.

Similar to the interventions for unintended pregnancy, most programs focusing on gender norms reported changes in attitudes and knowledge, important precursors to behavior change. Many programs, however, did achieve changes in behavior such as increased condom use or increased use of counseling and treatment services—behavior change that can lead to reduced transmission of HIV and STIs in the long run.

Table 4: Examples of Interventions Targeting STIs and HIV/AIDS

PROJECT/INTERVENTIONS	RH OUTCOMES	GENDER OUTCOMES
Tanzania: Tuelimishane • Community theater skits on sexual communication, infidelity, and conflict resolution • Peer support groups to discuss social norms, gender, HIV/AIDS, and related issues	• Increased condom use; percent of non-use during last sex went from 57% to 45% • Improvements in attitudes toward violence against women; for example, VAW justified for noncompletion of house work went from 20% to 8%.	• Improvements in attitudes toward gender norms for men and women; for example, of men who agreed at baseline that a woman needs husband's permission to work, at endline 30% disagreed, compared to 14% of control
South Africa: Stepping Stones • Peer groups employed adult education methods focusing on gender-related issues including sexual health, family planning, gender-based violence, and HIV/AIDS	• Women had fewer new HIV and Herpes infections in the intervention group (15% and 31% fewer, respectively) • Men reported reductions in risky behaviors	• Improvements in couple communication • Increases in awareness about violence against women
Brazil: Program H • Group education sessions explored sexuality, RH, gender roles, and HIV/AIDS • Social marketing carried out through radio, print materials, and community events to promote a gender-equitable lifestyle	• Improved gender norm scale scores associated with reduction in reported STI symptoms	• Significant improvements in attitude toward inequitable gender norms at intervention sites

5 Harmful Practices: Barriers to Reproductive Health

Harmful practices—including early marriage and childbearing, female genital mutilation/cutting, and gender-based violence—play a substantial role in undermining reproductive health, especially among girls and young women. Further, some of the most innovative, gender-transformative work in the reproductive and sexual health field focuses on the reduction of harmful practices. In this review, interventions are classified by three types of harmful practices: early marriage and childbearing (EM&C); female genital mutilation/cutting (FGM/C); and gender-based violence, specifically, intimate partner violence/sexual violence (IPV/SV).

I. Early Marriage and Childbearing

Early marriage and childbearing (EM&C) is associated with a wide range of negative social and health consequences. It is an abuse of girls' human rights, robbing them of educational and economic opportunities as well as the chance simply to be children. In some settings, marriages are arranged in infancy, with variation in the age at which co-habitation begins. In other settings, both the husband and the wife are married in their teenage years. Often, however, female brides are much younger than their husbands, and they are unready for sex, especially with an older stranger. In these situations, sexual initiation after an early marriage often amounts to socially sanctioned rape, in some cases legal, and in others (where marriages take place before the statutory minimum age) illegal but virtually never prosecuted.

Early marriage almost always leads to early childbearing.[40] About 15 million young women between 15 and 19 years of age give birth every year, accounting for over 10 percent of the births worldwide. Most of these young mothers are married.[41] Early childbearing has been shown to contribute to mortality and morbidity during pregnancy, labor, and childbirth, and increases the risk of premature births.[42] It also contributes to rapid population growth. In countries where contraceptive use is at least moderately high, increasing the number of years between generations by increasing the age at which women begin having children may have a greater impact in reducing population growth than further reducing fertility rates.[43]

EM&C Interventions

The three EM&C interventions included in the review are broad in focus. All employed gender-transformative approaches and sought to influence attitudes and behaviors of a range of community stakeholders. Linking social vulnerability and limited life options with early marriage, life-skills education projects with unmarried adolescent girls aimed to increase their self-esteem and literacy. Life-skills programs taught girls about the risks of early mar-

---

THE 11 INTERVENTIONS ON HARMFUL PRACTICES

Berhane Hewan (Ethiopia)

Building Life Skills to Improve Adolescent Girls' Reproductive and Sexual Health (India)

Delaying Age at Marriage in Rural Maharashtra (India)

Navrongo FGM/C Experiment (Ghana)

Awash FGM/C Elimination Project (Ethiopia & Kenya)

Five Dimensional Approach for the Eradication of FGM/C (Ethiopia)

Tostan Community-based Education Program (Senegal)

Soul City (South Africa)

Through Our Eyes (Liberia)

One Man Can Campaign (South Africa)

Intervention with Microfinance for AIDS and Gender Equity (IMAGE) (South Africa)

---

40 Adhikari, 2003.

41 ICRW, 2004.

42 UNICEF, 2001.

43 Bongaarts, 1994; Caldwell and Caldwell, 2003.

riage, as well as addressing issues such as self-esteem and development of educational or vocational skills.

Some projects aim to sensitize entire communities to the risks and disadvantages of early marriage. One strategy is to mobilize adolescent girls to form support groups, while simultaneously promoting community dialogue about early marriage and health risks. In some areas, fiscal incentives are provided to families who do not marry off their young daughters during the project.

The three projects reviewed employed gender strategies to reduce early marriage and its consequences, achieving such reproductive health goals as:

- Increased contraceptive use among married, adolescent girls;
- Increased knowledge of reproductive and sexual health; and
- An increase in the average age of marriage within communities.

II. Female Genital Mutilation/ Cutting (FGM/C)

The practice of FGM/C affects between 100 million and 140 million women and girls worldwide, most of whom live on the African continent. In some settings, the mutilation or cutting is much more extensive than in others. FGM/C tends to be associated with particular ethnic groups more than with nations or religions, socio-economic status, or educational levels.[44] Forms of FGM/C range from infibulation, the most severe, in which all external genitalia is removed and the vaginal opening is stitched and narrowed, leaving a small hole for urine and menstrual flow, to less extreme cutting in which all or part of the clitoris is removed.[45] FGM/C can lead to immediate complications, such as hemorrhaging and infection. Long-term risks include dermoid cysts and abscesses, repeated urinary tract infections, birth complications, infertility, and negative psychological impact. Studies have linked FGM/C to increased risk of urinary and menstrual problems, infertility, poor maternal and newborn health, and socially debilitating conditions such as malodorous urine retention or painful and difficult sexual relations.[46]

In the last two decades, FGM/C has gained international recognition as a health and human rights issue. The most promising approaches include community-based solutions and addressing rights as well as the social, legal, economic, and health dimensions of FGM/C. Several donor organizations have reached consensus about the most effective approach to FGM/C interventions, as articulated in "Toward a Common Framework for the Abandonment of FGM/C".[47]

FGM/C Interventions

The FGM/C projects reviewed are all set in Africa, and all approaches employ gender transformative elements. The projects combine FGM/C interventions with interventions on other topics and all have emphasized community involvement, taking into account community attitudes regarding gender roles. By involving communities, programs seek to transform cultural norms rather than just behavior. FGM/C interventions are often partnered with educational modules on topics such as rights, problem-solving, hygiene, and women's health. Other programs pair FGM/C messages with livelihood and skills building activities.

One approach has been to promote dialogue between men and women about FGM/C, as well as about other health issues, such as family planning. This is done using behavior change communication messages through multiple channels, including community meetings, performances, and mass media activities. Some programs have identified specific groups within communities to target with tailored interventions, addressing each group's role in the perpetuation or elimination of FGM/C.

The projects have employed gender strategies to reduce the practice of FGM/C and have achieved such reproductive health outcomes as:

- Reduced numbers of girls undergoing FGM/C (according to self-reporting);
- Changes in attitudes regarding marriage to girls who have not undergone FGM/C;
- Increases in knowledge about the risks of FGM/C;

---

44 Chege et al., 2004; see also Feldman-Jacobs and Clifton, 2010.

45 WHO, 2008.

46 See H. Jones et al., 1999; L. Morison et al., 2001; WHO, 2006; PRB, 2008.

47 UNICEF, 2007.

- Reductions in FGM/C prevalence among participants' daughters; and
- Declines in the proportion of women who believe that FGM/C is necessary.

III. Gender-Based Violence

Gender-based violence, including intimate partner violence (IPV)—physical violence perpetrated by men against their female partners—and sexual violence (SV), are worldwide public health problems[48] associated with a wide range of negative physical, psychological, social, and economic consequences for abused women themselves and for children whose mothers are exposed to violence. The reported prevalence of IPV/SV varies considerably across settings. A multi-country WHO study reported rates as high as 71 percent in rural Ethiopia and between 21 and 47 percent in other countries.[49] In analyses of data from the Demographic and Health Surveys (DHS) conducted between 1995 and 2004 in 12 countries, prevalence of domestic violence ranged from 18 to 53 percent.[50]

Gender-Based Violence Interventions

The GBV interventions in the 2009 review focus on IPV and SV. Like many of the EM&C and FGM/C interventions described above, the projects with documented success in addressing IPV/SV also have adopted multi-sectoral, multi-dimensional approaches to reducing harmful practices. All of the evaluated interventions found related to IPV/SV are gender transformative in nature as they seek to change a harmful behavior rooted in gender inequality. They are all situated in Africa, particularly in South Africa, where rates of IPV/SV are among the highest in the world.[51]

Only one of the four interventions in the GBV section focuses primarily on engaging men—the One Man Can Campaign in South Africa.[52] The project conducts educational workshops with men, and provides them with kits of resources to use to act on their concerns about violence, including stickers, clothing, factsheets, and information about how to seek or help others to seek services.

Other programs sought to influence both men and women or just women, at the individual, community, and social environment levels.

Behavior change communication was an important strategy, including prime-time radio and television programs. Through these channels, projects provided information and promoted dialogue about IPV/SV. Messages could then be reinforced through print materials. Some programs focused on increasing women's empowerment and agency in relationships. One approach was through micro-lending and an educational program focused on gender awareness, HIV, and issues of violence.

Still other programs have engaged entire communities in dialogue about IPV/SV. Working with a community in Liberia, the "Through Our Eyes" project[53] aimed to amplify voices from within the community through participatory engagement in the production of video tapes about domestic violence.

The four projects incorporating gender strategies to reduce intimate partner and sexual violence achieved many reproductive health outcomes, including:

- Reductions in the experience of IPV/SV;
- Less accepting attitudes toward violence;
- Increases in help-seeking behavior;
- Reductions in stigma toward discussing sexual violence and women's rights; and
- Improvements in attitudes supporting women's rights.

The outcomes reported from these programs were a mix of outcomes directly related to the harmful practice, as well as reproductive health. This illustrates the multi-sectoral nature of achieving reproductive health. Programs can target a specific inequity of practice, rather than a RH indicator, and still realize very real and important RH outcomes.

48 Heise and Garcia-Moreno, 2002; Heise, Ellsberg, and Gottemoeller, 2002; Heise, Pitanguy, and Germain, 1994.

49 Garcia-Moreno et al., 2005.

50 Kishor and Johnson, 2004.

51 Mathews et al., 2004.

52 Peacock, 2008.

53 See http://c4c.org/projects/eyes.html

Table 5: Examples of Interventions Targeting Harmful Practices—EM&C, FGM/C, and IPV/SV

PROJECT/INTERVENTIONS	RH OUTCOMES	GENDER OUTCOMES
India: Delaying Age at Marriage in Rural Maharashtra		
• Improved the social status of girls through increasing their skills related to gender, legal literacy, and team building • Initiated evening education sessions for unmarried adolescent girls	• Delayed age at marriage in intervention area (proportion of marriages to girls younger than 18 dropped from 81% to 62%)	• Increased knowledge of life skills • Increased willingness to act autonomously and influence household decisions
Senegal: Tostan Community-Based Education Program (FGC)[54]		
• Community-level educational program on human rights, problem solving, hygiene, women's health, FGC, and early marriage	• Decreased prevalence of FGC among daughters (from 87% at baseline to 79% at endline) • Change in attitude toward importance of FGC • Increased knowledge and awareness of FP and STIs	• Increased support for girls to go to school • Increased awareness of women's rights • Increased couple communication about FP
South Africa: Intervention with Microfinance for AIDS and Gender Equity (IMAGE)		
• Women's micro-finance loans to participants • Gender awareness and HIV educational program for women	• Decreased experience of IPV/SV in past year (from 11% to 6%) • Reduced acceptance of violence by women	• Increases in women's economic assets • Increased self-confidence and participation in decisionmaking among women

---

54 While the term FGM/C is used throughout this publication, TOSTAN uses FGC as it believes it to be less pejorative and judgmental.

6 Meeting the Needs of Youth

Nearly half of the world's population is below the age of 25, including an estimated 1.2 billion adolescents ages 10-19, the majority of whom live in developing countries.[55] Adolescence is a time of transition from childhood to adulthood and, as such, it is a critical time to provide young people with the knowledge, skills, and healthy practices they need to ensure a lifetime of good sexual and reproductive health. Adolescents, and particularly adolescent girls, face a range of sexual and reproductive health risks, including STIs, HIV/AIDS, unintended pregnancy, and sexual violence and coercion. Pregnancy and complications of childbirth and unsafe abortions are the leading cause of death for young women ages 15 to 19 worldwide.[56] In 2009, an estimated 5.4 million young people (ages 15-24) were infected with HIV. Prevalence was highest in sub-Saharan Africa, where 90 percent of HIV-positive children and adolescents live. HIV prevalence is increasing fastest among young women in the region and girls are often infected at six to ten times the rates of their male counterparts in southern Africa.[57]

protection, and access to services. Gender norms related to sex can have detrimental effects on young men as well as adolescent women, particularly for STIs and HIV and for risk of sexual and physical violence.[59]

Waiting to initiate sex, known as "delaying sexual debut," can reduce the number of sexual partners and, therefore, reduce the risk of unintended pregnancy and contracting HIV.[60] Opinions vary on what are appropriate programs for adolescents, ranging from teaching abstinence-only until marriage to providing comprehensive sex education (including means of protection from pregnancy and disease). Research demonstrates that curriculum-based sexual education programs decrease unintended pregnancy and STIs. There is strong evidence that, in countries with comprehensive approaches to programming—including sexuality education, supportive environments, and youth-friendly sexual and reproductive health services—the incidences of adolescent pregnancy, abortion, and STIs are much lower than in countries where these services are not available.[61]

THE SEVEN INTERVENTIONS THAT TARGET YOUTH

African Youth Alliance (Ghana, Tanzania, Uganda)

Guria Adolescent Health Project (Georgia)

Transitions to Adulthood - Adolescent Livelihoods Training (India)

Transitions to Adulthood - Tap and Reposition Youth (Kenya)

New Visions (Egypt)

Ishraq (Egypt)

First-time Parents (India)

Interventions Focused on Youth

The seven highlighted interventions that address youth focused primarily on gender norms, providing information, and building skills related to sexual and reproductive health. Several of the interventions in other chapters of the *New Evidence* publication (such as HIV/AIDS or early marriage and childbearing in Harmful Practices) are relevant to young people, risky

Gender and sexual norms are established early in life and dictate the context of sexual relations, such as when and with whom to have sex, and whether to use protection.[59] Gender inequalities influence a young person's vulnerability to and ability to be informed about sex,

55   UN Population Division, 2008.

56   WHO, 2004.

57   See Children and HIV and AIDS at www.unicef.org/aids/. See also UNAIDS, 2009.

58   Eggleston, Jackson, and Hardee, 1999; Blakemore, 2003

59   See Pulerwitz, Barker, and Nascimento, 2006.

60   Pettifor et al., 2004 , in Gay et al., 2005.

61   Grunseit, 1997.

behaviors, and negative health outcomes. The themes of gender attitudes, partnerships, life skills, and participation of youth are common throughout many interventions.

All seven of the interventions with youth used gender-transformative approaches, in whole or in part. Several sought to improve adolescent reproductive health by promoting gender-equitable norms. Some of these projects worked only with youth, some with male or female adolescents separately, some with parents or communities. The interventions themselves often comprised life skills education and training, such as skills to provide opportunities for out-of-school girls; reached young married women with RH information and services; or empowered girls to address their own needs.

Community involvement and increasing supportive environments for young people were common themes, using village committees made up of a broad group of stakeholders to help define and support the recruitment and program activities. Interventions at multiple community levels were used for policy, youth-friendly services, behavior change communication, and livelihood skills training. One program worked through the community by focusing on parents, working together with youth to design and implement a program on sexual and reproductive health for youth.

Some projects focused on male youth only and encouraged gender sensitivity, increased reproductive health knowledge, and developed life skills. Male college students or peers often facilitated the sessions for younger youth. Other programs targeted female youth and focused on life-skills and decisionmaking. One approach to life-skills training used a combination of vocational and financial counseling with follow-up from a peer educator. RH information and messages were incorporated as part of the curriculum. Micro-grants were included in some programs, while others used group-based micro-finance and mentoring, in addition to a focus on gender and RH issues.

These programs incorporating gender strategies to improve the reproductive health of youth achieved many outcomes, including:
- Increased contraceptive use;
- Improved knowledge about reproductive health, including family planning and HIV;
- Higher self-esteem;
- Higher levels of income and household assets;
- Improved attitudes toward gender roles in marriage, violence, and FGM/C;
- Increased use of health services by young people; and
- Increased couple communication about reproductive health and family planning.

In addition to the RH outcomes in knowledge/attitudes and behavior, programs often seek to empower the next generation. Gender-transformative programs for youth may have the most impact in the long-run because gender norms may be easier to change in youth, and may last throughout their lifetimes. An important element of these programs will be learning to what degree gender transformation among youth is sustained over time and passed on to the next generation.

Table 6: Examples of Interventions Targeting the Needs of Youth

PROJECT/INTERVENTIONS	RH OUTCOMES	GENDER OUTCOMES
Egypt: Ishraq • Literacy, education, and life skills classes for girls • Sports and physical activity program for girls • Home skills and livelihoods training for girls	• Decline in support for FGM/C (intention to cut daughters declined from 71% to 18%) • Reduced acceptance of violence against women • Decline in proportion of girls who preferred marriage before age 18	• Increased gender-equitable attitudes in girls who participated for more than one year (as measured by questionnaire)
India: First-time Parents • Integrated health and social interventions for married adolescents • Provided RH information through home visits and neighborhood meetings • Training for health care providers on the needs of youth • Support groups for adolescent girls	• Increased RH knowledge • Increased use of health services for ante- and post-partum care (62% increase in preparations for childbirth)	• Increased breastfeeding immediately after birth • Improved partner communication about FP and household decisions • Increased willingness to express disagreement with husband

7 Conclusion

In the past five years there has been a clear increase in the evidence that integrating gender into policies and programs does improve RH outcomes. Today, more and more women and men involved in such programs are reaping the benefits of gender-integrated programming and more rigorous evaluations are measuring the effects. The 2009 *"New Evidence"* publication makes an important contribution to the growing body of literature on gender-based approaches to health policy and programming. The evidence presented suggests that incorporating strategies in RH programs that address gender inequality contribute to reducing unintended pregnancy, improving maternal health, reducing HIV/AIDS and other STIs, eliminating harmful practices, and meeting the needs of youth – all broadly included under the term "reproductive health."

The findings reported in this publication confirm that substantial progress has been made in RH and gender equality, and gender-equitable outcomes are measured more often than they were five years ago. In the past, gender integration seemed to take hold most effectively in the field of HIV/AIDS, since the link between inequitable gender relations and the spread of HIV/AIDS and STIs had been well-documented. In recent years, the importance of gender in the other RH areas included in this report is now increasingly demonstrated. And perhaps most significantly, a majority of the interventions in this review employed transformative approaches—a big step forward.

New Findings

Many RH interventions have sought to change underlying beliefs and attitudes that shape norms related to power dynamics between women and men, including in sexual and reproductive health. These programs, working with men and women of all ages, have had success in improving gender-equitable views. The most frequently measured gender outcomes were *attitudes* regarding gender equity and women's rights and partner communication about FP and other RH issues (see Appendix Table A.2). Some programs have been successful in changing behavior, most commonly by increasing condom use, but also, in some cases by reducing gender-based violence.

All of the 40 programs in the review achieved positive RH outcomes. Some of the most common RH outcomes measured included knowledge and use of contraceptives, knowledge of HIV/AIDS transmission and prevention, condom use, and use of HIV/AIDS and pregnancy care services (see Appendix Table A.1). Thirty of the 40 interventions measured gender impact; all of these reported positive changes on a range of gender outcomes. The gender outcomes that were measured reflect multiple dimensions of women's empowerment, including self-confidence or self-esteem, community participation and social networks, mobility, decision-making power, and practical skills related to micro-finance.

Several key findings emerged in the *"New Evidence"* review:

- **Gender-integrated strategies are stronger and better evaluated than five years ago.** The strategies used to integrate gender are grounded in deep theoretical and practical knowledge of the effects of gender on RH. The most promising strategies for improving RH outcomes include those that seek to directly confront harmful or inequitable gender norms (e.g. IMAGE, Program H, Stepping Stones), increase community awareness and dialogue around gender and RH (e.g. Soul City, Through our Eyes, Somos Diferentes Somos Iguales), or increase couple communication (e.g. First-time Parents Project). Also, the more current evaluations were much more likely to use experimental and quasi-experimental designs. No evaluation in 2004 used ran-

domized control trials; five evaluations in "New Evidence" used this "gold standard" methodology.

- **Incorporating gender into a range of strategies leads to a better understanding of RH issues.** Looking at the 40 interventions, it becomes clear that careful incorporation of a strategy to address gender inequality leads to a better understanding of the RH issue at hand. Inequitable-gender relations in the ability to negotiate safe sex and expectations of intimate relationships fuel transmission of HIV. Strategies to meet the needs of youth focus on establishing strong foundations for young women and men to grow into adulthood in good reproductive health; understanding the gender roles that guide their behavior leads to more effective programs. Examining harmful practices, one can see that many are clearly rooted in gender roles and expectations; any effort to mitigate these practices needs to encompass the social constructions of gender that have been used to rationalize those practices over time.

  The unintended pregnancy interventions appear to incorporate gender in less ambitious or transformative ways compared to other RH areas. Maternal health has the fewest number of evaluated interventions. Nonetheless, evidence exists that the healthy timing and spacing of pregnancy and childbirth can be improved by incorporating gender in programs.

- **Formative research is critical.** As noted in many of the interventions, programs to integrate gender benefit greatly from initial formative research to determine specific social and gender dynamics in project areas. Formative research is a critical tool to ensure that projects are meeting local needs and are implemented within the local context.

- **Programs that integrate gender can benefit from working at multiple levels.** The projects reviewed include work with individuals, couples, families, community leaders, health-care providers, and policymakers, among other groups. Many of the projects also linked individual-level interventions with community-level interventions, such as mass media or social marketing campaigns. Some of these programs sought to empower both women and communities. Some worked not only with the health sector, but also in the areas of agriculture, education, and economic development. Because changing norms is a community process, projects will benefit from careful consideration of the multiple levels (personal, interpersonal, family, community, and systems) at which gender norms operate and inclusion of a community involvement or mobilization component.

- **Projects that integrate gender need to focus on costs, scale up, and identifying policy and systemic changes required to "mainstream" gender.** Notably absent from many of the projects reviewed is adequate attention to the costs of the projects and the feasibility of scaling up the interventions. Given the time-intensive nature of some of the interventions, particularly for those that seek to examine and change personal or community views about gender norms, considerations for scale up and sustainability are critical. Moreover, few of the projects included discussion about national or sectoral policies that might exacerbate gender inequality or, conversely, enhance gender equality.

Future Directions

This publication makes a critically important contribution to the continuing quest for evidence that incorporating gender components into programs improves RH outcomes. While the reviewers might have wished for more conclusive data and more in-depth descriptions of what makes a program gender transformative, there can be no doubt that the field has come a long way in the last five years.

Many challenges remain, not the least of which is that monitoring and evaluation are critical if we are to prove beyond a shadow of doubt that integrating strategies that address gender inequality yields improvements in RH outcomes. Donors should be encouraged to focus their funding efforts on gender integration interventions and evaluations, and, in

turn, to encourage implementing organizations to measure gender impact.

Given the evidence presented here, public health actors and development workers need to focus particularly on:

- Scaling up and replicating the programs that have been proven to work;
- Focusing on transformative approaches in interventions, particularly those that seek to reduce unintended pregnancy;
- Undertaking cost-effectiveness research to shed light on how to achieve these improvements in RH in a manner that is affordable and feasible for donors, governments, and programs;
- Institutionalizing positive achievements through policy change; and
- Conducting sustainability analyses to learn how long these changes last, and what follow-up may be needed over time to ensure that the positive impacts of interventions to improve gender-equity are maintained and passed on to future generations.

It is the fervent hope of the authors that more program planners, policymakers, and funders will insist on moving toward a gender-transformative approach in their RH programs. The way forward—focusing on well-evaluated projects that address policy, systems, and cost issues, scaling up gender integration, and addressing sustainability of equitable gender relations over time—will make important contributions to the health and lives of women, men, and families around the world.

References

Adhikari, R. K. "Early Marriage and Childbearing: Risks and Consequences." In *Toward Adulthood: Exploring the Sexual and Reproductive Health of Adolescents in South Asia,* eds. S. Bott, et al. Geneva: World Health Organization, 2003.

Antwi, P.M. and Y.P.A. Oppong. "Ghana's Attempts at Managing the HIV/AIDS Epidemic. A Review of Efforts." Working Paper Series16, no. 6. In *Series on HIV/AIDS in Sub-Saharan Africa: Sex, Gender and Policy.* Boston: Harvard Center for Population and Development Studies, 2003.

Atkinson, S. and M. Farias. "Perceptions of Risk During Pregnancy Amongst Urban Women in Northeast Brazil." In *Social Science and Medicine* 45, no. 12 (1995): 1789-1804.

Bezmalinovic, B., W.S. Duflon, A. Hirschmann, and R. Lundgren. *Guatemala City Women: Empowering a Vulnerable Group to Prevent HIV Transmission.* Report-in-Brief, Women and AIDS Research Program. Washington, DC: ICRW, 1997.

Biddlecom, Anne and Bolaji M. Fapohunda. "Covert Contraceptive Use: Prevalence, Motivations, and Consequences." In *Studies in Family Planning* 29 (1998): 360-372.

Blakemore, J.E.O. "Children's Beliefs about Violating Gender Norms: Boys Shouldn't Look like Girls, and Girls Shouldn't Act like Boys." In *Sex Role* 48 (2003):411-419.

Boender, C., D. Santana, D. Santillan, K. Hardee, M.E. Greene, and S. Schuler. *The "So What?" Report: A Look at Whether Integrating a Gender Focus into Programs Makes a Difference to Outcomes.* Washington, DC: PRB for the IGWG, 2004.

Bongaarts, J. *Population Policy Options in the Developing World.* Research Division Working Paper No. 59. New York: The Population Council, 1994.

Bradby, B. "Will I Return or Not? Migrant Women in Bolivia Negotiate Hospital Birth." In *Women's Studies International Forum* 22, no. 3 (1999): 287-301.

Caldwell, B.K. and J.C. Caldwell. "Below-Replacement Fertility: Determinants and Prospects in South Asia." In *Journal of Population Research* 20, no.1 (2003): 19–34.

Chege, J., I. Askew, S. Igras, and J.K. Muteshi. *Testing the Effectiveness of Integrating Community-Based Approaches for Encouraging Abandonment of Female Genital Cutting into CARE's Reproductive Health Programs in Ethiopia and Kenya.* Nairobi: FRONTIERS in Reproductive Health and CARE, 2004.

DiMatteo, M.R. "The Physician-Patient Relationship: Effects on the Quality of Health Care." In *Clinical Obstetrics and Gynecology* 37, no.1 (1994):149-161.

Eggleston, E., J. Jackson, and K. Hardee. "Sexual Attitudes and Behavior Among Young Adolescents in Jamaica." In *International Family Planning Perspectives* 25, no.2 (1999):78-84 & 91.

Feldman-Jacobs, C. and D. Clifton. *Female Genital Mutilation/Cutting: Data and Trends Update 2010.* Washington, DC: PRB, 2010.

Garcia-Moreno, C., L. Heise, H. Jansen, M. Ellsberg, and C. Watts. "Violence Against Women." In *Science* 310, no. 5752 (2005): 1282-1283.

Goldberg, H.I. and A. Toros. "The Use of Traditional Methods of Contraception Among Turkish Couples." In *Studies In Family Planning* 25, no.2 (1994): 122-128.

Grunseit A. I*mpact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: A Review Update.* UNAIDS Best Practice Collection. Geneva: UNAIDS, 1997.

Heise, L. and C. Garcia-Moreno. "Violence by Intimate Partners." In *World Report on Violence and Health,* eds. E. Krug, L. Dahlberg, J. Mercy, A. Zwi and R. Lozano. Geneva, Switzerland: World Health Organization, 2002.

Heise, L., M. Ellsberg, and M. Gottemoeller. "A Global Overview of Gender-Based Violence." In *International Journal of Gynaecological Obstetrics* 78, no. S1 (2002):5-14.

Heise L., J. Pitanguy, and A. Germain. *Violence Against Women: The Hidden Health Burden.* World Bank Discussion Paper 255.Washington, DC: World Bank, 1994.

Hoang, T.A., T.H. Minh, N.M. Duc, B.T. Thanh Mai, P.V. Thien, V.S. Ha, P.T. Thu Ha, Q.T. Trang, S.R. Schuler, and D. Santillán. *Impact of the Cairo Program of Action: Gender, Women's Empowerment, and Reproductive Health in Four Vietnamese Communities.* Research Results Report. Hanoi, Vietnam: Population and Development International, 2002.

Hodnett, E. "Caregiver Support for Women During Childbirth." In *Cochrane Review.* Oxford: Cochrane Library, 2001.

Hogan, M.C., K.J. Foreman, M. Naghavi, S.Y. Ahn, M. Wang, S. M. Makela, A.D. Lopez, R. Lozana, and C. Murray. "Maternal Mortality for 181 Countries, 1980-2008: A Systematic Analysis of Progress Towards Millennium Development Goal 5." In *The Lancet* 375, no. 9726 (2010): pp. 1609-1623.

Hope, Ruth. *Addressing Cross-Generational Sex: A Desk Review of Research and Programs.* Washington, DC: PRB for the IGWG and IYWG, 2007.

Human Rights Watch (HRW). *Double Standards: Women's Property Rights Violations in Kenya.* New York: HRW, 2002.

Interagency Gender Working Group (IGWG) and WHO. *A Summary of the "So What?" Report: A Look at Whether Integrating a Gender Focus Into Programs Makes a Difference to Outcomes.* Washington, DC: PRB for the IGWG, USAID, and WHO, 2005.

International Center for Research on Women (ICRW). *Delaying Age at Marriage in Rural Maharashtra, India.* Washington, DC, ICRW, 2004.

Jessop, S.M., C. Morrissey, E. Dusch, A. Cox, and E. Jonas, eds. *MotherCare's Initiatives: Actions and Results of 31 Projects,* 1993- 2000. Arlington, VA: John Snow, Inc., 2000.

Jones, H., N. Diop, and I. Kabore. "FGC Practices in Burkina Faso and Mali and Their Negative Health Outcomes. In *Studies in Family Planning* 30, no. 3 (1999) 219-230.

Khobotlo M. et al. *Lesotho: HIV Prevention Response and Modes of Transmission Analysis.* Maseru, Lesotho National AIDS Commission, 2009.

Kishor, S. and K. Johnson. *Profiling Domestic Violence: A Multi-Country Study.* Calverton, Maryland: ORC Macro, 2004.

Mathews, S., N. Abrahams, L. Martin, L. Vetten, L. van der Merwe, and R. Jewkes. *Every Six Hours a Woman Is Killed by her Intimate Partner: A National Study of Female Homicide in South Africa.* Gender and Health Research Group. Pretoria, South Africa: Medical Research Council, 2004.

Morison, L., C. Scherf, G. Ekpo et al. "The Long-term RH Consequences of FGC in Rural Gambia: A Community-Based Survey." In *Tropical Med and Intl Health* 6:8 (2001): 643-653.

Nachbar, N. *Report on the Use of the Community Diagnosis to Explore Safe Motherhood: A Two Country Comparison and Methodological Critique.* Technical Working Paper #6. Arlington, VA: John Snow, Inc., MotherCare, 1997.

Peacock, Dean. *Sonke Gender Justice and the One Man Can Campaign.* Johannesburg, South Africa: One Man Can Campaign, 2008.

Pettifor A., A. van der Straten, M. Dunbar, S. Shiboski, and N. Padian. "Early Age of First Sex: A Risk Factor for HIV Infection among Women in Zimbabwe." In AIDS 18, no.10 (2004):1435-1442. Cited in: J. Gay, K. Hardee, M. Wood, C. Wingfield, E. Kidder, K. Fleming, A. Hairston, and F. Cleghorn. *HIV/AIDS Interventions: What is the Evidence?* Washington, DC: The POLICY Project, 2005.

Population Council. "Love, Sex, and Abortion Among Unmarried Youth in Ho Chi Minh City: Implications for Policy and Program Interventions." Unpublished paper, 2000.

Pulerwitz, J., G. Barker, M. Segundo, and M. Nascimento. *Promoting More Gender-equitable Norms and Behaviors among Young Men as an HIV/AIDS Prevention Strategy.* Washington, DC: Horizons Program: 2006.

Raju, S, and A. Leonard, eds. *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality.* New Delhi, India: The Population Council South and East Asia Regional Office, 2000.

Riley, N. "Gender, Power and Population Change." In *Population Bulletin* 52, no. 1 (May 1997).

Robey, B., E. Thomas, S. Baro, S. Kone, and G. Kpakpo. *Men: Key Partners in Reproductive Health.* A Report on the First Conference of French-Speaking African Countries on Men's Participation in Reproductive Health, March 30-April 3, Ouagadougou, Burkina Faso. Baltimore, MD: JHU/CCP, 1998.

Ronsmans, C. and W.J. Graham. "Maternal Mortality: Who, When, Where and Why." *The Lancet* 368, no. 9542 (2006): 1189-1200.

Roth, D. and M. Mbizvo. "Promoting Safe Motherhood in the Community: The Case for Strategies That Include Men." In *African Journal of Reproductive Health* 5, no. 2 (2001): 10-21.

Rottach, E., S.R. Schuler, and K. Hardee. *Gender Perspectives Improve Reproductive Health Outcomes: New Evidence.* Washington, DC: PRB for the IGWG, 2009.

Sargent, C.F. *Maternity, Medicine, and Power: Reproductive Decisions in Urban Benin.* Berkeley: University of California Press, 1998.

Schuler, S.R., L. Bates, and M.K. Islam. "Paying for Reproductive Health Services in Bangladesh: Intersections Between Cost, Quality and Culture." In *Health Policy and Planning* 17, no. 3 (2002).

Schuler, S.R., L. Bates, and M.K. Islam. "Reconciling Cost Recovery with Health Equity Concerns in a Context of Gender Inequality and Poverty." In *International Family Planning Perspectives* 28, no. 4 (2002): 196-204.

Schuler, S.R., M.E. Choque, and S. Rance. "Misinformation, Mistrust, and Mistreatment: Family Planning among Bolivian Market Women." In *Studies in Family Planning* 25, no.4 (1994): 211-221.

Schuler, S.R. and Z. Hossain. "Family Planning Clinics Through Women's Eyes and Voices: A Case Study from Rural Bangladesh." In *International Family Planning Perspectives* 24, no. 4 (1998):170-175, 205.

Schuler, S.R., E.N. McIntosh, M.C. Goldstein, and B.R. Pande. "Barriers to the Effective Use of Family Planning Services in Kathmandu." In *Studies in Family Planning* 16, no. 5 (1985): 26-27.

Sedgh G., R. Hussain, A. Bankole, and S. Singh. *Women with an Unmet Need for Contraception in Developing Countries and Their Reasons for Not Using a Method.* Occasional Report no. 37. New York: Guttmacher Institute, 2007.

Sen, G., P. Ostlin, and A. George. *Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why It Exists and How We Can Change It.* Final Report to the WHO Commission on Social Determinants of Health. Women and Gender Equity Knowledge Network. Stockholm, Sweden: Karolinska Institute, 2007.

Sosa, R., J. Kennell, M. Klaus, S. Robertson, and J. Urrutia. "The Effect of a Supportive Companion on Perinatal Problems, Length of Labor, and Mother-Infant Interaction." *New England Journal of Medicine* 303, no. 11 (1980): 597-600.

UNAIDS. *AIDS Epidemic Update December 2009.* Geneva: Joint United Nations Program on HIV/AIDS, 2009.

United Nations Children's Fund (UNICEF). Children and HIV and AIDS. Accessed online July 1, 2009, at www.unicef.org/aids.

UNICEF. *Early Marriage: Child Spouses.* Innocenti Digest 7. Florence: UNICEF, Innocenti Research Centre, 2001.

UNICEF. *Toward a Common Framework for the Abandonment of FGM/C.* New York: UNICEF on behalf of the Donors Working Group on FGM/C, 2007.

United Nations Development Fund for Women (UNIFEM). *Gender and AIDS Web Portal.* Accessed Dec. 1, 2009, at www.genderandaids.org.

United Nations Population Division (UNDP) (2008). Online database. Accessed online Dec. 1, 2009, at http://esa.un.org/unpp.

United Nations Population Fund (UNFPA). *State of the World Population.* New York: UNFPA, 2008.

Upadhyay, U.D. *Informed Choice in Family Planning: Helping People Decide.* Population Reports, Series J, No. 50. Baltimore, MD: JHU Bloomberg School of Public Health, 2001.

Vissandjee, B., R. Barlow, and D. Fraser. "Utilization of Health Services Among Rural Women in Gujurat, India." *Public Health* 111 (1997): 135-148.

Weissman, A., J. Cocker, L. Sherburne, M.B. Powers, R. Lovich, and M. Mukaka. "Cross-generational Relationships: Using a 'Continuum of Volition' in HIV-Prevention Work among Young People." *Gender & Development* 14, no. 1 (2006): 81-94.

World Health Organization (WHO). *Eliminating Female Genital Mutilation: An Interagency Statement.* Geneva: WHO, 2008.

WHO. "Maternal Health and Safe Motherhood: Findings From Concluded Research Studies." *World Health Statistics Quarterly* 48 (1995): 2-3.

WHO. *Maternal Mortality Update: Delivering into Good Hands.* Geneva: World Health Organization, 2004.

WHO, *Women and Health: Today's Evidence Tomorrow's Agenda.* Geneva, 2009.

WHO Study Group on Female Genital Mutilation and Obstetric Outcome. "Female Genital Mutilation and Obstetric Outcome: WHO Collaborative Prospective Study in Six African Countries." *The Lancet* 367 (2006):1835.

Zhang, J., J.W. Bernasko, E. Leybovich, M. Fahs, and M.C. Hatch. "Continuous Labor Support From Labor Attendant for Primiparous Women: A Meta-Analysis." *Obstetrics and Gynecology* 88, no.4 (1996): 739-744.

Appendix: Quick Reference Guide

The following tables summarize the reproductive health outcomes and gender outcomes of the interventions discussed in the *New Evidence* report. They are meant to provide, at a glance, details about the programs described throughout the various chapters. Many of the 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 crosscut areas of reproductive health.

Reproductive Health Outcomes of Interventions

Reproductive Health Outcomes	Interventions
Healthy Timing, Spacing, and Limiting of Pregnancies	
Greater contraceptive knowledge	Awash FGM/C Berhane Hewan Tostan Community Empowerment Program Cultivating Men's Interest in Family Planning Guria Adolescent Health Project Involving Men in Maternity Care (South Africa) Male Motivation Campaign Men in Maternity (India) PRISM Project Reproductive Health Awareness Social Mobilization or Government Services Together for a Happy Family
Greater contraceptive use	African Youth Alliance Program Awash FGM/C Berhane Hewan First-time Parents Project Guria Adolescent Project Men in Maternity mothers2mothers PRACHAR I & II PRISM Project REWARD Together for a Happy Family
Greater awareness of fertility	Cultivating Men's Interest in Family Planning Reproductive Health Awareness
Improving Maternal Health	
Increase in use of skilled pregnancy care	First-time Parents Project REWARD Social Mobilization or Government Services
Increase in joint decision-making with partner about contraception	Men as Partners Men in Maternity (India)
Reduced case fatality rate	FEMME Project
Increase in client satisfaction with providers and care	PROCOSI
Decline in unmet need for contraceptives	PROCOSI
Increase in screening of pregnant women for Syphilis	Men in Maternity
Increase in women's emergency obstetric care needs being met	FEMME Project
Greater knowledge of warnings signs in pregnancy	Men in Maternity (India)
Improved provider clinical skills & knowledge of FP methods & STI care	Women's Empowerment Model to Train Midwives and Doctors
Increase in awareness of prenatal care	Tostan Community-based Education Program

Reproductive Health Outcomes of Interventions

Reproductive Health Outcomes	Interventions
Reducing HIV/AIDS and Other STIs	
Greater knowledge of HIV/AIDS transmission and prevention	African Youth Alliance Program Berhane Hewan Men as Partners New Visions One Man Can Play Safe Somos Diferentes, Somos Iguales
Greater condom use	Program H Tuelimishane Yaari Dosti Play Safe Somos Diferentes, Somos Iguales Stepping Stones Yaari Dosti
Increase in visits to centers that provide HIV/AIDS STI services	Integration of RH Services for Men in Health and Family and Welfare Centers Involving Men in Sexual and Reproductive Health Play Safe Social Mobilization or Government Services Somos Diferentes, Somos Iguales
Lower reported STI symptoms	Program H Stepping Stones
Greater knowledge of STI symptoms	Tostan Community-based Education Program
Increased exclusive breastfeeding	mothers2mothers
Greater receipt & ingestion of nevirapine	mothers2mothers
Greater CD4 testing	mothers2mothers
Eliminating Harmful Practices	
Decrease in belief that IPV/SV is justified under some circumstances	One Man Can Soul City Stepping Stones
Greater knowledge of IPV/SV resources	Somos Diferentes, Somos Iguales Soul City
Decrease in incidence of violence	Tostan Community-based Education Program Stepping Stones Yaari Dosti
Increased community action and protest against harmful practices	Five Dimensional Approach for the Eradication of FGM/C Soul City

Reproductive Health Outcomes of Interventions

Reproductive Health Outcomes	Interventions
Attitudes toward IPV/SV	IMAGE Men as Partners New Visions Tuelimishane
Decrease in risk of IPV/SV	IMAGE
Greater awareness of fertility	Cultivating Men's Interest in Family Planning Reproductive Health Awareness
Decrease in controlling behavior by intimate partner	IMAGE
Increased uptake of RH services	Through Our Eyes
Greater knowledge of harmful consequences of FGM/C and advantages of not cutting girls	Awash FGM/C Tostan Community-based Education Program Ishraq
Attitudes toward FGM/C	Five Dimensional Approach for the Eradication of FGM/C in Ethiopia New Visions
Increase in number of men who marry uncircumcised girls	Five Dimensional Approach for the Eradication of FGM/C in Ethiopia
Decrease in FGM/C incidence	Tostan Community-based Education Program Navrongo FGM/C Experiment
Increase in age at marriage	Delaying Age at Marriage in Rural Maharashtra
Increase in interval between marriage and first birth	PRACHAR I & II
Greater knowledge of risks of early childbearing	PRACHAR I & II
Fewer adolescent pregnancies	PRACHAR I & II
Fewer adolescent marriages	Berhane Hewan

Meeting the Needs of Youth

Reproductive Health Outcomes	Interventions
Greater sexual and reproductive health knowledge	Building Life Skills to Improve Adolescent Girls' R&SH Delaying Age at Marriage in Rural Maharashtra Transitions to Adulthood - Livelihoods Training
Increase in decision-making ability related to condom use	African Youth Alliance Program Transitions to Adulthood - Tap and Reposition Youth
Increase in decision-making ability related to sex	Transitions to Adulthood - Tap and Reposition Youth
Increase in age at sexual debut	African Youth Alliance Program

Gender Outcomes of Interventions

Gender Outcomes	Interventions
Increased gender-equitable attitudes and beliefs	Tostan Community-based Education Program IMAGE Men as Partners New Visions One Man Can Campaign Program H Tap and Reposition Youth Tuelimishane Yaari Dosti
Increased partner communication about reproductive health or family planning	Awash FGM/C Cultivating Men's Interest in Family Planning First-time Parents Project Involving Men in Maternity Care (South Africa) Men in Maternity (India) PRISM Project ROCOSI Reproductive Health Awareness Stepping Stones Together for a Happy Family Yaari Dosti
Women's increased self-confidence, self-esteem, or self-determination	Building Life Skills to Improve Adolescent Girls' R&SH Ishraq mothers2mothers Somos Diferentes, Somos Iguales Soul City
Women's increased participation in the community and development of social networks	Berhane Hewan First-time Parents Project Transitions to Adulthood - Livelihoods Training
Increased support (emotional, instrumental, family planning, or general support) from partners or community	First-time Parents Project Social Mobilization or Government Services
Higher scores on an empowerment scale for women	IMAGE Ishraq Somos Diferentes, Somos Iguales
Increased life and social skills	Delaying Age at Marriage in Rural Maharashtra Transitions to Adulthood - Livelihoods Training
Women's increased decision-making power	Through our Eyes
Higher formal educational participation for women or girls	Berhane Hewan
Women's increased mobility	First-time Parents Project
Improved gender relations within the community	Through our Eyes
Women more articulate in discussing IPV/SV and RH	Through our Eyes
Decreased tolerance for kidnapping of girls	Guria Adolescent Health Project

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

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