a summary of the 'SO WHAT?' report

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

IGWG

WHO

a summary of the ‘SO WHAT?’ report

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

July 2005

IGWG

World Health Organization

Acknowledgments

This brief was prepared by Charlotte Feldman-Jacobs of the Population Reference Bureau (PRB), in collaboration with Dr. 'Peju Olukoya of the World Health Organization (WHO) and Michal Avni of the United States Agency for International Development (USAID). Special thanks are due to the authors of the original "So What" report, Carol Boender, Diana Santana, Diana Santillán, Karen Hardee, Margaret E. Green, and Sidney Schuler; as well as to Mai Hijazi and Diana Prieto of the USAID Bureau for Global Health, and the following reviewers: Manisha Mehta of EngenderHealth; Jane Cottingham and Manuella Colombini of WHO; Waafas Ofosu-Amah and Elizabeth Lule of the World Bank; and Judith Bruce and Saumya Ramarao of the Population Council.

This publication was produced by the Population Reference Bureau for the Interagency Gender Working Group (IGWG), a network comprising non-governmental organizations (NGOs), cooperating agencies (CAs), and the USAID Bureau for Global Health. Funding was provided by the U.S. Agency for International Development (under the BRIDGE project, GPO-A-00-00004-00) and by the Department of Gender, Women and Health, World Health Organization. The examples provided in this publication include experiences of organizations beyond USAID and WHO. This publication does not provide official WHO or USAID guidance nor does it endorse one approach over another. Rather, the document presents examples of innovative approaches for integrating gender into reproductive health programmes and summarizes the evidence of their impact to date.

Department of Gender Women and Health
Family and Community Health
World Health Organization

Table of Contents

I. Introduction

More than a decade has now passed since the International Conference on Population and Development (ICPD) in Cairo. At the time, the Programme of Action (POA), with its emphasis on improving reproductive health and promoting gender equity, marked a major shift in national population policies and donor strategies worldwide. Now, however, governments and organizations everywhere are asking a question that goes one step further: Does taking a gender-based approach to policy and programming as proposed in the POA have an effect on health, particularly reproductive health outcomes?

The Interagency Gender Working Group (IGWG) of the United States Agency for International Development (USAID) has taken stock of some of the reproductive health programmes since the ICPD that integrate gender. In a lengthy 2004 publication reviewing those interventions, known as *"The 'So What?' Report: A Look at Whether Integrating a Gender Focus Into Programmes Makes a Difference to Outcomes,"* the IGWG has concluded that **the evidence does suggest that integrating gender into reproductive health programmes has a positive impact on achieving reproductive health outcomes.**

This summary of that lengthy review is intended to present policymakers and programme managers with a clear and accessible picture of what happens when gender concerns are integrated into reproductive health programmes. It is not an attempt to update the information or data contained in the original 2004 report. However, in some instances, where more recent global estimates are available, these have been noted in footnotes.[1]

Methodology

In 2001, an IGWG task force began a review of the existing evidence that integrating gender into reproductive health programmes makes a difference to outcomes — both reproductive health outcomes and gender outcomes. The review focused on four components of reproductive health programmes, including interventions to:

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

After careful consideration of nearly 400 reproductive health interventions undertaken by programmes to address gender-related barriers, the IGWG task force narrowed its focus to 25 interventions that met its criteria. In order to be included in this review, an intervention had to satisfy the following three questions:

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

Approaches to Gender Integration

Gender integration refers to strategies that take gender norms into account and compensate for gender-based inequalities. In the household and the community, women's and men's roles and relative power shape the division of labour, the allocation of responsibilities, and behaviour affecting reproductive health and health service utilization.[2]

There are generally three types of gender integration strategies: those that **exploit gender inequalities**, those that **accommodate gender differences**, and those that actually **transform gender relations**.

Not all interventions seek to transform gender relations, although, from a gender perspective, that would be the preferred outcome. Some interventions may actually *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.

Still other interventions *accommodate gender differences*. Such interventions make it easier for women to fulfil the duties ascribed to

1. This summary brief does not give detailed information about each of the interventions, but those gender and reproductive health experts who wish more information may access the original report (hereafter referred to as Boender et al., 2004), which can be found on the IGWG website, under www.igwg.org/pubstools.htm or ordered at prborders@prb.org.

2. Caro et al., 2003.

them by their gender roles, without attempting to reduce gender inequality. Such strategies might include community-based distribution, changes in service hours, special training of female providers, child-care provision within clinics, or fee waivers.

Interventions that seek to *transform gender relations* may take more time to bring about results, but such changes are more likely to bring long-term and sustainable benefits to women and families.

Programmes 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 health care providers.

Many gender-integration programmes focus on involving men in reproductive health and several examples are included in this review. Male involvement is critical to promoting gender equity in reproductive health and other development programmes, yet alone does not guarantee the promotion of gender equity.

Evaluation

The interventions selected for inclusion in this paper were limited to those that have been evaluated — in other words, 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, evaluations of the 25 interventions upon which this paper is based are of varying quality and thoroughness. Moreover, in evaluating the impact of gender integration it is difficult to isolate the effects of a gender perspective in programming. And while some of the evaluations could have been done in a more scientifically rigorous manner, the authors felt that the examples collected here comprise the strongest evidence available to date on this topic.

Evaluation Methods and Problems

The task force members encountered many stumbling blocks in their search for properly evaluated interventions. 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. Ideally, sufficient time would have elapsed between the interventions and evaluations. Unfortunately, few such studies had been conducted at the time the IGWG task force undertook its review, usually because of lack of resources.

Nevertheless, the intervention studies included in this review did use a variety of evaluation methods (both qualitative and quantitative), including 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, and facility or national data used for comparison.

Overview

The following chapters are organized by reproductive health issue: maternal morbidity and mortality, unintended pregnancy, STIs/HIV/AIDS, and quality of care. However, many of the chosen interventions have documented effects in more than one of these areas. These initiatives have been placed in chapters according to the most significant outcome they document and the reproductive health outcomes of the interventions described.

The gender outcomes are not as clear in many of the studies, perhaps because gender outcomes are so rarely measured. Some of the gender outcomes that are mentioned, particularly in the qualitative analysis, are women's increased mobility and literacy, women's greater self-confidence and self-esteem, and greater partner communication (see Appendix, Table A.2, for a list of the gender outcomes of interventions reviewed).

II. Unintended Pregnancy

Safe and reliable family planning methods and related RH services for all by 2015 are primary goals of the ICPD's *Programme of Action*. Fertility has declined in many countries worldwide as family planning programmes 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 by 2000, excluding China.[3] Still, one-third of births (32 percent) in the developing world are ill timed or unwanted, as documented in the Demographic and Health Surveys estimates for 51 developing countries.[4]

Unintended pregnancies affect the well being of women, children, and families. In fact, some health experts believe that unintended pregnancies carried to term are more likely to involve complications.[5] Women with unintended pregnancies may be subject to increased physical abuse by their partners during pregnancy.[6]

Moreover, many unintended pregnancies end in abortion.[7] Of the 46 million pregnancies that are terminated each year around the world, it is estimated that 19 million were carried out under unsafe conditions in 2000. According to WHO, every year, 68,000 women die of complications of abortion performed by unqualified people or in unhygienic conditions, or both; many suffer serious, often permanent disabilities.[8]

Unintended pregnancy results from many factors, among them lack of access to contraception. 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.

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. Women are often treated as targets of family planning programmes rather than as partners in and beneficiaries of reproductive health care. Women are often precluded by gender norms from asking for and receiving RH information, and, at the same time, the gender stereotype that family planning is a woman's problem is one reason that programmes have been slow to involve men.

The balance of power between men and women in the household also has implications for contraceptive use and reducing unintended pregnancies. Women without their own sources of income may not be able to seek fee-based family planning services.[9] Men often regulate women's access to health services through control of finances, women's mobility, means of transportation, and health care decisions.[10]

When women do access health services, they may face unequal power relations with family planning providers, who often assume an authoritarian role and expect patients to be passive.[11] Female clients may remain silent and have unanswered questions or concerns that affect the success of their use of family planning methods.[12] The eight-country Women's Studies Project, conducted by Family Health International (FHI), found that "women … want more female providers, more emotional support, help with side effects, and more information on contraceptive methods."[13]

Another barrier is that gender norms often dictate that women — particularly young women — appear ignorant about sexual matters.[14] Women who visit clinics for contracep-

3. United Nations, 2000.
4. Westoff, 2001.
5. Institute of Medicine, 1988.
6. Goodwin et al., 2000.
7. 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. WHO's work in the area of abortion is in line with the ICPD+5 consensus agreement that "in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible."
8. WHO, 2004.
9. Schuler et al., 2002b.
10. Robey et al., 1998; Goldberg and Toros, 1994.
11. DiMatteo, 1994.
12. Schuler et al., 1985; Schuler and Hossain, 1998.
13. Barnett and Stein, 1998: xiii
14. Bezmalinovic et al., n.d.; Population Council, 2000b.

tives may be stigmatized as promiscuous or too independent, especially where women's physical mobility outside the home is limited.[15] Some women may have to use contraception secretly when their husbands disapprove.[16] This is especially true for women who live with the threat of physical abuse from their partners. Young women may be caught in a vicious cycle: lack of information leads to adolescent pregnancy leads to dropping out of school and economic dependence.

Interventions Related to Unintended Pregnancy

Family planning programmes have developed a number of strategies that circumvent barriers to contraceptive use, often by accommodating gender differences. One such strategy is community-based distribution (CBD), which provides family planning services at various community locations, often at the home of clients, rather than through fixed clinics. CBDs have been the subject of much debate, as they are designed to overcome practical obstacles imposed by gender inequality — such as restrictions on women's mobility or lack of access to money — without confronting the issue of inequality per se.[17]

Another 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, or involve men by providing them with reproductive health services, particularly through all-male clinics.[18]

The IGWG task force identified nine evaluated interventions related to unintended pregnancy that aim to transform gender relations. Many of the programmes are in settings where women have little autonomy in their daily lives and little assertiveness in their relationships with husbands and health care providers. In order for these women to make behavioural changes, they need practical skills in long-term thinking, problem solving, and decision-making, and a sense of self-efficacy. Many of the programme strategies 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 programmes 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. Many of them offer training in more than reproductive health, in areas such as literacy, employment skills, legal rights, parenting, child health, and social mobilization. Others focus on strengthening women's voice in community planning, in bringing issues to government officials and donor organizations, and educating men on the importance of women's reproductive health and family planning.

The nine unintended pregnancy interventions:

- **Stimulating Dialogue Through Radio Shows** (Zambia)
- **Autodiagnosis Through the ReproSalud Project** (Peru)
- **Training-of-Trainers in Health and Empowerment** (Mexico)
- **Programme for Adolescent Mothers** (Jamaica)
- **Better Life Options Programme (BLP)** (India)
- **Husbands and Postabortion Care** (Egypt)
- **Father's Role in Postpartum Family Planning** (Turkey)
- **Reaching Men Through Agricultural Extension** (Honduras)
- **Mayan-Language Educators in Gender and Family Planning** (Guatemala)

15. Schuler et al., 1994.
16. Castle et al., 1999.
17. See Boender et al., pp. 11-13, for a more in-depth discussion of Gender Integration and Community-Based Distribution.
18. Ojeda, 1998.

RH Outcomes of the Interventions

The nine interventions that were examined under unintended pregnancy showed evidence of the following reproductive health outcomes [19]:

- Greater family planning use
- Greater contraceptive knowledge
- Fewer child deaths
- Lower fertility
- Fewer adolescent pregnancies
- Increase in age at marriage
- Greater receptivity to family planning information

Two of the interventions are described in the table below in the hope that they will be useful to programme planners as examples of integrating gender into reproductive health programmes to effect unintended pregnancy.

19. See Appendix table A2 for complete list of interventions in which each of the RH outcomes was monitored and evaluated.

Table 2

Examples of Interventions Targeting Unintended Pregnancy

Project/Interventions	RH Outcomes	Gender Outcomes
Peru: Autodiagnosis & ReproSalud		
• Works with women's groups • Feedback gathered in workshops • Uses socio-dramas, storytelling, body-mapping, problem trees • Includes husbands in education	Increase in 14 of 15 indicators of RH knowledge & practice Example: Contraceptive use of women increased from 58.4% to 71.8%.	Increase in men and women in 14 of 15 gender-equitable attitudes & practices Example: Increase in joint decisions on sex, family planning & number of children
India: Better Life Options Programme (BLP)		
• 6-10 month trainings of adolescent girls • Family life education • Literacy and vocational skills • Information on health, especially reproductive health	Participants found to have • fewer children and fewer child deaths • later age at marriage (18 years of age compared to 17.6 for controls) Also, participants more likely than controls to: • Discuss family planning with husbands (55% more) • Use contraception (36% compared to 27%) • Have children immunized (63% vs. 32%)	Participants more likely than control group to: • Have higher literacy rates (95% vs. 68%) • Use public transportation (58% vs. 25%) • Decide autonomously when to marry (25% vs. 7%)

III. Maternal Mortality and Morbidity

Reducing maternal mortality, the death of women from pregnancy and delivery-related causes, is another major goal of the ICPD *Programme of Action* as well as of the Safe Motherhood Initiative.[20] The ICPD goal was to reduce levels of maternal mortality measured in 1990 by 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 them in the developing world.[21] An estimated 40 percent of pregnant women experience pregnancy-related health problems, with 15 percent suffering from serious or long-term complications. About 300 million women suffer from disabilities, such as anaemia, 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.[22]

The death of a mother has broad family 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."[23] A pregnant adolescent is at even greater risk for pregnancy-related death — up to five times more likely for mothers under age 15.[24] Moreover, poor maternal health and nutrition contribute to low birth weight in 20 million babies each year — almost 20 percent of all births.[25]

The five major direct medical causes of poor maternal health are haemorrhage, obstructed labour, induced abortion, sepsis (infection) and hypertensive disorders, and they account for approximately 80 percent of all maternal deaths.[26] Poor nutrition in mothers is also associated with an increased risk of maternal death and poor health.[27] Nutrient deficiencies that pre-exist pregnancy are often made worse by childbearing.

Lack of antenatal and postpartum care and the absence of trained birth attendants all contribute to poor maternal health.

Yet, there is a large body of research and programme experiences that "demonstrates that pregnancy and childbirth need not put most women at significant risk."[28] Health care policies and programmes can be improved to reduce maternal morbidity and mortality. Community involvement in locally based safe motherhood interventions, referral to medical centres, antibiotics, and surgery can make all the difference.

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 lack of decision-making power can limit their access to health care and negatively affect maternal health outcomes. Limited access to education translates into a poor understanding of basic health care concepts — including the danger signs in pregnancy. Women who have not played 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.

In many societies, men control household expenditures and decision-making in the family. Families may be reluctant to use scarce resources for women's health care or nutri-

20. The Safe Motherhood Inter-Agency Group (IAG) launched the Safe Motherhood Initiative in 1987 (see www.safemotherhood.org). For updated information on maternal and child health, see www.who.int/gb/ebwha/pdf_files/WHA58/WHA58_31-en.pdf.
21. According to new estimates from WHO, there are now 529,000 maternal deaths per year, resulting in a global ratio of 400 maternal deaths per 100,000 live births.
22. Starrs, 1998; Fortney and Smith, 1996; Stewart et al., 1997.
23. Brundtland, 1999.
24. United Nations Dept. of International Economics and Social Affairs, 1991.
25. Bellamy, 1998.
26. World Health Organization, 1997.
27. Huffman et al., 2001; Mackey, 2000.
28. Ransom and Yinger, 2002.

tional needs. Although men may be the principal decision-makers on seeking health services, there may be little communication with their wives about their health during pregnancy and the postpartum period.

During labour, women may be expected to demonstrate their strength or to suffer through labouring or birthing with little or no aid. Even though many studies have demonstrated the beneficial impact of labour companions on clinical outcomes, physicians and other obstetric service providers may be reluctant to allow family members and other support people to participate in the care of a woman in labour.

Interventions That Reduce Maternal Mortality and Morbidity

Some interventions for safe motherhood accommodate gender differences in order 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.[29] Instead of challenging gender norms, these interventions focus instead on making women aware that it is important to gain their husband's permission (before labour begins) for necessary health care or on educating men about recognizing and responding to danger signs.

Other interventions focus on transforming gender roles in order to improve maternal health. Some of the strategies in this chapter's interventions aim to increase women's access to and control of resources where men dominate financial decision-making 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.[30] Two of the interventions use credit and savings groups and emergency loan funds, supplied through women's cooperative agricultural production or market activities, as a way to increase women's financial ability to care for themselves during childbearing years.

Some programmes 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 control over who is present during labour and delivery. 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 programmes 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 family, 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 strategy in many programmes. Unfortunately, few strategies to involve men have been tested. The Warmi Project in Bolivia (see chart below) demonstrates the importance of providing men with information about pregnancy and birth, and involving them during pregnancy. In the India Pati Sampark project, when male outreach workers targeted the husbands of pregnant women, the wives' attendance at prenatal clinics increased.

The three interventions included:

- Warmi Project in Rural Bolivia
- Advocacy and Income Generation With Indian Women
- *Pati Sampark* ("Contact the Husband") (India)

In summary, the strategies used in maternal health initiatives reviewed here include (1) forming community-based women's groups, (2) economic empowerment of women, (3) reaching men through male outreach workers, and (4) letter writing campaigns to health officials advocating for increased access to clinics, physicians, and government services. The most effective programmes have maintained women's groups for several months, allowing them to develop their priorities and activities.

29. Ransom and Yinger, 2002.

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

RH Outcomes of the Interventions

The three interventions that were examined under maternal mortality and morbidity showed evidence of the following reproductive health outcomes:

- Increase in use of skilled pregnancy care
- Greater knowledge of warning signs in pregnancy
- Better nutrition
- Men's improved knowledge of wives' antenatal care
- Fewer obstetrical complications
- Better post-abortion recovery
- Lower maternal mortality

Two of the interventions are described in the table below in the hope that they will be useful as examples of how integrating gender into reproductive health programmes can have a positive effect on maternal mortality and morbidity.

Table 3

Examples of Interventions Targeting Maternal Mortality/Morbidity

Project/Interventions	RH Outcomes	Gender Outcomes
Bolivia: Warmi Project		
• Women's groups formed to identify problems and solutions • Women received literacy training, practice in speaking and information on rights • Raised money from family gardens for emergency loan funds • Letter writing campaign to MoH for better services	Maternal mortality ratios improved—from 141 per 10,000 total births at baseline to 99 post-intervention Neonatal mortality ratios improved—from 70 per 1,000 live births at baseline to 16 post-intervention Perinatal mortality ratios improved—from 102 per 1,000 total births at baseline to 38 post-intervention	Increase in women's groups—in some areas from 30% to 69% Increase in mothers belonging to women's groups—in some areas from 7% to 57%
India: Advocacy and Income Generation for Women		
• Used community agricultural projects with men to introduce RH programme for women • Formed women's groups and letter writing campaigns • Trained traditional birth attendants • Initiated savings and credit groups	Post intervention, increase in: • Antenatal visits • HIV knowledge • Contraceptive use	Increase in indicators of women's status, e.g.: • In politics, women's participation went from 17% to 77% • In belief in "right to mobility," went from 57% to 95%

IV. Sexually Transmitted Infections (STIs)/HIV/AIDS

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. In Africa, HIV/AIDS is now the leading cause of death and HIV-positive women outnumber infected men. 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.[31]

The AIDS pandemic is causing untold suffering in individuals, families, and societies. AIDS is exacerbated by poverty and, in turn, families ravaged by the disease are often propelled into poverty. 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."[32]

Emerging evidence has illustrated the critical role of gender and sexuality in influencing sexual interactions and men's and women's ability to practice safe behaviours. The studies included in this chapter highlight 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.[33]

Gender-Related Barriers to Reducing STIs/HIV/AIDS

Gender norms and the imbalance of power between men and women have a direct impact on sexual behaviour and, therefore, STI risk. Norms may discourage women from displaying knowledge and communicating about sex and related topics with partners and even with health professionals. Standards of pre-marital virginity may limit young women's access to information about sex and even lead to riskier sexual behaviours such as anal sex.[34] Male promiscuity 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.[35]

Stigma and discrimination are at the heart of the AIDS pandemic, as fear, shame, and 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.[36]

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. Survival strategies of some women in poverty include prostitution and the provision of sex to multiple partners who offer material gifts in return. Although programmes are increasingly promoting condom use, women are often unable to negotiate such protection because of fear of abandonment. In the case of commercial sex workers, they are often at the mercy of their pimps, clients, and even the police.[37]

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

31. UNAIDS, 2000. The 2004 estimates released by UNAIDS and WHO are that globally 39.4 million people are living with HIV and that just under half of these are women. In sub-Saharan Africa almost 57 percent of all people infected with HIV are women and girls. In 2004, an estimated 3.1 million people died of AIDS.
32. Loewenson, 2001.
33. Weiss and Gupta, 1998.
34. Leynaert et al., 1998; Padian et al., 1997.
35. Hoang Tu Anh et al., 2002.
36. Nyblade et al., 2002.
37. Adeokun et al., 2002; Chikamata et al., 2002.

women are pressured to submit to abortion rather than risk having an HIV-positive baby.

Interventions Related to Reducing STIs/HIV/AIDS

Some of the existing interventions to prevent STI/HIV transmission are targeted at high-risk groups, such as commercial sex workers, truck drivers, gay men, and intravenous drug users, and often accommodate gender realities rather than trying to change them. For example, strategies to protect sex workers from contracting STIs or HIV/AIDS have included educating brothel owners or enacting laws to enforce condom use among clients. Also, female condoms and potentially microbicides are often viewed as attractive options because they are woman-controlled and, therefore, do not necessitate convincing partners to wear a condom.

However, transforming gender relations is essential for ending the spread of STIs and HIV. Programmes for adolescents in particular target attitudes and social contexts that increase STI/HIV vulnerability, such as the acceptance of men as macho and as sexual predators. Many programmes bring adolescent boys and girls together and involve them in projects and discussions focusing on gender identity.[38] In Uganda, one of the only countries in sub-Saharan Africa where the incidence of HIV has declined, the Ministry of Information publishes a monthly newspaper insert that provides a forum for young people's opinions and concerns about sex and relationships.[39]

In this review, most of the interventions that target STIs/HIV/AIDS attempt to transform gender relations. Some are aimed at groups at high-risk for STIs/HIV; others attempt to reach clients of other reproductive health services or members of selected neighbourhoods. The majority take place in urban areas.

Changing the balance of power is central to the design of these interventions. Many programmes have been successful at stimulating dialogue among beneficiaries on the relationship between gender norms and sexual behaviour. Still other programmes use behaviour change communication strategies and 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 programmes challenge the acceptance of male promiscuity and infidelity and norms of female sexual ignorance. Peer educators have also addressed such sensitive topics as virginity, sexual behaviour, and women's fear of sexual and physical abuse, economic abandonment, or increased infidelity in retaliation for asking partners to use condoms.

The 10 STI/HIV/AIDS Interventions:

- **Sexual Negotiation Skills Among Inner-City Women** (U.S.)
- **Sex Workers in Sonagachi and Beyond** (India)
- **Empowering Women to Make Safe Contraceptive Method Choices** (Mexico)
- **Educating Prenatal Clients on STIs/HIV** (Guatemala)
- **Integrating STI/HIV Prevention Into Family Planning Services** (Brazil)
- **Peer Education With Factory Workers** (Thailand)
- **Talking About Sexuality With Poor Urban Women** (Brazil)
- **Strengthening Traditional Women's Associations** (Senegal)
- **Talking About Violence as a Barrier to Condom Use** (South Africa)
- **Peer Education Among Adolescent Girls** (Brazil)

To help women avoid transactional sex, education programmes have offered vocational training in income-generating activities. The Sonagachi project in India focuses on training sex workers as peer educators in STIs/HIV/AIDS and self-esteem, aiming to increase knowledge and decision-making power of sex workers, who are typically powerless in relation to brothel owners, clients, and police. Another intervention shows how strengthening of other women's groups, such as traditional Senegalese organizations concerned with fertility, can also improve condom use.

38. de Keijzer et al., 2002.

39. Henry, 1995: 32.

RH Outcomes of the Interventions

The ten interventions examined under STI/HIV/AIDS showed evidence of the following reproductive health outcomes:

- Greater knowledge of HIV/AIDS transmission and prevention
- Greater condom use
- Lower STIs
- Greater knowledge of STI symptoms

Three of the interventions are described in the table below in the hope that they will be useful as examples of how integrating gender into reproductive health programmes can have a positive effect on reducing STIs/HIV/AIDS.

Table 4

Examples of Interventions Targeting STIs/HIV/AIDS

Project/Interventions	RH Outcomes	Gender Outcomes
Mexico: Women and Safe Contraceptive Method Choices		
• Screening for safe IUD use in clinic • One group given education sessions by nurses on contraceptive methods and STIs • Educated group allowed to "self screen" for appropriate contraceptive method	In self-screened group, 52% of infected women correctly chose not to use IUD In physician-screened group, 5% correctly chosen not to use IUD	Not assessed
Thailand: Peer Education with Factory Workers		
• Peer education session with single-sex and mixed-sex groups • Trained peer leaders who then recruited groups • Ten 2-hour sessions, using comic books and romance novels • Increasing awareness of young, single factory workers re HIV risk	Post-intervention, participants better at identifying high risk behaviours, e.g.: • Peer pressure (from 41% to 70%) • Male promiscuity (from 59% to 75%)	Post-intervention, increase in belief that: • girls could raise subject of HIV/AIDS with boys (from 29.9% to 42.3%) • girls should carry condoms (from 47.7% to 84.6%)
Senegal: Strengthening Traditional Women's Association (TWA)		
• Use TWAs to disseminate information re STIs/HIV/AIDS, condoms • Public ceremonies, dance, songs, role playing • Neighbourhood discussion groups	Post-intervention, increase among women in knowledge of STIs/HIV, including how HIV transmitted Post-intervention, women reported increased use of condom. In one site, the number went from 28 to 35 (N=80)	Increase in women's belief that they have right to ask husbands to use condoms (from 25% to 32%)

V. Quality of Care Initiatives

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 framework[40] and in continuous quality improvement approaches that adapt total quality management principles for use in health care.[41] In both approaches, clients' needs are the central focus of programmes. The Bruce-Jain framework identifies six elements relevant to improving the quality of care in family planning programmes: 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 meet client needs. The organizational environment must be structured to optimize quality care for clients. By using scientific and statistical methods to identify problems and develop solutions, managers and staff continuously improve services provided by their programmes. The Maximizing Access and Quality initiative (www.maqweb.org) and performance improvement methods[42] are also designed to improve the quality of services and care.[43]

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 Centre for Human Services (www.qaproject.org), embraces a quality of care framework that is systems-based, client-centred, 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) analyse the service delivery as a whole, examining various dimensions of quality: technical performance, effectiveness, efficiency, safety, access, interpersonal relations, continuity, physical aspects, and choice.[44] In their analysis, teams may identify barriers to quality of care that result from unequal gender relations and norms.

Although access is often treated separately from quality of care, access is included here as a key component of quality. The IGWG task force believes 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 issues, must include attention to barriers affecting access.

The three interventions:

- **Female Providers at MaxSalud** (Peru)
- **Female Relative Support in Labour** (Botswana)
- **Smart Patient Programme** (Indonesia)

Gender-Related Barriers to Improving Quality of Care

Gender-related barriers to quality of care are common to various health care settings. Such barriers include women's limited access to health services because of restrictions on their mobility — such as societal norms or women's care-taking responsibilities for other members of their family (children, the elderly, or the sick). Gender norms often place children's and men's health above women's health, and women may not be able to seek care or follow-up in a timely manner nor have the resources needed to do so. Women may be too "shy" to

40. Bruce, 1990.

41. Hardee and Gould, 1993.

42. Caiola and Sullivan, 2000.

43. 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 (see IPPF, 2000). Also, see the WHO Strategic Approach to Strengthening Reproductive Health Policies and Programmes, www.who.int/reproductive-health/strategic_approach/index.htm.

44. Massoud et al., 2001.

ask questions during health consultations or may be constrained by paternalistic patterns of decision-making and communication between health care providers and clients. Sometimes, "advances" in medicine place women in hospitals alone, whereas they are used to being with family and traditional birth attendants in their own homes. Masculinity norms also often exist and keep men away from health services or limit their involvement in the health care of their partners and/or children.

Interventions That Improve Quality of Care

Most interventions that have addressed gender barriers to quality of care *accommodate* gender differences rather than *challenge* gender relations. For example, a health centre may decide to add a small childcare facility so that mothers can visit health care facilities even when they do not have anyone with whom to leave their children. Some health services have tried to make their settings more male-friendly, for example, by offering evening hours of operations, allowing the presence of male partners during childbirth, or introducing couple counselling. Still others, recognizing women's lack of economic resources lower fees to make services more accessible.

The three programmes described in the longer "So What?" report attempted to improve 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, obstetrical outcomes were improved by allowing women to choose a female family member to accompany them through labour and delivery. Increasing the power of women in labour by permitting them to be accompanied by family is a very low cost intervention and, therefore, easily replicable in a variety of settings. Each of these interventions involved making services more client-centred and responding to women's requests, concerns, questions, and choices.

RH Outcomes of Interventions

The three interventions that were examined under Quality of Care showed evidence of the following reproductive health outcomes:

- Increased clinic visits
- Improved client-provider interaction

Table 5

Examples of Interventions Targeting Quality of Care

Project/Interventions	RH Outcomes	Gender Outcomes
Botswana: Relative Support in Labour		
• In hospital setting • Women allowed to chose female relative to accompany them through labour, delivery	Resulted in fewer C-sections (6% vs 13%), fewer vacuum extractions (4% vs 16%), and less use of oxytocin (13% vs 30%)	Not measured
Indonesia: Smart Patient Programme		
• In family planning clinics • One-on-one sessions with patient educators pre-appointments • Coached on right to speak out, skills in asking questions and seeking clarification	Contraceptive use higher in clients at 8 months after intervention	Women with patient education asked more questions (6.3 vs 4.9); Women clients from intervention group received better information from providers

VI. Conclusion

"Policy-makers and programme managers are unlikely to find short cuts to gender-sensitive programmes, 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 programmes so that they do more to empower women."[45]

It has been more than a decade since the Cairo Programme of Action (POA) proclaimed that gender equity was a key component to achieving reproductive health. This review contributes to the ongoing discussion. It does this by examining the evidence that a gender-based approach to policy and programming as proposed in the POA has an effect on reproductive health outcomes.

Indeed, the interventions highlighted here provide this evidence. The interventions and their outcomes demonstrate that *integrating gender into reproductive health programmes does appear to have a positive impact on reproductive health outcomes,* whether by exploiting, accommodating or transforming gender inequities.

Moreover, among the interventions that measured gender outcomes, the results were positive as well. Specifically, qualitative data in particular 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. Where quantitative data was available, it demonstrated that gender-sensitive programmes had stimulated conversations between men and women about family planning and STIs/HIV; led to 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 labour, and reproductive health matters.

Much work still needs to be done on improving the methodology for evaluation in this respect. 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.

Recommendations

This review provided many important lessons for reproductive health researchers and practitioners, but many of the lessons are of particular interest to policymakers and programme managers as well. In fact, several of them may be applied to non-reproductive health issues where appropriate.

1. Integrate gender into programmes to achieve positive reproductive health outcomes.

With very few exceptions, the programmes that integrated gender achieved positive reproductive health outcomes. Changes were particularly likely to be seen in knowledge and attitudes rather than in practices, perhaps because gender relations take a long time to change and the evaluations were typically short term.

2. Focus on community participation or community empowerment strategies when seeking to transform gender relations.

Gender-integrated components of reproductive health programming are often embedded in participatory or community empowerment initiatives. These programmes 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.

3. Provide support for 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 being developed and tested. Researchers and programme implementers need to be trained in effective use of

45. Barnett and Stein, 1998.

these measurement tools. Funding for evaluation needs to be allocated, scaled up, and long-term. Sufficient time and funding are needed for programmes to show effects.

4. Recognize the unique contribution that gender integration brings to the success of STI/HIV interventions, achieving sustainable health results and greater gender equity.

Ten of the programmes reviewed focused on STI/HIV reduction, more than in any other area. 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 behaviour is strongly regulated by gender norms, and economic inequities between women and men leave women powerless in transactional sex.

References

Adeokun L et al. Promoting dual protection in family planning clinics in Ibadan, Nigeria. *International Family Planning Perspectives,* 2002, 2:87-95.

Barnett B, Stein J (1998). *Women's Voices, Women's Lives: The Impact of Family Planning.* A Synthesis of Findings from the Women's Studies Project. Research Triangle Park, NC, Family Health International.

Bellamy C (1998). *The state of the world's children 1998.* New York, UNICEF.

Bezmalinovic B et al. (n.d.). Guatemala City women: empowering a vulnerable group to prevent HIV transmission. Report-in-Brief, Women and AIDS Research Programme. Washington, DC, ICRW.

Boender C et al. (2004). *The 'so what?' report: a look at whether integrating a gender focus into programmes makes a difference to outcomes.* Washington, DC, PRB for the USAID's Interagency Gender Working Group.

Bruce J. Fundamental elements of quality of care: a simple framework. *Studies in Family Planning,* 1990, 2:61-91.

Brundtland Gro Harlem. Speech to the maternal mortality advocacy meeting, Maputo, Mozambique, World Health Organization, April 19, 1999.

Caiola N, Sullivan R (2000). *Performance improvement: a strategy for reproductive health service delivery.* Available online at www.reproline.jhu.edu.

Caro D et al. (2003). *A manual for integrating gender into reproductive health and HIV programmes: from commitment to action.* Washington, DC, PRB for the USAID's Interagency Gender Working Group.

Castle S et al. A qualitative study of clandestine contraceptive use in urban Mali. *Studies in Family Planning,* 1999, 3: 231-248.

Chikamata DM et al. Dual needs: contraceptive and sexually transmitted infection protection in Lusaka, Zambia. *International Family Planning Perspectives,* 2002, 2:87-95.

de Keijzer B et al. (2002). Constructing new, gender-equitable identities: Salud y Género's work in Mexico." In: *Involving men to address gender inequities: three case studies.* Washington, DC, PRB for USAID's Interagency Gender Working Group.

DiMatteo MR. The physician-patient relationship: effects on the quality of health care. C*linical Obstetrics and Gynaecology,* 1994,1:149-161.

Fortney J, Smith JB eds. (1996). *The base of the iceberg: prevalence and perceptions of maternal morbidity in four developing countries.* Research Triangle Park, NC, Family Health International.

Goldberg HI, Toros A. The use of traditional methods of contraception among Turkish couples. *Studies in Family Planning,* 1994, 2:122-128.

Goodwin MM et al. Pregnancy intendedness and physical abuse around the time of pregnancy: findings from the pregnancy risk assessment monitoring system, 1996-1997. *Maternal and Child Health Journal,* 2000, 20:85-92.

Grasmuck S, Espinal R. Market success or female autonomy? Income, ideology, and empowerment among micro-entrepreneurs in the Dominican Republic. *Gender and Society,* 2000, 2:231-255.

Hardee K, Gould B. A process for service quality improvement in family planning. *International Family Planning Perspectives,* 1993, 4:147-152.

Henry K. Straight talk for youth: Ugandan girls and boys learning to escape gender stereotypes. *AIDScaptions,1995,* pp.32-33.

Hoang T et al. (2002). *Impact of the Cairo programme of action: gender, women's empowerment, and reproductive health in 4 Vietnamese communities.* Research Results Report. Hanoi, Vietnam, Population and Development International.

Huffman S et al. (2001). *Essential health sector actions to improve maternal nutrition in Africa.* Washington, DC, The LINKAGES Project.

Institute of Medicine (IOM) (1988). *Prenatal care reaching mothers, reaching infants.* Washington, DC, National Academy Press.

International Planned Parenthood Federation/Western Hemisphere Region (2000). *Manual to evaluate quality of care from a gender perspective.* New York. IPPF/WHR.

IPAS.www.ipas.org

Leynaert B, Downs AM, de Vincenzi I. Heterosexual transmission of Human Immunodeficiency Virus: variability of infectivity throughout the course of infection." European Study Group on Heterosexual Transmission of HIV. *American Journal of Epidemiology,* 1998, 148:88-96.

Loewenson R (2001). *HIV/AIDS implications for poverty reduction.* New York, United Nations Development Programme.

Mackey M (2000). *Improving nutrition and reproductive health: the importance of micronutrient nutrition.* Washington, DC, The Futures Group International.

Massoud R et al. (2001). *A modern paradigm for improving healthcare quality.* QA Monograph Series 1(1). Bethesda, MD, Published for the U.S. Agency for International Development (USAID) by the Quality Assurance Project.

Nyblade L et al. (2002) *Choosing between two stigmas: the complexities of childbearing in the face of HIV infection in sub-Saharan Africa.* Paper presented at the Annual Meeting of the Population Association of America, May 9-11, 2002.

Ojeda Gabriel (1998). *Profamilia centers for men.* Paper presented at the FAO/WHO/UNFPA Thematic Workshop on Male Involvement in Sexual and Reproductive Health Programmes. Rome, November 9-13, 1998.

Padian NS et al. Heterosexual transmission of Human Immunodeficiency Virus (HIV) in Northern California: results from a ten-year study. *American Journal of Epidemiology,* 1997, 146:350-357.

Population Council (2000). Love, sex, and abortion among unmarried youth in Ho Chi Minh City: implications for policy and programme interventions. Unpublished paper.

Quisumbing AR, Maluccio JA (1999). *Intrahousehold allocation and gender relations: new empirical evidence.* Working Paper Series No. 2, World Bank Development Research Group/Poverty Reduction and Economic Management Network. Washington, DC, World Bank.

Ransom E, Yinger N (2002). *Making motherhood safer: overcoming obstacles on the pathways to care.* Washington, DC, Population Reference Bureau.

Robey B et al. (1998). *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.

Schuler SR, Bates L, Islam MK. Reconciling cost recovery with health equity concerns in a context of gender inequality and poverty. *International Family Planning Perspectives,* 2002, 4:196-204.

Schuler SR, Choque ME, Rance S. Misinformation, mistrust, and mistreatment: family planning among Bolivian market women. *Studies in Family Planning,* 1994, 4:211-221.

Schuler SR et al. Barriers to the effective use of family planning services in Kathmandu. *Studies in Family Planning,* 1985, 16, no.5 :26-27.

Schuler SR, Hossain Z. Family planning clinics through women's eyes and voices: a case study from rural Bangladesh." *International Family Planning Perspectives,* 1998,4:170-175, 205.

Starrs A. *The safe motherhood action agenda: priorities for the next decade.* A report on the Safe Motherhood technical consultation in Sri Lanka, October 1997. New York, Family Care International in collaboration with the Inter-Agency Group for Safe Motherhood, 1998.

Stewart MK, Stanton CK, Ahmed O (1997). *Maternal health care.* DHS Comparative Studies, no. 25. Calverton, MD, Macro International, Inc.

Thomas D (1997). Incomes, expenditures, and health outcomes: evidence on intra-household resource allocation. In: Haddad L, Hoddinott J, Alderman H, eds, *Intra-household resource allocation in developing countries: models, methods, and policy.* Baltimore, MD, Johns Hopkins University Press.

United Nations (1999). *Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development, New York, United Nations* (A/S-21/5/Add.1). Accessed online at http://www.un.org/popin/unpopcom/32ndsess/gass.htm on July 8, 2005.

United Nations (2000). *World population prospects: the 2000 revision.* New York, United Nations Population Division.

UNAIDS, WHO (2004). *AIDS epidemic update 2004, UNAIDS/04.45E*. Accessed online at http://www.unaids.org/wad2004/EPIupdate2004_html_en/epi04_00_en.htm on July 8, 2005.

UNAIDS (2000). *Report on the global HIV/AIDS epidemic.* Accessed online on www.UNAIDS.org/epidemic_update/report, July 1, 2003.

United Nations Department of International Economics and Social Affairs (1991). *The world's women: trends and statistics 1970-90.* New York, United Nations.

Weiss E, Gupta GR (1998). *Bridging the gap. addressing gender and sexuality in HIV prevention.* Washington DC, International Centre for Research on Women.

Westoff CF (2001). *Unmet need at the end of the century.* Demographic and Health Surveys Comparative Reports no. 1. Calverton, MD, Macro International.

who.int/reproductive-health/strategic_approach/index.htm.

World Health Organization (WHO) (2005). *The World Health Report 2005: make every mother and child count*. Geneva, World Health Organization.

World Health Organization (WHO) (2004). *Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2000*. Geneva, World Health Organization.

World Health Organization (WHO) (1997). *Coverage of maternity care: a listing of available information, fourth edition.* Geneva, World Health Organization.

Appendix: Quick Reference Guide

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

Table A.1

Reproductive Health Outcomes of Interventions

Reproductive Health Outcomes	Interventions
Unintended Pregnancy	
Greater family planning use	Egypt—Husbands and Post-abortion Care Guatemala—Mayan-Language Educators in Gender and Family Planning India—Advocacy and Income Generation with Indian Women India—Better Life Options Programme Peru—Auto diagnosis Through the ReproSalud Project Turkey—Father's Role in Postpartum Family Planning
Lower fertility	India—Better Life Options Programme
Fewer adolescent pregnancies	Jamaica—Programme for Adolescent Mothers
Fewer child deaths	Bolivia—Warmi Project in Rural Bolivia India—Better Life Options Programme
Increase in age at marriage	India—Better Life Options Programme
Greater contraceptive knowledge	Brazil—Talking about Sexuality with Poor Urban Women Honduras—Reaching Men Through Agricultural Extension India—Pati Sampark: "Contacting the Husband" Mexico—Training-of-Trainers in Health and Empowerment Peru—Auto diagnosis Through the ReproSalud Project
Greater receptivity to family planning information	Zambia—Stimulating Dialogue Through Radio Shows
Maternal Mortality/Morbidity	
Lower maternal mortality	Bolivia—Warmi Project in Rural Bolivia
Increase in skilled obstetrical care	Bolivia—Warmi Project in Rural Bolivia India—Advocacy and Income Generation with Indian Women India—Better Life Options Programme Peru—Auto diagnosis Through the ReproSalud Project
Men's knowledge of wives' antenatal care	India—Pati Sampark: "Contacting the Husband"
Better post-abortion recovery	Egypt—Husbands and Post-abortion Care
Fewer obstetrical complications	Botswana—Female Relative Support in Labour
Better nutrition	India—Better Life Options Programme Mexico—Training-of-Trainers in Health and Empowerment
Greater knowledge of warning signs in pregnancy	Honduras—Reaching Men Through Agricultural Extension Mexico—Training-of-Trainers in Health and Empowerment Peru—Auto diagnosis Through the ReproSalud Project

Table A.1

Reproductive Health Outcomes of Interventions (continued)

Reproductive Health Outcomes	Interventions
STIs/HIV/AIDS	
Lower STIs	India—Organizing Sex Workers in Sonagachi and Beyond South Africa—Talking about Violence as a Barrier to Condom Use
Greater knowledge of STI symptoms	Honduras—Reaching Men Through Agricultural Extension Peru—Autodiagnosis Through the ReproSalud Project
Greater condom use	India—Better Life Options Programme India—Organizing Sex Workers in Sonagachi and Beyond Mexico—Training-of-Trainers in Health and Empowerment Senegal—Strengthening Traditional Women's Associations South Africa—Talking about Violence as a Barrier to Condom Use U.S. Low-resource—Sexual Negotiation Skills Among Inner-City Women
Greater knowledge of HIV/AIDS transmission and prevention	Brazil—Integrating STI/HIV Prevention into Family Planning Services Brazil—Peer Education among Adolescent Girls Guatemala—Educating Prenatal Clients on STIs/HIV Honduras—Reaching Men Through Agricultural Extension India—Advocacy and Income Generation with Indian Women India—Better Life Options Programme India—Organizing Sex Workers in Sonagachi and Beyond Mexico—Training-of-Trainers in Health and Empowerment Senegal—Strengthening Traditional Women's Associations Thailand—Peer Education with Factory Workers
Quality of Care	
Increased clinic visits	Peru—Auto diagnosis Through the ReproSalud Project Peru—Female Providers at MaxSalud
Improved client-provider interaction	Indonesia—Smart Patient Programme

Table A.2

Gender Outcomes of Interventions Highlighted in This Review

Gender Outcomes	Interventions
Higher scores on empowerment scale	Mexico—Training-of-Trainers in Health and Empowerment
Increase in equitable gender attitudes and awareness of rights	Brazil—Peer Education among Adolescent Girls Brazil—Talking about Sexuality with Poor Urban Women India—Advocacy and Income Generation with Indian Women India—Better Life Options Programme Jamaica—Programme for Adolescent Mothers Peru—Auto diagnosis Through the ReproSalud Project Senegal—Strengthening Traditional Women's Associations Thailand—Peer Education with Factory Workers
Women's increased mobility	India—Better Life Options Programme
Increase in women's willingness to protest or seek help for domestic violence	India—Advocacy and Income Generation with Indian Women Peru—Auto diagnosis Through the ReproSalud Project
Women's increase in literacy	India—Better Life Options Programme
Greater formal education for women or girls	India—Better Life Options Programme Jamaica—Programme for Adolescent Mothers
Increase in women's participation or leadership roles in the community	Bolivia—Warmi Project in Rural Bolivia India—Advocacy and Income Generation with Indian Women India—Better Life Options Programme Zambia—Stimulating Dialogue Through Radio Shows
Women's greater self-confidence or self-esteem	Brazil—Peer Education Among Adolescents India—Better Life Options Programme Jamaica—Programme for Adolescent Mothers Zambia—Stimulating Dialogue Through Radio Shows
Women's greater decision-making power	India—Better Life Options Programme Peru—Auto diagnosis Through the ReproSalud Project
Greater partner communication about reproductive/sexual health or family planning	Brazil—Integrating STI/HIV Prevention into Family Planning Services Guatemala—Educating Prenatal Clients on STIs/HIV Honduras—Reaching Men Through Agricultural Extension Peru—Auto diagnosis Through the ReproSalud Project
Increase in women's sexual negotiation skills	U.S. Low-resource—Sexual Negotiation Skills Among Inner-City Women
Increase in women earning income	India—Better Life Options Programme
Greater support (emotional, instrumental, family planning, or general support) from partners	Egypt—Husbands and Post-abortion Care Guatemala—Mayan-Language Educators in Gender and Family Planning Honduras—Reaching Men Through Agricultural Extension
Women's greater assertiveness in client-provider interactions	Indonesia—Smart Patient Programme

THE INTERAGENCY GENDER WORKING GROUP (IGWG), established in 1997, is a network comprising non-governmental organzations (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) programmes with the goal of improving reproductive health/ HIV/AIDS outcomes and fostering sustainable development. For more information, go to **www.igwg.org**.

The **WORLD HEALTH ORGANIZATION** (WHO), the United Nations specialized agency for health, was established on 7 April 1948. WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. For more information, go to **www.who.int**.

For additional copies contact:
Population Reference Bureau
1875 Connecticut Ave., NW, Suite 520
Washington, DC 20009-5728
www.prb.org
phone: (202) 483-1100
fax: (202) 328-3937
email: prborders@prb.org

Department of Gender, Women and Health
Family and Community Health
World Health Organization
Avenue Appia 20
CH-1211 Geneva 27
Switzerland
www.who.int/gender/
email: genderandhealth@who.int