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# TRANSFORMING GENDER NORMS, ROLES, AND POWER DYNAMICS FOR BETTER HEALTH



*Evidence from a  
Systematic Review  
of Gender-integrated  
Health Programs in  
Low- and Middle-  
Income Countries*

This publication was prepared by Arundati Muralidharan,<sup>1</sup> Jessica Fehringer,<sup>2</sup> Sara Pappa,<sup>3</sup> Elisabeth Rottach,<sup>3</sup> Madhumita Das,<sup>4</sup> and Mahua Mandal.<sup>2</sup>

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The International Center for Research on Women is an applied research institute focused on women and girls. It is headquartered in Washington, DC, and has a regional office in New Delhi.

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**SEPTEMBER 2015**

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## EXECUTIVE SUMMARY

The Gender, Policy and Measurement program, funded by the Asia bureau of the United States Agency for International Development, undertook a comprehensive, systematic review of the impact of gender-integrated programs on health outcomes. The findings are primarily intended to inform the work of government officials, donors, nongovernmental organizations, and other key stakeholders involved in health programming in India, as well as other low- and middle-income countries around the world. The *Transforming Gender Norms, Roles, and Power Dynamics* review is guided by the perspective that all health programs must employ evidence-based strategies that promote gender equity and empower women and men to achieve better health.

This review presents evidence showing how gender-integrated programming influences health outcomes in low- and middle-income countries: in particular, reproductive, maternal, neonatal, child, and adolescent health (RMNCH+A); HIV prevention and AIDS response; gender-based violence (GBV); tuberculosis (TB); and universal health coverage (UHC). We were guided by the following objectives:

- Assess the extent to which gender-integrated health programs accommodate or transform gender norms, roles, and relationships.
- Identify gender-accommodating and gender-transformative strategies in health programs.
- Understand how gender-integrated programs impact RMNCH+A, HIV and AIDS, GBV, TB, and UHC outcomes.
- Identify quantitative and qualitative methodologies used to evaluate gender-integrated health programs.

The review process consisted of five steps:

1. An evidence review committee was constituted to lead the review.
2. Pertinent articles were sought in online databases, organizational and conference websites, peer-reviewed journals, sourced bibliographies, and key informant interviews.
3. The evidence review committee assessed the relevance of these articles using established criteria.
4. The committee abstracted data from the relevant articles according to key criteria on program design/content, evaluation methodology, health and gender outcomes, and scale-up. At this time, the articles were also rated on the strength of the evidence they presented.
5. The committee analyzed the data and reported the results.

Programs were categorized as “gender-transformative” if they facilitated critical examination of gender norms, roles, and relationships; strengthened or created systems that support gender equity; and/or questioned and changed gender norms and dynamics. They were categorized as “gender-accommodating” if they recognized and worked around or adjusted for inequitable gender norms, roles, and relationships.

A total of 145 relevant gender-aware programs in low- and middle-income countries were identified, with the number of transformative programs (n = 88) exceeding accommodating programs (n = 57). Almost one-third of these programs were implemented in South Asia, mostly in India. Gender integration was strongest for HIV, GBV, and adolescent health programs; a considerable number of these programs used gender-transformative strategies. Gender integration was weak for tuberculosis and UHC programs. Gender-aware programs were often targeted in their approach and implemented in community settings. A vast majority of these interventions were designed and implemented by nongovernmental organizations,

and there was limited evidence of interventions that had been scaled up or integrated into government programs.

Gender-aware programs used one or more of the following five strategies:

1. Challenge gender norms and inequalities that impede access to health services and healthy behaviors.
2. Promote equitable relationships and decision making.
3. Empower girls and women through economic opportunities, education, and collective action.
4. Adjust health systems to address barriers to health information and health services.
5. Involve the community to disseminate information and support behavior change.

Overall, gender-aware programs improved health status, health behaviors, and health knowledge. Several transformative programs went further, shaping gender-equitable attitudes, increasing the frequency of joint decision making by men and women, and increasing women's self-confidence and self-efficacy.

A range of quantitative and qualitative designs were used to evaluate gender-aware programs, including randomized controlled trials (N = 25), quasi-experimental studies (N = 57), and nonexperimental studies (N = 47). Some evaluations employed both quantitative and qualitative methods, largely to supplement and confirm survey findings (N = 69). Seventeen interventions used only qualitative methods. Some programs used quantitative or qualitative tools to measure gender outcomes. Eighteen evaluations specifically sought to measure the added value of a gender approach to health outcomes. Notably, only a small number of evaluations measured program effects over time.

This review provides evidence of the most effective gender-integrated strategies used by programs in low- and middle-income countries worldwide. Its results underscore the need to conduct gender analysis in order to understand how health needs and behaviors differ among women, men, and transgender people; to identify evidence-based strategies that respond to and mitigate the specific gender barriers faced by these groups; and to incorporate these strategies into programs. To promote these programs' sustainability and widespread reach, gender-aware strategies should be integrated and scaled up through government health systems in collaboration with nongovernmental organizations and other private sector partners.



## ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
AYH	adolescent and youth reproductive health
ERC	evidence review committee
GBV	gender-based violence
GEM	Gender Equitable Men scale
GPM	Gender, Policy and Measurement
HIV	human immunodeficiency virus
HTSP	healthy timing and spacing of pregnancy
ICRW	International Center for Research on Women
IGWG	Interagency Gender Working Group
IIPS	International Institute for Population Sciences
IPV	intimate partner violence
LMICs	low- and middle-income countries
MSM	men who have sex with men
NGO	nongovernmental organization
NCHN	neonatal and child health and nutrition
PMTCT	prevention of mother-to-child transmission
RCT	randomized controlled trials
RMNCH+A	reproductive, maternal, neonatal, child, and adolescent health
SBCC	social and behavior change communication
SM	safe motherhood
STI	sexually transmitted infection
TB	tuberculosis
TG	transgender
UHC	universal health coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development



# INTRODUCTION

## Background

The Gender, Policy and Measurement (GPM) program, funded by the Asia bureau of USAID, is collaborating with USAID health programs and other partners in the Asia region to strengthen programs in family planning and maternal, neonatal, and child health.

As part of this effort, USAID/India commissioned GPM to review the published and unpublished literature on the impact of gender-integrated programs on health outcomes. The review's findings are primarily intended to inform donors, nongovernmental organizations (NGOs), government officials, and other key stakeholders involved in health programming in India. However, because the review was comprehensive and global in scope, it can also serve to inform programming efforts in other countries. Given the review's structure and process—with the first phase focusing on evidence from South Asia and the second phase focusing on global evidence—the findings are presented as a comparison between South Asia and other low- and middle-income countries (LMICs).<sup>1</sup>

## Context

The international development community increasingly recognizes the influence of gender on health outcomes. As a result, international organizations such as the World Health Organization and the United Nations have advocated integrating strategies to address men's and women's needs and concerns in health programs and policies. Unlike a person's sex, which is physiological, gender is determined by society's views of the appropriate roles and behaviors for women and men (World Health Organization, 2014b). Gender norms in a given society can lead to differences between females and males in social position and power, access to resources and services, and health-related behaviors.

Gender norms play a powerful role in shaping the futures of adolescent girls and boys. In LMICs generally, adolescent girls face a multitude of challenges, including inadequate access to education, poor nutrition, early marriage, and low social status (United Nations Children's Fund, or UNICEF, 2011). In India, adolescent girls are becoming increasingly vulnerable to HIV infection and have less comprehensive knowledge of the disease than their male peers (International Institute for Population Sciences [IIPS] and Macro International, 2007). Gender disparities in HIV prevalence are also seen in eastern and southern Africa, where girls are at a far greater risk for infection (UNICEF, 2011). Adolescent boys face their own health risks when they seek to conform to prescribed gender norms. For example, risk taking to prove masculinity may manifest in sexually high-risk behavior, substance abuse and alcohol use, or violence against others (Barker et al., 2007; UNICEF, 2011). Moreover, many young men perceive condom use as emasculating, leading them to engage in unsafe sexual practices (Abdool Karim et al., 1992).

Conforming to prescribed norms around masculinity can also put the health of adult men at risk. For example, men who derive their self-esteem and social status from their sexual relationships with multiple partners have a higher risk of acquiring HIV (Brown et al., 2005; Price and Hawkins, 2002). Furthermore, men may perceive seeking HIV treatment services as a sign of weakness and a threat to their manhood (Nyamhanga et al., 2013; Skovdal et al., 2011). Similarly, men with tuberculosis (TB) may avoid treatment. According to studies in South Asia, where TB is often equated with job loss and an inability to provide for the family, fear of financial trouble and shame discourage men from seeking treatment (Ahsan et al., 2004; Atre et al., 2004; Begum et al., 2001; Karim et al., 2008; Karim et al., 2007; Qureshi et al., 2008).

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<sup>1</sup> LMICs are classified here according to the World Bank's country and lending groups scheme. See <http://data.worldbank.org/about/country-and-lending-groups>.

In households and communities, power dynamics between women and men can affect health for ill or good. In families, men often control decisions about the health of their wives and children, including the family's use of health services (IIPS and Macro International, 2007). For example, studies in Ethiopia and Iran have found a link between husbands' approval and women's use of modern contraception and maternal and child health services (Mohammed et al., 2014; Rahnama et al., 2010). In contrast, studies throughout South Asia have shown that women's greater decision-making autonomy translates into greater use of maternal and child health services and positive health outcomes (Allendorf, 2010; Haque, 2012; Shroff, 2011).

Power inequalities can lead to more severe forms of control, such as gender-based violence (GBV). GBV manifests in many forms and can occur across the entire life cycle, from sex-selective abortion to intimate partner violence (IPV) (Interagency Gender Working Group [IGWG], 2014). In South Asia, GBV is a serious problem, with significant human, economic, and social consequences. It transcends socioeconomic groups and a culture of silence persists, as women are socialized to accept and tolerate it, particularly when inflicted by their intimate partners. Slightly more than one-third of women in India report having experienced violence at some point after the age of 15, most often at the hands of a husband or other intimate partner (IIPS and Macro International, 2007). Globally, 35 percent of women report having experienced either IPV or nonpartner sexual violence at some point in their lives. On average, 30 percent of women who have been in a relationship report experiencing some form of physical or sexual violence, inflicted by their partner (World Health Organization, 2013). Many barriers deter women from reporting instances of violence, such as reliance on their family or husband's family for help in addressing violence, costs associated with seeking services, poor quality of care, and fear of violent reprisals or loss of financial support (McCleary-Sills et al., 2013). Along with the psychological and social consequences, GBV and IPV contribute to low use of reproductive and maternal health services (Rahman et al., 2012a), adverse child health outcomes (Rahman et al., 2012b; Silverman et al., 2011), and increased risk of HIV and other sexually transmitted infections (STIs) among both survivors and male perpetrators (Dunkle et al., 2006; Jewkes et al., 2010; Population Reference Bureau, 2010; Silverman et al., 2008; Townsend et al., 2011).

Traditional practices can reinforce gender inequalities at the community level, creating more barriers to positive health outcomes. Early marriage, for example, can be extremely detrimental to the health of young women and girls. Even though marriage before the age of 18 is illegal in Bangladesh, India, and Nepal, among other countries, the prevalence of early marriage is high (Plan International and International Center for Research on Women [ICRW], 2013). Reacting to financial pressure, parents may marry off their daughters at young ages, thus truncating the girls' educational attainment (Plan International and ICRW, 2013). Early marriage increases the probability of early childbearing, which impacts the health of the mother as well as the baby and is associated with many social, economic, and emotional consequences (Mahotra et al., 2011; Plan International and ICRW, 2013). Furthermore, adolescent girls forced into early marriage often have little knowledge of reproductive health, and gender norms that restrict mobility hinder their access to health services (IIPS and Macro International, 2007; Pande et al., 2006a; Plan International and ICRW, 2013). The existence of early marriage is strongly linked to low contraceptive use, high fertility rates, unwanted pregnancies, unsafe abortions, and increased incidence of GBV (Diamond-Smith et al., 2008; Kaye et al., 2005; Rastogi and Therly, 2006). Female genital mutilation, another harmful traditional practice, is common in the Middle East and Africa, where UNICEF estimates that more than 125 million girls and women alive today have been cut (UNICEF, 2013). Female genital mutilation is deeply rooted in gender inequality and carries with it serious consequences, including severe bleeding, problems urinating, infections, cysts, infertility, complications in childbirth, and an increased risk of newborn deaths (World Health Organization, 2014a).

Empowerment, particularly through formal or informal education, can protect women's sexual and reproductive health. It introduces them to the information and skills necessary to take control of their own

health and the health of their children (Adhikari, 2010). Globally, numerous studies link higher educational attainment to a host of positive health outcomes: for example, use of maternal health services, reducing the risk of maternal mortality and morbidity (Ochako et al., 2011; Paredes et al., 2005; Ribeiro et al., 2009; Yesuf and Calderon-Margalit, 2013); use of family planning, and modern methods in particular (Ibnouf et al., 2007); and greater reproductive health knowledge, which among other things makes sexual debut in adolescence less likely (Thin Zaw et al., 2013).

In low-resource settings, however, adolescent girls may have limited access to education. Long distances, insecure travel routes, and inadequate facilities for girls to manage menstruation can deter girls from attending school. Examples of other barriers are the costs associated with schooling and the perception that girls' education is of little value (Garg et al., 2012; Mahon and Fernandes, ND; Plan International and ICRW, 2013).

For people who do not conform to traditional gender roles and norms, the effects of gender on health can be particularly acute. In many countries, transgender persons also face immense barriers to HIV services and treatment, mainly due to stigma and discrimination (Beattie et al., 2012; PAHO, 2013). For example, a study in Chennai, India, of *kothi*-identified<sup>2</sup> men who have sex with men (MSM) and *hijras*, or transgender women, found HIV stigma, sexual prejudice, and fears about the consequences of disclosure to be powerful barriers to seeking treatment (Chakrapani et al., 2011). As a result, transgender persons are more likely to engage in unprotected sex and have little knowledge of the risks of acquiring HIV and other STIs that are associated with various sexual practices (Newman et al., 2012; Richter et al., 2013; Vu et al., 2012). Although the health barriers and needs of transgender populations have attracted increasing attention, the literature focuses on male-to-female transgender persons (Kenagy and Hsieh, 2005). Literature on the needs of female-to-male transgender persons in the developing world is virtually nonexistent, pointing to the lack of recognition of this transgender group.

MSM who are not transgender also face many barriers to prevention, testing, and treatment services for HIV (e.g., fear of a positive test result, stigma, and the discriminatory attitudes of healthcare staff) (Beattie et al., 2012; Bengtsson et al., 2014; Geibel et al., 2008; Mumtaz et al., 2010; Nagaraj et al., 2013). Experiences by MSM of physical and sexual violence are also significantly associated with high-risk sexual behavior and increased risk for HIV infection (Deuba et al., 2013; Dunkle et al., 2013).

Finally, much of the global health literature on sexual minority populations focuses on HIV and overlooks the broader needs of these groups for vital health services.

Recognizing how gender influences health is key to positive health outcomes. The impact of gender on the health of women, men, girls, and boys reaches across a wide spectrum of social, economic, and health issues—from the influence of education and income on a woman's ability to seek antenatal care to the effects of norms around masculinity on men's sexual health risks. Furthermore, conceptualizing gender and health requires surpassing traditional ideas of gender and considering the unique needs of transgender and other sexual minority groups.

## Rationale

Gender-integrated programs recognize the influence of gender roles and norms on health access, use, and subsequent health outcomes. They actively promote gender equity by addressing and/or transforming those roles and norms through their design, implementation, and monitoring and evaluation strategies. This review is guided by the perspective that all health programs must employ evidence-based strategies that promote gender equity and empower women and men to achieve better health. Reproductive health

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<sup>2</sup> “In Chennai, *kothis* are a relatively visible subgroup of MSM whose gender expression is feminine. *Kothis* are primarily receptive partners in anal sex, and a significant proportion engage in sex work” (Chakrapani et al., 2011, p.1,687).

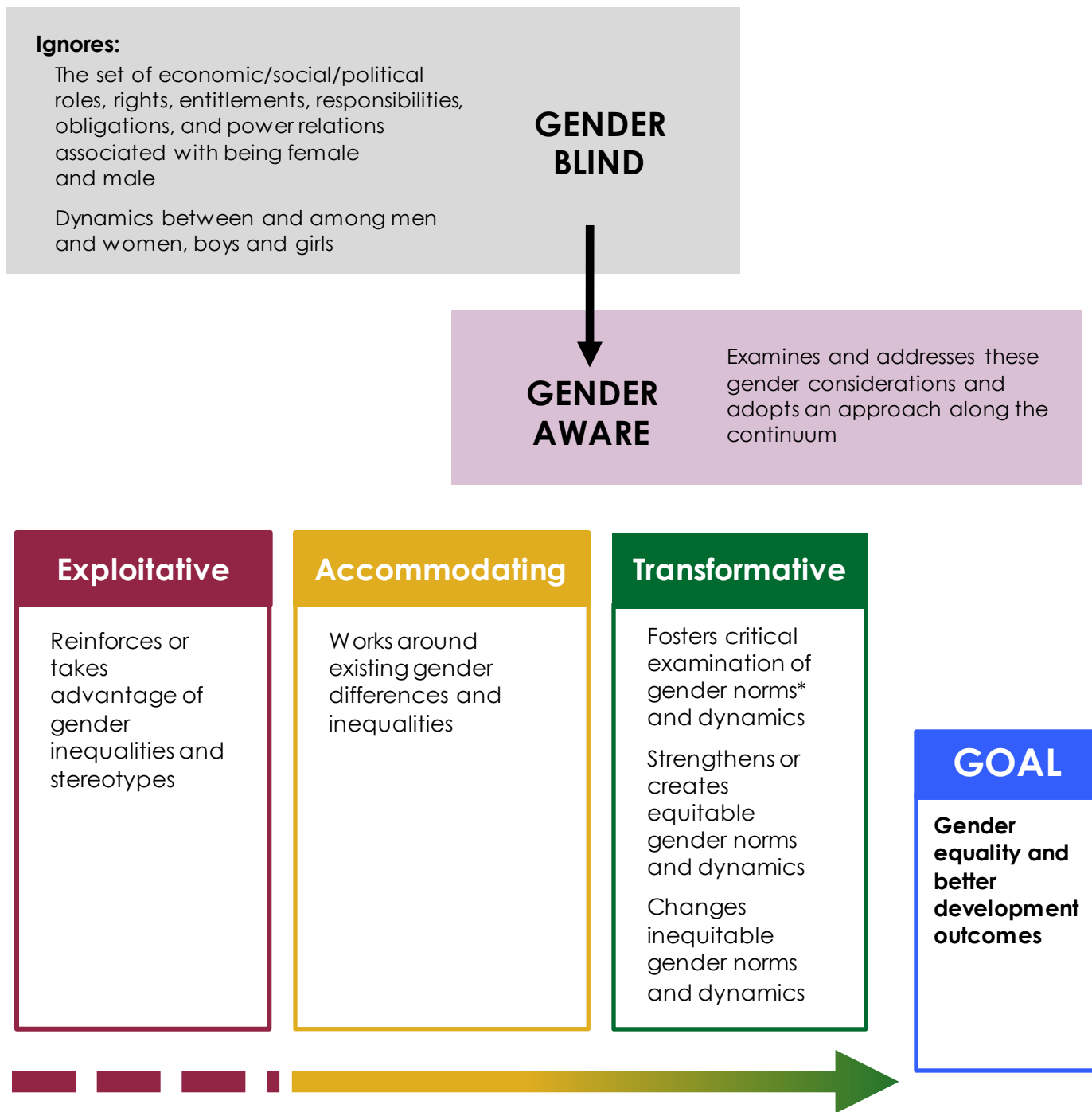
programs, which have historically taken the lead in applying gender-focused strategies, exemplify this thinking. This review builds on earlier evidence (Boender et al., 2004; Rottach et al., 2009) to examine the published and unpublished literature on gender-integrated programs that respond to key and emerging health issues in LMICs.

## **Aim**

This study reviews the evidence of how gender-integrated programming influences reproductive, maternal, neonatal, child, and adolescent health (RMNCH+A); HIV; GBV; TB; and universal health coverage (UHC) outcomes in LMICs across the globe, with a focus on India. In doing so, the review seeks to identify effective gender strategies. These in turn may inform countries' programming efforts and policy initiatives, equipping stakeholders with the knowledge and skills to identify entry points in current and ongoing programs and policies for integrating gender. The study's findings are organized according to the following overarching objectives:

1. To assess the extent to which gender-integrated health programs in LMICs accommodate or transform gender norms, roles, and relationships
2. To identify gender-accommodating and gender-transformative strategies in health programs in LMICs (as defined in Figure 1)
3. To understand how gender-integrated programs impact RMNCH+A, HIV, AIDS, GBV, TB, and UHC outcomes
4. To identify the quantitative and qualitative methods used to evaluate gender-integrated health programs

**Figure 1. Gender Equality Continuum Tool<sup>3</sup>**



\* Norms encompass attitudes and practices

\* System consists of a set of interacting structures, practices, and relations

<sup>3</sup> Source: Interagency Gender Working Group (IGWG). 2013. Adapted from Geeta Rao Gupta, “Gender, Sexuality and HIV and AIDS: The What, The Why and The How” (Plenary Address at the XIII International AIDS Conference), Durban, South Africa: 2000; Geeta Rao Gupta, Daniel Whelan, and Keera Allendorf, “Integrating Gender into HIV and AIDS Programs: Review Paper for Expert Consultation, 3–5 June 2002,” Geneva: World Health Organization, 2002.

## METHODOLOGY

The review was conducted in two phases from July 2013 through March 2014. Phase I focused on gender-integrated programs in eight South Asian countries, with a specific focus on India. Phase II considered programs in all other LMICs. Additionally, key informant interviews with organizations implementing or researching gender-integrated programs in India were conducted to corroborate and add to review findings. These interviews were conducted only in India, because the study's primary goal was to inform programming efforts. The review process consisted of the following six steps (see Annex A for more details on methods):

1. An evidence review committee (ERC), made up of members of the GPM team, was formed to lead the review.
2. Systematic searches were conducted for relevant articles and program documents from South Asian countries and other LMICs.
3. The relevance of articles and program documents was assessed to determine eligibility for review.
4. Data were abstracted from relevant articles and program documents.
5. The strength of this evidence on gender integration was then assessed.
6. The results were analyzed and reported.

## Inclusion Criteria

Programs or interventions selected for inclusion in this review had to meet the following criteria:

- Be implemented in a low- and middle-income country (according to the World Bank's classification)
- Be gender-aware (see the definition in Figure 1)
- Measure one or more of the following health outcomes: RMNCH+A (including nutrition); HIV and other STIs (including prevention of mother-to-child transmission, or PMTCT); GBV; TB; and UHC
- Include an evaluation component<sup>4</sup>

We used the gender equality continuum tool, developed by the IGWG, to define and classify programs according to the approach they take to gender integration. The term “gender-blind” refers to programs that do not demonstrate awareness of the set of roles, rights, responsibilities, and power relations associated with being male or female. “Gender-aware” programs, in contrast, examine and address gender considerations and can be exploitative, accommodating, or transformative. “Gender-exploitative” approaches are unacceptable. They exacerbate existing gender inequalities, taking advantage of gender inequalities in order to reach a program goal. “Gender-accommodating” approaches recognize gender norms and inequalities and work the intervention around the gender barriers. A “gender-transformative” intervention recognizes gender norms and inequalities, challenges and addresses them, and seeks solutions to overcome them by empowering women, men, girls, and boys, as well as sexual minorities such as transgender persons and MSM.

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<sup>4</sup> Program descriptions or lessons learned were accepted for India-based gender-aware programs. These documents did not require an evaluation but were used instead to enrich understanding of program implementation processes and trends. They were not factored into the relevancy counts nor were they part of the data analysis.



Often, programs will use a combination of transformative and accommodating strategies. The ERC classified a program as accommodating or transformative based on the dominant approach used. Because gender norms are context-specific, a gender strategy may be accommodating in one area and transformative in another. The continuum of gender equality is useful not only to categorize approaches but also to demonstrate the range of approaches available to policymakers and programmers.

## Health and Gender Outcomes

The health and gender outcomes reported here are those that emerged from the literature review, plus those listed in two earlier studies of the links between gender and reproductive health (Boender et al., 2004; Rottach et al., 2009). The health outcomes of primary interest are those related to health status, behaviors, practices, attitudes, and knowledge.

A total of 196 documents from peer-reviewed journals and the gray literature, covering 145 gender-integrated programs in LMICs, were found to be relevant and selected for data abstraction (see Figure 2). The review found that many programs jointly addressed and achieved outcomes in two or more health areas. For instance, a program may have impacted not only HIV outcomes but also GBV outcomes. Such cross-cutting interventions are considered in each of the health areas they address.

This report classifies outcomes in terms of their direct or indirect impact on health or gender. For example, attitudes toward early marriage may directly impact health because early childbearing increases many maternal and neonatal health risks. In contrast, attitudes toward girls' education have an indirect impact on health. This is because an intervention that promotes positive attitudes toward girls' education may lead parents to enroll or keep their daughters in school, thus delaying or avoiding early marriage and, in turn, the health risks of early childbearing.

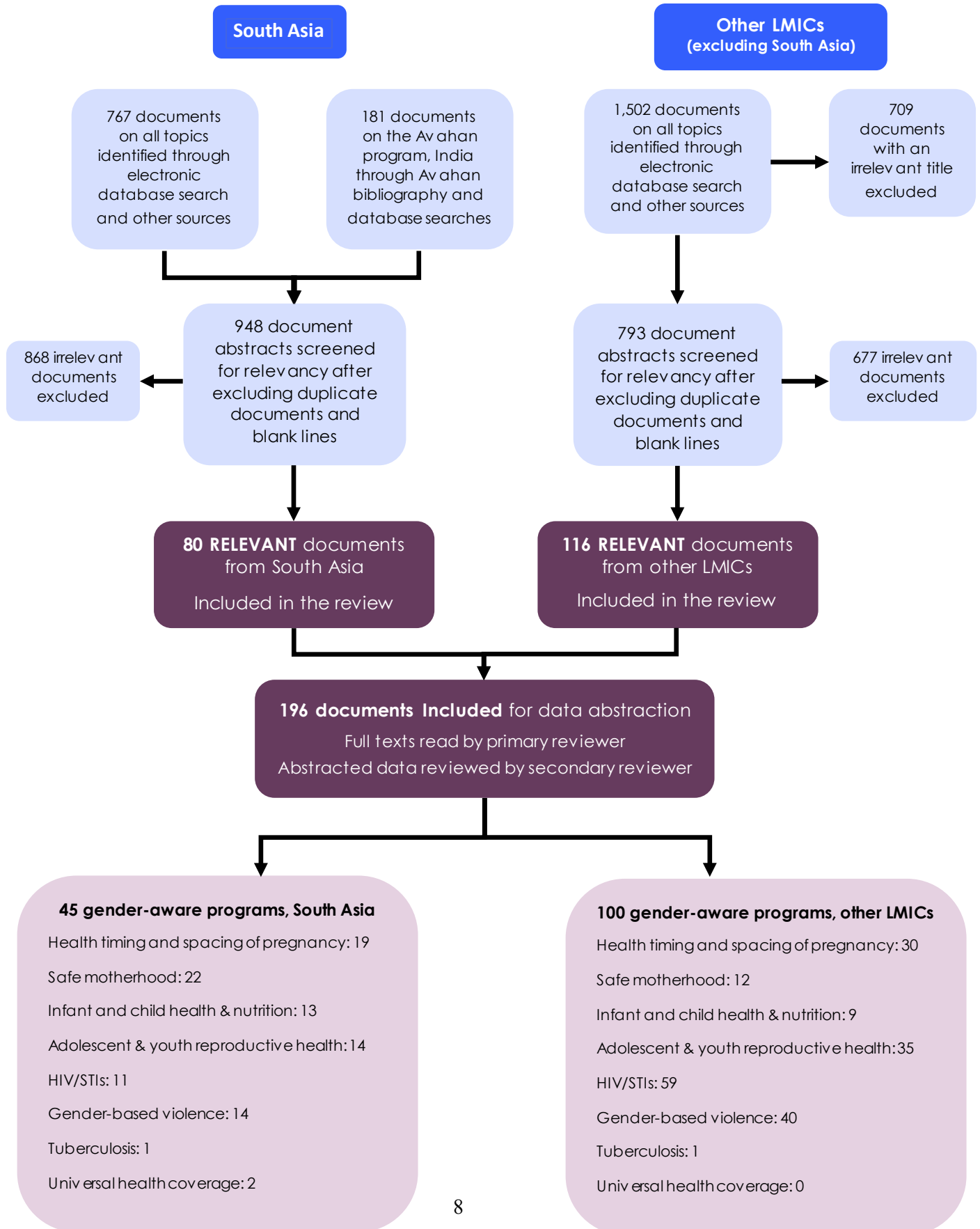
## Strength of Evidence

The ERC developed a scale to rate the strength of evidence for each intervention, drawing on an earlier published framework (Barker et al., 2007). Using this adapted scale (detailed in Annex A, Table 2), two reviewers independently assessed the interventions in terms of the following two rating points:

1. Rigor of evaluation design: rigorous, moderate, or limited
2. Level of impact: high, moderate, low, or mixed

The committee then averaged these assessments to arrive at an overall rating: effective, promising, or unclear.

**Figure 2: Results of Document Search and Relevancy Review**



## FINDINGS

The results of the systematic review are organized by four key objectives and are presented as comparisons between South Asia and all other LMICs across five regions (East Asia and the Pacific, Europe and Central Asia, Latin America and the Caribbean, the Middle East and North Africa, and sub-Saharan Africa).

### **Objective 1: Assess the Extent to Which Gender-integrated Health Programs in Low- and Middle-Income Countries Accommodate or Transform Gender Norms, Roles, and Relationships**

To accomplish this objective, we determined the proportion of gender-transformative and -accommodating programs affecting change in a given aspect of health and noted relevant implementation trends.

#### **Key result 1.1: Majority of gender-aware programs were transformative**

In LMICs across all six regions, 145 gender-aware programs were identified, and transformative programs (n = 88) outnumbered accommodating programs (n = 57). This trend holds true for South Asian countries, where transformative programs accounted for almost two-thirds of the 45 gender-aware programs in the region (see Table 1). Most of the programs excluded from the review were gender-blind: that is, they did not meet the study's criteria for awareness of gender considerations or power dynamics (see Annex A). The review found no examples of programs that were gender-exploitative.

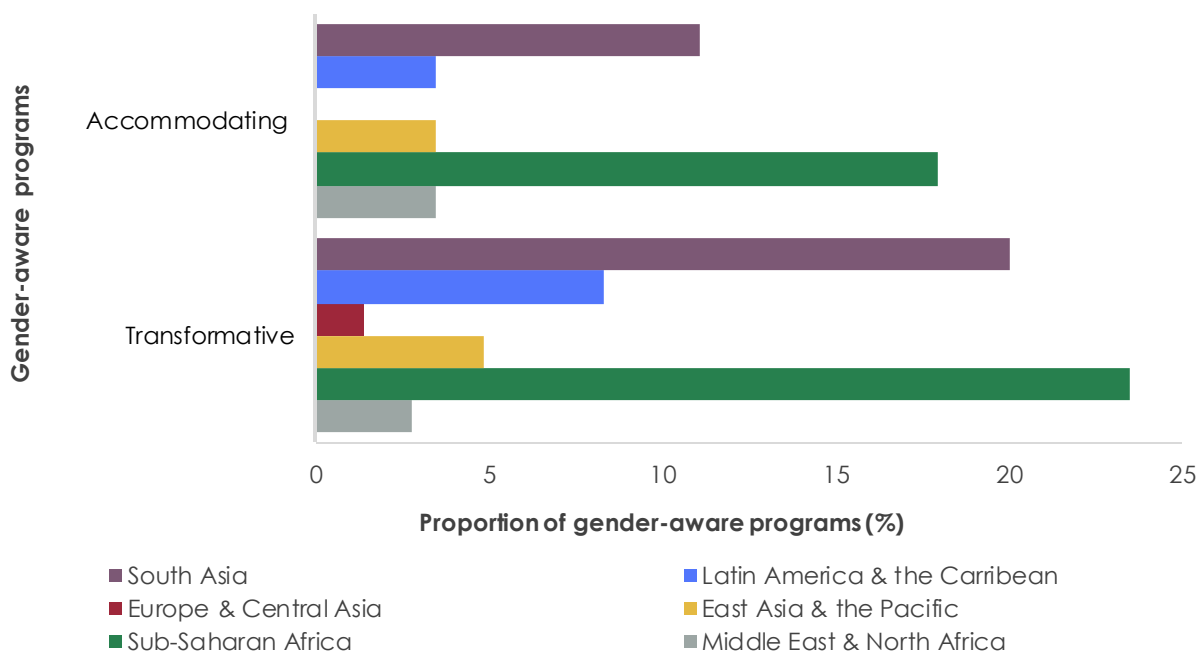
**Table 1. Number of Gender-integrated Programs in Low- and Middle-income Countries**

Region	Accommodating	Transformative	Total
East Asia & the Pacific, Europe & Central Asia, Latin America & the Caribbean, the Middle East & North Africa, and Sub-Saharan Africa	41 (41%)	59 (59%)	100
South Asia	16 (36%)	29 (64%)	45
<b>Global Total</b>	<b>57</b> <b>(39%)</b>	<b>88</b> <b>(61%)</b>	<b>145</b>

**Key result 1.2: The majority of gender-integrated programs were implemented in sub-Saharan Africa and India**

Figure 3 offers a detailed view of the programs’ geographic distribution.

**Figure 3. Gender-aware Programs by Geographic Region**



Gender-aware programs in sub-Saharan African countries were found mostly in South Africa, Kenya, Tanzania, and Uganda. Many of these programs addressed HIV prevention, a significant health priority for the region. In South Asia, India was clearly leading the way (see Box 1), implementing close to three-quarters of the gender-aware programs and affecting nearly the full range of health outcomes assessed in the review, with the exception of UHC and TB, where limited interventions were identified.

**Box 1: Gender-aware Programs in South Asia**

**Transformative**  
 India: 23  
 Bangladesh: 3  
 Nepal: 2  
 Afghanistan: 1

**Accommodating**  
 India: 9  
 Bangladesh: 2  
 Nepal: 2  
 Pakistan: 3

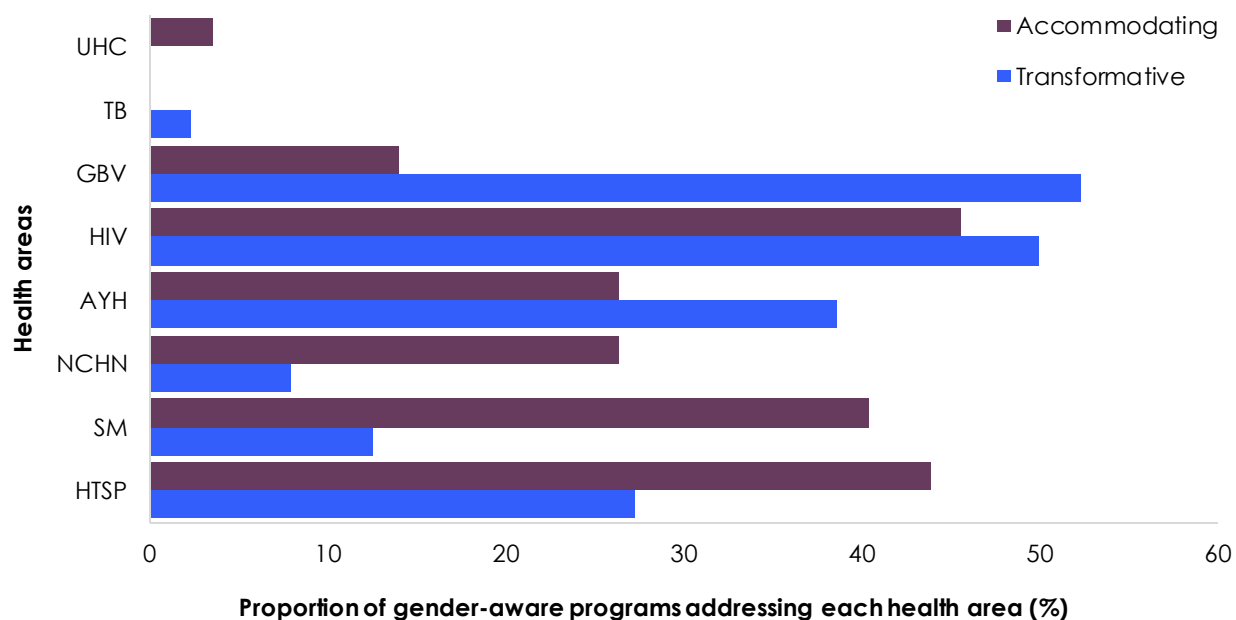
**No gender-aware programs**  
 Bhutan  
 Sri Lanka  
 Maldives

**Key result 1.3: Gender integration was strongest for HIV, GBV, and adolescent and youth reproductive health programs**

The review assessed the strength of gender integration by comparing the proportion of gender-transformative and -accommodating programs resulting in positive outcomes—changes in health status, health-related behavioral or attitudinal changes, or changes in health knowledge—in a given health area. The higher the proportion of transformative programs compared with accommodating programs, the greater the strength of integration. Gender integration was strongest for HIV and GBV programs, where approximately half of all gender-aware programs that addressed HIV or GBV used gender-transformative strategies. Other health areas with high proportions of transformative programs were adolescent and youth reproductive health (AYH). For safe motherhood (SM), healthy timing and spacing of pregnancy (HTSP), and neonatal and child health and nutrition (NCHN), gender integration was found to be moderate, with accommodating programs outnumbering

transformative ones. Gender integration was weak for TB and UHC: in all LMIC countries, only two gender-aware programs focused on TB and two focused on UHC. Figure 4 presents both accommodating and transformative programs by health area.

**Figure 4: Trends in Gender-integrated Health Programs by Strength of Gender Integration (LMICs Across All Six Regions)**



Regional differences in the health areas addressed by gender-transformative and -accommodating programs exist (see Box 2). In the five LMIC regions excluding South Asia, a considerable proportion of gender-aware programs were implemented to reduce HIV-related risk factors, a leading health concern in sub-Saharan Africa. To a lesser extent, programs also aimed to promote equitable gender norms to counter GBV, encourage HTSP (for example, contraceptive use), and reduce harmful practices that undermine adolescent health. In South Asia, starker differences were evident in the types of health areas addressed by transformative and accommodating programs. Fewer programs addressed HIV at all in South Asia than in the other LMIC regions. Transformative programs in this region focused on GBV, AYH, and HTSP; accommodating programs more commonly focused on SM and NCHN.

**Box 2: Main Health Areas Addressed by Gender-transformative and -accommodating Programs, by Region**

**Transformative programs**  
 South Asia: GBV, AYH, HTSP  
 Other LMICs: HIV, GBV, HTSP, AYH

**Accommodating programs:**  
 South Asia: SM, NCHN  
 Other LMICs: HIV, HTSP, AYH

**Key result 1.4: Gender-aware programs were targeted in their approach and often implemented in community settings**

Gender-aware programs reached out to one or more beneficiary groups to include those most at risk for a particular health condition; those at a particular stage of life, such as adolescents; and those whose attitudes and behaviors place the health of others at risk.

In sub-Saharan Africa, HIV programs often worked with men to mitigate high-risk behaviors and reduce violence against female partners (Exner et al., 2009; Kalichman et al., 2008; Kalichman et al., 2009;

**Box 3: Salient Implementation Themes**

1. Involve individual, family, and community
2. Focus on life stage/phase (e.g., young adolescents ages 10–14, newly married couples without children)
3. Engage men and boys
4. Enhance the capacity of different cadres of health care providers

Pulerwitz et al., 2010), while in India, many HIV programs focused their efforts on high-risk groups such as sex workers and on stakeholders such as the police and brothel owners (Ghose, 2011). The difference reflects the disparate nature of the epidemic in these two regions: a generalized HIV epidemic in sub-Saharan Africa versus one concentrated in high-risk groups in India. In sub-Saharan Africa and Latin America, male engagement programs commonly addressed men’s conceptions of masculinity and how these shape men’s behavior and interactions. In India, engaging men and boys was a central component of several transformative HTSP, AYH, and GBV programs. This was also a component of some SM initiatives, given Indian men’s role as primary decisionmakers (Achyut et al., 2011; Achyut et al., 2009; Das et al., 2012; FHI360, 2013; Khandekar, 2008; Pathfinder International, 2011b; Sinha, 2008). Two transformative GBV

programs in India—Gender Equity Movement in Schools and Parivartan—emphasized the importance of working with adolescent boys and young men to counter inequitable gender norms that fuel GBV from a young age (Achyut et al., 2011; Achyut et al., 2009; Das, 2012). Transformative programs advocating delayed age at marriage for adolescent girls in Egypt, Ethiopia, and India engaged community gatekeepers such as religious leaders, community leaders, and parents (Gage, 2009; Mekbib and Molla, 2010; Pande et al., 2006; Selim et al., 2013). Across all LMICs, some programs enhanced the capacity of community outreach or health workers, peer educators, and healthcare providers to deliver care that is sensitive and responsive to the needs of beneficiary groups.

Successful programs, whether accommodating or transformative, were often implemented in settings where program beneficiaries gathered, felt safe, and/or would be receptive to intervention messages. Across all LMICs, localities where people live emerged as the ideal settings for transformative programs, possibly because these programs actively involved individuals, families, and the larger community to change social norms and improve health outcomes. Some transformative interventions were carried out at work sites or in schools to ensure consistent contact with a program’s beneficiaries. Accommodating programs were much more likely than transformative programs to be sited at health facilities, suggesting that transforming gender norms is more challenging in clinical settings.

Many interventions recruited and trained community members to be peer educators, change agents, or health volunteers. The roles of these people varied slightly with the type of gender-aware intervention. In accommodating programs, peer educators disseminated relevant information, working around gender inequities to increase access to information. In transformative programs, change agents served to question and change gender norms, roles, and dynamics and mobilize a community to counter gender-inequitable attitudes and behavior.

**Box 4: Most Common Intervention Settings in South Asia in which Health Areas are Addressed**

- Community:** HTSP, AYH, HIV, GBV, SM, NCHN  
**School:** GBV  
**Worksite:** HIV, GBV  
**Health facility:** HTSP, SM, NCHN, HIV

### **Key result 1.5: Nongovernmental organizations designed and implemented gender-aware programs, but with limited evidence of scaling up through the government structure**

Across all LMICs, gender-aware programs were designed and implemented by international NGOs and academic institutions, in partnership with local NGOs and/or community-based organizations. Some NGOs collaborated with government health services to improve access to health services and facilities. Of the 145 gender-aware programs assessed in this review, only five were government-run: the Lady Health Worker program in Pakistan; two pilot programs in India involving accredited social health activist workers; the Matlab Family Planning and Maternal and Child Health program in Bangladesh; and a conditional cash transfer program in Mexico. All five were gender-accommodating in their approach (Bhutta et al., 2011; Feldman et al., 2009; Hafeez et al., 2011; IFPS Technical Assistance Project, 2012a; Innovations for Maternal, Neonatal and Child Health, 2013; Schultz, 2009).<sup>5</sup>

Nongovernmental organizations—responsible for designing nearly all of the gender-integrated programs that this review considered—often implemented programs external to the government health system. The lack of government involvement limits opportunities for spreading and sustaining effective gender-integrated programs.

These findings have two implications for future gender-aware programs. First, the lack of government involvement may limit opportunities for scaling up effective gender-aware program components. Second, the limited evidence of transformative programs that have been scaled up calls into question whether transformative elements can be scaled up and sustained.

## **Objective 2: Identify Gender-accommodating and -transformative Strategies in Health Programs in LMICs**

We identified five overarching gender-aware strategies: three transformative and two accommodating.

### **Key result 2.1: Transformative programs challenged gender norms, roles, and dynamics**

Many of the programs the review identified as transformative employed multilevel and culturally relevant strategies, generating change at the individual level and simultaneously shaping supportive structures at the family, community, and health systems levels to encourage and sustain health benefits.

#### **Key result 2.1.a: Transformative programs empowered disadvantaged groups, promoted critical reflection, and fostered social and behavior change**

The vast majority of transformative programs employed strategies to challenge gender inequalities that preclude the practice of healthy behavior and hinder access to health services by individuals, households, and communities. A total of 45 programs empowered such disadvantaged or at-risk groups as adolescent girls, young men, and married youth through group health education and life skills training or by building social support or social networks. These group sessions equipped beneficiaries with the knowledge and skills required for contraceptive use, safer sex practices, delaying sexual debut, and averting early marriage. Of these programs, 18 used this strategy alone, while the remaining programs used this strategy in combination with social and behavior change communication (SBCC; described below) or critical reflection.

Thirty-four transformative programs facilitated critical reflection on gender norms and barriers that adversely affect health. Many HIV and GBV programs used interactive group activities that encouraged

<sup>5</sup> The Indian government is scaling up three transformative programs in India: Avahan (HIV), Gender Equity Movement in Schools (AYH, GBV), and Prachar (HTSP, AYH). Because they have yet to be evaluated, they are not included in this review.

beneficiaries to consider how inequitable gender norms and roles impact their health, health behavior, and interactions with others (see Box 5). Notably, critical reflection was often part of programs for men and boys. A few interventions fostered critical reflection among community health workers or peer educators and trained them to be change agents to impart health education and contest inequitable gender norms in the community (Bartel, 2010). For 14 programs, this strategy was used concurrently with SBCC, while 10 programs implemented this strategy alone.

**Box 5: Example of Key Result 2.1.a: Critical Reflection**

***African Transformation  
(Uganda, Tanzania, Zambia)***

***Bring together people in face-to-face dialogue for critical reflection***

**What:** Workshops conducted with groups of men and women over several weeks to discuss gender equity, social roles, traditional and cultural norms, reproductive and sexual health of men and women, STIs including HIV, violence in relationships, life skills, and joint management of resources.

**How:** African Transformation brings about gender equity in communities through critical reflection and planning. Participants evaluate how gender norms shape their own lives, their families, or their communities. To facilitate this, videos, audios, and/or written profiles of role models were shown during interactive, community-based workshops led by trained facilitators. Role models were men, women, or couples who had overcome gender-related barriers and challenges. These video profiles facilitated in-depth exploration and discussions related to such topics as gender and equity; social roles; traditional and cultural norms; women's and men's reproductive health; HIV and other STIs; violence between partners; life skills; managing household resources; and the benefits of networking.

**Outcomes:** More men and women participated in activities to reduce harmful traditional practices and expressed their willingness to intervene in episodes of violence (Johns Hopkins Bloomberg School of Public Health, 2007).

**Overall effectiveness:** Effective

SBCC strategies at the community level served to reinforce and sustain the benefits gained from activities promoting critical reflection and empowerment of disadvantaged groups in 36 interventions. SBCC strategies often comprised community-based activities (such as street theatre or wall paintings) and mass media activities (often a combination of information and entertainment) and questioned gender norms, roles, and relationships that adversely affect girls, women, boys, and men (see Box 6).



**Box 6: Example of Key Result 2.1.a: Social and Behavior Change Communication*****Somos Diferentes, Somos Iguales  
(Nicaragua)*****Catalyzing Personal and Social Change Around Gender, Sexuality, and HIV**

**What:** A communication strategy with multiple components launched to prevent the spread of HIV.

**How:** Mass communication activities such as entertainment education programs; local capacity building; and the development of links, coordination, and alliances within communities. Television series, radio programs, and youth groups served as platforms to introduce and discuss taboo and sensitive topics such as sexuality, masculinity, gender norms, and risk perception, while also emphasizing the importance of social support at the community level to spark and sustain healthy attitudes and behaviors.

**Outcomes:** Consistent condom use, reduced HIV stigma and discrimination, increased risk reduction communication with partners, increased decision-making ability related to sex and condom use among youth (Solorzano et al., 2008).

**Overall effectiveness:** Effective

SBCC activities were often directed at community stakeholders, such as parents and community and religious leaders who influence the primary beneficiaries' behavior. This strategy was most often used to address HTSP, HIV, GBV, and AYH. Fourteen programs used SBCC as a stand-alone strategy (see Table 2).

**Table 2: Overview of Transformative Strategy 1: Challenging Gender Norms and Inequalities that Impede Access to Health Services and Healthy Behavior**

Strategy	Total (n)	Effective (%)	Promising (%)	Unclear (%)
Empowering disadvantaged groups (only)	18	56	39	6
Critical reflection (only)	10	60	20	20
SBCC (only)	14	36	21	43
Empowerment + SBCC	17	53	29	18
Critical reflection + SBCC	14	64	36	-
Empowerment + Critical reflection	5	80	-	20
All three	5	40	20	40

**Key result 2.1.b: Transformative strategies promoted equitable relationships and decision making**

The review found that some HTSP, AYH, HIV, and GBV programs in LMICs equipped girls, women, boys, and men with communication, negotiation, and decision-making skills to use contraceptives, practice safer sex, delay age at marriage, and refrain from GBV. Although many of these programs aimed to improve the power dynamics of heterosexual couples, a subset focused on bettering communication between adolescents and their parents, especially in matters related to early marriage and adolescent sexual health. All but one program used this strategy in combination with the strategy challenging gender

norms. A small number of programs (N = 5) worked with male partners, providing them with information to enhance spousal support for healthy sexual and reproductive behavior. Box 7 showcases a community-based intervention in India that used this strategy effectively to delay first birth and increase spacing between two children. A few programs additionally equipped community volunteers, peer educators, or community health workers with the skills to involve and engage men to promote contraceptive use, avert HIV, and prevent GBV (Jewkes et al., 2008; Jewkes et al., 2010; Kalichman et al., 2009). Programs employing this strategy to address HIV, HTSP, AYH, and GBV were effective or promising (see Table 3).

**Box 7: Example of Key Result 2.1.b: Promote Equitable Relationships Through Communication and Decision Making with Men, Women, and Couples**

***Prachar (India)***

***Delaying first birth and increasing spacing between births***

**What:** Prachar aimed to change sociocultural norms related to healthy timing and spacing of pregnancy with young, newly married couples and couples with just one child.

**How:** Using a life-cycle approach and varied communication strategies at different levels (individual, household/family, group, and community) and with diverse stakeholders (youth, parents, community leaders, healthcare providers), Prachar advocated postponing marriage and childbearing until age 21 and maintaining an interval of 36 months between children. Change agents conducted interactive group activities/training workshops to identify and address barriers to healthy reproductive behavior (e.g., parental and societal norms and pressures that encourage early marriage and childbearing; myths, fears, and misconceptions about pregnancy and contraception; negotiation skills with spouse, in-laws, and parents). Regular household visits by change agents and refresher trainings were conducted to reinforce key messages. Interactive activities, such as the *Nav Dam pati* or newlywed ceremony, were conducted with couples to promote spousal communication and joint decision making for contraceptive use and family planning (Pathfinder International, 2011b).

**Outcomes:** There was greater participation by women in decisions about contraceptive use; and increased demand for and use of contraceptives.

**Overall effectiveness:** Effective

**Table 3: Overview of Transformative Strategy 2:  
Promoting Equitable Relationships and Decision Making**

Strategy	Total (n)	Effective (%)	Promising (%)	Unclear (%)
Strengthening communication and negotiation skills for women, men, couples	17	65	29	6
Increasing spousal support for healthy sexual and reproductive health behaviors	7	43	14	43
Increasing spousal support + strengthening communication and negotiation skills	1	100	--	-

### **Key result 2.1.c: Transformative strategies empowered girls and women through economic opportunities, education, and collective action**

Transformative strategies sometimes addressed the upstream determinants of health or the structural barriers that prevent women and girls from improving their health, particularly in the areas of HIV, GBV, and AYH. These programs recognized that low status in society and restricted opportunities for education and livelihood undermine girls' and women's ability to make healthy decisions, engage in healthy behaviors, or even seek healthcare. In response, they provided opportunities for education and/or employment (N = 19) with the aim of enhancing the capacity of girls and women to protect themselves from HIV, GBV, and early marriage, as well as to make healthy reproductive and sexual health choices. Economic empowerment involved women in microfinance or microcredit activities to boost their financial agency and decision-making power (see Box 8). Some of these programs empowered mothers to improve their children's health and nutritional status (CEDPA, 2001; Smith, 2011). In India, two HIV interventions with sex workers—the “Avahan” program and the “Sonagachi” project—mobilized sex workers to take collective action to protect themselves from HIV and other STIs and to reduce their experience of stigma, discrimination, and violence (Biradavolu, 2009; Blanchard, 2013; Ghose, 2011; and Swendeman, 2009). Most of the interventions encouraging women's empowerment were rated as effective or promising. Only four of the programs were implemented using empowerment strategies as the only transformative gender strategy. The remaining 17 programs were implemented in combination with the strategy to challenge gender norms.

**Table 4: Overview of Transformative Strategy 3: Empowering Girls and Women through Economic Opportunities, Education, and Collective Action**

Strategy	Total (n)	Effective (%)	Promising (%)	Unclear (%)
Livelihoods	13	54	38	8
Women's and girls' education	2	--	100	--
Livelihoods + education	3	67	--	33
Collective action	2	100	--	--
Collective action + livelihoods	1	100	--	--

### **Key result 2.2: Accommodating strategies adjusted for or worked around gender inequalities and barriers**

Accommodating programs worked around gender barriers by making adjustments to the health system and engaging communities to disseminate information and support behavior change. Many programs strengthened linkages between health facilities or healthcare providers and the community through door-to-door provision of health information, commodities, and services and ensured more equitable access to health information, often by reaching out to women and men who may have previously lacked this access (Schultz, 2009; Varkey et al., 2004). Additionally, some accommodating programs recognized the powerful influence that the family and larger community have on health outcomes and carried out activities that mobilized the community to support (and in some instances, demand) access to health information and services (Engebretsen, 2013; Nasreen, 2012).

#### **Key result 2.2.a: Accommodating programs strengthened and increased linkages between health services and communities**

Recognizing that gender inequalities hinder access to health information and use of health services, accommodating interventions connected health systems to beneficiary groups, reducing barriers without directly challenging gender norms. Popular approaches are building or reinforcing links between a

community and local health services (often through health workers), building the capacity of healthcare providers to deliver information and services to a community, establishing youth-friendly health services, conducting home visits to provide health information and products, and instituting voucher systems to encourage the use of services. This strategy was prominent among programs focused on HTSP, SM, and NCHN in South Asia and on HIV and AYH in LMICs as a whole.

**Key results 2.2.b: Accommodating programs addressed inequalities in access to health information**

A common strategy was to gather a specific underserved group to convey essential health information—for example, adolescent girls, who often face stigma and discrimination when trying to access reproductive healthcare, or fathers, who may feel unwelcome at a women-centered child health clinic. Additionally, convening these groups served to encourage and support behavior change in individuals. Group sessions tended to be held in a community setting; a few were in schools and at worksites. Most interventions employing this strategy focused on HIV, GBV, HTSP, SM, and NCHN. Most were determined to be effective or promising. Two that incorporated UHC in India were rated as unclear (Innovations in Family Planning Services Technical Assistance Project, 2012; Innovations for Maternal, Neonatal and Child Health, 2013).

**Key result 2.2.c: Accommodating programs fostered community involvement in disseminating information and supporting behavior change**

Some accommodating programs—in particular those focused on HTSP and SM—mobilized such stakeholders as community and religious leaders and parents, as well as the community at large, to support and demand access to health information and services. In this way, they improved access to information and supported behavior change without directly challenging familial and community norms and power dynamics. Many employed “mid media,” such as street theater and wall paintings, and mass media, such as radio and television. Almost all of the accommodating programs using this strategy alone were rated as unclear.

**Table 5: Overview of Accommodating Strategies: Health Systems Adjustments and Community Involvement**

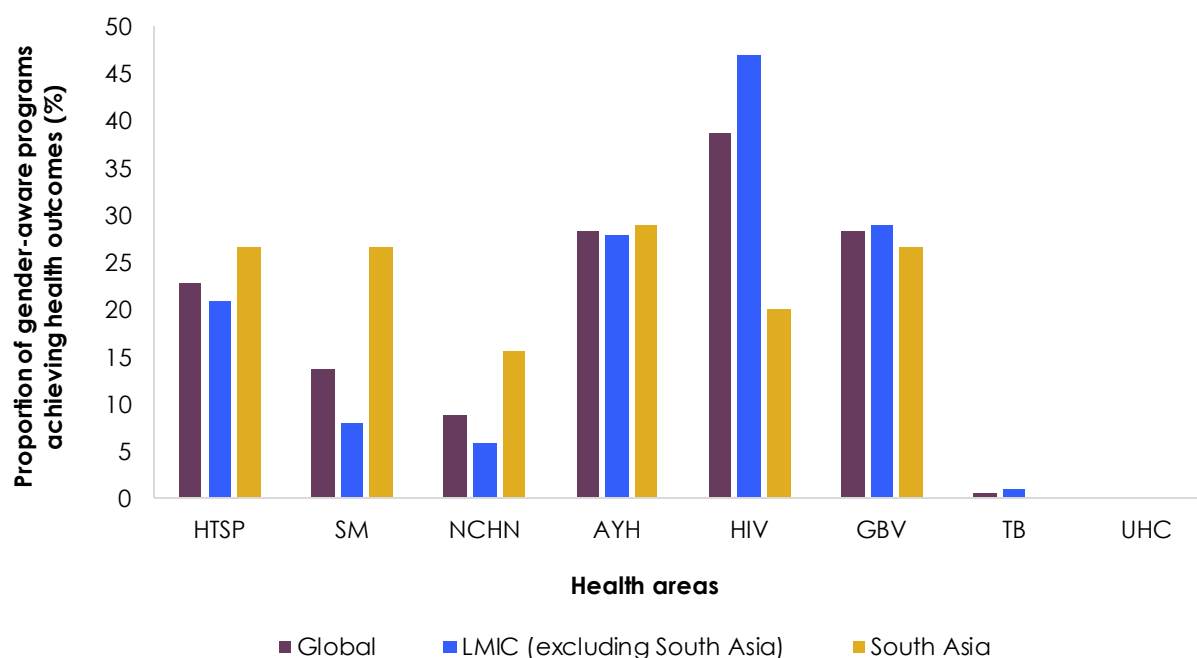
Strategy	Total (n)	Effective (%)	Promising (%)	Unclear (%)
Strengthening linkages (only)	5	40	40	20
Addressing inequalities in access to health information (only)	23	39	43	17
Addressing inequalities in access to health information + strengthening linkages	13	38	31	31
Engaging and involving communities (only)	6	--	17	83
Engaging and involving communities + health system adjustments	10	20	50	30

## Objective 3: Understand How Gender-integrated Programs Impact Health Outcomes

Gender-aware programs in LMICs in all six regions improved health outcomes—defined as changes in health status, behavior, attitudes, and knowledge—in all of the health areas assessed. Transformative interventions went further than accommodating interventions by engendering favorable attitudes toward health and gender equality (see Box 9). The share of programs affecting change in South Asia and in other LMICs differed by health area (see Figure 5). In South Asia, programs were more likely to improve outcomes related to AYH, SM, HTSP, and GBV than other health issues. In LMICs in the other five regions, programs were most likely to improve outcomes related to HIV, followed by AYH and GBV. The review found little evidence anywhere of gender-aware programs improving TB and UHC.

Gender aware programs improved health status, behavior, attitudes, and knowledge across the full range of health areas

Figure 5: Health Outcomes Achieved in Each Health Area, by Region<sup>6</sup>



### Key result 3.1: Transformative HTSP and AYH programs improved health status and increased healthy behaviors

Gender-aware AYH programs succeeded in increasing age at marriage and age at first birth (Gage, 2009; Pathfinder International, 2011). More commonly, transformative programs worked with youth and community stakeholders to improve attitudes toward adolescent sexual health and early marriage, sexual decision making among young men and women, and parent-child

#### Box 9: Key Attitudinal Outcomes Achieved, by Health Area

**HTSP:** Increased supportive attitudes toward women's role in decisions about FP

**AYH:** Increased progressive attitudes toward delaying age at marriage for girls

**HIV:** Reduced stigma related to condom use

**GBV:** Reduced tolerance for GBV

<sup>6</sup> The percentages do not total 100, because many programs addressed more than one health area.

communication. Programs in Egypt, Yemen, and Ethiopia increased awareness of the laws and risks related to early marriage and changed the attitudes and behavior of religious and community leaders and parents surrounding these issues.

HTSP programs increased women's use of contraceptives, and some also increased men's use. Concurrently, many of these accommodating and transformative programs also increased women's knowledge of fertility, pregnancy, pregnancy prevention, and contraception. A few transformative programs raised awareness of these issues among men (FHI360 and Johns Hopkins Bloomberg School of Public Health, 2013; Lundgren et al., 2005; Odeyemi and Ibude, 2011; Pathfinder International, 2011b). Additionally, a few transformative programs enhanced spousal communication about family planning. A transformative program in Nepal and another in Malawi reduced unmet need for contraceptives (O'Donnell, 2009; Shattuck et al., 2011).

**Table 6: AYH-related Health Outcomes of Gender-aware Programs, by Country**

Health Outcomes Achieved	Programs in India*	Programs in Other LMICs*
<b>Delayed first birth</b>	Prachar ( <i>Pathfinder International, 2011b</i> )	--
<b>Increased age at marriage</b>	Delaying Age at Marriage ( <i>Pande et al., 2006c</i> ) Prachar ( <i>Pathfinder International, 2011b</i> ; <i>Nanda et al., 2011</i> )	Berhane Hewan [Ethiopia] ( <i>Mekbib and Molla, 2010</i> ; <i>Erulkar and Muthengi, 2009</i> )
<b>Prevention of early marriages</b>	--	Gage, 2009 [Ethiopia]
<b>Improved parent-child communication</b>	Prachar ( <i>Pathfinder International, 2011b</i> ; <i>Wilder et al., 2005</i> )	IMAGE [South Africa] ( <i>Pronyk et al., 2006</i> ; <i>Pronyk et al., 2008</i> ; <i>Phetla et al., 2008</i> ; <i>Kim et al., 2009</i> )
<b>Improved attitudes toward early marriage</b>	Développement Holistique des Filles (DHF) Community Project (Aubel, 2010) Prachar ( <i>Pathfinder International, 2011b</i> )	Berhane Hewan [Ethiopia] ( <i>Mekbib and Molla, 2010</i> ; <i>Erulkar and Muthengi, 2009</i> ) Ishraq [Egypt] ( <i>Brady et al., 2007</i> ; <i>Selim et al., 2013</i> )

\* For details on the gender strategies used by each program, see the *Transforming Gender Norms, Roles, and Dynamics for Better Health—Gender Integrated Programs Reference Document*

### Key result 3.2: Transformative HIV programs reduced HIV risk and vulnerabilities

Transformative programs in South Asia and other LMICs went beyond HIV education, condom distribution, and the provision of health services to strategically address such upstream factors as HIV-related stigma and discrimination, which compound vulnerability to HIV. These programs improved negotiation capacities; countered stigma around condom use and people living with HIV; and reduced high-risk behaviour, such as alcohol use, drug use, transactional sex, and multiple partners. The majority of these programs affected change in immediate and intermediate outcomes related to knowledge, attitudes, and behavior. Notably, only a few programs succeeded in altering health status outcomes such as the acquisition of HIV and other STIs.

The Avahan program, a landmark HIV program in India, aimed to reduce HIV transmission among female sex workers. Its strategies were community mobilization and collectivization activities to overcome gender barriers that undermine women's ability to negotiate safer sex practices. Avahan was implemented in six Indian states that accounted for 83 percent of India's population living with the virus. As a result, female sex workers engaged in safer sex, were better able to negotiate condom use with their clients, conducted advocacy with the police to reduce violence, and used STI services. Most importantly, these changes reduced the prevalence of STIs, including HIV, among the sex workers.

#### Box 10: HIV Outcomes Achieved

##### Accommodating programs

- **Increased PMTCT**  
(Conkling et al., 2010; Falnes et al., 2011; Ditekemena et al., 2011)
- **Decreased STI prevalence among youth in school and women**  
(Chong et al., 2012; Baird et al., 2012)
- **Increased demand for condoms**  
(Chong et al., 2012)

##### Transformative programs

- **Led to safer sex practices**  
(Schensul et al., 2010; Kaponda et al., 2011)
- **Improved communication about safer sex**  
(Paine et al., 2002; Pronyk et al., 2008; Kaponda et al., 2011; Solorzano et al., 2008)
- **Reduced alcohol use**  
(Bradley et al., 2011; Erulkar et al., 2011; Schensul et al., 2010; Wechsberg et al., 2011)
- **Reduced number of sexual partners**  
(Kalichman et al., 2009; Sherman et al., 2010; Sikkema et al., 2010)
- **Reduced stigma over condom use**  
(Paine et al., 2002;)

### Key result 3.3: GBV programs reduced tolerance for GBV

GBV programs primarily employed transformative strategies. They engaged female and male adolescents and youth, adult men, and stakeholders such as mothers-in-law and healthcare providers to reduce tolerance or acceptance of violence against women and girls. They also stepped up community action to stop violence and improved communication between partners and family members to reduce violence. Consequently, these programs, most of which were implemented in community settings, were able to decrease the perpetration of violence by men, reduce incidents of violence against women (as reported by women), and to a limited extent, improve conflict resolution through the use of negotiation tactics (CARE International, 2012; Hoang et al., 2013; Jewkes et al., 2008; Jewkes et al., 2010).

#### Box 11: Integrating GBV Services into Other Health Services Conferred Benefits

- Increased knowledge of GBV and available GBV services
- Increased detection of GBV
- Improved screening, counseling, and referrals for GBV

In South Asia, there was little evidence of interventions that sought to improve health outcomes by integrating GBV in maternal and other health services for women. In Vietnam and Kenya, the review captured two accommodating GBV interventions (see Box 11). They strengthened the health systems' response to preventing violence, offered services to those experiencing violence, and affected change in related indicators (Budiharsana and Tung, 2009; Turan et al., 2013). The intervention in Vietnam was implemented in a large public hospital; in Kenya, a rural antenatal clinic that also offered HIV testing and PMTCT services was the intervention site.

**Key result 3.4: Gender-aware SM programs increased use of antenatal care; gender-aware neonatal and child health programs improved parents' knowledge and health promotion practices**

Safe motherhood programs commonly increased women's use of skilled care during pregnancy, delivery, and the postpartum period (Conkling et al., 2010; Mushi et al., 2010; Sinha, 2008). In South Asia, accommodating and transformative programs increased women's food intake during pregnancy and encouraged men to support their wives in seeking facility-based care and access to nutritious food (Intrahealth International, 2012; Sinha, 2008). Although most SM programs everywhere aimed to reduce maternal mortality, none achieved outcomes related to health status (e.g., lower maternal mortality rates) or in health systems (e.g., greater availability of emergency obstetric care, the lack of which is one of the key contributors to maternal deaths).

**Box 12: Transformative NCHN Interventions Achieved Important Outcomes**

- Increased breastfeeding
- Reduced stunting
- Increased child immunization
- Increased child supplementation with Vitamin A
- Improved dietary diversity
- Increased provision of oral rehydration solution to children with diarrhea

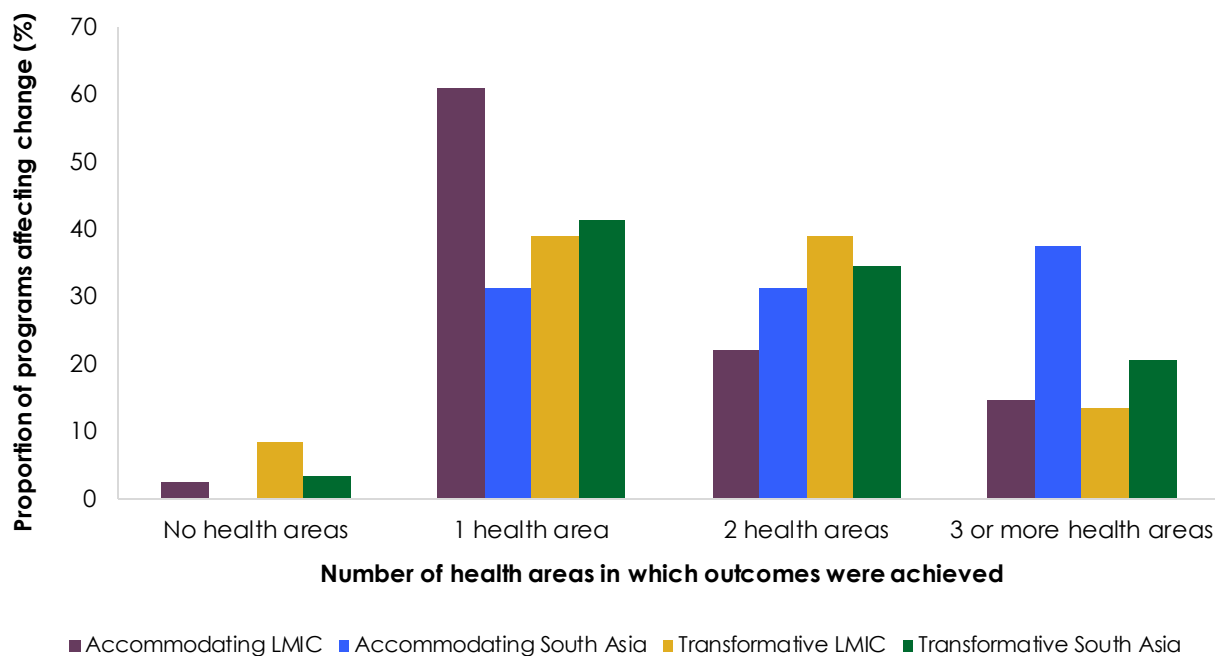
Accommodating NCHN programs in LMICs outside of South Asia increased fathers' involvement in caring for their children (Barker et al., 2009; Sahip et al., 2007; Sloand et al., 2010). In South Asia, accommodating programs improved neonatal health outcomes such as reducing perinatal and neonatal mortality and increasing breastfeeding of newborns. They also increased fathers' knowledge of newborn and child care (Innovations for Maternal, Neonatal and Child Health, 2013; Nasreen, 2012; Varkey et al., 2004). Transformative programs in South Asia that addressed structural barriers increased the number of children being immunized and well-nourished children and lowered the prevalence of stunting by improving nutritional intake (CEDPA, 2001; Khatun et al., 2004; Smith, 2011). One evaluation in Bangladesh examined whether a structural intervention to improve child health brought about "gender and socio-economic equity in health," by comparing stunting rates in children in intervention and control areas (Tran et al., 2013). Interestingly, the evaluation found that stunting prevalence decreased among girls but increased among boys. A possible explanation was that mothers were redistributing limited resources more equitably among their female and male children, and as a result, male children were getting less to eat than before. This is the only study in the review that demonstrated reductions in gender disparities related to child well-being. Transformative programs conveyed health benefits to mothers, as well, including increased use of skilled pregnancy care, increased consumption of iron and folic acid supplements, and increased institutional deliveries.

**Key result 3.5: Many gender-aware programs changed two or more related health areas**

Figure 6 presents the proportion of accommodating and transformative programs in South Asia and other LMICs achieving outcomes in one or more health areas.



**Figure 6: Accommodating and Transformative Programs Achieving One or More Positive Health Outcomes**



With one exception, the majority of programs across all six regions conferred benefits in one or two health areas, reflecting perhaps a more focused attention on that area to bring about behavior change. In contrast, most of the accommodating programs in South Asia achieved outcomes in two or more health areas.

The combination of outcomes achieved by health area differed slightly by gender-aware category and region (see Tables 7 and 8). In South Asia, accommodating programs often changed health outcomes related to HTSP, while also improving SM and NCHN outcomes. In other LMICs, accommodating programs had positive outcomes in the domains of HTSP plus HIV and/or AYH. The most significant difference between South Asia and other LMICs—in particular, between sub-Saharan Africa and India—emerged in HIV and GBV programs. Three of the five transformative HIV programs in India changed GBV-related outcomes; none of the accommodating HIV programs did. In sub-Saharan Africa, however, accommodating and transformative HIV programs alike improved outcomes related to AYH, HTSP, and GBV (in various combinations). To a great extent, accommodating programs changed the level of knowledge and, to a lesser extent, attitudes across these multiple health areas. Transformative programs, in contrast, tended not only to facilitate positive shifts in attitudes but also to engender healthy behavior in the health areas they addressed. Not surprising, behavioral and health status outcomes were more commonly achieved in a certain health area when it was the primary focus. Knowledge and attitudinal outcomes were more commonly achieved in the supplementary health areas.

**Table 7: Combination of Health Outcomes Achieved by Gender-aware Programs in LMICs Excluding South Asia**

	HTSP	SM	NCHN	AYH	HIV	GBV
HTSP						
SM	T					
NCHN	A	A				
AYH	A & T	A				
HIV	A & T	A&T	A	A & T		
GBV	T	T		T	T	

Dark blue boxes reflect a greater number of programs addressing this combination. Light-blue boxes indicate fewer programs involving such combinations. "T" stands for transformative programs, and "A" for accommodating programs.

**Table 8: Combination of Health Outcomes Achieved by Gender-aware Programs in South Asia**

	HTSP	SM	NCHN	AYH	HIV	GBV
HTSP						
SM	A					
NCHN	A	A				
AYH	T	A				
HIV	T	A	A	T		
GBV	T	T	T	T	T	

Dark blue boxes reflect a greater number of programs addressing this combination. Light-blue boxes indicate fewer programs involving such combinations. "T" stands for transformative programs, and "A" for accommodating programs.

**Key result 3.6: Little to no evidence of gender-integrated TB or UHC programs was found**

The review found little to no evidence of the impact of gender-integrated programs on TB or UHC outcomes, even though these health areas are affected by many gender-related factors. Women and men have different risk factors for TB and experience different social and economic consequences, as well as barriers to diagnosis and treatment. Therefore, a gender-focused approach is critical for assessing the impact of the disease on men and women (ACTION, 2010; Atre et al., 2011; Theobald et al., 2006). For example, program strategies should take into account gender-based differences in healthcare-seeking behavior. Women delay seeking care for TB and tend ultimately to choose lower-quality care than men. Among the reasons for this delay are a woman’s economic dependence on her husband, restricted mobility, resistance to seeking services from a male provider, and fear of treatment’s financial burden (Ahsan et al., 2004; Begum et al., 2001; Karim et al., 2008; Karim et al., 2007; Qureshi et al., 2008). Men tend to equate TB with financial problems—for example, job loss and reduced family income. The attendant shame and reduced self-esteem that men experience can keep them from disclosing their symptoms and seeking treatment (Atre et al., 2004).

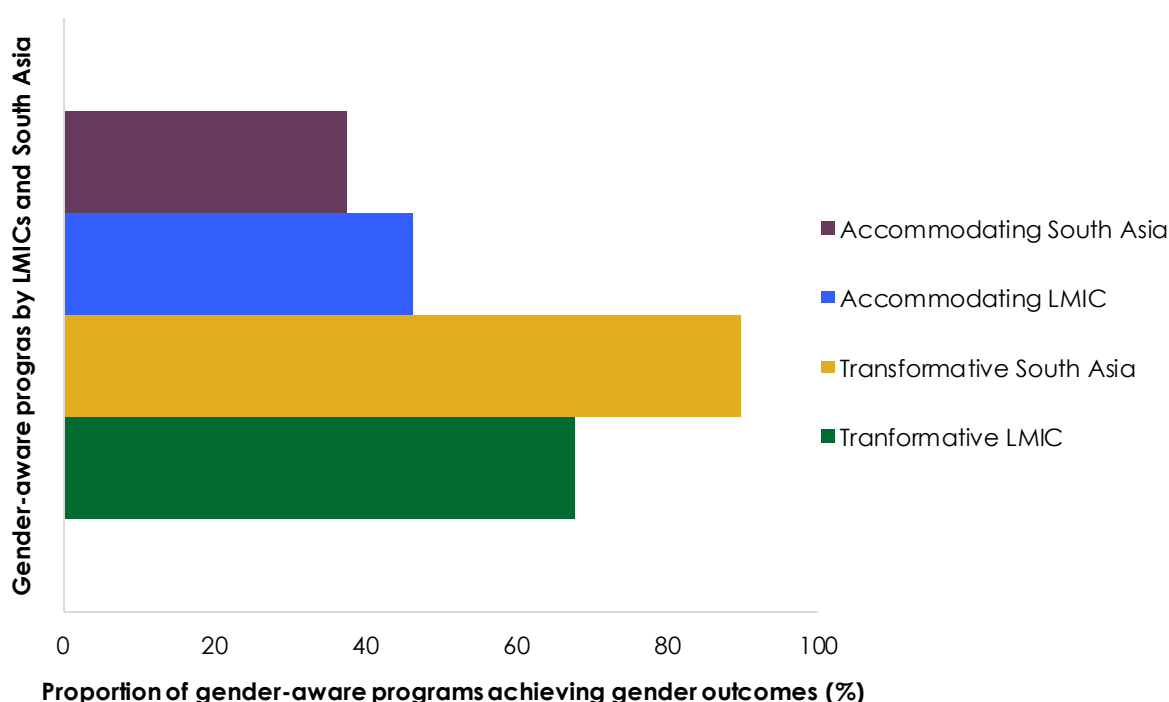
According to the World Health Organization, the overarching goal of UHC is “to ensure that all people obtain the health services they need without suffering financial hardship when paying for them” (World Health Organization, 2012). Implementing a service scheme on such a large scale, however, can lead to

complacency and inadequate attention to gender and the unique and different needs of women and men. At present, no government is systematically applying a gender lens to the design and implementation of its UHC system (Rodin, 2013). Without a clear understanding of a gender approach to UHC, governments will overlook the different needs of women, men, and sexual and gender minorities. For example, gender-based differences exist in terms of access to and use of health services, which in turn are influenced by access to and control of household resources, power and decision-making roles within a household and in the wider community, and harmful traditions and cultural practices (Gerber, 2013; Rodin, 2013).

### **Key result 3.7: Gender-transformative programs achieved gender outcomes**

A larger share of transformative programs in South Asia than in other regions improved gender outcomes. In general, transformative programs may have been more likely to report having achieved gender outcomes, simply because they were more likely to measure them.

**Figure 7: Percentage of Gender-aware Programs Achieving Gender Outcomes, by Region**



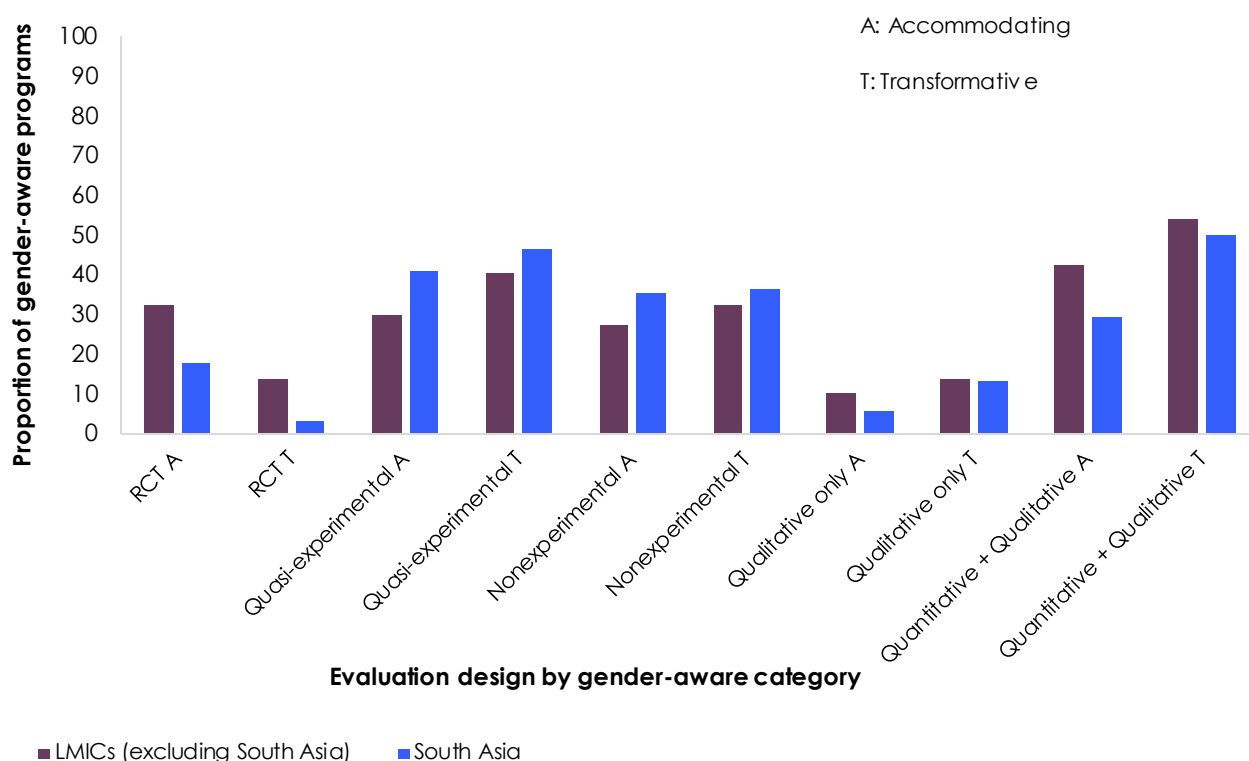
Transformative programs recognized that gender norms, attitudes, and roles undermine health. Their strategies improved both health and gender outcomes, particularly in the areas of HTSP, AYH, HIV, and GBV. A majority of transformative gender-aware programs, irrespective of their health focus, promoted gender-equitable attitudes and beliefs, and enhanced women's self-confidence, self-efficacy, and self-determination. While interventions in both South Asia and other LMICs attained gender outcomes, the types differed slightly. Programs in South Asia improved women's and girls' decision-making power, beliefs on women's right to refuse sex, community and partner support, and building social networks and life and social skills. In other LMICs, programs increased women's social networks and access to safe spaces, financial agency and access to social entitlements, and gender-equitable decision making. These findings suggest that inequitable gender norms manifest in different ways across cultures and that gender-aware programs are sensitive and responsive to these cultural nuances.

## Objective 4: Identify Quantitative and Qualitative Methodologies Used to Evaluate Gender-integrated Health Programs

### Key finding 4.1: Quasi-experimental and nonexperimental designs were most often used to evaluate gender-aware programs

Gender-aware programs in LMICs were evaluated using a range of quantitative methods, including randomized controlled trials (RCTs) (N = 25), quasi-experimental studies (N = 57), and nonexperimental studies (N = 47). Qualitative methods were often used with these quantitative methods, largely to supplement and confirm findings from the surveys (N = 69). Seventeen interventions were assessed only qualitatively, typically using in-depth interviews and focus group discussions. A higher share of accommodating and transformative programs used quasi-experimental and nonexperimental methods in South Asia than in the other five regions (see Figure 8). RCTs were more common in regions other than South Asia. More transformative than accommodating programs used a mix of quantitative and qualitative methods, particularly in regions other than South Asia.

Figure 8: Evaluation Methods in South Asia and LMICs Elsewhere, by Gender-aware Category

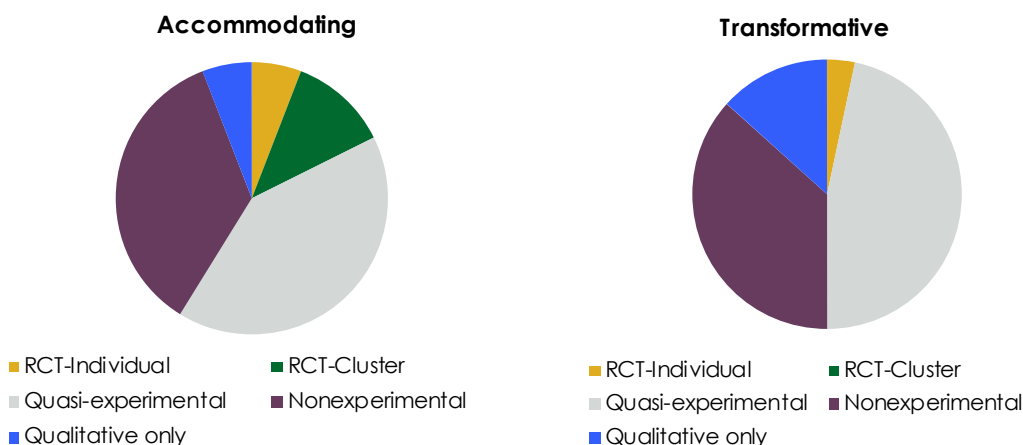


### Key result 4.2: Different types of study designs within each category measured program impacts

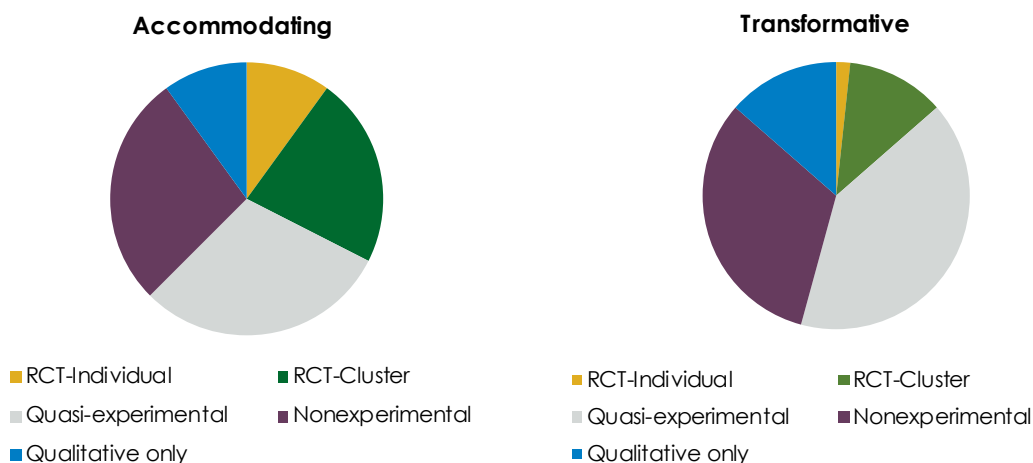
Different types of RCTs and quasi-experimental and nonexperimental methods were employed to measure program impacts. Figures 9 and 10 show the proportions of these study designs employed in South Asia and in the five other regions. Variation in types of RCTs was more prominent in programs implemented outside of South Asia, owing to the relatively higher number of RCTs identified in sub-Saharan Africa. Everywhere, the quasi-experimental pre- and post-test design was more common than the post-test-only design. Among nonexperimental designs, cross-sectional studies conducted at two or more

points in time and longitudinal studies were most common. Qualitative assessments typically involved in-depth interviews, focus groups discussions, or both.

**Figure 9: Relative Proportions of Study Designs Used in South Asia**



**Figure 10: Relative Proportions of Study Designs Used in Regions Other than South Asia**



#### **Key result 4.3: Few evaluations measured program effects over time**

Sixteen evaluations examined whether a program's effect on health outcomes had been sustained over time. These evaluations employed nonexperimental design (N = 4), quasi-experimental design (N = 5), RCT design (N = 6), and qualitative only design (n=1) (Chong et al., 2012; Kalichman et al., 2009; Kaponda et al., 2011; Midhet et al., 2010; Pande, 2006b; Sabido et al., 2009; Sikkema et al., 2010; Tipwareerom et al., 2011; Venguer et al., 2007; Paine, 2002; Jewkes, 2008; Jewkes, 2007; Phan Van, 2012; Sahip, 2007; Doyle, 2010; Doyle, 2011; Feldman et al., 2009; Sloand et al., 2010). Eleven of the sixteen programs were transformative and only two were implemented in South Asia. Studies varied by the period between post-intervention assessments. In some, these assessments were conducted a few weeks or one month apart, while in others, there was a gap of 12 months to two years between assessments. Most evaluated interventions (n = 11) focused on promotion of HIV/STI prevention behaviors.

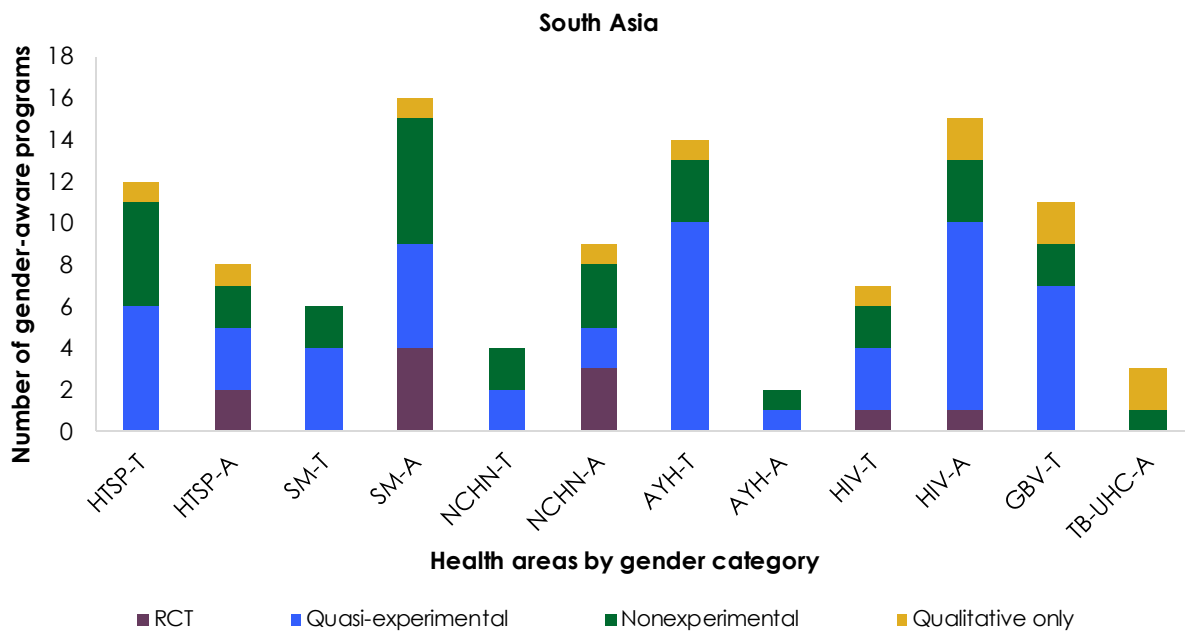
The evaluation results of these mostly HIV-focused interventions suggest that favorable behavioral changes may not be immediate and are not easily achieved. Changes in knowledge and attitudes showed

mixed results over time across interventions, with some interventions reporting some decline in knowledge and attitudes over time and others reporting maintenance or improvements at successive measurements.

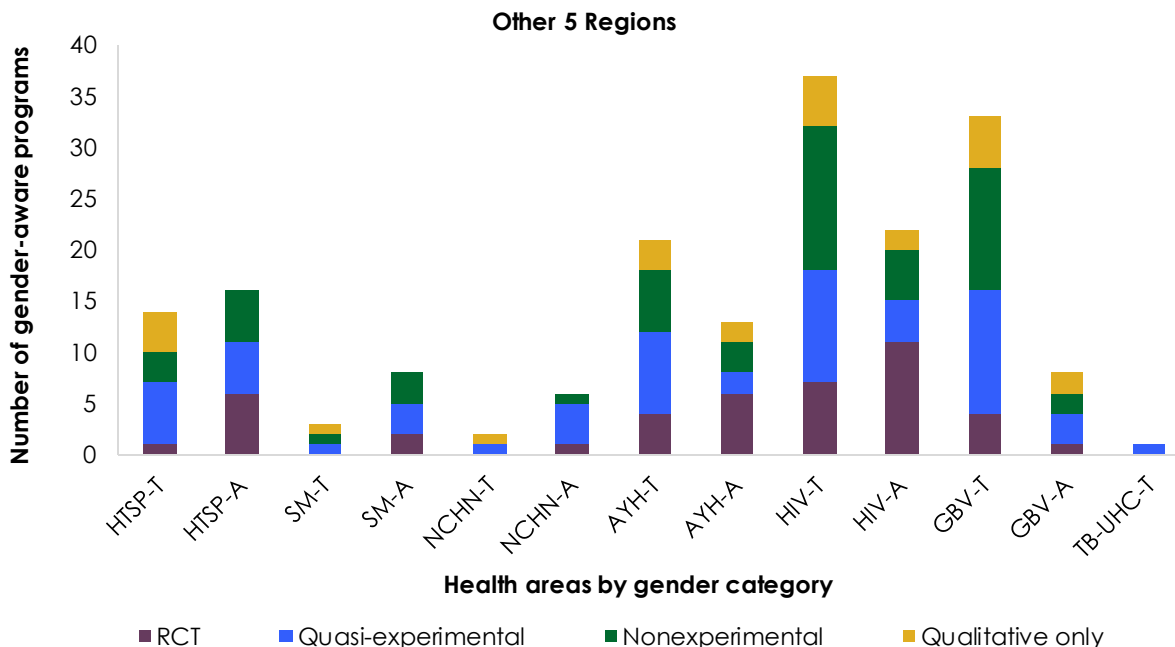
**Key result 4.4: Evaluation designs varied by health area and level of effectiveness**

The evaluation designs the studies employed varied by health area and level of effectiveness. Figure 10 highlights the different evaluation designs measuring the effect of gender-aware programs addressing different health issues. In LMICs outside South Asia, RCTs were used for both accommodating and transformative programs affecting change in health areas other than SM, TB, and UHC. In South Asia, the four RCTs found examined three accommodating programs on SM, NCHN, and HTSP, and one transformative program on HIV and GBV. Another difference between South Asia and the other five regions was use of qualitative-only studies. In LMICs outside South Asia, studies using purely qualitative tools more commonly examined transformative programs—possibly to assess whether an intervention had successfully shifted inequitable norms affecting health. Figure 11 shows the study designs used to evaluate programs in South Asia and the other five regions.

**Figure 11: Study Designs by Health Areas in South Asia and All Other Regions**



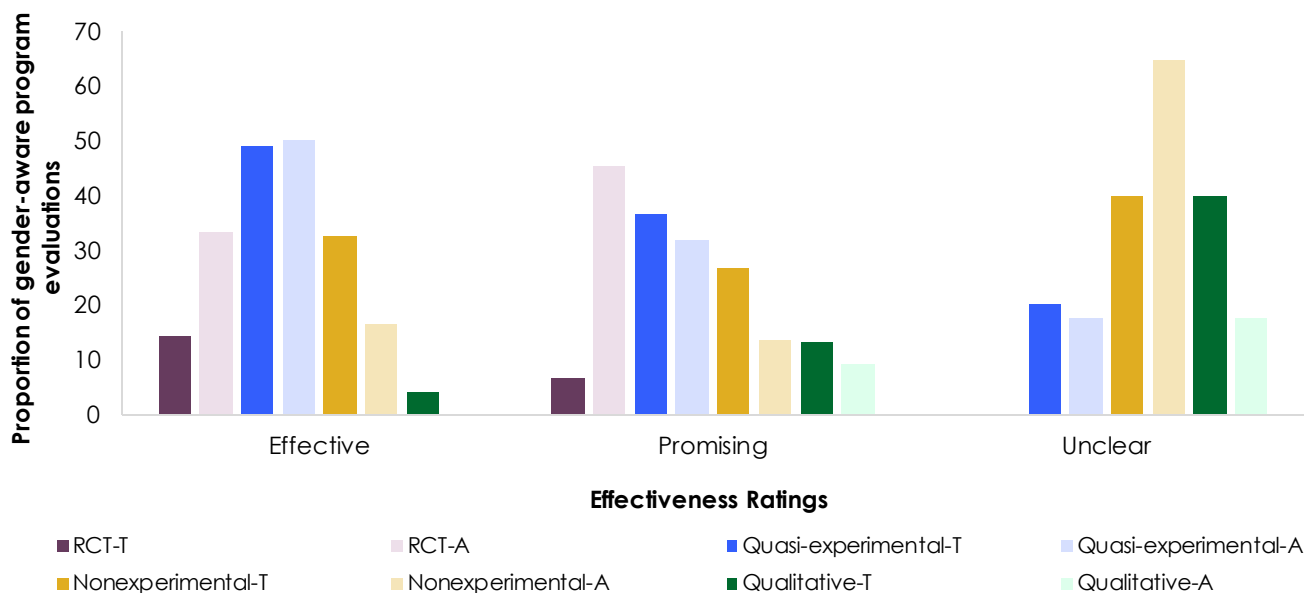
Programs using mixed methods for evaluation are subsumed in the quantitative method category.



Programs using mixed methods for evaluation are subsumed in the quantitative method category.

The analysis revealed a relationship between the type of study design and a program's effectiveness (effective, promising, or unclear, as rated by the ERC) (see Figure 12). Due to the methodological rigor of RCTs and the rating scale this review used, none of the RCT evaluations employing RCT designs were rated unclear. Program evaluations using quasi-experimental designs were mostly effective or promising. As demonstrated in Figure 12, a higher proportion of program evaluations using nonexperimental or qualitative-only methods for evaluation were ranked unclear than of those using more rigorous quantitative methods. Among transformative programs, one-quarter were effective, one-third were promising, and a little less than half were unclear. Qualitative assessments of accommodating programs using qualitative-only evaluation methods were few and rated as promising (N = 2) or unclear (N = 3).

**Figure 12: Gender-aware Program Evaluations by Study Design and Level of Effectiveness**



**Key result 4.5: Qualitative and quantitative evaluations measured gender outcomes**

Sixty percent of RCT evaluations, 63 percent of quasi-experimental evaluations, and about 49 percent of nonexperimental evaluations found changes in gender indicators. Notably, three-fourths of the qualitative studies documented positive changes in gender outcomes.

Gender Equitable Men scale	(e.g., Das et al., 2012)
Gender index	(e.g., Solorzano et al., 2008)
Empowerment index	(e.g., Bandiera et al., 2012)
Autonomy/agency index	(e.g., Feldman et al., 2009)
Decision-making scale	(e.g., Sebastian et al., 2005; Tipwareerom et al., 2011)
Masculinity scale	(e.g., Schensul et al., 2010)
Vulnerable girls index	(e.g., Underwood and Schwandt, 2011)
Gender role attitudes scale	(e.g., Engebretsen et al., 2013)
Qualitative measures	(e.g., Lundgren et al., 2013)

Eighteen evaluations specifically attempted to examine the added value of gender on health outcomes (Abdel-Tawabet al., 2008; Achyut et al., 2009; Achyut et al., 2011; Ashraf et al., 2010; Baird et al., 2011; Baird et al., 2012; Bartel et al., 2010; Byamugisha et al., 2011; Fritz et al., 2011; Ghose et al., 2011; Hadden, 1997; Hallman and Roca, 2011; Kim et al., 2009; Midhet and Becker, 2010; Mullany et al., 2009; Pham et al., 2012; Phetla et al., 2008; Pronyk et al., 2006; Pronyk et al., 2008; Sherman et al., 2011; Smith, 2011; Swendeman et al., 2009; Susin and Giugliani, 2008; Wingwoodet, 2013). A microfinance initiative, for example, measured its impact on HIV and GBV outcomes with and without sessions on



gender and HIV. The evaluation found that the microfinance-only intervention achieved outcomes related to economic well-being (e.g., greater ability to pay back debt; greater ability to meet basic needs in the previous year) but not to HIV or GBV. When microfinance was combined with the gender and HIV sessions, it achieved gender outcomes related to empowerment and health outcomes related to both HIV (e.g., greater household communication about sex and HIV; greater participation in HIV marches and rallies) and GBV (less likely to have experienced physical and/or sexual interpersonal violence) (Kim et al., 2009). However, it did not achieve any behavioral outcomes related to condom use.

Ninety-one programs achieved gender outcomes. Of these, 35 (most of them transformative) used gender scales to measure changes in gender outcomes (see Box 13). Many of these programs favorably impacted HIV, HTSP, AYH, and GBV outcomes. Some programs (particularly those working with men and boys) used adapted versions of the Gender Equitable Men (GEM) scale, which measures attitudes toward gender norms in intimate relationships or differing social expectations for men and women. Other programs constructed and used different scales comprising several items measuring one or more gender domains. Some gender scales addressed a single area such as decision making or masculinity, while others (the GEM scale, for example) assessed a range of gender norms and attitudes. Among programs that did not include a specific gender scale, the quantitative surveys added individual items on gender attitudes and norms, social networks, or financial agency to the larger questionnaire.

Nine transformative interventions that worked with men to address GBV and HIV in India, Brazil, Malawi, Namibia, Uganda, Tanzania, Zambia, and Ethiopia used adapted versions of the GEM scale (Khandekar et al., 2008; PATH, 2012; Promundo and Sonke Gender Justice Network, 2012; Pulerwitz et al., 2010; 2012; Shattuck et al., 2011; Singh, 2011; Verma, 2008; Underwood, 2007). These programs facilitated progressive gender attitudes toward male participation and support, facilitated more gender-equitable attitudes, and encouraged partner communication. The Rishta HIV program for men living in low-income settlements in Mumbai, India constructed a masculinity scale to examine men's perceptions of gender equity (Schensul, 2010). One of the Avahan projects, in India, examined impact on sex workers' empowerment using a scale measuring three domains: power within (self-confidence); power over resources (e.g., possession of a bank account); and power with (social networks) (Blanchard, 2012). The Men as Partners program, in South Africa, and a mass-media intervention for HIV prevention in Nicaragua used a gender index to evaluate changes in gender-related attitudes and norms, asking program beneficiaries to agree or disagree with statements on the performance of household tasks; decision-making attitudes; gender norms related to sex, sexuality, and condom use; and attitudes related to sexual coercion and violence (Ditlopo et al., 2007; Solorzano et al., 2008). An HTSP program in Mexico used an autonomy index to examine women's power and role with respect to finances and household decisions (Feldman et al., 2009). In Burkina Faso, the *Filles Éveillées* intervention, which worked with migrant female domestic workers, used a scale that measured attitudes about gender roles, social capital, and self-confidence (Engebretsen, 2013). Some programs did not use an index or scale, but included individual items in surveys to assess girls' access to social support (Erulkar et al., 2013) and gender norms (Doyle et al., 2010). The review identified few examples of qualitative gender assessment tools. One intervention in Nepal, for instance, used participatory qualitative methods with adolescents—pile sorts, storytelling, pie charts, and projective drawings of change—to assess how gender norms and roles shifted as a result of the program.

## LIMITATIONS

This review has certain limitations—some internal to the review process and methodology and others external to it.

1. **Limited evidence on TB, UHC, and scaled-up interventions:** The most significant limitations are the scant literature in South Asia and LMICs elsewhere on gender-aware interventions specific to TB and UHC and the lack of evidence on scaled-up programs. The ERC addressed the first gap by running additional literature searches using broader search terms specifically for TB and UHC documents. This search found numerous articles, but few met the criteria for relevance. The ERC also found few documents discussing cost-effectiveness and scaling up of impactful gender-aware interventions. Although scale-up was not a core objective of this review, insights into how and which intervention components are scalable and at what cost could have better informed recommendations, particularly for governments seeking to enhance their current and future health programs.
2. **Varying quality of documents:** This review included documents from peer-reviewed journals as well as gray literature from online sources. Consequently, the depth of information provided and data quality varied across documents. Some studies furnished insufficient details on the intervention components, evaluation methodologies, and even the findings. The ERC addressed this issue by adapting an evidence rating scale that assessed the evaluation design and level of impact for each intervention (Barker et al., 2007). When the ERC reviewed documents presenting insufficient information, they contacted organizations implementing these interventions for details. For instance, we asked people involved in the Avahan initiative, in India, to explain how the program integrated gender and how this component may have differed across the 100-plus sites in which the intervention was implemented.
3. **Determining the impact of gender on health outcomes:** Most of the interventions in this review had multiple components, often delivered at different levels, and aimed to bring about improvements in knowledge, attitudes, behaviors/practices, and health status. Most evaluation designs were unable to isolate the effects of individual components on the health outcomes of interest.
4. **Exclusion of documents in other languages:** This review only searched for documents in English and did not include publications in other languages.

## CONCLUSION

This systematic review assessed in depth the body of evidence on gender-integrated programming in LMICs around the world. The regional focus (with special attention to South Asia) facilitated a comparative, nuanced look at the unique sociocultural and economic contexts in which people experience and respond to various health issues. This review found 145 gender-integrated interventions. Almost 30 percent were implemented in South Asia, and most of these in India. Gender integration was strongest for HIV, AYH, and GBV; moderate for HTSP, SM, and NCHN; and weak for TB and UHC. The review found limited evidence of gender-aware programs that had been integrated into a government health system and scaled up; instead, NGOs designed and implemented the majority of programs in select communities and populations. Few programs had been implemented long term, making it difficult to assess whether the health benefits conferred by programs were sustained.

Gender-integrated programs improved health and gender outcomes across the range of health areas. Overall, gender-aware programs increased healthy behaviors and improved knowledge of health issues and healthy practices; transformative programs cultivated gender-equitable attitudes, norms, and interactions. Many programs effected change in two or more related health areas, but the extent of change within each area differed. Additionally, transformative programs measured and achieved gender outcomes.

Although specific strategies differed, both accommodating and transformative programs improved access to health services, conducted group health education with program beneficiaries, and involved communities in facilitating and maintaining benefits. Additionally, transformative programs used strategies to promote women's agency through education, employment, and empowerment.

Quantitative, qualitative, and mixed evaluation methods assessed program impacts. Quasi-experimental and nonexperimental study designs were most common, and qualitative methods often complemented survey findings. In addition to measuring health outcomes, evaluations of transformative programs assessed gender outcomes as well.

# RECOMMENDATIONS

## Overall Recommendations for Gender-aware Interventions

- Integrate promising gender-aware strategies in government health programs and scale them up—both to enhance their benefits and to ensure their sustainability.
- Consider and be more responsive to gender norms and inequalities when policymakers and government program planners develop and implement health policies and programs. Donor agencies and NGOs can support government agencies and officials to strengthen the gender-responsiveness of policies and programs through capacity-strengthening initiatives. Likewise, ministries of gender or other gender machinery can be strong allies and resources for policymakers to strengthen health policies and make programs more responsive to gender considerations.
- Conduct cost-effectiveness studies to make the case for integrating effective and promising gender-aware strategies in government health programs and scaling them up.
- Conduct gender analysis routinely to understand how the health needs and behaviors of women, men, and transgender people differ, as well as the gender-related factors that drive these differences. Based on the findings, governments, donors, and NGOs should incorporate in their health programs evidence-based strategies that respond to and mitigate the gender barriers faced by these groups.
- Focus programmatic efforts on the gender barriers that accompany particular life stages (e.g., helping newly married couples with no children to delay their first child).
- To sustain program participation, deliver gender-aware programs in settings where program beneficiaries—especially such hard-to-reach and vulnerable groups as youth, MSM, and sex workers—typically congregate and feel safe.
- Strengthen HIV programs for MSM, transgender people, and other high-risk populations by recognizing and addressing the gender- and HIV-related stigma and discrimination they face.
- Strengthen maternal and child health programs outside of South Asia by addressing the gender constraints that women and children (especially female children) face in attaining good health and accessing maternal and child health and nutrition services.
- Apply a clear and focused gender perspective to existing TB programs or in the design of new TB programs. Differences in the rates of TB infection between women and men should be documented and analyzed, and the specific social contexts of exposure and vulnerability to infection among men and women should be accounted for. Furthermore, women and men should not be regarded as two homogenous groups; examine vulnerabilities and socioeconomic differences within those groups, such as rural women versus urban women or educated men versus uneducated men, and how those differences impact vulnerability to TB infection and health-seeking behavior.
- When devising a UHC scheme, create a clear path for applying a gender approach to address the unique and different health needs of women, men, adolescents, and sexual minorities and the gender-based differences in access to and use of health services and subsequent health outcomes. Implementing a large-scale service scheme without recognizing gender-based constraints and challenges will undermine the scheme's achievements.

## Recommendations for Program Strategies

- Deploy strategies that bring about changes in gender dynamics and norms at the level of family and community to provide a supportive environment for changes by individuals in gender attitudes and behavior.
- Employ SBCC strategies to change gender norms. Improve health knowledge, attitudes, and practices of relevant stakeholders such as parents, religious leaders, and community leaders, enlisting their support to strengthen and sustain key program messages and impacts.
- Involve and engage men as partners and clients, particularly in programs addressing HIV, GBV, and HTSP. Implement intervention strategies that enable males to encourage and support their partners' healthy practices, as well as ensure their own health and well-being.
- Implement GBV programs for adolescent girls and boys that encourage critical reflection to inculcate sustainable gender-equitable norms from a young age.
- Train peer educators in gender, communication, and negotiation skills, eliciting the active participation of male peer educators (especially in HIV, GBV, and HTSP programs) to reach underserved and difficult-to-reach groups such as men and boys, migrant workers, and youth. Critical reflection is an effective strategy to enable peer educators to serve as change agents who can identify inequitable gender norms and understand how these norms influence people's health and health behavior, as well as the agents' own interactions with the communities they serve.
- Target specific structural drivers that serve either as barriers to or opportunities for gender equality, implementing interventions that address these drivers. An example is to empower girls and women economically, through microfinance activities or formal education, enabling them to make healthy choices, increase their negotiating power, and enhance their efficacy and self-confidence.

## Recommendations for Evaluations

- Define the theory of change on which the gender-aware program is based. This will make it easier to identify the health and gender outcomes the program seeks.
- Conduct multiple endline assessments to see if a program's benefits are sustained over time. This in turn can enable policymakers and program implementers to identify and select gender-aware strategies that confer long-term benefits.
- Use mixed evaluation methods to capture the extent of change in health and gender outcomes, as well as to explore the mechanisms or pathways by which change has been achieved.
- Measure changes in gender outcomes (both attitudes and behaviors), in addition to health outcomes, using appropriate gender scales or measures.
- Specify the causal pathway by which gender can benefit health, and develop well-defined, gender-specific qualitative and quantitative measures to study how and to what extent gender changes health outcomes.
- Measure gender outcomes carefully because some gender concepts such as "empowerment" and "agency" are broad and difficult to capture. Therefore, clearly define or operationalize terms before conducting research and break them down into measurable components or indicators.
- Conduct and present statistical analyses that enable policymakers and program implementers to know whether changes are significant.
- Increase the use in South Asia of methodologically rigorous evaluation designs.

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## ANNEX A: DETAILED METHODS

### **Step 1: Convene an Evidence Review Committee**

The ERC's seven members represented GPM and the Public Health Foundation of India. They had experience in conducting gender analysis and/or designing, implementing, and researching gender-integrated health programs. One ERC member was lead author of the *Gender Perspectives* (Boender et al., 2004) report. The ERC determined a search methodology to identify articles for the review, establishing criteria for relevant articles and criteria to categorize gender-aware programs and assess the strength of evidence. Furthermore, the ERC reviewed articles for relevance and abstracted and analyzed the data.

### **Step 2: Conduct searches**

The ERC used the following search criteria to identify the documents they would assess for relevance:

1. Only literature in English
2. Literature on health interventions conducted in LMICs (as defined by the World Bank's classification system<sup>7</sup>)
3. Literature on interventions addressing RMNCH+A and HIV and other STIs,<sup>8</sup> PMTCT of HIV, nutrition, and GBV from January 1, 2008 to June 30, 2013<sup>9</sup>
  - a. RMNCH+A further broken down into HTSP, SM, AYH, and harmful traditional practices
4. Literature on health and nutrition of children ages five years and under, TB, and UHC from January 1, 2000 to June 30, 2013<sup>10</sup>
5. Literature on gender-integrated health interventions
  - a. Also reviewed: gender-aware interventions from South Asia and other low- and middle-income countries presented in the *So What* and *Gender Perspectives* reports
6. Literature on interventions outside of India with an evaluation component (search terms including evaluation, research, study, etc.)
7. Literature on health interventions implemented in India: evaluations or program implementation experience without an evaluation component<sup>11</sup>

Given the review's focus on gender-integrated health interventions, the ERC expanded the search strategy to include gray literature and any unpublished documents or reports from organizations working in low- and middle-income countries. A member of the GPM team, trained in conducting literature searches, carried out a comprehensive search for published and unpublished studies on the identified health areas of

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<sup>7</sup> According to the World Bank classification system, South Asian countries are India, Nepal, Bhutan, Bangladesh, Pakistan, Afghanistan, Sri Lanka, and the Maldives.

<sup>8</sup> Literature on STIs was not searched for specifically during Phase I (South Asia review). Phase II (global review) included a detailed search for gender-integrated STI interventions.

<sup>9</sup> The starting point for RMNCH+A interventions in this review was 2008, because the *Gender Perspectives* report covered articles in prior years.

<sup>10</sup> The starting point for articles on NCHN, TB, and UHC was 2000, because the two previous reports—*So What* and *Gender Perspectives*—did not capture health outcomes reported after 1999.

<sup>11</sup> This review considered India-based interventions without an evaluation component in order to draw on valuable lessons on program implementation. However, the review found few such articles, and the information gleaned from them matched the results of evaluated interventions.

interest. This covered a wide range of electronic databases, organizational websites, and conference websites. The first such search was conducted in July 2013. Updated electronic literature searches were conducted again in October 2013 (focusing on UHC and TB interventions in South Asia) and in February 2014 (focusing on menstrual hygiene management, water, sanitation and hygiene, and organizational websites). During data abstraction from August to October 2013 (South Asia review), and again from February to March 2014 (global review), the ERC considered references in relevant articles to identify documents not included in the initial electronic search. Additionally, the team interviewed informants in key India-based organizations working in gender and health areas, for a contextual understanding of program implementation experience. After each interview, the informants were asked to share gender-integrated program documentation or research that could be relevant to the review. The ERC team also sourced bibliographies in publications of the Bill & Melinda Gates Foundation on the Avahan program in India, in publications on health issues (for example, the bibliography of a USAID evidence review of gender dynamics and behavior change communication and child health), and the *So What* (Boender et al., 2004) and *Gender Perspectives* (Schuler et al., 2009) reports. The Avahan documents were reviewed and synthesized separately.

**Table 1: Search Sources**

Source Category	Source Name	Timeline
Online databases searched	PubMed/MEDLINE	June–July 2013 December 2013– January 2014
	POPLINE	
	Scopus	
	EMBASE	
	ECONLIT Journals Science Direct	
Organizational websites searched	USAID	June–July 2013 December 2013– January 2014
	Development Experience Clearinghouse	
	World Health Organization	
	Reproductive Health Library	
Key journals searched	<i>Studies in Family Planning</i>	June–July 2013 December 2013– January 2014
	<i>Reproductive Health Matters</i>	
	<i>Lancet</i>	
	<i>Journal of Acquired Immune Deficiency Syndromes</i>	
Conference websites searched	International Family Planning Conference	June–July 2013 December 2013– January 2014
Representatives of organizations involved in health interventions and health research in India interviewed		August–October 2013
References of relevant review documents searched		August–October 2013 December 2013– January 2014

Source Category	Source Name	Timeline
Sourced bibliographies searched	Avahan Gender dynamics	September–October 2013
Organizational websites searched	Men Engage Population Council Sonke Gender Justice	February–March 2014

Preliminary search documents were stored in EndNote (software for reference management). The file contained the document title, authors, date of publication, source, abstract, and URL. This search yielded 2,341 documents.

### **Step 3: Establish relevance**

After duplicate documents were eliminated, 1,702 documents remained to be reviewed for relevance (see Figure 2, p.8 for details). The ERC formed review pairs to ensure that two people independently reviewed each document. Each reviewer pair examined titles and abstracts of 150 to 170 documents.

**Title relevancy:** (for Phase 2 documents only, owing to the volume of documents identified during the search): Reviewers first read the titles of the articles from LMICs in the regions other than South Asia. Those that described policies, frameworks, guidelines, tools/toolkits, protocols, guidebooks, handbooks, and so forth were eliminated as irrelevant. The reviewer noted in the “title relevancy” column in the master spreadsheet either I, R, or CD, denoting the following:

- R = Article title is relevant; include in abstract review.
- I = Article is irrelevant; exclude from abstract review.
- CD = There is not enough information to determine relevance; reviewers “cannot decide” from the title whether the study falls within the inclusion criteria. In these cases, reading the abstract was necessary to determine relevance.

The list of articles determined to be irrelevant based on their titles was then scanned by a secondary reviewer. If the reviewer questioned the title relevancy determination, the code was changed from I to R and the abstract was reviewed, as described below.

Using the data from the EndNote file (Step 2), an ERC member created an abstraction database in Microsoft Excel with the following fields: Authors, Year, Title, Journal/Other, Publisher/Organization, Volume Number, Issue Number, Date of Publication, Abstract, URL, First Reviewer (R1), Initial Relevance (R1), Reason for being irrelevant (R1), Comments (R1), Second Reviewer (R2), Initial Relevance (R2), Reason for being irrelevant (R2), Comments (R2), Final Relevance. An additional field was added to check supporting studies that did not meet the relevance criteria but whose content would be useful for the background and discussion sections of this report.

**Abstract relevancy:** Each reviewer carefully read the title and abstract of each document to determine abstract relevance. If an abstract presented insufficient information to determine relevance, the reviewers read the full text of the document. A relevant document was marked R and included in the final review; each irrelevant document was marked I and excluded from the final review; documents that were difficult to categorize were marked CD. Each reviewer briefly noted the reason for documents categorized as I or CD. Reasons for irrelevance were as follows: the document did not document an actual intervention, or if an intervention was documented, the intervention was not gender-aware; the document did not cover any of the health outcomes of interest; or the document lacked an evaluation component. A document was

marked R in the “Final Relevance” column only if both reviewers agreed. Any disagreement over a document’s relevance had to be resolved by the two reviewers. If a resolution was not reached, a third reviewer appraised the document to determine final relevance.

To meet the objectives of this review, the ERC used the following inclusion criteria:

- The document had to be from a study conducted in an LMIC (according to the World Bank’s classification). In Phase I, the program had to have been implemented in South Asia. For Phase II, the program had to have been implemented in an LMIC outside of South Asia.
- The document had to describe a gender-aware intervention according to IGWG criteria (see Figure 1, p. 5).
- The document had to measure one or more of the following health outcomes: RMNCH+A (including nutrition), HIV and other STIs (including PMTCT), GBV, TB, or UHC (see Box 2, p. 11, in this report’s main text).
- The intervention had to have an evaluation component.<sup>12</sup>
- An Avahan document was marked relevant if it discussed any of the following:<sup>13</sup>
  - Community mobilization
  - Collective identity
  - Community-led structural interventions

Following the review for relevance, two ERC members randomly checked 10 percent of the documents marked irrelevant. None of the irrelevant documents checked were found to be relevant. A total of 196 documents were appraised as relevant and selected for data abstraction (see Figure 2, p. 8). These cover 45 gender-aware programs in South Asia and 100 programs in other LMICs. The review found that some interventions achieved outcomes in more than one health area. For instance, a program could achieve both SM and neonatal health outcomes. Such interventions are reported for each health area they address, and as a result, the total number of interventions does not match the total number of programs (see Annex B for the number of documents and interventions by health area, gender category, and country).

#### Box A: Health and Gender Outcomes

Health and gender outcomes for this review were identified drawing on the reproductive health outcomes and gender outcomes listed in the *So What* and *Gender Perspectives* reports, as well as the outcomes that emerged from the articles the ERC reviewed. Given that the review’s aim is to explain how gender-integrated programs improve health outcomes, we focused on health outcomes related to RMNCH+A, nutrition, HIV, GBV, TB, and UHC. We included health outcomes related to knowledge, attitudes, and behavior/practices. Like its predecessors, this review considered any gender outcomes that were reported. Attitudinal outcomes that directly relate to or impact a health outcome are listed as a health outcome, while gender-related attitudes and behaviors that indirectly

<sup>12</sup> The ERC made a conscious decision to include documents that describe a program or intervention conducted in India to get a more nuanced understanding of how gender is integrated into health programs and to learn from gender-program implementation experience that may not necessarily involve an evaluation. Documents on formative research conducted in India were also considered if they explicitly stated that they report on formative research on the gendered dimensions of the health issue/outcome of interest that inform a specific intervention, and if documents describing the intervention’s implementation could be located. These documents were not considered in relevancy counts and were not included in the analysis of relevant articles.

<sup>13</sup> These criteria were determined based on input from experts familiar with the Avahan program who could identify the program’s gender-integrated components.

### Step 4: Abstract data

The 196 relevant documents were divided among ERC members for data abstraction; each member reviewed and abstracted data from an average of 30 documents. An ERC member developed a SharePoint database with data abstraction fields. Each reviewer carefully read the full-text document and extracted information related to each field. A second reviewer checked each abstracted document for completeness, correctness, and relevance. The two reviewers discussed and resolved any disagreements over the relevance of the documents and/or abstracted data. For some studies, organizations that implemented a specific intervention and/or conducted the studies were contacted in an effort to gather more information. For instance, some organizations were asked about the gender measurement scale they used, or to clarify how they integrated gender in an intervention. Documents were categorized as accommodating or transformative based on how intervention strategies addressed gender inequalities (see Box B).

#### Box B: Gender-aware Interventions

##### Gender-accommodating Intervention

- Recognizes gender norms and inequalities and works the intervention around them
- Does not address/challenge/change gender norms and inequities

##### Gender-transformative Intervention

- Focuses on creating critical awareness of gender norms, roles, and inequities
- Actively challenges and addresses gender norms, roles, power imbalances, distribution of resources, and other gender-related inequities
- Addresses gender inequities by empowering women or men
- Addresses the root causes of gender inequities

Additional procedures were followed for rating the strength of evidence for each intervention. Drawing on published criteria (Barker et al., 2007), the ERC developed a scheme for rating evidence (see Table 2). This review's adapted scale had two rating points: (1) rigor of evaluation design (i.e., rigorous, moderate, and limited); and (2) level of impact (i.e., high, moderate, low, and mixed), decided on the basis of the types of health outcomes achieved. The final effectiveness rating (i.e., effective, promising, or unclear) was assigned using a combination of these two rating points.

**Table 2. Criteria for Rating the Effectiveness of Interventions**

Evaluation Design	Level of Impact	Overall Effectiveness
<p><b>Rigorous</b></p> <ul style="list-style-type: none"> <li>• Randomized controlled trial (includes randomized control/comparison group)                             <ul style="list-style-type: none"> <li>○ Must include:                                     <ul style="list-style-type: none"> <li>• Statistical significance testing</li> <li>• Adequate discussion of sample-size calculation and selection (e.g., discuss how power/sample size were calculated; discuss why certain people were selected)</li> </ul> </li> </ul> </li> <li>• Quasi-experimental (includes control/comparison group but not randomized)                             <ul style="list-style-type: none"> <li>○ Must include:                                     <ul style="list-style-type: none"> <li>• Statistical significance testing</li> <li>• Adequate discussion of sample-size calculation and selection</li> </ul> </li> </ul> </li> <li>• Either of the above plus qualitative data</li> <li>• Systematic qualitative study (for example, in-depth interviews or focus group discussions) with clear analysis noting sampling strategy (e.g., purposive, quota, snowball, etc. and numbers of interviews conducted and with whom) and analysis process (e.g., coding, memos, etc.), and with indications of validity; also, it looks at changes in outcomes related to the intervention, such as changes in attitudes or health status.</li> </ul>	<p><b>High</b></p> <ul style="list-style-type: none"> <li>• Change in health status</li> <li>• Self-reported behavior + change in knowledge + change in attitudes</li> <li>• Self-reported behavior change + change in knowledge</li> <li>• Self-reported behavior change + change in attitudes</li> <li>• Self-reported behavior change only</li> </ul> <p>Behavior change reported by one or more target groups/intervention sites</p>	<p><b>Effective</b></p> <ul style="list-style-type: none"> <li>• Rigorous design + high impact</li> <li>• Rigorous design + moderate impact</li> <li>• Moderate design + high impact</li> </ul>

Evaluation Design	Level of Impact	Overall Effectiveness
<p><b>Moderate</b></p> <ul style="list-style-type: none"> <li>• Quasi-experimental or randomized controlled trial missing one of the following: <ul style="list-style-type: none"> <li>○ Statistical significance testing</li> <li>○ Adequate discussion of sample-size calculation and selection</li> </ul> </li> <li>• Nonexperimental, with pre- and post-test <ul style="list-style-type: none"> <li>○ No comparison/control group <ul style="list-style-type: none"> <li>• May be: <ul style="list-style-type: none"> <li>• Cross-sectional (with two or more time points) or longitudinal/cohort/panel (multiple time points, same people)</li> </ul> </li> </ul> </li> <li>○ Must also include: <ul style="list-style-type: none"> <li>• Statistical significance testing</li> <li>• Adequate discussion of sample-size calculation and selection</li> </ul> </li> </ul> </li> <li>• Nonexperimental + qualitative data</li> <li>• Policy analysis: must involve systematic methods</li> <li>• May include unsystematic qualitative data; such data do, however, track changes in outcomes related to intervention, such as changes in attitudes or health status <ul style="list-style-type: none"> <li>○ Data analysis unsystematic (no coding, memos, etc.) but study does mention that data analysis was conducted</li> <li>○ Sampling strategy not outlined; study does, however, note numbers of in-depth interviews, focus group discussions, and so forth</li> <li>○ Indications of validity lacking</li> </ul> </li> </ul>	<p><b>Moderate</b></p> <ul style="list-style-type: none"> <li>• Self-reported change in attitude + change in knowledge</li> <li>• Self-reported change in attitude only</li> </ul> <p>Attitudinal change reported by one or more target groups/intervention sites</p>	<p><b>Promising</b></p> <ul style="list-style-type: none"> <li>• Rigorous design + low impact</li> <li>• Rigorous design + mixed impact</li> <li>• Moderate design + moderate impact</li> <li>• Moderate design + low impact</li> <li>• Moderate design + mixed impact</li> </ul>

Evaluation Design	Level of Impact	Overall Effectiveness
<p><b>Limited</b></p> <ul style="list-style-type: none"> <li>• Qualitative data with basic description of methods and results or process evaluation data only                             <ul style="list-style-type: none"> <li>○ Analysis process not discussed</li> <li>○ Sampling strategy not outlined</li> <li>○ Numbers of in-depth interviews or focus group discussions may be unclear</li> <li>○ Indications of validity lacking</li> </ul> </li> <li>• Limited quantitative data                             <ul style="list-style-type: none"> <li>○ Lacks more than one of the following:                                     <ul style="list-style-type: none"> <li>• Statistical significance testing</li> <li>• Adequate discussion of sample-size calculation and selection</li> <li>• Control/comparison group</li> <li>• Pre-/post-test</li> </ul> </li> </ul> </li> </ul>	<p><b>Low</b></p> <ul style="list-style-type: none"> <li>• Change in knowledge</li> <li>• Unclear or confusing results (some positive, some negative)</li> </ul>	<p><b>Unclear</b></p> <ul style="list-style-type: none"> <li>• Limited design, regardless of impact</li> </ul>
	<p><b>Mixed</b></p> <ul style="list-style-type: none"> <li>• High for one target group/intervention site and moderate to low for another (in the same direction, but higher for one group/site than another)</li> <li>• Moderate for one target group/intervention site and low for another (in the same direction, but higher for one group/site than another)</li> </ul>	



### **Step 5: Synthesize data**

To facilitate thematic analysis of abstracted data, an ERC member created and ran reports for each health outcome category, using Microsoft Access database software. These reports presented the outcomes in each health category, organized by gender-aware category (accommodating and transformative), country, Indian states, setting in which the intervention was delivered, gender outcomes, evaluation methodologies, and evidence rating. The team examined the data from the perspective of the number of gender-aware interventions. Documents relating to the same intervention were identified, grouped, and analyzed as one intervention. While synthesizing documents under the same intervention, the team extracted salient and distinct features of the intervention presented by each document.

Drawing on the database reports, the team created tables to identify patterns. For each health outcome category, the analysis looked for patterns in:

- Gender-aware strategies employed by accommodating and transformative programs
- Differences in the types of health outcomes measured and achieved<sup>14</sup> by accommodating and transformative programs
- Types of gender outcomes<sup>15</sup> concurrently achieved by programs addressing health outcomes
- Types of gender-aware strategies used by accommodating and transformative programs, and any differences
- Differences in the settings in which transformative and accommodating programs were delivered, and the settings in which health outcomes were achieved
- Differences in the number and types of quantitative and qualitative evaluation methods used to assess the impact of programs on specific health outcomes

Documents relating to the Avahan program in India were analyzed separately, owing to the nature of the Avahan program, the large number of articles (28) identified, and variations in the way the program was implemented in target states across India. The synthesis of Avahan documents grouped interventions implemented in four of the six Avahan states: Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu.<sup>16</sup> For each state, the analysis identified the implementing partners, the components or strategies an intervention used to prevent the spread of HIV among sex workers, and the health outcomes addressed.

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<sup>14</sup> The analysis examined whether the health outcomes achieved for accommodating and transformative interventions under each health category differed in terms of indicators relating to knowledge, attitudes, behaviors/practices, skills, health status, healthcare providers, and health system/policy.

<sup>15</sup> Gender outcomes were also organized according to knowledge, attitudes, behavior/practices, skills, healthcare providers, and health system/policy.

<sup>16</sup> No relevant articles were found for Avahan implementation in the Indian states of Manipur and Nagaland.

## ANNEX B: GENDER CONCEPTS AND DEFINITIONS

**Sex:** The classification of people as male or female. At birth, infants are assigned a sex based on a combination of bodily characteristics: chromosomes, hormones, internal reproductive organs, and genitalia. (*USAID Gender Equality and Female Empowerment Policy*)

**Gender:** A culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements, and obligations associated with being female and male, as well as the power relations between and among women and men and boys and girls. The definition and expectations of what it means to be a woman or girl and a man or boy and sanctions for not adhering to those expectations vary across cultures and over time, and often intersect with other factors such as race, class, age, and sexual orientation. Transgender individuals, whether they identify as men or women, are subject to the same sets of expectations and sanctions. (*USAID's Office of HIV/AIDS/PEPFAR, modified from IGWG*)

**Gender equity:** The process of being fair to women and men and boys and girls. To ensure fairness, measures must be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men and boys and girls from operating on a level playing field. (*IGWG training resources*)

**Gender equality:** The state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources. Genuine equality means more than parity in numbers or laws on the books; it means expanded freedoms and improved overall quality of life for all people. (*IGWG training resources; USAID Gender Equality and Female Empowerment Policy*)

**Gender-based violence:** In the broadest terms, violence that is directed at individuals based on their biological sex, gender identity, or perceived adherence to culturally-defined expectations of what it means to be a woman or man or girl or boy. GBV refers to both public and private expressions of physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation. GBV is rooted in economic, social, and political inequities between men and women. GBV can occur from infancy through childhood and adolescence, through the reproductive years, and into old age (Moreno, 2005), and can affect women and girls and men and boys, including transgender individuals. Specific types of GBV include (but are not limited to) female infanticide; early and forced marriage, “honor” killings, and female genital cutting/mutilation; child sexual abuse and exploitation; trafficking in persons; sexual coercion, harassment, and abuse; neglect; domestic violence; economic deprivation; and elder abuse. (*Adapted from USAID's Strategy to Prevent and Respond to Gender-Based Violence Globally*)

**Empowerment:** Expansion of people's capacity to make and act on decisions affecting all aspects of life—including decisions related to health—by proactively addressing socioeconomic and other power inequalities in a context in which this capacity was previously denied. Programmatic interventions often focus specifically on empowering women, because of the inequalities in their socioeconomic status. (*Adapted from “The Conditions and Consequences of Choice: Reflections on the Measurement of Women's Empowerment,” by Naila Kabeer [1999]*)

**Men's engagement:** A programmatic approach that involves men and boys (a) as clients and beneficiaries, (b) as partners, and (c) as agents of change in actively promoting gender equality, women's empowerment, and the transformation of inequitable definitions of masculinity. In the health context, this comprises engaging men and boys in addressing their own reproductive, sexual, and other health needs and supporting those of women and girls. Men's engagement also includes broader efforts to promote equality with respect to caregiving, fatherhood, and division of labor, and ending GBV.

**Gender mainstreaming:** The process of incorporating a gender perspective into organizational policies, strategies, and administrative functions, as well as into the institutional culture of an organization. This process at the organizational level ideally results in meaningful gender integration as outlined below. *(Adapted from IGWG training resources)*

**Gender integration:** Strategies applied in programmatic design, implementation, and monitoring and evaluation to take gender considerations (as defined in “gender,” above) into account and to compensate for gender-based inequalities. *(Adapted from IGWG training resources)*

**Transgender:** An umbrella term referring to individuals who do not identify with the sex category assigned to them at birth or whose identity or behavior falls outside of stereotypical gender norms. The term encompasses a diverse array of gender identities and expressions, including identities that fit within a female/male classification and those that do not. “Transgender” is not the same as “intersex,” which refers to biological variation in sex characteristics, including chromosomes, gonads, and/or genitals that do not allow an individual to be distinctly identified as female or male at birth.

**Gender identity:** One’s personal sense of being male, female, neither, or both.

**Sexual orientation:** One’s sexual or romantic attractions. The term includes sexual identity, sexual behavior, and sexual desires.

**Heterosexism:** The presumption that everyone is heterosexual and/or the belief that heterosexual people are naturally superior to lesbian, gay, transgender, and bisexual people. *(Adapted from IGWG training resources)*

**Homophobia:** The fear of, aversion to, or discrimination against homosexuals or homosexual behavior or cultures. Homophobia also refers to internalized heterosexism by homosexuals as well as the fear of men or women who transgress the sociocultural definitions of what it is to be a “true man or woman” or embody “true masculinity or femininity.” *(Adapted from IGWG training resources)*

## ANNEX C: PROGRAM REFERENCES

### Transformative Programs: South Asia

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