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Saving lives. Improving health.
Transforming futures.

Chapter 8: Gender equality continuum

Gendor 101 training materials

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Jhpiego is a nonprofit global leader in the creation and delivery of transformative health care solutions that save lives.

In partnership with national governments, health experts and local communities, we build health providers' skills, and we develop systems that save lives now and guarantee healthier futures for women and their families. Our aim is revolutionizing health care for the planet's most disadvantaged people.

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Chapter 8: Gender equality continuum

Learning objectives

By the end of this session, participants will be able to:

- Distinguish between gender-blind, gender-exploitative, gender-accommodating, and gender-transformative programs
- Describe the features of a gender-transformative program

Time needed

1 hour 30 minutes

Materials needed

- Four copies of this Jamboard template
  - See "Advanced preparation" below for additional notes about preparing Jamboard copies
- Participant Handout: Levels of the Gender Equality Continuum
- Facilitator Resource: Moving Toward Gender-Transformative Programming PowerPoint
- Facilitator Resource: Gender Equality Continuum Case Studies
- Facilitator Resource: Additional Gender Equality Continuum Case Studies by Technical Area
- Facilitator Resource: Gender Equality Continuum Case Studies—Answers
- Facilitator Resource: Additional Gender Equality Continuum Case Studies by Technical Area—Answers

Advance preparation

1. Email copies of the Participant Handout: Levels of the Gender Equality Continuum to participants.
2. Make one copy of the Jamboard template for each of the four groups.
   - Review the **Facilitator Resource: Gender Equality Continuum Case Studies** and select the case studies that are most relevant to your group.
   - Copy and paste one case study onto each frame of the four Jamboards (there are two frames per Jamboard, and there should be different case studies on each frame). You should replace the example case studies that are currently on the Jamboard frames.
   - As you are adding case studies to each Jamboard, make sure that *two of the groups* have *one case study in common* (all other case studies should be unique to each group). Additionally, each Jamboard should include case studies corresponding to two different categories of the gender equality continuum.
   - Label each Jamboard "Group 1", "Group 2", etc.
   - Prepare a list of your Jamboards and their links to ensure you can easily copy and paste the information into the Zoom chat during the live session. Example:
     - Group 1: [link to Jamboard]
     - Group 2: [link to Jamboard]

- Group 3: [link to Jamboard]
- Group 4: [link to Jamboard]

3. Save a copy of the **Moving Toward Gender-Transformative Programming PowerPoint** to your laptop and practice presenting before the session to ensure that you fully understand the various concepts.
4. Review the two options for facilitating a discussion around case study examples (see "The gender equality continuum") and decide which option you will implement during the session.
5. [If you will be implementing **Option 1: Zoom Annotations** below] You will use slides 17 and 20 of the **Moving Toward Gender-Transformative Programming PowerPoint** for the plenary exercise.
6. [If you will be implementing **Option 2: Zoom Polling** below] Log into Zoom.us and add the following poll to your Zoom meeting *(review the Technical Facilitator Guidance for more information on adding polls to a Zoom meeting).*
   - Question: Where would you place the case study along the Gender Continuum?
   - Answer Choices (single choice):
     - Blind
     - Exploitative
     - Accommodating
     - Transformative
7. [If you will be implementing **Option 1: Zoom Annotations** below] Check to ensure that Zoom annotations is enabled for your Zoom meetings. *(Review the Technical Facilitator Guidance for more information on enabling annotations).*

Steps

Introduction (5 minutes)

Facilitator note: The Facilitator Resource: Additional Gender Equality Continuum Case Studies by Technical Area includes case studies based on the following technical areas: agriculture; education; environment; family planning/reproductive health/HIV/gender-based violence (FP/RH/HIV/GBV); health policy; key populations; male health; maternal, newborn, and child health (MNCH); water, sanitation, and health (WASH); and youth. These scenarios are available for you to incorporate into the activity if you find them useful. The answers for these case studies can be found in the Facilitator Resource: Additional Gender Equality Continuum Case Studies by Technical Area—Answers.

1. **Technology Action:** At any point after participants arrive, you may begin to prepare breakout rooms for the "Applying the gender equality continuum" activity.
   - 4 groups (randomly distributed participants)
   - Check "Breakout rooms automatically close after"
     - 5 minutes
   - Check "Notify me when time is up"
   - Countdown after closing breakout room: 30 seconds

2. Explain to participants that they will spend some time exploring how gender can affect the outcome of a project by becoming familiar with a conceptual framework known as the *gender equality continuum*. The Interagency Gender Working Group (IGWG) designed the continuum as a guide to various projects on how to integrate gender. This framework categorizes projects/programs based on how they treat gender norms and inequities in their design, implementation, and monitoring and evaluation.

The gender equality continuum (25 minutes)

1. **Technology Action:** Screenshare the Moving Toward Gender-Transformative Programming PowerPoint
2. Use the facilitator discussion points under each slide to explain the various levels of the continuum. Present slides 1 through 14. (Spend no more than 15 minutes on this step).
3. When you get to slide 15, explain that the group will discuss two project examples. Ask for a participant to read the first example aloud.

> **Facilitator Note:** For steps 4-8, select from one of the following options. Consider with which option you are most comfortable, as well as which option will best engage your specific participants.

Option 1: Zoom Annotations

1. Next, explain that each participant will have an opportunity to share where they think the project falls along the continuum. Display a simple slide showing the gender equality continuum. Explain that participants will share where they think the case study falls by using Zoom's annotation feature.
2. Explain how to use Zoom's annotation feature using the following language:
3. "There are two steps required in order to access the Zoom annotation feature. First, find the green bar at the top of your screen that says 'You are viewing [name's] screen.' You may need to move your cursor in order to see this. Next to the green bar, it will say 'View Options'. Click on 'View Options'. Then click 'Annotate'. You will now be able to annotate on the screen. Everyone will be able to see what you write or add. We're going to use the 'Stamp' feature. Find where it says 'Stamp' near the top of your screen. Then, select the 'Star'. Now, you can click anywhere on the screen in order to add a star."
4. Ask everyone to stamp the section of the gender equality continuum where they would place the case study. Then, invite a few participants to share where they placed the case study and why. Finally, explain the answer and allow participants to ask questions. (Spend no more than 5 minutes on the first example). Clear the annotations from the screen by clicking the icon of a trashcan.
5. Repeat step 6 for the next example. (Spend no more than 5 minutes on the second example)
6. Before moving on to the next part of the activity, allow participants to ask any lingering questions. Remind participants that they can access the **Participant Handout: Levels of the Gender Equality Continuum** from their email after this session if they'd like to review anything discussed.

Option 2: Zoom Polling

1. Next, explain that each participant will have an opportunity to share where they think the project falls along the continuum.
2. **Technology Action:** Launch your Zoom poll. Give participants 30 to 45 seconds to respond, and then close the poll once all or most participants have responded. Share the results of the poll.

3. Invite a few participants to share how they responded and why. Finally, explain the answer and allow participants to ask questions. (Spend no more than 5 minutes on the first example)
4. Repeat steps 5 to 6 for the next example. (Spend no more than 5 minutes on the second example)

> **Technology Note:** You will be informed that "Re-launching the poll will clear existing polling results. Do you want to continue?" Select "Continue".
>
> If you would prefer to have all results of the poll saved, you may create two separate polls (one for each case study). Note that this will need to be completed prior to the start of the session.

5. Before moving on to the next part of the activity, allow participants to ask any lingering questions. Remind participants that they can access the **Participant Handout: Levels of the Gender Equality Continuum** from their email after this session if they'd like to review anything discussed.

Applying the gender equality continuum (55 minutes)

1. Tell participants that in the next part of the session they will have a chance to look at more program/project examples and place them along the continuum.
2. Explain that participants will be divided into four breakout groups, and that each breakout group will receive two case studies. The case studies will be written on a Jamboard; each case study will be on a separate frame.
3. **Technology Action:** Screen share a sample Jamboard to show the group as you explain the following.

   Each group will have 5 minutes to read their case studies and decide (as a group) where each of the examples fall along the continuum. Once the group has reached a consensus, one individual should drag and drop the star onto the correct spot along the continuum. Remind participants that some projects may not fit squarely under one category but may instead fall somewhere along the continuum. Remind participants that, to move to the next frame with the second case study, they should click the black arrow (>) at the top of the screen.

> **Technology Note:** If participants are having any problem moving their star icon, explain that participants should move their cursor over the star such that their cursor switches to an icon with four arrows (see image to right). This cursor will allow them to move the star.
>
> 

4. Explain that you will share in the chat links to each group's Jamboard. Explain that, as they are being moved to a breakout room, participants will see on their screen to which numbered room they are being moved. Once they are in their breakout rooms, their room number will appear at the top of the Zoom screen. Their breakout room number will represent their group number, and should thus be used to know which Jamboard to open.
5. **Technology Action:** Copy and paste into the chat links to each Jamboard. Jamboards should be clearly labeled Group 1, Group 2, etc. (see example below).
   - Example:
     - Group 1: [Link to Jamboard]
     - Group 2: [Link to Jamboard]
     - Group 3: [Link to Jamboard]
     - Group 4: [Link to Jamboard]

6. Make sure participants understand the instructions. Remind them that they should use the "Ask for Help" button if they have questions for a facilitator while in their breakout room. (Spend no more than 5 minutes on steps 1 to 7).
7. **Technology Action:** Open the breakout rooms.
8. **Technology Action:** Open each Jamboard on a different tab in your computer. Regularly review each Jamboard to ensure that at least one participant has opened the board and, eventually, that groups have dragged and dropped their star onto a location along the continuum. Join any groups where no one is on the Jamboard after 30-40 seconds, or where no star has been moved after 3-4 minutes.

> **Technology Note:** Anonymous circles at the top right corner of the Jamboard will indicate whether or not participants have opened the Jamboard.

9. **Technology Action:** Send a broadcast message reminding participants when they have 1 minute left. After approximately 5 minutes, close the breakout rooms.
10. **Technology Action:** Share your screen and show the first group's Jamboard.
11. Ask for a spokesperson from Group 1 to explain their group's work. Ask the representative to read the first case study assigned to their group, and then to explain why the group placed the example where they did. Next, ask the other workshop participants if they agree with the placement and if not, where they think it should go. Allow for some discussion and debate before offering the answer (refer to **Facilitator Resource: Gender Equality Continuum Case Studies—Answers**). Then, ask the same group representative to read the second case study assigned to their group, and follow the same process used for the group's first case study.
12. Repeat step 12 for the remaining case studies. (Spend no more than 4 minutes on each case study).

> **Facilitator note:** For the two groups that had one case study in common, after one of the groups has explained its placement, ask the other group if it placed the example in the same category and if not, why.
>
> **Facilitator note:** In most cases, there is no "correct" answer for these examples, as participants' interpretation of the project's intention or design will inevitably be influenced by their cultural/social realities. Encourage diversity in this exercise, letting people explain their placements and any assumptions they made to arrive at their decision.

Closing (5 minutes)

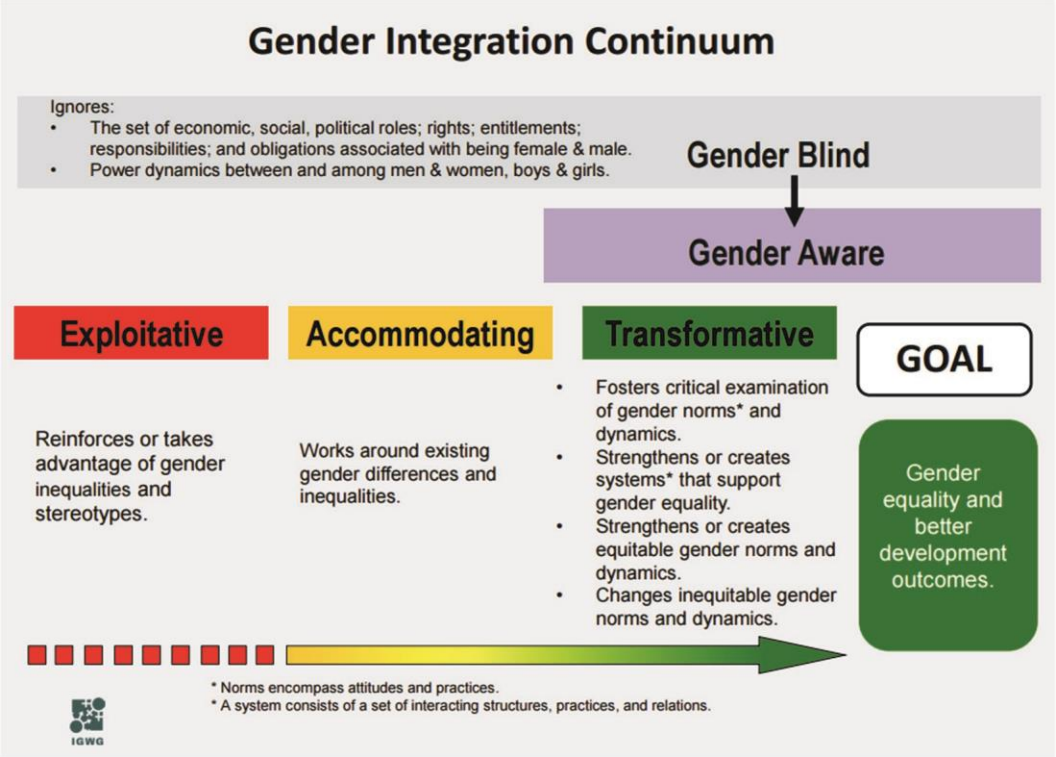
1. End the session by reminding participants of the following points:
    - Projects/programs will not necessarily fall neatly under one level of the continuum. For example, a project/program may include both accommodating and transformative elements.
    - Although the continuum focuses on gender integration in the design phase, it can also be used to monitor and evaluate gender and health outcomes with the understanding that sometimes programs lead to unintended consequences. For example, an accommodating approach may contribute to a transformative outcome even if that was not the intended objective; conversely, a transformative approach may produce a reaction that, at least temporarily, exacerbates gender inequities.
    - Projects/programs must follow two gender-integration principles:
        - Under no circumstances should programs/policies adopt an exploitative approach since one of the fundamental principles of development is to "do no harm."

- The overall objective of gender integration is to move toward gender-transformative programs/policies, thus gradually challenging existing gender inequities and promoting positive changes in gender roles, norms, and power dynamics.

Sources

- Population Reference Bureau. 2009. A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action, 2nd ed. Washington, DC: Population Reference Bureau; 9–17.
- Population Reference Bureau. 2017. *The Gender Integration Continuum: Training Session User's Guide*. Washington, DC: Population Reference Bureau; 20–22.
- Population Reference Bureau. 2017. *The Gender Integration Continuum: User's Guide Scenarios Bank*. Washington, DC: Population Reference Bureau; 3–19.

Participant handout: Levels of the gender equality continuum



Source: IGWG, https:/www.igwg.org/about-igwg

The graphic depicts a specific program environment. The gender equality continuum is a tool for designers and implementers to use in planning how to integrate gender into their programs.

- **Gender-blind** programs do not consider the gender norms that characterize the social environment and the ways in which they might affect program/project participants. Gender-blind programs/policies do not consider how gender norms and unequal power relations affect the achievement of project objectives, or how the project objectives might impact gender norms and unequal power relationships.
- **Gender-aware** programs are designed to take advantage of existing gender norms and power relations, accommodate them, or transform them. Programs may have multiple components that fall at various points along the continuum. The ultimate goal of development programs is to achieve health outcomes while transforming gender norms to achieve greater equality between women and men. The part of the arrow related to "transformative" is green to signal that it is okay to proceed. It then extends indefinitely toward greater equality (beyond the arrow). Gender-aware programs can be categorized as:
    - Gender exploitative (taking advantage of existing harmful gender norms)
    - Gender accommodating (working around harmful gender norms without striving to challenge or change them), or
    - Gender transformative (actively addressing harmful gender norms and working to change them).
- **Gender-exploitative** programs (on the left of the continuum) take advantage of rigid gender norms and existing power imbalances to achieve their objectives. Although using a gender-exploitative approach may seem expeditious in the short run, it is unlikely to contribute to sustainable results

and can, in the long run, result in harmful consequences and undermine the program's intended objective. Under no circumstances should programs take advantage of existing gender inequalities in pursuit of health outcomes ("Do no harm!").

- **Gender-accommodating** programs (in the middle of the continuum) acknowledge the role of gender norms and inequities and seek to develop actions that adjust to and often compensate for them. Although such projects do not actively seek to change these norms and inequities, they strive to limit their harmful impacts on gender relations. A gender-accommodating program may be considered a missed opportunity because it does not deliberately contribute to increased gender equity, nor does it address the underlying social, political, and economic factors that perpetuate gender inequities. However, in social and cultural contexts where gender norms remain a highly sensitive issue, gender-accommodating approaches often provide a sensible first step to gender integration because they strive to ensure that all project participants can equally benefit from the project's efforts. As unequal power relations and harmful gender norms are recognized and addressed through programs, a gradual shift toward challenging gender inequities may take place.
- **Gender-transformative** programs (at the right end of the continuum) actively strive to examine, question, and change harmful gender norms and power imbalances between women and men as a means of achieving positive health outcomes as well as gender equity. Gender-transformative approaches encourage critical awareness among men and women of gender roles and norms; promote women's social, economic, and political positioning; challenge the unequal distribution of resources and allocation of duties between women and men; and/or address the power relationships between women and others in the community, such as service providers and traditional leaders.

The gender-equality continuum, in brief:

- Blind: Projects that do not take gender into account at all.
- Aware: Projects that acknowledge the role of gender norms and develop actions to adjust to them rather than challenge and transform them.
- Exploitative: Projects that reinforce or take advantage of gender inequalities.
- Accommodating: Projects that work around existing gender norms and inequalities and do not seek to challenge or change them.
- Transformative: Projects that seek to transform gender norms to achieve positive health outcomes and gender equality.

Facilitator resource: Gender equality continuum case studies

Case study 1: Strengthening PLHIV networks in the Asia-Pacific region

A project in the Asia-Pacific region sought to strengthen the organizational capacity of networks for people living with HIV (PLHIV). To help foster organizational development, the project supported the development of a detailed, user-friendly manual with concrete step-by-step guidance on how to carry out a self-assessment of organizational strengths and weaknesses, with resource materials and activities to strengthen areas identified as challenges. PLHIV regional network members led development of the manual and serve as a technical assistance resource to country-level organizations as they seek to implement network strengthening**.** Women members of the PLHIV networks complained that the manual did not take into account the special needs of women living with HIV.

Case study 2: Preventing malaria in Nigeria

A malaria prevention program in Nigeria sought to increase the use of bed nets in a poor, rural area. Due to budget constraints, the program was only able to provide one net per family. Community health workers emphasized the dangers of malaria during pregnancy and encouraged families to prioritize pregnant mothers to use the nets. However, because men are the main breadwinners in many Nigerian families, the families agreed to prioritize male heads of household and sons to sleep under the nets to ensure that they would not miss work or forego crucial earnings due to being sick with malaria.

Case study 3: Female condom promotion in South Africa

A pilot program was designed to increase the acceptability and use of female condoms in South Africa. Historically, female condoms were promoted to women. The program designed its strategies around findings from preliminary research that showed that men's interest in any contraceptive method was likely to be based on maintaining control over their partners' sexuality. Program strategies were also based on evidence that men are preponderantly concerned with retaining control over the means of protection against HIV and sexually transmitted infections. The program therefore decided to promote the female condom to men through male peer promoters. This involved: (1) demonstrating to men the use of the female condom; (2) explaining to men that self-protection and sexual pleasure are compatible with the use of the female condom, especially when compared to currently available barrier alternatives; and (3) giving female condoms to the men to use with their female partners.

Case study 4: Condom social marketing in Guatemala

The goal of a condom social marketing campaign in Guatemala was to increase condom sales for HIV, sexually transmitted infections, and pregnancy prevention. The campaign capitalized on social and cultural values that focus on male virility, sexual conquest, and control. It depicted macho men having multiple female sex partners, with slogans referencing different color condoms and saying on Monday it's yellow for Yolanda, on Tuesday it's red for Ruby, on Wednesday it's blue for Beatriz, etc.

Case study 5: Female genital cutting prevention program in Kenya

A female genital cutting (FGC) intervention in Kenya sought to reduce the incidence of harmful cutting. Project staff realized that creating a law to prohibit the practice would not address the cultural and social motivations of the community, and would likely result in driving the practice "underground." Instead, the project hired a medical anthropologist to work with the community.
Through qualitative interviews with groups of women, men, and religious leaders, the project sought to understand the meaning and functions that the ritual provides to the community. They determined that the ritual is a rite of passage for girls to enter adulthood. Together with community members, the project staff adapted the FGC ritual by eliminating the harmful cutting but keeping the "healthy" cultural

elements, such as seclusion of girls, dance, storytelling, gift giving, health, hygiene, and sexual education, emphasizing a woman's role with her partner. As a result, a new rite-of-passage ritual was created for girls called "circumcision with words," which has become accepted by the entire community.

Case study 6: Gender-based violence prevention in Burundi

A community-based outreach program in Burundi sought to reduce gender-based violence (GBV) and its resulting health complications, including HIV. Recognizing that adolescent girls and young women are at particular risk of experiencing GBV, the program planners used a peer-based prevention model to empower young women and adolescent girls to protect themselves from GBV. It focused on educating participants about the prevalence and health consequences of GBV, as well as their right to live free of violence. Some topics included safety planning for women whose male partners are violent, peaceful conflict-resolution skills, and where to seek GBV services for physical, sexual, emotional, and financial abuse.

Case study 7: Sexual enrichment for married couples in Mozambique

An HIV prevention project in Mozambique sought to promote safer sex among married couples by tackling one of the reasons that husbands were having sex outside of their marriages: they were bored with their sex lives at home. Preliminary research showed that men justified extra-marital sex by complaining that their wives would not agree to sexual experimentation, especially with regard to sex positions. Women, on the other hand, reported that, "I am never asked what I like in sex, if I like sex, and if I even want sex, so why should I do anything that gives him pleasure?" To transform these gendered expectations that pose as challenges, the project promoted greater dialogue among couples about their sexual desires. The project successfully advocated with local temples and mosques by explaining to religiously affiliated participants the importance of talking more openly about sex and helping them understand that open dialogue among married couples about sex and pleasure is not a threat to culture, religion, or people's sensibilities. Religious leaders supported the project, teaching couples about better sex by getting women and men to talk openly about what they like and do not like about sex in group and couple settings.

Case study 8: Mass media to reach youth on reproductive health in Nicaragua

A Nicaraguan nongovernmental organization produced a popular TV soap opera (*telenovela*) to introduce a range of social and health issues (e.g., pregnancy, HIV prevention, gender-based violence, and discrimination against the physically disabled) into public debate. Since the soap opera was particularly popular with youth, it presented the opportunity to address and challenge traditional gender roles. One storyline followed a young couple as they fell in love, and through their discussions about intimacy, contraception, and sexually transmitted infections. The male character in the couple was sensitive and caring toward his female partner, and they engaged in open communication about sexuality and family planning. In another episode, the young woman was raped. The telenovela then dealt with the aftermath of sexual violence, including women's legal rights in Nicaragua, and the effect of rape on intimacy.

Case study 9: Tackling gender barriers to keep midwives in school in Ethiopia

In Ethiopia, gender inequalities result in low participation and success of women in education. The few women that join higher education institutions generally have lower academic performance and higher forced withdrawal than men. Gender barriers include poor academic performance, pregnancy, adjustment challenges, lack of orientation, low self-confidence, and financial constraints.

Jhpiego, through the USAID-funded Strengthening Human Resources for Health Project, implemented a project to reduce gender disparities in midwifery pre-service education. The project has supported health education institutions to establish gender offices, trained gender counselors to conduct life skills training for female students, provided orientation and academic counseling services to female students, and supported female students to adapt to college life. The project also supported gender offices to recognize high-performing female students, establish sexual harassment policies, and provide scholarships to female students in need. The gender offices have also served as a space where female students receive mentorship and social/financial support, thereby minimizing dropout rates and improving academic performance. For example, female students receive counseling so they do not leave school when they get pregnant.

Case study 10: Community-based delivery of long-acting methods of contraception in Ethiopia

The ministry of health (MoH) in Ethiopia wants to address the unmet need for contraception by expanding access to long-acting methods, including the implant (Implanon/Jadelle). To meet this need, the MoH is training community health extension workers, who already go door-to-door addressing a range of health issues (for example, water and sanitation, HIV, immunization, and family planning) to offer Implanon. Community health workers are being trained to provide information on Implanon (as part of their family planning counseling), screen women for medical eligibility criteria, and provide Implanon (in addition to condoms and contraceptive pills).

Case study 11: HIV/AIDS prevention in Thailand

This HIV/AIDS prevention project provided education, negotiation skills, and free condoms to commercial sex workers (CSWs) in Thailand. Although knowledge and skills among CSWs increased, actual condom use remained low. After further discussions with the CSWs, project managers realized that CSWs weren't successful in using condoms because they did not have the power to insist on condom use with their clients. The project then shifted its approach and enlisted brothel owners as proponents of a "100% condom -use policy." Brothel owners, who did have power and authority, were able to insist that all clients use condoms. Since the vast majority of brothels in the project region participated in the project, it resulted in significant increases in safe- sex practices.

Case Study 12: Social marketing campaign in Tanzania

A social marketing campaign in Tanzania had a similar goal: to increase condom sales. Project designers realized that in Tanzania, only a small percentage of condom sales were to women. Training indicated that women were having a hard time initiating condom use. Therefore, one of its posters explicitly showed a woman at a bar talking to a male partner and insisting that he use a condom.

Case Study 13: Supply chain system in Country X

Recognizing that contraceptive stock-outs are a significant problem in delivering high-quality and reliable services, the ministry of health (MoH) in Country X redoubled its efforts to improve its supply chain system. This involved a thorough assessment to better quantify and forecast commodity needs at the central, regional, and service delivery point (SDP) levels. An electronic Logistics Management and Information System (eLMIS) was developed to capture more detailed information about the procurement, shipping, and issuing of commodities. The MoH agreed to hire more supply chain staff, and additional training was provided to all personnel in order to roll out the new system. But the MoH did not consider gender factors affecting staff training— for example, rolling out the training without checking current composition of staff, and which times, locations, and format are optimal depending on the sex/gender make up of their eLMIS staff. There was no gender analysis of demand for commodities and patterns of stock-outs (for example, are emergency contraceptive or other methods that women can use clandestinely readily available).

Facilitator resource: Additional gender equality continuum case studies by technical area

Family planning/reproductive health/HIV/gender-based violence (FP/RH/HIV/GBV)

FP/RH/HIV/GBV scenario #1

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

FP/RH/HIV/GBV scenario #2

In rural Egypt, women tend to follow strict cultural rules related to modesty and seclusion that substantially restrict their physical mobility outside the home. This, coupled with limited control over resources and decision-making, has affected women's ability to access family planning services. To address these challenges, the local health district trained female community health workers to bring reproductive health services to women's doorsteps. These health workers visit women in their homes, providing counseling, information, and access to certain methods of contraception.

FP/RH/HIV/GBV scenario #3

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

FP/RH/HIV/GBV scenario #4

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

FP/RH/HIV/GBV scenario #5

During regular business hours, public sector family planning clinics in urban Uganda are often busy, with many clients congregating and waiting to be seen by providers. To take advantage of this captive

audience, a clinic developed short videos that run on a continuous loop, providing details about available contraceptive methods. The information shared includes basic details on how the methods are administered, their health advantages, and possible side effects.

Health policy

Health policy scenario #1

A local council and an NGO teamed up to build a public library in a mid-size, highly dispersed town with a third of its population living in nearby neighborhoods not easily accessible by local transport. From the outset, the library aimed to work with young people—both males and females—as part of the community's efforts to improve secondary education. After great deliberation and effort, a local philanthropist living abroad agreed to donate land at the lively center of town, facing the local cafes and billiard halls that attract young and middle-aged men. A stipulation of the donation was that the philanthropist's male cousin, an expert librarian, would manage the library. The library charged a small annual membership fee, limited the number of borrowed books to three at a time, and required that the books be returned or renewed after 1 week. After young women visiting the library complained they were being harassed by the men smoking and playing billiards across the street, the librarian opened a new rear entrance for women and designated a section of the library for women's use only.

Health policy scenario #2

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

Health policy scenario #3

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

Health policy scenario #4

In Country Q, community-based NGOs sought to gain inheritance and property rights for women. To do so, these groups conducted an analysis to identify which processes—at the level of cultural norms, implementation and decision-making structures, and written laws— presented barriers to women

accessing their rights, and developed an advocacy strategy based on this analysis. In particular, the analysis identified key barriers such as cultural norms that "women who love don't talk about money and property" and structural barriers where local land boards were physically far from women and also institutionally unfriendly (very male dominated). The advocacy strategy thus decided to focus on lobbying traditional decision-making structures led by traditional male authorities, such as councils of elders, to increase their awareness and support for women's property rights, and have them in turn issue decrees to support women's rights and raise the issue of women's inheritance and property rights with local land boards. In the first 6 months after the advocacy was initiated, 20 women were able to reclaim their property.

Health policy scenario #5

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

Health policy scenario #6

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

Health policy scenario #7

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

Health policy scenario #8

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

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

Health policy scenario #9

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

Health policy scenario #10

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

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

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

Key populations

Key populations scenario #1

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

Key populations scenario #2

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

Key populations scenario #3

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

Key populations scenario #4

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

Key populations scenario #5

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

Male health

Male health scenario #1

To increase contraceptive use and male involvement, a family planning project initiated a communication campaign promoting the importance of men's participation in family planning decisionmaking. Messages relied on sports images and metaphors, such as "Play the game right. Once you are in control, it's easy to be a winner" and "It is your choice." The campaign increased the use of contraceptive methods. When evaluating impact, the project asked male respondents who should ideally be responsible for making family planning decisions—them, their partners, or both members of the couple. The evaluation found that, "Whereas men were far more likely to believe that they should take an active role in family planning matters after the campaign, they did not necessarily accept the concepts of joint decision-making. Men apparently misinterpreted the campaign messages to mean that family planning decisions should be made by men alone."

Male health scenario #2

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

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

Male health scenario #3

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

Maternal, newborn, and child health (MNCH)

MNCH scenario #1

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

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

MNCH scenario #2

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

MNCH scenario #3

A child survival project in Country Q, aiming to reduce disease and death rates among children and women of reproductive age, focused on using indigenous knowledge and cultural resources to increase and improve communication and health-seeking behavior during pregnancy. Research showed that one of the most important obstacles to women's maternal health care-seeking behaviors was the absence of discussion about pregnancy between husbands and wives, as well as with other household members. The women in this area felt that they could not take advantage of maternal services because they could not initiate conversations with their husbands or solicit their consent and financial support as the heads of household. The project staff asked a *griot* to compose a song to educate people about maternal health care, along with promoting the *pendelu* (a traditional article of women's clothing) as a symbol of pregnancy and couple communication. This campaign dramatically increased the level of communication between wives and husbands concerning maternal health. Additionally, the campaign resulted in more positive attitudes and behaviors related to pregnancy at the household level, including husbands supporting their wives by reducing their workloads, improving their nutrition, and urging them to seek medical attention and maternal health services.

MNCH scenario #4

A group of HIV-positive mothers of small children organized to become advocates for prevention of mother-to-child transmission of HIV (PMTCT) and for HIV-positive mothers. The group encourages women to attend prenatal clinics, where they can access PMTCT services if they are HIV-positive. The group also educates HIV-positive mothers in their communities in life skills, PMTCT, infant care, and human rights. They use song, dance, and drama, as well as appearances on television and radio, where

they share their experiences as HIV-positive mothers and call for a reduction in stigma and discrimination. The peer educators also increase women's access to income by training HIV-positive mothers in personal financial management and income generation by tailoring, farming, and selling handicrafts. Finally, the group partners with HIV-positive men's networks to encourage men to value fatherhood and to become involved in PMTCT.

MNCH scenario #5

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

MNCH scenario #6

A multipronged program to improve maternal and child health in several Delhi slums works on diarrheal case management, increasing institutional births, and increasing immunization, among other things. The program conducts community outreach through the formation of women's groups focused on health, and has also provided some limited access to credit. Although the program targets women of reproductive age and children, it also reaches out to men as decision-makers. The program runs local TV ads for services, encouraging men to support their partners in taking children for prevention and treatment, and directing messages at men and women. The program reaches out to religious leaders and men at mosques on the need to take their wives for services.

Water, sanitation, and health (WASH)

WASH scenario #1

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

WASH scenario #2

The Central American Hand Washing Institute aimed to reduce disease and death among children under age 5 through a communication campaign promoting proper handwashing with soap to prevent diarrheal disease. Four soap companies launched handwashing promotion campaigns that included radio and television advertisements; posters and fliers; school, municipal, and health center programs; distribution of soap samples; promotional events; and print advertisements. The basic approach was to present a mother as the caretaker of the family and to describe or illustrate the three critical times for handwashing: before cooking or preparing food; before feeding a child or eating; and after defecation, cleaning a baby, or changing a diaper. The promotion also emphasized essential aspects of handwashing technique: use water and soap, rub one's hands together at least three times, and dry hands hygienically.

WASH scenario #3

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

Youth related

Youth scenario #1

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

Youth scenario #2

A project sought to involve young people in the care and support of people living with HIV (PLHIV). This project carried out formative research to assess young people's interest and to explore the gender dimensions of care. The assessment explored what caregiving tasks male and female youth feel more comfortable with and are able to provide, as well as what tasks PLHIV themselves would prefer a male

or female youth provide. Based on this research, the project adopted an approach that incorporates preferred tasks for young women and young men.

Youth scenario #3

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

Youth scenario #4

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

Youth scenario #5

A program in Country N challenges traditional boys' and girls' roles. It works with 10- to 14-year-old boys and girls, bringing them together at child clubs for participatory workshops 1 hour per week for 8 weeks.

Sessions explore young people's hopes, dreams, and ideas about gender equality, power, and fairness. They identify small actions that brothers can take to promote respect and empower girls in their homes. Results of the initial program show boys are making small changes in their own behavior—helping their sisters and mothers with household chores; advocating for their sisters' education and against early marriage; and encouraging family members, friends, and neighbors to do the same. Compared with those who did not participate, more girls in the program-intervention group state that their brothers and other boys in their communities are making small changes toward gender equality. Parents also report that their sons now help their daughters with schoolwork and chores, and that their households are more peaceful as a result.

Facilitator resource: Gender equality continuum case studies—answers

#	Case study	Category	Explanation
1	A project in the Asia-Pacific region sought to strengthen the organizational capacity of networks for people living with HIV (PLHIV). To help foster organizational development, the project supported the development of a detailed, userfriendly manual with concrete step-by-step guidance on how to carry out a self-assessment of organizational strengths and weaknesses, with resource materials and activities to strengthen any areas identified as challenges. PLHIV regional network members led development of the manual and served as a technical assistance resource to country-level organizations as they sought to implement network strengthening. Women members of the PLHIV networks complained that the manual did not take into account the special needs of women living with HIV.	**Blind**	Although the project ensured the participation of its target audience in the manual's development, the manual itself did not take into account specific challenges faced by women living with HIV. As a result, the project ignored the important needs of a significant portion of its target audience, and it may also have compromised its potential for impact.
2	A malaria prevention program in Nigeria sought to increase the use of bed nets in a poor, rural area. Due to budget constraints, the program was only able to provide one net per family. Community health workers emphasized the dangers of malaria during pregnancy, and encouraged families to prioritize pregnant mothers to use the nets. However, because men are the main breadwinners in many Nigerian families, the families agreed to prioritize male heads of household and sons to sleep under the nets, to ensure that they would not miss work or forego crucial earnings due to being sick with malaria.	**Blind**	The project failed to account for gender norms (leaving it up to families to make the decision on their own) and in so doing may have significantly undermined its objectives by failing to address the important health needs of pregnant mothers. Additionally, the project may have contributed to a larger health issue resulting from the contraction of malaria during pregnancy.
3	A pilot program was designed to increase the acceptability and use of female condoms in South Africa. Historically, female condoms were promoted to women. The program designed its strategies around findings from preliminary research that showed that men's interest in any contraceptive method was likely to be based on maintaining control over their partners' sexuality. Program strategies were also based on evidence that men are preponderantly concerned with retaining control over the means of protection against HIV and sexually transmitted infections (STIs). The program therefore decided to promote the female condom to men through male peer promoters. This involved: (1) demonstrating to men the use of the female condom; (2) explaining to men that self-protection and sexual pleasure are compatible with the use of the female condom, especially when compared to currently available barrier alternatives; and (3) giving female condoms to the men to use with their female partners.	**Exploitative**	This program had an explicit intention of empowering men to use a technology that was developed to give women more control over decisions about contraception and protection from STIs and HIV. It exploited dominant norms supporting men's power over sexual and reproductive decisions to achieve a health outcome, and it reinforced men's control over the means of protection. Although some may interpret this project as accommodating rather than exploitative, because it engaged men around the use of a method ostensibly controlled by women, it ended up shifting that control to men.
4	The goal of a condom social marketing campaign in Guatemala was to increase condom sales for HIV, STIs, and pregnancy prevention. The campaign capitalized on social and	**Exploitative**	The campaign capitalized on social and cultural values supporting men's virility, sexual conquest, and

#	Case study	Category	Explanation
	cultural values that focus on male virility, sexual conquest, and control. It depicted macho men having multiple female sex partners, with slogans referencing different color condoms and saying on Monday it's yellow for Yolanda, on Tuesday it' s red for Ruby, on Wednesday it's blue for Beatriz, etc.		control. It reinforced the expectation/stereotype that "macho" men have multiple female sexual partners. It also contradicted other health efforts to promote safer sex practices through partner reduction.
5	A female genital cutting (FGC) intervention in Kenya sought to reduce the incidence of harmful cutting. Project staff realized that creating a law to prohibit the practice would not address the cultural and social motivations of the community, and would likely result in driving the practice "underground." Instead, the project hired a medical anthropologist to work with the community. Through qualitative interviews with groups of women, men, and religious leaders, the project sought to understand the meaning and functions that the ritual provides to the community. They determined that the ritual is a rite of passage for girls to enter adulthood. Together with community members, the project staff adapted the FGC ritual by eliminating the harmful cutting but keeping the "healthy" cultural elements, such as seclusion of girls, dance, storytelling, gift giving, health, hygiene, and sexual education, emphasizing a woman's role with her partner. As a result, a new rite-of-passage ritual was created for girls called "circumcision with words," which has become accepted by the entire community.	**Accommodating to transformative**	This is an example of a project that does not fall neatly on the continuum. Indeed, the project is accommodating but also includes some elements that make it somewhat transformative. Although the project contributed to the elimination of a harmful cultural practice through community engagement, it did not challenge the gender norms underpinning the practice and that revolved around the social control of women's/girls' sexuality (e.g., importance of female virginity), and the promotion and protection of traditional/reproductive roles for women (i.e., being wives, being mothers). To become truly transformative, the project would need to engage communities in challenging dominant norms of femininity so as to shift women's social positioning. However, given the highly sensitive and controversial nature of FGC, the project may be considered slightly transformative in the sense that it began challenging the idea that girls' transition to womanhood requires a measure to physically preserve their virginity.
6	A community-based outreach program in Burundi sought to reduce gender-based violence (GBV) and its resulting health complications, including HIV. Recognizing that adolescent girls and young women are at particular risk of experiencing GBV, the program planners used a peer-based prevention model to empower young women and adolescent girls to protect themselves from GBV. It focused on educating participants about the prevalence and health consequences of GBV, as well as their right to live free of violence. Topics included safety planning for women whose male partners are violent, peaceful conflict-resolution skills, and where to seek GBV services for physical, sexual, emotional, and financial abuse.	**Accommodating to transformative**	The program is mostly accommodating but also includes some transformative aspects. On one hand, the program focused on restoring power to women by equipping them with the information and skills needed to reduce their vulnerability to violence. On the other hand, the program may have perpetuated the dominant social perception of women as helpless victims. The program also placed all of the responsibility for violence prevention on women, and did not include any strategies to engage men in violence prevention, or provide space for men to reflect on dominant gender norms condoning violence against women.

#	Case study	Category	Explanation
7	An HIV prevention project in Mozambique sought to promote safer sex among married couples by tackling one of the reasons that husbands were having sex outside of their marriages: they were bored with their sex lives at home. Preliminary research showed that men justified extra-marital sex by complaining that their wives would not agree to sexual experimentation, especially with regard to sex positions. Women, on the other hand, reported that, "I am never asked what I like in sex, if I like sex, and if I even want sex, so why should I do anything that gives him pleasure?" To transform these gendered expectations that pose as challenges, the project promoted greater dialogue among couples about their sexual desires. The project successfully advocated with local temples and mosques by explaining to religiously affiliated participants the importance of talking more openly about sex and helping them understand that open dialogue among married couples about sex and pleasure is not a threat to culture, religion, or people's sensibilities. Religious leaders supported the project, teaching couples about better sex by getting women and men to talk openly about what they like and do not like about sex in group and couple settings.	**Transformative**	The project challenged the dominant social norm that sex should not be discussed, and especially that men and women should not discuss sex and sexual pleasure. The project also contributed to greater equity in intimate relationships by encouraging women and men to engage in dialogue about sex. This has the potential to contribute to greater joint decision-making about other reproductive and sexual matters.
8	A Nicaraguan NGO produced a popular TV soap opera (*telenovela*) to introduce a range of social and health issues (e.g., pregnancy, HIV prevention, GBV, and discrimination against the physically disabled) into public debate. Since the soap opera was particularly popular with youth, it presented the opportunity to address and challenge traditional gender roles. One storyline followed a young couple as they fell in love, and through their discussions about intimacy, contraception, and STIs. The male character in the couple was sensitive and caring toward his female partner, and they engaged in open communication about sexuality and family planning. In another episode, the young woman was raped. The telenovela then dealt with the aftermath of sexual violence, including women's legal rights in Nicaragua, and the effect of rape on intimacy.	**Transformative**	The soap opera drew attention to the importance of equity in intimate relationships, and challenged the idea that partners should not discuss issues related to sex and reproduction. The use of a sensitive, respectful, and caring male partner also challenged dominant norms of masculinity.
9	In Ethiopia, gender inequalities result in low participation and success of women in education. The few women that join higher education institutions generally have lower academic performance and higher forced withdrawal than men. Gender barriers include poor academic performance, pregnancy, adjustment challenges, lack of orientation, low self-confidence, and financial constraints. Jhpiego, through the USAID-funded Strengthening Human Resources for Health Project, implemented a project to reduce gender disparity in midwifery pre-service education. The project has supported health education institutions to establish gender offices, trained gender counselors to conduct life skills training for female students, provided orientation and academic counseling services to female students, and supported	**Transformative**	The project contributed to creating an enabling environment within teaching institutions aimed at ensuring the academic success of female students. The project also addressed systemlevel barriers hindering women's access to, and successful completion of, midwifery training. The project's efforts to promote women's equal access to midwifery pre-service education may potentially contribute to transforming the face of the health care workforce in Ethiopia by increasing the availability of competent female health care workers.

#	Case study	Category	Explanation
	female students to adapt to college life. The project also supported gender offices to recognize the best-performing female students, establish sexual harassment policies, and provide scholarships to female students in need. The gender offices have also served as a space where female students receive mentorship and social/financial support, as a means of minimizing dropout rates and improving female students' academic performance (e.g., female students receive counseling so they do not leave school when they get pregnant).		
10	The ministry of health (MoH) in Ethiopia wants to address the unmet need for contraception by expanding access to long-acting methods, including the implant (Implanon/Jadelle). To meet this need, the MoH is training community health extension workers, who already go door-to-door addressing a range of health issues (for example, water and sanitation, HIV, immunization, and family planning) to offer Implanon. Community health workers are being trained to provide information on Implanon (as part of their family planning counseling), screen women for medical eligibility criteria, and provide Implanon (in addition to condoms and contraceptive pills).	**Accommodating**	Implant information, screening, and provision are added to a program that takes into account an existing gender norm that women may spend a majority of their time working at home and therefore may be best reached with health services and information through community health extension workers who go door-to-door.
11	This HIV/AIDS prevention project provided education, negotiation skills, and free condoms to commercial sex workers (CSWs) in Thailand. Although knowledge and skills among CSWs increased, actual condom use remained low. After further discussions with the CSWs, project managers realized that CSWs weren't successful in using condoms because they did not have the power to insist on condom use with their clients. The project then shifted its approach and enlisted brothel owners as proponents of a "100% condom use policy." Brothel owners, who did have power and authority, were able to insist that all clients use condoms. Since the vast majority of brothels in the project region participated in the project, it resulted in significant increases in safer sex practices.	**Accommodating**	The project did not attempt to transform gender norms and power imbalances, but instead utilized the existing power imbalance that brothel owners have over CSWs and their clients, and enlisted them to insist that all clients use condoms.
12	A social marketing campaign in Tanzania had a similar goal: to increase condom sales. Project designers realized that in Tanzania, only a small percentage of condom sales were to women. Training indicated that women were having a hard time initiating condom use. Therefore, one of its posters explicitly showed a woman at a bar talking to a male partner and insisting that he use a condom.	**Accommodating/ transformative**	On one hand, this campaign challenged gender norms by explicitly showing a woman talking to a male partner about condom use. By showing a women *insisting* that the man use a condom, the campaign challenges norms that women cannot speak up and negotiate condom use. On the other hand, simply showing images modeling women negotiating condom use does not necessarily build a woman's skills to do so or address the power dynamics in a relationship that inhibit a woman from doing so. The campaign could be more transformative by also

#	Case study	Category	Explanation
			engaging men and woman in communication and negotiation around condom use.
13	Recognizing that contraceptive stock-outs are a significant problem in delivering high-quality and reliable services, the MoH in Country X redoubled its efforts to improve its supply chain system. This involved a thorough assessment to better quantify and forecast commodity needs at the central, regional, and service delivery point (SDP) levels. An electronic Logistics Management and Information System (eLMIS) was developed to capture more detailed information about the procurement, shipping, and issuing of commodities. The MoH agreed to hire more supply chain staff, and provided additional training to all personnel in order to roll out the new system. But the MoH did not consider gender factors affecting staff training —for example, rolling out the training without checking current composition of staff, and which times, locations, and format are optimal depending on the sex/gender make up of their eLMIS staff. There was no gender analysis of demand for commodities and patterns of stock-outs (for example, are emergency contraceptive or other methods that women can use clandestinely readily available).	**Blind**	This project is gender blind because it did not conduct a gender analysis or leverage existing information on gender in context to inform project activities. The project did not consider how gender may affect staff training, and how stock-outs may differ based on gender-related factors.

Facilitator Resource: Additional Gender Equality Continuum Case Studies by Technical Area—Answers

#	Case study	Category	Explanation
FP/RH/HIV/GBV Scenarios			
F1	Staff in an HIV clinic in Chile carried out a situational assessment to better understand the reproductive health priorities of HIV-positive women at their clinic. One of the primary issues HIV-positive women expressed was their desire to control their fertility so they could choose whether and when they wanted to become pregnant. However, women reported that a major barrier continues to be the ability to use condoms or other forms of birth control that might be discovered by their partners, as many of their partners are opposed to both. Male partners may even take the suggestion of using such methods as a sign of infidelity and grounds to beat a woman, they said. Based on the information they collected, clinic staff decided to offer only Depo-Provera shots (longeracting injectables) to all women, and de-emphasize (and reduce their supplies of) any other types of STIs or pregnancy-prevention methods.	**Accommodating**	The program has identified that male partners are often opposed to birth control or condoms and see these as signs of infidelity and grounds for beating a woman. Instead of seeking to change these male norms and unequal gender relations, the HIV clinic staff chose to emphasize a more clandestine method of family planning and de-emphasize other methods that may be more easily detected by male partners.
F2	In rural Egypt, women tend to follow strict cultural rules related to modesty and seclusion that substantially restrict their physical mobility outside the home. This, coupled with limited control over resources and decision-making, has affected women's ability to access family planning services. To address these challenges, the local health district has trained female community health workers to bring reproductive health services to women's doorsteps. These health workers visit women in their homes, providing counseling, information, and access to certain methods of contraception.	**Accommodating**	Rather than changing gender-based norms, practices, and inequalities in rural Egyptian communities that prohibit women's mobility and access to resources, the health district brought female community health volunteers to women's homes to offer them contraception.
F3	A community-based intervention in South Africa combined a microfinance program with a gender and HIV curriculum. Its goals were to reduce HIV vulnerability and GBV, promote women's empowerment, improve family well-being, and raise awareness about HIV. In the project, groups of five women guaranteed each other's loans, meeting every two weeks to discuss business plans, repay loans, and apply for additional credit. In addition, the groups took part in a participatory learning and action program with sessions on relationships, communication, cultural beliefs, GBV, HIV prevention, critical thinking, and leadership. The microfinance groups elected leaders to participate in additional training on community mobilization. These leaders went on to organize dozens of community events to raise awareness on GBV and HIV.	**Transformative**	This intervention intentionally transformed gender inequalities by increasing women's access to economic resources and leadership while seeking to promote more equitable relationships through education and skills-building on communication and GBV and also mobilizing participants to then lead awareness events on GBV and HIV.
FP/RH/HIV/GBV Scenarios			
F4	In Country Q and elsewhere, family planning clinics will offer female clients a choice of "hidden" contraceptive methods, such as Depo-Provera shots, Norplant, or an IUD, if	**Accommodating**	The program identified that male partners are often opposed to birth control or condoms and see these as

#	Case study	Category	Explanation
	the woman expresses fear that her husband does not support her use of contraception even though she expresses her desire to limit or space births. Some women may fear violence if their partner finds oral contraceptive pills in the house or if they suggest use of a condom. Clinicians will assure women that the IUD and Norplant are basically invisible, and that their partners are unlikely to realize that they are receiving Depo-Provera shots at well baby clinic visits.		signs of infidelity and grounds for beating a woman. Instead of seeking to change these male norms and unequal gender relations, the HIV clinic staff chose to emphasize a more clandestine method of family planning and de-emphasize other methods that may be more easily detected by male partners.
F5	During regular business hours, public sector family planning clinics in urban Uganda are often busy, with many clients congregating and waiting to be seen by providers. To take advantage of this captive audience, a clinic developed short videos that run on a continuous loop, providing details about available contraceptive methods. The information shared includes basic details on how the methods are administered, their health advantages, and possible side effects.	**Blind**	Based on the information provided, the clinic has not taken into consideration gender norms, practices, or inequalities (e.g., whether men or women are more likely to see the information, whether there will be resistance to the methods based on gender norms or related barriers) that may impact the program's intended outcome.
Health Policy Scenarios			
H1	A local council and an NGO teamed up to build a public library in a midsize, highly dispersed town with a third of its population living in nearby neighborhoods not easily accessible by local transport. From the outset, the library aimed to work with young people—both males and females—as part of the community's efforts to improve secondary education. After great deliberation and effort, a local philanthropist living abroad agreed to donate land at the lively center of town, facing the local cafes and billiard halls that attract young and middle-aged men. A stipulation of the donation was that the philanthropist's male cousin, an expert librarian, would manage the library. The library charged a small annual membership fee, limited the number of borrowed books to three at a time, and required that the books be returned or renewed after 1 week. After young women visiting the library complained they were being harassed by the men smoking and playing billiards across the street, the librarian opened a new rear entrance for women and designated a section of the library for women's use only.	**Blind then accommodating**	At the outset, the library was not located in a place that took into consideration the threats and unwelcoming environment to women. However, after women complained, the librarian accommodated these concerns and opened a rear entrance. However, he did not institute any practices that aimed to prevent harassment, for example, by changing underlying gender norms that support harassment of women.
H2	A study found that a requirement for overseas training for medical career progression created an obstacle for female doctors who were not able to leave husbands and family at that period in their lives. In the survey, female doctors described an assumption in the upper ranks of the medical establishment that women did not want, or were not able, to advance their careers because of family responsibilities, which resulted in pervasive discrimination against women in promotions and scholarship awards for overseas study. The study found that nearly half of the graduates were not	**Blind**	The training program did not consider the gender constraints that female doctors face due to family responsibilities and burden of care on women as well as concerns around housing and security for doctors moving to rural areas. As a result, women tended to drop out of medical training programs at higher rates.

#	Case study	Category	Explanation
	taking postgraduate training, mainly because of the pressures of family responsibilities. These graduates also believed they were discriminated against through common stereotypes of female doctors as "inefficient" and lacking motivation because they were more likely to work part-time or take career breaks. The study also identified that adequate housing and security were the primary concerns for women doctors moving to rural areas, not salary incentives. Ultimately, female graduates had a high "rate of exit" from medicine.		
H3	Seclusion of girls and women is considered a sign of female respectability; respectability also requires that women travel in the company of a male family member. At the same time, women serve as community-level paramedical staff, in recognition of their frequently greater acceptability to local clients and their ties to the community. Anecdotal evidence suggests that the cultural expectation of female respectability constrains the full range of community outreach activities and supervisory performance expected from trained community midwives. For example, female supervisors are required to return home before nightfall. Recently, the government enacted directive measures to address the problems of getting health staff to work in rural areas. In the face of cultural difficulties in recruiting women, they established a system of compulsory health service for women.	**Exploitative**	Recognizing that females are more accepted as community-level paramedical staff, the government required health service for women. Yet women were difficult to recruit because of gender-based norms and expectations that dictate, for example, that respectable women are not out after nightfall. Without seeking to change the gender norms and stigma around women's mobility in the evening and instead exploiting the expected role of women as caregivers, the government increased potential discrimination and risk for women.
H4	In Country Q, community-based NGOs sought to gain inheritance and property rights for women. To do so, these groups conducted an analysis to identify which processes—at the level of cultural norms, implementation and decision-making structures, and written laws— presented barriers to women accessing their rights, and developed an advocacy strategy based on this analysis. In particular, the analysis identified key barriers such as cultural norms that "women who love don't talk about money and property" and structural barriers where local land boards were physically far from women and institutionally unfriendly (very male dominated). The advocacy strategy thus decided to focus on lobbying traditional decision-making structures led by traditional male authorities, such as councils of elders, to increase their awareness and support for women's property rights, and have them in turn issue decrees to support women's rights and raise the issue of women's inheritance and property rights with local land boards. In the first 6 months after the advocacy was initiated, 20 women were able to reclaim their property.	**Accommodating/ transformative**	The advocacy strategy focused on increasing support for women's property rights within traditional male dominated decision-making structures. Therefore, although the gender norm of women not having property rights was questioned and transformed, the advocacy efforts were still directed at men as the decision-makers. The program did not transform male norms and attempt to promote decision-making structures inclusive of women.
H5	A project in Region Q sought to strengthen the organizational capacity of networks for people living with HIV (PLHIV). To help foster organizational development, the project supported the construction of a detailed, user-friendly manual with concrete step-by-step guidance on how to carry out a self-assessment of organizational strengths and	**Blind**	Per the description, the project did not consider gender in the design of the manual to provide guidance on special considerations for women vs. men.

#	Case study	Category	Explanation
	weaknesses, and resource materials and activities to strengthen areas identified as challenges. PLHIV regional network members led development of the manual, and serve as a technical assistance resource to country-level organizations as they seek to strengthen networks of PLHIV.		
H6	Health Workers for Change addresses gender biases in health workers' personal, organizational, and professional lives through reflective- and action-oriented training using participatory methods developed under the leadership of the Women's Health Project in Country Q. These courses address gender relations as well as race, class, and other axes of discrimination. Health workers go through a process of value clarification and self-reflection about how their organization and work mirrors their society more broadly. They are encouraged to put themselves in the shoes of others and thus develop empathy for the role of other actors in the health system. Actions devised through the training arise from analyzing health workers' own context and experience base. Within their organizations, health workers that participated in the program were able to make changes within their direct power and influence, but were not able to make wide-ranging institutional changes that were much more difficult to implement.	**Transformative**	The workshops intentional ly sought to facilitate reflection on gender relations and biases in participants to then precipitate change in their facilities. Although participants had limited influence, the workshop transformed gender and power dynamics at the relational level for health workers.
H7	In Country Q, a community health worker program relied exclusively on female staff members in ways that reinforced the beliefs that only women can provide maternal health advice. The program also failed to challenge prevailing beliefs that excused men from taking responsibility for childcare, failed to sanction forms of male sexuality that increased STI risk among their wives, and failed to question norms around domestic violence that inhibited women from talking to male health workers in their homes.	**Accommodating**	The program did not challenge or change gendered beliefs, but it also did not actively reinforce them.
H8	A program in Country Q provided support to community-based female health workers. They were allowed to assume broader roles than the simple health care tasks they were originally charged with and thus became trusted confidants and respected advocates for their fellow community members. Their work was explicitly and frequently recognized by professional health care workers and strengthened by the formation of their own peer support group. Functioning referral systems supported them. They were acknowledged by their communities of origin. Managers were sympathetic to their concerns and responded by listening and providing infrastructural support when possible. Lastly, these workers received continuous training and regular supervision. The strategic support the female communitybased workers received greatly sustained their work and permitted the flexibility to adapt their work to suit community needs.	**Blind but possibly transformative**	On one hand, the program did not actively identify or address gender constraints or inequalities that community-based female health workers may face (e.g., possible harassment, balancing other care work, overall discrimination against women). However, the program may have been empowering for females who otherwise may have received little acknowledgment, mobility, or respect in their communities.

#	Case study	Category	Explanation
H9	In Country Q, female community-based volunteers were very successful in making contraceptive methods widely available throughout the country. Although their work was highly regarded by village leaders as well as the general population, it was perceived as an extension of their roles as caregivers. Women's work as family planning volunteers did not significantly increase their decision-making roles within their households or access to education or paid work.	**Exploitative**	The program could be considered exploitative because it recognized women's ability to access other women to offer family planning services and reinforced the perception of women as caregivers.
H10	In Country Q, a new strategy sought to reform traditional gender norms that constrained health workers' efforts in service delivery and assuming tasks for which they were trained, but prevented from performing by doctors. The strategy entailed subtly redefining the meaning of *purdah* (seclusion) for female staff and the communities in which they worked. *Purdah* was reinterpreted as: "An emphasis on the external and physical criteria of seclusion to an internalized, moral code of conduct. Observance of inner purdah does not require physical seclusion; rather it manifests itself through politeness in interpersonal behavior, religious orthodoxy, modesty in dress and language, and, above all, through strictly professional behavior and attitudes toward men. As long as this moral code of conduct is followed, the health workers argued, purdah was not broken." After gaining the initial approval of village elites, female health workers were able to expand their duties to include providing medicines and injections. Gradually, they became known as "little doctors" linked to "big doctors" through effective referral systems. When male senior staff visited their female colleagues for supervision in the field, they treated them with respect rather than reprimanding them in public. Over time, female health workers assumed increasingly influential and respected roles in the villages where they worked, often giving advice to villagers regarding important decisions or resolving local disputes.	**Accommodating/ transformative**	Although women no longer needed to remain secluded, something transformative, the norms of modesty, politeness, and moral code of conduct for women were still maintained.
Key Populations Scenarios			
K1	Project managers in Country Q have seen an uptick in arrests of men who have sex with men (MSM) in public spaces. In response, they prepare personal safety workshops for MSM. In the workshops, the facilitators tell the MSM participants, "If you're worried about your safety, try being less 'obvious,'" and they ask participants to come up with strategies to look and act more masculine.	**Exploitative**	The project is reinforcing traditional gender roles and gender as a binary—i.e., male or female.
K2	A project in Country Q develops support groups for transgender people to talk about the violence they face. Through partners, the project offers gender-affirming services (such as hormone therapy) as well as HIV prevention, care, and treatment. It also	**Transformative**	The project is providing a space for transgender people to talk about violence they face due to gender-

#	Case study	Category	Explanation
	provides referrals and accompaniment to legal assistance for individuals who have been discriminated against or have experienced violence.		based discrimination, as well as to access legal resources to take action against it.
K3	A program that provides HIV services to female sex workers in drop-in centers recently launched an outreach campaign with the message that "sex workers take care of themselves because they are the backbone of their families and communities." The drop-in center provides space for the children of sex workers, and the first question on the new client form is, "What services do your children need?"	**Blind and exploitative**	The program did not consider gender in its design or messaging. It did not consider whether women's main concern was about being caretakers or their children and reinforced the stereotype that women should be concerned first and foremost about their children.
K4	A program to support people who inject drugs (PWID) offers clean needles, HIV testing, and condoms to PWID. Its outreach workers are all men, as a situation analysis showed that 95% of PWID are men. Outreach workers wear shirts with an image of two men running across a finish line and a message that says, "You are a valuable member of society."	**Accommodating**	The program considered the gender of most PWID, i.e., men, and targeted empowering messages just to men.
K5	MSM face such severe stigma and discrimination in health settings that they find it difficult to access sexual health services, including STI and HIV counseling, testing, and treatment. An organization working on HIV prevention and mitigation established a pilot program to work with MSM. The group focused on *kothis*—biological males who adopt feminine behaviors and attributes, including normatively feminine sexual roles. The project established a place where they could meet and support one another, providing information on health care and other resources, training local health care providers on how to provide services to *kothis* in a sensitive manner, and organizing medical visits at the meeting space itself. In focusing on *kothis*, staff decided not to work with penetrators whose numbers are much larger and who do not publicly acknowledge having sex with men. They also decided to focus only on commercial sex workers and on sexual activity occurring in public spaces.	**Accommodating/ transformative**	The organization sensitized health providers on working with a nontraditional gender group, *kothis*. Although it did not work with all high-risk individuals or *kothis*, particularly those that do not publicly disclose as such, the organization still sought to transform attitudes of health workers. It could have been more transformative by working with all *kothis* and the broader society to increase acceptance of *kothis*.
Male Health Scenarios			
M1	To increase contraceptive use and male involvement, a family planning project initiated a communication campaign promoting the importance of men's participation in family planning decision-making. Messages relied on sports images and metaphors, such as "Play the game right. Once you are in control, it's easy to be a winner" and "It is your choice." The campaign increased the use of contraceptive methods. When evaluating impact, the project asked male respondents who should ideally be responsible for making family planning decisions—them, their partners, or both members of the couple. The evaluation found that, "Whereas men were far more likely to believe that they should take an active role in family planning matters after the campaign, they did not necessarily accept the concepts of joint decision-making.	**Exploitative**	The project capitalized on men's desire to be in control and the winner to dominate decision-making around family planning.

#	Case study	Category	Explanation
	Men apparently misinterpreted the campaign messages to mean that family planning decisions should be made by men alone."		
M2	A reproductive health project in an indigenous community wanted to encourage men to become involved in family planning and be more supportive of their wife's or partner's choices. GBV is an issue in this community, and women sometimes fear that their use of contraception will result in their partner becoming violent toward them. Project planners were also concerned about increasing rates of STIs in the area, as the men have been migrating to a nearby mining town for work, returning with infections, and spreading them to their partners in the village. The project introduced a pilot effort to address these issues. It offered an STI clinic one day each week for men in the local women's clinic. Some of the project designers thought that by bringing men into the women's clinic for services, they would become more comfortable in the clinic, start to feel a sense of belonging there, and so be more likely to accompany their partners to the clinic for services, where they could be brought into discussions on family planning, safe motherhood, domestic violence, and other related issues.	**Blind**	Although the program acknowledged the need to engage men in family planning and STI services, it did not consult women and men on whether bringing men into a women's clinic was desirable or comfortable for both men and women.
M3	A participatory, group intervention was piloted in Mumbai with young men ages 16 to 24. Data indicate that almost half of new HIV infections in India occur in young men under age 30. Other data suggest that most boys are socialized into a sense of masculinity characterized by male dominance in sexual and other relationships—and that these norms may promote poor sexual health and risk-taking for young men and their partners. Adapting an intervention (Program H) from Brazil, a behavior change intervention sought to stimulate critical thinking about gender norms. Exposure to the program resulted in a decline in reported violence against any sexual partner and increased condom use. A social marketing campaign is also underway, with the tag line, "Real men have the right attitude."	**Transformative**	The intervention intentionally sought to reduce male dominance in relationship by changing gender norms to reduce violence and sexual risk-taking.
MNCH Scenarios			
MN1	To decrease markedly high rates of maternal mortality in Country Q, a US based organization initiated a project to reduce disease and death associated with postpartum hemorrhage, particularly among young mothers. The project included community-level interventions to raise awareness among traditional birth attendants, young women, and mothers-in-law about the markers for postpartum hemorrhaging that should trigger an emergency response. During the project's midterm evaluation, community members reported that recognizing the warning signs of distress was not enough to prompt action for mothers who delivered at home. The decision to seek	**Accommodating**	The organization's ultimate intervention of establishing a community fund to cover costs of emergency transport for women experiencing postpartum hemorrhage does not address women's lack of control over household resources, lack of decision-making power, and poor status in the household.

#	Case study	Category	Explanation
	medical care for a new mother in distress was influenced by many factors, including the availability of household resources, the power distribution in the household, and the relative status of the new mother in the household vis-à-vis her in-laws. The organization subsequently amended the project to establish a community fund to cover the costs of emergency transportation for women experiencing postpartum hemorrhage and other forms of distress.		
MN2	In Country Q, a donor project works to strengthen and create more efficient systems, structures, and interventions to reduce maternal mortality in three rural communities. Project interventions focus on the four major causes of maternal mortality and address conditions that lead women to delay seeking lifesaving treatment for emergency obstetric complications. The project trains facility- and community-based health workers, including traditional birth attendants, in improved maternal health care practices. One of the interventions includes sensitizing male traditional village leaders in this Muslim region, in recognition of their influence over community norms and behaviors. The leaders are encouraged to promote quick action from household members and neighbors when someone suspects that a laboring woman is having emergency obstetric complications, emphasizing that the baby's life may be at stake.	**Accommodating**	The project recognizes the power and influence of male leaders in the community but does not seek to promote greater gender equality, which would allow women to take action for themselves when they have obstetric complications.
MN3	A child survival project in Country Q, aiming to reduce disease and death rates among children and women of reproductive age, focused on using indigenous knowledge and cultural resources to increase and improve communication and health-seeking behavior during pregnancy. Research showed that one of the most important obstacles to women's maternal health care-seeking behaviors was the absence of discussion about pregnancy between husbands and wives, as well as with other household members. The women in this area felt that they could not take advantage of maternal services because they could not initiate conversations with their husbands or solicit their consent and financial support as the heads of household. The project staff asked a *griot* to compose a song to educate people about maternal health care, along with promoting the *pendelu* (a traditional article of women's clothing) as a symbol of pregnancy and couple communication. This campaign dramatically increased the level of communication between wives and husbands concerning maternal health. Additionally, the campaign resulted in more positive attitudes and behaviors related to pregnancy at the household level, including husbands supporting their wives by reducing their workloads, improving their nutrition, and urging them to seek medical attention and maternal health services.	**Transformative**	The program changed gender dynamics in couples' relationships by promoting communication between husbands and wives around maternal health, while promoting gender equity in access to resources and household care and increasing male support for women during pregnancy.

#	Case study	Category	Explanation
MN4	A group of HIV-positive mothers of small children organized to become advocates for prevention of mother-to-child transmission of HIV (PMTCT) and for HIV-positive mothers. The group encourages women to attend prenatal clinics, where they can access PMTCT services if they are HIV-positive. The group also educates HIV-positive mothers in their communities in life skills, PMTCT, infant care, and human rights. They use song, dance, and drama, as well as appearances on television and radio where they share their experiences as HIV-positive mothers and call for a reduction in stigma and discrimination. The peer educators also increase women's access to income by training HIV-positive mothers in personal financial management and income generation by tailoring, farming, and selling handicrafts. Finally, the group partners with HIV-positive men's networks to encourage men to value fatherhood and to become involved in PMTCT.	**Transformative**	The group promotes gender equality by giving women skills that can generate income, while also encouraging men to play a greater role in parenting.
MN5	The Government of India began integrating HIV into the National Rural Health Mission in April 2008. The government issued a circular to district reproductive and child health (RCH) officers asking whether they were willing to work on HIV and to report cases of HIV-positive women who came for antenatal care (ANC). One intervention developed subsequently is working to improve ANC quality for HIV-positive women by addressing gender and quality of care issues. For example, special spousal counseling exists for women in ANC who test positive for HIV. The husband is encouraged to come in for a variety of tests, and the program reports his HIV status to him first. They also put HIV-positive women in contact with a lawyers' network and NGOs in the area working with people living with HIV. The program also introduces the woman and the health care worker to the obstetrician who will attend her labor and birth. This doctor gives the woman her fourth and extra ANC checkup in the third trimester and registers her name on the books to receive Nevirapine prophylaxis when she goes into labor to prevent mother- to-child transmission.	**Accommodating**	The services do not transform gender norms and relations but rather promote respectful, nondiscriminatory services and facilitate a woman's access to other services she may need. Men are encouraged to come in for tests, which does not necessarily change gender dynamics or relations in the couple.
MN6	A multipronged program to improve maternal and child health in several Delhi slums works on diarrheal case management, increasing institutional births, and increasing immunization, among other things. The program conducts community outreach through the formation of women's groups focused on health, and has also provided some limited access to credit. Although the program targets women of reproductive age and children, it also reaches out to men as decision-makers. The program runs local TV ads for services, encouraging men to support their partners in taking children for prevention and treatment, and directing messages at men and women. The program reaches out to religious leaders and men at mosques on the need to take their wives for services.	**Accommodating/ transformative**	Aspects of this program, such as women's groups, which have proven to be empowering for women by increasing social capital and agency, may be transformative. However, the program targets men as decision-makers and does not seek to transform male norms to be more equitable or promote joint decision-making.

#	Case study	Category	Explanation
WASH Scenarios			
W1	Government data showed high incidence rates of diarrhea and other intestinal infections among school-age children in several rural provinces in their country. In response to this public health problem, and in an effort to increase the number of days children spend in the classroom (and decrease the number they spend at home being sick), several communities were selected for a behavior change campaign. The campaign aimed to raise awareness of handwashing as a highly effective means of reducing such illnesses and introduced a simple protocol for handwashing by all household members. The campaign targeted women with messages encouraging them to be "good mothers" and "take proper care of their families" by strictly enforcing the handwashing protocol for everyone in their homes. Some messages implied that if a child is sick, it means the mother is not "doing her job well." Follow-up studies showed the messages were effective, with a high rate of adoption of the new handwashing protocol and a subsequent reduction in intestinal diseases among school-age children.	**Exploitative**	The campaign reinforced gender norms of expectations that women are caretakers of their families and that they are not doing their job if their child is sick, all in the name of increasing handwashing and reducing disease.
W2	The Central American Hand Washing Institute aimed to reduce disease and death among children under age 5 through a communication campaign promoting proper handwashing with soap to prevent diarrheal disease. Four soap companies launched handwashing promotion campaigns that included radio and television advertisements; posters and fliers; school, municipal, and health center programs; distribution of soap samples; promotional events; and print advertisements. The basic approach was to present a mother as the caretaker of the family and to describe or illustrate the three critical times for handwashing: before cooking or preparing food; before feeding a child or eating; and after defecation, cleaning a baby, or changing a diaper. The promotion also emphasized essential aspects of handwashing technique: use water and soap, rub one's hands together at least three times, and dry them hygienically.	**Accommodating**	The campaigns presented women in their traditional role as caretaker of the family and did not identify a role for men in the caretaking activities.

#	Case study	Category	Explanation
W3	A WASH program in a rural area of Country Z increased the number of water sources in a community, and decreased the average distance and amount of time that community members had to travel to the water source. A final project evaluation found, as expected, that women were the main beneficiaries of these changes. Given that obtaining household water was a women's role, women experienced the greatest reductions in time burden. The final evaluation also found a surprising result: Women in several focus group discussions reported that the increased access to water sources had decreased household conflict, including violent conflict and beatings from their husbands. The women explained that previously the longer distances they traveled to water sources would sometimes require them to be out after dark; in these cases, their husbands would often accuse women of infidelity, and at times beat them. Now that women spend less time away from home and are returning before dark, they do not face the same conflict and accusations from their husbands.	**Blind**	It is not clear whether the program did a gender analysis to understand gender constraints, opportunities, barriers, or possible consequences of the intervention in terms of the status of men and women. Although women were expected beneficiaries, the program did not intentionally take gender into account in the program design as explained. In some ways, the program was gender transformative (i.e., reduced conflict and beatings and increased time availability). On the other hand, the program did not intentionally seek to change norms and relationship dynamics to reduce suspicion of infidelity for being out after dark or the practice of violence by husbands.
Youth Scenarios			
Y1	A project for youth at risk of participating in gangs created an activity and training center to provide attractive alternatives to life in the streets for adolescents. The center was open to both young men and women, although the primary focus was intended to be young men, who were presumed to be the greatest threat to the community. To the operator's distress, young women were the center's principal clientele. The young women, who were not attending school because they had become pregnant, often arrived with their babies and toddlers. The center offered them an alternative to the isolation of their homes, a chance to let their children play with others, and stimulating classes and access to computers. The center director noted that the presence of young children deterred young men from going to the center. In response, the director established a schedule of times when children were allowed to come to the center with either their mother or father (or both) and other times when no children were allowed. Classes were offered during the "no children" hours, under the assumption that without children present more young men would show up and there would be fewer distractions for class participants (both women and men). Class offerings included job skills training, parenting, healthy gender relations, and conflict management.	**Accommodating and transformative**	On one hand, the project accommodated the male norms and preference of not wanting to be around children and leaving childcare to mothers. On the other hand, the project offered classes in parenting, gender relations, and conflict management, which aim to promote gender equality.
Y2	A project sought to involve young people in the care and support of people living with HIV (PLHIV). This project carried out formative research to assess young people's interest and explore the gender dimensions of care. The assessment explored what caregiving tasks male and female youth feel more comfortable with and able to	**Accommodating**	The project accommodated gender-based preferences and roles related to caregiving tasks.

#	Case study	Category	Explanation
	provide, as well as what tasks PLHIV themselves would prefer a male or female youth provide. Based on this research, the project adopted an approach that incorporates preferred tasks for young women and young men.		
Y3	Health project staff were concerned about rising STI and pregnancy rates among youth. Unable to convince the predominantly Roman Catholic public school system to incorporate a reproductive health and HIV curriculum in the high schools, the program staff decided to instead recruit volunteer peer educators to conduct charlas, or informal discussion groups. Peer educators ran afterschool neighborhood youth charlas in mixed-sex groups to discuss issues related to dating, relationships, reproductive health, contraception (including condoms), and STI/HIV testing. They also provided information on where participants could access contraceptives (including condoms) and STI/HIV testing.	**Blind**	The project did not consider gender-based preferences of whether discussions should be run in mixed-sex groups or other gender norms or dynamics to inform the intervention.
Y4	An NGO produced a popular television soap opera (a telenovela) to introduce a range of social and health issues into public debate, such as pregnancy prevention, HIV, GBV, and discrimination against the physically disabled. Since the soap opera was particularly popular with youth, it presented an opportunity to address and challenge traditional gender roles. A storyline in the telenovela followed a young couple as they fell in love and through their discussions about intimacy, contraception, and STIs. The male character in the couple was sensitive and caring toward his female partner, and they engaged in open communication about sexuality and family planning. In another episode, the young woman was raped. The telenovela then dealt with the aftermath of sexual violence, including its effects on intimacy and women's legal rights. Using mass media, this program presented alternative gender role models, and raised awareness and public discussion about gender and reproductive health.	**Transformative**	The soap opera challenged traditional gender roles through reflection of sexual violence, women's legal rights, and couples relationships, especially as they relates to reproductive health.

#	Case study	Category	Explanation
Y5	A program in Country N challenges traditional boys' and girls' roles. It works with 10- to 14-year-old boys and girls, bringing them together at child clubs for participatory workshops 1 hour per week for 8 weeks. Sessions explore young people's hopes, dreams, and ideas about gender equality, power, and fairness. They identify small actions that brothers can take to promote respect and empower girls in their homes. Results of the initial program show boys are making small changes in their own behavior—helping their sisters and mothers with household chores; advocating for their sisters' education and against early marriage; and encouraging family members, friends, and neighbors to do the same. Compared with those who did not participate, more girls in the program intervention group state that their brothers and other boys in their communities are making small changes toward gender equality. Parents also report that their sons now help their daughters with schoolwork and chores, and that their households are more peaceful as a result.	**Transformative**	The program encouraged boys' participation in traditionally female roles and facilitated exploration of ideas around gender equality, power, and fairness.