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First Generation of Gender and HIV Programs: Seeking Clarity and Synergy

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ABSTRACT

In the past decade, there have been expanding resources to address the underlying gender dimensions of HIV. This has been particularly urgent in sub-Saharan Africa as the female-to-male infection ratios in young populations has reached 3 to 1 and sometimes above. The phrase “gender and HIV” has become commonplace yet does not provide any specific guidance as to target audiences, content, or measurable results. It can include everything from microcredit programs for HIV-positive women to workplace programs seeking to change negative male norms, to efforts to increase respect for diverse sexual and gender identities. This review mines the first generation of programs to provide an empirical foundation to inform a next generation. We examined 63 illustrative (and among the largest and best known) “gender and HIV programs.” Data were obtained via programs’ own reports (garnered largely through interactive interviews) of how they selected their populations and targeted their interventions; whether, and to what degree, they conceptualize and address the distinct needs of males and females. It also inquired as to whether there were explicit links between populations of males and females in program design and in measurement of results. Pressing for clarity and answers to these questions will assist in translating the current interest in “gender” into more precise tailoring of interventions to specific age, gender, and partnership-status profiles. We conclude this program review with several recommendations: (1) redirecting HIV programs to primary prevention, building the protective assets of those most at risk, particularly the youngest of those who face the highest risk—adolescent girls and young women deserve a larger share of resources and policy attention than they have been receiving; (2) locating populations of males for intervention guided by the needs of the most at-risk females; (3) defining gender-specific goals for females and males as separate but linked “social accounts,” resulting in (a) safer and more confident girls and women who are able to claim their rights, act on their own behalf, and have opportunities and choices and (b) men and boys who will benefit from less rigid gender roles and who recognize the full humanity of others and treat them with respect.

HOW WE GOT TO “HERE”

In the past several years, the phrase “gender and HIV” has become commonplace in policy and program discourse.¹ Yet what “gender programming” means varies widely, depending on context. It is a big tent, perhaps too big. “Gender programming” includes microcredit programs seeking to empower women, workplace programs seeking to reach men and boys, and efforts to increase respect for the diversity of gender identities, to name just a few initiatives to which the term refers.

This review examines an illustrative set of first-generation gender-and-HIV programs identified in a review conducted by the Population Council. Based on the programs’ own reports (garnered largely through interviews), we summarize how programs select their populations and target their interventions. We also examine whether, and to what degree, they conceptualize and address the distinct needs of males and females in program design and in measurement of results. Pressing for clarity and answers to these questions will assist in translating the current interest in “gender” into specific and measurable strategies to reduce HIV incidence among females, manage its effects, and, over the longer term, address the underlying male–female power imbalances that drive the pandemic in many settings. Tailoring interventions as closely as possible to specific age, gender, and partnership-status profiles could lead to more effective programming.

Moving from Women to Gender

The evolution of program strategies provides useful background. In the early 1990s, as the limitations of the women in development (WID) approach became clearer (WID tended to focus on women as a target group and did not address the gender and power structures that underlie women’s subordination), a new approach emerged—gender and development (GAD). This strategy recognizes that ensuring women’s access to and control of resources and their attainment of equality requires an understanding of their relations with males across their life cycle as gatekeepers, partners, peers, and predators. GAD focuses on the distinctive roles, assets, and needs of females and males (ideally, by class groups). It directs attention to power relations between men and women and considers the social constructs that subordinate women.

A parallel evolution occurred in the late 1980s as the reproductive health approach redefined family planning programs (and the notion of population control). Women’s health advocates pushed for making women “subjects not objects” in program design, for paying far greater attention to women’s reproductive health needs, and for investment in the social, cultural, and economic assets that women need to achieve sexual and reproductive health (Sen and Grown 1987; Germain and Ordway 1989; Sen et al.1994). Although women were the target group of the great majority of such programs, some early programs sought to facilitate male adoption of family planning by providing condoms and vasectomies. While protecting men, this strategy reduced the burden of fertility control on women. The reproductive health approach was affirmed both by the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women. Both conferences also noted

“men’s shared responsibility in matters related to reproductive and sexual behavior,” as well as their responsibility in HIV-transmission prevention, the importance of their contribution to family income and children’s education, and the equal value of girls and boys (United Nations 1994 and 1995).

These trends encouraged a host of “male-involvement” programs, such as “men in maternity” and other efforts, which typically included men (usually those in relationships) as presumptive supporters of women’s sexual and reproductive health. In the mid-1990s, the designation of “men as partners” entered the discourse (Wegner et al. 1998; EngenderHealth 2010). This idea, too, has evolved, and, increasingly, underlying gender norms have been highlighted, for example, at a meeting on Power and Sexual Relations cosponsored by the Interagency Gender Working Group (IGWG) and the Population Council (2001). In the context of that meeting, Paul Delay observed that HIV has essentially become a “girl’s epidemic driven by male behavior” (page 40). Unfortunately, that observation is still accurate.

Rigid gender roles increase the risk of HIV transmission and other adverse outcomes for men and boys and, to an even greater extent, for women and girls (see, for example, United Nations 1995, paragraphs 98 and 108; Whelan 1999; Gupta 2000; Boender et al. 2004; and Barker and Ricardo 2005). Indeed, at the Global Symposium on Engaging Men and Boys in Achieving Gender Equality (2009, Rio de Janeiro, Brazil), UNAIDS Executive Director Michel Sidibé spoke of the need to “work over the long term to end the social acceptance of violence against women and the gender inequality that underpins it” (Sidibé 2009).

Gender norms play a role for males and females in social and sexual situations; they help determine, for example:

- the number and type of sexual partners women and men are expected to have (or to say they have);
- the circumstances that are considered appropriate for sex;
- who can negotiate the timing of sex;
- whether and when contraception and condoms are used; and
- the role of violence (or its threat) in keeping women in sexual relationships.

In the context of the HIV pandemic, gender norms not only influence the degree to which women can negotiate protection from HIV but also ensure their disproportionate share in caring for the ill, reduce their access to property when a partner dies, and play a role in a host of other negative health, social, and economic consequences.

Consequently, the field has moved away from looking at the behavior of males and females in isolation and toward the examination of the complex interactions between males and females within communities, families, and intimate partnerships. We have begun to consider issues of power and inequality more directly. Specifically, we have begun thinking about how to:

- address gender inequality and social structures that routinely deny women opportunities and access, violating their rights and depriving them of the assets they need to ensure their own and their families’ well-being;
- challenge notions of masculinity and closely associated behaviors and practices, such as the acceptance of violence to control women and girls;

- target the role of traditional gender norms as they affect girls and women throughout their lives: in early childhood, when girls are given less health care and food than boys; in schools, where boys' contributions are more prized than girls' and where girls often face harassment, leading them to drop out; and in relationships, where power disparities and norms around masculinity and femininity generate expectations and behaviors—around sexuality, parenting, and household work—that ultimately harm both women and men, as well as girls and boys.

Explorations of these issues are vital, but do not provide practical guidance on how to set priorities among individuals who suffer because of gender norms (potentially all of us), how and when to build females' protective assets, and, crucially, whether and when men should be engaged to optimize females' health and well-being.

In our review, some people confuse the word “gender” with women and girls. This lack of clarity leads to inefficiencies and is occasionally used cynically as well. Some “gender” programs do little more than include females nominally as tertiary beneficiaries (that is, they involve no contact with females, just acknowledgment of their plight). Others involve men superficially in maternity care with no further examination of wider norms that bear on women's reproductive health, such as men's role in child care and support of positive infant-feeding choices. Some innovative and intellectually grounded programs take on the challenge of addressing male norms and behavior and clearly identify males as the subject and core beneficiaries of the interventions (a perfectly valid approach). Other programs appear to have hung out a shingle to catch the “gender-and-HIV” funding wave. A particularly high risk of this opportunism may be found in many programs intended to benefit young people, which typically capture more male than female participants (see, for example, Weiner 2007). Such bias occurs because it is usually easier, more acceptable, and safer for males to participate in extra-household and community programs in public spaces. Indeed, a study of youth programs in Ethiopia found that the majority of services rendered were HIV-related, presumably because funding was available for such services. More than 70 percent of the males being counted reported having received an HIV message. Yet this message typically included nothing about gender (less than 2 percent of interactions addressed gender issues). Less than one-fifth of these males were told about condoms, let alone received them (Mekbib et al. 2005). This worrying example is just one of many that illustrate the loosely constructed content of many “youth and HIV” programs.

Loosely constructed content may indicate a lack of clarity about which groups a program is seeking to serve, their distinctions, and how to prioritize them. As the population affected by the HIV pandemic becomes increasingly young, poor, and female, clarifying programs' intentions is critical in already resource-limited settings. This review and assessment of past projects was undertaken in order to apply lessons learned from them and offer guidance for moving forward.

METHODOLOGY: IDENTIFYING AND MEASURING PROGRAMS

We carried out an Internet-based search using Google and development databases (including PopLine, Eldis, and Development Gateway) to find ongoing or recently completed programs that address gender in the context of HIV and AIDS. The only geographic limitation we set was that programs had to be operating in a developing country (multicountry programs were also included). Additional programs were found by word-of-mouth, by searching websites of United States-based international NGOs involved in reproductive health and HIV, and via requests for information on gender-focused listservs. This approach generated a list of nearly 200 programs. Programs that included women as their target but did not indicate that they addressed gender issues or norms were not included. As a result of these exclusions, approximately 160 gender-and-HIV programs were identified. Of these, 130 were selected by focusing on countries receiving PEPFAR funding. Brazil and India were included because of their significant efforts to address issues of gender and HIV. Because we had resources to conduct interviews with about half this number, we randomly selected 75 programs. We invited the program managers to participate in an interview. Twelve did not reply, were not reachable, or were unable to complete an interview. The result was a final sample of 63 programs from across sub-Saharan Africa, North Africa, South America, and Asia. Most of the programs (70 percent) were operating in sub-Saharan Africa.

This review is not meant to be a comprehensive study of gender-and-HIV programs. The programs we found are likely to be better networked and resourced (and often larger) than those we did not find. We may have missed some smaller innovative programs as well as some poorly implemented and managed programs. The most significant selection bias is that we did not include a significant subset of programs that were identified through our search because they did not have a meaningful gender component—that is, we excluded 30 programs that, despite being self- or donor-identified as “gender and HIV,” merely included women as targets. Thus, our sample is strongly biased toward those programs that have demonstrated a relatively more meaningful approach to addressing gender norms, vulnerabilities, and/or inequalities between males and females. Although the programs included in our review are consequently likely to be among the stronger programs operating, the sample provides a lens into the gender-and-HIV field.

We developed a structured, open-ended questionnaire that included questions about who the program’s target populations were; what activities were being carried out; how programs had changed over time; and how the programs defined and addressed gender issues in their design, implementation, and evaluation.

We conducted interviews with program managers between November 2006 and June 2007, mostly by telephone and a few in person. Respondents with poor telephone connections or tight schedules completed the questionnaire electronically. All interviews were transcribed, and quantitative data were extracted and entered into an SPSS database. Because this was not a formal qualitative study, no coding software was used, and transcripts were stored in Microsoft Word.

Site visits were beyond the scope of this project; therefore, the data are based primarily on program managers’ self-reports. The possibility of respondent bias is strong. We tried to encourage interviewees to offer critical reflection about actual program implementation (versus

idealized plans), and probed for specific examples to provide nuance and greater accuracy in the data. Nonetheless, these data likely reflect a more positive perspective than would be found by observation and rigorous process evaluations.

The gender-related content of each program was evaluated based on the managers' self-reports. In the interviews, we left the notion of gender open to solicit participants' unbiased responses. Respondents were also invited to share any relevant materials. Based on participants' responses, program materials, and interviewer-completed assessments, we categorized the projects (see below). In addition, we conducted nine key-informant interviews with a subset of managers from well-known programs.

The analysis considered:

- selection of participant populations;
- strategies for engagement; and
- assessment and validation of outcomes.

Programs were rated by two researchers as to the strength of their approach to confronting gender issues, using several different scales. (See the appendix for the instruments used by the raters.) Both raters held master's degrees in gender studies or public health, and had worked in the area of gender both programmatically and as researchers. When a disagreement arose between the raters, the differences were discussed until consensus was achieved. The scales attempted to consider more than the programs' simple activities in order to:

- rate whether these activities were likely to improve gender and power relations between females and males (that is, to foster greater equality in relationships), rather than simply fostering more progressive responses regarding gender norms and expectations from males or females;
- measure whether programs actively confronted the problems created by traditional gender norms and gender inequality as a core part of their programming, or whether programs addressed gender superficially, for example, by simply working with men without giving attention to gender norms and inequality;
- assess whether participants were selected purposefully, for example, by asking females which males were problematic or influential in their lives and including those males in the program rather than just including males from the community in general; and
- if the program had been evaluated, learn whether gender-attitude change or behavior change was assessed only by self-report or confirmed by others in the participants' lives.

FINDINGS

Most of the 63 programs surveyed (70 percent) were operating in sub-Saharan Africa. The rest were based in India (22 percent), North Africa (3 percent), Brazil (2 percent), and Vietnam (2 percent) (see Table 1). Half of the programs were implemented by single NGOs; slightly more than a third (35 percent) were implemented by multiple NGOs, and the rest by research organizations. The two main funding sources for the programs were the United States Government (including USAID, PEPFAR, CDC, and NIH) and private donors, which each supported approximately one-third (37 percent) of the participating programs. The remaining

programs were funded by other bilateral agencies, their country’s national or local government, or multilateral groups.

Program scale varied greatly (see Table 1), from boutique programs that were reaching fewer than 500 participants, to very large programs that claimed to reach more than 10,000 people. A number of the large programs were mass-media campaigns, and the great majority of these did not have rosters of beneficiaries; in these cases, program reach was based on program managers’ best estimates.

Table 1 Percentage distribution of 63 programs included in review, by location, size, and sources of funding

Variable	Percent
Location	
Sub-Saharan Africa	70
India	22
North Africa	3
Brazil	2
Vietnam	2
Size (number of participants/beneficiaries)	
> 5,000	54
1,000 – 5,000	24
< 1,000	22
Main funding source	
United States Government	37
Private donors	37
Multilateral donors	11
National / local government	8
Other bilateral	5

Selection of Participant Populations

In the three decades since the HIV pandemic was recognized, qualitative and quantitative data have been used to identify which groups are at the highest risk of HIV infection, and more recently, how gender norms increase a person’s vulnerability to HIV. Programmatic and monetary support, however, has increasingly been drawn to treatment. Recently, experts have argued that targeting financial resources toward prevention would be most efficient (Bongaarts and Over 2010). Data and program efforts should be directed toward identifying high-risk populations and intervening early to build their protective health, social, and economic assets and mitigate the impact of the virus on their lives. Young women, who bear an increasing share of HIV infection, must be reached early—ideally before their first sexual experience (which is coerced for many girls in high-risk settings) and in time to address other factors, for example, school dropout, need to generate income without skills, and so on, which put them at risk for acquiring HIV.

What We Found

The designers of the programs sampled understood the importance of reaching younger populations, although sometimes their young population was in fact, relatively old (“youth,” in some cases, was defined as continuing to the age of 35).

In terms of broad demographic features, the 63 programs surveyed seem reasonable in their orientation. Of those we surveyed, more than half (64 percent) were working with both females and males, with a fourth working only with females and the rest working only with males (see Figure 1).

The vast majority of programs surveyed included young people. Only 11 percent of the programs were for adults only (see Figure 2). Forty percent focused exclusively on youth² and very young adolescents (defined as those between ages 10–14).

Programs may have been designed to work only with males, only with females, or with both groups, and we hoped to see clearly defined target populations and cogent rationales for these priorities. In many societies, a cross-section of males may be predicted to have negative attitudes toward females, but certain subsets of males—for example, gang leaders—may be particularly important proponents of male gender norms and, therefore, reasonably subject to special intervention. In the case of females, those at risk of forced or unsafe sexual relations should be prioritized. Program designers and managers may also want to support their programming for females with efforts that aim to address the men who are problematic to them in the short or long term—from an HIV-prevention, sexual and reproductive health, or development perspective. For example, in some settings, benefiting adolescent girls might require targeting the fathers who force them to marry young rather than targeting the girls’ male peers; for female urban migrants, their employers or clusters of men in public locations may be predators, gatekeepers, or both vis-à-vis the girls’ health. Potential male participants in HIV programs intended to complement efforts to improve females’ safety, health, and well-being include:

- fathers who, with the complicity of mothers, may force their daughters’ unwanted sexual initiation or early marriage;
- older males preying on young girls. The age gap between women and their “partners” at sexual initiation is often greater than at any other point in females’ sexual life cycle;

Figure 1: Sex of participants in 61* of the 63 gender-and-HIV programs reviewed

64 percent (39) of programs work with both males and females

36 percent (22) of programs work with either females or males exclusively
Of these:

- 68 percent (15) of programs work with females only
- 32 percent (7) work with males only

*Two programs are missing data on these variables.

Figure 2: Age of participants in the 63 gender-and-HIV programs reviewed

11 percent (7) of programs worked exclusively with adults

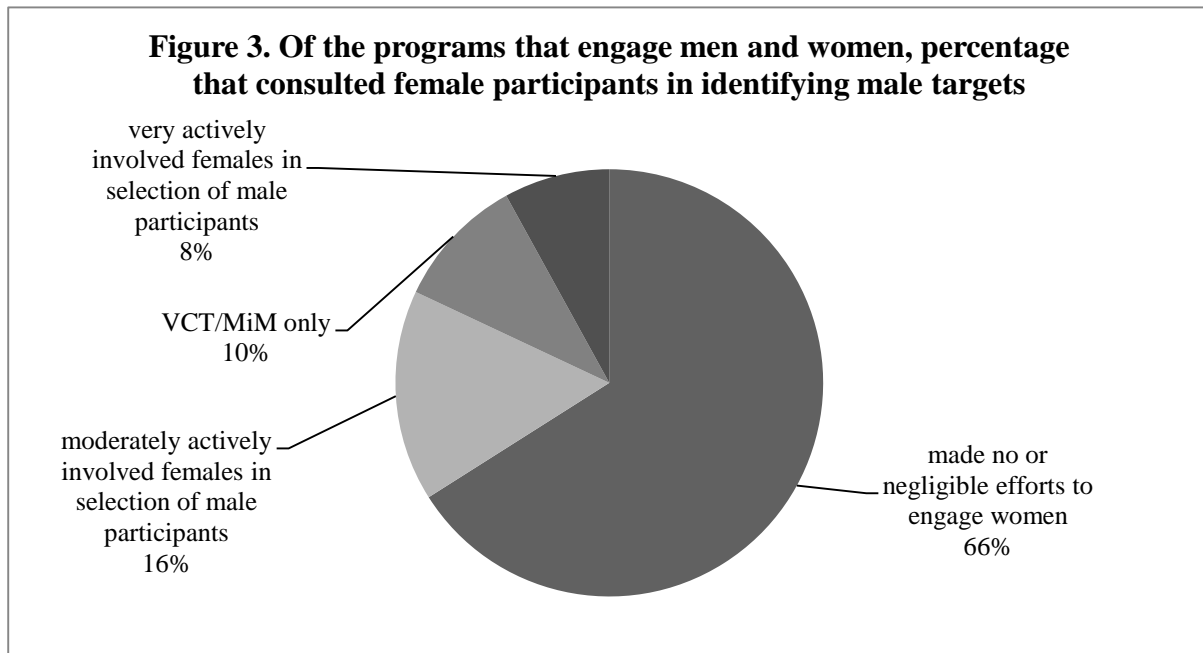
89 percent (54) of programs included young people

40 percent (24) of programs focused exclusively on young people and/or very young adolescents

- clusters of men in specific public locations who create risks and often confine girls’ movements, thereby limiting their ability to build health, social, and economic assets;
- employers of girls in domestic service; such girls frequently work at exploitative jobs and work before they are legally employable; and
- brothers, who, by not performing their fair share of family labor, limit girls’ potential and who, motivated by their internalized concern for “protecting” their sisters’ reputations, may actively discourage their sisters from taking advantage of new opportunities.

The process of recruiting participants for a program must proceed from a clear theory as to why reaching these participants is important. Ideally, once the key populations have been selected, the program will be able to define explicitly what is to be changed by the program for these core participants/beneficiaries (in terms of the protective environment, and behavioral and attitudinal change).

Once the core population has been selected, programmers need to determine which gatekeepers, including who among the opposite sex, should be engaged. Seeking some marker of rudimentary “alignment” of male and female audiences, we asked our program informants whether females in a program were consulted in identifying male participants, and vice versa (see Figure 3). Upon initial query, about half of those programs that target both males and females did not involve females in identifying male participants.



VCT = Voluntary counseling and testing.

MiM = Men in maternity.

In the mixed-sex programs in our sample, even those programs that claimed to involve participants in selecting the opposite-sex participants, most were not doing so in a significant way. For example, one respondent asked about partner involvement said that participants were asked to “‘bring in your partner,’ but nothing special [was said].”

Not only was recruitment often casual, we found little evidence of female participants’ setting goals for behavior or attitudinal change for their partners. Many program managers interviewed did not see the value of targeting a particular group with particular behavior changes in mind, opting instead for a more general message to a broad catchment population. In some cases, large numbers of participants are valued over having clearly defined target populations. The exchange below provides an example:

Q: If the program targets both males and females, are female participants consulted in identifying the male participants?

A: [We] didn’t select participants. We wanted to reach everyone in our catchment area—we wanted to reach all young people. We didn’t ask young girls [which] males [to reach]. Coverage was much higher.

In a number of the interviews, respondents made clear that donors’ zeal for numbers has led programs to present the data on inputs, such as sending messages, as if presenting a message were as important as receiving it or as reducing risk. The first generation of gender-and-HIV programming tended to prioritize a “drive for numbers.”

In contrast to this scattershot definition of purpose, some managers were reflective and articulate about the strategic decisions they were making.

Q: How did you recruit the female and male participants?

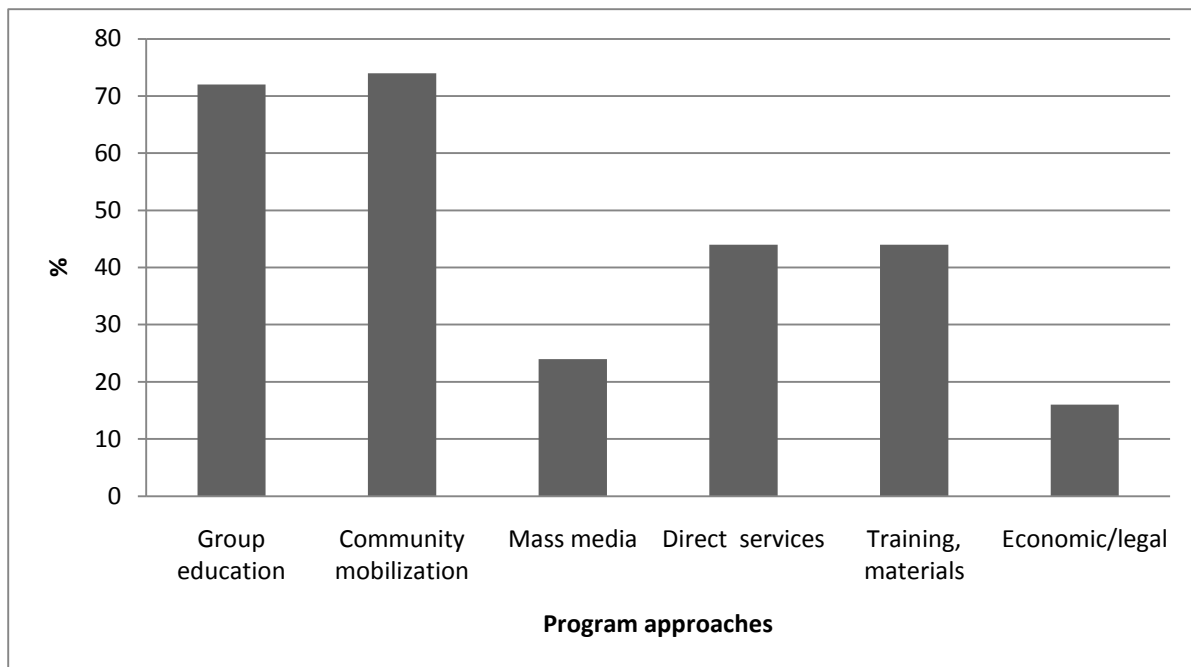
A: [We were] planning to work with both when we first started. It is consultative but also intuitive. For example, if we’re working with pregnant women, we tend to work with males in their direct circle, their husbands and fathers-in-law. That’s important; that’s critical.

One program had defined well-thought-out reasons for *not* reaching out to certain seemingly relevant groups, but identifying other influences instead:

We don’t ever specifically target direct relatives; that creates a threat for women. We [work more] at the street level. Street leaders are the first layer of response for women experiencing violence. Street leaders know what’s going on in all the houses. In slums, poor areas, there are community watch groups, volunteers, and counselors who are involved in the work and who do respond directly.

We asked broadly what programs’ strategies were (see Figure 4). About 70 percent of the programs described their work as “group education” or “community mobilization.” Forty-four percent reported offering direct services, training, or informational materials. Mass-media campaigns (24 percent) and economic/legal interventions (16 percent) were also reported.

Figure 4 Percentage of programs, by strategy for reaching target population



Program approaches varied to some extent by target group. For example, half of the female-only programs said they were working to build women’s economic assets—likely recognizing that women’s lack of economic authority renders them vulnerable, even when they have access to complete information. None of the male-only programs were taking this approach—presumably because economic power and sexual risk are less closely entwined for males than for females. Programs that included men were more likely to use group education and community mobilization than other approaches, probably because more than three-fourths of the programs that included men in their gender-and-HIV work sought to influence gender norms, and group education and community mobilization are strategies generally employed to that end.

Validation of Outcomes

We asked managers about their current monitoring and evaluation strategies. Of those programs that included males, 62 percent reported that they tried to assess—either formally or informally—whether men’s gender attitudes or behavior had changed as a result of their involvement in the program. Some of the desired outcomes included participants’ being less likely to abuse their partners or more likely to participate in household chores or in seeking reproductive health services with their partners than those not involved in the programs. These changes were gauged by men’s self-reports, however. Only about a third of these programs that include men reported that they had confirmed the reported changes with the men’s partners or peers.

When probed, few (13 percent) of all programs that engaged males tried directly to seek women’s and girls’ opinions about changes in their partners’ (or male peers’) behavior or attitudes. When we probed further, we found that even among these programs, the confirmation

was obtained by superficial means and included word-of-mouth accounts that still relied heavily on self-reports. Some programs opposed this type of confirmation, or were unable to probe more extensively because they faced budgetary constraints:

Q: Were men's reports of behavior change confirmed by the women in their lives?

A: We would actually never consider [doing that] in the field. The whole issue of contacting the partner of a male is an added burden. It may or may not [be harmful]... possibly for her and/or for her partner. Also, this intervention was done with a budget of \$100,000.

Programmatic Meanings—Initial and Evolving—of Gender Sensitivity

We probed to find evidence of any of the three following processes:

- prioritizing certain populations of males and females, or pairings of them, by consulting individual community members in the selection of participants to ensure that those in the community who are most in need are receiving the intervention (either because they are at risk or because they put others at risk)
- identifying specific goals in terms of asset-building, attitude change, and behavior change by age and sex, and in some cases, partnership status
- addressing attitudes, behaviors, and power dynamics between males and females who interact with each other

The picture was mixed. Some self-described “gender” programs had well-thought-out rationales for placing a primary emphasis on gender issues:

Q: Is gender a primary topic addressed by this program?

A: Yes. Gender and coercion are the number-one driver [of HIV]. The way we try approach [gender] is by looking at the identity of young people as really defined by three factors: who you think you are (self-efficacy, self-esteem, goal setting), who society thinks you are (issues of gender, coercion, perceptions of womanhood), and who society lets you be.

Some programs also showed special sensitivity to their local context and acknowledged potential problems that had to be considered.

[The initial problem was HIV, stigma, and silence]. “We worked with women first, and men as partners, not just ordinary men, but men in leadership only. We did not want to look like a feminist movement (we would have been looked down upon). . . .”

“The program does not try to get the husbands into the program. If you do that, you won't achieve your objectives in this community. When husbands are present, the women won't talk anymore. [We want to] empower women, raise their voices. We can't achieve that if men/husbands are there.”

In addition to self-reports, investigators assessed the gender-related components of each program independently and rated them based on scales that evaluate the extent to which the programs addressed specific issues. The three measures we used were:

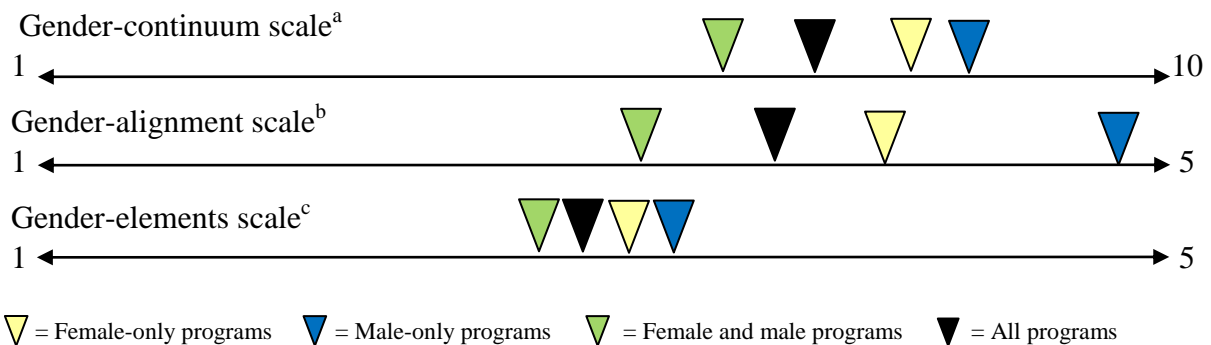
(1) a gender-continuum scale, a modified version of Gupta’s gender scale (Gupta 2000), which ranks gender programs from harmful to transformative;

(2) a gender-alignment scale, developed by the investigators of this review, which assesses the degree to which a program attempts to align the needs of women and men (or girls and boys) in a particular ecological context and explicitly identifies specific goals—by age and sex—in terms of whom to reach, asset-building, attitudinal change, and behavior change. This scale also considers to what extent each program consults females concerning the identity of the influential males in their lives. (It produces the overall mean of a program’s gender-alignment scores, with a scale of one to five, on four dimensions: program design, participant identification, implementation, and evaluation.)

(3) a gender-elements indicator: a single question assessing the relative emphasis placed by a program on its gender element(s). This indicator was scored on a scale from one to five, ranging from no/very weak (for example, a program that included a small project that tried to address gender issues in some minimal way but was otherwise gender-blind) to very strong (that is, a program that addressed gender issues in a meaningful way and for which such issues are central). (Further details concerning these measures are given below and in the appendix.)

We used these three measures to examine different dimensions of the programs’ gender components in order to obtain a detailed picture of the intensity and quality of the work (see Figure 5).

Figure 5 Measures of programs’ gender-related components







^a Scale based on the Gupta continuum: 1–2 = harmful; 3–4 = neutral; 5–6 = sensitive; 7–8 = influencing; 9–10 = transformative.

^b Gender-alignment scale: 1 = undermining; 2 = none; 3 = low; 4 = medium; 5 = high. ^c Gender-elements scale: 1 = nonexistent to very weak; 2 = superficial; 3 = adequate or small, but not exceptional in implementation; 4 = better than average; 5 = strong and central to the program.

Not surprisingly, for this sample of gender-and-HIV programs almost all (93 percent) reported that they had a meaningful gender component. Yet, only one-third of the programs were found (by interviewers) to have gender as a strong, central focus. We acknowledge that these are subjective measures, based on our raters' assessments after conducting interviews with program managers and reading additional sources (for example, websites, materials, and research papers). Also, as noted in the methodology section, the programs in our sample are among the stronger gender-and-HIV programs that we found; we excluded a large number that would have ranked poorly on all these scales.

The average score that programs received using the gender-continuum scale was 6.75, that is, gender sensitive (see Table 2). The mixed-sex programs, which might have been the most diffused, often centering on the community and doing less than other programs to target either males or females consistently, have the lowest average score on each of the three measures, scoring on average 6.1 out of 10 (that is, gender sensitive) on the gender-continuum scale), 3.2 out of 5 (that is, low) on the gender-alignment scale, and 2.8 out of 5 (that is, adequate but not exceptional) on the gender-elements scale. Male-focused programs had the highest average scores, although they were fewer in number, and thus a dilution of the average score was less likely. In contrast, female-focused programs have a greater challenge because they must grapple with the structural inequalities women face in society (for example, limited access to and control over resources) as well as their relatively lesser power than men in intimate relationships, and conservative gender norms (for example, norms that foster submissiveness in females).

Table 2 Mean scores on gender-assessment scales

	Gender-continuum scale (1 to 10)	Gender-alignment scale (1 to 5)	Gender-elements scale (1 to 5)
Female-only programs 	7.6	3.9	3.2
Male-only programs 	7.9	4.9	3.3
Female and male programs 	6.1	3.2	2.8
All programs 	6.8	3.6	3.0

REPORTED CHANGES, CHALLENGES, AND PROGRAM APPROACHES OVER TIME

A hallmark of good management and innovation is flexibility in programming for changing needs or for responding to information indicating that certain parts of the program could work better if altered. In our sample, many programs have modified their practices over time; two-thirds of the managers interviewed reported that their gender work (as they defined it) changed over the course of the project. About one-fourth reported that program content had evolved, and about three-fourths said that their gender work had increased in intensity. Some of

the changes included expanding to work with both sexes after initially working with only one, working with younger age groups, or starting to work with couples after initially targeting only women or only men. Beginning to work with couples was a particularly striking change—75 percent of the programs that at the time of the interview were working with couples had not been doing so at the beginning of their projects.

Q: Has the problem statement changed over the course of the project?

A: When we started out, working with different communities in, we focused on young men and other support groups. We had a male-involvement program using sports as a medium to attract the community. Other key partners were TBAs, women's clubs, and parents of boys participating in the program. Over time, we learned that male involvement alone wasn't enough. Young women also had a key role [to play] within rural communities. If you work only with young men, the difference you make is not as large as if you work with young women, too.

The manager quoted above describes a program with the capacity to improve on its original design; incorporating young women when realizing that working with men alone proved insufficient for effecting real change. The program described below is another good example of such change.

Q: With whom did the program work when it first started?

A: Initially [it worked with] women only until 1995, until we realized we were catching the women too late. If we wanted to actually change the women's behavior, they needed to be [prepared] better. Now [we work with both] women and girls.

This reflection demonstrates that working with young girls before they are forced or selected into the sexual marketplace (and, similarly, that working with young males while their concepts of masculinity and entitlement are more malleable) can be a useful approach for programs aiming to improve gender relations.

Sensitivity to the challenge of dealing with young people of both sexes is increasing. In the passage below, the respondent considers that services for young people are disproportionately utilized by boys and young men.

A: We got to our youth centers and wondered, "Where have all the girls gone?" What are you guys still doing here? We had to deal with this. Through our programs [we] seek to confront our own stereotypes. I think we're relatively successful. There has been quite a strong attitudinal change among our leaders.

RECOMMENDATIONS MOVING FORWARD

Programs operate with varying levels of clarity regarding the populations that are most at risk, the salience of their interventions for different subpopulations, and outcomes that are both measurable and desirable. Not surprisingly, those programs that are most aggressive in explicitly

identifying and dismantling conservative gender norms, addressing structural constraints, and empowering girls and women are those that consider gender to be central to their program. Programs working with both males and females might be expected to be the most gender-effective (that is, the most likely to aim to empower women or to confirm male reports of behavior change), but our analysis shows that the programs that focus on only males or only on females currently do a better job. Their rationales are clearer and more explicit than those of programs targeting both sexes.

Single-sex programs must now line up and complement each other. What would the ideal parallel interventions for males and females look like? A gender-aligned program can work primarily with females, or males, or both, but must consider or attempt to transform power dynamics between males and females (in an intimate relationship; in an employer-employee relationship, or another situation). This approach must permeate program design, implementation, and evaluation.

This approach challenges the field to be specific about the intention and process of addressing gender, rather than simply labeling programs as having to do with gender. Some steps that could be taken to improve the way in which these programs select core participant populations include:

- selecting females deliberately with specific criteria based on, for example, the extensiveness of their vulnerability to abuse or risk and data on the age at which coerced sex might take place.
- using data to identify geographic areas in which concentrations of especially vulnerable females exist, for example, districts in which girls in domestic service live or work;
- asking the participating females to identify which males are problematic to them;
- prioritizing the males to reach and planning the programs to address men by presenting the most severe problems in order of urgency;
- selecting participants deliberately and appropriately. For example, when both males and females are to be targeted by a program, the program could commence by identifying females and then asking them to identify the influential men in their lives (for example, partners, fathers, brothers, peers, friends, clients);
- consulting with affected females to devise a plan to foster change in male behavior (also, consulting with male informants to collect evidence of what might be done to change their attitudes in an area of particular interest to females);
- providing realistic, private, and safe means to assess change with the participating females.
- consulting couples on issues of power and equality, determining the appropriate sequence: when to work with individuals; when single-sex groups are effective; when it makes sense to work with mixed-sex groups or couples (for example, instituting participatory workshops that involve males and females together and in single-sex groups, in order to examine the social and gender norms that shape the sexual behaviors and attitudes, reproductive health, and HIV risks of both sexes); and
- focusing more (than has been done in the past) on transforming gender norms in programs that work with females, and focus more on empowering females (or at least preparing males to support female empowerment) in programs that work with males.

Programs for males might benefit from:

- selecting participants deliberately in consultation with female stakeholders, for example, seeking out men who have a history of violence and those who are “baby fathers,” partners of pregnant women, employers, brothers, and fathers;
- extending the effectiveness of current male-focused programs by working in parallel to build the protective assets of the affected females, for example, their social support, livelihood skills, safety nets, knowledge, access to services, and safe channels of expression;
- ensuring that programs aiming to deconstruct how social norms of masculinity are harmful to males and females move beyond attitude change to effect behavior change, including behavior that spans the continuum from violence against women to everyday acts of discrimination and dismissiveness that (subtly and not so subtly) stifle, confine, and tyrannize women; and
- confirming the attitude and behavior changes reported by males by asking the females in their lives what changes they perceive.

Designing Programs for Adolescents

A critical issue is a lack of policies concerning adolescents in most countries. Most have “youth” policies for people aged 15–35. There are two problems with this age range. (1) The upper age boundary will pull resources to the older age groups—particularly males. (2) It excludes the time of maximum risk for girls, that is, the period when they are going through puberty (typically two years earlier than boys). Pubescent girls face extreme and sexualized pressures that in many cases are violent in nature. In Haiti, Liberia and Zambia, for example, more than half of reported rapes are experienced by girls younger than 15. The current youth policy approach excludes the youngest girls and tends to address females after the worst things have happened and when their options are much more limited—after they have become pregnant, after they marry and bear a child in acquiescence to what they believed was their only choice, or after they have been forced by economic need into sexual or marital relationships.

Programs that work with younger adolescents and youth must deliver content and strategy with sexual initiation and relationship patterns in mind. A larger proportion of girls (in some communities as high as 55 percent) report their first sexual experience as unwanted, tricked, or forced (Hallman 2005). Many girls who are classified as “ever having sex” do not report themselves as being in relationships. Adolescent relationships can be transitory and changeable. Tracking age differences in sexual partners is important. The girls’ partners at sexual initiation are often not male peers but rather older males. Moreover, as girls age, the number of current partners they report who are more than ten years older than they are may increase. This situation likely reflects the increasing economic dimension of sexual relationships as girls age (that is, formal or informal exchanges of sex for gifts and money). Table 3 presents the example from Liberia of the age difference between women and their first sexual partner.³

Table 3 Percentage of survey respondents by the age difference between women and their first sexual partner, among females currently aged 15–24, Liberia, 2007

Region	Women 15–24		
	Partner younger/ same age	Partner < 10 years older	Partner ≥ 10 years older
Monrovia	4.5	57.6	37.9
Northwestern	8.5	59.2	32.4
South Central	6.8	53.1	40.1
Southern Eastern A	3.4	42.7	53.8
Southern Eastern B	1.5	53.1	45.4
North Central	3.7	61.2	35.1
Urban	5.4	58.5	36.0
Rural	3.8	55.7	40.6
National	4.6	57.1	38.4

Programs for young people in our sample tend to include both young men and young women (75 percent). Observational studies of youth programs—coverage exercises—have been conducted in six countries (Burkina Faso, Ethiopia, Guatemala, Guinea Bissau, Liberia, Malawi, and Mauritania). These assessments suggest that even if programs intend to reach adolescent girls or younger adolescents (especially excluded groups such as those who do not speak the dominant language), it is often older male youths who are the largest program beneficiaries (Weiner 2007).

For example, in coverage exercises conducted in Burkina Faso, Ethiopia, and Guinea Bissau, more than half of the beneficiaries of youth programs intended for both males and females were males. In Mauritania that figure was 80 percent. Moreover, many of the young people being reached by these programs were older than the official cut-off age (Weiner 2007). Therefore, programs targeting young people in particular, but also those addressing adults, should do more work aimed at just females or just males. As observed many times in the Rio MenEngage conference (2009), progress with males on many subjects can be made only by working with all-male groups. The same is true for females. Young people need their own age- and gender-specific spaces in which to work with peers.

More Rigorous Evaluation and Validation

Formal evaluation is required to determine whether programs are working. Longitudinal studies are needed to assess change over longer periods of time, as well as to evaluate the degree to which changes are sustained. Reports of attitude and behavior change should be gauged by methods other than self-reports alone, such as asking the women and girls in men’s lives about changes in men’s attitudes and behavior. Violence can be a moving target, that is, as women become more sensitive to their rights and appropriate boundaries, reports of violence and abusive behaviors may increase because they feel greater permission to report it or they begin to define

behaviors that were previously accepted as less acceptable. Furthermore, violent incidents, not only reports of them, may increase as females begin to behave more freely before the males in their lives fully accept this change. Rigorous evaluation is all too rare in many programs, but when results are available, they can be striking. For example, an evaluation of one program in Ethiopia, Berhane Hewan, found a statistically significant decrease in an objective indicator of gender-based violence, namely, child marriage. The normative age of marriage increased by almost two years in the experimental communities (Erulkar and Muthengi 2009). The evaluation recorded a significant increase in school retention. As more programs are designed to include an evaluation, determining what is to be measured becomes important.

Some specific outcomes and processes that could be measured are:

- reductions in the violence that is enshrined in social institutions, so-called structural violence, such as child marriage or female genital mutilation;
- changes in attitudes, levels of violence, and feelings of security between individuals and within the community;
- achievement of defined goals by sex and age for males and females (as groups or as individuals) in terms of gains and changes sought in attitudes, knowledge of rights, and behaviors. For example, programs could link sex and age inputs to a primary client, for example, a female who at Time 1 does not know her rights and knows them at Time 2 or a male who at Time 1 does not have or know how to obtain a condom and who knows how to obtain and use a condom at Time 2.
- tracking potential synergies of inputs to clients who have a relationship with each other that is not necessarily sexual; the relationship could be due to work or community. For example, are there greater impacts of programs that address the males and females in a dyad, such as simultaneously building the protective assets of females while working with appropriately selected men on a parallel set of benchmarks for them? Does everybody do better when the program works with both sides of this situation?
- confirmation of outcomes with both partners of a couple rather than relying on one-sided self-reports for program evaluation, for example:
 - Assess changes in females’ autonomy and agency by asking both partners about such changes.
 - Assess changes in men’s use of the threat of violence to control their intimate partner by questioning both partners.
 - Assess men’s willingness to carry a fair share of the work burden by questioning both partners whether participation in child care has been equalized.

CONCLUSION

Since we began this project to review the content of gender-and-HIV programs, interest has increased concerning how to enhance links between programs to improve the safety of girls and women and programs to change unhealthy male norms.⁴ One difficulty has been, and continues to be, that the conversation never remains focused for long on the subject of building

girls' and women's protective assets. The discussion inevitably, and usually quickly, moves to "what about the boys," "what about the men?" Girls and women are often regarded as dependents or social juniors and are assumed to be more difficult to reach. Similarly, programmers may feel helpless to affect the social processes that increase the risk of HIV infection. They are more confident about investments in the treatment of bad outcomes. Thus, preventive work, indeed normative work, when it is undertaken is typically more often focused on men and boys than on girls and women. Little long-range planning occurs for strategies to help women and girls protect themselves.

We conclude this program review with several recommendations. Successful reduction of risks for girls requires redirecting HIV programs to primary prevention, to build the protective assets of those who are most at risk, particularly the youngest of those who face the highest risk. It is also time to examine independently what is needed for males and females, particularly young males and females, in the current HIV context.

In each setting we need to identify the populations who are at the highest risk of HIV infection and who are the least likely to have the social resources to prevent, mitigate, or treat it. We must focus our investments on these people. We must then determine which other populations must be contacted, involved, and potentially turned into allies in order to optimize our efforts.

We need to ask basic questions about what we want for our sons and our daughters and define the distinctive conditions of their needs during their childhoods and adolescence. We want our daughters to be protected and confident and to live their lives freely. We want our sons to have good values, to refrain from attempting to solve their problems through violence, not to develop a sense of superiority over females, and certainly not to use force to express their needs or obtain their ends.

Efforts to protect girls and women are about girls and women. Efforts to change male norms are about boys and men. They are related but separate social accounts. Allocation of resources should honor and invest in both of these social accounts, giving priority to those who are most vulnerable. All society benefits from these investments.

Because HIV prevalence among adolescent females is often several times higher than among males of this age, young women deserve a larger share of resources and policy attention than they have been receiving.

In conclusion, we believe that if we clarify our investment focus, we can achieve:

- safer and more confident girls and women who are able to claim their rights, act on their own behalf, and have opportunities and choices;
- men and boys who will benefit from less rigid gender roles and who recognize the full humanity of others and treat them with respect; and
- social institutions that reject discrimination, abuse, and violence.

Investing in improving the norms and behaviors of both males and females is important, but we must approach these investments with open eyes. Sequencing and prioritizing the allocations of investment to the most vulnerable people is crucial, and it is an ethical imperative.

NOTES

- 1 For example, such agencies as WHO, PEPFAR, the World Bank, and others have made commitments and developed specific guidance for programs on gender and HIV (World Bank 2004; PEPFAR 2007; WHO 2009), and a recent report by the Center for Global Development and International Center for Research on Women (Ashburn et al. 2009) points out that integrating some elements of gender and HIV has become increasingly commonplace in programs.
- 2 The ages included were specified by each of the programs individually.
- 3 Data are drawn from “The Adolescent Experience In-Depth: Using Data to Identify and Reach the Most Vulnerable Young People: Liberia 2007.” 2009. New York: Population Council. <http://www.popcouncil.org/pdfs/PGY_AdolDataGuides/Liberia2007.pdf>
- 4 In the early stages of this project, in order to gain perspectives from inside and outside of our organization, we met with many colleagues, including Gary Barker, Meg Greene, Andrew Levack, Julie Pulerwitz, Naomi Rutenberg, Ravi Verma, and others. These consultations sparked course corrections in our review, ongoing discussion, as well as a paper commissioned by the USAID IGWG. The review, “Synchronizing Gender Strategies: A cooperative model for improving reproductive health and transforming gender relations” by Greene and Levack, is a thoughtful paper moving this discussion forward. It can be accessed at <www.prb.org/igwg_media/synchronizing-gender-strategies.pdf>.

REFERENCES

- Ashburn, Kim, Nandini Oomman, David Wendt, and Steven Rosenzweig. 2009. “Moving Beyond Gender as Usual.” Washington DC: Center for Global Development.
- Barker, Gary, and Christine Ricardo. 2005. “Young Men and the Construction of Masculinity in Sub-Saharan Africa: Implications for HIV/AIDS, Conflict, and Violence,” *Social Development Department Working Series*, Paper No. 26. World Bank: Washington, DC.
- Boender Carol, Diana Santana, Diana Santillán, Karen Hardee, Margaret E. Greene, and Sidney Schuler. 2004. *The “So What?” Report*. IGWG: Washington, DC.
- Bongaarts, John and Mead Over. 2010. “Global HIV/AIDS Policy in Transition,” *Science* 328(5984): 1359–1360.
- EngenderHealth. 2010. “Men as partners.” <<http://www.engenderhealth.org/our-work/gender/men-as-partners.php>>. Accessed 2 October 2010.
- Erulkar, Annabel and Eunice Muthengi. 2009. “Evaluation of Berhane Hewan: A program to delay child marriage in rural Ethiopia.” *International Perspectives on Sexual and Reproductive Health* 35(1): 6–14.

- Germain, Adrienne and Jane Ordway. 1989. "Population control and women's health: Balancing the scales." New York: International Women's Health Coalition.
- Greene, Margaret, and Andrew Levack. 2010. "Synchronizing Gender Strategies: A cooperative model for improving reproductive health and transforming gender relations." Washington, DC: Population Reference Bureau on behalf of the Interagency Gender Working Group.
- Gupta, Geeta Rao. 2000. "Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How." Plenary Address XIIIth International AIDS Conference, Durban, South Africa, 12 July.
- Hallman, Kelly. 2005. "Gendered socioeconomic conditions and HIV risk behaviours among young people in South Africa." *African Journal of AIDS Research* 4(1): 37–50.
- Mekbib, Tekle-Ab, Annabel Erulkar, and Fekerte Belete. 2005. "Who are the targets of youth programs: Results of a capacity building exercise in Ethiopia." *Ethiopian Journal of Health Development* 19(1): 60–62.
- Population Council. 2009. "The Adolescent Experience In-Depth: Using Data to Identify and Reach the Most Vulnerable Young People: Liberia 2007." New York: Population Council. <http://www.popcouncil.org/pdfs/PGY_AdolDataGuides/Liberia2007.pdf>. Accessed 29 March 2010.
- Population Council and Interagency Gender Working Group. 2001. *Power in Sexual Relationships: An Opening Dialogue Among Reproductive Health Professionals*. Report of a meeting held 1–2 March 2001, Washington, DC. New York: Population Council.
- President's Emergency Plan for AIDS Relief (PEPFAR). 2007. "Responding to Critical Issues: Gender and HIV/AIDS," in *The Power of Partnerships: PEPFAR Third Annual Report to Congress*.
- Sen, Gita, Adrienne Germain, and Lincoln Chen. 1994. *Population Policies Reconsidered: Health, Empowerment, and Rights*. Boston, MA: Harvard School of Public Health.
- Sen, Gita and Caren Grown for the project Development Alternatives with Women for a New Era (DAWN). 1987. *Development, Crises and Alternative Visions: Third World Women's Perspectives*. New York: Monthly Review Press.
- Sidibé, Michel. 2009. Opening Address, Global Symposium on Engaging Men and Boys in Achieving Gender Equality, Rio de Janeiro, Brazil, 30 March. <http://data.unaids.org/pub/SpeechEXD/2009/20090330_sp_engagingmen_en.pdf>. Accessed October 2, 2010.
- United Nations. 1994. *Programme of Action*. International Conference on Population and Development.
- United Nations. 1995. *Platform for Action*. Fourth World Conference on Women.

- Wegner, Mary Nell, Evelyn Landry, David Wilkinson, and Joanne Tzanis. 1998. "Men as partners in reproductive health: From issues to action." *International Family Planning Perspectives* 24(1) 38–42.
- Weiner, Adam. 2007 "Assessing equity of access in youth programs." *Transitions to Adulthood Brief No. 28*. New York: Population Council.
- Whelan, Daniel. 1999. *Gender and HIV/AIDS: Taking Stock of Research and Programmes*. UNAIDS: Geneva.
- World Bank. 2004. *Integrating Gender Issues into HIV/AIDS Programs: An Operational Guide*. World Bank: Washington, DC.
- World Health Organization (WHO). 2009. *Integrating Gender into HIV/AIDS Programs in the Health Sector: Tool to Improve Responsiveness to Women's Needs*. WHO: Geneva.

Appendix: Raters' Gender-assessment Guides

(1) Gender-continuum Scale

Using an adaptation of Gupta's framework (Gupta 2000), how would the program be categorized?

10-point scale:

HARMFUL >>> NEUTRAL >>> SENSITIVE >>> INFLUENCING>>> TRANSFORMATIVE

Harmful	1	__
	2	__
Neutral	3	__
	4	__
Sensitive	5	__
	6	__
Influencing	7	__
	8	__
Transformative	9	__
	10	__

“Harmful” was defined as causing women disadvantage or harm (for example, programs that reinforce gender stereotypes or inadvertently place women at risk).

“Neutral” was defined as gender-blind—no harm is caused, but no awareness exists in the program of the different needs of males and females or of the role of gender norms and inequality in shaping people's risk for HIV infection or access to resources.

“Sensitive” was defined as meeting the distinct needs of females and/or males (for example, providing women access to female condoms because use of male condoms is controlled by men) but not addressing the power disparities in relationships or the norms and structures that underlie girls' and women's risk of HIV infection.

“Influencing” was defined as seeking to change gender attitudes and foster gender-equitable norms, particularly for men in the areas of sexual and reproductive health. Other examples include raising awareness among policymakers about topics such as gender inequality in the workplace or educating judges about violence against women. Although these types of influencing activities are necessary, they are not sufficient to fundamentally transform power relations between males and females at the beneficiary level.

“Transformative” was defined as describing programs that seek to empower women, to “free women and men from the impact of destructive gender and sexual norms” (Gupta 2000, page 6), and to fundamentally transform relationships between males and females from relationships built on inequality to relationships based on equality. These are programs that aim to eliminate the imbalance of power between women and men by addressing the norms, disparate capacities and opportunities, and structural factors that underlie inequality and discrimination.

(2) Gender-Alignment Scale

In each of the following program stages: To what degree do programs strategically consider the entry point and target population and attempt to align the needs of women and men, girls and boys in a particular ecological context? To what extent do they attempt to consult females as to which males are problematic to them? To what extent do programs consult males

with regard to which females they interact with or have influence over? To what extent do they consult with gatekeepers in order to determine who should be targeted or brought into the intervention? With the aim of transforming power dynamics between males and females (be they in an intimate relationship, employer-employee relationship, or other relationship), this scale is employed to determine to what degree programs explicitly identify specific goals by age and sex in terms of whom to reach, asset-building, attitudinal change, and behavior change.

Score: 1 = undermining; 2 = none; 3 = low; 4 = medium; 5 = high

Program design:

- 1 _
- 2 _
- 3 _
- 4 _
- 5 _

Participant identification:

- 1 _
- 2 _
- 3 _
- 4 _
- 5 _

Actual implementation:

- 1 _
- 2 _
- 3 _
- 4 _
- 5 _

Evaluation:

- 1 _
- 2 _
- 3 _
- 4 _
- 5 _

FINAL SCORE: __

(3) Gender-elements Scale

On a scale of 1–5, how would you rate the magnitude of the gender element(s) of this program, that is, what is the relative emphasis given to gender in the context of the overall program?

- 1 _
- 2 _
- 3 _
- 4 _
- 5 _

Score: 1 = nonexistent to very weak; 2 = superficial; 3 = adequate or small component, but not exceptional in implementation; 4 = better than average; 5 = strong and central to the program

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