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## CHALLENGE AND CHANGE:

Integrating the Challenge of Gender Norms and Sexuality in a Maternal Health Program

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## Foreword and Acknowledgements

We wrote “Challenge and Change” in order to document some of the processes that we undertook to integrate gender and sexuality factors into a maternal health project in Uttar Pradesh, India from 2007-2009. It aims simply to tell a story about how we undertook that complicated, messy process of layering into a maternal health project not only the challenging topic of gender discrimination but also a process of challenging ourselves to think about our work differently. In it, we don’t share the results of our research findings (which are documented elsewhere) or the impact of the work (also shown elsewhere), but rather some of the details about how it played out in real life. We hope these descriptions and lessons are useful to others as they may be addressing gender and sexuality as critical components of maternal health programs.

The successes of a project can only be possible with the hard work and talent of many people. With grateful thanks, we would like to acknowledge the dedication, creativity, and courage of Rashmi Kapoor, Padma Singh, Bharti Srivastava, Aparajita Mani, and Bandana Gupta who tirelessly and cheerfully contributed their talents to the work of ISOFI as CARE India’s Research Associates. We would also like to thank Suniti Neogy, who oversaw ISOFI integration in UP, and shared her enthusiasm and talents for creating new tools at the community level. Many thanks to Suman Bisht, the ISOFI project manager and Gender and Diversity Coordinator of CARE India, who showed brilliance in finding creative solutions every day. Doris Bartel, CARE’s Senior Advisor for Sexual and Reproductive Health shared her insights and support from Washington and Brooke Barnes, Program Associate for Sexual and Reproductive health, provided support from Atlanta. The successes of ISOFI could not have been accomplished without the strong support of Ravi Lal Das,



Acting Program Manager, Pratibha Sharma, CARE's UP State Representative, and Veena Padia, State Director for CARE's work in Uttar Pradesh. The entire team of the MNH project and our lead partner on that project, PATH, deserve kudos for a job well done and the dedication to make it so. We gratefully acknowledge the valuable contributions of ICRW staff throughout the design and implementation of the project, including the insights and recommendations of Sarah Kambou, Ravi Verma, Deepmala Mahla, Annie George, Hiralal Nayak, and Aprajita Mukherjee. Finally, we would like to share our heartfelt gratitude to the Ford Foundation, for their generous support of the idea that gender and sexuality rights are keys to optimizing maternal health outcomes

## I. Background

For decades, CARE and other development organizations have worked with communities to improve both the quality and accessibility of local health services for women and newborns. Our programs have been designed to promote, among other things: access to information that will positively affect choices about family planning; basic elements of antenatal care for all pregnant women; skilled delivery at birth; referral to basic and comprehensive emergency care when complications arise; and essential newborn care, including warming, cord care and immediate and exclusive breastfeeding. These strategies have been proven to improve maternal and newborn health and survival.<sup>1</sup>

While rates of morbidity and mortality for mothers and newborns have dropped in many countries, the global burden of maternal mortality has not significantly diminished in more than a decade, despite the aims of the United Nations



Millennium Development Goals to significantly improve maternal health by 2015. A recent series in *The Lancet* called for a more comprehensive approach to achieving better health to address factors outside the health care system, such as reducing poverty, improving women's attainment of higher levels of education and access to economic resources, in addition to community-based social protection and mobilization efforts.<sup>2</sup>

CARE's experiences in maternal and newborn health (MNH) have confirmed to us that improving quality of health services is not enough, nor is improving demand for health services or even teaching people about health behaviours. Reducing social barriers can, in fact, help improve the health of the community. Moreover, we have learned that addressing certain cultural norms related to gender and sexuality, such as early marriage, women's limited mobility, or household violence can also significantly influence health outcomes. Through close collaboration with communities, we now are able to carefully design and incrementally implement projects that holistically address social determinants of poor health, with each project tailored to the needs and resources of the community where it is implemented.

Because peer pressure and social expectations play a large role in how people behave, it is important to include individual behaviour change models as well as social change models that mobilize communities on issues of inequity based on gender, race, ethnicity or caste. It is also important to link work at the community level with the strengthening of health service capacity, so the health service sector can contribute to the reduction of discrimination, stigma and other barriers that keep women and newborns from achieving their full potential.

This is the story of CARE's and ICRW's novel effort to improve MNH in the Indian state of Uttar Pradesh by fully integrating existing state-of-the-art health interventions with new activities designed to address some basic underlying causes of poor health – namely, discrimination based on gender and sexuality.

## II. Inner Spaces Outer Faces Initiative (ISOFI)

CARE's Inner Spaces Outer Faces Initiative (ISOFI) was designed to share a simple lesson: Every person has both an "internal space" and an "outer face." Their internal space includes their perceptions of issues such as gender, sexuality, family and identity. Their outer face represents the way they communicate ideas with others. Although these two concepts are very connected and can be mutually reinforcing, they can also conflict. For example, the inner beliefs and values of staff members implementing reproductive health programs might not be in alignment with the public face of traditional public health paradigms. A public health professional who is working to reduce the risk for HIV infection among commercial sex workers may experience shame and stigma if some family members wonder why, for instance, a married, middle-class professional would work with people who are considered by many to be morally questionable. Another public health professional working with unmarried adolescents may believe that providing sexual and reproductive health information and services for unmarried people is not proper, based on his or her culture, even though that professional is working to serve the needs of an entire community, including unmarried people.

The first phase of ISOFI (2004–2006) explored ways to build staff and organizational capacity to identify and address gender and sexuality inequities in the context of CARE's reproductive health programs. Building on these efforts, the second phase of ISOFI (2007–2010), which is the focus of this report, aimed to improve the capacity of both staff and community members to address social as well as medical issues related to MNH, and to measure the effectiveness of both.

The first phase used structured, iterative loops of reflection/learning, action/experimentation and analysis/dissemination, known as the “ISOFI Innovation System.”<sup>3</sup> This phase showed us that staff members’ personal beliefs and values can and should be explored through training, mentoring and support. This support must continue as staff carefully and respectfully work with community members to explore their values and beliefs related to gender and sexuality. Results of this first phase included a marked improvement in how staff rated their own personal and professional understanding of the nuances and social construction of gender and sexuality norms.

As delighted as we were by the results of the first phase, we wanted to go further, and to measure if it was making a difference in the effectiveness of CARE programs. So for the second phase of ISOFI (2007 –2010), we teamed with our research partner, the International Center for Research on Women (ICRW), to systematically integrate gender and sexuality rights into a MNH project. We aimed to improve not only health knowledge, behaviours and outcomes, but also attitudes and behaviours related to gender and sexuality.

We launched the second phase at the start of a new, community-based MNH project designed to boost demand for and uptake of appropriate clinical health services for mothers and newborns during pregnancy, delivery and the postpartum period. Using lessons learned from the first phase of ISOFI, we began integrating the gender and sexuality interventions into this “anchor” project.

CARE was the primary implementation partner in two of the nine districts targeted by the MNH project, in Barabanki and Raibareilly.<sup>4</sup> The project was designed to maximize community-based behaviour-change and advocacy efforts at the local government level, across a wide geographic zone with a large population. The project used up to four levels of intervention, depending on where it was implemented: (1) district- and sub-district-level advocacy for commitment to MNH activities; (2) community-level interventions through training of government-paid health outreach workers to support established village health and sanitation committees and to establish new mothers’ committees focused on behaviour change; (3) household-level counselling and support for pregnancy, delivery and the postpartum period; and (4) a more intensive household-level intervention focused on household services and commodities. Not all villages or even sub-districts received all the interventions. The project was designed so that 100 percent of the targeted population received level 1 interventions, at least 40 percent received level 2, and at least 15 percent received level 3 and 4. The primary target population was pregnant and lactating mothers and newborns, and the capacity of the community-based health system to support healthy MNH behaviors and care.



Key health behaviours targeted by the project included: birth preparedness, recognition of danger signs in pregnancy, immediate and exclusive breastfeeding, clean cord-cutting practices and thermal care for newborns. To achieve a high level of awareness about better health practices among pregnant women and new mothers, and to get them to put those practices into action, the project initiated community-level interventions through existing committees established by the government of India’s National Rural Health Mission, such as village health and sanitation committees (VHSCs) and by establishing new mothers’ committee meetings involving Anganwadi workers (AWWs),<sup>5</sup> accredited social health activists (ASHAs),<sup>6</sup> cord-cutters, local birth attendants (known as dai), pregnant women,

and mothers-in-law or sisters-in-law as well as district- and sub-district-level consortia meetings. Some home visits were scheduled for pregnant women who could not come to the mothers' committee meetings, and for all pregnant women living in communities targeted for level 3 and 4 activities.

CARE and ICRW chose to implement ISOFI interventions in project areas that were receiving all four levels of MNH intervention. In order to test the validity of the ISOFI interventions, we chose a quasi-experimental design:

- From 2007–2009, specific ISOFI components were layered into the four levels of intervention in selected sub-districts in the intervention district (Barabanki); this was achieved through capacity building, reflective practice and modification of intervention methodologies.
- CARE and ICRW measured the differences between the districts in 2007 and again in 2009.

### Interventions were designed as follows:

	Control District (Raibareilly)	Intervention District (Barabanki)
<b>Level 1</b>	MNH advocacy at the district level.	MNH advocacy at the district level, layered with advocacy on issues related to gender and sexuality.
<b>Level 2</b>	Level 2 MNH behaviour-change interventions through meetings, training and support of community-level groups, such as village health and sanitation committees (VHSC).	MNH behaviour-change interventions through meetings, training and support of community-level groups, such as VHSC; included layered training, coaching and behaviour-change communication (BCC) activities related to gender and sexuality.
<b>Level 3</b>	Household-level counselling on MNH (15% of households).	Household-level counselling and support (15% of households); included training, mentoring and support of community-based health providers to give social support and referral with regard to gender and sexuality factors conducted in home visits.
<b>Level 4</b>	Intensive household-level interventions e.g., home visits (15% of households).	Intensive household-level interventions (e.g., home visits) in 15% of households; included training, mentoring and support of community-based health providers to give social support and referral with regard to gender and sexuality factors, via home visits.
<b>Additional Interventions</b>		Communitywide media events and health fairs focused on gender, sexuality and MNH issues, such as “couples’ meets” and “new parents’ meets,” film discussions, puppet and magic shows, and community theater.  Staff training, coaching and reflective practice on gender and sexuality issues, as they relate to their personal lives and professional responsibilities.

As described in the following pages, we used these platforms for MNH behaviour-change interventions as opportunities for exploring values and challenging assumptions about gender and sexuality norms. We integrated iterative and open-ended exercises for discussion on gender and sexuality with ongoing project interventions at all levels. In some sub-districts, we also organized men's group meetings in remote villages, where other outreach efforts would not work, and created new platforms for public dialogue that promoted discussion and debate about social norms,

including a “couple’s meet” and “new parents’ meet.” ISOFI also introduced larger social events open to the general public, such as puppet shows, magic shows, street plays and film screenings, each with a facilitator to prompt public discussion about gender values and norms in the community.

As the second phase of ISOFI was layered into the project interventions, activities at all four intervention levels were carried out by project staff, their local NGO partners and the government health care workers targeted for capacity building. These included field officers, project coordinators and field supervisors working closely to build capacity of community-based health providers (e.g., ASHAs and AWWs) and the auxiliary nurse midwives (ANMs),<sup>7</sup> in collaboration with health facility staff. To ensure that the interventions related to gender and sexuality were fully integrated into the project, four additional field staff and a supervisor were hired; they worked closely with the MNH project to implement the full spectrum of originally planned activities as well as the modified activities designed by staff and community members.

### III. Transform Staff Capacity

The first phase of ISOFI showed the importance of personal reflection and transformation as steps toward addressing issues of gender and sexuality in MNH programs. Using these lessons, we wanted to give staff the opportunity to weigh their own values, beliefs and opinions about gender and sexuality through dialogue with their peers. Many issues related to gender and to sexuality are considered taboo for public or “polite” discussion especially those related to domestic violence or sexual expression. In our experience, many people, including public health professionals, lack skills and experience when it comes to discussing such topics. Project staff members were all health professionals and well-versed in methods to improve health-related behaviours. When presented with the idea of addressing factors related to gender and sexuality in addition to health behaviours, many staff members were interested and excited; they wanted tools and practical strategies, since their professional training had not prepared them for addressing these issues. However, other staff members questioned whether the project allotted enough time for introducing a gender and sexuality component.

From our experiences in the first phase of ISOFI, we knew that a one-off training was not sufficient. So we incorporated multiple opportunities for staff to explore issues related to gender and sexuality and begin a process of self-transformation, including iterative opportunities to reflect and think critically about the issues. These opportunities included: training workshops, monthly project meetings, quarterly all-staff meetings, qualitative and participatory assessments with community members, cross-visits to other field sites, and an off-site retreat that included an invitation to spouses and children.

#### Training Workshops

We began by offering two training workshops to all project and partner staff in the district. The first workshop was organized within six months of the start of the project (January 2008) and the second about six months later (June 2008). We designed the workshops to ensure that participants would have some exposure to a variety of opinions and values related to gender and sexuality issues, and be able to speak about them sensitively in professional settings. For the most part, CARE staff members in India are middle-class, well-educated professionals, but as a group are not necessarily familiar with many of the discrimination-related issues faced by those outside their own caste or economic class. Thus, the workshops aimed to increase their understanding of gender norms and gender roles, sexual roles and identities, power and control, and social exclusion. Facilitators for the trainings were chosen

from a local sexuality-rights NGO with strong ties to groups that advocated for the rights of socially marginalized groups (lesbian, gay, bisexual, and transgender people (LGBT), sex workers, etc.). This helped to ensure that the workshops used local language and presented material in a locally appropriate context, and it also strengthened links between the project and local NGOs.

The workshops were designed to be participatory. Although some theoretical presentations were made, most workshop time was devoted to exercises, films and group discussions.<sup>8</sup> The theoretical presentations were aimed at ensuring consistent understanding of basic gender concepts and introducing some statistical data about health, gender and sexuality trends in India. The workshop facilitator then led group discussions that explored how participants had experienced the intersection of social expectations around gender, health and sexuality.

To build their facilitation skills, participants were also coached in taking notes for the group, making presentations and helping to facilitate discussion using sensitive, open-ended questions. Through workshop activities, participants explored key issues of reproductive and sexual health, as well as their own assumptions and expectations related to gender, sexuality, feelings of power or powerless, and their own judgmental attitudes.

In the second round of training (June 2008), content was based on participants' requests for tools and applications they could use in a project setting. Working in teams, they were encouraged to explore their own ideas for how to integrate improved awareness and behaviour related to gender and sexuality into maternal, neonatal, child health and nutrition programming.

### Routine Reflective Practice

In addition to the two trainings, we introduced periodic meetings for reflection and learning for project staff members and implementing partners. We wanted to encourage ongoing critical observation and learning, and so we

#### Some comments from staff and partners on the training workshops:

"The last exercise has helped me to see how the core values have to be followed in a village. When the women did not come for the meeting after calling them for a number of times, I used to get irritated, but now I realize that it is her choice and I should respect it."

"We need to begin things from our own homes. We have been biased [for] a long time. If we are able to change ourselves, it will in itself be a big change."

"I have become more flexible, and now there is less rigidity."

"The sessions had discussions based on self, and hence it was good for sensitivity."



encouraged staff to reflect and learn through a method known as reflective practice. Reflective practice is simply a set of activities for repeated periodic reflection and critical thinking, individually and as a group. The facilitator uses the exercises to help the participants focus on what, why and how they are doing things, seeking alternative options for action when necessary. It helps the group consider consequences, both good and bad, and synthesizes and tests new ideas.<sup>9</sup>

During reflective practice sessions, staff members shared with one another the gender or sexuality issues they thought were most pertinent to their work, how they were addressing those factors, and gender-related issues they had noticed since the last discussion. We also asked staff to make recommendations for changes in intervention methods, based on their observations.

Some of these sessions were led by outside facilitators, while others were facilitated by ISOFI staff members. In the early part of the project, reflective practice sessions were held with MNH project staff and their NGO partners, both jointly and separately. Later, many of the sessions were conducted during routine project-specific staff meetings.

When MNH project staff members were asked how they had integrated gender and sexuality issues into ongoing program activities, they said that they were initiating meetings with couples instead of with just women, and were modifying their MNH tools and exercises designed to promote discussions with mothers' committees or VHSCs. They said the discussions they were having with women, family members or local leaders brought up issues of women's mobility, sex during pregnancy and low level of communication between spouses. They also reported that the married women with whom they spoke most often requested services and information related to contraception and domestic violence.

In one of the early sessions, one recommendation that came out of the discussions was to find ways to increase communication between spouses to foster a more enabling environment for change. MNH staff also wanted to find more ways to work closely with husbands, because although men played a large role in decision making about finances and care during pregnancy and delivery, they had been left out of program plans. In addition to working directly with husbands to increase their knowledge and enhance their attitudes and behaviour with regard to health and gender issues, some MNH staff felt that the program needed more community-level components of social change interventions to bring the debate about men's role in MNH care and gender relations to the whole community. They believed that addressing these issues at a community level as well as in smaller groups (e.g., through VHSCs, mothers' committees and home visits) would make the interventions more effective.

“We challenge each other to be honest and less hypocritical, to explore inconsistencies and how we inadvertently reinforce that which we are trying to change.”

As this report demonstrates, we turned the recommendations from these reflective practice sessions into practical interventions that were layered into existing MNH project activities.

### **Cross Visit to External Implementing Organization**

We initiated one cross-visit for staff to a community-based MNH program in 2007, prior to implementation of activities in this second phase. ISOFI staff members travelled with their families to a nearby state in India to visit a local organization that focused on community-based MNH. This cross-visit had multiple purposes: to exchange information with another health-focused organization, to learn about its community interventions, and to increase staff capacity in clinical MNH information, such as how to recognize pregnancy-related complications. An unofficial objective was to help husbands of female staff members build trust and confidence in their spouses' work. This was important because female staff members often experienced pressure from their family to remain home or not to travel unaccompanied, which their job responsibilities made nearly impossible.

The visit was successful in that it built the confidence of the ISOFI staff members to provide accurate medical/clinical information on MNH issues and it gave them an idea for developing a possible community-based intervention. After discovering that students from a nearby secondary school present health-focused theatre performances to the community, the ISOFI team collaborated with a local college to plan and stage theatre performances focusing on discussions of early marriage, male involvement in pregnancy and newborn care, and recognition of pregnancy danger signs by family members. The visit was also successful for the unofficial reason that it encouraged family members to become more interested in and trusting of the project activities. After this visit, for example, one staff member's family allowed her to purchase and use a motorcycle when her job took her outside her village.



## IV. Plan for Action Based on Analysis with Community

Based on experiences addressing gender and sexuality at the community level, we knew that values, attitudes and beliefs about these issues vary from person to person, and from community to community. We wanted to ensure that the interventions not only were appropriate for each targeted community, but that community members actually wanted them. Although project staff were members of these communities, had worked in them for many years and therefore had many strong opinions about locally held values and beliefs, we wanted to make sure that these were not false assumptions. We used gentle exploratory exercises to discover a variety of opinions and values across the communities.

Through this process, we consistently found attitudes among certain individuals that did not seem to fit the social norm. In fact, in each community we found a variety of opinions and behaviours that ranged from fairly traditional to quite non-traditional. Some of this variability emerged from one-on-one discussions, but some of the most valuable information came from discussions in the community at large.

### Reviewing existing data

We started by reviewing existing primary and secondary data sources. The MNH project had conducted a rapid assessment at the planning stage just prior to initiation of activities. The purpose of the assessment was to (1) explore the social, economic, cultural and institutional factors that influence MNH and (2) identify barriers to health services and behaviours, particularly for vulnerable groups. This assessment used a variety of qualitative methods, including mapping exercises, transect walks, venn diagrams, ranking and focus group discussions.

The assessment identified several gender-related barriers, listed below.

- The mobility of pregnant women is restricted by both self and community. Pregnant women restrict their own movement outside the home due to shame at their own pregnant condition. As woman said, “The whole village will come to know about the pregnancy, which is because of sex.” Because of this shame, some women do not even tell family members about their pregnancy, thereby potentially delaying prenatal care.
- Women continue to do household and agricultural work throughout their pregnancy. It is believed that heavy work will keep them fit and active, which will eventually lead to an easy delivery. It is also believed that if the woman rests too much, her child will be born will be inactive and lazy. The traditional period of rest after delivery, when the mother is considered impure and not allowed to do any work (a period known as saur), used to be 38 days. Women reported that this period of rest is often only 3–4 days for women in nuclear families.
- In traditional Indian family culture, females are the last ones to eat; in fact, most of the time they eat only what is left after others have eaten. Women typically will not cook another meal for themselves, even if the leftover food is insufficient.

### Additional exploration of community issues: qualitative inquiry

To augment previous community assessments and increase our understanding about how gender and sexuality influences MNH, we conducted a nine-day qualitative study in February 2008. Designed by ICRW and implemented jointly with CARE, the study focused on women’s agency and autonomy in the context of marriage and nuclear/

joint families, as well as on linkages with natal families. Because the assessments had already provided significant information on community attitudes, norms and barriers with regard to health care, we wanted to dig more deeply into the lives of a few people, to gain a more nuanced insight into issues that affect health MNH and other health behaviours.

We decided to perform this “deep dive” through in-depth interviews involving several different types of families in the district. A total of 30 individual interviews were conducted by same-sex interviewers. They focused on mapping social networks and support during pregnancy and postpartum, and also decision-making and participation in health care services. These interviews represented the first opportunity for project staff to discuss these issues with men.

Each day, each team held a debriefing session. After all the interviews were complete, the entire research team came together for a day of documentation and preliminary data analysis from their notes. In addition, recordings of their interviews were transcribed and further analyzed.

The qualitative inquiry helped CARE staff more fully understand the underlying causes of health behaviours at home as well as some barriers to health service utilization. One staff member who participated in both the original rapid assessment and the qualitative inquiry said, “Some of the factors were realized during the rapid assessment, but we did not choose them for intervention. But now I can see that how important it is for the woman to have agency to decide and access health services. We definitely need to look into the power dynamics at the household level while we plan our interventions.”

The exercise also helped change the opinion of some staff members who had been sceptical about gender and sexuality as key factors in achieving health outcomes; the interviews with men were particularly convincing. This was a key turning point in beginning to think about gender as an issue that affects men as well as women. Staff began to see differences in how family structure and support influenced health behaviours and health care uptake by pregnant women. By the end of the exercise, they could see how ISOFI could complement MNH objectives. In addition, staff members felt that their experiences during this exercise had improved their ability to address gender and sexuality issues in the community.



## Some Key Findings from the Qualitative Study

**Nuclear versus extended families:** About half of the respondents were living in nuclear families rather than with their extended family (husband’s parents and/or siblings). Women and men reported better couple communication in nuclear families. Women’s preference for extended versus nuclear family setups was mixed. Men generally said they preferred a nuclear family setup, saying it ensures a better future for their children and saves their wives from excessive domestic chores.

**Men’s role in MNH:** Both men and women reported that the role of men during pregnancy and childbirth is minimal. Their role was to bring fruits and other food that their wives wanted or were advised to eat and also to arrange for transportation, if needed. Men from nuclear families reported that they took on the task of filling water and carrying cattle feed while their wives were pregnant. Men were struck by their own ignorance of maternal health and strongly felt that they needed information on immunization, pregnancy care and delivery.

## V. Implementation of Activities

Based on results from the community assessment, we designed interventions to address key gender and sexuality issues linked with MNH, including: how women communicate with their husbands (including mutually consensual sex); women's nutrition status and food intake; men's knowledge of and contribution to antenatal, delivery and postpartum care and support in the household; women's mobility; and women's workload during pregnancy and postpartum.

To do this, we modified MNH project strategies and tools to include creative new ways to address gender and sexuality issues; we layered these new approaches into existing strategies to improve health knowledge and behaviours, such as breastfeeding and recognition of danger signs during pregnancy.

We addressed these issues at various levels of implementation by the MNH project: household, community, within the health sector services, and at the community and district levels. At the household level, activities focused on home visits, mothers' committees and VHSC meetings. At the community level, MNH messages were reinforced through media events that focused on gender and sexuality issues; these events included puppet shows, film screenings, street theatre and magic shows for the public. We also launched public "couples' meets" and "new parents' meets" (described below). These well-attended events were both entertaining and educational. Most important, they promoted public dialogue and debate about some key gender and sexuality norms identified by the project: violence, couple communication, mobility, lack of men's participation and women's nutrition.



ISOFI built the capacity of local NGO partners, community-based health providers and district-level health officials and other local authorities to understand and address these issues. For example, as the MNH project trained district-level health officials and improved the basic MNH knowledge of frontline health workers, ISOFI layered in modifications of these strategies that promoted improvements in women's mobility, increased responsibility of household members for reducing the workload of pregnant women and new mothers, increased intake of nutritious food, and acknowledgement of women's sexual rights.

### Community-level interventions

For community level interventions, we modified the exercises designed for the MNH project in order to incorporate the concept of gender and sexuality as social and behavioural barriers to improved MNH. One example was an exercise in which the facilitator explored MNH-related beliefs and practices using a train analogy. Participants included women who attended the mothers' committee meetings, such as pregnant women, lactating women and their mothers-in-law. There were three compartments in the "train," and each compartment represented a trimester of pregnancy. The facilitator asked the group questions about common practices and possible complications during the three trimesters of pregnancy. We modified the tool to generate additional discussion about the enabling environment for a pregnant woman, including:

- Who makes decisions about caring for her?
- When and why can she make decisions for herself?
- When or why can she attend clinical care by herself or without permission?
- Who needs to be notified when danger signs are noticed?
- Who will make the decision about what to do, and how?
- What are common beliefs about sex during pregnancy?
- During this activity, participants also discussed restrictions on pregnant women regarding their mobility and how to overcome those restrictions.

### Some new issues emerged from discussions using exercises like the one described here.

**Violence:** The issue of violence was raised by women during discussions about mobility. When asked if women are able to access health services and, if so, if they can go unaccompanied, they replied that if they went out themselves, or went out without permission, they would be subjected to violence. When asked why they face violence when they go out, they said it is because men and other family members do not want women to go out. They added that they are abused when they don't cook well or when the children are crying or when they have not completed household chores. Some women said violence can happen for no specific reason.

**Sex:** The older women said sex could harm the growing fetus, and so pregnant women should avoid it altogether. Some men also said they understood it was not recommended medically during pregnancy. Pregnant women said they did not feel any sex drive during pregnancy and sometimes felt pain when they had sex, since they were uninterested. Some said during pregnancy they feel tired or don't want to have sex very often, but that men sometimes force sex on them. Some women said they also face violence when they say no to sex.

The “bead game” was one especially popular activity designed by ISOFI for use at the community level interventions. It was designed to address some of the pressure women felt to give birth to boy children. With the help of two colored beads representing the X and Y chromosomes, the game demonstrated how the sex of a child is determined. The key point, that it is a chromosome from the *man* that determines the sex of the child, was overwhelmingly popular with the women, who said they were often blamed by their husbands or families if they did not produce a baby boy. This game became so popular that it was used in most of the group meetings, and community-based health providers, such as AWWs and ASHAs, were trained to facilitate the exercise as part of their routine job activities.



For another project activity, we took flash cards used to generate MNH discussions in the community and modified them to prompt dialogue about men as key supporters for women’s rights, including their role as caregivers during pregnancy and postpartum. We worked with a local NGO called Sahayog to develop a set of these modified flash cards. They focused on a woman’s right to seek care with a skilled provider, their needs for rest and increased nutrition during pregnancy and while breastfeeding, the importance of a supportive environment in the home where the division of labour is shared, and preventing violence in the home. The flash cards were incorporated as job aids into routine care provided by government-paid community health workers.

### Home visits

MNH project staff planned to visit at least 15 percent of the pregnant women at home, focusing on those who did not come to the mothers’ committee meetings and who also were in the last trimester of pregnancy. In the sub-districts where we focused our ISOFI interventions, more than 1,200 women were visited at home at least three times during pregnancy and postpartum. We made home visits a priority because we realized that many of the issues women were bringing up, such as those related to sex and violence, required careful and confidential support. Also, the mothers’ committee meetings generally were not attended by pregnant women themselves, but rather by their mothers-in-law.

In ISOFI sub-districts, we focused on one to three home visits for every pregnant woman. At first, these visits were conducted by four field staff hired specifically to supplement regular MNH project staff. They initiated the home visits in advance of the official start of level 3 intervention activities, because these activities had been delayed for other unrelated reasons. Eventually, the MNH project began home visits in both Barabanki and Raibareilly. The field staff started training NGO partners in conducting home visits and providing confidential and sensitive counselling and referrals. Later, the staff encouraged, coached and mentored the accredited social health activists (ASHAs) to conduct these home visits as part of their ongoing job responsibilities for the government of India’s Integrated Child Development Services.

The home visits allowed project staff and participants to discuss household-specific problems as well as issues too sensitive for public debate, such as consensual sex and domestic violence. Home visits were generally conducted during the day, so often the husbands were not home. Many women, however, specifically requested a consultation while their husbands were present. When this happened, staff would return when the husband was present, so the couple could be counselled together. We were encouraged to discover that during these discussions, the husbands frequently had many questions about MNH and became quite engaged. We also found that the discussions with other family members helped create more sustainable solutions to behaviour change. During the home visits, for example, women were counselled

about the importance of eating a sufficient amount and variety of nutritious foods throughout the day. However, they commonly reported that by midday they had eaten very little, except for drinking some cups of tea. They gave various reasons for not eating, such as being too busy or not having enough food left after others had eaten. But solutions could often be found after bringing other household members into the discussion.

### **Training frontline community-based health service providers**

We focused on ensuring the efficiency and sustainability of the MNH project by training community-based health providers to think critically about issues of gender, sexuality and discrimination, and to develop skills to address those issues in their day-to-day work.

One component of the government of India's Integrated Child Development Services (ICDS) is the Anganwadi Centre, which is staffed by an Anganwadi worker (AWW). The Anganwadi Centre is responsible for preschool education for children 3–6 years of age, monitoring their physical growth and distributing pulses and grains to them as supplementary feeding. On a fixed day every month, the centre is visited by the Auxiliary Nurse Midwife (ANM), who provides immunizations, counselling, health education and antenatal checks. Other community-based health providers include ASHAs, who make home visits to pregnant and lactating mothers. The MNH project aimed to collaborate with all these community-based health providers, giving them additional training on MNH technical issues so they could counsel and refer women, when necessary.

Through ISOFI, we augmented MNH project support to community-based health providers with training workshops, mentoring and on-the-job coaching. In the first round of training, participants included 60 AWWs, 58 ASHAs, 12 ANMs (all women) and 92 VHSC members from villages in the four intervention sub-districts. We began their training in the same way we began with our own staff: an orientation workshop focused on comparing personal values and beliefs with local social norms related to gender and sexuality, and examining how these social expectations might impact health.





## Ama's Story

We trained community-based health providers in gender-sensitive counselling skills. With ongoing mentoring, many were able to incorporate these skills into their day-to-day work. Sometimes, even the basic mobility of health workers was an issue to overcome. One example was Ama, a 32-year-old government health extension worker living with her husband in an extended household of five brothers and their parents. She was the youngest of the five daughters-in-law in the house. Being the youngest, she was not comfortable leaving her house and walking out in the village alone. Though she had been trained by the government health department about a year earlier, she had not yet made a single home visit.

CARE staff met with her in her home several times and invited her to accompany them on home visits as well as to a group training of new mothers, which she did. When the ISOFI team organized a training session on gender and sexuality, she completed the entire training. She continued to accompany CARE staff on home visits and during group training and other support activities for new mothers. One day, she agreed to facilitate a group meeting for new mothers, and she did pretty well. After eight months of coaching, she was comfortable raising issues of gender and sexuality in her discussions and home visits. Within that time, she accompanied eight women to the hospital or clinic for delivery. When asked about any significant changes in the last year, she reported, "I am no longer afraid of family or society!"

We also offered a second training workshop to the same providers that focused on specific pregnancy-related issues such as mobility, access to food, rest, male involvement, son preference and consensual sex. In this training, we focused on how to use the ISOFI-developed tools and exercises to help them feel comfortable addressing these issues as health professionals, counselling where possible and referring where necessary. The health providers were trained to facilitate the "bead game" and to use flash cards (described on page 14).

We noticed that during the first training, participants reacted very personally to discussions about gender-related social expectations. They debated and discussed the issues from the perspective of their own lives, not of the lives of their clients. During the second training, they began to address the issues as health providers, with their clients in mind.

## Couples' Meets

One ISOFI innovation was the creation of village-level "couples' meets." ISOFI invited young married couples to meet together in a public setting, such as a schoolyard or clinic yard. By inviting both husband and wife, we were able to overcome traditional limitations on women's mobility; while accompanied by her husband, a woman could leave the house in a publicly sanctioned way. Because the meets themselves were outside of what was considered normal village activity, they generated much interest. The meets lasted less than two hours and consisted of games, exercises and discussions designed to keep everyone interested and entertained. The activities focused on issues of women's rights, mobility, family planning, couple communication and decision making, and fathers' participation in maternal and newborn care. It is important to note that when men discussed gender issues at the meets, everyone, including their wives, were able to hear their opinions. The meets were initially organized and facilitated by CARE staff; by the end of the intervention period, the ASHAs had received enough coaching, mentoring and training to facilitate the sessions themselves.

## New Parents' Meets

The idea for a new parents' meet emerged from one of the reflective practice sessions with staff, in which the discussion focused on how to support an enabling environment for

pregnant and lactating women in the home. Project staff felt good about the success they had achieved in teaching pregnant women and their mothers-in-law about health issues. However, they felt that they had not yet found a good way to reach husbands and fathers with information, support and coaching to help them play a supportive role in pregnancy and newborn care. While some men had participated in the couples' meets describe above, the teams wanted to find a way to encourage the active participation of fathers as care-takers of children, in a way that would reinforce positive parenting behaviours and also be fun.

The final design of the new parents' meet was different from the village-level couples' meet. This event was larger, longer and involved more stakeholders in planning and implementation. The new parents' meet was designed as a 6–7 hour mela, or fair, that would take place on a particular day. The event was promoted among 7–10 villages and jointly supported by staff of three health and development projects being conducted by CARE. Booths were operated by staff members who provided information on topics including child health and nutrition, breastfeeding and family planning. AWWs were present to weigh babies as part of a normal weight check. There were also competitive exercises (e.g., fathers competed for a prize for correctly bathing a baby), quizzes and films.

Four new parents' meets were held (one in each sub-district) towards the end of the project intervention cycle. All the communities participating in the ISOFI interventions in these sub-districts were invited, and almost 1,000 people attended the new parents' meets.



## Men's groups

Another spontaneous project innovation was the formation of men's groups. The idea for a men's group began one day in a particular village, when it was clear that the VHSC members would not be able to meet. CARE staff members decided to gather available village men to participate in some exercises to promote MNH discussion, but first they asked the men to share their thoughts on several issues related to gender, including: decision making about sex and family planning, division of household labor, and expectations that society has for men. The men reported that they felt they were under tremendous pressure by society to act in "manly" ways, which included making all household decisions and earning an income. They revealed that they were not expected to be an integral part of discussions about women's health because those issues were supposed to be addressed exclusively by women. They felt that if they showed interest in women's health, even by just helping out with a woman's daily work, they would be ridiculed by their peers. But many were interested in changing these expectations. These issues became topics that the men's groups addressed in subsequent meetings.

Men's groups eventually formed as alternatives to VHSCs in other villages. CARE staff worked with group members to plan community efforts promoting men's participation in MNH care, the sharing of household labor, and the prevention of violence against women.

## Community media events

To ensure a supportive community environment for addressing issues of gender and sexuality, we implemented four types of community media events: low-cost participatory theater, puppet shows, magic shows and film screenings. Each event focused on generating community dialogue around particular gender or sexuality issues that women had identified as problematic, including their ability to make health care decisions, mobility, choices with regard to marriage, and discrimination against girls, mothers of girls and women in general. Over the course of the project, attendance in these events totaled over 50,000 participants. There were 67 magic shows, 22 puppet shows, 21 theatrical skits, and seven film discussions. (See the table shown for attendance details.) It is important to note that multiple events took place in each sub-district, therefore it is possible that people attended more than one event.

### Number of Participants in ISOFI Community Media Events

Activity	Men	Women	Adolescent and children	Total
<b>Magic show</b>	10,550	6,385	12,871	29,806
<b>Film show</b>	4,623	3,093	3,938	11,654
<b>Puppet show</b>	1,580	1,529	2,337	5,446
<b>Skit</b>	1,065	1,025	1,315	3,405

## VI. Reflections on Challenges and Lessons

### Fostering organizational and staff ownership

We designed the second phase of ISOFI as an integration or layering of gender factors into a pre-existing MNH anchor project. The "layering" components came from a separate funding stream and implementation agenda, which brought with it some challenges and some successes. The challenges included creating a unified team and staffing structure, as well as ownership and buy-in from all stakeholders.

**Staffing structure:** Creating an integrated staffing structure for both initiatives proved a challenge at the start. ISOFI was originally designed to be implemented solely with existing MNH project staff. However, some senior staff had expressed concern that a focus on gender may distract the MNH project team from achieving its targeted deliverables. With a short intervention period and very ambitious goals, each person working on the MNH project had a very tight schedule. In the end, as cited in the descriptions above, we hired four additional staff with a supervisor to augment the efforts of the MNH project staff in the field. Their scope of work was to collaborate with partner NGOs, the frontline health workers, to integrate gender and sexuality interventions into ongoing MNH activities. The additional staff members attended all MNH project workshops, so that the partner NGOs would be as fully integrated into the project as possible. Eventually, these additional staff members functioned as an extension of the MNH project. The additional ISOFI field staff helped MNH project staff meet their targets. In some cases, workloads were divided between MNH and ISOFI project staff. Due to a high rate of turnover among NGO partner staff, the four additional field staff were often asked to fill in gaps or train new hires. They were able to introduce the new team members to a fully integrated platform of interventions, rather than two sets of interventions competing for time and attention. This resulted in better synergy and coordination at the field level, and eventually in seamless integration of gender issues into MNH programming.

**Involving senior management:** Buy-in from senior management was the first step toward building synergy at the field level. When senior staff from CARE India headquarters and the state level showed support for collaboration on the ground, the teams started to come together. We organized meetings to show how ISOFI is a unique experiment and how investment in ISOFI can help achieve project and organizational objectives.



**Regular capacity building and synergy meetings:** We invited CARE India staff from several health projects being implemented in the state to participate in gender and sexuality workshops as well as attend synergy meetings with all project team members, including NGO partners. A key message in these meetings was that ISOFI and the MNH project are complementary interventions that will benefit everyone.

### Using an ecological model to plan interventions at multiple levels

There are myriad ways that cultural norms around gender and sexuality can impede better health. So it might seem daunting to design interventions that aim to help communities overcome these barriers. We found it helpful to think about our interventions using an ecological model, which places individuals within a hierarchy of social levels. We designed the overall ISOFI package of interventions to include interventions at several of these levels: household, community, district and health services. By placing emphasis on the enabling environment, we were hoping to create a model of sustainable social change, rather than simply individual behaviour change.

Through our extensive phase of analysis (described on page 10), we generated a set of gender and sexuality issues that both women and men reported as problematic and then developed ways to address them at these different levels. The following two examples illustrate how the MNH project addressed some of the gender discrimination issues at multiple levels of society:

**Mobility:** To address women's general lack of mobility i.e., their inability to move about the community in order to access MNH information and social support the project used interventions at multiple levels to change community expectations and norms. Many young women in this district were profoundly isolated. First, we reached out to them with home visits, and built personal relationships with them and their families to overcome the isolation and provide support. These women were more likely then to attend Mothers' Committee or other group support meetings. Then we raised the topic of women's mobility through public media events such as puppet shows, magic shows, theatre and film discussions, trying to promote the idea that women's ability to travel unaccompanied was a normal thing. To draw women out of their homes in a publicly sanctioned way, we used creative public events that invited men to bring their wives along to learn about health (e.g., couples' and new parents' meets). Although it was not the norm in this region for women and men to appear in public together, the couples' meets helped to create the public perception that it is acceptable for women and men to leave their homes together to seek important health information and support. The fact that many men were cheerfully bringing along their wives helped to encourage some of their more sceptical peers to do the same.

**Men's engagement:** Project staff found creative ways to promote change in community and health providers' perceptions about men's roles in MNH as well as change in men's actual behaviour. At the household level and in peer groups (e.g., mothers' committees and VHSCs), staff used flash cards to promote new ways of thinking about men's roles with regard to domestic chores and MNH. The public perception of men's roles and understanding of MNH issues was reiterated in public media messages and through the couples' and new parents' meets. As described earlier, when VHSCs were not coming together in some villages, the staff invited men in the village to start a men's group as a substitute. These men's groups actively supported the promotion of MNH information to men and women as well as addressing issues of gender discrimination, such as restricted mobility and violence. Furthermore, the attitudes of health care providers toward men's involvement with MNH also changed. With training, followed by coaching and mentoring, the community health extension workers began to welcome men into their counselling sessions and to encourage them to understand and support MNH care.

These examples illustrate how the project helped the entire community become more aware of gender issues. The ecological approach to social change promoted an enabling environment for those women and men who wanted to make changes in their own lives. Public discussions about gender and sexuality allowed debate and reflection about previously unquestioned social norms. Community members came to realize that there were many more opinions about these topics than they had thought.

### Using a model of self-reflection, innovating along the way

All the gender and sexuality interventions were layered into an existing project timeline and strategy. We wanted these interventions to be based on local needs and to be designed on-site. To do this, we focused on building the capacity of project staff and community-based health providers to think critically about social norms and factors how they influence their own thinking as well as the lives and health of the community in general. We used this approach with staff, community members, community leaders and health providers. We deemphasized simply conveying messages and instead promoted the notion of people asking questions and having discussions about real-life situations. This approach was successfully used at each level, and promoted a sense of fun, engagement and relevance for participants. Many project staff reported feeling that they themselves had changed for the better, and were more personally committed to a new lifestyle of gender equity, both personally and professionally.

Staff reported gaining confidence to speak easily and sensitively, in public and private, about issues they had not been comfortable with earlier, such as sex during pregnancy, domestic violence, spousal communication and power dynamics, and men's participation in pregnancy and newborn care. Some ISOFI staff members noted that their spouses had also become interested in learning about gender and sexuality issues, thus the project generated more discussions at home.

### Extra work versus "state of mind"

Many staff members initially balked at the extra time that the training and reflective practice sessions required. After two years, however, they no longer saw it as additional work, but rather as an integral part of their work. As the MNH staff and local partner NGO field workers began to fully understand and implement the ISOFI-modified tools and approaches, they began to realize that interactive discussions about gender and sexuality created more interest and participation in the community.



#### Staff comments:

"ISOFI is a dialogue approach, with questions rather than mechanical message transmission, and it is more effective."

"We continuously discuss and challenge ourselves, which helps create a platform for challenging others. We draw on examples that come up in the community."

"ISOFI gives women space to express their views, to increase awareness, to become part of decision making, and to increase their control. And we change our role, from being one of experts to being facilitators of change."

Within the first year of initiating ISOFI in the four sub-districts, the project staff and implementing partners said that they noticed a difference in both the level and style of participation in the sub-districts where ISOFI was being implemented: participation in general seemed to be higher, and women seemed to be more vocal in the meetings. They noticed that they asked more questions, shared more of their own opinions and seemed to be more interested in the information that was presented. As a result, local implementing partners came to believe that using the modified exercises and tools might be a better way to achieve their project targets and had a good change for achieving sustainable change. One said:

*“ISOFI messages will be permanent because they represent real change for the whole life – not just during pregnancy.”*

Furthermore, because the project had focused on building the capacity of the Government of India’s community health workers and systems, gender and sexuality factors were beginning to be incorporated into this system. Many community health workers were addressing issues of gender and sexuality as part of their normal work responsibilities. The district administrator for Barabanki District as well as senior Ministry of Health staff at the district and sub-district levels expressed significant support for ISOFI and the need to replicate the lessons more broadly.

*“ISOFI recognized the gender issues and addresses the root causes – what people do and why they do it.”*

**District Magistrate, Barabanki**

*“The integration of gender in all our trainings, in what we do, is the gift from ISOFI.”*

**District Program Officer, ICDS**

**“ISOFI is embedded in [the project]. It is a mental state, not additional work. ISOFI is work from the heart. ”**



### Changes I See in Myself: Bharti

- *I looked down upon sexual relations outside or before marriage. As a result even while working with adolescents on reproductive and sexual health, I used to strongly oppose it on the grounds of morality. I used to blame the girls who got pregnant. Now I am not judgmental.*
- *Earlier I used to blame men for all the ills that women faced. However, now I understand how socialization impacts men too.*

### Changes I See in Myself: Rashmi

- *At the time of marriage, my in-laws wanted a house wife for their son. However, when my husband's business declined, I decided to work. At that time I faced a lot of verbal harassment from my family. My in-laws were not too keen that I step out of the house. At the most, they wanted me to do teacher's training and become a school teacher. They felt that if I become financially independent I will begin to control my husband. But with support of friends, I applied for the CARE project. Even after so many years of working I don't have control over my finances. My husband keeps the ATM card with him and I still have to ask him for my every day expenses. However, I am now able to express my needs to him. Earlier I would not express my desire or needs at all. But now I feel that it is my money and I know that there is money so I tell him what I need and he too respects my desires. Like when I initially joined ISOFI I used to travel by bus but it was very difficult to negotiate the traffic. Then I put pressure on my family that I need a scooter to travel and finally they gave in and bought me a scooter.*
- *I have become mobile. In the initial years of marriage, I never went out alone. My mother-in-law and later my daughter accompanied me everywhere. But, when my daughter refused to come with me I had to start going out alone. However, I would only go to nearby places. Then when I joined ISOFI, I had to go to remote villages alone. I never thought I would be able to do it. Now I travel 25-28 Kms every day on my scooter. I have become more confident now. Now when there is a wedding in the family and if my husband is not coming with me I go on my own on my scooter.*
- *In the beginning when I started working on this project, my husband helped me with the household chores. I used to feel very guilty about it. I felt that I was not being a good wife and mother. My in-laws also used to make remarks about it. Now I don't feel guilty, I feel that we are sharing family responsibilities. Now he even helps me in the kitchen.*

### Changes I See in Myself: Padma

- *I used to have very low opinion of sex workers. But after I went to the first ISOFI training and attended various other gender trainings, my thinking has changed about them. I had a very moralistic attitude about them. But now I look at it as a livelihood issue.*
- *When I was in an earlier program on health and nutrition, I had to interact with 2 healthcare workers in a particular sub-district who had a lesbian relationship. When I came to know about it I distanced myself from them but after ISOFI training my thinking changed about these issues. When I had to interact with them again, I became good friends with them and have worked well with them.*
- *Similarly, I was very hostile towards those who married by choice. I could never justify their action and could never interact with them normally. Now I am not judgmental about these things.*
- *Talking about sexuality or sexual issues with men was a big issue for me. I used to feel that people in the field will not accept these. I felt that they will think I am a loose woman. However, I realized that if you initiate these discussions then the community is very open about it. Now I don't feel any embarrassment. Now I can raise these issues in any programme and in any setting.*

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<sup>1</sup> Darmstadt et al., 2005; Campbell et al., 2006

<sup>2</sup> Ekman et al., 2008

<sup>3</sup> Walking the Talk, ICRW and CARE, 2006.

<sup>4</sup> Estimated district population was 2,602,270 in Raibareilly and 2,426,597 in Barabanki (2001 census).

<sup>5</sup> An Anganwadi worker (AWW) is a community volunteer who runs a village preschool, providing education and food for enrolled children. She also counsels the community members on reproductive and child health issues.

<sup>6</sup> An ASHA is a community-level volunteer who counsels couples on healthful behaviours, assists auxiliary nurse midwives (ANMs) during village immunization sessions, and motivates and accompanies women for institutional delivery.

<sup>7</sup> ANMs are posted to areas with a population of more than 5,000. An ANM visits every Anganwadi center in that area once a month, where she conducts immunization sessions and other health-related services for pregnant women.

<sup>8</sup> Examples can be found in the ISOFI toolkit ([www.care.org/reprohealth](http://www.care.org/reprohealth)) and in the manual “Ideas and Action: Addressing the Social Factors that Influence Sexual and Reproductive Health.”

<sup>9</sup> More detailed explanation of reflective practice can be found in the ISOFI toolkit ([www.care.org/reprohealth](http://www.care.org/reprohealth)).





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