

Meeting Challenges, Seeding Change

Integrating Gender and Sexuality into Maternal and Newborn Health Programming through the Inner Spaces, Outer Faces Initiative (ISOFI)

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BACKGROUND

Many believe that gender plays a large role in influencing health outcomes. Women's autonomy, mobility and control over resources have long been shown to be important predictors of maternal health outcomes.¹⁻¹¹ Studies have also shown that men's gender attitudes and behaviours can significantly influence reproductive health outcomes.^{6, 12-15} In addition, community perceptions and norms related to gender can play a role in reproductive health outcomes, as some recent studies have shown.^{4, 16} As a result, researchers and policy advocates have increasingly called for greater attention to gender discrimination issues as underlying social determinants of health. Many are now calling for gender "transformative" approaches to health interventions, which aim to transform gender attitudes, behaviours, norms and systems along with health interventions.¹⁷

While the need for transformative approaches to both changing gender norms and strengthening health systems might seem apparent, there are relatively few implementation models to guide such transformations. The Inner Spaces, Outer Faces Initiative (ISOFI) provides one such model. ISOFI was initiated by CARE and the International Center for Research on Women (ICRW) in India and Vietnam in 2004, and led to development of the "ISOFI Innovation System." The iterative steps of this system focus on building staff and organisational capacity to critically analyse the social construction of gender and explore how gender influences personal values and beliefs and programmatic designs and choices. In turn, through the analysis-reflection-action cycle of the ISOFI Innovation System, staff can help community health providers and other stakeholders to analyse gender issues, reflect on local barriers and opportunities, and make implementation plans to catalyze change.

PROJECT DESCRIPTION

Using the ISOFI Innovation System as a model, CARE and ICRW initiated an action research project in the Indian state of Uttar Pradesh in 2007 to test its effectiveness within the context of maternal and newborn health (MNH) programming. Uttar Pradesh accounts for a large percentage of newborn and maternal mortality in India. The state also ranks below the national average on many gender indicators, such as mobility, autonomy of decisions and control over household resources.^{5, 18-20}

The research was designed to explore how programme interventions that focused on gender equity and sexuality (such as decision making autonomy, gendered division of household labour, spousal communication about sex and contraception, and attitudes about domestic violence) might influence maternal and newborn health practices and outcomes. CARE and ICRW believed that gender-equitable practices such as these represent an intermediate step on a path toward improved MNH practices and outcomes. Thus, an MNH intervention that addressed these gender norms and practices, in addition to the traditional health interventions intending to increase specific health behaviours and use of key services, would be synergistic and mutually reinforcing, and might ultimately result in improved maternal and neonatal health.

CARE and ICRW integrated the ISOFI Innovation System into an MNH project that focused on improving health behaviours at the individual, household and community level, and enhancing the capacity of health systems to provide sustained MNH improvements. This project was implemented by CARE in two districts as part of a larger initiative to reduce maternal and newborn mortality and morbidity in Uttar Pradesh.¹ This initiative aimed to address specific health behaviours of women of reproductive age, including preparation for childbirth, having skilled attendants at birth, immediate breastfeeding, and thermal and cord care, as well as to develop supportive government systems at the community and district level.

ISOFI was designed to address gender and sexuality factors not as a standalone model but rather as a collection of integrated and embedded components within the MNH project. The goal was an intervention package that addressed

both health and gender factors at household, community and facility levels, allowing for multiple points of entry and reinforcement along the MNH continuum of care.

All MNH behaviour-change interventions in the project were used as opportunities for exploring values and challenging assumptions related to gender and sexuality norms. For example, iterative and open-ended exercises for discussion on gender and sexuality values and beliefs were integrated with meetings of Village Health and Sanitation Committees (VHSCs) and Mothers' Committees as well as with district and sub-district health meetings.

The project also worked closely with the government of India's district health staff to build the capacity of community-based health providers – accredited social health activists (ASHAs), auxiliary nurse midwives (ANMs) and Anganwadi workers (AWWs).¹¹ For example, staff from CARE and local NGO partners initiated interventions that incorporated men – husbands and fathers – into the MNH programming. Staff worked with community-based health providers to counsel men about their involvement in and support for MNH, including child care and contributions to household labour. As the community-based health providers grew more confident, they began to see the issue as a key component of their own job responsibilities.

The project also aimed to help reduce women's isolation and lack of mobility in pregnancy and postpartum by creating "New Parents' Meets" and "Couples' Meets." These events brought couples together in public settings, providing safe and interactive spaces for them to learn about health practices as well as to discuss individual attitudes and community perceptions about gender norms that play a role in MNH outcomes. These events were supplemented by community media events (e.g., puppet shows, magic shows, theatre productions and movies) that focused on gender-related discrimination in India.

Rather than delivering a standard set of messages about gender equity, ISOFI interventions facilitated dialogues that explored people's perceptions regarding normal expectations for men and women (e.g., gender roles) in that community, and encouraged them to think critically about community perceptions compared with personal beliefs and values. Typically, as participants in the small group activities or public media events shared an opinion or questioned community values, it became clear that there was not one universally accepted norm in the community. Inevitably, a wide variety of opinions was offered, allowing everyone to see that gender norms universally perceived as normal were, in fact, not accepted or practiced by everyone. Through interactive public events like the New Parents' Meets, new gender behaviours were being modelled – men were bathing babies, for example, and women were not only seen in public with their husbands, they were speaking their opinions.

These results could not have been achieved without building the capacity of those who work in health care to think critically about gender norms and how it affects their own work responsibilities. Using the ISOFI Innovation System, the project conducted gender and sexuality training for NGO staff and implementation partners as well as for the community-based health providers in the intervention district. The training was followed by coaching and mentoring, follow-up training and support for reflection and learning on the job. In this way, the ISOFI Innovation System worked to improve everyone's capacity for critical thinking about gender and sexuality as social constructs, helping them speak more openly and act more confidently when addressing these very sensitive issues.

EVALUATION METHODOLOGY

ICRW and CARE used a quasi-experimental operations research design, comparing a community-based MNH intervention in four sub-districts of one district (Raebareilly) to the same MNH intervention in four sub-districts of the second (Barabanki), where gender and sexuality programme components were layered with the existing MNH project. Both districts received the same MNH intervention package in the same time period. The districts were adjacent but had separate offices, staff and intervention partners.



The qualitative data were collected through in-depth interviews with men and women of reproductive age at baseline (2007), midterm (2008) and endline (2009). Data were also collected through in-depth key informant interviews with health care providers, NGO staff implementation partners, and both Mothers' Committee and VHSC members in the intervention district at endline (2009).

For the quantitative analysis, ICRW and CARE implemented a survey among women of reproductive age at both baseline (2007) and endline (2009). This research focused on measuring changes in health behaviours and outcomes as well as key gender and sexuality attitudes and practices. Health- and gender-related indicators examined in the analysis included:

- Skilled attendant at birth,
- Preparation for childbirth,
- Health-treatment-seeking behaviours,
- Immediate and exclusive breastfeeding,
- Family planning use,
- Neonatal death,
- Mobility,
- Autonomy of decisions,
- Gendered division of household labour,
- Spousal communication about sex and family planning,
- Tolerance of domestic violence.

The quantitative analysis used a multi-stage sampling technique.ⁱⁱⁱ Both the baseline and endline surveys were limited to married women of reproductive age (15–45) with a pregnancy outcome in the previous six months. Table 1 (on page 4) shows the final number of women surveyed.

Table 1: Sample size of ISOFI baseline and endline surveys

District	Baseline (2007)	Endline (2009)	Total
Barabanki (Intervention)	336	329	665
Raebareilly (Control)	327	339	666
Total	663	668	1331

Description of the Sample Population

Based on descriptive data from the quantitative survey, the population demographics in the intervention and control site were similar at baseline and endline (Table 2). At baseline, the age of respondents ranged from 16–45. The average age at baseline was 26.29, and the average age at endline was 26.63. The average number of living children ranged from 2.64 to 2.89. In general, respondents had low education levels, but more women in the control community reported having 10 or more years of education (baseline and endline).

While the communities were similar in terms of demographic factors at baseline, they were not similar in terms of health indicators; the control community had much better health indicators, perhaps because of resources available in that district. While this did not have much impact on the ISOFI intervention package, it did limit the comparability of the two communities.

Table 2: Distribution of respondents according to selected characteristics

CHARACTERISTIC	BASELINE		ENDLINE	
	Intervention n=336	Control n=324	Intervention n=329	Control n=339
Respondent's age mean (range)	26.34 (16-45)	26.84 (18-45)	26.12 (16-45)	26.45 (18-44)
Respondents' education				
No school	69.16%	58.64%	67.17%	59.29%
1-9 years	26.55%	28.40%	24.92%	27.43%
10 or more years	4.49%	12.96%*	7.90%	13.27%*
Spouse's age mean (range)	29.86 (20-50)	30.03 (20-50)	30.22 (19-50)	30.02 (20-51)
Spouse's education				
No school	40.00%	28.88%	30.40%	30.68%
1-9 years	42.69%	41.30%	42.55%	50.74%
10 or more years	17.31%	29.81%*	27.05%*	18.58%
Husband six or more years older than wife	8.21%	6.03%	12.88%	10.75%
Marriage before age 18	58.93 %*	38.51%	54.10%	51.03%
Number of living children mean (range)	2.80 (0-8)	2.64 (0-8)	2.74 (0- 9)	2.89 (0-9)
Caste				
Scheduled caste/tribe	43.12%	39.50%	56.84%*	47.20%
Other backward caste	37.39%	42.63%	34.65%	40.71%
Other caste	19.45%	17.87%	8.51%	12.09%
Religion†				
Hindu	76.72%	87.35%	86.32%	89.68%
Muslim	22.99%*	12.65%	13.68%	10.32%
Household economic index mean (range)	8.42 (0-25)	8.77 (1-28)	9.19 (0-27)*	7.69 (0-27)

† One respondent reported Christianity at baseline.

*pvalue<.05. Significance testing assessed differences between communities at baseline and endline.

FINDINGS

Health Indicators and Gender and Sexuality Variables

Health indicators improved over time in both the control and intervention communities. As Table 3 illustrates, skilled attendance at birth, preparation for childbirth, immediate breastfeeding and family-planning use improved in both districts. Neonatal death declined. In some cases, the rate of change in the intervention community was greater than in the control community, but not in all cases. There were also improvements in the sexuality and gender indicators among women of reproductive age, including improved mobility, autonomy of decisions, gendered division of household labour, and spousal communication about sex and family planning. In many instances, the rate of improvement was greater in the intervention community than in the control community. Among factors related to gender, the greatest rates of change were related to women's reports of mobility, their attitudes about justification for refusing sex with their husband, and their ability to express their sexual needs to their husband.

Table 3: Percentage of respondents reporting selected gender and health attitudes and behaviours by site

OUTCOME VARIABLE	INTERVENTION		CONTROL	
	Baseline n=336	Endline n=329	Baseline n=327	Endline n=339
Maternal and Newborn Health Indicators				
Trained delivery care	37.05% (123)	84.80% (279)*	52.94% (171)	74.34% (252)*
Preparation for childbirth	56.76% (189)	91.38% (297)*	83.80% (272)	92.98% (311)*
Current use of family planning	7.14% (24)	34.65% (114)*	6.79% (22)	27.43% (93)*
Antenatal care use	42.99% (144)	87.23% (287)*	82.72% (268)	97.64% (331)*
Breastfed within 1 hour	27.41% (88)	39.29% (121)*	64.42% (203)	75.00% (246)*
Neonatal deaths	7.17% (22)	5.45% (17)	5.74% (17)	3.34% (11)
Gender and Sexuality Variables				
Can go out alone (mobility)	18.15% (61)	37.69% (124)*	26.71% (89)	12.09% (41)*
Involved in decisions about household earnings	24.40% (88)	39.51% (141)*	38.27% (126)	49.26% (178)*
Woman can be justified in refusing sex	36.61% (123)	94.53% (311)*	54.01% (178)	71.09% (241)*
Help with household chores during pregnancy	55.52% (186)	79.03% (260)*	78.40% (257)	75.81% (257)
Spousal communication about family size	64.88% (218)	70.52% (232)	65.53% (212)	55.16% (187)*
Express physical or sexual needs to spouse	25.37% (85)	67.48% (222)*	36.45% (120)	35.40% (120)

* Difference between baseline and endline within the same community is significantly different at 5% level.

While the quantitative survey did not measure changes in men's attitudes or behaviours, the qualitative data at endline showed that some new fathers reported in interviews that they were involved in maternal and newborn care. Of the men interviewed at endline, several mentioned that they had accompanied their respective wives to the health facility at least once as part of her antenatal or postnatal care. Some men saw themselves as responsible for helping to care for their wives. Other men reported wanting to be involved but lacking the time to do so, citing heavy workloads and multiple responsibilities – especially when living in a nuclear household setting, without additional family members to help.

Most men interviewed at endline mentioned various ways they had tried to help their wives in their most recent pregnancy and delivery. Most of this care was directed at ensuring that their wives had nutritious food to eat, like green vegetables and fruits. Some mentioned that they had helped with household chores, such as lifting heavy objects, fetching water from the tap or doing



other heavy physical work. However, these men also mentioned fear of ridicule by family members; they reported that the remarks of family members were sometimes a deterrent to helping their wives. **According to one new father in the intervention district:**

“When my wife asked me to get her something, I would bring it separately for her. I would fill the water, wash my own vest and underwear, and she washed my pants and shirts. Even if I asked her not to wash them, she would not listen. Of course, I used to feel shy, as other members in the family would say that not only does he wash his own clothes, he washes his wife’s clothes, too!”

Another respondent said:

“I wanted to take my newborn daughter out for a walk in the village, but people would say that ‘Look, there goes the woman with her child!’ or ‘He is slave to his wife!’”

At endline, the qualitative data showed greater communication between some couples, and greater shared participation in health-related activities. **As one woman said:**

“We learn to go out together, to go to the health centre together, and to show love between each other.”

Communication about sex also increased between husbands and wives. Many men and women reported that they had abstained from sex once they learned about the pregnancy, and most women reported that they had less interest in sex during pregnancy. At the time of the endline survey, however, some said they had increased awareness about what can be normal about sexuality during pregnancy, and about enjoyment of sex and consent for sex. Some women said they were able to express their sexual desires to their husbands and willingly engaged in sex with their husbands during pregnancy. **As one woman said:**

“Both men and women can enjoy sex, when there is good communication.”

Capacity of Health Care Providers

The ISOFI intervention provided training, mentoring and support to the government of India's community-based health providers (ASHAs, AWWs and ANMs) so they could begin to think critically about gender and sexuality factors, and address discrimination as part of their work. In-depth interviews and focus group discussions with community-based health providers at endline revealed some new insights and ways of thinking and working. **One ANM reported the following:**

"I am touched by my own unequal treatment of the girl child. We prefer the boy child [over the girl child], even though men drink and treat us badly while girls take care of us. We need to appreciate our daughters."

At endline, community-based health workers spoke about the change in their own attitudes about men's involvement in MNH. They reported how they now actively seek out and encourage men to become more knowledgeable and involved. Some reported feeling more open and confident to discuss issues like sex during pregnancy. They felt that not only was it their responsibility to speak with husbands about the importance of respecting their wives' right to ask for or refuse sex, they themselves felt more comfortable doing so routinely.

In general, the community-based health workers reported at endline that they had greater confidence in talking with men, in speaking out in general and in their own ability to move about the community (i.e., their mobility). They felt more confident in their own skills and abilities, and felt they received more respect from community members. **One ASHA reported that the role modelling and mentoring she received from CARE staff gave her the skills and confidence to find a new way to work:**

"I am now visiting other ASHAs in my neighbouring villages to discuss the themes I learned through ISOFI. I am now speaking with husbands, comfortably talking with women at home or in groups, and role modelling women's rights."

Associations between ISOFI Intervention District and Gender and Health Variables

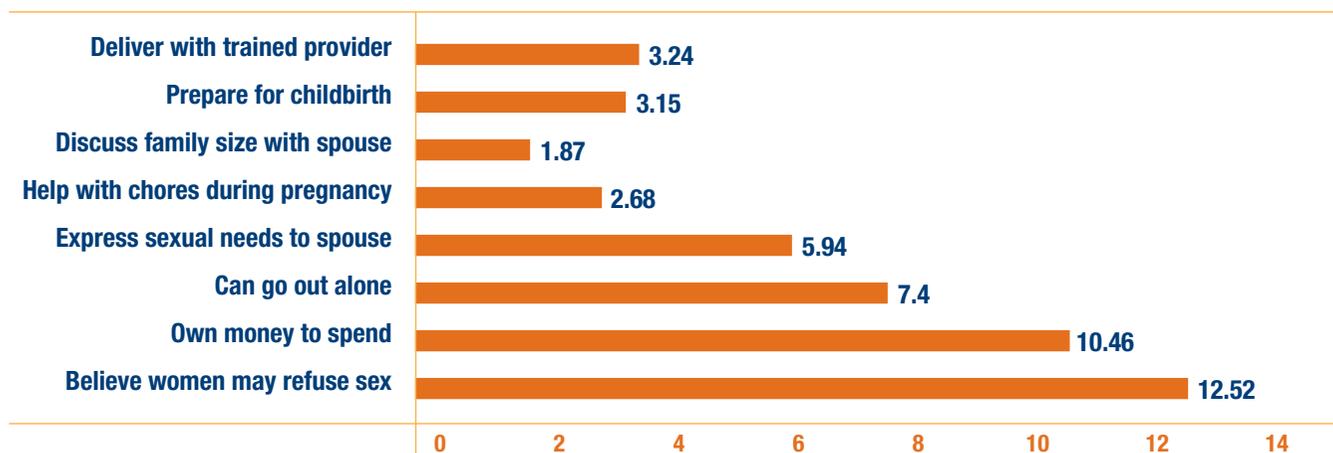
CARE and ICRW used the survey data to quantify the influence of ISOFI interventions on key outcomes in the intervention district compared to those in the control district. Specifically, a difference-in-differences analysis was used. This method allowed CARE and ICRW to measure the strength of the associations between exposure to ISOFI interventions and health and gender outcomes.²¹ This analysis controlled for the differences in the two communities at baseline and endline, and changes in both communities over time. Therefore, the difference-in-differences method isolated the influence of exposure to ISOFI interventions on selected outcomes.

The ISOFI intervention was strongly associated with positive changes in gender and sexuality behaviours and attitudes (see Figure 1). At endline, women living in the intervention district were 7.4 times more likely to report that they are able to go out unaccompanied. In addition, women in the intervention community were 2.68 times more likely to report receiving help with household chores during pregnancy and 1.87 times more likely to discuss the number and timing of children with their spouses. As shown in Figure 1, women who lived in the intervention district at endline were more likely to report that they felt women could refuse sex for at least one reason, that they have their own money and can decide how to spend it, and that they can express their physical and sexual needs to their husband.

Though the ISOFI intervention was not as strongly associated with improvements in some of the anticipated health behaviours, it was strongly associated with two of the project's primary health behaviour goals: preparation for childbirth and skilled attendance at delivery. Women in the intervention community at endline were 3.15 times more likely to prepare for childbirth and 3.24 times more likely to deliver their last child in a medical facility or with a trained provider.

Figure 1

Associations Between Living in the Intervention District at Endline and Selected Factors (Adjusted Odds Ratios)*



*All odds ratios are significant at the 5% level.

Summary of Findings

As anticipated, the findings indicate that both the intervention and control communities made considerable gains in maternal health indicators, including skilled attendance at birth, preparation for childbirth, health-treatment-seeking behaviours, immediate breastfeeding, family-planning use and reduction in neonatal deaths. This confirms the value of a well-planned health intervention that addresses barriers to good health.

It was anticipated that gender and sexuality norms and practices would improve in the intervention communities, where CARE implemented a package of interventions at multiple levels using the ISOFI Intervention System, and our analysis confirmed this. While some gender and sexuality indicators improved in both communities, certain key gender and sexuality behaviours, such as women’s mobility and attitudes about sex, showed much greater change in the intervention communities.

The results of the difference-in-differences analysis indicated that at endline, respondents in the intervention district reported significantly greater rates of preparation for childbirth and delivery in a medical facility or with a trained provider, above and beyond the influences of the standard MNH project and other interventions occurring in both communities during the same period.

LIMITATIONS

As with any operations research programme, ISOFI had some limitations. First, there are some inherent challenges to layering one project within a separate anchor project, when the two have distinct funding streams and objectives. Second, within any quasi-experimental project design, there is possibility of diffusion of innovation and learning from the intervention site to the control site. While efforts were made to prevent diffusion by selecting sites with different staff and attempting to limit discussion between the two groups of staff, some ideas may have been transferred from one site to another.

The intervention and control districts were also quite different in terms of health indicators at baseline. Though the quantitative analysis controlled for many of these differences, it is still important to view the results with some caution. It should also be noted that during the intervention period, the government of India's Janani Suraksha Yojana (JSY) initiative, which aimed to reduce maternal and newborn mortality by promoting institutional delivery, was taking place in both districts as part of a safe motherhood initiative under the National Rural Health Mission. In addition, the ISOFI interventions were implemented for only two years, a relatively short duration for seeing change in deeply embedded attitudes. Finally, the project results are specific to India and might not apply to populations in other countries.

CONCLUSIONS

Health programmes must move beyond a purely biomedical model of disease prevention, treatment and mitigation, and begin to address gender barriers to health – specifically, maternal and newborn health. Despite adverse structural conditions for women such as early marriage and low levels of schooling, a multi-layered, participatory, dialogic intervention can change certain key gender attitudes and health behaviours that impact maternal and newborn health.

These findings corroborate previously reported research that shows that it is possible to transform gender attitudes and practices in a relatively short period of time. The ISOFI Innovation System accomplished this by introducing participatory and iterative discussions about gender expectations among household members, Village Health and Sanitation Committees and community members in general, allowing people to reflect on their own attitudes, behaviours and reasons for change. Another core element of the ISOFI model was giving space and guidance to health workers themselves to reflect on their own values and explore and challenge their own attitudes; this process can play an important part of transforming health system, services and policies that have inherent gender bias.

Achieving more equitable gender attitudes and behaviours is, of course, a desirable outcome as a step toward the goal of gender equality. In addition, as this report shows, layering simple, community-based gender-transformative interventions into a community health intervention can also provide incremental benefits with respect to desired MNH behaviours. By addressing gender inequalities through change in gender attitudes and behaviours, health programmes may be able to improve the quality of health outcomes and the efficiency by which those outcomes are achieved.

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ⁱ CARE implemented the project in two districts as part of a larger MNH project in nine districts that was led by PATH (Program for Appropriate Technology in Health)

ⁱⁱ An AWW is a community volunteer who runs a village preschool, providing education and food for enrolled children. She also counsels community members on reproductive and child health issues. An ASHA is a community-level volunteer who counsels couples on healthful behaviours, assists ANMs during village immunization sessions and motivates and accompanies women for institutional delivery.

ⁱⁱⁱ Multistage sampling: 1) selection of sub-districts (blocks) [8]; 2) selection of local governance units (gram panchayats) [24]; 3) selection of villages; 4) selection of respondents from list of women who recently delivered.



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