

Walking the Talk: Inner Spaces, Outer Faces A Gender and Sexuality Initiative



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Walking the Talk: Inner Spaces, Outer Faces A Gender and Sexuality Initiative

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Chapter I

ISOFI: An Innovative Gender and Sexuality Project

How can you ask me if ISOFI has made a difference in my life? Would I have ever been allowed to leave my village without this project? I have spent a night away from home this past week for the first time in my life. (Married Woman, India)

I think we can only work with target groups [on gender and sexuality] if we can break the iceberg inside ourselves. (Director, Youth Union, Vietnam)

Some of us have different sexual tastes. Some of us like dillis, and some like samosas. But what if the samosa is infected? Some of us like sex with eunuchs. What is the difference between god and the devil if everything is the same? (Migrant, India)

I have changed in a positive way. I used to be very bossy. I used to look down on women, even my mother, but now I have more appreciation towards [women]. (CARE Male Staff, Vietnam)

Sometimes I used to beat my wife. It was difficult...my ego is the main problem... Now I am practicing what I have learned in [ISOFI] trainings at my home, too. (NGO Worker, India)

I am 40 years old. I have been married for many years. This is what I have learned from ISOFI: I have the right to refuse sex, and I have the right to ask for sex. (CARE Female Staff, Vietnam)

This report details the two-year innovation phase of ISOFI (Inner Spaces, Outer Faces Initiative), a novel project focusing on gender and sexuality as important factors that influence reproductive health outcomes on multiple dimensions. Information on the methods used by the ISOFI project to mainstream gender and sexuality into the sexual and reproductive health work, including HIV/AIDS, of CARE in sites in India and Vietnam are discussed. It also offers analysis of evaluation data that serves to illuminate the successes and challenges of the project.

Partners

ISOFI is a project jointly managed by CARE, one of the world's largest private voluntary organizations (PVOs) dedicated to promoting empowerment, anti-discrimination, opposition to violence, and sustainable impact on the fundamental causes of poverty, and the International Center for Research on Women (ICRW), a private, non-profit organization focused on improving the lives of women in poverty, advancing women's equality and human rights, and contributing to broader economic and social well-being. The Ford Founda-

tion, a global leader in supporting research and advocacy on human rights, sexuality and sexual and reproductive health, provided funding to CARE and ICRW for ISOFI's first phase. ISOFI is a community-centered project seeking to address the underlying causes of poor sexual and reproductive health.

Background and Context

In the past decade, there has been increased commitment by field-based organizations such as CARE to improve reproductive health and ensure reproductive rights in developing countries. However, these organizations continue to struggle with the definition and implementation of programmatic efforts that make a meaningful difference in the lives of individuals, especially women. Existing evidence suggests that in order for programmatic efforts to achieve desired outcomes, it is essential to acknowledge and address gender and sexuality as fundamental components of reproductive health and rights. At a minimum, this requires understanding that both gender and sexuality are socially defined and constructed, that institutional arrangements for sexual behavior (such as marriage

systems) define gender-based power relations, and that social norms and ideologies manifest idealized views of male and female sexuality. It also requires understanding how in a given social setting, existing institutions and norms define knowledge, behavior, partners, motivations and power dynamics within sexual relationships and behavior, and how these factors directly affect reproductive health outcomes.

Gender equality means that women and men enjoy the same status. Gender equality means that women and men have equal conditions for realizing their full human rights and potential to contribute to national, political, economic, social and cultural development, and to benefit from the results. (UNDP, 2003)

Within many communities across the world, conditions of poverty and social injustice are sustained, in part, by silence that envelops issues of gender, sexuality, preferences and power. Without provision of safe venues for processing and systemic support, most field staff are unable to come to terms with their own internal quandaries and questions, and are unable to genuinely "walk the walk" of development.

This is particularly true of HIV/AIDS programs, where staff deal with a range of issues considered taboo in many societies. CARE and ICRW proposed to address the identified challenge systemically, through an organizational change strategy that promotes deep personal learning and structural realignment, aiming to generate significant shifts in how a select group of country offices undertakes reproductive health programming.

Building on Prior Research

As reproductive health is such a central piece of people's lives and sexual identities, the nexus of HIV/AIDS prevention, maternal health and family planning is intrinsically intertwined with gender and sexuality. Or as the 2005 Millennium Project report on HIV/AIDS stated: "Experience has shown that information alone is not enough.... This requires going beyond imparting basic facts to promoting

greater discussion of sexuality, gender and relationships: silence on these matters has proved a powerful impediment...." (Ruxin, Binagwaho, & Wilson, 2005). Scarce literature in the development and public health fields documents the impact of incorporating sexuality into the work of organizations. In addition, little has been written concerning the intersection between gender roles and sexuality. A forthcoming book on gender and sexuality will add to the literature (Costa, in process). It has also been recognized that HIV/AIDS education should be broadened to include discussions of gender roles, sexuality and relationships (Mane, Bruce, Helzner, & Clark, 2001; Weiss & Rao Gupta, 1998).

Gender

Though a 2005 review of gender mainstreaming by development institutions, UN agencies and NGOs found that most international institutions have attempted to include gender mainstreaming in their programming (Moser & Moser, 2005), gender mainstreaming has failed to achieve its full potential to transform organizations, programs and communities. This remains true because seldom are principles and concepts translated into actionable, practical and sustainable interventions (Vlassof & Garcia-Moreno, 2002). A recent evaluation of UNDP's efforts to undertake gender mainstreaming concluded that: "gender mainstreaming has not been visible or explicit; there is no corporate strategic plan for putting the gender mainstreaming policy into effect; steps have been simplistic and mechanistic and UNDP has not acted on previous assessments...." (United Nations, 2005). While numerous "how to" manuals exist on gender mainstreaming (Caro, Schueller, Ramsey, & Voet, 2004; CIDA, 2000, 2005; Schalkwyk, 1998; SIDA, 1997), and measuring results of gender mainstreaming (CIDA, 2005), few reports

Gender equity is the process of being fair to women and men. To ensure fairness, measures must often be available to compensate for historical and social disadvantages that prevent women and men from otherwise operating on a level playing field. Equity leads to equality. (UNDP, 2003)

describe how specific gender mainstreaming efforts or gendered interventions have contributed to specific measurable outcomes. As concluded in a recent evaluation of the British government's Department for International Development (DFID), "most gender evaluations have not been good at linking institutional changes and policy to results in the real world: available evidence from other evaluations suggests the benefits of gender mainstreaming and those benefits of gender equality are at best embryonic and at worst still to become visible..." (Watkins, 2004). Similarly, an evaluation by SIDA on its support for the promotion of gender equality in partner countries found that "gender inequalities in health care are not addressed systematically" (Mikelson, Freeman, & Keller, 2001). In addition, policy commitments to address gender often "evaporate in planning and implementation processes" (Moser & Moser, 2005).

Sexuality

Sexuality has long been recognized as a key element in reproductive health (Moore & Helzner, 1996; United Nations, 1994; Zeidenstein & Moore, 1996).

The literature has documented that ignoring sexuality issues and simply telling people to use condoms for HIV/AIDS prevention is rarely effective (MacPhail & Campbell, 2001). A 2005 evaluation comparing the effectiveness of methodologies to encourage condom use found that presentation of a leaflet to promote condom use "did not result in significant changes" (Krahe, Abraham, & Scheinberger-Olwig, 2005). Communications on issues of sexuality are key to promoting condom use (Bruhin, 2003; Zulu, 2003; Holschnieder and Alexander, 2003). In fact, the literature notes that "social dimensions of ...sexuality, pleasure...have to be addressed for effective condom promotion" (Khan et al., 2004). With AIDS looming as a global catastrophe, much is at stake (Ruxin et al., 2005). A plethora of peer-reviewed journal articles concerning sexuality in developing countries have focused on issues of theory (Dowsett, 2003); legislative impacts (Amado, 2004); current practices (Wright, Plummer, Mshana, Wamoyi, & Shigongo, 2006); the need for more sexuality information for adolescents (Lesch & Kruger, 2005; Ogulayi, 2005; Wright et al., 2006); the effectiveness of providing sexuality education for adolescents and children in schools (Gay & Daniels, Forthcoming; Grunseit, 1997; Grunseit, Kippax, Aggleton, Baldo & Slutkin,

Text Box I: Collaborating Organizations	
TARSHI Talking about Reproductive and Sexual Health Issues New Delhi, India	Maintains a sexuality resource center for the Asia region; operates a telephone hotline that provides information and referral services on issues related to sexuality and reproductive health; conducts training on gender and sexuality; publishes research on sexuality; and conducts public education and advocacy.
CREA Creating Resources for Empowerment in Action New Delhi, India	Conducts training on gender and sexuality; implements leadership programs that address women's rights; and conducts public education and advocacy.
CIHP Consultation of Investment in Health Promotion Hanoi, Vietnam	Conducts training, promotion and research based on participatory and rights-based approaches concerning gender, sexuality and health.
LIFE Quality of Life Promotion Centre Ho Chi Minh City, Vietnam	Conducts research and training with vulnerable women and communities, including HIV-positive people.

1997; Irvin, 2000; Kirby, Laris, & Rolleri, 2005); the need for sexuality education for adults (Amaran, Onakedo, & Adenigyi, 2005); how norms impact sexuality (Baylies, 2000; WHO, 2005); and methodologies to research sexuality (Askew, 2005). Other less recent articles have discussed the need for sexuality training for providers (Becker & Leitmann, 1997). Only a few articles have discussed how sexuality training has been effectively incorporated in an effort to improve reproductive health and reduce HIV risk, with both examples coming from Latin America (Pick, Givaudan, & Brown, 2000; Pick, Givaudan, & Poortinga, 2003; Rogow & Diaz, 1999). Findings from the ISOFI initiative will add knowledge to this previously neglected area.

"Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors." (WHO, 2006)

In addition to HIV/AIDS risk, ISOFI emphasizes sexuality as a construct that influences gender, leading to increased vulnerabilities but also an increased sense of agency (Vance, 1984). Gender power relations are only infrequently taken into account when trying to understand human sexuality (Dixon-Mueller, 1993). Programs tend to overemphasize male predatory behavior and female weakness, reinforcing the gendered system that ISOFI seeks to avoid through an empowerment and rights-based framework. Focusing only on risk, disease and danger in relation to sexuality often leads to the polarization of male and female sexuality, which is used to justify the need for restricting female sexuality (Vance, 1984).

Project Overview

ISOFI was initiated in pilot sites in two countries, India and Vietnam. CARE India, CARE Vietnam, CARE USA and CARE Australia have been integral actors in the ISOFI project. From its inception in 1946, CARE's approach has evolved from a needs-based to a rights-based approach -- a shift that has become increasingly advocated in many spheres. The Millennium Declaration, for example, describes its rights-based approach as the following: "The Millennium Development Goals are not a charity ball. The women and children who make up the statistics that drive the Goals are citizens of their countries and of the world. ...[t]hey have rights – entitlements to conditions, including access to healthcare that will enable them to protect and promote their health...." (Freedman et al., 2005). ISOFI is modeled around this rights-based approach to community empowerment, and its goal is to provide a strong foundation for integrating gender and sexuality into CARE's programmatic approach to achieving reproductive health.

ISOFI has been a collaborative venture from the start, and has been formulated and implemented by a host of local organizations working in conjunction with CARE and ICRW. These organizations have been critically important to the ISOFI process by bringing fresh perspectives from outside the confines of CARE and ICRW, and providing essential training in gender, sexuality and reproductive rights. These organizations include TARSHI, CREA, CIHP and LIFE. Descriptions of each are provided in Text Box 1.

ISOFI's objectives for these pilots included the following: (1) Two CARE country offices will have

The biggest change is now we use condoms every time and practice safe sex. We had never heard of HIV before. We learned about HIV through the ISOFI trainings. (Male trucker, India)

a solid technical and programmatic strategy for addressing gender and sexuality in future or current reproductive health field projects; (2) develop and disseminate a documented approach for integrating gender and sexuality into reproductive health programming in multiple country settings; and (3) establish a synergistic, learning partnership that promotes and supports institutional evolution and innovation at CARE and ICRW beyond the parameters of the proposed project. ISOFI has at-

People who were shy have opened up and have started sharing about their lives, even their personal lives, their families...This has brought many of us closer. We have become more confident. (Vietnam)

tempted to achieve these objectives by addressing issues of gender and sexuality associated with reproductive health concerns.

Viewing gender and sexuality as interlinked concepts, the ISOFI initiative uses community-based and participatory methodologies to address the underlying, often sub-conscious, concerns related to gender inequality and sexuality. ISOFI's methodology is two-tiered, focusing first on personal

lives and subsequently effecting changes within their own organization, so that CARE staff were more effective change agents with target populations and communities. Initial assessments indicated that CARE staff experienced change as a result of ISOFI and that this, in turn, resulted in profound changes that improved the design and delivery of reproductive health interventions among hard-to-reach populations. The goal of ISOFI was to mainstream gender and sexuality into CARE's global reproductive health programs, thus contributing to CARE's ongoing organizational transformation.

The ISOFI experience, which combines sexuality and reproductive health into an integrated model, is a unique initiative. This document attempts to capture the initiative's promise to the field of reproductive health by discussing how ISOFI has addressed gender and sexuality issues to refine existing interventions and make them more responsive to the realities and preferences of the communities they serve. Participants in the pilot sites stated that the work of ISOFI profoundly affected their lives.

Text Box 2: Vietnam Methodology

In Vietnam, ISOFI was piloted across the northern and southern regions in several sexual and reproductive health/HIV projects. These ranged from a youth-focused garment factory behavior-change project to an innovative project to create a human-rights-based curriculum and practicum on HIV/AIDS for students in government-run policymaker-training programs.

Gender and Sexuality Perspective Building

The CARE Vietnam team began ISOFI activities in October 2004 with an introductory "sensitization" workshop on gender and sexuality that brought together more than 25 team members from nine different projects. CREA facilitated this participatory four-day launch workshop, which was intended to enhance conceptual understanding, increase personal awareness related to power relations and raise sensitivity related to gender and sexuality.

Reflective Practice

Directly following the initial workshop, with the support of ICRW, the CARE Vietnam team explored and reflected on the programs that are currently being implemented. Through the **Portfolio Review and Needs Assessment (PRNA)**, the project teams identified a need to institutionalize gender in a more systematic manner. However, the teams also felt that given the sensitivities of the government on issues of human rights and sexuality, the approach to gender and sexuality integration should be incremental.

Activity Planning

The project teams worked collectively to brainstorm, debate and develop activities to begin the process of "operationalizing" all that they had absorbed, both in terms of project activities and staffing policies. Five of the seven sexual/reproductive health and HIV/AIDS projects designed and implemented gender and sexuality activities that are described throughout this report.

Text Box 3: India Methodology

In India, ISOFI was piloted in two districts: Lucknow, in the state of Uttar Pradesh (UP) and Bhilwara, in the state of Rajasthan. The platform for ISOFI's implementation is the Reproductive and Child Health, Nutrition and AIDS (RACHNA) program, which encompasses all of CARE India's health, nutrition and reproductive health programs.

Orientation & Perspective Building

CREA facilitated a workshop for staff from the pilot districts, Lucknow and Bhilwara, in August 2004. It was the first workshop for CARE India staff on sexuality, and participants described it as a liberating experience, since they were able to discuss personal and formerly prohibited aspects of their lives related to sexuality. The workshop's participatory approach, which included the use of exercises and films, challenged participants to think, debate and reconcile controversial issues like prostitution, cross dressing and homosexuality.

Reflective Practice

To build on the transformative experience gained at the gender and sexuality workshop, the teams engaged in reflective practices to gain a better understanding of what this new learning on gender and sexuality means for them; how their values and beliefs are reflected in the way they think and program; how they are able to break the silence around sexuality at their personal level and at the program level; how to openly discuss sex and gender roles with communities; and how to address the positive aspects of sexuality, like sexual pleasure. Once staff was oriented on gender and sexuality, an intensive **Portfolio Review and Needs Assessment (PRNA)** was conducted with the two district teams and the Program Management Teams (PMT) in Uttar Pradesh and Rajasthan. The objective was to identify gaps and opportunities when integrating gender and sexuality using group reflection and analysis around key questions.

Activity Planning

*** Bhilwara, Rajasthan**

A workshop on gender and sexuality was organized for NGO partners from two regions in Rajasthan in November 2004. One significant activity the team has undertaken is the integration of gender in folk media campaigns that address topics such as celebrating the birth of a girl child, emphasis on rest during pregnancy, nutrition for the girl child, and various male and female methods for birth spacing. Gender and sexuality activities continued for the duration of the project, and are described throughout this report.

*** Lucknow, Uttar Pradesh**

NGO partners were introduced to ISOFI and identified ways in which gender and sexuality could be integrated in their reproductive health programming. The team also mapped out agencies in Lucknow that are working on gender and sexuality. In addition to NGO partners, the UP team influenced the state government to nominate a gender point person from the Health and Integrated Child Development Services (ICDS). In January 2005, a workshop on gender and sexuality for ICDS functionaries was organized in Lucknow, facilitated by headquarters staff. Gender and sexuality activities were designed and implemented for each component of the Reproductive and Child Health, Nutrition and AIDS Program (RACHNA). They are described in detail within this report.

Findings from the end of project evaluation (see Chapter 5) point to potential pathways for future innovation in sexual and reproductive health programming. In fact, several of the interventions modified on the basis of ISOFI inputs, such as increasing mother-daughter communication regarding sexuality and sexual health, are precisely what the literature has suggested as important avenues for HIV/AIDS prevention (Damalie, 2001).

The first phase of ISOFI put into practice the recommendations set out in the Platforms of Action for ICPD held in Cairo in 1994, and the Fourth World Conference on Women (FWCW) held in Beijing in 1995, along with the 10-year reviews of ICPD and FWCW. The Beijing Platform recommended addressing the problems of sexually transmitted infections, HIV/AIDS and sexual and reproductive health in gender-sensitive programs (UNFPA, 2004). The first phase of ISOFI has paved the way.

CARE and ICRW are planning a second phase of ISOFI in order to answer the crucial question, “So what?” What evidence can be gathered to document a positive, measurable impact on sexual and reproductive health outcomes through the systematic and contextually tailored integration of gender and sexuality into CARE’s ongoing sexual and reproductive health programs? This anticipated second phase of ISOFI will attempt to garner more concrete evidence than that suggested by other documents addressing the issue of impact (Boender et al., 2004). ICRW and CARE will utilize this second phase of ISOFI to conduct a well-designed operations research study with pre- and post-measurement of selected gender, sexuality and reproductive health outcomes.

ISOFI’s significance has been to address issues of power and powerlessness, pleasure and pain, in two different Asian contexts. As village women who participated in ISOFI activities stated in a focus group discussion:

Some in the community complain about ISOFI and say, ‘these are things done at night and behind a curtain. Their shame is they discuss it in the daytime. ISOFI staff have nothing better to do than come from the city and waste their time with meetings.’ But we have seen a lot of change because of the access to information... (Village Women, India)

An overview of the ISOFI model is described in Chapter 2 of this report. Chapter 3 describes personal transformation of CARE staff as well as the experiences and effects of this learning on CARE as an organization. Chapter 3 also provides details about the innovative methodologies used by CARE staff, implementing partners and communities. Chapter 4 describes the field application of ISOFI learnings, with discussion of how gender and sexuality were incorporated into reproductive health interventions such as condom promotion, maternal health care and breast feeding, as well as how technical support was provided. Chapter 5 presents findings from the end-of-project evaluation, based on the analysis of baseline and endline survey data. Finally, Chapter 6 provides a brief discussion, recommendations and next steps.



Chapter 2

The ISOFI Model: Creating an Enabling Environment for the Effective Integration of Gender and Sexuality

Over the past several years, CARE has strategically committed time and resources to integrating gender and diversity into its programming principles and administrative policies. CARE undertook numerous initiatives to integrate gender into all relevant functional areas of the organization. In human resources, CARE instituted progressive gender and diversity policies and integrated relevant competencies into the performance appraisal system. In ongoing support to field programs, CARE provides technical materials on gender integration, trains staff in gender analysis and supports projects throughout implementation. CARE also promotes the systematic consideration of gender in project design, monitoring and evaluation. In other words,

there has been a substantial global effort to ensure that CARE programming is not only gender-informed but also gender-responsive. In light of political commitment at the highest institutional levels and sizeable investment in systems and capacity, CARE expected gender to be more fully and holistically integrated into field programs by this point in time. In reflecting on efforts to integrate gender and the added dimension of sexuality into reproductive health and HIV/AIDS programming, staff working with ISOFI observed the absence of sexuality in programming and expressed concerns about integrating these concepts into programs. Examples of concerns early in the ISOFI process are provided in the text box below.

Text Box 4: Pre-ISOFI Perceptions on Integrating Gender and Sexuality

Headquarters Perspectives

...[G]ender issues usually come up once during a 'gender workshop.' That is usually enough to spark interest (or not) in certain individuals...a once-in-a-lifetime workshop isn't enough. (CARE Advisor)

Gender is much more ingrained within and accepted by staff; it's the sexuality piece that is far, far behind. (CARE Advisor)

Traditionally CARE projects have avoided sexuality and dealt with reproduction in a very technical or medical way. (CARE Advisor)

I find that sexuality is often in the unspoken "assumptions" column of the log frame of reproductive health programs. (CARE Advisor)

We need people who are comfortable and experienced with the issues...to mentor our CARE programs. (CARE Advisor)

Field Perspectives

We've realized that we needed to change 'us' before we [could] advocate change in communities. (India)

I don't dare add another topic about sexuality. For the target group, it might be sensitive. For the first step, they should have basic knowledge about gender. If they are okay with gender, we go to the further step of sexuality. (Vietnam)

So for myself, I'm alone in the forest [of gender and sexuality], and I'm trying to see where is the exit. (Vietnam)

We have realized that women open up and talk about sexuality, but then we become hesitant. (Male Staff, India)

...[I]f I cannot convince my family [about gender equity], then how can I convince my project beneficiaries? I work with local women. They have more difficult living conditions than me - so if I can't convince my family, how can they convince their families? (Vietnam)

Among other programmatic issues, these staff observations reflect how divergence between personally held and professionally expressed values and attitudes around gender and sexuality can affect all aspects of programming: design, implementation and evaluation. Lived experience of gender and sexuality is deeply rooted in social systems and cultural meaning, and represents an individual's essence as a human being – it structures personal life. That lived experience of gender and sexuality often creates tension within the professional sphere, effectively tempering the design and delivery of interventions framed to address reproductive health and HIV/AIDS, which are intrinsically linked to gender and sexuality. Essentially, it is unrealistic to ask field staff to uphold and promote gender-sensitive or, even more ambitiously, gender-transformative principles when they haven't had an opportunity to process and integrate those principles into their personal lives.

Finally, in the previous quotes, staff identify a fundamental need: to open a dialogue around sex, sexuality and sexual health. In their experience, project educational materials deal with reproductive organs but not with the power, pleasure, pain and shame associated with those same sexual sites. Field staff promote condoms – and their effec-

Just giving a condom and asking a person to go and explain what are the different methods and pros and cons - this is not going to work until and unless you relate to [people] as human beings. That is what ISOFI has done for me. I have a very, very soft corner - a special corner - for [ISOFI]. (India)

tiveness with birth spacing as with the prevention of sexually transmitted infections - but overlook the importance of intimacy in sexual relations and the reality of gendered control over sexual encounters. Project strategies are primarily framed around heterosexual sex and refrain from addressing less visible patterns of sexuality such as male-to-male sex or sexual practices deemed outside the mainstream such as male-to-female anal sex. As with gender, staff need to explore and comprehend their values, attitudes and beliefs relating to sexuality as well as their understanding of its placement within conceptual frameworks and models of behavior change.

Change theory supports the creation of safe and non-judgmental "space" where individuals can examine and explore sensitive and deeply personal subject matter. Such theory influenced the design of the ISOFI Innovation System (IS), which is described in the remainder of this chapter.

Text Box 5: Guiding Principles for the Design of the ISOFI Innovation System (IS)

- **Development practitioners need space to explore and understand their own values, attitudes, beliefs and experiences of gender and sexuality.**
- **Personal learning and change in relation to gender and sexuality will be critical to enhancing organizational effectiveness in addressing gender and sexuality.**
- **Processes and practice in the professional sphere should encourage people to recognize and maximize their lived experience of gender and sexuality.**

***Inquiry as Everyday Practice:
The ISOFI Innovation System (IS)***

In response to the observations and reflections previously noted, CARE and ICRW agreed to design and test a field-based methodology to integrate gender and sexuality systematically into existing reproductive health projects. Planned as a first phase, the Inner Spaces/Outer Faces Initiative initially focused on personal learning and change, and then segued naturally to organizational learning and change. ISOFI as a methodology features **structured iterative loops of reflection/learning, action/experimentation and analysis/assimilation**. Its systemic nature means that a safe space for reflection and dialogue can and should be carved out at all levels of an organization.

This realization made me actually see that because of my judgmental attitude, I tended to become dominating. I realized that these were shortcomings in my character, and I needed to address them. Thus, I tried to make amends. The enabling environment in ISOFI was instrumental in facilitating self-reflection. Nowhere was it said that you have to change, so I really did not feel this was a project. The facilitation process was excellent - always. Because of the learning environment, there is self-realization that things can improve if there is change. (India)

With the two-year pilot now at an end, CARE and ICRW have consolidated ISOFI learning and tools into the ISOFI Innovation System (ISOFI IS), which has been rigorously field tested by CARE in two countries: India, in Lucknow District (Uttar Pradesh) and Bhilwara District (Rajasthan); and Vietnam, in Hanoi and Ho Chi Minh City. The ISOFI IS comprises five intervention modules, the first four of which are administered sequentially in an initial phase, but all of which are practiced iteratively across the project cycle. Those five intervention modules are:

- **Portfolio Review and Needs Assessment;**
- **Gender and Sexuality Training**
- **Reflective Dialogues** (collective reflection);
- **Personal Learning Narratives** (individual reflection);

- **Participatory Learning and Action** (application of learning to interventions)

There still is a contradiction between our inner and outer faces. (India)

The ISOFI IS has a participatory evaluation module that can be applied as a mid-term process review or as an end-of-project evaluation. (The five intervention modules are described in this chapter, with the evaluation module described in the Annexes.) Exercises conducted with the assistance of these modules were the source of the numerous quotations and visuals appearing throughout this report.

Genesis of a Methodology

As fundamental to ISOFI's design, CARE and ICRW incorporated principles and processes associated with three interrelated domains: social psychology represented by Kurt Lewin and the legacy of his work relating to group dynamics and experiential learning; androgogy, which frames education as freedom and promotes the assimilation of learning with life experience, represented by Brazilian educationalist Paolo Freire; and Participatory Action Research (PAR), an approach noted for improving social practice and promoting social justice, represented by diverse schools of thought ranging from Fals Borda to Whyte to Reason and McTaggart, and by innovative applications of PAR in development practice, such as Participatory Learning and Action (PLA), espoused by Chambers, Cornwall and Gaventa. Theory that inspired ISOFI's overall design is summarized below and linked to aspects of the ISOFI IS.

ISOFI Challenge #1: As adults employed by an international development organization in low- or middle-income countries, CARE staff are generally well educated, highly motivated, seasoned and experienced, and enjoy relatively high status within

their community. As in any society, their worldview and perspectives on gender and sexuality were initially shaped by prevailing socio-cultural systems, values and norms through a process of socialization. Gradually, life experiences, personal inquiry and exposure to global media introduce new information on gender and sexuality that requires processing.

What is an effective method for challenging adults to think differently about profoundly sensitive issues such as gender and sexuality? To address this challenge, the ISOFI team drew on the disciplines of social psychology and androgogy.

Kurt Lewin, a social psychologist of the early 20th century, posited that re-education may affect people's cognitive structure (the organization of ideas, facts and beliefs), values and behavior. In order to re-educate or re-socialize adults, they must pass through a three-phase process: **unfreezing** (creating internal disequilibrium); **changing** (finding a new equilibrium for themselves); and **refreezing** (re-stabilizing). As an essential first step to learning, the unfreezing process needs to prompt change through heightened anxiety, introduce or reorganize information, and allow for safe and non-judgmental reflection. Next comes a period of change when individuals experiment with new behaviors within a supportive group environment.

With time and practice, new behaviors and perspectives are assimilated into an individual's personality and life systems, and refreeze only when significant others (e.g., spouse, kin, close friends) confirm or validate the changes.

Paolo Freire, a Brazilian educator of the 20th century, remarked in his classic work *Pedagogy of the Oppressed* (1970) that, "No one can unveil the world for another." By striving to develop critical consciousness – to perceive with purpose the social, political and economic injustices that serve to exclude certain individuals from society – people learn to perceive and critique their own personal and social reality. For Freire, informal education was dialogical, involving deep respect for others' knowledge, value and contribution to society. Silence and complacency can be broken through collective reflection and dialogue, motivating individuals to take action to transform themselves and society.

Application of Theory to ISOFI IS: All of the ISOFI intervention modules are multipurpose and contribute to learning and change at both the individual and organizational level. For this particular challenge, given the need to "shake up" individuals (per Lewin's unfreezing) and raise their consciousness (per Freire), the ISOFI team developed the first four of five intervention modules to be admin-

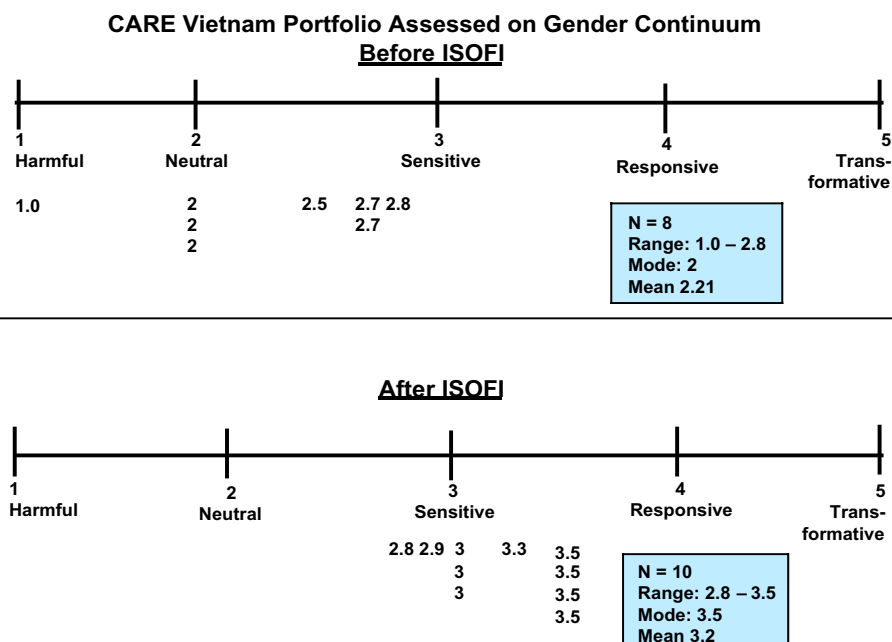
Text Box 6: ISOFI's Gender Continuum

Over the course of ISOFI, staff evaluated CARE's progress in integrating gender into its existing portfolio by assessing program strategy against a gender continuum adapted from a model developed by ICRW . ISOFI's gender continuum is below:

- 1) A gender-blind approach exploits inequalities and reinforces stereotypes. An example of a gender-blind approach is using a virile, strong man to promote condom use.
- 2) A gender-sensitive approach recognizes that people's needs are different and accomodates societal roles without attempting to reduce inequalities. An example of a gender-sensitive approach is promoting the "female condom" so that women can use condoms for prevention, without having to negotiate their use with their male partners.
- 3) A gender-transformative approach seeks to create more equitable relationships and challenges gender and societal norms. An example of a gender-transformative appraoch is a CARE income-generation training project in Allahabad, India, where women are given training in hand-pump repair rather than traditionally defined skills such as sewing or tailoring.
- 4) An empowering approach aims to equalize the balance of power and addresses structural and societal barriers, which empowers vulnerable people to claim their rights. An example of the empowerment approach is the Sonagachi project in West Bengal, India, where sex workers organized themselves in order to demand the right to health care.

Diagram I: CARE Vietnam: Progress Along the Gender Continuum

In Vietnam, participants in the end-of-project review assessed progress in applying gender across the CARE program portfolio. Conducted in two parts, the first focusing on pre-ISOFI and the second on post-ISOFI, each participant provided a score relating to the portfolio's performance on gender. One participant felt that the pre-ISOFI portfolio included elements harmful to gender, such as promoting labor-exploitive cooking stoves. However, all participants agreed that CARE's performance on gender dimensions substantially improved post-ISOFI.



istered sequentially in the earliest stage of initiating personal learning and change, and then to be taken up again at appropriate junctures in the project cycle. They are:

- Portfolio Review and Needs Assessment
- Gender and Sexuality Training
- Reflective Dialogues
- Personal Learning Narratives

The **Portfolio Review and Needs Assessment (PR/NA)** assembles primary stakeholders (e.g., managers, advisors, field staff, partners) to appraise the state of the organization's program portfolio in relation to gender and sexuality as reflected in project content, strategies, activities, monitoring and evaluation, staffing and partnerships. The facilitators establish the parameters of the portfolio to be examined but may include current, past and pending projects and may extend across several development sectors (e.g., reproductive health, microenterprise and food security). Facilitators

lead participants through a structured reflection exercise, working from a facilitation guide. One key tool adapted for the PR/NA is the "gender continuum" described above. Depending upon the size of the portfolio under review, the PR/NA can take from a half day to a full day. In most cases, it should not extend beyond a full day, as length of a "reflection" session early in the ISOFI process could potentially discourage project staff anxious about field activities and deliverables. As with any participatory process, length of the PR/NA should be determined by the staff participating in the module. A sample of the PR/NA facilitation guide used in India and Vietnam is available in Annex I.

The **Gender and Sexuality Training** proved an essential intervention module for unfreezing people's perspectives, particularly those on sexuality. CARE and ICRW worked closely with local resource centers such as TARSHI in India to develop the module. Conducted over the course of three to four days, the curricula were contextualized and sought to challenge participants' preconceived

notions of gender norms and gender roles, sexual norms and sexual identities, the role of power and control, and the detrimental effect of social exclusion. The trainings were grounded in social construction theories for understanding both gender and sexuality. Facilitators relied heavily on experiential exercises and maintained a highly interactive and supportive environment. The benefit of involving local resource centers for this particular intervention module is that staff from these centers are quite up to date on the latest group communication techniques, and they bring a new and refreshing perspective to the organization. These centers offered periodic training courses on gender and sexuality, which were used to train new staff members as they came on board.

Senior Managers --> Strategy and Outcomes

Middle Managers --> Intervention Design and Outputs

Field Staff --> Activity Implementation and Inputs

As a methodology for collective reflection, **Reflective Dialogues** are held quarterly and can involve relevant staff at multiple levels of the organization - field-level, middle management and senior management. As appropriate, Reflective Dialogues may also involve implementing partners at each of the corresponding levels. While thematically interrelated, the nature of the reflection is adapted to suit the role and responsibilities of staff and partners operating at each level. As NGOs focus principally on implementation – and staff often view time away from implementation as costly – a Reflective Dialogue session should normally take from a half day to a full day, extending in exceptional circumstances beyond a full day. During Reflective Dialogues, staff review progress against the past quarter’s workplan and then engage in active problem solving and theory building to reassess the

We are so involved in proving our competencies that we do not even want to honestly reflect. (India)

current situation vis-à-vis the integration of gender and sexuality into the project’s strategies, interventions, and monitoring and evaluation system. Essentially, the reflection is built around four basic operational questions:

- **What did we set out to do?**
- **What actually happened?**
- **Why did it happen?**
- **What will we do to move forward?**

Through structured probing, staff process observations and learning around gender and sexuality, as well as explore linkages of that learning to change at the personal level (inner spaces), at the professional level and at the organizational level (outer faces). In this first phase of ISOFI, facilitators from CARE and ICRW led the official reflective dialogue discussions in India and Vietnam. As staff in CARE India became more comfortable with the exercise and began to appreciate the power of reflection, they carried out their own reflective sessions as needs arose. Through this methodology, participants are constantly testing the logic and effectiveness of theories that are put into practice, and adapting interventions to be increasingly responsive within socio-cultural contexts as they become better understood.

...[B]ut after ISOFI, there has been a revelation - a personal journey within me. (India)

Finally, in order to encourage regular personal reflection, the ISOFI team introduced the **Personal Learning Narrative**, an opportunity for staff undergoing transition to think through the effect of learning around gender and sexuality on their personal lives. Originally conceived as periodic written reflection, the ISOFI team quickly adapted the methodology, as they realized that staff don’t have the time (or perhaps the inclination) to write personal narratives. An interview methodology effectively substituted for written narratives, with up

to three indepth interviews conducted by facilitators from CARE and ICRW at the conclusion of each Reflective Dialogue session. Given the number of staff participating in ISOFI in India, for example, each individual was interviewed twice during the course of the 18-month pilot. In indepth interviews conducted during the evaluation phase of ISOFI, participants spoke about the degree to which they had been able to refreeze their internal frames on gender and sexuality, and analyzed the various factors affecting their ability to stabilize new beliefs, attitudes and values. These findings are reported in Chapter 3.

ISOFI Challenge #2: Over the past 10 years, CARE as an organization has been moving steadily from a needs-based approach toward a rights-based approach, which seeks to reduce risk and vulnerability by addressing underlying causes of poverty and of social exclusion. Central to the success of a rights-based approach is the effective and systematic integration of gender into all aspects of organizational culture, structure, systems and programming. Further, when applying a rights-based approach to reproductive health and HIV/AIDS, it is crucial to understand how sexuality interacts with gender to create interconnected risk and vulnerability, the ramifications of which extend beyond public health to social and economic outcomes.

Generally, CARE staff understand well the concept of gender, less so the concept of sexuality. Yet, as ISOFI participants observed time and again, as comfortable as they were with gender concepts, they just didn't know "how to do" gender. They were even more unsure about how to broach sexuality with implementing partners and community members.

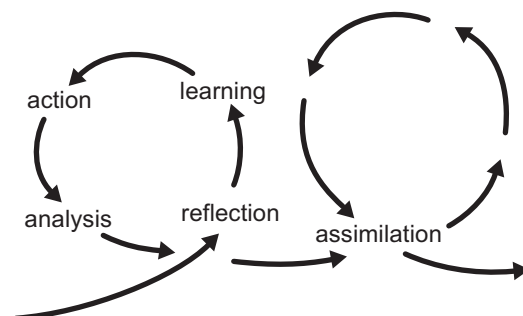
What methodology will support CARE's purposeful transition to rights-based programming while building staff capacity to concretely integrate gen-

der and sexuality into strategies and interventions? To address this issue, the ISOFI team drew from the teachings of Paolo Freire and from the various schools of participatory action research and their innovative applications, such as Participatory Learning and Action (PLA), espoused by Robert Chambers and Andrea Cornwall. Relevant theory and its application are summarized below.

Praxis is fundamental to Freire's pedagogy of emancipation. Freire argued that all action must be informed by social, cultural, economic and political realities, and must seek to transform the world that is. Further, this liberatory action should strive to increase simultaneously the community's capacity for critical reflection and action as well as build its social capital. In this way, action contributes to the attainment of social justice both by rectifying inequities through a process of conscientization and collective action, and by consistently demonstrating principles closely associated with social justice (e.g., respect, transparency, dignity) in daily life.

True praxis can never be merely cerebral; it must involve action. Nor can it be limited to mere activism. It must include serious reflection. Freire regards reflection without action as sheer verbalism, "armchair revolution," whereas action without reflection is "pure activism," that is, action for action's sake. (Crotty, 1998)

With its origins in social science, **Action Research**, as an orientation to inquiry and social action, evolved and diversified as it integrated new domains. Reason and Bradbury (2001) distinguish Action Research from traditional academic research by emphasizing that Action Research is "a participatory, democratic process concerned with developing practical knowing in the pursuit of



worthwhile human purposes...,” and more specifically, “[i]t seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities.” Within Action Research, there are iterative cycles of action, analysis and reflection that lead to an ever more precise articulation of the research problem and foster ever-increasing depths of perception to those seeking solutions to real-world problems. By virtue of these iterative loops of action and reflection, change occurs throughout the research process; the research team is constantly adjusting its conceptual framework so that it accurately reflects "reality" as layers of meaning are unveiled.

While many schools of thought abound, Whyte and others distinguish between Action Research and Participative Action Research (or **Participatory Action Research**), where people from the subject organization or community actively participate in framing and conducting the research, interpreting data, and presenting findings and recommendations. As with all forms of Action Research, Participatory Action Research links directly to social action, and when practiced in its most genuine form is truly emancipatory. Sohng (1995) remarks: “Ideally, this collaborative process is empowering... Participatory research reflects goal-oriented, experiential learning and transformative pedagogy.”



ISOFI staff adapted PLA tools in the course of their fieldwork. Here CARE India staff interview an adolescent girl on her sexual and reproductive health history, using a bi-directional timeline.



ISOFI participants developed expertise in applying PLA tools to the issues of gender and sexuality. Here a staff member from CARE Vietnam uses cartooning to depict "most significant change" as it relates to ISOFI's impact on personal and professional spheres.

Application of Theory to ISOFI IS: For this particular challenge, the ISOFI team developed an intervention module based on an innovative application of PAR to development practice: **Participatory Learning and Action (PLA)**. For ISOFI's purposes, the PLA exercises were focused around gender and sexuality as they related to the host project's purpose - e.g. improving maternal health among rural women or improving safe sex practices among mobile populations. This module serves multiple purposes: It expands and reinforces personal and professional learning; it deepens organizational learning and promotes genuine partnership; it transfers ownership and builds capacity of community members; practically speaking, it identifies specific entry points where gender and sexuality can be more effectively addressed, and provides abundant information for "tweaking" project strategies, interventions and project materials. PLA of various scope and themes can be conducted throughout the project life cycle; however, the ISOFI team undertook the first PLA as the earliest stage of personal learning was drawing to a close.

Among its principles, PLA promotes ownership, diversity of meaning and experience, collective learning and action, and social transformation. ICRW developed field guides for the PLAs in India;

this field guide was adapted for use in Vietnam. In keeping with the tenets of PLA, a variety of qualitative tools are used to collect and analyze information; recommendations focus on immediate application of new learning to action. Tools used during the ISOFI PLAs on gender and sexuality included: social and vulnerability mapping; body mapping; Venn diagram; cartooning; bi-directional timeline; and stakeholder analysis, among others. Visuals developed during the PLAs appear throughout this report. Full reports from the PLAs on gender and sexuality are available from CARE India and CARE Vietnam.

Conclusion: Drawing from the domains of social psychology, androgogy and Participatory Action Research, CARE and ICRW developed a field-based Innovation System to complement and enhance CARE's multi-year initiative to address gender and diversity in relevant operational and programmatic areas. As described in detail above, the ISOFI IS is comprised of five intervention modules: Portfolio Review and Needs Assessment; Gender and Sexuality Training; Reflective Dialogues; Personal Learning Narratives; Participatory Learning and Action

on Gender and Sexuality; and a participatory evaluation module. As a defined system, ISOFI guides managers and field staff through a structured process that focuses initially on personal learning and change around gender and sexuality, then by design helps participants move forward with organizational learning and change and application to field interventions.

As a methodology inspired by Freire's pedagogy of emancipation, the ISOFI IS seeks to empower and build the social capital of all individuals involved in its process: community members, service providers, NGO partners, field staff, managers and technical advisors. At its core, the ISOFI IS upholds the principles of critical consciousness, praxis and social action. ISOFI exercises prompt participants to question, critique, reflect and envision. As such, participants begin to perceive their lived experience of gender and sexuality through a new lens and, within a supportive environment, integrate new thinking around gender and sexuality into their personal frameworks as well as begin to apply new principles to their work as agents of social change.

Text Box 7: Post-ISOFI Perceptions on Integrating Gender and Sexuality

Headquarters Perspective

I am more aware of how words reflect my subconscious attitudes, and how I need to be more conscious of child-learned versus adult-learned attitudes. (CARE Advisor)

...[W]e are better at avoiding a victim perspective of women. We see women as agents able to make choices. This is a radical change. We are also better at seeing how masculinity is constructed in ways that hurt men as much as it hurts women. (CARE Advisor)

...[T]here is momentum, but it needs concerted attention. Because ISOFI was only two years, we've only made a dent in how individuals within CARE look at the issues; it takes a lot longer to get groups of individuals to change the way they do business. (CARE Advisor)

Field Perspective

ISOFI started in May 2004. By September 2005 we were able to talk very confidently about issues of gender and sexuality with elected officials. By October 2005, we started organizing folk shows with [themes of] gender and sexuality. (India)

...[P]ower ranking helps us to identify sub-groups inside a group - for example, HIV-positive people. Sub-groups have different challenges... Understanding resources and power among the beneficiary group[s]... helps me to [design] better interventions. (Vietnam)

What [ISOFI] has given me as a person is the confidence to go ahead, the opportunity where I can with my team work out, try out, experiment and learn... make mistakes... and yet learn to do things in a different way. (India)

Chapter 3

Inner Spaces: Deeply Personal and Inherently Systemic

If you are something from inside and you portray something else on the outside... you cannot do anything... (India)

...[W]hatever is there in your heart cannot actually be taken out. (India)

[Now] we understand each other. [ISOFI] gave us an opportunity to open our hearts and share our feelings. We talked about things which we never mentioned in the past. (Vietnam)

As reflected in the quotes above, ISOFI facilitates examination of one's own beliefs and attitudes with the assumption that such inquiry leads to personal transformation (Freire, 1985). Peter Senge and colleagues (2004) indicate that, "in order to 'create the world anew' we will be called to participate in changes that are both deeply personal and inherently systemic." Indeed, a central assumption underpinning ISOFI is that personal change is a necessary component of an authentic program embodying transformation. One cannot challenge harmful social norms such as gender and sexuality inequities, either in communities or within CARE, without also examining one's own subjective position. Rather than simplifying complexities of gender and sexuality, through ISOFI, CARE staff were called upon to explore, question and reflect in an iterative process, which gave way to multiple perspectives in a variety of field contexts. That is, staff perceptions represented different views that both challenged and contributed to their personal development and organizational commitment.

ISOFI practices reveal that the process of reflection and personal change is most effective when

carried out collectively. Participating in a group that is organized around shared meanings leads to coordinated and effective action (Bohm, 1985; Isaacs, 1994; Jaworski, 1998). Group relationships - strengthened through provocative training, reflection, dialogues, supportive coaching and participatory interventions - form the basis of problem solving, leading to formation of decisions, which are best implemented by those who make them collectively (Lewin, 1946; Schein, 1995, 2006; Trist, 1975). CARE and ICRW maintain that tangible progress on gender issues, such as gender equality, is intrinsically linked to shifts in organizational culture (Oxfam 2003 cited in Moser & Moser, 2005). ISOFI was designed with the understanding that ISOFI project staff could realistically expect to achieve at the program level only what they could achieve within the organization itself. External facilitators, community members and staff challenged beliefs and perceptions which, as predicted, led to disequilibrium in the workspace. As Kurt Lewin (1951) attested years ago, if people share a common objective, they are likely to act together to achieve it. An intrinsic state of tension within group members motivates movement toward the achievement of desired common goals (Johnson and Johnson 1995). Reflection, disequilibrium and dialogue prompts individuals to contemplate action that is most successful in a group setting, since it provides psychological safety to "embrace" error and learn without judgment (Michael, 1973, 1992; Schein, 1995). This represents the heart of the ISOFI approach adopted by CARE through the support of ICRW.

Inner Spaces: Reflection and Personal Change

A heavy emphasis on "unfreezing" personal beliefs took place, particularly in the early days of the initiative. As one participant recalls, "ISOFI has melted a stone." Almost all staff reported that personal transformation helped them let go of old ideas, thereby influencing their behavior and having lasting effects. The reported changes became increasingly apparent as staff narrated stories about themselves and their colleagues that reflected greater tolerance and acceptance of the beliefs, identities and behaviors of others. This melting away took place through participation in reflective dialogues and continuous co-creating and re-creating project interventions - which ultimately represented a gateway to authentic personal and organizational change.

Even if you [change your actions], you can do it intentionally initially, but then it becomes part of your personality. (India)

Now I argue that there should be a distinction between what you personally think and what is accepted at social level... (India)

The workshops and reflections helped me to understand that each person has his/her own identity and nature and I can't change them according to my wish. I should accept them as they are. (India)

A sense of solidarity with beneficiaries grew as ISOFI processes cultivated interdependency among actors. Staff observed various kinds of commonalities they shared with NGOs and government partners as well as communities. This helped them to question socially constructed barriers such as class, religion and caste. The distance between themselves and community stakeholders began to diminish. It became notable that when ISOFI teams engaged in meaningful conversations with the communities, things changed. Both staff and communities developed new levels of trust for one another; they became more cooperative and forgiving. They engaged more equally as members in a process. As one PLA participant from India reported, "the boundaries be-

tween CARE staff and community stakeholders dissipated."

As Robert Chambers (2005) describes, when a learner interacts with a poor person as teacher, the challenge is to know how to adapt – the sheer unfamiliarity of it all, with so much to take in, and then afterward the opportunity to review, reflect and



In the beginning, I felt so uncomfortable talking to the sex workers when we engaged in participatory exercises. I couldn't bear to hear their language. Although I made it through each day, I couldn't sleep at night. I had nightmares until I suddenly realized that they were like me - they were mothers with children to feed. They had the same concerns that I had about earning enough; we were not very different from each other. I felt much better, and my nightmares went away. (India)

digest the experience – it's a powerful experience. Not only does the interaction reveal new insights, but it challenges values, beliefs and raises questions about the sort of people we are and want to be.

Women in ISOFI Who Inquire

Personal change among CARE staff was reflected in stories of familial and community relationships. Several women described ways they challenged traditional norms and values within their families. One woman asserted the following:

So now I tell myself: No, I am not going to get swayed by what my father says. I'm not going to get swayed by what my husband says. I have to find my own perspective... (India)

By taking stands, as reflected in the quotes above, women stepped out of traditional roles that reportedly restrained them. Several women revealed that they became more self-assured in both their personal and professional lives. After discovering their voice and understanding that it is their right to use it, a few women revealed ways they had taken the initiative in seemingly insignificant ways. Female staff often spoke about having more courage and trust in themselves to make decisions and be leaders. They attributed these changes to the numerous candid discussions held with colleagues and family members over the course of their ISOFI experience.

It is my right to share what I want or tell to anybody with whom I am having relations. I have to share my feelings and my views. I have seen this change in me and I feel that it is because of ISOFI only. (India)

I am different now, more confident. I don't accept roles just because I'm a woman. I know this is difficult in my society, since Vietnamese men are not interested in such independent women. But now I can't go back to the old way. (Vietnam).

Men in ISOFI Who Inquire

A few men described their once-held beliefs of gendered roles reflecting conventional attitudes about women in relation to family responsibilities. Several participatory exercises led men through a reverse analysis of gendered roles, allowing them to consider gender-biased expectations of men and not only those applied to women.

Many male staff grappled with gender concepts more constructively as they became conscious of oppressive masculinity constructs through PLA techniques that were then strengthened by ongoing reflection, coaching and trainings. By depicting images of the ideal man, for example, they observed that men also endure pressure and bear a different kind of discrimination by reinforcing gender dichotomies. During this exercise, together with men in the communities, CARE staff spoke of unanticipated findings, including male burdens to

impress girls, earn adequate salary and develop a muscular body. They spoke of “looking good” and the skill it takes to “trap girls to fall in love.”

Actually, when I talk about my wife, I feel that she is always confined to the four walls of the house. I used to feel that every woman does this for the family. But I took a decision... I would look after the house the whole day today. After doing that, I realized that I did not get even five minutes of break. (India)

In the past, I thought I would never wash my wife's clothes. But the project helped me to have a broader view... (Vietnam)

Before ISOFI, I was never much into the gender thing. Now I have confidence in dealing with the issues related to gender and sexuality. ISOFI has brought gender into focus. (India)

By shifting their behavior from traditional male roles to ones manifesting emancipatory qualities, these male staff experimented with changing power dynamics within the private domain of their homes, where gender is generally most deeply rooted. Testing new behaviors, with support of colleagues, they cultivated confidence and commitment to support similar transformative processes within their workplace and in the communities where ISOFI operates.

Sexuality: Learning by Inquiry

Many staff stated that before ISOFI they avoided discussing matters related to sex, since it was generally forbidden to do so, even between spouses. As time progressed, however, comfort levels broadened as staff increasingly discussed matters of sexuality more candidly. As one CARE Vietnam staff reported during a reflective dialogue, “I am more comfortable to discuss sexuality... I do not feel shy or embarrassed any longer.” Pleasure was discussed in the context of decisionmaking and consensus between adults. Staff and project partners deliberated while co-producing, improvising and promoting exploration, excitement and fun. It was in this context that personal commitment to justice and “doing what is right” evolved.



Participants in CARE Vietnam's Gender and Sexuality Workshop situate sites of power, pleasure, pain and shame through bodymapping.

Once discussions of sex were normalized within the workplace setting and new perspectives regarding pleasure, empowerment and meanings applying to sexuality were introduced, CARE staff extended these conversations to their families, a sign that new changes were in the process of refreezing. As one staff revealed, when referring to her spouse, *"I need to be more expressive about my desires."* Awareness of one's needs and one's rights in the context of marriage and seeing pleasure as fundamental, offered opportunities for staff to reinterpret their roles as sexual partners.

But now I can see that I have the right to refuse sex and also I have the right to ask for sex - because I realize that women also have the need of sex. (Vietnam)

I never used to ponder that sexuality can be enjoyed also... these can be very pleasurable activities not only for you, but also for your partner. (India)

As observed in the quotes above, ISOFI perspectives often enhanced relationships between sexual partners. Moreover, individual capacities to claim agency, manifested by declaring one's choice related to both safety and desire, evolved spontaneously.

Acceptable social norms relating to sexuality were also challenged. For example, one staff member in India described a fictitious world in which a majority of people identified openly as homosexual. Her colleagues contemplated how it would feel to

be a sexual minority (a heterosexual) if such a community existed. They agreed that sexual orientation and behaviors inconsistent with dominant beliefs and norms could lead to displaced bigotry, which is antithetical to CARE's core principles. One CARE India staff reports her views: *"I will never make fun of gays. Earlier I used to think that gays are obsessed with just sex. But now I know they are normal people."*

Challenges at Home

Some staff reported that although they themselves are enlightened, they still struggle with encouraging similar change within their family and communities. While they and their spouse may be more open to transform attitudes and behaviors, many extended-family members continue to resist change as shifts in power dynamics are revealed. Staff's concern over the reaction of others when gender stereotypes are challenged is raised as a concern.

My husband and I talk very openly about sex, and he shares in the household duties. But, I can see that the change in my family happens very slowly. I wonder who to convince, how to talk with other family members about gender and sexuality... you know it's a difficult topic, especially for my mother-in-law. (Vietnam)

People around do not have the same orientation as me. For example, my wife's knowledge and awareness on gender and sexuality is different than mine. She agrees that we should share household duties, but says that I am the one in charge. I don't think that's right. (Vietnam)

What will people think if I [a man] bring the clothes to wash in the river, in front of all to see? (Vietnam)

From Personal to Organizational Change

Teams coalesced as trust was established. Greater openness extended beyond gender and sexuality inequities that were specifically explored through ISOFI to include other forms of discrimination and injustice. Several staff reported a sense of release

Diagram 2: ISOFI Stakeholder Analysis: CARE Vietnam

Beginning of ISOFI



More specifically, the exercise led participants through a reflection on organizational elements that could either foster or inhibit integration of gender and sexuality: Who played a central role in implementing and/or influencing the ISOFI project; what were those roles; how did relationships among stakeholders evolve during the course of project implementation and with what effect; and why did roles evolve as they did. In CARE Vietnam, ISOFI began (see above diagram) as an externally prompted initiative, supported by senior managers and an ISOFI focal person. Local partners and ISOFI staff played a key role, supported by external technical resources. Key: ARMU is CARE's Asia Regional Management Unit, which is based in Bangkok.

Middle Stage of ISOFI



By the project's midpoint (see diagram above), senior managers at CARE Vietnam had handed over responsibility for ISOFI to the ISOFI focal person. She in turn had increased responsibility in managing the project and in interacting with ISOFI colleagues at CARE Vietnam. At this stage, technical support broadened to include local individuals and organizations with expertise in gender and sexuality. Local partners became more central to the process as well as project beneficiaries and community members. At mid-point, ISOFI participants recognized that a number of CARE staff were not directly involved with ISOFI and were not benefitting from the opportunity for learning and change.

End of ISOFI



ence. The Ford Foundation as a donor entered the picture as staff were thinking of pursuing funding for a second phase. Beneficiaries and community members played a more substantial role in ISOFI's implementation.

For the Vision 2008 (at right), participants indicated the importance of equal involvement among local partners, CARE staff, CARE senior management and the ISOFI focal point person. They felt in this manner gender and sexuality would be more effectively integrated into CARE systems and programming, and would be more effectively transferred to local partners. Media is introduced as a powerful communication channel for normative change around gender and sexuality. CARE Australia, CARE USA and ARMU disseminate ISOFI's learning throughout the CARE world.

2008 ISOFI Stakeholders

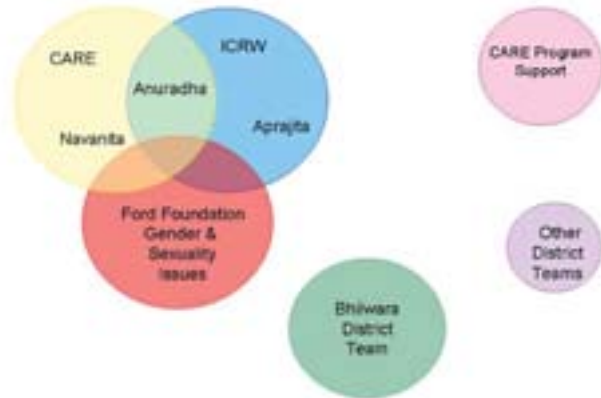


By the end of the ISOFI (see diagram left), participants felt that local partners had become more central to the initiative's implementation and success. Non-ISOFI CARE staff were pulled closer through outreach and curiosity about the ISOFI experi-

Diagram 3: ISOFI Stakeholder Analysis: CARE India

As explained in Diagram 2, during the end-of-project workshop, participants were asked to conduct an analysis of ISOFI stakeholders at three points during the project cycle: the beginning, mid-point and end. Once analysis was completed, participants were asked to envision the ideal configuration of stakeholders to be realized by 2008. In India, CARE staff consider that, at baseline (see diagram right), the three main stakeholders driving the ISOFI process are the ISOFI point person at CARE, the ISOFI resource people at ICRW and the Ford Foundation. As a new project, the CARE Program Support Unit plays an administrative role. The Bhilwara District Team that leads the ISOFI pilot in Rajasthan sees itself as distant from ISOFI in the early phases of project implementation.

Baseline



By mid-point (diagram left), stakeholders have shifted considerably. Central figures in implementation comprise a small group of people and external resource organizations (e.g., ICRW, CREA and TARSHI) directly involved in creating and supporting the learning, reflection, application on the ground and documentation. Staff emphasize the critical role of the CARE country director in providing feedback on the team's efforts and indicating his strong support of the initiative. At this stage, the district team also names an ISOFI point person to centralize communications.

Midpoint



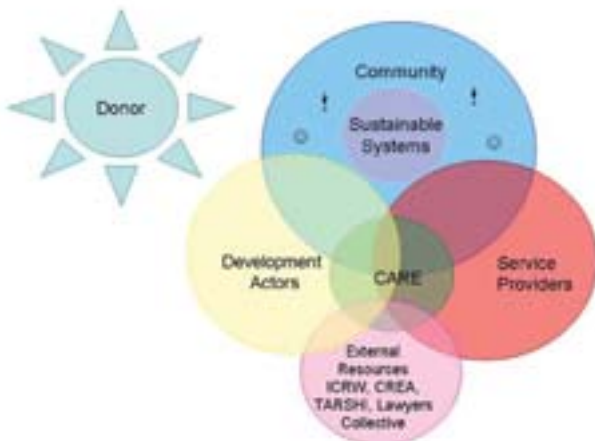
By endline (diagram right), NGO partners, community members and service providers play a much larger role in ISOFI's implementation. This configuration reflects the district team's success in transferring knowledge on gender and sexuality and ISOFI IS skills to NGO implementing partners, and the emerging change within communities. Note as well the introduction of the CARE MOLD Unit, which is the internal learning unit for CARE India. District team members were deeply concerned about documenting ISOFI's success for replication and scale up.

Endline

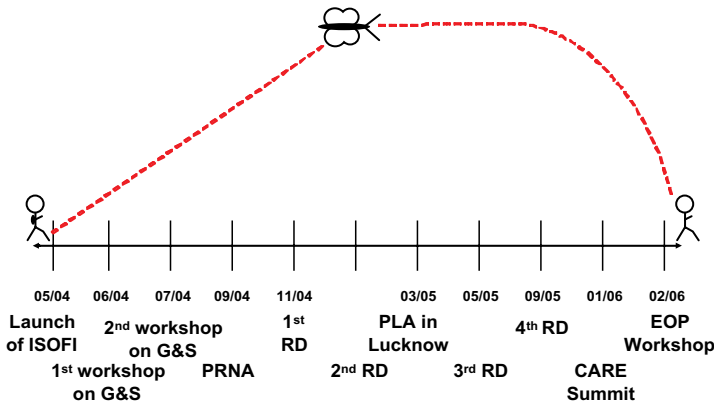


As a vision of an ideal configuration of stakeholders (diagram left), the community, service providers and development actors (including NGOs, government and to some extent the private sector) take center stage in sustaining ISOFI's implementation. CARE is still centrally involved but its role shifts to one of support and accompaniment. The external resource organizations continue to refresh the process with new perspectives on gender and sexuality, communication techniques, methodologies for evaluating progress, and materials. The staff clearly demonstrate their appreciation of a "Donor Sun" to support the initiative and help it grow.

Vision 2008



ISOFI Timeline Rajasthan



Initially we thought [ISOFI] was going to be burdensome, but later on we were flying. (India)

and freedom with newfound perspectives. They expressed excitement in sharing ideas, new knowledge and insights.

We feel liberation and wish others could become the same way... (India)

I don't know when I started, but every night when I go to sleep, I reflect on all things that happened during the day. Since I've worked for ISOFI, I started to think about people. (Vietnam)

I think ISOFI has created a big army of passion-driven people who dream and sleep [gender and sexuality]. (India)

As staff adjusted their life to one more consistent with ISOFI principles, organizational change became inevitable. Trust and solidarity grew among team members as new RD perspectives were shared and deliberated, and action was agreed upon collectively. As a result, communication among staff and with supervisors improved. But it was the staff who changed the course of action at CARE. Supervisors provided and protected the space. Experience revealed that shared assumptions or norms cannot be changed one individual at a time. The critical interplay between the system and the individual (Schein, 2006) became apparent as ISOFI project staff observed how CARE influenced staff through relationships and at the same time, how staff changed CARE as they themselves changed.

Mainstreaming gender and sexuality work requires a radical change of mindset and behavior, which places relationships at center stage.

I think the best thing that happened is [ISOFI] helped in improving team work because the barriers diminished... it helped in building understanding, I would say, a team able to relate to each other. (India)

It helps us to share experiences among ourselves; that way we can see gender, diversity and sexuality in our own organization. (Vietnam)

Our team relationship improved and became friendlier and more open. We gained confidence and built camaraderie around ourselves. (India)

We fear the jokes [of working on a sex project], but we also relish the opportunity to influence ourselves and our organization. (India)

Staff reported that they developed into more effective colleagues and partners. Reflections and new perspectives lead to actions that were not pre-determined based on conventional program practices. Some staff expressed concern, however, about the seeming ambiguity and lack of clarity, since preset agendas and workplans were not forthcoming. They felt a need for more structure and conventional forms of program measurement and evaluation. Concerns were reported as follows:

But even at the first workshop or the "orientation workshop," I wasn't clear about the concept, because at that time they didn't provided the guideline of activities or objectives, and the way we integrate sexuality and gender into the existing activities of our project. (Vietnam)

We need to spell out more clearly what we want. Like, you know, the objective of ISOFI so that we can interlink it with programming. (India)

We were excited about working on gender and sexuality but we also had fears and apprehensions. We asked ourselves, what should we do, what will this mean to us? What will happen to our privacy? (India)

By and large, staff became comfortable with the murky (often perplexing) mental terrain that accompanies critical examination of oneself and one's relationships. Reflective practices facilitated reex-

amination of once deeply held assumptions among many staff members. In many cases, this produced tension and uncertainty within the group. Within six months, however, staff relied more on intuition and learning through innovation and reflection than on a fixed approach based on a conventional gender mainstreaming model.

While embracing new attitudes and beliefs related to gender and sexuality, they also adopted an autonomous working style. It encouraged both independent thinking and team collaboration, which instigated meaningful action. As a result, staff became committed to the ISOFI process and more confident in once unfamiliar territories. Examples include:

In the beginning, I found it difficult to find the answers on my own. I wanted more guidance. But today I see the advantage of the ISOFI approach. I can do things on my own together with the team. Now we would like our supervisors to have more confidence in us to take the next steps in ISOFI. (India)

ISOFI didn't push us to learn or integrate certain things in our projects... it let us feel comfortable and if we feel it is necessary, we find a way to integrate it into our work. (Vietnam)

ISOFI doesn't tell you what to do. It just lets you grow and helps you to learn with your mistakes. It has helped us to actually take ownership. I think that this is what it has done for the entire ISOFI team. (India)

We had the liberty to design and create interventions... (India)

Gradually, institutional policies changed. For example, both CARE Vietnam and CARE India designated a point person to lead gender and sexuality integration activities. To ease the burden of childcare for staff, one of the ISOFI sites established a crèche. A community of practice was established in another ISOFI site to enhance learning among and between CARE staff and communities. Since ISOFI did not provide directives or top-down instructions, managers developed solutions based

on reflections from staff and learning from the field. Consequently, staff claimed that supervisors became more supportive, and supervisors reported that ISOFI strengthened them in their role as managers.

There is increasingly more support among management who believe work on gender and sexuality are important. (Vietnam)

I am a better supervisor now... There are no definite answers in the realm of gender and sexuality, so we are okay with making mistakes. (India)

Conclusion

The findings reveal that personal change took place across all ISOFI sites in India and Vietnam. These changes impacted not only CARE staff but also their families, communities and the CARE organization itself. Staff in Vietnam discussed obstacles and concerns they confronted, particularly in their attempts to intervene with gender and sexuality messages in their families and communities. In contrast, Indian staff reported stories of change within their family, communities and their teams. In both countries, the participants believed that strong support from CARE and ICRW staff enabled the project to move forward successfully. While staff from both countries cited that the lack of clear goals, objectives and outcomes represented challenges, they also appreciated the fluidity and flexibility offered through the ISOFI approach.

During the first year, CARE and ICRW focused on fostering personal change - transforming inner spaces - through reflection. Reflective learning methodologies first developed by Freire (1985) and Lewin (1946, 1951), gave rise to uneasiness, particularly with the introduction of sexuality in the early stages of exploration. As staff became more comfortable with the material and new processes of engagement, greater openness, confidence and leadership emerged, particularly among women,

who assumed the leadership role in ISOFI. Male staff changed the way they understood and practiced gender equity. Consequently, personal transformation led to organizational changes, reflected in policies such as appointing gender and sexuality point persons. But more importantly, staff worked more cooperatively and thereby continued advancing collective action practices that support women's rights through new understandings of sexuality. This included working with men to reconstruct masculinities that are less harmful to both men and women. Parallel changes among staff and the organization present opportunities for reciprocal learning between the individual, team and the organization as a whole. This chapter explored these personal and organizational transformation processes that took root at CARE through ISOFI. It represents the basis for programmatic change described in Chapter 4.



A folk theater team from Rajasthan used findings on coercive power relations between truck drivers and cleaners to begin to address, through puppetry, the causes, manifestations and consequences of these power imbalances in the context of HIV/AIDS.

Chapter 4

Outer Faces: Field Application and Program Transformation

Before [ISOFI] a good girl was someone who stayed home and was sweet; now we believe that standing on your feet is a good thing. (Adolescent Girl, India)

The vagina is the future and happiness of the family. (Vietnam)

Like my father, there was no education for me or my sister, but I send my daughter to school. My father scolded me so I explained it to him. (Migrant Worker, India)

Introduction

Gender and sexuality-related inequities lie at the root of poor sexual and reproductive health, including HIV/AIDS risk and vulnerability. As implied within the ISOFI framework, personal learning and change around gender and sexuality will, in turn, lead to desirable changes in field practice – and will foster improvement in program quality while enabling community agency. When commenting on ISOFI’s effect on program strategy, a staff member from CARE India remarked, “*empowerment within is important as we work towards empowerment of communities.*” This statement encapsulates the spirit of ISOFI, serving as the root of its success. This chapter focuses on “empowerment of communities.” It builds on previous chapters by describing ISOFI field applications and their transformative effects on programs.

As findings from ISOFI reveal, sexuality is part of life. Whether for physical, emotional and psychological well-being or whether for livelihoods, sexuality is central to human existence. Sexual rights are a precondition not only for reproductive rights, but also for gender equality (Cornwall, 2004). Viewed as a site of oppression through an almost exclusive association with disease, danger and overpopulation (Gosine 2004; Vance 1984; Jolly, 2004),

sexuality is largely avoided by development practitioners. Widely held as key preventive measures in the larger interest of the public’s health, interventions that restrict sexuality have come to the forefront in recent years.

Gender power relations are rarely taken into account when trying to understand human sexuality (Dixon-Mueller, 1993). As the ISOFI pilots illuminate, several masculinities coexist, ranging from dominating to accommodating ones. Through ISOFI exercises these masculinities are examined, opening them up to reconstruction by rewarding those masculinities that emphasize reconciliation, self-analysis and collaboration (Connell, 2000). A combined framework consisting of both public health and human rights provides an opportunity to understand what is meant by women’s rights vis-à-vis men. Understanding the ways that sexuality influences gender places women in a new perspective - as resilient, rather than as victims – and provides the groundwork for promoting women as agents of change. Human rights principles offer strategic tools for advancing well-being, centering on women’s ability to set the course of their own lives (Gupta 2003; Freedman, 1994) and men’s opportunity to explore and recreate gender and sexuality constructs that reflect cooperation and justice.

This chapter reports on the extent to which ISOFI changed the nature and content of CARE’s health interventions and influenced program implementation. Findings demonstrate the ways reflective and participatory methodologies, when applied to integrating gender and sexuality, lead to real, tan-

gible change on the ground. CARE works through partners in-country, namely government agencies and NGOs; this chapter summarizes changes reported by partners in all three ISOFI pilot sites, two in India and one in Vietnam.

Background

In addition to individual and organizational change among CARE staff and systems, changes were also observed among partners and/or communities in all three ISOFI pilot sites. As reflected in the literature above, gender inequities represent key underlying causes of vulnerability affecting reproductive health and HIV/AIDS risk. A key program assumption – that norms of sexuality affect gender roles and behavior in SRH and HIV programs – was explored through qualitative methods described in Chapter 2. Through ISOFI, CARE and ICRW found that exploration and familiarity of one’s own sexuality, for example, reduces prejudice, expands comfort zones and eases communication around sexuality. Greater ease, in turn, enhances counseling on condom and contraceptive use, for example, which is often reported by field staff as an embarrassing undertaking.

As discussed in Chapter 2, ISOFI consists of a series of intervention modules that enhances personal and organizational learning and change. The fifth intervention module comprises Participatory Learning and Action (PLA) exercises structured around gender and sexuality with target populations (e.g., truckers, sex workers and lactating women). Building on cumulative learning generated through the first four intervention modules and ongoing project work, the PLA exercises are conducted in collaboration with implementing partners and target groups. Their specific purpose is to gather information around gender and sexuality as they relate to a particular theme, for example, reducing vulnerability to HIV/AIDS. During the PLA, CARE field staff are able to communicate previous relevant learning around gender and sexual-

ity to implementing partners and target groups, while all three parties are involved in gathering intervention-specific information around gender and sexuality to refine project strategies, interventions and activities.

Accompaniment Through the Messiness of Altering Long-Held Beliefs

Once CARE staff were themselves more comfortable with gender and sexuality, their roles became that of facilitators, supporters and innovators as partners increasingly assumed more direct responsibility for the application of ISOFI to field activity. CARE staff accompanied partners throughout their learning process as NGOs gained new insights and capacities through supportive coaching, co-facilitation opportunities and joint reflective practice. NGO and government partners became more confident dealing with gender and sexuality as they explored their own internal beliefs and values related to gender and sexuality. One ISOFI site in India established a gender and sexuality “community of practice” consisting of staff, partners and community members. The members of the community of practice use storytelling techniques to facilitate dialogue and share lessons learned through ISOFI.

As with all development work that seeks to change social norms, critical and potentially harmful reactions can and do occur. Such was the case of a potentially violent incident in Lucknow, India, involving a young married woman previously beaten by her father-in-law for participating in an ISOFI-sponsored activity. In her determination to attend the activities a second time, she slipped out of the hands of her father-in-law in his attempt to beat her for leaving home against his orders. In response to this and other such incidents, CARE staff reflected carefully on whether and how to get involved in domestic violence within the community. Rather than advise the young woman whether or not she should continue to attend ISOFI activities, the CARE staff accompanied community

women who were angered by the violence committed against many women in their community. The women convened to develop and implement a strategy to address male-perpetrated violence against village women. Two years later, CARE staff report a dramatic decrease in male-perpetrated violence against women within this community. In another ISOFI site where violence against sex workers was rampant, government counterparts such as law enforcement agencies, which are known to perpetrate frequent and severe abuse against sex workers, now request technical assistance from CARE and its implementing partners to support their learning around gender and sexuality. As discussed with ISOFI implementers, harm may arise when intervening in communities, not due to reflective interventions but because of the inequities already entrenched in most societies. Reflective practices bring these issues to the surface, providing opportunities to contemplate action.

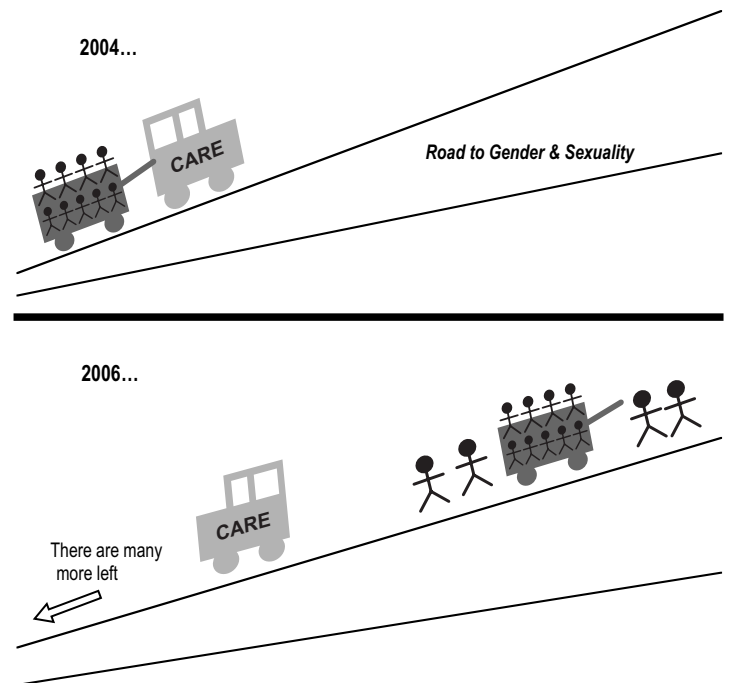
As reported by NGO partners in India and Vietnam, ISOFI has positively influenced their performance working with the community on reproductive health and HIV/AIDS interventions:

Before the training, I was ashamed of my work with sex workers. Now I realize how important this work is. (NGO Partner, India)

CARE partners are more confident to provide counseling, and they are able to talk without shame and shyness. (Vietnam)

Voices From Field Staff and Partners

Partners have been critical to the ongoing success of ISOFI. Not only for the purpose of scaling up and enhancing the spread of innovations, but also to ensure continuity and connection to community systems such as the local village governing councils in Rajasthan or the youth unions in Vietnam. ISOFI worked with partners on two levels - those that staff learned from and those that staff transferred knowledge and capacity to. Expert NGOs, including CREA, TARSHI, CHIP, LIFE, pro-



CARE staff depict ISOFI in 2004 as a CARE Jeep pulling staff, NGO partners and community members up a steep learning curve. By 2006, many individuals are comfortable with the concepts of gender and sexuality, several move fast ahead on the issues, while others return to former values and norms. CARE is returning to assist more people to transform their attitudes, beliefs and practices around gender and sexuality. (India)

vided invaluable grounding through gender and sexuality training in the early phase of ISOFI. They accompanied staff through consultations and reviews. ISOFI implementing partners consisted of government counterparts from the ministry of health in India and ministry of youth and women's affairs in Vietnam. NGO partners included those working locally, consisting of health and welfare NGOs in India and youth NGOs in Vietnam. The ISOFI team aimed to influence partners on ISOFI principles while also building local capacities directed toward local contexts and needs.

Changing What We Do:

New Interventions Show Promising Results

When I participated in ISOFI activities, we normally talked and shared personal opinions. So I used this same process to discuss with the project partners and communities. (Vietnam)

We had a cross visit for the community women - a big achievement. We gained huge trust from the community. Community women were allowed to go with us. It was a high. (India)

CARE staff worked differently after adopting ISOFI principles and practices. Members' transformational experiences generated new program designs and activities, particularly behavior-change activities, that were continually analyzed and reshaped. In India, staff implemented a cascade of capacity-building exercises designed to multiply ISOFI's effect across implementing partners. As CARE staff completed ISOFI modules and exercises, they applied a similar process to their collaboration with state-level bureaucrats and district-level government workers. In India in particular, NGO stakeholders operating in ISOFI sites participated in most ISOFI activities and events. A state-level advisory committee was created in both Indian states for community health needs, in which gender and sexuality were included. CARE staff reached communities through partners. At each level, ISOFI implementers established trust as relationships grew through consistent interaction and by consciously acknowledging participants' local expertise.

People Change While Programs Transform

HIV-infected men seem to have as much difficulty with social contact and relationships as women. Women do not dare to expose themselves to other people and the community. So I have come up with different approaches to work with these differences. (Vietnam)

But things have changed a lot for me. In the beginning, I wasn't allowed out of the village. There were constraints on my mobility in this village since it's my marital - not natal - village. So there were restrictions on where I was allowed to go. Imagine? I was the village Angan Wadi worker, but not allowed to visit the homes [to do what was expected of me]... Now I visit all the homes. What influenced my husband was my own personal change, but also the men's meetings also influenced my husband. (Angan Wadi Worker,¹ India)

In addition to personal experiences that promoted critical examination of biases, ISOFI improved program quality by enhancing behavior and social change approaches. For example, ISOFI-informed training of trainers for health service providers helped change provider attitudes toward high-risk groups, youth in particular. ISOFI principles have been integrated comprehensively into capacity-building strategies rather than handling gender and sexuality as stand-alone sessions. In reference to new and modified interventions, one staff member from CARE India reported: "We discuss every-

Diagram 4: Bodymapping Exercise



CARE field staff adapted ISOFI modules and tools to suit the needs of implementing partners. An ISOFI workshop designed for local NGO partners in India included experiential exercises exploring how sexuality mediates gender constructs. In this workshop, staff avoided a narrow problem-focused perspective on sexuality, concentrating more on a sex-positive approach. In the course of the workshop, participants defined sexuality as "whatever we feel about sex, like singing," "dancing, playing;" "a belief based on human values... which keeps on changing with the time."

CARE staff also facilitated a body-mapping exercise that explored points of power, pleasure, pain and shame, a very popular exercise with ISOFI-trained staff that allows participants to reflect on personal experience. As reported by workshop participants, body mapping serves to "decrease shyness" and provide "good information about the opposite sex."

Right, a field exercise with recently married men in rural Lucknow District, India.

¹ The local health volunteer, or Angan Wadi Worker (AWW), is the infant- and child-development services field worker, sponsored by the Indian government. She receives a token compensation for her activities at the Angan Wadi Centre (AWC), where she provides supplementary nutrition for children and pregnant and lactating women; immunizations; nutrition and health education. There is one AWW per AWC; there is one AWC for a catchment area of 1,000 people.

thing, topics related to homosexuality, adolescent sexuality, extra-marital and premarital affairs.” Field staff spent evenings and weekends gathering together to discuss gender and sexuality. Using a gender and sexuality lens in their daily work became a matter of course, e.g., in designing baseline surveys, creating programs and information, education, communication (IEC) materials and training new staff.

To manage sensitivities related to sexuality, CARE staff in India focused on using sexuality concepts as a way to strengthen the family. An entry point to address a once taboo subject, the family represented a way to remain within cultural boundaries. Within this framework, staff covered several topics including: communication between husband and wife, and mothers and daughters; increased nutritional intake for girls; sending girls to school; and violence against women, including sex workers. By and large, these themes represent protective behaviors to reduce the risk of HIV transmission and improve reproductive health. Within this context, staff and partners integrated reflections on sexuality and its effect on gender and health into activities as a matter of course. Discussions emphasized pleasure, not as a separate issue but within the context of risk reduction.

ISOFI training exercises also included exploration of the world of sexually-marginalized groups. Discussions centered around sex workers, people who have sexual relations before or outside marriage, and homosexuality. Together with implementing partners, staff undertook various creative exercises, such as drawing images of the socially-defined “ideal man” and “ideal woman” to stimulate discussion on norms, conformity and social pressure. When challenges arose in assisting NGOs and community groups, CARE staff developed new exercises to overcome these challenges. (See Text Box 5 below.)

Many partners and community members involved with ISOFI indicated that their inhibitions reduced dramatically. In Vietnam, monks told staff that prior to ISOFI, they felt shy when their clients visited the pagoda to talk about condoms and their sexual relationships with HIV-positive people. When sexuality was first raised in ISOFI, they felt uncomfortable, since it contradicted certain Buddhist tenets restricting monks from sexual activity. Once they realized that desire and pleasure are linked to life and death, they began to discuss sexuality with greater ease and to value its importance when engaging with their communities.

Text Box 5: Imagine a World in Which... Reflection through Storytelling in India

The Story: *One day you are passing through a forest. There, a magician transports you 60 years into the future. In this new world, the majority of people are homosexual. A small percentage of people are heterosexual. Heterosexuals don't disclose their sexual orientation to others, as others do not accept heterosexuality there. Your sexual identity in the future is the same as it is today. In this situation, what will you do, and how will you feel?*

In response to entrenched attitudes among NGO implementing partners about sexuality and their denial that homosexuality is practiced in India, ISOFI staff developed a series of exercises meant to unfreeze these attitudes. This storytelling exercise featured several interactive exercises on gender and sexuality. The story sparked considerable debate. During the course of the storytelling exercise, participants voiced the following reactions to the scenario:

They feel awkward;
Will have relations with other heterosexuals secretly;
Opposite situation is difficult and bad;

No need for family planning;
No pleasure;
Threat to masculinity;
Will change [sexual orientation] according to the situation.

By the end of the workshop, participants made the following observations:

Homosexuals can also live life freely like heterosexuals. We should not discriminate against them;
We should give more importance to personal feelings than social constraints;
We shouldn't make decisions due to the fear of society.

ISOFI staff felt that the story had been very successful in opening channels of communication. During the ISOFI end-of-project evaluation, many NGO participants mentioned the exercise and the workshop specifically as significant to their personal learning and change around gender and sexuality.

Resistance as a Sign of Engagement

Some partners were a little skeptical because they thought that we were biased towards women and were providing information in favor of women from a gender point of view. (India)

Sexuality and pleasure is very sensitive to discuss, so we don't talk much about sexuality. (Vietnam)

While new modes of working inspired quality programming, some staff also reported challenges. CARE staff and staff from implementing partners often raised challenges in relation to sexuality and, at times, gender, including concerns about how they would be perceived by their communities if they were visibly supportive of gender. Sometimes staff viewed these challenges as a setback and grew frustrated with other, less supportive team members. A few people shifted back and forth within their positions on gender and sexuality, while leaders, passionate about recent insights, began to emerge. What did not arise, however, was heavy resistance from the field. Communities did not oppose discussions challenging entrenched beliefs regarding gender and sexuality, as was anticipated. Instead they welcomed reflective experiences, particularly those that discussed social restrictions, such as caste and ethnic differences.

Voices from the Community

The barriers between castes have broken. Now we are more of a friend. Earlier we used to discriminate a lot. As we started coming together and attended several meetings, all hesitations have washed out. To hell with the caste system. All humans are alike and same, their blood, too. Then why should we discriminate with others. (Young Woman, India)

ISOFI approaches are situated within local contexts and address real-life issues. In large part the explanation for communities' willingness to participate and to endorse findings. As a dialogical process, ISOFI prompted open communication in defined and maintained "safe" spaces. As they shared experience and insights into gender and sexuality, women's and men's stories spanned generations and ethnic groups. These differences

helped to provide a rich and diverse social context in which to question boundaries and restrictions, such as those produced by caste and ethnic differences.

Women's stories

We are more cohesive as a group of women. We have sessions where we tell stories.... We are no longer afraid. (Women, India)

We live in different corners of the village, so we don't meet often. Now we have met new friends. (Women, India)

ISOFI interventions with women in rural Indian communities focused largely on strengthening the *mahila mandals* (women's group) through village *Angan Wadi* workers.¹ One of four *mahila mandals*, strengthened through ISOFI, described their story. Prior to ISOFI, many of these women remained secluded within their homes and were not aware that they shared common problems with women living in the same village. Through ISOFI exercises, they became acquainted, realizing they shared similar concerns. After reflection and dialogue, they took collective action in their community to address their shared agenda: strengthening family relationships, particularly between husband and wife; shifting bias against the female child; and reducing violence against women. ISOFI implementers accompanied partners and the community through these processes.

Family Relationships as a Site of Resistance and Change

A lot of things changed in me personally. There is better communication with my husband. At first he thought it was odd to discuss things... the first time he laughed. CARE encouraged us; so I said to him, you won't get angry. If we don't talk about likes/dislikes, things will go unresolved. So he likes talking now. [Smiles]. (Angan Wadi Worker, India)

Earlier, our husbands got angry. Now I share and he listens and he doesn't get angry. (Community Woman, India)

Interventions to improve family relationships occurred through various approaches. Staff in India believed that sexuality themes were best discussed

in the context of the family during this entry stage. While staff were aware that traditional family models were not the only way people lived, they felt that a family focus was necessary while introducing potentially sensitive topics related to sexuality. Staff designed activities to promote couple communication. For example, they engaged newlywed couples in role plays related to gender. ISOFI teams organized picnics outside the village setting where newlyweds felt less constrained to try on these new roles and behaviors. Storytelling exercises, to share personal narratives, were also initiated.

After doing the body-mapping on myself, I feel less embarrassed to talk about sensitive body parts. Only if we can break the iceberg inside ourselves can we work with communities. (Youth Union Director, Vietnam)

In the earlier days, my husband wanted sex every night and would beat me if I didn't agree, even though I had swelling in my groin. Now he has reduced to having sex with me every three to four days. Now if I have pain, he stops, and doesn't beat me any more. I can even enjoy sex now. And I, myself, have initiated sex. This makes him happy. [Laughs]. (Angan Wadi Worker, India)

The vagina is the center of the city and the rest of the body is the suburbs... it is the site of intense pleasure but also the pain of child birth. (Sex Worker, Vietnam)

As these quotes demonstrate, several community women understood sexual pleasure to be an im-



During bodymapping in Vietnam, participants discussed parts of the body that are generally not discussed in public. This led to open discussions about sensitive topics.

portant aspect of strengthening the family. Awareness of one's own desires while also understanding one's rights helped women negotiate sexual interactions with their husbands. Once trust was established and facilitators gained confidence, community members shared personal narratives with one another, even in villages widely held as conservative strongholds in Indian society. Similarly, CARE Vietnam conducted participatory workshops that revealed the same kind of candidness within groups, particularly once they completed the body-mapping exercises.

Violence Against Women and Women's Mobility: What Does Sex Have to Do With It?

Staff accounts and women's stories reflected a reduction in violence against women in ISOFI communities. One village demonstrated success through the work of the *mahila mandal*. The village *Angan Wadi Worker (AWW)* described a case in which a man from the village battered his wife so heatedly that the entire village could hear. After one particularly severe incident, the transformed *mahila mandal* convened in the AWW's home. After reflection and deliberation, they concluded that an intervention was necessary and collectively proceeded to the perpetrator's house. The *Angan Wadi Worker* described what happened:

When we arrived, we saw that she was badly beaten and she requested that we call the police. We took her out of the house. Then he went to beat her in the rescuer's home, but the women took a stick and threatened to beat him. He went away. This incident has affected other men. Seeing women together, the men in our village do not beat their wives so much these days... Now I rarely hear complaints of abuse. (AWW, India)

Beating has gone down in our village. I visit homes, and now women share about themselves with a smile, rather than stories of being beaten [as before]. (Community Woman, India)

Women in communities frequently cited "increase in mobility" as a result of CARE's ISOFI interventions. The norms governing women's mobility in part reflect the level of women's autonomy

(Koenig, Ahmed, Hossain & Mozumder, 2003; Jejeebhoy & Sathar, 2001). Within Indian ISOFI sites, this translates into patterns affecting both young girls and adult women. Young girls, for example, are absent from school, while adult women are not permitted to travel outside certain geographic parameters. This includes restricted movement within the village, and even within the boundaries of the home. The most frequently reported explanation for restricted mobility is the fear that unmarried girls would “become pregnant if traveling unaccompanied” and that adult women would become “out of control” or someone might “make offensive comments” or “touch” them which, according to a local community member, “would be a disgrace to the family, and more so to the men of the family.”

In the earlier days, we stayed in home. Since CARE’s work, it helped us come out of the home and discuss issues like raising the girl child. The school is far (3 kilometers). Now we feel girls can go to school - though they are scared - and not just the boys. They now go in a group accompanied by an adult. ISOFI messages encouraged this change. (Community Woman, India)

The thinking of the community about women has changed. Earlier we were not allowed to go or sit anywhere. Now we can easily go and sit where we want. (Young Women, India)

Social-mobility-mapping exercises guided discussions regarding restricted mobility and its link to gender and sexuality. Several drawings revealed women moving only as far as the boundaries of their home and rarely outside the village. Reflections on this mapping exercise illuminated inequities linked to gender and sexuality that participants considered when contemplating action. Several women reported how they gained greater independence through resistance, and also by modeling behavior to one another. Several women report:

[The husbands] let us go out. When I went to a household, I could never see the face of women, since I was veiled. Now women are unveiled in the home. Now when they go out, they wear a veil, but don’t let it cover the face. (AWW, India)

*I used to **not** go out... Now we [in the village] watch each other go out... so, now we’ve all started going out. (Woman, India)*

Young Women’s Stories

Before (ISOFI), a good girl was someone who stayed home and was sweet. Now we believe that standing on your feet is a good thing. (Young Woman, India).

The Youth Union and NGOs have the tools now, and use them to forge new directions. (Youth Union, Vietnam)

Young women readily adopted gender and sexuality concepts by resisting inequities experienced in their families and communities. The Vietnam model focused on supporting local youth organizations to strengthen civil society and ensure sustainability. Through ISOFI applications, a local youth NGO based in Ho Chi Minh City advocated for improved sexual and reproductive health policies in Vietnam. Similarly, CARE India and partners helped form youth groups to raise awareness of HIV/AIDS risk and reproductive health. In India, the groups were separated by gender. In both settings, staff and partners integrated ISOFI principles, which led to collective agency through strengthened capacity and expanded relationships. The following quotes reveal newly acquired values, beliefs and aspirations among young women.

One girl was accused of having sex with a boy. With our new knowledge about gender and sexuality, we remembered that it’s not good to judge. It could have been me. Instead, we defended her from the taunts. (Young Woman, India)

We have established new friendships with other girls from different [caste] groups. It doesn’t matter. We encourage each other to pursue our dreams. For example, one of us wants to study music. (Young Woman, India)

Confidence through Unity

We are leaders in our communities because we can share the new information and knowledge that we have. (Young Woman, India)

We now know how to talk to boys, which is a new experience for us. (Young Woman, India)

One girl's parents accepted whom she wanted for her husband... We also don't want pressure to marry within our castes. (Young Woman, India)

Gaining knowledge and social cohesion through association with neighboring youth were two of the most common factors young women cited as leading to their greater sense of agency. Increased confidence among young women enabled them to negotiate independence and a sense of purpose. Several young women reported ways they began interpreting newfound beliefs into action, particularly in relation to their family and male peers.

We changed within ourselves. Now we can talk and name our body parts, such as breasts. We can talk about menstruation. Now we don't feel scared about menstruation because now we understand it. (Young Woman, India)

We now have access to information. Before only boys had access to information on sexuality through magazines and blue films... The boys used to trick us, since we didn't have the right information. (Young Woman, India)

I changed my attitude about sex before marriage. It is not socially accepted... Doesn't the woman get to have an orgasm? Women want satisfactory sex [whether in or outside marriage]. (Youth Union Leader, Vietnam)

Using a sex-positive approach helped young women and men deal with shame and guilt related to sexuality which inadvertently led to reinforcing and creating gender and sexuality myths. Contrary to the common practice of withholding information from girls for fear that they will become sexually active, correct information on sexuality empowered young women. Moreover, they were not compelled to rely on their male peers as primary sources of knowledge.

In Vietnam they took this a step further. Community members explored prevailing values related to premarital sex. They challenged dominant beliefs about sexual debut, particularly biases against young women. As youth representatives report:

I help my children understand. Sex outside of marriage is not accepted in our society. But I have become more tolerant. If a couple doesn't have premarital sex, how can they know if they are a good sexual match? (Youth Union Director, Vietnam)

I no longer judge out-of-wedlock sex. Our goal is safe sex. (Youth Union, Vietnam)

Men's Stories and Their Myths

Reflective dialogues and workshops provided safe spaces to dispel gender myths related to masculinity. They focused on subordinated masculinities, including those identifying as homosexual or being from socially marginalized groups. Facilitators guided sensitive conversations with deference to participant perspectives in a balanced manner.

Gender Myths

I learned from [ISOFI] training that gender is socially constructed and can be changed. I had an impression that men who have sex with men are not good... Now we say that we have no right to say anything or be judgmental about it. Our thinking has changed. (NGO Worker, India)

Gender myths, portraying men as oppressors, depict a narrow view of what is actually a range of changing patterns and roles among most men. While ISOFI does not discount women's subordination and dominance by men, it goes further to explore the range of masculinities that coexist and



Depiction by an adolescent girl of an ideal couple. (India)

are socially produced simultaneously. For example, sex workers told countless stories of what sounded like aggressive (sometimes violent) male sexualities coexisting with men's desires to be nurtured and romanced. As the quotes below illustrate, ISOFI staff observed the uncertainties, difficulties and contradictions men face, which shed new light on preconceived notions of masculinity. Some stories include the following:

I can't grow a mustache, but my father and uncle always pester me about it. I'm not considered [much of a man] without one. (Male Community Member, India)

Men who went through ISOFI exercises could not persuade their wives to let him to the housework. So men need to overcome not only themselves but also social prejudices. (Key Informant, Vietnam)

It was these entry points – circumstances where gender patterns are more open to change – in which ISOFI implementers intervened. Men exploring less dominant masculinities face criticism as described in the quote above. When working collectively, through reflective processes, they have better chances of overcoming categorical biases. As one Indian migrant reported, "Now we discuss openly and our hearts are open. We no longer feel shy and can discuss about all issues." Building awareness among boys and men of the diversity of masculinities that exist, beyond the narrow gender models they are familiar with, is an important undertaking that ISOFI implementers began to tackle through PLA exercises, such as the "ideal man" and "ideal woman" exercises.

Social and Behavior Change

Now all of us use condoms with sex workers. And now we talk about family planning with our wives and female relatives... (Migrant, India)

We do not talk about sexual pleasure with women but we do talk about it with men, which we did not do before. This has led us to adopt safe sex. (Male Community Member, India)

Like my father, there was no education for me or my sister, but I send my daughter to school. My father scolded me so I explained it to him. (Male Community Member, India)

Consequently, personal change was not only reflected by improved relations at the household level but also by desired behavior change consistent with desired program outcomes. As many of the quotes above reveal, explorations into sexuality played key roles in prompting change in behavior among men interviewed.

Change is slow

One man said, "Homosexuality is wrong, and eunuchs are wrong. Going to sex workers is wrong, but it's okay to have four wives as long as it's a wife." (Migrant, India)

We are more sensitive with our wives, but not necessarily with other women. We do force sex with sex workers. (Migrant, India)

We have learned that no one is wrong and we can talk about our feelings. But we don't change overnight. (Male Community Member, India)

Text Box 6: Case Study of Youth Group Meeting on Homosexuality

In Vietnam, the youth group organized a district meeting in Ho Chi Minh City with community stakeholders from the Communist Party including, among others, the Secretary of the Communist Party, Chairman of the People's Committee, the head of the Committee on Family, Population, Children, and head of the Commune Cell in the district. Youth from the organizing youth NGO and the local gay organization, which had until this point remained under-ground, spoke publicly for the first time about homosexuality and hardships homosexual men and women experience through social exclusion. There were long deliberations representing various perspectives from the community and from a few homosexual men who came out to the group. A nonjudgmental atmosphere allowed people to discuss feelings, including sometimes offensive biases. In response to a woman who announced that she believed a homosexual man can be detected by his physical appearance because he is effeminate and has a small penis, a gay-identified speaker calmly responded, "You see me. I am strong and manly. I have a wife and children. I'm also gay, and my sexual life is vibrant. What you say is actually a myth."

CARE Vietnam staff and partners believe that the meeting on clarifying myths on homosexuality was the beginning of a longer community dialogue on sexual rights. According to one Youth Union representative, "While we have long to go, we have made an important first step by breaking the ice."

ISOFI implementers also learned that gender and sexuality interventions should emphasize improving women's agency and autonomy, but not to the exclusion of men. It is not a zero-sum game. As women are more empowered, men do not lose power. More work is necessary to cultivate power among both men and women so that dominant-subordinate relationships do not persist. As the quotes above illustrate, gender myths still exist and change is slow. While substantial progress occurred, ISOFI implementers learned that interventions must be paced, beginning with small steps. The youth groups, women's collectives and men's groups strengthened and generated through ISOFI activities are nascent, requiring more support before they can work without close accompaniment.

Male Youth Stories

Particularly tenuous were interventions with male youth. Given the focus on strengthening women's agency, CARE staff and NGOs provided more attention to female youth groups in India. Myths, biases and insecurities flourish among young men who are beginning to explore their sexualities and conflicting masculinities. According to many young men, *sanskriti* (culture) demarcates sexuality related to expression, meaning and behaviors. Conflicting beliefs about masturbation, for example, leave many young men confused. Young men have questions about sexuality, and if not adequately answered, they rely on peers, magazines and blue films.

Masturbation is unnatural, against our culture. The most natural sex is between man and woman. (Male Youth, India)

We have fears of getting a small penis and not being able to give pleasure if we masturbate. (Male Youth, India)

We want to know what is good/bad, harmful/not harmful, natural/not natural. What are the answers to this? (Male Youth, India)

Conclusion

Patterns and themes observed across all groups include enhanced confidence, group cohesiveness, awareness related to links between gender and sexuality such as mobility and decisionmaking. Most ISOFI implementers, across all sites, revealed that participatory and action research methods provide opportunities for critical communication generating new and often painful knowledge. As the narratives point out, social structures produced by gender and sexuality render positions open for scrutiny through reflective practices. The key now is to keep critical reflection and community dialogue going.

Even where progress appeared slow and uncommitted, the ISOFI team consisting of CARE staff and partners, introduced the first public meeting on myths and beliefs about homosexuals from the subject position of gay men. Diverse groups and genders provided a rich social resource, so that when effectively mobilized, it gave CARE a much greater capacity to transform itself. Indeed, CARE staff, partners and communities continue to advance this work with their commitment to reflection and action. Their commitment to deepening understandings of gender, sexuality and its relation to power, provides the impetus to support well-being for all, not only the majority. They inspire the wider organization with their resilience, openness to learn, and capacity to transform earlier beliefs to ones that reflect democratic ideals consistent with CARE principles.

Personal change was not only reflected at the individual, household and organizational levels. As this chapter reveals, it shaped programs in considerable ways. Desired behavior change, reflecting desired program outcomes, demonstrated the extent to which action research methods improve program quality while also generating cross-learning opportunities. While the investment is great, particularly in the early phases of the program

cycle, development practitioners should invest in dedicated time to personal change, while also relinquishing control of the consequences.

Practitioners engaged with gender mainstreaming still have many challenges ahead. Gender myths keep well-meaning practitioners locked into a framework that informs their advocacy platform. The victim narrative is indeed a compelling one. It is not uncommon to hear staff raise concerns of poor suffering women "out there", that require development support to "help the feeble women out of their misery."

It is not unusual to also experience what CARE refers to as "gender fatigue." The role opposite to that of female victim is that of male oppressor. Men report that this is a role they are not comfortable with but do not have the space to voice dissent. We have learned that restrictive responses to sexuality, defined as protecting women from the would-be oppressor rather than protecting women's rights, can lead to unintended harm. While policy changes have been forthcoming when using such a framework, it runs the risk of mistakenly impeding other human rights goals, particularly those enabling conditions that grow women's agency, confidence, exploration and well-being related to sexual exploration (Miller, 2004).



External technical support stimulates broader reflection within country teams and promotes sharing across country offices.



Chapter 5

Assessing ISOFI's Progress and Effect on Personal and Organizational Change

Introduction

Throughout the initiative's two-year implementation, members of the core ISOFI team conducted regular visits to ISOFI sites in India and Vietnam in order to facilitate intervention modules such as Reflective Dialogues, provide technical assistance and monitor progress. Designed as a process project, ISOFI captures learning and field wisdom through extensive documentation that encompasses detailed implementation plans, reports, behavior-change communication materials, videos, photo archives and visual outputs from Participatory Learning and Action exercises around gender and sexuality (such as social and vulnerability maps). These materials have allowed the core team to assess ISOFI's evolution as an approach to integrating gender and sexuality into CARE's programming. As seen in this report, other qualitative methodologies such as indepth interviews and focus-group discussions collected pertinent data throughout the project on personal learning and change, organizational learning and change, and field applications. As a capstone to its evaluation strategy, CARE and ICRW conducted an endline survey to assess progress against baseline on the integration of gender and sexuality into CARE's organizational fabric. Chapter 5 reports these findings, and discusses their significance.

Methodology

Baseline and endline surveys were developed by ICRW in consultation with CARE. The survey instruments consist of qualitative and quantitative questions aimed at capturing CARE staff's knowledge of, attitudes toward and opinions on the inte-

gration of gender and sexuality into CARE reproductive health and HIV/AIDS programs.

ICRW administered the surveys electronically to three types of CARE staff: 1) project management staff, 2) field staff at CARE India and CARE Vietnam and 3) global sexual and reproductive health advisors affiliated with CARE USA as well as regional management staff covering Asia. In India and Vietnam, the respondents represented a cross section of CARE staff working either directly or indirectly with ISOFI. The sample was drawn from different levels within CARE, with key representatives from senior management, middle management and implementing field teams. A total of 64 staff (India: 46, Vietnam: 12, global: 6) participated in the baseline and 40 staff (India: 26, Vietnam: 8, global: 6) participated in the endline survey. The respondents in the Endline survey were not necessarily the same respondents as at baseline. Responses are reflections on the CARE country portfolio and are not just ISOFI-related. In drawing conclusions from the resulting data, it is important to remember that ISOFI was piloted in India and Vietnam only. CARE India, CARE Vietnam and CARE International staff participated in the survey and as such, the responses from CARE Global participants will be reflective of CARE's Global portfolio, and not just those projects nested in India and/or Vietnam.

The quantitative sections of the survey were entered into SPSS for analysis. The qualitative portions were closely examined for common themes and organized into matrices to facilitate analysis.

Respondent Demographics

Out of the 64 staff who participated in the baseline survey, 30 were males and 34 females. Age of respondents ranged between 23 and 57 years, with a mean age of about 37 years. Forty-six staff were from CARE India, 12 from CARE Vietnam and six from CARE Global.

Among the 40 staff who participated in the endline survey, respondents split evenly between males and females (20:20). The age range was similar to that at baseline, with a range from 26 to 52 years and a mean age of 37.6 years. Twenty-six respondents were from CARE India, eight from CARE Vietnam, and six from CARE Global.

Findings of the Baseline and Endline Surveys

I. Progress on Integrating Gender into CARE Reproductive Health and HIV/AIDS Programs

In the **baseline** survey, the majority of the respondents from **Vietnam** reported that gender equity was being integrated into CARE reproductive health and HIV/AIDS programs because both men and women were involved in implementing reproductive health and HIV/AIDS projects, and there was no gender-based discrimination in the selection or treatment of beneficiaries.

Others reported that gender equity was integrated into CARE reproductive health and HIV/AIDS programs by addressing traditional gender roles and gender-based discrimination. One respondent noted that while gender equity was integrated into CARE reproductive health and HIV/AIDS programs, more needed to be done.

In the **endline** survey, respondents overwhelmingly reported that with ISOFI's implementation, there has been a change in CARE **Vietnam's** incorporation of gender equity in its reproductive health and HIV/AIDS programs. Respondents reported that staff were better equipped, more

knowledgeable and more aware of issues of gender equity following ISOFI. Two respondents pointed out that for those staff who participated in ISOFI, change had occurred, but that among staff who had not participated and within the larger organizational levels, change had not been as forthcoming.

At **baseline** in **India**, participants were divided regarding the extent to which gender equity was currently being incorporated into CARE's reproductive health and HIV/AIDS programs. Some participants felt that incorporation was taking place:

Increasingly there is a more deliberate and consistent approach across CARE's programs in ensuring that gender-based power relations in decision making are equitable and fair. This is across the continuum, from access to information and awareness to making decisions that have implications for community, both as individuals and as a group.

Other staff reported at **baseline** that gender equity was incorporated into reproductive health and HIV/AIDS programs but not in a strong-enough manner, and that the link between the conceptual and the practical application of gender equity was not clearly understood within the organization:

As a mission, CARE's core values support gender equity but this is not yet visible in practice within the organization. The ratio of men vs. women amongst our staff is an example. Similarly, in our programming, although we have demarcated addressing gender issues as a priority, we are still groping in the dark how to go about this.

At **endline** in **India**, the majority of respondents reported that there had been a change in CARE's incorporation of gender equity into its reproductive health and HIV/AIDS programs.

Yes, at all levels! In recruitment, amongst the NGO partners, too, we see a good gender balance and sensitivity towards the issue. Whenever we have all staff aboard, we discuss about the issue and the staff shares the implementation of the gender-related activities in the field. The reproductive health program has gained the most – specially the high-risk behavior group as we have started talking about the sexuality issues without being judgmental. At the national level, too, gender and diversity is addressed in all the programs.

However, a few respondents reported at **endline** no change or no change at the country or organizational levels in particular. Others reported not having a clear idea as to whether there had been change or not.

ISOFI implementation has to be shared to the CARE universe for it to make a difference. It has impacted those who were directly involved with the program, it is these people who could be vehicles for transmission in all states that we work in. ISOFI needs to be programmed/integrated more holistically with proper structures /leadership /understanding/ accountability/ acceptance, and not as a one-off initiative.

At the **global** level at **baseline**, staff felt that gender equity was being incorporated at a conceptual level (i.e., during design and analysis) but that beyond disaggregating data by gender, it has been difficult for program managers to implement. There was also the feeling that traditionally, CARE tends to "target" women without addressing men's roles:

I think it is relatively well understood at a conceptual level in CARE that we are seeking ways to promote both the rights and empowerment of women throughout our programs. Realistically, I think it's hard for the RH programs to actualize this. I find that HIV and RH programs target women (and marginalized groups) particularly as people for whom they are hoping for behavior change or for women to "demand their rights," but often fail to achieve "empowerment." We don't have good conceptual grasp of gender equity as it relates to health, nor ways to measure it.

At **endline**, **global** staff reported that there had been changes in that CARE was incorporating gender equity considerations more into their programming; however, multiple staff indicated that this was part of a larger shift within the organization. While the staff recognized that ISOFI had played a part in enhancing the emphasis on gender within CARE, they mentioned that there are other supportive forces at play.

2. Integrating Sexuality into CARE Reproductive Health and HIV/AIDS Programs

In **Vietnam** at **Baseline**, staff were split regarding the extent to which sexuality was being incor-

porated into reproductive health and HIV/AIDS programs. Some respondents strongly felt that sexuality was being incorporated. Many felt that sexuality was being incorporated but that more still needed to take place. Other respondents felt that there was lack of understanding among staff regarding the value of incorporating sexuality into reproductive health programs:

Issues of sexuality are probably addressed much less clearly than issues of gender. Whilst information in relation to sexual health is a key part of CARE's reproductive and sexual health programming, issues in relation to sexuality and societal and social norms related to sex are often not addressed special in CARE's programming, as they are often sensitive and are also influenced by the personal opinion of staff.

In **India** at **baseline**, some respondents felt that sexuality was being incorporated into CARE reproductive health and HIV/AIDS programs by addressing such issues as the right to safe sex and reproductive health through IEC materials and campaigns, and through behavior change interventions to reduce risky sex. The majority of respondents, however, did not think that sexuality was being incorporated into CARE programs:

Very inadequately. Like most Indians I feel that the subject of sex is taboo in CARE as well. CARE still does not talk of same-sex sex and has no problem for eunuchs. While CARE is comfortable working with heterosexual prostitutes but not with male prostitutes.

There is no specific issue to our knowledge which takes care of the sexuality into CARE's reproductive health and HIV/AIDS program. I think only the rights to have "safe sex" have been incorporated in the HIV/AIDS program.

All of the **global** respondents felt that sexuality was not being addressed adequately in CARE reproductive health programs.

At **endline**, respondents were asked, "With ISOFI's implementation do you think there has been a change in CARE's incorporation of sexuality in its reproductive health and HIV/AIDS programs? If yes, how? If no, why not?" Some respondents reported that

there had been a positive change either in personal or organizational contexts, but most across all groups reported little organizational change. Respondents from **Vietnam** explained that there had not been change with CARE systems yet, but that the seed had been planted. Among **Indian** staff, the responses were split. Many respondents spoke of the need to extend change beyond the districts in which interventions had taken place. **Global** staff overwhelmingly answered that change will only occur at the upper levels of management, if the issues keep being pushed forward.

I think that gender will be integrated, because it's a priority of both the donor, the country office and the regional management unit. However, I'm afraid that we'll lose the focus on sexuality unless someone pushes the idea. (Global)

Yes there has been a change in CARE's incorporation of sexuality in its reproductive health and HIV/AIDS programs but that's limited to piloted districts only. The learnings of ISOFI are limited to district teams or Regional Managers. The higher officials or other district team members have different view. (India)

3. Staff Commitment to Integrating of Gender and Sexuality

At **baseline**, in response to the statement that "CARE program staff believe that it is critical to incorporate aspects of gender into reproductive health and HIV/AIDS programs," the majority of staff in India (54%) reported "always" compared to 36% in Vietnam and 33% among global respondents. The majority of staff (50%) in the global site responded occasionally, compared to 36% in Vietnam and 34.8% in India. Overall, the majority of

Table 1: Staff Beliefs About Incorporating Gender and Sexuality into Programs at Baseline

In my experience CARE program staff believe:	Vietnam (n=12)	India (n=46)	Global (n=6)
That it is critical to incorporate aspects of gender into reproductive health and HIV/AIDS programs.	36.4% always 36.4% occasionally 18.2% rarely 9.1% never	54.3% always 34.8% occasionally 8.7% rarely 2.2% never	33.3% always 50% occasionally 16.7% never
That it is critical to incorporate aspects of sexuality into reproductive health and HIV/AIDS programs.	36.4% always 36.4% occasionally 9.1% rarely 18.2% never	26.1% always 26.1% occasionally 41.3% rarely 6.5% never	16.7% always 66.7% rarely 16.7% never

Table 2: Staff Beliefs About Incorporating Gender and Sexuality into Programs at Endline

In my experience CARE program staff believe:	Vietnam (n=8)	India (n=46)	Global (n=6)
That it is critical to incorporate aspects of gender into reproductive health and HIV/AIDS programs.	100% always	65.4% always 26.9% occasionally 3.8% never	66.7% always 33.3% occasionally
That it is critical to incorporate aspects of sexuality into reproductive health and HIV/AIDS programs.	75% always 25% occasionally	46.2% always 38.5% occasionally 11.5% rarely	33.3% always 33.3% occasionally 33.3% rarely

staff across all three sites (73% in Vietnam, 89% in India, and 83% of global respondents) reported that in their experience CARE staff believed it was critical to incorporate aspects of gender into reproductive health and HIV/AIDS programs (See Table 1).

At **endline**, percentages of “always” and “occasionally” reports of gender integration increased across the board, with Vietnam having the largest percent change - with a leap from 36.4% reporting “always” to 100% (See Tables 1 and 2).

In response to the statement “*CARE program staff believe that it is critical to incorporate aspects of sexuality into reproductive health and HIV/AIDS programs,*” fewer staff reported at baseline that it was always or occasionally critical to incorporate sexuality into programs. At the global and India sites, the majority of staff reported “rarely” (67% and 41%) and in Vietnam 18% reported “never,” compared to 7% in India and 17% among global staff (Table 1 above). At **endline**, however, many more staff reported that it was important to program staff to incorporate sexuality into their programming. All groups had increased percentages of staff reporting “always” and “occasionally,” with the Vietnam team boasting the most change (See Table 2).

Apart from comparing **baseline** to **endline** perceptions of the importance of including gender and/or sexuality in CARE programming, there are some interesting findings on the relative importance of integrating the two concepts. Whereas at **baseline** nearly 75% of respondents said their fellow staff thought it was “occasionally” or “always” important to incorporate gender, only 45.8% could say the same for sexuality. This relationship remained the same at **endline**, where 73% of respondents thought staff found it important to integrate gender into their programming, whereas only 50% could say the same for sexuality. No association

seems to exist in **baseline** or **endline** data between the gender of the respondent and their views on the importance of integrating gender into programs.

In order to understand whether amount of participation in ISOFI had a difference in respondents' assessment of their resulting skill levels at endline, respondents were grouped into either "direct participants" or "indirect participants." In order to be characterized as a "direct participant," the respondent had to be part of the ISOFI core team. An "indirect participant" was one who had infrequent involvement with ISOFI.

Whether the respondent was directly or indirectly involved with ISOFI did seem to have an effect on their views on integrating gender into CARE programming. Twenty-seven respondents at **endline** reported having direct involvement with ISOFI, compared to 12 who had only indirect involvement. However, even those who were directly involved more often reported that integrating gender was more important than sexuality.

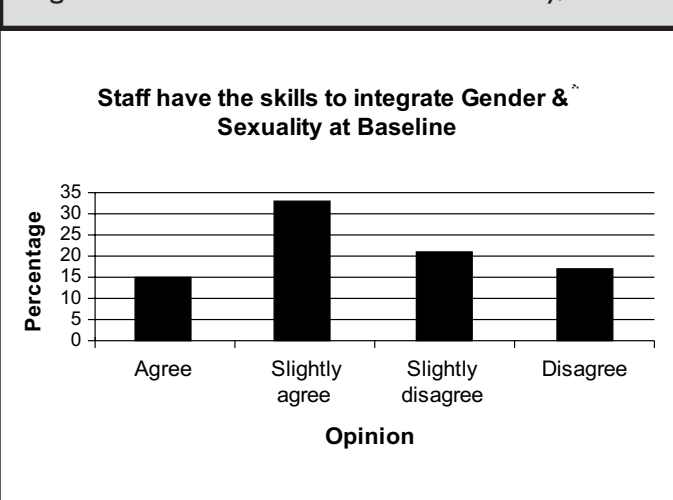
At **endline**, there was a large difference in the percentage of direct participants who thought it was always or occasionally important to integrate gender and sexuality into programming. While 81.5% thought it always important to integrate gender, only 48.1% felt the same for sexuality. Interestingly, among those indirectly involved in ISOFI, no difference between these two variables emerged.

At **baseline**, all staff were asked whether they felt they had the skills to "substantively apply both gender and sexuality concepts in reproductive health and HIV/AIDS programming." Approximately 48% reported that they agreed or slightly agreed that they did have the skills. (Diagram 5).

At **endline**, 77.5% of all staff reported agreeing or slightly agreeing with the statement, as compared to the 48% at baseline. Staff who had directly participated in ISOFI were much more likely to think CARE staff had adequate skills than those who only participated indirectly (See Diagram 6 below). Across the groups, only half of CARE Global responded "agree" or "slightly agree," compared to 84.6% (n=22) of CARE India and 75% (n=6) of CARE Vietnam.

In response to the statement “*In my experience, CARE program staff take both gender and sexuality into account during conceptualization, design, implementation, and monitoring and evaluation*” the majority of CARE Vietnam staff at **baseline** responded occasionally to all four project phases. The majority of program staff in **India** responded occasionally to all but one of the phases, Monitoring and

Diagram 5: Staff Skills in Gender and Sexuality, Baseline



Evaluation, which was evenly split between occasionally and rarely. Lastly, the majority of **global** staff reported rarely to all phases except for monitoring and evaluation, which was split evenly between occasionally and rarely (see Table 5).

Table 3: When CARE Program Staff Take Both Gender and Sexuality into Account

	Vietnam		India		Global	
	Baseline (n=12)	Endline (n=8)	Baseline (n=46)	Endline (n=26)	Baseline (n=6)	Endline (n=6)
The conceptualization of RH & HIV/AIDS programs	27.3% always 45.5% occasionally 27.3% rarely	60% always 25% occasionally 25% rarely	27.3% always 45.5% occasionally 27.3% rarely	60% always 25% occasionally 25% rarely	27.3% always 45.5% occasionally 27.3% rarely	60% always 25% occasionally 25% rarely
The design of RH & HIV/AIDS programs	27.3% always 54.5% occasionally 18.2% rarely	37.5% always 37.5% occasionally 25% rarely	27.3% always 54.5% occasionally 18.2% rarely	37.5% always 37.5% occasionally 25% rarely	27.3% always 54.5% occasionally 18.2% rarely	37.5% always 37.5% occasionally 25% rarely
The implementation of RH & HIV/AIDS programs	25% always 66.7% occasionally 8.3% rarely	37.5% always 50% occasionally 12.5% rarely	25% always 66.7% occasionally 8.3% rarely	37.5% always 50% occasionally 12.5% rarely	25% always 66.7% occasionally 8.3% rarely	37.5% always 50% occasionally 12.5% rarely
Monitoring and evaluation of RH & HIV/AIDS programs	27.3% always 36.4% occasionally 27.3% rarely 9.1% never	37.5% always 37.5% occasionally 25% rarely	27.3% always 36.4% occasionally 27.3% rarely 9.1% never	37.5% always 37.5% occasionally 25% rarely	27.3% always 36.4% occasionally 27.3% rarely 9.1% never	37.5% always 37.5% occasionally 25% rarely

4. Tension between the Personal and Professional Spheres

At **Baseline**, staff were asked to respond to the statement “I experience tension between my personal beliefs and my professional approach to gender and sexuality.” The majority of staff in **Vietnam** and **India** disagreed (67% and 60% respectively) and **Global** staff were evenly split.

Staff were asked in the **Endline** survey to describe if they had “more/the same degree/or less tension in their own personal beliefs on gender and sexuality as a result of participating in ISOFI.” Those directly involved overwhelmingly reported less tension in their own personal beliefs as a result of participating in ISOFI (19/25) whereas those indirectly involved, did not (4/9). It is interesting to note that some staff did report having more tension in their personal beliefs (4/33). As a result of a cross-group comparison, it emerged that **Vietnam** staff reported more tension for both gender and sexuality whereas global and India groups reported less on average (See Diagram 7).

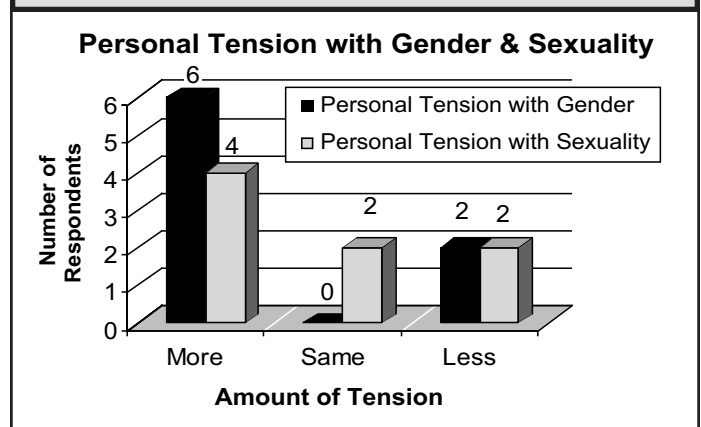
Diagram 6: Staff Skills in Gender and Sexuality, Endline



5. Institutional Commitment to Integration of Gender and Sexuality

On issues relating to CARE’s institutional commitment to integrating gender and sexuality in its reproductive health and HIV/AIDS programs, the majority of staff across all three sites at **baseline** agreed with most of the items endorsing CARE’s commitment. Staff were asked to what extent they

Diagram 7: CARE Vietnam Personal Tension



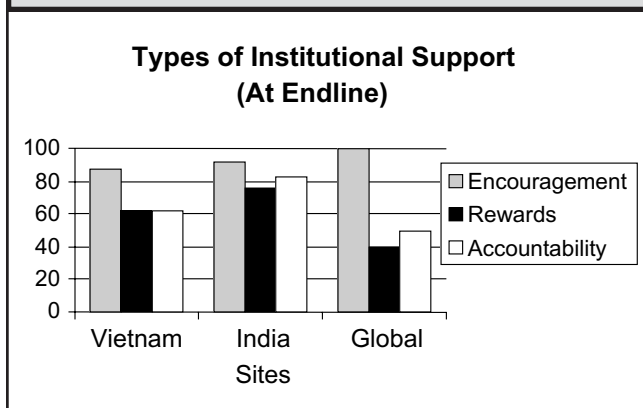
were “encouraged,” “rewarded for” and “held responsible” for integrating gender and sexuality into their programs.

Most respondents from **Vietnam** and **India** (100% and 60% respectively) agreed that CARE program staff are encouraged to apply gender and sexuality concepts into reproductive health and HIV/AIDS programming. The majority of **global** staff (67%) however disagreed. While the majority of Vietnamese respondents (64%) agreed that CARE program staff are rewarded for their application of gender and sexuality concepts, the majority of **Indian** and **global** respondents disagreed (63% and 83% respectively).

Lastly, 100% of **Vietnamese** staff agreed that CARE programs staff were held accountable by their supervisors for application of both gender and sexuality concepts into reproductive health and HIV/AIDS programming, whereas the majority of respondents in **India** (63%) and the **Global** site (83%) disagreed.

In the **endline** survey, almost 90% of all staff reported that they were encouraged to integrate gender and sexuality into programs. Over 80% at each site indicated that they were encouraged, and 60% and nearly 80% of **Vietnam** and **India** staff, respectively, indicated they were rewarded and held accountable for integration. Interestingly, the **glo-**

Diagram 8: Types of Institutional Support



Staff reported much lower levels of rewarding and accountability for integrating gender and sexuality concepts into reproductive health and HIV/AIDS programs, though the majority slightly agreed that they were rewarded (Diagram 8).

At **endline**, respondents were asked to rate CARE’s financial commitment to gender and sexuality with the following question: “CARE has made adequate **financial** resources available (either CARE’s own funds or other donor funds) to support the integration of both gender and sexuality into its reproductive health and HIV/AIDS programs.” The majority of staff in **Vietnam** and **India** (66.7% and 72.1% respectively) agreed, whereas the majority of **global** staff disagreed 83%.

Respondents were also asked, at **baseline**, to respond to the following question: “CARE Senior Management in my setting (for example, my country office) clearly endorses the importance of addressing both gender and sexuality.” The majority of staff from **Vietnam** and **India** agreed (75% and 89% re-

Table 6: Support for Gender and Sexuality Integration (Baseline)

In my experience, CARE:	Vietnam (n=12)	India (n=46)	Global (n=6)
Has made adequate financial resources available (either CARE’s own funds or other donor funds) to support the integration of both gender and sexuality into its reproductive health and HIV/AIDS programs.	66.7% Slightly agree 16.7% Slightly disagree 16.7% Disagree	34.9% Agree 37.2% Slightly agree 20.9% Slightly disagree 7% Disagree	16.7% Agree 33.3% Slightly disagree 50% Disagree
Senior Management in my setting (for example, my country office) clearly endorses the importance of addressing both gender and sexuality	41.7% Agree 33.3% Slightly agree 41.7% Slightly disagree	47.7% Agree 40.9% Slightly agree 6.8% Slightly disagree 4.5% Disagree	50% Slightly agree 16.7% Slightly disagree 33.3% Disagree

Table 7: Support for Gender and Sexuality Integration (Endline)

In my experience, CARE:	Vietnam (n=8)	India (n=26)	Global (n=6)
Has made adequate financial resources available (either CARE’s own funds or other donor funds) to support the integration of both gender and sexuality into its reproductive health and HIV/AIDS programs.	25% Agree 37.5% Slightly agree 37.5% Slightly disagree	69.2% Agree 26.9% Slightly agree 3.8% Slightly disagree	33.3% Slightly agree 33.3% Slightly disagree 33.3% Disagree
Senior Management in my setting (for example, my country office) clearly endorses the importance of addressing both gender and sexuality	25% Agree 62.5% Slightly agree 12.5% Disagree	53.8% Agree 34.6% Slightly agree 11.5% Slightly disagree	50% Agree 33.3% Slightly agree 16.7% Slightly disagree

spectively), whereas **global** respondents were evenly split between agree and disagree (see Table 6 below). At **endline**, staff from **India** and **global** agree with the statements, whereas **Vietnam** staff reported less agreement than at **baseline**.

6. Discussion

Enablers and Barriers to Integrating Gender and Sexuality at CARE

Upon review of the qualitative and quantitative data, participant perspectives emerged on the enablers and barriers to effective integration of gender and sexuality into programs. In 2004, an analysis of enablers and barriers was carried out with all staff across all three ISOFI sites. Two years later at the end-of-project workshops, enablers and barriers were assessed once more.

Enablers and Barriers in 2004

CARE leadership and commitment emerged as being critical to the integration of gender and sexuality into CARE's reproductive health programming in all three sites. In India, CARE leadership's commitment to the ISOFI process was perceived by CARE staff to extend from the country director through all levels of senior management to immediate supervisors. In Vietnam, only those who participated in ISOFI trainings felt the same urgency and commitment to the incorporation of gender and sexuality.

A 2004 analysis of enablers and barriers garnered from a portfolio review and needs assessment undertaken in each site found that support from headquarters, team bonding and sharing ideas and work contributed to the success of ISOFI. Participants also reported that the process of personal learning that was facilitated by ISOFI, as described in chapters 2 and 3, further contributed to ISOFI's success.

Barriers reported by Uttar Pradesh participants included peer pressure, the heavy workload and barriers in communication due to initial inhibition regarding sexuality. CARE's hierarchy also presented a barrier, along with the fact that ISOFI was not part of staff performance review. Rajasthan participants noted that CARE's field presence and credibility, CARE's sexual harassment policy and the different skills represented in the team contributed to ISOFI's success. Barriers included limited funds, lack of local experts and high staff turnover. In Vietnam, a barrier was that gender and sexuality were not seen as core skills within the organization.

Enablers and Barriers in 2006

By February 2006, end-of-project workshop participants found that CARE's policies contributed to the success of ISOFI. In Bhilwara, India, participants cited CARE's gender and diversity policy. In Lucknow, India, participants found that involvement with gender and sexuality issues created important career opportunities. Vietnamese participants noted as barriers that gender and sexuality were not explicit project objectives, not part of CARE's mandate and that sexuality in particular was not normally prioritized by donors.

CARE's links to the communities it serves was important to the success of ISOFI. Participants found that CARE's long history of work and the trust that had been built up over numerous years between CARE staff, these service providers and these communities formed an important basis to move forward the more sensitive issues of gender and sexuality.

The Indian sites indicated that the camaraderie of the CARE staff team charged with implementing ISOFI was very important to the success of ISOFI.

7. Conclusion

Progress on Integrating Gender into CARE Reproductive Health and HIV/AIDS Programs

The data indicate a definite increase in staff perceptions of how well gender equity is being incorporated into reproductive health and HIV/AIDS programming. Though some respondents in all sites reported that CARE had already been incorporating elements of gender equity in its programs, most agreed that ISOFI had served to enhance that situation. In fact, data from the end-of-project workshops, indepth interviews, focus groups discussions and endline surveys indicate that staff definitions of “gender” and “gender equity” have greatly evolved and been strengthened following their participation in ISOFI. Though the majority of respondents felt more needed to be done, particularly with integrating gender into the CARE systems and management levels, the general consensus was that gender issues and gender equity, in particular, had been incorporated more fully than before ISOFI’s implementation.

Integrating Sexuality into CARE Reproductive Health and HIV/AIDS Programs

Responses to whether issues of sexuality had been incorporated into CARE programs following ISOFI implementation were less positive overall. Though staff from Vietnam and India reported positive change within the pilot sites and staff, the majority from these two groups and all the CARE Global staff reported little, if any, organizational change had occurred. Findings from the end-line qualitative survey data as well as the end-of-project IDIs and FGDs support staff assertions that incorporating issues of sexuality into programming is much more challenging and takes more time and effort than does incorporation of gender concepts. One possible reason for this could be that whereas messages regarding gender equity can filter down through staff channels - with those directly involved passing on the messages to those not directly in-

involved - sexuality messages may be harder to diffuse. If sexuality is perceived as a more taboo subject, it is realistic to think that there may be less discussion and diffusion of relevant ideas to staff, particularly across hierarchical organizational levels. If discussing sexuality with a partner or friend is not usual practice, then expecting a local staff person to feel free enough to bring the issue up at a staff meeting in front of his/her supervisor might not be recognizing the reality of the situation. The following quotation illustrates this possibility:

Sexuality has been a much harder sell. Our understanding, biases, assumptions and cultural rules about sexuality are profoundly powerful. It is a very difficult thing to explore, specifically as relevant to development programming, even within the safer context of SRH. Many frontline staff who have repeatedly reflected over the last year and half understand its relevance, but more senior staff who have not benefited from this repeated exploration have not integrated sexuality into their own paradigm. (Global)

Staff Commitment to Integrating of Gender and Sexuality

When analyzing data on respondents’ views of their colleagues’ incorporation of gender and sexuality into programming, a trend similar to integrating sexuality can be seen. Though staff across all groups report increased need to incorporate both aspects, at baseline and endline, gender is much more emphasized than sexuality. At baseline, India and global staff report it being twice as important to integrate gender as to integrate sexuality. Though all groups report a positive increase at endline, this relationship remains the same.

An important lesson emerges from these data. Future interventions seeking to address gender and sexuality at both personal and organizational levels need to create a broad, enabling environment within the organization. This can be achieved through an institution-wide program of exposure to the concept of sexuality and its role in affecting gender and reproductive health outcomes. The data suggest that ISOFI made considerable

progress in this area, given that at endline, 81% of those directly involved compared with 48% of those indirectly involved reported it “always” important to integrate sexuality into reproductive health and HIV/AIDS programming.

At endline, the majority of staff reported positive change in the situation regarding CARE staff’s incorporation of gender and sexuality into project conceptualization, design, implementation and monitoring and evaluation. CARE Vietnam and CARE India staff at endline had a higher percentage of positive responses for each item than at baseline. Among CARE International, on the other hand, no staff reported “always” in the endline, but these results must be analyzed carefully, as the sample size for the global group is small (n=6). Global respondents do not report decreased percentages of “rarely” and “never” for all items.

Tension between the Personal and the Professional

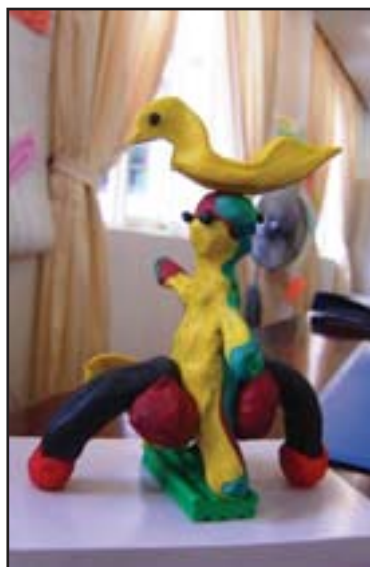
Whereas CARE India and CARE Global staff reported less overall personal tension with regard to issues of gender and sexuality, Vietnam reported more. Qualitative data support the fact that CARE Vietnam staff did internalize quite a bit of the ISOFI messages regarding sexuality and gender, but many are still processing this information, and haven’t yet “re-frozen” their internal frames on gender and sexuality.

Institutional Commitment to Integration of Gender and Sexuality

Though at baseline a very large percentage of staff at CARE Vietnam reported being encouraged and held accountable for integrating gender and sexuality into their programming, India and global staff did not respond nearly as positively. However, at endline, CARE India and CARE Global staff reported much more positively that they were encouraged and held accountable and, to a lesser extent, re-

warded for their efforts. Interestingly, the percentage of CARE Vietnam’s staff who reported being encouraged, held accountable for and rewarded declined by endline. A possible explanation is that at baseline, staff did not have a clear idea of what the integration of gender and sexuality actually entailed, and as their understanding, grew through the project, their perceptions on management’s response shifted.

When asked whether CARE had made adequate financial and senior management support available, CARE India and CARE International staff reported more support, in both forms, at endline than at baseline. However, CARE Vietnam staff reported more support at baseline than at endline.



Creative use of learning materials such as modeling clay prompted deep reflection on gender and sexuality as illustrated by these examples from the gender and sexuality workshop in Vietnam.

Chapter 6

Conclusions, Recommendations and Next Steps

ISOFI: An Overview

ISOFI was conceived as a collaborative learning partnership between CARE and ICRW, and based upon years of field experience working to improve the impact of development programs. ISOFI sought to address what the partners had identified as a key barrier to program performance: divergence between personally held and professionally expressed values and attitudes around gender and sexuality. In other words, an individual's lived experience of gender and sexuality creates tension and ambiguity for the individual when she or he is operating within the professional sphere. CARE and ICRW considered that this divergence tempered the effectiveness of a wide range of interventions: from behavior-change communication around condoms, family planning and breast-feeding, for example, to outreach and service delivery targeting youth, women and socially marginalized groups like sex workers or migrants. Consequently, CARE and ICRW developed and assessed a field-based approach to improve the effectiveness of CARE project staff and implementing partners in conceptualizing, designing and implementing reproductive health and HIV/AIDS interventions that are informed by and responsive to prevailing constructs of gender and sexuality.

Over the past several years, CARE has undertaken a substantial effort to ensure that supportive policies, principles and procedures are in place globally to promote gender-responsive humanitarian and development programming. As CARE continues to shift from a needs-based to a rights-based orientation, it is challenged like, so many development organizations, to operationalize gender in the

first instance and sexuality in the second. Through access to training and educational materials, CARE staff can define these concepts and link them theoretically to development outcomes. In their own words, most staff feel, however, that they cannot "do gender," much less understand and apply concepts of sexuality to programming. CARE and ICRW felt that it was critical to take on the challenge of learning how to more effectively apply concepts of gender and sexuality to programming, in light of CARE's capacity to reach millions of impoverished and socially marginalized women, men and children across the globe.

As a groundbreaking effort to integrate both gender and sexuality into reproductive health and HIV/AIDS programming, the ISOFI team drew upon lessons learned from gender mainstreaming models past and present. In addition, the team reviewed relevant theories of social change and pulled concepts and methodologies situated within the domains of social psychology, androgogy and participatory action research. True to a rights-based orientation, ISOFI was framed as an empowerment model and seeks through iterative loops of reflection and learning, action and experimentation, and analysis and assimilation to unveil the social, political and economic injustices that serve to exclude individuals from society. Fundamental to its design, ISOFI is anchored in the following principles:

- Development practitioners need space to explore and understand their own values, attitudes, beliefs and experiences of gender and sexuality;
- Personal learning and change in relation

to gender and sexuality will be critical to enhancing organizational effectiveness in addressing gender and sexuality; and,

- Processes and practice in the professional sphere should encourage people to recognize and maximize their lived experiences of gender and sexuality.

ISOFI is a systemic approach to organizational change, first promoting and supporting personal learning and change around gender and sexuality, then accompanying individuals as they explore organizational culture and constructs defining gender and sexuality, before launching into field-based applications. Once implanted in field practice, ISOFI continually enhances program interventions through short, iterative learning cycles incorporating reflective practice with gender analysis as well as analysis of social and cultural contexts. As needs arise, it is always possible to return to components focusing on personal and organizational learning and change around gender and sexuality. CARE and ICRW consider that ISOFI, unlike many other gender mainstreaming models, offers an actionable, practical and sustainable system for project staff, implementing partners and community members to grapple with the issues of gender and sexuality.

As described in Chapter 2, the ISOFI Innovation System comprises the following six modules:

- **Portfolio Review and Needs Assessment** assists stakeholders to appraise the organization's program portfolio in relation to gender and sexuality as reflected in project content, strategies, activities, monitoring and evaluation, staffing and partnerships;
- **Gender and Sexuality Training** is essential to "unfreezing" and expanding people's perspectives on gender and sexuality;

- **Reflective Dialogues** provide "safe space" for collective reflection, allowing groups to constantly test the logic and effectiveness of theories that are put into practice, and adapt interventions to be increasingly responsive to socio-cultural contexts as they become better understood;
- **Personal Learning Narratives** promote regular personal reflection, and allow individuals to analyze factors affecting their ability to stabilize new beliefs, attitudes and values around gender and sexuality;
- **Participatory Learning and Action (PLA)** is not only central to operationalizing gender and sexuality in very practical and pragmatic terms within local contexts, but also to empowering staff, implementing partners and community members as agents of social change. As Freire professed, for true praxis, all action must be informed by social, cultural, economic and political realities. PLA identifies specific entry points where gender and sexuality can be more effectively addressed, and provides information for engendering project strategies, interventions and materials;
- **Participatory Evaluation** provides a model for participatory interim process review or for endline evaluation.

The ISOFI IS prompts participants to question, critique, reflect and envision. With time and experience, individuals begin to perceive their lived experience of gender and sexuality through a new lens. Within a supportive environment, they integrate new thinking around gender and sexuality into their personal frameworks, as well as begin to apply new principles to their work as agents of social change.

ISOFI: Progress to Date

ISOFI provided CARE staff with time and space

for reflection and experimentation, tools and appropriate technical support for the effective integration of gender and sexuality issues into their personal lives, their professional work lives and their program planning and implementation. Change at a personal level took place across all ISOFI sites in India and Vietnam. Staff cited personal learning as key to the process, and perceived great benefits to themselves and to the communities they served. Differences in experience with personal learning and change were noted in relation to India and Vietnam. For example, personal change reported by staff in Vietnam was limited to individual experiences, and in a limited number of cases to their sexual partner. Staff in CARE Vietnam were often frustrated by a general lack of receptivity when they attempted to communicate gender and sexuality messages to their families and communities. In contrast, Indian staff reported stories of greater change within their family and communities. The important role of the prevailing social, cultural and political context is emphasized by this example.

In both countries, participants believed that strong support from CARE and ICRW carried the project through to a successful conclusion. Survey data indicate substantial progress in integrating gender compared to, as anticipated, a lesser degree of progress in integrating sexuality into reproductive health and HIV/AIDS programs. As a result of the initiative, staff commitment to integrating gender and sexuality increased considerably, and those who participated in ISOFI reported less tension between their personal beliefs and their professional approach to gender and sexuality. The majority of staff perceived positive change regarding incorporation of gender and sexuality into project conceptualization, design, implementation, and monitoring and evaluation. CARE staff cautioned, however, that the challenge remains to integrate gender more systematically into CARE systems and management levels at the level of the country office. Also, the majority of staff from CARE Viet-

nam and CARE India, and all of the CARE Global staff, reported little, if any, progress in integrating sexuality into CARE programming.

While staff from both countries reported that lack of clear goals, objectives and outcomes for ISOFI created challenges for them, they appreciated the fluidity and flexibility offered through the ISOFI approach. Respondents in all groups reported enhanced confidence and self-esteem as a result of participating in the project. More importantly, through participation in ISOFI, staff learned to work more cooperatively and will hopefully continue to undertake collective action to realize human rights in light of their expanded understanding of gender and sexuality.

As a methodology, ISOFI laid the groundwork for CARE staff to promote change in the community, so that, with time, women were not viewed as victims but as agents of change, and men were not considered oppressors but allies in promoting community and family well-being. Through ISOFI, CARE staff and partners transformed interventions to be more gender equitable and sustainable, for example, by understanding gender differences in the needs of HIV-positive men as compared to HIV-positive women, or promoting women's agency and mobility so that women could more freely access health services while men validated women's need to use health services. Further, the model effectively addressed sexuality through exploration of power and powerlessness, and pleasure and pain, rather than simply detailing the links between sexuality and disease. When attempting to address issues of sexuality, CARE staff in India choose to frame interventions initially as strengthening the family and promoting safe, pleasurable sex. In Vietnam, CARE staff, in collaboration with the Youth Union, addressed homophobia head-on through community dialogue. Anecdotal information in all three sites indicates emerging positive trends in reproductive health behaviors, such as condom use, reduction of number of

sex partners, immunization and reduction in gender-based violence.

ISOFI: Next Phase

With the successful conclusion of ISOFI's first phase behind them, CARE and ICRW have agreed to engage further on issues of gender discrimination and other forms of social exclusion that have direct effects on reproductive health, poverty and social justice. ISOFI I operated under the hypothesis that the integration of gender and sexuality into sexual and reproductive health programs would have positive effects on a range of cognitive, behavioral and health outcomes. Since CARE, its donors and implementing partners tend to modify their policy and program frameworks more readily in light of research evidence, in a second phase of ISOFI, CARE and ICRW will seek to answer the critical question: "So what?" What does the systematic and contextually tailored integration of gender and sexuality into CARE's ongoing sexual and reproductive health programs mean in terms of transforming gender relations, improving women's agency and most of all, showing evidence of a positive, measurable impact on sexual and reproductive health outcomes? CARE, as well as the broader development community, needs to answer these fundamental questions so that results-driven programming can also accommodate empowering processes that lead directly to people securing their right to health. With the momentum and interest generated by ISOFI's first phase, there now exists within CARE an opening for broader engagement, for providing evidence that such an approach leads to greater impact in sexual and reproductive health programming, for arriving at a clearer understanding of how to address gender and sexuality issues in CARE's development and relief work, and for sharing this knowledge with the broader community.

Recommendations

The following is a discussion of five broad recom-

mendations to advance the discourse on integrating gender and sexuality more effectively into health and development programs. Briefly, these recommendations comprise the following:

- Integrate critical reflection with analysis of social and cultural contexts to realize a fundamental shift in development practice – from a needs-based to rights-based approach.
- Merge results-based programming with participatory processes to design interventions informed by and responsive to prevailing constructs of gender and sexuality.
- Move beyond a biomedical model of disease prevention, treatment and mitigation to address underlying causes of poor reproductive health, i.e., gender and sexuality.
- Stimulate and support on-going personal and collective learning and change around gender and sexuality at all levels of the organization.
- Fund further research and programming in the area of gender and sexuality.

Integrate critical reflection with analysis of social and cultural contexts to realize a fundamental shift in development practice – from a needs-based to rights-based approach.

In CARE's view, a rights-based approach leads to sustainable development, as those who are empowered can continue to advocate for their needs and rights long after external development agencies have moved on to other sites and issues. As Lynn Freedman stated: "...[T]he embrace between public health and human rights creates what is potentially one of the most powerful sets of theoretical, practical and organizational tools for addressing the issues that loom largest in the international women's health arena at the dawn of the

twenty-first century” (Freedman, 2000: 429). Consequently, shifting staff perspectives on how and why to do development is a critical factor in re-orienting organizational culture and practice to a rights-based model. While gender and sexuality are pertinent to programming in all sectors of development, they are most visibly and directly implicated in strategies addressing reproductive health and HIV/AIDS.

As one approach to understanding and addressing the underlying causes of poverty and poor health, ISOFI demonstrated the effectiveness of supporting exploration into lived experiences of gender and sexuality. By broadening and deepening personal horizons, individuals could then more genuinely empathize with others when dealing with complex community issues such as HIV and AIDS or maternal health. Further, ISOFI provided tools and processes (see Chapter 2) by which CARE staff, implementing partners and community members could drill down and tease apart the tangle of social and cultural factors that contribute to heightened risk and vulnerability, particularly among socially marginalized groups. Most importantly, those involved with ISOFI reported increased confidence, self-esteem and sense of self as well as greater tolerance toward alternative lifestyles, identities and perspectives. They felt, in their own words, “liberated” and “empowered.” CARE and ICRW would suggest that empowered individuals, representing various sectors of society, are effective agents of social change individually and, when working as a group, more likely to build an authentic and sustainable foundation for rights-based development in communities.

Merge results-based programming with participatory processes to design interventions informed by and responsive to prevailing constructs of gender and sexuality.

Much of development assistance is currently framed as results-based or target-driven – evaluated ideally by outcome indicators such as HIV inci-

dence, maternal mortality and nutritional status, but measured more commonly by output indicators, like number of youth reached with HIV prevention messages, number of children immunized or number of girls attending schools. Results in their deconstructed form as targets are not inherently bad – they provide focus and direction, and introduce accountability and facilitate planning. In their most intense form, however, targets drive implementation, creating undue pressure on staff, partners and communities to focus only on meeting immediate numerical targets rather than promoting sustainable long-term change. Targets become an end in and of themselves, squeezing out time and space for reflection, creativity, adaptation and experimentation. In effect, in the blur of achieving targets, many staff lose sight of the result to which those targets contribute. The experience of many development projects would indicate that this is not a pathway to success.

Making progress on addressing root causes of poverty and poor health goes beyond a mechanical application of public health best practice. It requires an inductive approach that allows people to peel away the layers of complex social issues to perceive and then understand how causal factors interrelate, for example how social restrictions on women’s agency and mobility can negatively affect reproductive health. When an issue has been framed as holistically and as comprehensively as possible, the next step is to identify points of entry for the delivery of evidence-based strategies for action. Contrary to common opinion, integrating participatory processes into results-based programs does not imply delays or interruptions in programmatic activity. Rather, participatory processes ensure that strategies and interventions are designed as close to the problem as possible. Participation creates collective ownership, trust and engagement – and can open previously hidden or closed channels of communication. ISOFI holds the promise of genuine shifts in behavior change

rather than more transitory results usually achieved through target-driven development models. As noted by Rosalyn Petchesky (1998) : “Researchers and research groups interested in women’s reproductive and sexual health/rights as an aspect of development should value the *process* at least as much as the outcomes of their research.”

Move beyond a biomedical model of disease prevention, treatment and mitigation to address underlying causes of poor reproductive health, i.e., gender and sexuality.

To date, most public health work has engaged in a discussion of sexuality from a narrow biomedical viewpoint focusing on the intersection between sexuality and disease. ISOFI presents a very practical way to address sexuality in a manner that goes beyond a biomedical model and begins to address people’s personal concerns about sexuality: power and powerlessness, and pleasure and pain. Other methodologies, such as Stepping Stones, have been critical in promoting a more holistic model of integrating gender and sexuality meaningfully into reproductive health programs (Welbourn, 1995). As discussed in Chapter 1, condom promotion strategies that do not address the concerns faced by both men and women as they consider condom use, the need for intimacy and sexual pleasure, and power relations will not be as persuasive as possible in promoting condom use for HIV prevention. Regrettably, couple communication, which is critical to improving a range of reproductive health outcomes (Varkey et al., 2004; Zulu, 2003; Holschneider and Alexander, 2003), is often ignored in many public health initiatives.

Grounded in a rights-based philosophy, ISOFI has helped to advance the gender discourse within CARE from one of women as victims and men as oppressors to one of women as agents of their own development and men as vulnerable, given socially restrictive norms and identities. This two-year experience of purposefully exploring beyond a

biomedical model in pilot sites in India and Vietnam served to anchor CARE’s transition to a rights-based framework as it relates to reproductive health and HIV/AIDS programming. The challenge remains to bring the initiative to scale within CARE India and CARE Vietnam, and to influence the discourse on gender and sexuality within CARE globally and throughout the development community.

Stimulate and support ongoing personal and collective learning and change around gender and sexuality at all levels of the organization.

ISOFI engendered organizational evolution. CARE and ICRW’s experience over the past two years suggests that the creation and maintenance of a “safe space” within the organization is instrumental in evolving an institutional discourse on gender and sexuality. Within this non-judgmental space, people expand their perspectives on gender and sexuality through training, exchange and dialogue, and critical reflection on their personal attitudes, beliefs and practices. Designed as an intervention to “shake up” staff on their long-held perspectives on gender and sexuality, the ISOFI-sponsored trainings and reflective dialogues allowed staff to process their own issues with gender and sexuality prior to addressing gender and sexuality with implementing partners and community members. As discussed in chapters 1 and 2, numerous organizations conduct gender training for staff. Rarely does this training extend beyond a one-time event, and therefore many organizations have been disappointed with the results.

A key lesson learned from ISOFI: It is crucial to create space for learning, exploration and reflection at each level of the organization. People at the executive level, in senior and middle management and in field implementation should accompany one another through this change process. As such, a system-wide enabling environment is created, facilitating relevant discussion on gender and sexuality in all operational spheres.

Fund further research and programming in the area of gender and sexuality.

The Ford Foundation is an acknowledged leader in promoting work on gender, sexuality, reproductive health and human rights. Apart from the Ford Foundation, few other donors provide significant resources for research on sexuality or on the intersection of gender, sexuality and disease, despite the fact that sexuality is key to turning the tide on the AIDS pandemic. As discussed in chapters 1 and 2, many organizations have gender policies and undertake gender mainstreaming to some degree; few have effectively incorporated gender, much less sexuality, into their programming. Gender and sexuality are not a new frontier in the development arena, but their pertinence to human health and well-being is more sharply focused by the world's commitment to the Millennium Development Goals. Resources are urgently required to position gender and sexuality more strategically and productively within global efforts to eradicate poverty.

Next Steps

In light of the pilot's success as a collaborative learning initiative, CARE and ICRW have agreed to build upon the prolific learning generated during ISOFI's first phase to deepen their understanding of the effect of systematically integrating gender and sexuality into development programs. As a result, CARE and ICRW will undertake the following steps:

1. CARE and ICRW will conduct an Operations Research study in collaboration with a CARE sexual and reproductive health project to measure how the systematic and contextually tailored integration of gender and sexuality into sexual and reproductive health programs transforms gender relations, improves women's agency and, most of all, achieves positive, measurable impact on reproductive health outcomes.
2. The ISOFI core team will disseminate the end-of-project report widely within CARE and ICRW, and ensure that the tools developed under ISOFI are made available to CARE country offices. Further, the core team will advocate for institutional commitment to expand the ISOFI experience to new CARE country offices. CARE and ICRW will promote ISOFI as an emerging promising practice to relevant foreign assistance agencies, donors and the development community at large.
3. CARE and ICRW will broaden their experience with the ISOFI methodology by replicating it as a rights-based approach to sexual and reproductive health programming in other cultural contexts (e.g., African countries) and by adapting it to other contexts of social exclusion (e.g., HIV-positive women and men or ex-combatants in post-conflict settings).

References

- Amado, L. (2004). Sexual and Bodily Rights as Human Rights in the Middle East and North Africa. *Reproductive Health Matters*, 12(23), 125-128.
- Amoran, O., Onakedo, M., & Adenigyi, J. (2005). Parental Influence on Adolescent Sexual Initiation Practices in Ibadan, Nigeria. *International Quarterly of Community Health Education*, 23(1), 73-81.
- Askew, I. (2005). Methodological Issues in Measuring the Impact of Interventions against Female Genital Cutting. *Culture, Health & Sexuality*, 7, 463-477.
- Baylies, C. (2000). Perspectives on gender and AIDS in Africa. In C. Baylies & J. Bujra (Eds.), *Sexuality and gender in Africa: Collective Strategies and Struggles in Tanzania and Zambia*. London: Routledge.
- Becker, J., & Leitman, E. (1997). *Introducing Sexuality Within Family Planning: The Experience of Three HIV/STD Prevention Projects from Latin America and the Caribbean*. New York City: Population Council.
- Boender, C., Santana, D., Santillan, D., Hardee, K., Greene, M. E., & Schuler, S. R. (2004). *The 'So What?' report: A Look at Whether Integrating a Gender Focus Into Programs Makes a Difference to Outcomes*. Washington, DC: USAID.
- Bohm, D. (1985). Epilogue. In *Unfolding Meaning*. New York City: Doubleday.
- Bruhin, E. (2003). Power communication and condom use: patterns of HIV-relevant sexual risk management in heterosexual relationships. *AIDS Care*, 15(3), 389-401.
- Caro, D., Schueller, J., Ramsey, M., & Voet, W. (2004). *A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action*. Washington, DC: USAID Interagency Gender Working Group.
- Chambers, R. (2005). *Ideas for Development*. London: USA Earthscan.
- CIDA. (1999). *CIDA's Policy on Gender Equality*. Quebec: Canadian International Development Agency.
- CIDA. (2000). *Accelerating Change: Resources for Gender Mainstreaming*. Quebec: Canadian International Development Agency.
- CIDA. (2005). *CIDA's Framework for Assessing Gender Equality Results*. Quebec: Canadian International Development Agency.
- Connell, R. W. (2000). *The Men and the Boys*. Berkley: University of California Press.
- Cornwall, A. (2004). Preface. In A. Gosine (Ed.), *Sex for pleasure, rights to participation, and alternatives to AIDS: placing sexual minorities and/or dissidents in development* (Vol. 228). Brighton: IDS.
- Correa, S., & Petchesky, R. P. (1994). Reproductive and Sexual rights: A Feminist Perspective. In G. Sen, A. Germain & L. C. Chen (Eds.), *Population Policies Reconsidered: health, Empowerment, and Rights* (pp. 107-123). Boston: Harvard Center for Population and Development Studies.
- Crotty, M. (1998). *The Foundations of Social Research*. London: Sage.

- Damalie, N. (2001). *Communication between Mothers and Their Adolescent Daughters on the Subject of Sexuality and HIV/AIDS in Uganda* (No. 14). Addis Ababa: Organization for Social Science Research in Eastern and Southern Africa.
- Dawson, E. (2005). Strategic gender mainstreaming in Oxfam GB. *Gender and Development*, 13(2), 80-89.
- Derbyshire, H. (2002). *DFID Gender Manual: A Practical Guide for Development Policy Makers and Practitioners*: DFID.
- Dixon-Mueller, R. (1993). *Population Policy and Women's Rights: Transforming Reproductive Choice*. London: Praeger Publishers.
- Dixon-Mueller, R. (1993). The Sexuality Connection in Reproductive Health. *Studies in Family Planning*, 24(5), 269-282.
- Dowsett, G. (2003). Some Considerations on Sexuality and Gender in the Context of AIDS. *Reproductive Health Matters*, 11(22), 21-29.
- Freedman, L. (1994). Reflections on Emerging Frameworks on Health and Human Rights. *Health and Human Rights*, 1(4), 313-346.
- Freedman, L. (2000). Human Rights and Women's Health. In M. Goldman & M. Hatch (Eds.), *Women & Health*. San Diego: Academic Press.
- Freedman, L., Waldman, R., de Pinho, H., Wirth, M., Chowdhury, A., Rosenfeld, A., et al. (2005). *Who's Got the Power? Transforming Health Systems for Women and Children*. London: Earthscan.
- Freire, P. (1985). *The Politics of Education: Culture, Power and Liberation*. Houndmills, Basingstoke: Macmillan Publishers.
- Gay, J., & Daniels, U. (Forthcoming). *Gender Technical Brief on the African Youth Alliance*. New York City: UNFPA.
- Gosine, A. (2004). *Sex for Pleasure, Rights to Participation, and Alternatives to AIDS: Placing Sexual Minorities and/or Dissidents in Development* (Vol. 228). Brighton: IDS.
- Grown, C., Rao Gupta, G., & Kes, A. (2005). *Taking Action: Achieving Gender Equality and Empowering Women*. London: Earthscan.
- Gruseit, A. (1997). *Impact of HIV and Sexuality Education on the Sexual Behavior of Young People: A Review Update*. Geneva: UNAIDS.
- Gruseit, A., Kippax, S., Aggelton, P., Baldo, M., & Slutkin, G. (1997). Sexuality Education and Young People's Sexual Behavior: A Review of Studies. *Journal of Adolescent Research*, 12(4), 421-453.
- Gupta, G. R. (2003). Strengthening Alliances for Sexual Health and Rights. *Health and Human Rights*, 2(2,3).
- Holschneider, S., & Alexander, C. (2003). Social and Psychological Influences on HIV Preventative Behaviors of Youth in Haiti. *Journal of Adolescent Health*, 33(1), 31-44.
- Irvin, A. (2000). *Taking Steps of Courage: Teaching Adolescents about Sexuality and Gender in Nigeria and Cameroon*. New York City: International Women's Health Coalition.
- Isaacs, W. N. (1994). Dialogue. In P. Senge, C. Roberts, R. Ross, B. Smith & A. Kleiner (Eds.), *The Fifth Discipline Fieldbook* (pp. 357-364). New York City: Doubleday.
- Jaworski, J. (Ed.). (1998). *Synchronicity: the Inner Path of Leadership*. San Francisco: Berrett-Koehler Publishers.
- Jejeebhoy, S. J., & Sathar, Z. A. (2001). Women's Autonomy in India and Pakistan: the Influence of Religion and Region. *Population and Development Review*, 27(4), 687-712.
- Jolly, S. (2004). *Gender Myths*. Brighton: IDS.

- Khan, Z. (2003). *Closing the Gap: Putting EU and UK Gender Policy into Practice: South Africa, Nicaragua and Bangladesh*. London: One World Action.
- Khan, S., Hudson-Rodd, N., Siggers, S., Bhuyan, M., & Bhuyia, A. (2004). Safer Sex or Pleasurable Sex? Rethinking Condom Use in the AIDS Era. *Sex Health*, 1(4), 217-225.
- Khan, S. (2004). *Risk and needs assessment amongst males who have sex with males in Lucknow, India*. New Delhi: Naz Foundation International.
- Kirby, D., Laris, B., & Roller, L. (2005). *Impact of Sex and HIV Education Programs on Sexual Behaviors of Youth in Developing and Developed Countries* (No. 2). Research Triangle Park, North Carolina: Family Health International.
- Koenig, M. A., Ahmed, S., Hossain, M. B., & Mozumder, K. A. (2003). Women's Status and Domestic Violence in Rural Bangladesh: Individual- and Community-Level Effects. *Demography*, 40(2), 269-288.
- Krahe, B., Abraham, C., & Scheinberger-Olwig, R. (2005). Can Safer-Sex Promotion Leaflets Change Cognitive Antecedents of Condom Use? An Experimental Evaluation. *British Journal of Health Psychology*, May(Part 2), 203-220.
- Lesch, E., & Kruger, L.-M. (2005). Mothers, daughters and sexual agency in one low-income South African community. *Social Science & Medicine*, 61(5), 1072-1082.
- Lewin, K. (1946). Action Research and Minority Problems. *Journal of Social Issues*, 2, 34-46.
- Lewin, K. (1951). *Field theory in social science; selected theoretical papers*. New York City: Harper & Row.
- Macdonagh, S. (2005). *Evaluation of DFID Development Assistance: Gender Equality and Women's Empowerment*. Glasgow, UK: DFID.
- MacDonald, M. (2003). *Gender Equality and Mainstreaming in the Policy and Practice of the UK DFID: A Briefing from the UK Gender and Development Network*. London: Gender and Development Network.
- MacPhail, C., & Campbell, C. (2001). 'I Think Condoms are Good, but Aai, I Hate Those Things': Condom Use among Adolescents and Young People in a Southern African Township. *Social Science & Medicine*, 52, 1613-1627.
- Mane, P., Bruce, J., Helzner, J., & Clark, S. (2001). *Power in Sexual Relationships: An Opening Dialogue among Reproductive Health Professionals*. New York City: Population Council.
- Michael, D. N. (1973). *On Learning to Plan and Planning to Learn*. San Francisco: Jossey Bass.
- Michael, D. N. (1992). Governing by Learning in an Information Society. In S. A. Rosell (Ed.), *Governing in an Information Society*. Montreal: Institute for Research on Public Policy.
- Mikelson, B., Freeman, T., & Keller, B. (2001). *Mainstreaming Gender Equality: SIDA's Support for the Promotion of Gender Equality in Partner Countries*. Stockholm: SIDA.
- Miller, A. M. (2004). Sexuality, Violence Against Women, and Human Rights: Women Make Demands and Ladies Get Protection. *Health and Human Rights*, 7(2), 17-47.
- Moore, K., & Helzner, J. (1996). *What's Sex Got to Do with It? Challenges for Incorporating Sexuality into Family Planning Programs*. New York City: Population Council.

- Moser, C., & Moser, A. (2005). Gender mainstreaming since Beijing: a review of success and limitations in international institutions. *Gender and Development*, 13(2), 11-22.
- NACO. (2002). *Mainstreaming Gender into the Kenya National HIV/AIDS Strategic Plan 2002-2005*. Washington, DC: The Gender and HIV/AIDS Technical Sub-committee of the National AIDS Control Council.
- Ogulayi, M. (2005). An Assessment of the Awareness of Sexual and Reproductive Rights among Adolescents in South Western Nigeria. *African Journal of Reproductive Health*, 9(1), 99-112.
- Petchesky, R. P. (1998). Cross-Country Comparisons and Political Visions. In R. P. Petchesky & K. Judd (Eds.), *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures*. London: Zed Books.
- Pick, S., Givaudan, M., & Brown, J. (2000). Quietly Working for School-based Sexuality Education in Mexico: Strategies for Advocacy. *Reproductive Health Matters*, 8(18), 92-102.
- Pick, S., Givaudan, M., & Poortinga, Y. (2003). Sexuality and Life Skills Education: A Multistrategy Intervention in Mexico. *American Psychologist*, 58(3), 230-234.
- Reason, P., & Bradbury, H. (Eds.). (2001). *Handbook of Action Research : Participative Inquiry and Practice*. London: Sage Publications.
- Rogow, D., & Diaz, A. (1999). *Reprosalud: Evaluation of Project Impact on the Chavin Region: A Case Study* (unpublished report). Lima: USAID.
- Ruxin, J., Binagwaho, A., & Wilson, P. (2005). *Combating AIDS in the Developing World*. London: Earthscan.
- Schalkwyk, J. (1998). *Mainstreaming Gender Equality into the Use of the Logical Framework Approach*. Stockholm: SIDA.
- Schein, E. H. (1995). Kurt Lewin's Change Theory in the Field and in the Classroom: Notes toward a model of Managed learning. *Systemic Practice and Action Research*, 9(1), 27-47.
- Schein, E. H. (2006). From Brainwashing to Organizational Therapy: A conceptual and Empirical journey in Search of "Systemic" Health and a General Model of Change Dynamics. In R. Cummings (Ed.), *Handbook of Organizational Development*: Jossey-Bass.
- Senge, P. (1998). Introduction. In J. Jaworski (Ed.), *Synchronicity: the Inner Path of Leadership*. San Francisco: Berrett-Koehler Publishers.
- SIDA. (1997). *Handbook for Mainstreaming: A Gender Perspective in the Health Sector*. Stockholm: SIDA.
- Sohng, S. S. L. (1995, November 1-3). *Participatory Research and Community Organizing*. Paper presented at the The New Social Movement and Community Organizing Conference, University of Washington, Seattle.
- Trist, E. (1975). A Concept of Organizational Ecology. *Australian Journal of Management*, 2(2), 161-175.
- UNDP. (2003). *Mainstreaming Gender in Water Management: A Practical Journey to Sustainability: A Resource Guide*. Geneva: UNDP.
- UNFPA. (2004). *Beijing at Ten: UNFPA's Commitment to the Platform for Action*. New York City: UNFPA.
- United Nations. (1994). *Plan of Action: Report from the International Conference on Population and Development*. Cairo: United Nations.

- United Nations. (2005). *Evaluation of Gender Mainstreaming in UNDP: Executive Summary*. New York City: United Nations.
- Vance, C. S. (1984). Pleasure and Danger: Toward a Politics of Sexuality. In C. S. Vance (Ed.), *Pleasure and danger: Exploring Female Sexuality* (pp. 1-27). Boston: Routledge & Kegan Paul.
- Varkey, L., Mishra, A., Das, A., Ottolenghi, E., Huntington, D., Adamchak, S., et al. (2004). *Involving Men in Maternity Care in India*. New Delhi: Population Council.
- Vlassof, C., & Garcia-Moreno, C. (2002). Placing Gender at the Centre of Health Programming: Challenges and Limitations. *Social Science & Medicine*, 54(11), 1713-1723.
- Watkins, F. (2004). *Evaluation of DFID Development Assistance: Gender Equality and Women's Empowerment. DIFD's Experience of Gender Mainstreaming: 1995 to 2004*. Glasgow, UK: DFID.
- Weiss, E., & Rao Gupta, G. (1998). *Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention*. Washington, DC: International Center for Research on Women.
- Welbourn, A. (1995). *Stepping Stones: A Training Package on HIV/AIDS, Communication and Relationship Skills*. London: ActionAID.
- WHO. (2005). Gender, Sexuality and Harmful Sexual Practices. *Progress in Reproductive Health Research*, 67, 6.
- WHO. (2006). *Working definition of sexuality: WHO*.
- Wright, D., Plummer, M., Mshana, G., Wamoyi, J., & Shigongo, Z. S. (2006). Contradictory Sexual Norms and Expectations for Young People in Rural Northern Tanzania. *Social Science & Medicine*, 62, 987-997.
- Zeidenstein, S., & Moore, K. (Eds.). (1996). *Learning About Sexuality: A Practical Beginning*. New York: The Population Council.
- Zulu, E., & Chepngeno, G. (2003). Spousal Communication about the Risk of Contracting HIV/AIDS in Rural Malawi. *Demographic Research Special Collection*, 1(8), 247-278.

Annex I: PR/NA Guide

ISOFI Portfolio Review and Needs Assessment

Overview and Purpose

The Portfolio Review and Needs Assessment allows one to take a look at programs that are currently being implemented, programs that have recently ended and programs that are in the pipeline. An examination of how they are oriented and structured is conducted with a focus on looking for any gaps that may exist.

Methodology

In the context of ISOFI, through the use of a field guide, CARE and ICRW staff led a half-day discussion with project staff to identify current program strengths and gaps in order to identify opportunities for integration and entry points for gender and sexuality in the project cycle. In the case of both India and Vietnam, the field team developed a de-

tailed plan of action, which focused initially on learning and critical personal reflection and then moved to involving partners in the iterative learning process.

Tools/Guidelines

A set of reflections were used with the groups to explore the gaps and learning opportunities in the existing program portfolio to integrate gender and sexuality. It specifically looked at the following:

- Current level of integration of gender and sexuality in the existing portfolio
- Necessary conditions for integration of gender and sexuality including stakeholder analysis and ways to build ownership
- Existing learning mechanisms to foster understanding on gender and sexuality

Question Guide

1. In what ways are gender and sexuality being currently implemented in programs and within the organization?
2. What are the current mechanisms within the organization that have an explicit learning purpose?
3. What kinds of new knowledge are generated?
4. Who contributes to generating new knowledge and who benefits from it?
5. Is learning being documented and shared? If so, how?
6. How is learning currently applied?
7. If you could redesign or adapt your project to more effectively integrate gender and sexuality issues, what would you do and why?

Annex 2: EOP Methodology

ISOFI End-of-Project Evaluation Methodology

Throughout ISOFI, the monitoring and evaluation system collected both quantitative and qualitative data. Qualitative data was collected across many different venues and constructs. During the end-of-project evaluation, in addition to using in-depth interviews and focus groups discussion data, all project documentation and outputs from the end-of-project workshops were analyzed qualitatively. Quantitative data was collected in the form of baseline and endline surveys anonymously administered to CARE staff. The qualitative data was used to triangulate findings and inform the results from the quantitative data and served to provide rich contextual data that answers “why” - context that is often unobtainable from quantitative findings. The data collection process took throughout the project. The survey data analysis is presented in Chapter 5 of this report. All other qualitative data has been incorporated throughout the report.

In-depth Interviews and Focus Group Discussions

Qualitative data was collected from all ISOFI sites (two in India, two in Vietnam) and included in-depth interviews (IDIs) with CARE staff, key informant interviews with partner staff and focus group discussions (FGDs) with community groups. The ISOFI evaluation team conducted a total of 20 in-depth interviews, eight in Vietnam and 12 in India, and 11 key informant interviews with staff from NGO partners and health workers: One in Vietnam and the rest in India. Ten FGDs were completed in India with groups of adolescent girls and adolescent boys, migrant workers, truckers, sex workers and young mothers.

A sampling frame consisting of a complete list of names, positions and genders of CARE staff directly and indirectly taking part in the ISOFI project at all three sites was developed. Participants were selected from the list based on gender (equal numbers of men and women) and management level (participants were selected across management levels within the organization to ensure a representative sample and degree of participation within ISOFI). In India, participants were interviewed by phone; face-to-face interviews were conducted in Vietnam.

The ISOFI evaluation team obtained informed consent before conducting all in-depth and key informant interviews. The interviews and focus group discussions were based on a field guide highlighting topics for discussion and suggested probes.

Interview data were first reviewed by the research team for main themes and then were coded for retrieval and analysis using the NUD*IST program.

Documentation of Project Activities

Project-generated qualitative data also includes a collection of project documentation, including reports of Participatory Learning in Action exercises around gender and sexuality; portfolio review and needs assessments; detailed implementation plans; trip reports; and reflective dialogues. Findings described in these sources have been integrated and discussed throughout the report.

End-of-Project Workshops

Finally, qualitative data was collected from three end-of-project (EOP) workshops conducted in February 2006 in three ISOFI sites: Rajasthan and Uttar Pradesh in India, and Hanoi in Vietnam. The workshops sought to capture the learning from the ISOFI implementation experience in each of the locations, and designed to assess programmatic impact of ISOFI in order to draw lessons for future interventions. The workshops were structured around a participatory methodology to allow for and encourage maximum participation and feedback from participants. A total of 32 staff participated (Vietnam: 9; Lucknow, India: 13; Bhilwara, India: 10). Workshops were facilitated by Veronica Magar, Sexual and Reproductive Health Asia Re-

gional Advisor for CARE, and Sarah Degnan Kambou, Director for HIV/AIDS and Development for International Center for Research on Women.

Workshop participants reviewed key benchmarks during the two-year implementation period; conducted a stakeholder analysis to analyze key relationships, power relations and their transformation during ISOFI; changes in staff's personal lives or the lives of the communities where CARE works; progress in incorporating gender and sexuality during the course of ISOFI; enablers and barriers to incorporating gender and sexuality; and, finally, recommendations for ISOFI's next phase.

End-of-Project Workshop Agenda

Session	Session Title	Purpose/Objective	Methodology
1	Welcome	To open the workshop officially	Remarks before plenary audience
2	Introductions	To ensure all participants/facilitators are familiar with each other; to break the ice; to set the stage; to stimulate active participation	Any workshop game or icebreaker that communicates name, title, responsibility, involvement with ISOFI and something interesting about the person
3	Workshop Objectives and Methodology	To orient participants to the purpose and objectives of the workshop so they can meaningfully contribute to discussion and required outputs	PowerPoint of purpose and objectives and methodology, followed by questions and comments
4	ISOFI: Timeline	To elicit from participants their perspective on the project's key events/benchmarks and the relation of those events/benchmarks to the evolution of ISOFI and its impact within CARE	Small group work (3-4 participants per group) using Timeline tool; group work: 20 minutes; report back in plenary for 10 minutes per group; add'l questions/discussion from facilitators and the group
5	Tea and coffee break		
6	ISOFI: Stakeholder Analysis	To understand sources and relationships of power and influence effecting ISOFI's implementation and evolution from the participants' perspective; who, what, when and why: who played a key role in implementing and/or influencing the ISOFI project; what were those roles; how did relationships among stakeholders evolve during the course of project implementation and with what effect; and why did roles evolve as they did.	Small group work (3-4 participants per group) using Venn Diagram tool; group work: 30 minutes (10 mns: project start up phase; 10 mns: mid-point; 10 mns: final phase); report back in plenary for 15 minutes per group; add'l questions/discussion from facilitators and group
7	ISOFI: Most Significant Change	To understand what participants perceive to be the Most Significant of all Changes over the course of the ISOFI project. (Note: We are collecting individual perceptions of MSC through the endline survey. This exercise will ask individuals to share MSC stories, then to rank them so that the "most significant of all change" is identified.)	Small group work (3-4 participants per group) using Storytelling tool; group work: 30 minutes; report back in plenary 10 mns per group; add'l discussion and final ranking
8	Lunch		
9	CARE Reproductive Health: Portfolio Review	To assess the extent to which and in what way CARE reproductive health projects are integrating gender and sexuality in light of the presumed diffusion of ISOFI field experience, tools and lessons learned	Plenary discussion; brainstorming exercise followed by an anonymous G&S scorecard exercise conducted in plenary
10	Gender & Sexuality: CARE's Structural and Cultural Environment	To assess change in enablers and barriers to the integration of G&S identified during the baseline Needs Assessment, and to identify emerging enablers and barriers for the second phase	Small group work (3-4 participants per group) using Force Field Analysis; group work: 30 minutes; report back in plenary 10 mns per group; add'l discussion
11	Envisioning the Next Phase of ISOFI	To elicit recommendations on "where CARE should be/what CARE RH programming would look like" at the end of ISOFI Phase Two	Three groups: 1st Group) Desired ISOFI Stakeholder Relationships at end of Second Phase using Venn Diagram; 2nd Group) ISOFI Footprint or "legacy" at the end of Second Phase using Cartooning; 3rd Group) Recommendations on addressing existing and emerging enablers/barriers (identified in Session 10)
12	Summary	To summarize the workshop's proceedings, explain Next Steps	Remarks in plenary; reference to flip charts
13	Closing		