

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 | |
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| <p>TARSHI Talking about Reproductive and Sexual Health Issues New Delhi, India</p> | <p>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.</p> |
| <p>CREA Creating Resources for Empowerment in Action New Delhi, India</p> | <p>Conducts training on gender and sexuality; implements leadership programs that address women's rights; and conducts public education and advocacy.</p> |
| <p>CIHP Consultation of Investment in Health Promotion Hanoi, Vietnam</p> | <p>Conducts training, promotion and research based on participatory and rights-based approaches concerning gender, sexuality and health.</p> |
| <p>LIFE Quality of Life Promotion Centre Ho Chi Minh City, Vietnam</p> | <p>Conducts research and training with vulnerable women and communities, including HIV-positive people.</p> |

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.

