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 integration 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

1. 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 incorporated 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.

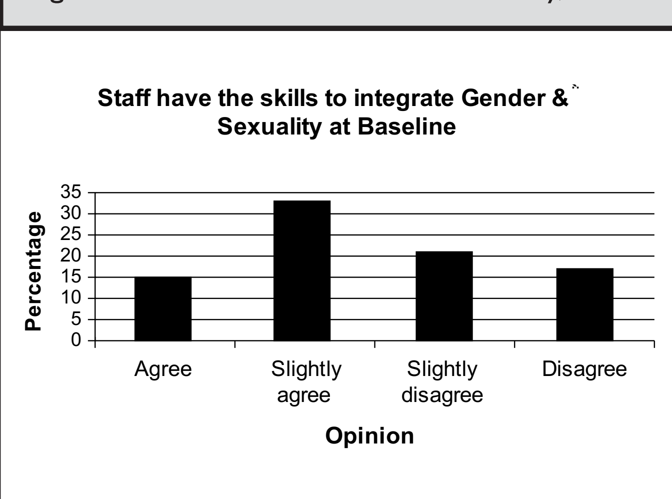
Whether the respondent was directly or indirectly involved with ISOFI did seem to have an effect on their views on integrating gender into CARE programming. Twenty-seven respondents at **endline** reported having direct involvement with ISOFI, compared to 12 who had only indirect involvement. However,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

Diagram 5: Staff Skills in Gender and Sexuality, Baseline



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 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.

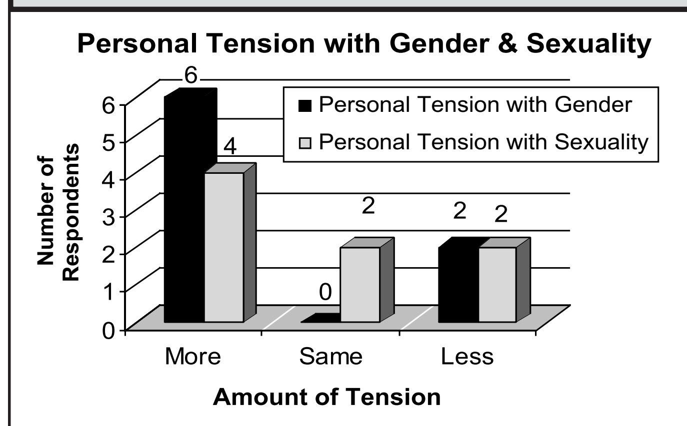
Staff were asked in the **Endline** survey to describe if they had "*more/the same degree/or less tension in their own personal beliefs on gender and sexuality as a result of participating in ISOFI*." Those directly involved overwhelmingly reported less tension in their own personal beliefs as a result 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



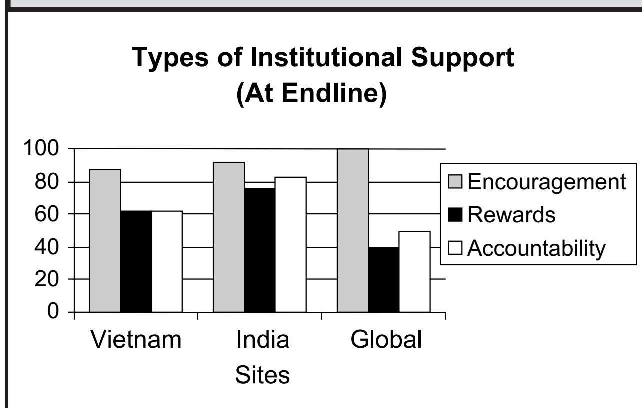
were "encouraged," "rewarded for" and "held responsible" for integrating gender and sexuality into their programs.

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



bal 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. Rajastan 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 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 been 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.

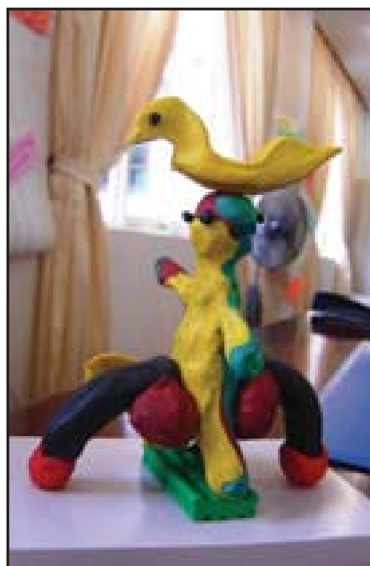
Tension between the Personal and the Professional

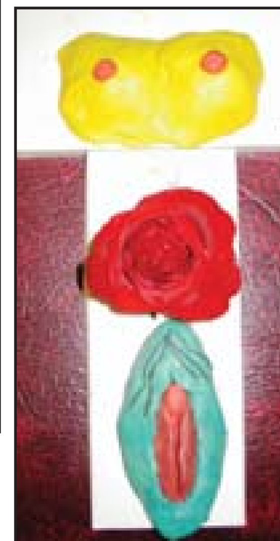
Whereas CARE India and CARE Global staff reported less overall personal tension with regard to issues of gender and sexuality, Vietnam reported more. Qualitative data support the fact that CARE Vietnam staff did internalize quite a bit of the ISOFI messages regarding sexuality and gender, but many are 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, rewarded 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.