

# 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).

