

An **Update** on

# **EFFECTIVE APPROACHES**

for **Gender-Integrated Interventions** for  
**Reproductive Health**

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*March 31, 2020*



## Acknowledgments

The authors gratefully acknowledge Susan Press and Alexia Stipkata, librarians at the United States Agency for International Development (USAID), who carried out searches of the published literature and guided us as we selected and refined search terms. We are grateful to our gender colleagues at USAID (Michal Avni, Afeefa Abdur-Rahman, Linda Sussman, Niyati Shah, Amelia Peltz, Emily Reitenauer, Meghan Mattingly, and Kristina Bishop) who helped guide the development of and reviewed drafts of this report, as well as internal and external reviewers, including Mary Ellen Duke, Julie Pulerwitz, Christopher Hook, and Myra Betron, who provided suggestions for strengthening this report. Finally, we owe a debt of gratitude to the authors of the *So What?* and *New Evidence* reports, including Carol Boender, Diana Santana, Diana Santillan, Karen Hardee, Margaret E. Greene, Sidney Schuler, and Elisabeth Rottach.

This publication is made possible by the generous support of USAID under cooperative agreement AID-AA-A-16-00002. The information provided in this document is the responsibility of PRB, is not official U.S. government information, and does not necessarily reflect the views or positions of USAID or the U.S. Government.

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# Executive Summary

## Background

This review extends two prior reviews—*So What?* (2004) and *New Evidence* (2009)—of evidence for gender-integrated interventions. We summarized the evidence, published from 2009 to 2016, for reproductive health (RH) interventions that promoted behaviors related to unintended pregnancy (UIP), maternal health, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), other sexually transmitted infections (STIs), gender-based violence (GBV), and menstrual hygiene management (MHM).

## Methods

We included evaluations of gender-accommodating (i.e., aim to compensate for, but not change, harmful gender norms or inequalities) and gender-transformative (i.e., aim to change harmful gender norms or inequalities) interventions, excluding gender-accommodating interventions that only increased access to family planning (FP), HIV, or maternal health services. Evaluations measured a behavioral outcome (or attitudes for GBV interventions) and used a moderate-to-rigorous evaluation design. From a systematic search of published literature and a targeted search of grey literature, we abstracted data from reports of 59 individual interventions (13 for UIP, 10 for maternal health, 26 for HIV/AIDS, and 10 for GBV) and drew on nine reviews.

## Results

Relative to the earlier reviews, we identified a larger number of evaluation reports (i.e., 59 versus 25 in 2004 and 40 in 2009) despite applying more stringent criteria for evaluation rigor. We identified more evaluations for interventions addressing HIV/AIDS than other RH outcomes. Interventions addressing UIP and GBV tended to be gender-transformative, addressing couple communication and gender norms. HIV/AIDS and maternal health interventions that engaged men to promote use of HIV and maternal health services tended to be gender-accommodating, encouraging men's support for women's service use. HIV prevention interventions were gender-transformative, addressing couple communication, decisionmaking and norms that support a sexual double standard. Effects on health behaviors and gender-related outcomes (for example, perceived gender norms) were mixed. Gender-transformative interventions were more likely to achieve planned outcomes. Addressing gender norms more broadly was more likely to produce health outcomes than focusing on couple communication and decisionmaking alone. Participatory approaches that engaged women and men in social change efforts tended to produce both health and gender-related outcomes. There were some gaps; we found few policy, service delivery, and health system changes that were gender-integrated and found no evaluations (that met our criteria for rigor) for HIV/AIDS interventions for men who have sex with men and other key populations.

Although we included only evaluations that used moderate-to-rigorous designs, we noted evaluation gaps. Not all evaluations measured gender-related outcomes. Second, few evaluations were designed to measure the “value added” of gender-integration or to identify which intervention components contributed to outcomes. Finally, there were limited data on cost, sustainability, and scalability.

## Conclusions

There is continued growth in the evidence base for gender-integrated reproductive health interventions. Although gender-accommodating and gender-transformative interventions had effects, they were more uniformly positive when interventions addressed gender norms and inequalities in group and community settings and promoted community ownership of change.

# Introduction

In 2015, world governments adopted a “gender equality compact” that is key to achieving Sustainable Development Goals (SDGs).<sup>1</sup> The compact recognizes the need to promote gender equality on its own and in pursuit of other SDGs, including SDG 3 (health and well-being). Efforts to achieve gender equality to reduce poor reproductive health (RH) outcomes began with the Programme of Action of the 1994 International Conference on Population and Development (ICPD) and have continued to the present (for instance, access to RH services as a target for SDGs).<sup>2,3</sup> Such initiatives recognize that in most countries, women’s and girls’ lower status makes it difficult for them to control reproductive outcomes.

Since the ICPD, governments and donors have supported gender-integrated RH interventions: interventions that address gender dynamics, or harmful gender norms and inequalities in power and access to resources. As these interventions grow in number and diversity (such as facility changes to reduce disrespect and abuse and community dialogue around gender norms), we need to summarize the evidence. What gender-integrated interventions are implemented? Do they improve gender and health outcomes?

## **Gender**

Culturally defined roles, responsibilities, and rights associated with being female and male and the power relations between and among women and men, boys and girls.

## **Gender equality**

State or condition that affords women and men equal enjoyment of rights, socially valued goods, opportunities, and resources.

## **Gender integration**

Strategies applied in program design, implementation, monitoring, and evaluation to take gender considerations into account and to compensate for gender inequalities.<sup>4</sup>

## **Reproductive health interventions promote behaviors related to:**

- Unintended pregnancy.
- Maternal health.
- Human immunodeficiency virus/acquired immune deficiency syndrome.
- Other sexually transmitted infections.
- Menstrual hygiene management.

For this report, they also include interventions to reduce and mitigate gender-based violence.

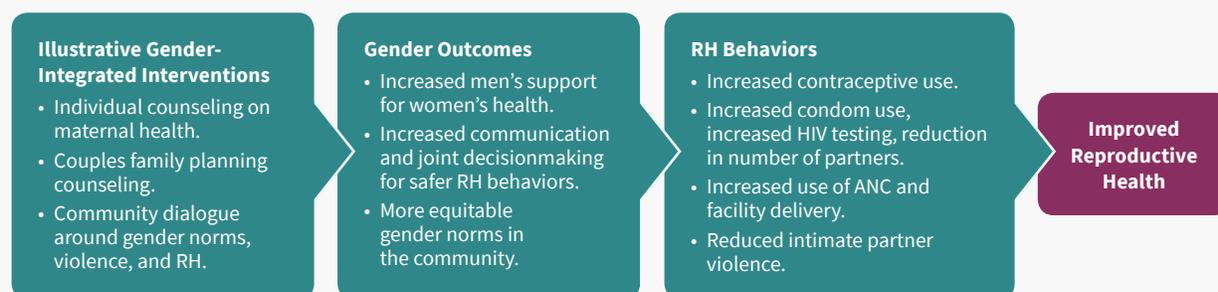
# Background

This review extends two prior reviews of gender-integrated interventions, *The “So What?” Report: A Look at Whether Integrating a Gender Focus Into Programs Makes a Difference to Outcomes* and *Gender Perspectives Improve Reproductive Health Outcomes: New Evidence*<sup>5,6</sup> and focuses on interventions related to:

- Unintended pregnancy (UIP) (such as contraceptive use).
- Maternal health (such as antenatal care (ANC) services, improved prenatal nutrition).
- Human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and other sexually transmitted infections (STIs) (such as condom use, voluntary medical male circumcision).
- Gender-based violence (GBV) (such as intimate partner violence (IPV), child and early/ forced marriage).

Although not included in all definitions of RH, GBV is associated with poor RH outcomes.<sup>7-9</sup> We also consider menstrual hygiene management (MHM) interventions, an area of increased attention since 2009.

**Figure 1. Theory of Change for Gender-Integrated Interventions**



Source: Interagency Gender Working Group, 2019.

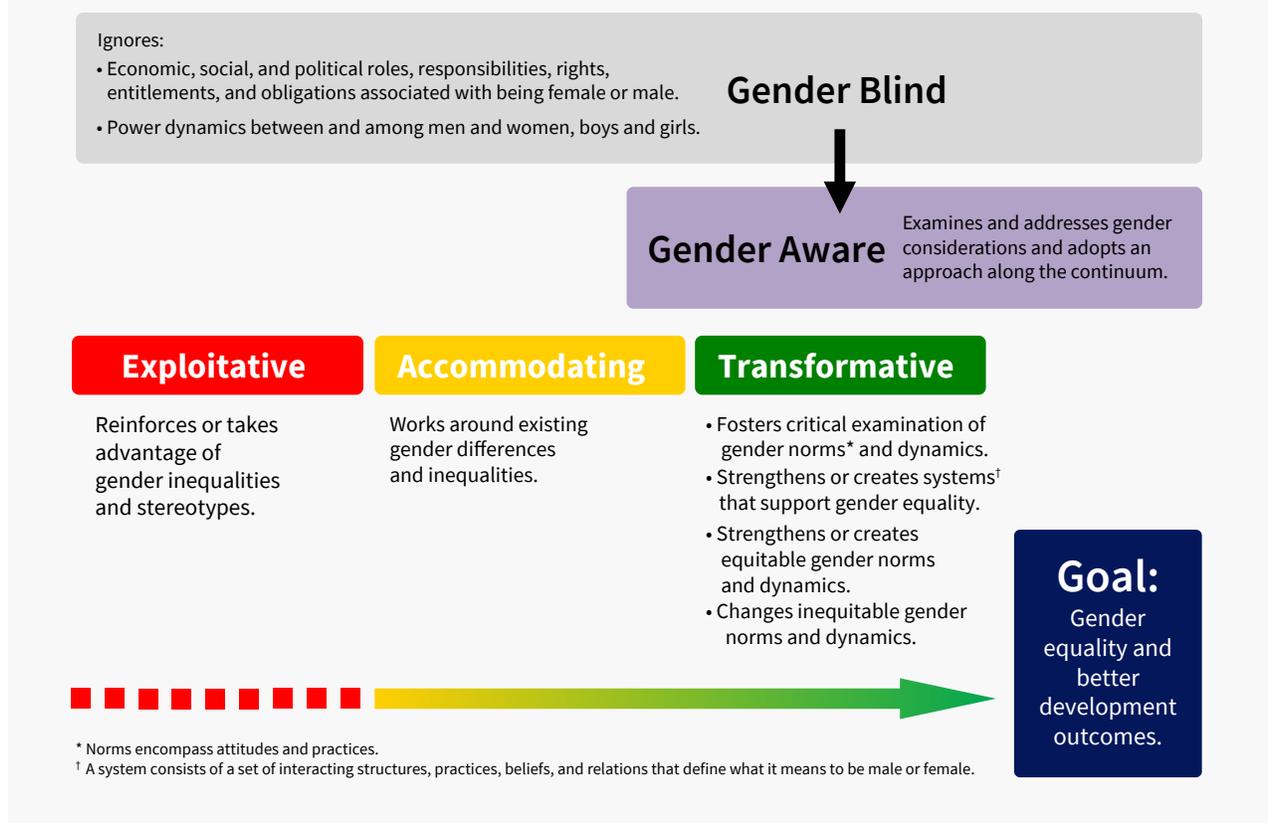
## Gender-Integrated Interventions

Gender-integrated interventions address gender dynamics and other barriers (such as knowledge and attitudes) to improve health. Even in contexts where change is happening, traditional gender norms may uphold a sexual double standard, whereby it is acceptable for men to have premarital sex, show their virility by having multiple partners or children or both, and make decisions about the conditions of sex. On the other hand, women are expected to be passive, faithful, and submit to one man. Gender-integrated interventions address these and other gender dynamics as intermediate outcomes, on the pathway to improved health (Figure 1).

## Gender-Integration Continuum Tool

The Gender-Integration Continuum Tool (Figure 2) provides a framework for understanding approaches to addressing gender.<sup>10,11</sup> The tool highlights differences between failing to recognize how gender dynamics affect health (*gender blind*) and recognizing and addressing the role of gender dynamics (*gender aware*). Gender-aware interventions exist along a continuum from *exploitative* to *transformative*. Because *gender-exploitative* interventions reinforce harmful gender dynamics, we excluded them from this review.

**Figure 2: Gender-Integration Continuum Tool**



Source: Interagency Gender Working Group, 2009; updated 2019.

*Gender-accommodating* interventions compensate for, but do not change, gender dynamics. For example, an intervention might bring HIV testing to male factory workers, but not challenge ideas about roles in decisionmaking about condoms. Gender-accommodating approaches that increase access to family planning (FP), HIV, and maternal health services (such as vouchers) are now common and considered high impact practices.<sup>12,13</sup> We omitted such interventions unless they included a transformational component.

*Gender-transformative* interventions change gender dynamics. They may encourage critical reflection on gender norms, increase women’s access to resources, promote joint decisionmaking between partners, or improve counseling to increase agency in decisionmaking and in these ways increase reproductive empowerment (that is, the ability to make and act on decisions about one’s reproductive health). They may also increase reproductive empowerment at a broader level by engaging women and men in community change.<sup>14</sup>

## Cross-Cutting Issues

There is an increased focus on engaging men to meet their own health needs (for instance, by using condoms for dual protection from HIV/AIDS and UIP), as supportive partners and fathers (for instance, by sharing decisionmaking), and as change agents (for instance, by advocating for equitable family roles). Male engagement interventions reach men to transform gender dynamics and other factors such as knowledge and attitudes.<sup>15</sup> Recent calls for gender-synchronized approaches recognize that men and women uphold harmful norms and inequalities and so call for working with both sexes.<sup>16</sup>

# Methods

We relied on a systematic search of the published literature and a targeted search of the grey literature to identify primary documents (hereafter “reports”) that evaluated gender-integrated interventions implemented in developing countries and literature views of such interventions. The interventions sought to modify behaviors or service utilization or both related to the reduction of UIP, improved maternal health, the prevention and mitigation of HIV/AIDS, other STIs, or GBV, and improved MHM. We considered policy, service delivery, and social and behavior change (SBC) interventions.

## Evaluation Designs

In line with other recent reviews, we included reports that measured a behavioral outcome (including use of FP, HIV, or maternal health services), and used moderate-to-rigorous evaluation designs:

- Baseline and endline data from an intervention group with multivariate analyses.
- Endline data from intervention and comparison groups with multivariate analyses.
- Baseline and endline data from randomized intervention and control groups.<sup>17-19</sup>

We included evaluations whether they reported on a gender outcome and whether the comparison group was a non-gender-integrated intervention or no intervention. We included evaluations of GBV interventions even if they did not measure a behavioral outcome due to difficulty measuring change in GBV behaviors in a short time period. We reported on costs and sustainability if data were available.

## Published Literature

Working with librarians, we identified search terms and exclusion criteria to apply to PubMed, POPLINE, and ScienceDirect databases. We used multiple Medical Subject Heading (MeSH) and keyword search terms for each of four categories: RH outcome, gender integration, intervention and evaluation, and country (Table 1). We used an iterative approach, starting with terms used in similar reviews and refining terms as we proceeded.<sup>20,21</sup> We excluded duplicate reports, reports published in languages other than English, and those published before 2009 (the last year included in *New Evidence*).

**Table 1: Illustrative MeSH and Key-Word Search Terms**

### **Reproductive Health Outcomes**

- UIP: contraception, unintended pregnancy, birth spacing.
- Maternal health: antenatal care, postnatal care, breastfeeding, labor and delivery.
- HIV/AIDS and STIs: HIV, AIDS, prevention of mother to child transmission, antiretroviral treatment, condom, sexually transmitted infections.
- Menstrual hygiene management: menstruation.
- GBV: sexual violence, intimate partner violence, spousal abuse.
- General: adolescent health services, reproductive health services, sexual behavior.

### **Gender Integration:**

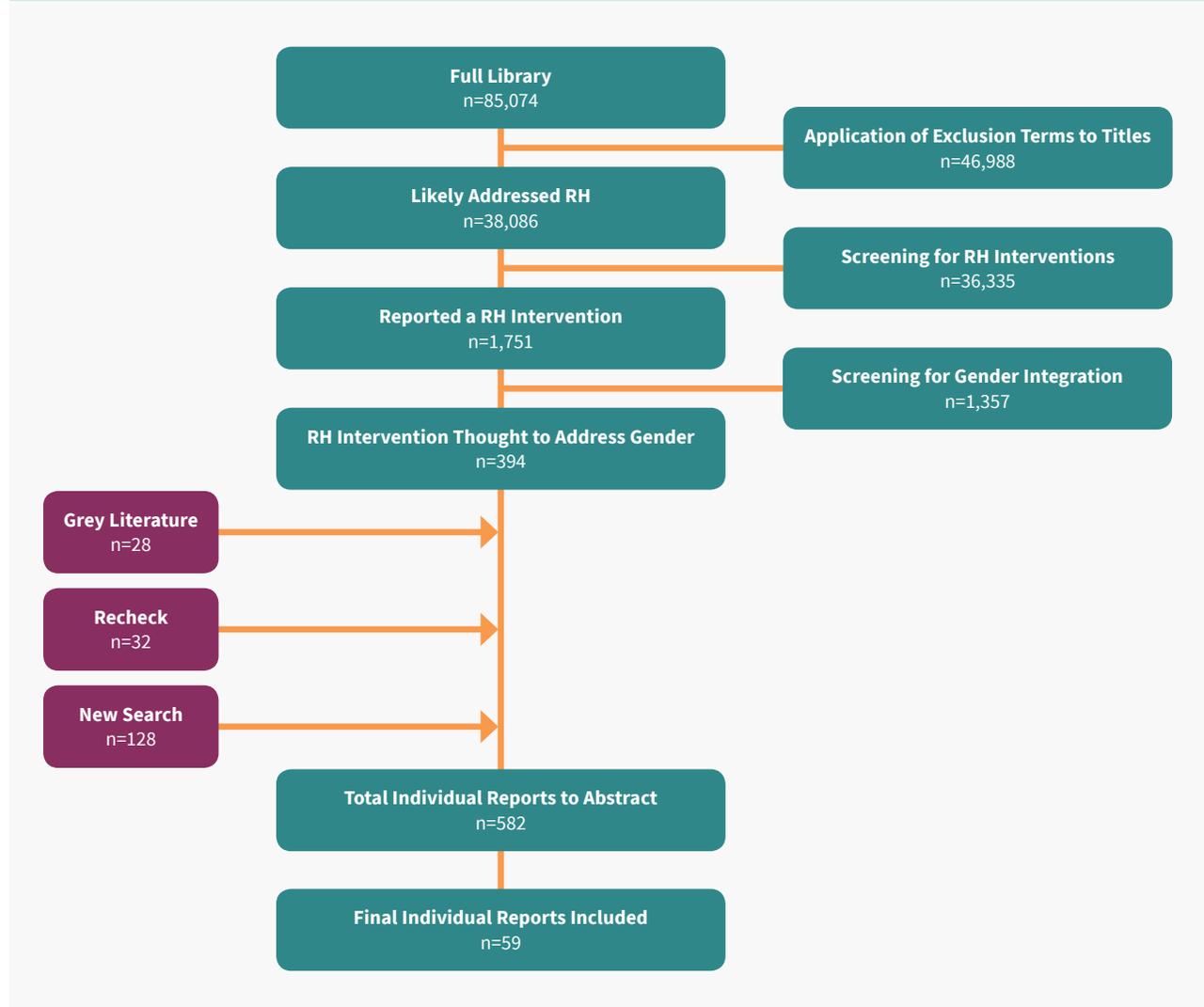
femininity, masculinity, gender norms, sexism, empowerment, men who have sex with men, autonomy, negotiating, spouse

### **Developing Countries**

Low- and middle-income countries in the 2015 World Bank Country Classification.

We added 85,704 citations to an EndNote database in August 2015 and used a multi-step process to remove non-relevant citations (Figure 3). An initial scan suggested that many citations were not relevant (for example, those that mentioned potential effect of a cancer diagnosis on pregnancy). Two authors (SC, JK) applied exclusion terms for non-RH health outcomes (such as “kidney,” “cardiovascular,” and “ocular”) to titles, assuming that if a title referred to another health outcome the report did not focus on RH. We retained 38,086 citations.

**Figure 3: Review Process for Identifying Evaluation Reports for Reproductive Health Gender-Integrated Interventions**



Next, each author reviewed one-third of the abstracts to determine whether a citation reported on an intervention. Before proceeding individually, all three authors reviewed the same 20 citations to ensure consistency. At this step, we retained 1,751 citations. A closer review of these 1,751 abstracts indicated that although they mentioned gender, interventions were not gender-accommodating or gender-transformative. After reviewing the same 20 citations to achieve consensus, each author categorized one-third of the abstracts along two dimensions: gender-integrated

intervention (yes, no, unsure, not an evaluation) and type of intervention, such as clinic-based interventions and various types of SBC interventions (e.g., community-engagement, peer group). Based on this review, we retrieved 394 reports.

## Grey Literature

Based on experiences with the published literature, we used a streamlined process to search the grey literature. In early 2016, two authors (SS, JK) used smaller sets of search terms for RH outcomes, interventions, and gender-integration to search Google Scholar and Development Experience Clearinghouse (DEC) to review titles and abstracts. From 91 relevant citations, we retained 28 reports after screening for gender-integration.

## Updated Search

In February 2017, we took two steps to update our search. First, we applied search terms for RH outcomes and intervention types to citations we excluded from our endnote database during the process described above. We identified, categorized, and added 32 citations back into our EndNote database. Second, we used an abbreviated set of search terms for each RH area and type of intervention to search citations added to PubMed and Google Scholar from August 2015 through February 2017. One author (JK) reviewed titles and abstracts and downloaded (to our EndNote database) 128 citations.

## Literature Reviews

Our searches of the published and grey literature identified 91 systematic or other reviews of RH interventions. One author (SS) read the reviews. If a review focused on gender-integrated interventions in developing countries and drew from evaluations that met our criteria for rigor, we relied on the findings from the review. Nine reviews met this standard (not shown in Figure 3). From other reviews, SS identified citations for evaluations that met our criteria and added them to our EndNote database as needed.

## Data Abstraction and Synthesis

After abstracting data for the same 20 reports to check for consistency, each author abstracted bibliographic data, setting and context, RH outcome, gender integration, and evaluation design (Appendix 1) for one-third of the remaining 582 reports. We excluded reports that did not meet our criteria for rigor and had insufficient descriptions of the interventions. Because they are standard high impact practices, we also excluded reports of community health workers, voucher and workplace interventions that increase access to FP, and maternal health or HIV services that did not include gender transformational elements.<sup>12,13</sup> We refined our categories for intervention type, focusing on the target population: individual, couple, group (including economic empowerment interventions), community (including mass media), health systems, and multi-component interventions (such as community and mass media). We included 59 individual reports: 13 for UIP, 10 for maternal health, 26 for HIV/AIDS, and 10 for GBV. When an intervention addressed GBV and another outcome, we included it in the results for the other health area (for instance, an intervention that addressed HIV and GBV is in the HIV section only).

# Results

We have summarized results separately for each RH outcome—UIP, maternal health, HIV/AIDS, GBV, and MHM. For each outcome, we begin with a summary of how gender dynamics influence health. Next, we provide the results by the intervention categories and report on the number of gender-accommodating and gender-transformative interventions and summarize intervention content and effects. For UIP, maternal health, HIV/AIDS, and GBV, we provide two case studies in Appendix 2. Tables in Appendix 3 provide information about each individual report included in this review.

## Unintended Pregnancy

### Background

An estimated 222 million women in developing countries are at risk for an unintended pregnancy because they want to space or limit births but are not using modern contraception.<sup>22</sup> Approximately one-fourth (23 percent) of these women cite their own or a partner's opposition as a reason for not using contraception,<sup>22</sup> suggesting the importance of partners' support and underlying gender norms. Gender norms may shape fertility desires and women's ability to negotiate for and use contraception. During adolescence, gender norms frequently idealize sexual ignorance for girls, leaving them with inaccurate information on fertility and family planning.<sup>23</sup> In addition, in many settings preferences for early childbearing and a large family may stem from a desire to prove one's masculinity or femininity and from the value placed on sons. When partners' preferences diverge (or are unknown to each other) women may not use contraception in order to please their partners or because their partners make contraceptive decisions.<sup>24-26</sup> Data suggest that when women have a greater role in household decisionmaking they want a smaller family and that more open communication between partners about family planning increases contraceptive use.<sup>26-28</sup>

We identified evaluations of 13 interventions that attempted to reduce UIP by increasing the use of modern contraceptive methods among individuals or couples who wanted to delay or avoid pregnancy (Appendix 3, Table 1). We identified one review of economic empowerment (EE) interventions, which we included with group interventions. All interventions were gender-transformative, addressing communication and decisionmaking between partners or women's empowerment or both.

### Individual Interventions

One individual-level intervention reached men and another reached women; both were gender-transformative. As described in Case Study #1 (Appendix 2), the intervention for men used one-to-one sessions addressing FP knowledge and attitudes, gender norms, and partner communication to reach young men who were married to or living with a female partner. Relative to men in the control group, men in the intervention group were significantly more likely to report contraceptive use at endline.<sup>29</sup> An intervention for female FP clients in India included provider training to address gender dynamics in FP counseling, offering Standard Days Method (which requires partner communication). The intervention had mixed effects; gains in contraceptive use were larger for women who had relatively more relationship decisionmaking power and who were illiterate than for women who had less decisionmaking power or who were literate.<sup>30</sup>

### Couples' Interventions

Three gender-transformative couples' interventions had mixed effects. The interventions engaged men in FP counseling with their partners and addressed couple communication; one intervention also addressed IPV. Two of the interventions included community discussions, to reinforce the content of the couples counseling. One intervention led to increased use of contraception among those not using it at baseline and another led to use of more effective contraceptive methods.<sup>31,32</sup> The intervention that addressed IPV, in two sessions for men and one

session for couples, led to increased contraceptive use and to a reduction (by about half) in women's self-reported experience of IPV.<sup>33</sup> Two evaluations reported improvements in couple communication and men's willingness to be involved in FP.<sup>31,33</sup>

### **Group Interventions**

We identified two group interventions, both of which were gender-transformative, using participatory approaches to engage women in community change and taking steps to improve FP services. In Bangladesh, women's groups met monthly to identify problems, prioritize actions and solutions, and take steps to make changes they identified. Although the intervention was associated with changes in knowledge regarding family planning, it did not increase contraceptive use.<sup>34</sup> In Kenya, women met to identify actions that would raise awareness around and address barriers to family planning and use of services for dealing with early pregnancy bleeding. The intervention did not lead to increased contraceptive use.<sup>35</sup>

EE approaches are gender-transformative; they seek to improve girls' and women's educational and economic opportunities and thus increase their status relative to boys and men. Because education and employment are associated with contraceptive use, EE interventions may indirectly affect contraceptive use. An evidence summary of EE interventions including vocational training (such as skills training), microfinance (such as small loans), and cash transfers found limited evidence of effectiveness on contraceptive use.<sup>36</sup> However, some programs for youth increased condom use.<sup>36</sup>

### **Community Interventions**

Two gender-transformative interventions engaged community members in activities and discussions around gender norms and FP. An intervention in Kenya held community dialogues with men and women to normalize discussions of gender norms and family planning, and it coordinated efforts with FP services to increase access (to provider training and procurement of supplies, for example).<sup>37</sup> The other intervention used a social network approach, bringing together influential male and female members of social networks to discuss issues related to FP (for instance, gender norms and benefits of couple communication) and share what they discussed in their social networks.<sup>38</sup> Both interventions improved self-reported contraceptive use and gender outcomes (such as partner communication about FP and women's participation in decisionmaking).<sup>37,38</sup>

A social marketing program in Pakistan encouraged male responsibility for contraception, with a focus on condoms and increased access to condoms. Radio and TV spots modeled couple communication and male responsibility for FP. Two evaluation reports indicated that the program increased contraceptive use as well as some measures of gender dynamics (such as FP communication between partners).<sup>39,40</sup>

### **Multi-Component Interventions**

We identified three multi-component interventions that combined community mobilization (such as outreach and community dialogue), group activities, mass media, or linkage to FP services. Implemented in four countries, one multi-component intervention addressed couple communication and joint decisionmaking, along with other FP barriers (such as knowledge and FP service quality).<sup>41,42</sup> At the mid-term, contraceptive use increased in all four countries. Different intervention components were effective in different countries. For example, outreach was significantly associated with contraceptive use in all countries, and in one country recall of exposure to religious leaders was related to men's approval of family planning.<sup>42</sup> A community intervention in Uganda used a life-stage approach to reach adolescents with content on gender norms and FP (Appendix 2, Case Study #2). The intervention increased modern contraceptive use and improved gender-related outcomes (for instance, acceptance of more equitable roles for men and women) in some participants.<sup>43</sup> In India, engagement of community leaders, community mobilization (such as street theater and education), group meetings, and couples counseling for improved communication and decisionmaking resulted in increased age at marriage and increased age of first birth.<sup>44</sup>

## Maternal Health

### Background

Although the global maternal mortality ratio (MMR) fell from 385 in 1990 to 216 in 2015, in 2015 sub-Saharan Africa accounted for 66 percent of maternal deaths and its MMR was 546 per 100,000 live births, above the SDG target of 70.<sup>3,45</sup> Poor prenatal care (including lack of ANC, poor nutrition, and limited use of bed nets) and lack of access to maternal child health (MCH) services contribute to maternal mortality. Gender dynamics are among several factors that influence women's use of MCH services and adoption of healthier behaviors (such as appropriate nutrition during pregnancy and breastfeeding). For example, women's agency in decisionmaking increases their use of ANC services and having a skilled birth attendant at delivery.<sup>46-48</sup> Women's autonomy in decisionmaking depends, in part, on their partners and other family members who may restrict women's access to MCH services.<sup>49</sup> Men's limited knowledge of maternal health and their negative perceptions of MCH services (including concerns they are unsafe) may contribute to their reluctance to have their wives use services.<sup>50,51</sup>

There is growing attention to disrespect and abuse in maternal health services, a gender issue because of women's generally low status and power differentials between women and providers. Women's perception of these services, including concerns about the quality of care and how providers will treat them (whether they will be neglected or shouted at, for instance), influence whether they seek services.<sup>46,49,52,53</sup> Survey, observational, and qualitative data confirm that some women are treated with disrespect and abuse in maternal health services.<sup>54-58</sup>

We identified evaluations of 10 gender-integrated maternal health interventions that attempted to improve at least one maternal health outcome (such as MCH service use or improved nutrition during pregnancy) (Appendix 3, Table 2). We also identified one systematic review of participatory action interventions for improving maternal and neonatal health outcomes. For the most part, the interventions were gender-accommodating, engaging partners or other family members or both to increase their knowledge about maternal health and their support for women's access to maternal health services.

### Couples' Interventions

Eight gender-accommodating couples' interventions provided information and encouraged partners or other family members to support women during pregnancy and after birth (for instance around nutrition, birth preparedness plans, and transportation). Most interventions were embedded in programs that included policy changes and maternal health service improvements. Two interventions focused on breastfeeding and six addressed maternal health more broadly. Male engagement varied; some interventions provided information at community events for men, and others offered educational and counseling sessions for couples. Women could participate even if their partners did not; only one evaluation documented the extent of male participation. Two interventions increased the duration and prevalence of breastfeeding at various points (for example, at 24 weeks).<sup>59,60</sup> Effects on select health outcomes (such as the use of ANC services, use of a skilled birth attendant, and taking iron folate) were mixed; no intervention had statistically significant effects on all measured outcomes. Four interventions increased use of ANC services<sup>61-64</sup> and three increased facility delivery or use of a skilled birth attendant.<sup>64-66</sup> None assessed changes in gender outcomes (such as communication and gender equitable roles).

We identified one gender-transformative couples' intervention (Appendix 2, Case Study #3) that used checklists and action cards to reach women and their partners at home with education and counseling that promoted dialogue within the family and joint decisionmaking. Although the intervention did not increase use of ANC services, it did increase men's participation in health behaviors (for instance by escorting their wives to ANC).<sup>67</sup>

### Group Interventions

A meta-analysis of participatory action groups reported reductions in maternal and infant mortality.<sup>68</sup> Participatory action groups promote reproductive empowerment by engaging people in discussions about their health and community actions using a phased approach to: (a) identify and prioritize problems that affect maternal health,

(b) plan actions to improve health, (c) implement actions, and (d) assess activities. The meta-analysis showed that women in communities with participatory action groups experienced significantly reduced maternal mortality (37 percent) and reduced neonatal mortality (23 percent), but did not see a reduction in stillbirths. Reductions in mortality were larger when at least 30 percent of group participants were pregnant.<sup>68</sup>

### **Health Systems Interventions**

We identified an evaluation of an intervention to reduce disrespect and abuse in labor and delivery services (Appendix 2, Case Study #4). The intervention worked with policy makers, providers, and the community and was associated with reductions in most measures of disrespect and abuse.<sup>69</sup>

## **HIV/AIDS**

### **Background**

Despite declines in the number of new HIV infections since 2010, globally 1.8 million people were newly infected in 2016.<sup>70</sup> Eastern and southern Africa bear a substantial HIV burden, with 19.4 million people living with HIV and 43 percent of all new infections in 2016.<sup>70</sup> Although the majority of people living with HIV were women, men (51 percent) were less likely than women (67 percent) to be on antiretroviral therapy (ART); patterns were similar in regions with a large number of developing countries.<sup>70</sup> These differences stem, in part, from gender dynamics. A recent synthesis identified three dimensions of traditional notions of masculinity—uncontrollable male sex drive, capacity to perform sexually, and power—that are associated with sexual risk behaviors (multiple concurrent partners and non-condom use, for instance).<sup>71-73</sup> Because women are expected to be faithful and submit to one partner, they may be unwilling or unable to negotiate for safer sex.<sup>73-77</sup> Gender disparities in employment and control of land may lead to transactional sex, in which women have difficulty negotiating for safer sex with men who control economic opportunities.<sup>78,79</sup> The notion that men should be in control conflicts with the expectation that patients should be compliant and may contribute to men’s lack of adherence to ART.<sup>80</sup> Women’s reliance on their husbands complicates disclosure of their HIV status and access to HIV care; women may fear that their partners will leave them if they disclose their HIV status.<sup>81</sup>

Because same sex relationships go against gender norms in most contexts, men who have sex with men (MSM) face stigma and discrimination, which are associated with sexual behaviors (such as having multiple partners, not using condoms, and having girlfriends to “pass”) that place men and their partners, including female partners, at risk for HIV.<sup>82,83,84</sup> Stigma and discrimination also limit use of HIV services; those who expect or experience stigma from providers are less likely to seek services or seek care promptly.<sup>85-88</sup>

Limited educational and employment opportunities may push some women into transactional sex or sex work. Female sex workers (FSWs) report that needing money for children or other family members leads to unprotected sex with paid partners in exchange for extra money.<sup>89,90</sup> FSWs enact traditional female roles with their primary partners because they rely on their partners for protection or they want to be seen as feminine and so may not use condoms with their primary partners.<sup>91</sup> Sex workers also experience or believe they will experience stigma and discrimination in health services.<sup>87,90,92</sup>

Evaluations of 26 interventions that met our inclusion criteria addressed HIV prevention (including condom use, partner reduction, voluntary medical male circumcision (VMMC), HIV testing, or prevention of mother to child transmission (PMTCT)) (Appendix 3, Table 3). Several of the interventions also addressed GBV, in recognition of the association between GBV and HIV risk. We identified four systematic literature reviews that summarized results of economic empowerment interventions and sex worker interventions. We did not identify evaluations of gender-integrated interventions that met our criteria for rigor and that addressed other STIs alone, the needs of MSM or other key populations, or adherence to ART.

### **Individual Interventions**

Four gender-transformative interventions for individuals engaged women for their own risk reduction (n=2), to provide support for dealing with IPV (n=1), or to encourage their husbands to seek VMMC (n=1). Two of the interventions provided information about HIV risk reduction and prepared women to negotiate for safer sex (by discussing gender norms around communication, for instance). One of the two did not increase condom use while the other, which raised issues around violence and encouraged safety planning, was associated with an increase in condom use, with stronger effects among HIV positive women and those who did not know their status.<sup>93,94</sup> The third intervention, for pregnant women receiving HIV testing and counseling, provided IPV counseling and made referrals to on-site staff GBV services. Women in the intervention (versus the control) were more likely to disclose IPV to their providers and felt more supported. Changes in HIV risk behaviors (such as non-condom use) were not assessed.<sup>95</sup> The fourth intervention provided pregnant women education around the benefits of VMMC and prepared them to encourage their husbands to seek VMMC services (for instance by offering tips for when to raise the topic and engaging in role play); it did not increase VMMC.<sup>96</sup>

### **Couples' Interventions**

Couples' interventions addressed sexual transmission of HIV (n=3) or mother to child transmission (n=5). Three gender-transformative couples interventions engaged high-risk couples (those who were sero-discordant or engaged in drug use, for instance) in couples or group counseling to address gender norms, couple communication and negotiation, and HIV-related knowledge and attitudes. Two similar interventions were carried out by the same research group in different countries; they had modest effects on condom use (effects for seropositive individuals only, for instance) or none at all.<sup>97-101</sup> The third intervention increased condom use and reduced incidence of hepatitis C (HCV) infection, but not HIV.<sup>102</sup> Two evaluations reported on gender-related outcomes; the evaluations showed some effects on experiences of intimate partner violence.<sup>99,101</sup>

Five gender-accommodating couples interventions addressed PMTCT, engaging men in support of women's health by encouraging HIV testing during pregnancy or prompting serodiscordant couples to use contraception. Four of the five interventions promoted HIV testing during ANC by providing letters of invitation or information to men or in-home HIV testing. The interventions had mixed effects: two increased individual or couples HIV testing,<sup>103,104</sup> two did not affect HIV testing,<sup>105,106</sup> and one reported reduced testing.<sup>107</sup> A home-based counseling intervention reported increased identification of HIV positive men and serodiscordant couples.<sup>104,108</sup> One intervention provided information (via counseling or video or both) about FP to serodiscordant and sero-concordant couples; it did not increase contraceptive use, but was associated with a shift toward more effective contraceptive methods and a reduction in pregnancy if a couple used contraception at baseline.<sup>109,110</sup> The evaluations did not measure gender-related outcomes.

### **Group Interventions**

Seven group interventions focused on HIV prevention and engaged women (n=2), men (n=4), or boys and girls together (n=1) in gender-transformative education, dialogue, and activities to promote condom use, partner reduction, HIV testing, VMMC, or some combination of these. All the interventions addressed partner communication and decisionmaking and some addressed gender roles in the family (such as men's role in childcare). Three interventions did not reduce HIV risk behaviors (such as non-condom use).<sup>111-113</sup> Three had mixed effects (increased condom use but no reduction in concurrent partnerships, for example, or reduced unprotected vaginal sex but no reduction in STI incidence).<sup>114-116</sup> Only one had uniformly positive effects on outcomes measured; it addressed VMMC among men and was associated with increased VMMC and condom use among men who were circumcised.<sup>117</sup> Of four evaluations that reported gender dynamics outcomes, three reported significant effects on relationship control, communication, and beliefs about egalitarian gender roles.<sup>112,115,116</sup>

Evidence for the effect of EE, which aims to increase women's educational or economic status, on HIV prevention comes from two systematic reviews.<sup>118,119</sup> Although most EE interventions reached girls and women in the general population, a handful reached FSWs. Results were mixed; only a minority of the studies in the reviews reported significant effects on condom use or number of partners. However, the interventions may have effects on HIV-related behaviors for some groups; the interventions reduced HIV incidence among girls who received support to return to school (versus those who stayed in school), improved older women's economic outcomes, and helped sex workers exit sex work.<sup>118,119</sup>

In addition, a fairly well-known gender-transformative group-based intervention (Stepping Stones) was evaluated in multiple countries. Stepping Stones brings men and women together in groups to build knowledge and reflect on factors in their communities that shape GBV and the risk for HIV. Participants share information with others in their networks or implement community activities or both. A review of seven quantitative evaluations from eight countries reported mixed effects. The only study to measure HIV incidence found no change, although herpes simplex virus (also called herpes type 2) incidence declined. Condom use increased significantly in only two of the countries and communication (for instance with partners, with friends, or with family) about HIV increased in only three countries. In only one of five studies did scores on a scale measuring gender equality increase.<sup>120</sup>

### **Community Interventions**

Three gender-transformative interventions engaged communities in dialogue about gender norms, GBV, and risk reduction. In one community-led intervention with a focus on HIV and GBV, reductions in men's HIV risk behaviors (including condom use at last sex and number of partners) and improvements in women's ability to refuse sex, partner communication, and joint decisionmaking were reported.<sup>121</sup> In another intervention, community activities (specifically action groups, IPV watch groups, and peer group sessions) sought to increase awareness of and change norms around HIV and GBV. The intervention was associated with a reduction in HIV incidence and in women's reports of experiencing physical and sexual IPV within the last year.<sup>122</sup> The third intervention, described in Case Study #5 (Appendix 2), relied on video testimonials and group dialogue about gender norms. The intervention was associated with a reduction in multiple partnerships and increases in measures of gender equitable attitudes and gender roles.<sup>123</sup>

One mass media intervention mailed postcards to men to encourage them to use VMMC services. Of the four postcards, one suggested that women prefer men who have been circumcised and was gender-accommodating in that it linked VMMC to women's pleasure. The evaluation showed that the postcard that suggested women prefer circumcised men did not increase clinic visits or VMMC.<sup>124</sup>

### **Multi-Component Interventions**

We identified a rigorous evaluation for a gender-transformative intervention that combined individual counseling and group counseling for women around marital conflict, IPV, and HIV (Appendix 2, Case Study #6). The intervention focused on women's problem-solving and skills for partner communication and negotiation; it was associated with a reduction in women's self-reports of marital conflict, marital sexual coercion, and proportion of unprotected vaginal sex acts but not IPV.<sup>125,126</sup>

### **Interventions for Sex Workers**

Two systematic reviews reported on interventions for sex workers.<sup>127,128</sup> Community empowerment interventions bring sex workers together to express their needs and work with gatekeepers (such as police) and thus promote reproductive empowerment. These programs include outreach, peer education, condom distribution, and improved HIV and STI services. A meta-analysis of such interventions, with most reports from the Avahan project, showed that they reduced HIV and STIs and increased condom use.<sup>127</sup> A systematic review of SBC approaches (such as counseling and peer education) that addressed gender norms (such as condom negotiation) reported few significant effects on condom use and mixed effects on HIV incidence.<sup>128</sup>

## Gender-Based Violence

Gender-based violence is directed at individuals based on their sex, gender identity, or adherence to culturally-defined expectations of what it means to be a woman, a man, a girl, or a boy.<sup>4</sup> Although men can experience GBV, beliefs that men have a right to control women and women's limited opportunities leave females vulnerable to violence by males. Research suggests that breaking away from traditional roles (by adopting more gender equitable attitudes, for instance) reduces the risk for GBV.<sup>133</sup> Forms of GBV that influence RH outcomes include: intimate partner violence (IPV); non-partner sexual violence (SV); child, early, and forced marriage (CEFM); and female genital mutilation/cutting (FGM/C) (see box). These forms of GBV have direct effects (such as forced sexual intercourse) and indirect effects (difficulty negotiating contraceptive or condom use, for instance) on RH.<sup>129,130</sup> Intimate partner violence may lead to UIP, HIV and other STIs, and pregnancy complications.<sup>7-9</sup> Relative to women married at age 20 or older, child brides are more likely to experience pregnancy complications (such as obstetric fistula and hemorrhaging) and to die in childbirth. Child brides may be at greater risk for HIV due to an inability to reject unsafe sexual practices and because their partners are often older and at increased risk for HIV.<sup>131</sup> FGM increases risk for HIV, birth complications, and infertility.<sup>134</sup>

We identified 10 interventions that addressed GBV alone (Appendix 3, Table 4) and two systematic reviews on interventions to prevent child marriage and FGM/C. We divided interventions into 3 groups: IPV or SV or both, CEFM, and FGM/C. All prevention interventions were gender-transformative and all evaluations measured GBV attitudes or behaviors.

### Group Interventions for IPV

We identified four group interventions; three focused on GBV prevention and were conducted in workplaces (n=1), schools (n=1), and other sites (n=1), often with men, boys, or boys and girls. The interventions included activities to examine gender norms and decrease acceptance of GBV. A workplace intervention affected attitudes toward GBV, although perpetration of GBV was not measured.<sup>135</sup> A school-based program using a toolkit and action plan with teachers and students resulted in a reduction in physical violence.<sup>136</sup> Another intervention targeting gender-equitable attitudes among student-athletes resulted in marginally significant improvements in reduction of physical violence.<sup>137</sup>

One group intervention responded to the needs of sexually exploited Congolese girls. The intervention provided psycho-social support and group counseling, as well as intervention sessions for parents, and was associated with reduced depression and anxiety.<sup>138</sup> We identified an evaluation of one EE intervention in Uganda that was expected to have an effect on IPV; it included microcredit and village loans savings groups. The intervention did reduce tolerance for IPV but did not affect experiences of IPV.<sup>139</sup>

### Intimate partner violence (IPV):

physical, sexual, and emotional abuse and controlling behaviors by an intimate partner. Globally, 30 percent of women have experienced IPV.<sup>129</sup>

### Non-partner sexual violence (SV):

rape, trafficking, and sexual harassment perpetrated by someone other than an intimate partner. Globally, 3 percent to 12 percent of women have experienced sexual violence.<sup>130</sup>

### Child, early, and forced marriage (CEFM):

at least one partner is below the age of 18 and has not consented to marriage. On average, 15 million girls will be married each year.<sup>131</sup>

### Female genital mutilation/cutting (FGM/C):

partial or total removal of the female external genitalia or other injury to female genital organs. An estimated 125 million females have been subjected to FGM/C in 29 countries with data.<sup>132</sup>

### **Multi-Component Interventions for IPV**

We identified an evaluation for one multi-component gender-transformative GBV intervention. Community mobilization activities and interactive group education for young men raised awareness of IPV and sexual risk behaviors, promoted community dialogue and critical reflection on gender norms, and promoted gender-equitable norms. The three-armed evaluation compared young men living in communities that received both components, those that received only the community mobilization, and those that received no intervention. Young men in both intervention communities were significantly more likely to show increased support for gender equitable norms, and there was a positive trend in the reduction of reporting IPV perpetration.<sup>140</sup>

### **Child, Early, and Forced Marriage**

A 2012 systematic review on interventions to prevent child marriage suggested that empowering girls and offering incentives that provide alternatives to marriage can prevent child marriage.<sup>141</sup> Methodological limitations of the reviewed studies underscored the need to identify how programs prevent child marriage and whether impact is sustained beyond the implementation period.<sup>141</sup>

Three evaluations of gender-transformative child marriage interventions were published after the 2012 review. A retrospective evaluation of a state-run cash transfer program for delaying marriage in India, in which parents were given a bond at a daughter's birth, reported increased school enrollment, but not delayed age at marriage. Qualitative data suggested that lack of messaging about gender norms and the bond's purpose weakened effects.<sup>142</sup> An intervention in Bangladesh that offered skills development was associated with a significant decrease in the probability of child marriage among girls in intervention versus control villages.<sup>143</sup> To identify a minimum set of effective intervention components, communities in three countries were randomized to receive one or a combination of intervention components (specifically community mobilization, educational supports, and asset transfers) (Appendix 2, Case Study #7).<sup>144</sup> Community mobilization promoted an enabling environment, and educational supports and asset transfers delayed marriage for girls in different age groups.

### **Female Genital Mutilation and Cutting (FGM/C)**

A review of evaluations of interventions to prevent FGM/C in countries with high prevalence included a range of interventions: training, education, media, and outreach and advocacy. Weakness in intervention implementation and methodological limitations in the evaluations led the authors to conclude that interventions had limited effectiveness and that the evidence base needs to be improved.<sup>145</sup> However, an evaluation of a community mobilization intervention in Senegal (not included in the 2012 review) reported improvements in knowledge and attitudes and reduced prevalence of FGM/C (Appendix 2, Case Study #8).<sup>146</sup> The intervention used a participatory action approach, raising awareness and knowledge and preparing community members to undertake efforts to address FGM/C.

## **Menstrual Hygiene Management**

Menstruation is a normal part of life but is taboo in many countries; females who are menstruating are considered “unclean” or “dirty,” and may be isolated.<sup>147-149</sup> These taboos combined with limited access to toilets, clean water, and sanitary supplies reduce girls' and women's opportunities for participating in school, work, and social activities.<sup>150-153</sup> A systematic review identified “hardware” (for instance, access to sanitation and sanitary products) and “software” (for instance, education on menstruation) interventions to promote school attendance, employment opportunities, knowledge, and improved psychosocial outcomes (such as reduced embarrassment and improved attitudes toward menstruation).<sup>154</sup> Gender-accommodating interventions allowed girls to remain in school but did not challenge stigma and other norms associated with menstruation. However, a few that addressed norms around menstruation were gender-transformative in that they sought to change norms that limit opportunities outside the home. The review concluded that there is insufficient evidence of intervention effectiveness.<sup>154</sup>

# Discussion

We identified evaluations of 59 gender-integrated interventions and nine literature reviews addressing UIP, maternal health, HIV, GBV, and MHM. There were more evaluations of interventions addressing HIV prevention than UIP, MCH, or GBV. Few interventions addressed more than one health outcome even though the same gender norms contribute to all outcomes. The notable exceptions were a handful of interventions that addressed GBV and HIV or FP use. Although the lack of integration may reflect the interests of donors, interventions that address underlying gender norms may contribute to improved health overall.

## Gaps

We found few evaluations of gender-integrated policy and service delivery interventions; notable exceptions included couples counseling in FP, HIV services that engaged men and women at the same time, and an intervention that addressed disrespect and abuse in maternity care. Nor did we find evaluations of gender-integrated interventions addressing the HIV-related needs of MSM and other key populations for HIV prevention and care. Across RH areas, gender-integrated policies (such as addressing the needs of GBV survivors in FP or HIV services) and service delivery improvements are being implemented, and there is growing interest in gender-based inequalities in the health workforce. The interventions are either in the early stages or are not evaluated rigorously, making it difficult to link policy changes to improved health behaviors. Interventions for MSM and other key populations have been evaluated in developed countries and are being implemented in developing countries.<sup>155-157</sup>

Although we included only evaluations that used moderate-to-rigorous designs, we noted gaps. First, not all evaluations, including gender-transformative interventions, measured gender-related outcomes (such as joint decisionmaking, attitudes toward IPV, and gender equitable attitudes). At a minimum, gender-transformative interventions should measure gender outcomes to identify whether they had intended effects. The development of standard measures (for roles in decisionmaking, for instance) may contribute to this. Second, few evaluations measured the “value added” of gender-integration (that is, they did not compare gender-integrated to standard interventions), and none compared gender-accommodating to gender-transformative interventions.

We found little documentation of cost or scalability. The data we found suggested a tension among complexity, coverage, and effectiveness; interventions need to address barriers at multiple levels but must be easily implemented at scale.<sup>135</sup> Within complex interventions, various components may have different effects on different groups and those components vary in cost. This suggests the need for a clear theory of change to direct efforts to target interventions and for the cost data to assess whether and how to take interventions to scale.

## Main Themes

Overall, there were more gender-transformative than gender-accommodating interventions, in part because interventions to reduce UIP and HIV transmission addressed couple communication and joint decisionmaking, deliberately trying to shift the traditional balance of power in relationships. Interventions that addressed a wider array of gender dynamics (such as women’s economic empowerment and dialogue around men’s role in childcare) tended to combine a focus on GBV and another outcome, such as HIV, or were implemented for groups or communities or both. Gender-transformative participatory interventions engaged participants in collective action, an important component of reproductive empowerment. Gender-accommodating interventions sought men’s support for women’s health with a focus on prevention of mother-to-child transmission or on antenatal care. Most interventions engaged men to address knowledge, couple communication and negotiation, and sometimes gender norms and gender roles. Most of the interventions that engaged men were also gender-synchronized, intentionally engaging men and women at the same time and in a coordinated manner, either as couples or within group and community settings.

Intervention effects varied by health area and how interventions addressed gender. Interventions that promoted couple communication and joint decisionmaking had mixed effects. More uniformly positive effects were reported for efforts to engage groups and communities in dialogue and community-led efforts to change harmful gender norms and reduce inequalities (such as IPV and men's role in childcare). Additionally, how women's empowerment is addressed matters; economic empowerment in the absence of norm change may not always produce health effects. Participatory action approaches had positive effects on some, but not all, RH outcomes.

## Unintended Pregnancy

Although most interventions to reduce UIP were gender-transformative (that is, they addressed communication and decisionmaking), effects were mixed; a few had no effects, most had effects for some participants, and only a handful increased FP use for all participants. Those that increased FP use for all participants addressed a broader range of gender dynamics, such as intimate partner violence or gender roles in the family. An important activity was allowing time for reflection and dialogue (such as about family roles or male responsibility for FP), which was done more often in community-level and multi-component interventions.

## Maternal Health

Most maternal health interventions were gender-accommodating (that is, they sought to improve men's knowledge of maternal health and enlist their support) and had mixed effects. The focus on gender-accommodating approaches may be related to perceptions that maternal health services are for women only. Gender-transformative approaches included participatory activities and health system changes. Women's participatory action groups were associated with reduced maternal and infant mortality in a meta-analysis, and health system changes coupled with community mobilization (such as holding providers accountable for quality maternal health services) were associated with reduced disrespect and abuse during delivery. Participatory approaches are consistent with the reproductive empowerment framework that identifies expressions of empowerment for decisionmaking in relationships, community leadership, and collective action.

## HIV/AIDS

Evaluations of HIV interventions typically measured several outcomes, such as testing, condom use, and partner reduction. Most individual, couple, and group interventions had mixed or no effects (for example, an effect on one measure of condom use but not another or effects for men but not women), whether gender-accommodating or gender-transformative. However, community approaches that included participatory action and engaged a wider cross-section of the population had more positive effects on HIV and gender-related outcomes. Economic empowerment interventions had mixed effects on HIV-related behaviors (for instance, effects of conditional cash transfers for education for younger women). Few EE interventions addressed broader gender norms, although some did add content on HIV prevention. HIV prevention for sex workers may need to include components that address their empowerment, specifically their ability to advocate for and work toward community change.

## Gender-Based Violence

Most GBV prevention interventions are gender-transformative insofar as they challenge gender norms. Group- and community-led change interventions (such as for FGM/C or child marriage) were the most common interventions, and most led to reductions in support for GBV, with community-led approaches reporting behavioral outcomes. An EE intervention improved attitudes but not self-reported IPV prevalence. Conditional cash transfer programs that lacked messaging on norms did not delay marriage, but linking transfers or skills building with community dialogue did.

# Recommendations

Overall, we found continued growth in the number of evaluated gender-integrated interventions since *New Evidence* was published in 2009. The evidence of positive effects, particularly for group and community interventions, makes the case for addressing gender dynamics and the importance of engaging groups and communities to modify harmful gender norms. In addition, approaches that encourage the community to identify and address issues of gender norms and IPV are promising. Interventions that engage men and do so in a gender-synchronized manner have advanced; the focus on couple communication and joint decisionmaking should be broadened to include dialogue that places current patterns of communication and negotiation within the broader context of traditional gender roles that often leave women subservient to men.

Gaps remain. We know very little from evaluations about the role of a more gender equitable health workforce, the impact of gender equitable policies and gender-sensitive providers, and what works for specific populations (such as key populations) or for select outcomes (such as menstrual hygiene management or FGM/C). In some cases, interventions need to be developed (for a gender equitable workforce, for instance) and in other cases rigorous evaluations need to be carried out (around gender equitable policies, for instance). Evaluations compared gender-integrated interventions to no interventions or a standard of care, not to a comparable intervention that does not address gender. Thus, we do not know whether addressing gender dynamics is an added benefit. Also, although many gender-integrated interventions have multiple components, few evaluations assess the effects of the separate components; we do not know what is the minimal effective intervention, an important issue when resources are limited. Finally, we know little about sustainability, cost, and scalability—what are the long-term effects, at what cost, and how can they be taken to scale? Programs and research need to move in these directions to make a more compelling case for gender-integrated interventions.

## APPENDIX 1

# Data Abstraction Form

### Article Information

1. Title.
2. Last name of lead author.
3. Year published.
4. Country.
5. If not from the portal (should not happen, but just in case) provide article title and journal.

### Reproductive Health Are and Gender Dynamics

1. Type of health outcome (UIP, MH, HIV, GBV).
2. Type of intervention (e.g., individual counseling, couple counseling, group, community, mixed).
3. Gender-transformative or gender-accommodating.
4. Components of intervention that make it gender-transformative or gender-accommodating (e.g., topics addressed, engagement of males, norms addressed, women's empowerment).
5. Intensity of the intervention (e.g., duration, number of group sessions).

### Evaluation Design

1. Does the evaluation use quantitative or qualitative data? (Note: if qualitative data only, do not complete data abstraction.)
2. Does the evaluation measure behavioral outcome? (Note: if no, do not complete the data abstraction.)
3. What is the target population?
4. Does the evaluation have a baseline and at least one endline data collection period? If yes, what are the time points for data collection?
5. Does the evaluation randomize individuals, couples, groups, or communities (or some geographic area)? If no, does the evaluation assign individuals, couples, groups, or communities to conditions?
6. What is the unit of assignment (individuals, couples, groups, communities)?
7. Does the analysis control for confounding factors and/or adjust for potential selection biases? If yes, what analytic method(s) is/are used?
8. Describe/define behavioral outcome measured.
9. Does the evaluation measure gender-related outcomes? If yes, define/describe them.

### Outcomes

1. Abstract RH-related outcomes.
2. Abstract gender-related outcomes.

## APPENDIX 2

# Case Studies

### CASE STUDY #1: Malawi Male Motivators, Malawi<sup>29</sup>

#### Gender Issues

In many countries, men play a dominant role in contraceptive decisions. When men see few benefits to spacing children, or when they lack information or hold negative attitudes toward FP, they are unlikely to support contraceptive use. The Malawi Male Motivators intervention motivated husbands and partners of young women to identify benefits of FP and discuss FP with their partners.

#### Intervention

The intervention drew on the information-motivation-behavior (IMB) model, which suggests that relevant information and motivation (such as attitudes and skills) prompt behavior change. Male peer educators, or “male motivators,” held five one-to-one visits with men (over six months) to:

- Share their experiences.
- Discuss benefits of birth spacing, gender norms, gender roles, and community perceptions of FP.
- Build skills for partner communication and decisionmaking.

#### Evaluation Design

The randomized controlled evaluation collected data at baseline and one month after the intervention. Four hundred eligible men (that is, men 18 years or older and married or living with a female partner age 24 or younger who were not using contraception, pregnant, or breastfeeding) were randomized.

#### Results

After the intervention, 78 percent of men in the intervention and 59 percent in the control group reported using contraception; the 19 percentage point difference was statistically significant in multivariate analysis (see table below). There were no significant differences between the two groups in most other outcomes (indicated by “NS” in the table). There was a significant difference in frequency of FP communication with the subjects’ wives or partners, with a smaller increase in the intervention group. Analyses showed that communication contributed to contraceptive use, and qualitative data suggested that participants believed that their communication with their partners improved (they found it easier to talk to their partners, for instance).

#### Summary of Intervention Effects, Malawi Male Motivator Project (Malawi)

Outcome	Percentage point or mean difference, if statistically significant
Use of modern contraceptive method	19 (PPD)
Correct FP knowledge	NS*
FP attitudes	NS
Self-efficacy for using FP with partner	NS
Agreement with equitable gender norms	NS
Communication with partner and others about FP	NS
Frequency of FP communication with partner	0.61 (mean difference)

\*NS=association measured, not statistically significant

**Conclusion**

The intervention was associated with increased contraceptive use, although the mechanisms of effect are unclear. The intervention did not increase communication with partners, although qualitative data suggest the intervention may have changed communication. Research is needed to identify characteristics of communication that lead to increased contraceptive use.

## CASE STUDY #2: Gender Roles, Equality and Transformations (GREAT), Uganda<sup>43</sup>

### Gender Issues

Gender norms that lead to power imbalances between males and females often contribute to gender-based violence (GBV) and limited use of contraception. Acceptance of gender norms solidifies during adolescence, making work with youth important. Gender Roles, Equality and Transformations (GREAT) catalyzed discussion around gender norms, GBV, and FP among youth and adults and was developed with scale and sustainability in mind.

### Intervention

GREAT worked at multiple levels:

- Community action cycle: Dialogue and action planning among community leaders and mobilizers to transform attitudes and norms around gender, GBV, and reproductive health.
- Radio serial drama: 50-episode drama, aired on local radio station, told stories of fictional families as they dealt with real-life issues surrounding relationships, GBV, and parenting.
- Scalable toolkit: Activity cards, radio serial drama discussion guide, community engagement game, and flipbook used in existing groups (such as youth groups) to generate dialogue and learning.
- SRH service linkages: Training for healthcare providers and Village Health Teams to strengthen their ability to meet the needs of adolescents and improve referral systems.

### Evaluation Design

The quasi-experimental evaluation drew on cross-sectional household- and school-based surveys from intervention and comparison communities at baseline and after two years of implementation. Analyses were stratified by age and marital status: very young adolescents (10 to 14 years old), older adolescents (15 to 19 years old, no children and not married), and married or parenting adolescents (15 to 19 years old, parenting or married or cohabiting). The table presents statistically significant percentage point differences (PPD) from a propensity score analysis that compared those exposed to the intervention to a derived set of those not exposed to the intervention. Some outcomes were not evaluated for some groups (“n/a” in the table). Non-significant results indicated by “NS.”

### Results

The intervention improved gender and family planning outcomes for some groups (see table). The intervention was associated with increased communication about FP (11.5 PPD) and increased contraceptive use (10.4 PPD) among married or parenting adolescents. Among older adolescents who were not married or parenting, the intervention reduced the acceptance of gender beliefs about family planning; for example, there was a -11.3 PPD in the belief that men should be offended if their wives asked them to use condoms. There were no differences among married or parenting adolescents.

GREAT was associated with several measures of gendered beliefs and perceived gender norms (such as acceptability of educational inequality between boys and girls and perception of who did or should do various household chores) among older adolescents who were not married or parenting and among married and parenting adolescents. For example, changes in perceptions of the value of education and who does or should do household chores were significantly different at endline. Finally, the intervention had limited effects on GBV behaviors (for instance, it found no differences in reports on unwanted touching on buttocks and breasts).

The annual cost per person-contact was \$6.62 (ranging from \$1.76 for radio to \$26.48 for community action cycle), with more people listening to the radio than participating in other components.

## Summary of Intervention Effects, GREAT (Uganda)

Outcome	Very young adolescents	Older adolescents	Married and/or parenting adolescents
<b>Behaviors to avoid an unintended pregnancy</b>			
Currently using FP	n/a**	NS*	10.4
Discussed when to have a child	n/a	n/a	NS
Discussed FP with partner	n/a	n/a	11.5
<b>Acceptance of gendered beliefs about family planning<sup>§</sup></b>			
Man should be offended if wife asks to use condom	n/a	-11.3	NS
Girls who carry condoms are promiscuous	n/a	-8.9	NS
Solely women's responsibility to avoid pregnancy	n/a	NS	NS
Man and woman should decide on method together	n/a	NS	NS
<b>Other gender outcomes (scales)</b>			
General gender norms	n/a	-11.8	-6.5
Rights and privileges of men	n/a	-16.5	-9.4
Boys educational inequality	n/a	-20.7	-9.7
Household roles sharing	n/a	-11.8	-6.5
% girls touched by boys without permission	NS	NS	n/a
% boys who touched girls without permission	NS	-7.7	n/a

<sup>§</sup> Lower scores represent more gender equitable beliefs and outcomes, and a negative percentage point difference indicates that those in the intervention had more egalitarian beliefs or behaviors.

\* NS=association measured, not statistically significant

\*\* n/a=not applicable, association not measured

### Conclusion

For some groups of participants, this intervention was associated with changes in attitudes and perceived gender norms related to men's and women's roles in society in general and in the family in particular. These changes may have laid the foundation for increased contraceptive use, although the inconsistent effects across groups suggests the need for further work to understand how changes in perceived gender norms and attitudes are linked to contraceptive use.

## CASE STUDY #3: Home Based Life Saving Skills, Tanzania<sup>67</sup>

### Gender Issues

Men's lack of knowledge about pregnancy and norms that limit their engagement in maternal health reduces their ability to support women's health and well-being. Furthermore, men's higher status positions them as gatekeepers and decisionmakers about women's health. Women's responsibility for household work may limit their opportunities to care for themselves during pregnancy (for instance, they may lack time for rest). The Home Based Life Saving Skills program sought to increase men's involvement in maternal health by increasing knowledge, building support, and encouraging joint decisionmaking.

### Intervention

Community health workers (CHWs) made at least four home visits with pregnant women, husbands, and other family members to share information and discuss men's role in maternal health.

- Visit 1: Early antenatal care, danger signs and actions.
- Visit 2: Birth preparedness and complication readiness (BP/CR), rest and nutrition, and men's support (such as help with chores).
- Visit 3: Danger signs and referrals, BP/CR plans, joint decisionmaking for delivery.
- Visit 4: Maternal and newborn danger signs and actions, BP/CR, and joint decisionmaking.

### Evaluation Design

The quasi-experimental evaluation collected data from men whose partners delivered at health facilities (in the previous two years) in intervention and comparison districts at baseline and two years later.

### Results

In analyses that compared changes over time between the intervention and comparison groups, there was a modest increase in facility deliveries, but the 19 percentage point difference (PPD) was not statistically significant (i.e., "NS" in table). Differences in all measures of male engagement were statistically significant, including men's reporting of accompanying their wives to ANC (14.8 PPD) and taking three or more birth planning or birth complications actions (23.7 PPD).

#### Summary of Intervention Effects, Home Based Life Savings Skills (Tanzania)

Outcome	Percentage point difference
Wife's facility delivery	NS*
Knowledge of at least three danger signs per phase (pregnancy, birth, postpartum)	37.7
Knowledge of at least three birth preparedness/complication readiness signs (BP/CR)	24.6
Accompanied wife to ANC	14.8
Shared decisionmaking for delivery	43.5
Took three or more BP/CR actions	23.7
Sum of male involvement (five items)	46.2

\*NS=association measured, not statistically significant

**Conclusion**

Although the increase in facility-based deliveries was only marginally significant, the intervention did increase men's support for women's health during pregnancy, including taking at least three actions to prepare for birth and reduce pregnancy complications, which may contribute to improved health for women and infants. In addition, men who participated in the intervention were significantly more likely to share decisionmaking about accessing ANC and delivery services. This evaluation highlights the promise of engaging men and women together in interventions and emphasizes the need to strengthen programs so that male engagement leads to improved health outcomes.

## CASE STUDY #4: Heshima Project, Kenya<sup>69</sup>

### Gender Issues

Disrespect and abuse (D&A) in maternal health services are associated with poor quality of care and poor health outcomes. Instances of D&A stem, in part, from unequal status and power between providers and women. Heshima used a multi-level approach to change policies, attitudes, and accountability.

### Intervention

The intervention worked with policymakers, providers, and community members:

- Policymakers: Engaged in dialogue among government, civil society, and professionals to prompt new policies.
- Providers: Trained in respectful care to improve attitudes and encourage respect for clients' rights. Offered counseling and taught coping skills to deal with stress.
- Community members: Engaged in dialogue to strengthen the facility-community link. Community leaders mediated cases of D&A and referred women to counseling.

### Evaluation Design

The evaluation collected data in all 13 intervention facilities at baseline and two years after implementation began. Exit interviews with 15 to 45 year old women who delivered in the past 24 to 48 hours assessed six types of D&A. Observations of provider-patient interactions during labor and delivery identified seven types of D&A (see table). Analyses of women's self-reports controlled for demographic characteristics.

### Results

The intervention was associated with statistically significant reductions in women's reports of most forms of D&A from baseline to endline. There was about a 7 percentage point reduction in women's reports of feeling humiliated or disrespected, experiencing verbal abuse, and being detained. Percentage point reductions in others forms of D&A were lower, but still significant. Although rates of abandonment increased, the change over time was not statistically significant (NS in table).

Analyses of the observational data showed that most forms of D&A declined over time. However, non-consensual care (that is, not obtaining consent before vaginal exam) was common at baseline and was significantly higher (+20.1 PPD) at endline, and bed sharing during the postpartum period increased significantly from baseline to endline (+11.4 PPD).

## Summary of Intervention Effects, Heshima (Kenya)

Outcome	Percentage point change, baseline to endline
<b>Women's Self-Report of:</b>	
Feeling humiliated or disrespected	-6.9
Physical abuse	-2.1
Privacy violated	-1.7
Confidentiality violated	-2.1
Verbal abuse	-6.7
Detention	-7.2
Abandonment	NS*
<b>Observation During Examination:</b>	
Non-consented care	+20.1
Verbal abuse	NS
Lack of privacy	-20.9
<b>Observation During Delivery:</b>	
Physical aggression	-3.4
Verbal aggression	NS
Lack of privacy	-12.3
<b>Observation, shared bed postpartum</b>	<b>+11.4</b>

\* NS= association measured, not statistically significant

### Conclusion

This evaluation shows the promise of interventions to modify health systems to improve health, in part by engaging actors at all levels and changing the power dynamics between providers and patients. Further work is needed to confirm these results in more rigorous evaluation studies.

## CASE STUDY #5: Tchova, Tchova, Mozambique<sup>123</sup>

### Gender Issues

In places where men are domineering and women are expected to be subservient, women have difficulty negotiating condom use. If women do start discussions about condoms or other means of protection, their male partners may think that they have side partners. Through community discussion and a radio magazine, Tchova Tchova addressed gender norms to increase self-efficacy to talk about HIV, decrease HIV stigma, and reduce HIV risk behaviors.

### Intervention

Based on theories of normative influence (the use of communications to promote norm change) and convergence (the use of dialogue to share, create, and clarify new ideas), Tchova, Tchova included:

- Facilitated Community Dialogues: Video profiles of “Mozambican trendsetters” (testimonials on how individuals overcame gender bias and other barriers) were shown in 10 weekly community dialogue sessions. Discussion topics included protecting one’s family from HIV, living without domestic violence, and ways men and women can support each other.
- Radio magazine: Thirty-four 12-minute programs reinforced ideas explored in the community dialogues and presented ways of speaking up and addressing issues.

### Evaluation Design

The evaluation used a posttest-only design, with data collected from randomly selected participants and non-participants (that is, men and women who agreed to participate in the next round of community dialogues). Analyses controlled for demographic characteristics.

### Results

The intervention had statistically significant effects on all gender outcomes measured and was associated with a reduction in multiple partners. For example, when comparing participants to non-participants there was a 29 PPD in the percentage who were above the mean in a scale measuring gender attitudes (such as whether married men can assist in tasks typically assigned to women) and a 16 PPD in the percentage who reported talking with their partners about HIV in the past 3 months. Intervention participants were significantly less likely to report having two or more partners (PPD -5).

#### Summary of Intervention Effects, Tchova, Tchova (Mozambique)

Outcome	Percentage point or mean difference
Gender attitudes (% above mean)	29 (PPD)
Gender behaviors (shared household tasks)	3 (mean difference)
HIV partner communication in the past three months	16 (PPD)
Two or more sex partners (including spouse)	-5 (mean difference)

### Conclusion

The intervention was associated with positive changes in gender attitudes and gender-specific behaviors (specifically household tasks and partner communication). The rather large difference between participants and non-participants in attitudes suggest the potential for longer-term effects of the intervention. The intervention did not measure condom use or other preventive behaviors, something that should be addressed in future interventions.

## CASE STUDY #6: RHANI Wives, India<sup>125,126</sup>

### Gender issues

Intimate partner violence (IPV) directly (through sexual violence by an HIV-infected partner) and indirectly (through limited negotiation for safer sex, for example) contributes to an increased risk for HIV among women. RHANI (Reducing HIV among Non-Infected) Wives sought to develop problem-solving and negotiation skills so wives could be more assertive about their needs with their husbands.

### Intervention

Drawing on social cognitive theory (for instance, knowledge, skills, and norms) and theory of gender and power (for instance, gender inequality, marital conflict, and partner communication), the intervention included four individual counseling sessions and two group sessions for women over a six-to-nine-week period.

- Individual sessions: Problem solving skills and action plans for dealing with conflict about sexual relationships, financial and family pressures, and husband's alcohol use.
- Group sessions: Women shared their stories, lent social support, and discussed harm reduction.
- Counselor training: Counselors were trained on protocols for IPV survivor safety.

### Evaluation Design

The randomized controlled trial collected data from women at baseline and approximately four months later. Geographic clusters (selected for the number of alcohol venues) were randomized to intervention or control. Eligible women (those aged 18 to 40 years who resided with husbands for at least two months and whose husbands engaged in heavy drinking or who had ever experienced spousal violence) were enrolled. Multivariate analyses controlled for demographics and compared change over time between the two groups. In the table, the percentage point differences at endline are presented for IPV-related variables and rate ratios are presented for HIV-related variables.

### Results

The intervention had significant effects on marital conflict and violence, as well as on one measure of risk for HIV. Endline percentage point differences showed that marital conflict (-5.2) and sexual coercion (-4.1) were lower for women in the intervention and control groups. Rate ratios were presented for HIV-related behavioral outcomes. The intervention was associated with a reduction in the proportion of unprotected vaginal sex acts (RR = .83, or .83 times the rate of unprotected sex in the intervention group as compared to the control) but not with measures of condom use, as indicated by "NS" in the table.

### Summary of Intervention Effects, RHANI Wives (India)

Outcome	Percentage point difference or rate ratio
Marital conflict (past three months)	-5.2 (PPD)
Intimate partner violence (past three months)	NS
Sexual coercion	-4.1 (PPD)
Proportion of unprotected sex with husband, past 30 days	0.83 (rate ratio)
Number of vaginal sex acts with husband, past 30 days	NS
Any marital condom use in the past 90 days	NS
Marital condom use at last sex	NS

\*NS=association measured, not statistically significant

**Conclusion**

This intervention, which combined individual and group activities, had positive effects on IPV, a risk factor for HIV transmission and other negative RH outcomes. In addition to helping women build skills for dealing with abusive and unsafe situations, interventions to reduce men's perpetration of violence are needed.

## CASE STUDY #7: Building an Evidence Base to Delay Marriage in Sub-Saharan Africa, Ethiopia, Tanzania, and Burkina Faso<sup>144</sup>

### Gender Issues

Child, early, and forced marriage (CEFM) is a form of GBV that stems from the devaluation of girls and their limited autonomy to reject early marriage. CEFM results in negative health consequences and is associated with intimate partner violence. This project sought to identify the minimum intervention package needed to delay marriage among rural girls ages 12 to 17. Interventions addressed structural barriers (such as access to education and economic opportunities) and gender norms.

### Intervention

Four intervention packages were tested:

- Community dialogue to modify norms: Community groups discussed and devised strategies to end child marriage, or religious and community leaders gave weekly talks.
- School supplies to retain girls in school: Girls who remained unmarried and in school were given school supplies.
- Asset transfer to increase the value of girls: Families and girls who remained unmarried and in school were provided livestock assets.
- All three intervention components.

### Evaluation Design

The quasi-experimental five-arm evaluation (four communities received one intervention package and one community served as the comparison) collected data from girls at baseline and after two years of implementation. Analyses were stratified by country and age (that is, ages 12 to 14 and ages 15 to 17) and controlled for demographics. In Burkina Faso, the conditional asset transfer package was omitted from the analyses, as were outcomes for girls ages 12 to 14 due to low numbers of marriage. In Ethiopia, analyses were limited to baseline to endline outcomes in the intervention communities because of lack of comparability between the intervention and comparison communities. Results were reported as risk ratios; values less than one indicate that girls in the intervention communities were less likely to be married at endline (Burkina Faso and Tanzania). Non-statistically significant effects are indicated by “NS”.

*Burkina Faso and Tanzania:* At endline girls ages 15 to 17 living in the Burkina Faso community that received community dialogue had approximately two-thirds less risk of being married than girls living in the comparison community (a risk ratio of 0.33). In Tanzania, girls ages 12 to 14 in the community that received all three components had two-thirds less risk of being married than girls in the comparison community (RR = 0.33), and girls ages 15 to 17 in the community that received the conditional asset transfers had roughly half the risk of being married as girls in the comparison community (RR = 0.52).

### Summary of Intervention Effects, Age at Marriage Project (Burkina Faso and Tanzania)

	Burkina Faso		Tanzania	
	Ages 12 to 14	Ages 15 to 17	Ages 12 to 14	Ages 15 to 17
Community dialogue	n/a**	0.33	NS	NS
School supplies	n/a	NS*	NS	NS
Asset transfer	n/a	n/a	NS	0.52
All components	n/a	NS	0.33	NS

\* NS= association measured, not statistically significant

\*\* n/a=not applicable, association not measured

*Ethiopia:* Girls ages 12 to 14 who lived in communities that received schools supplies had about 90 percent less risk (RR = .09) of being married at endline versus baseline. Girls ages 12 to 14 living in communities that received the community dialogue intervention had just over 50 percent less risk of being married at endline versus baseline. Among girls ages 15 to 17, those residing communities that received the conditional asset package or in communities that received the full package had approximately half the risk of being married at endline versus baseline.

Summary of Intervention Effects, Age at Marriage Project (Ethiopia)		
	Ages 12 to 14	Ages 15 to 17
Community dialogue	0.42	NS
School supplies	0.09	NS
Asset transfer	NS*	0.57
All components	NS	0.38

*\*NS=association measured, not statistically significant*

The project collected cost data. Costs varied significantly. In all countries, community dialogue and school promotion cost roughly the same: between \$9 and \$20 per community member served for community dialogue. This was less than the cost of conditional assets. Costs for livestock assets varied, in part because of the different livestock provided (for instance, goats versus chickens).

Age at Marriage Project: Intervention costs (in US dollars) per girl/person served per year			
	Burkina Faso	Ethiopia	Tanzania
Community dialogue	\$12	\$20	\$9
School supplies	\$13	\$20	\$18
Asset transfer	\$33	\$32	\$107
All intervention components	\$60	\$29	\$117

### Conclusion

Although there were challenges in implementing the evaluation as planned, the evaluation showed that different intervention packages were effective in different countries and for different age groups, highlighting the importance of tailoring interventions by age. For younger girls, some combination of educational supports and community dialogue were more effective; for older girls, some combination of asset transfers and community dialogue appeared to be more effective. This is in line with where girls may be in the transition from school to work and suggests the importance of combining structural opportunities with normative change.

## CASE STUDY #8: Tostan Village Empowerment Program, Senegal<sup>146</sup>

### Gender Issue

Female genital mutilation/cutting (FGM/C) is recognized as a violation of bodily integrity and is associated with poor health outcomes. In most instances, girls lack the autonomy to object to FGM/C. Tostan's Village Empowerment Program built community capacity to identify and take action on issues, including FGM/C and the norms and traditions that support it.

### Intervention

Community management committees, made up of women and men, participated in training and inter-village meetings to plan activities to end FGM/C.

- Training: Participants were taught about rights (such as the right to bodily integrity), problem-solving, basic hygiene, and women's health.
- Inter-village meetings: Participants discussed what they learned in training and identified and planned collective action around FGM/C. They also contacted other villages, often through family members, to spread messages about ending FGM/C.

### Evaluation Design

The quasi-experimental longitudinal design collected data from women at baseline, immediately post-intervention, and two years after the intervention. Twenty intervention villages were randomly selected and two villages from a matched comparison area were selected for the evaluation. Endline percentages in the table are provided for three groups and are from analyses that compared changes over time.

### Results

In intervention and comparison villages there were reductions in the proportion of women who approved of FGM/C, but the reduction was larger and statistically significant in the intervention communities. By endline, less than 30 percent of the women in intervention villages approved of FGM/C, compared to nearly 60 percent in the comparison villages. Patterns were similar for having daughters cut in the future. At baseline, 66 percent of women in intervention villages and 71 percent of women in comparison villages reported that all their daughters had been cut. There was a statistically significant decrease over time in the proportion of women in intervention villages (to 59 percent for training participants and 57 percent for other village members) who reported that their daughters had been cut, but not in the comparison villages.

### Summary of Intervention Effects, Tostan Village Empowerment Program, Senegal

	Intervention villages, training participants	Intervention villages, other women	Comparison villages
Approved of FGM/C	16%	28%	60%
Would have daughters cut in the future	12%	23%	54%
All daughters were cut	59%	57%	70%

### Conclusion

This community-based intervention reduced the acceptance and practice of FGM/C, with change occurring among women who participated in the training and those who did not. This suggests both the importance of community-directed change and diffusion of information and ideas within community networks for bringing about changes in norms and practices.

## APPENDIX 3

# Detailed Findings, Effects of Gender-Integrated Interventions

**Table 1: Detailed Findings, Effects of Gender-Integrated Interventions for Reducing Unintended Pregnancy**

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>INDIVIDUALS</b>				
<b>Shattuck et al., 2011</b>	<ul style="list-style-type: none"> <li>• Contraceptive use</li> <li>• Men age 18 or older, married to or living with young women</li> <li>• Malawi</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• One-on-one sessions, male motivator</li> <li>• Referral for contraception</li> <li>• Topics: FP, gender norms, benefits of communication</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized individuals</li> <li>• Intervention</li> <li>• Control</li> <li>• Longitudinal: baseline and one month</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Contraceptive use</li> </ul> <p><b>No differences (vs. controls)</b></p> <ul style="list-style-type: none"> <li>• Perceived gender norms</li> <li>• Partner communication</li> </ul>
<b>Leon et al., 2014</b>	<ul style="list-style-type: none"> <li>• Contraceptive use</li> <li>• Married women ages 15 to 49 at risk for unintended pregnancy</li> <li>• India</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Theater, puppets, paintings</li> <li>• Topic: FP, partner decisionmaking, and communication</li> <li>• Strengthen FP services, gender, and introduce Standard Days Method</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned catchment areas</li> <li>• Intervention</li> <li>• Comparison</li> <li>• Cross-sectional: baseline and two years</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Beliefs about a woman’s role in decisions about her earnings and visiting others</li> </ul> <p><b>No differences (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Decisionmaking power in household</li> <li>• Met need for contraception. However, increase for illiterate women with more relationship power</li> </ul>
<b>COUPLES</b>				
<b>Tilahun et al., 2015</b>	<ul style="list-style-type: none"> <li>• Contraceptive use</li> <li>• Married couples, wives ages 15 to 49</li> <li>• Ethiopia</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Couples education and counseling, in home (two visits)</li> <li>• Monthly community gatherings/meetings</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized kebeles</li> <li>• Intervention</li> <li>• Control</li> <li>• Longitudinal: baseline and post-test</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Partner communication</li> <li>• Agree women can decide to use FP without husband’s consent</li> <li>• Husband’s participation in FP services</li> </ul> <p><b>No differences (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Contraceptive use. However, increase among those not using at baseline</li> </ul>

**Table 1: Detailed Findings, Effects of Gender-Integrated Interventions for Reducing Unintended Pregnancy** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>Zhu et al., 2009</b>	<ul style="list-style-type: none"> <li>• Contraceptive use</li> <li>• Women age 24 and younger who had had an abortion</li> <li>• China</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Engage partner in FP education and counseling</li> <li>• Provide methods</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized hospitals               <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Control</li> </ul> </li> <li>• Longitudinal: baseline, leaving FP services, and six months</li> <li>• Multivariate time x treatment analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Use of more effective methods</li> <li>• Consistent condom use</li> <li>• Correct condom use</li> </ul> <p><b>No differences (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Contraceptive use</li> </ul>
<b>Raj et al., 2016</b>	<ul style="list-style-type: none"> <li>• Contraceptive use, intimate partner violence</li> <li>• Married couples, husbands ages 18 to 30</li> <li>• India</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Men alone (two) and couples (one) counseling</li> <li>• Topics: Fertility goals, FP, safe motherhood and happy family life, male involvement, communication, marital violence</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized geographic clusters               <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Control</li> </ul> </li> <li>• Longitudinal: baseline, nine months, 18 months</li> <li>• Multivariate time x treatment analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Contraceptive use</li> <li>• Partner communication</li> <li>• Men’s attitudes toward sexual IPV</li> </ul> <p><b>No differences (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Pregnancy</li> <li>• Men’s reports of sexual or physical IPV</li> <li>• Men’s attitudes toward physical IPV</li> </ul>
<b>GROUPS</b>				
<b>Harris-Fry et al., 2016</b>	<ul style="list-style-type: none"> <li>• Contraceptive use</li> <li>• Married women of reproductive age</li> <li>• Bangladesh</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Participatory learning: identified problems, activities, and plans; implemented strategies</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized unions               <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Control</li> </ul> </li> <li>• Cross-sectional: baseline and 18 months</li> <li>• Time x treatment analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Unmet need for contraception</li> <li>• Ideal age for first marriage</li> </ul> <p><b>No differences (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Unmet need for spacing</li> <li>• Ideal age for first birth</li> </ul>

**Table 1: Detailed Findings, Effects of Gender-Integrated Interventions for Reducing Unintended Pregnancy** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>Undie et al., 2014</b>	<ul style="list-style-type: none"> <li>• Contraceptive use, use of services for early pregnancy bleeding</li> <li>• Women ages 18 to 49</li> <li>• Kenya</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Community action: assessed issues, planned, and implemented activities</li> <li>• CHW outreach</li> <li>• Service strengthening</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned communities                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Comparison</li> </ul> </li> <li>• Cross-sectional: baseline and 18 months</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Awareness of contraceptive methods</li> </ul> <p><b>No differences (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Contraceptive use</li> <li>• Use of post-abortion care services</li> </ul>
<b>COMMUNITIES</b>				
<b>Wegs et al., 2016</b>	<ul style="list-style-type: none"> <li>• Contraceptive use</li> <li>• Women and men ages 18 to 49</li> <li>• Kenya</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Ongoing dialogues in community venues (3.5 years)</li> <li>• Topics: gender, sexuality, FP</li> </ul>	<ul style="list-style-type: none"> <li>• Cross-sectional survey, baseline and three years, intervention only</li> <li>• Multivariate, propensity score matching, effect of exposure</li> </ul>	<p><b>Improvements (exposed vs. unexposed)</b></p> <ul style="list-style-type: none"> <li>• Contraceptive use (women only, not significant for men)</li> </ul>
<b>Igras et al., 2017</b>	<ul style="list-style-type: none"> <li>• Contraceptive use</li> <li>• Women and men of reproductive age</li> <li>• Benin</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Dialogue for influential individuals, share in networks</li> <li>• Radio stories &amp; discussions</li> <li>• Topics: FP, attitudes, gender norms</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned communities                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Comparison</li> </ul> </li> <li>• Cross-sectional: baseline and 18 months</li> </ul>	<p><b>Improvements (exposed vs. unexposed)</b></p> <ul style="list-style-type: none"> <li>• Contraceptive use (women only, not significant for men)</li> <li>• Partner communication (men and women)</li> </ul>
<b>Agha et al., 2010 and 2012</b>	<ul style="list-style-type: none"> <li>• Contraceptive use</li> <li>• Married men and women, ages 15 to 49, urban</li> <li>• Pakistan</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Condom social marketing</li> <li>• Topics: healthy timing and spacing, male responsibility</li> </ul>	<ul style="list-style-type: none"> <li>• Post-test survey, intervention only</li> <li>• Multivariate analysis assessed effect of exposure</li> </ul>	<p><b>Improvements (exposed vs. unexposed)</b></p> <ul style="list-style-type: none"> <li>• Contraceptive use</li> </ul> <p><b>No differences (exposed vs. unexposed)</b></p> <ul style="list-style-type: none"> <li>• Believe condoms do not reduce pleasure</li> </ul>

**Table 1: Detailed Findings, Effects of Gender-Integrated Interventions for Reducing Unintended Pregnancy** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>MULTI-COMPONENT</b>				
<b>Speizer et al., 2014; Krenn W</b>	<ul style="list-style-type: none"> <li>• Contraceptive use</li> <li>• Men and women, ages 15 to 49</li> <li>• India, Kenya, Nigeria, and Senegal</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Mass media and outreach</li> <li>• Improved FP services</li> <li>• Topics: timing and spacing, male responsibility, communication</li> </ul>	<ul style="list-style-type: none"> <li>• Longitudinal survey, baseline and two years, intervention only</li> <li>• Multivariate analysis, addressed endogeneity, assessed effect of exposure to each intervention component</li> </ul>	<p><b>Improvements at midline</b></p> <ul style="list-style-type: none"> <li>• Contraceptive use</li> </ul>
<b>Wandiembe et al., 2015</b>	<ul style="list-style-type: none"> <li>• Contraceptive use, GBV</li> <li>• Married, newly parenting, or unmarried youth ages 10 to 19</li> <li>• Uganda</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Community action cycle</li> <li>• Radio serial drama</li> <li>• Toolkit (activities) for groups</li> <li>• FP service linkages/ referrals</li> <li>• Topics: gender, GBV, FP</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned communities <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Comparison</li> </ul> </li> <li>• Cross-sectional: baseline and two years</li> <li>• Multivariate, propensity score matching, effect of exposure</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Contraceptive use (married/parenting)</li> <li>• Perceptions of gender norms and men's role (married and unmarried)</li> </ul> <p><b>No differences (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Partner communication</li> <li>• Experiences of GBV</li> </ul>
<b>Daniel et al., 2012</b>	<ul style="list-style-type: none"> <li>• Child marriage, contraceptive use</li> <li>• Married and unmarried youth ages 15 to 24</li> <li>• India</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Orient community leaders</li> <li>• Workshops</li> <li>• Married: separate sex groups, couples counseling, home visits</li> <li>• Train RH providers</li> <li>• Topics: FP, norms, partner communication and decisionmaking</li> </ul>	<ul style="list-style-type: none"> <li>• Survey, five years post-intervention with workshop participants and “similar age cohort” in comparison area</li> <li>• Multivariate analyses</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Among those not married at time of training: increased age at marriage for men and women</li> <li>• Among all: <ul style="list-style-type: none"> <li>· Increased age at first birth</li> <li>· Contraceptive use</li> </ul> </li> </ul>

**Table 2: Detailed Findings, Effects of Gender-Integrated Interventions for Improving Maternal Health**

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>COUPLES</b>				
<b>Bich et al., 2014</b>	<ul style="list-style-type: none"> <li>Breastfeeding</li> <li>Couples, wife pregnant</li> <li>Vietnam</li> </ul>	<ul style="list-style-type: none"> <li>Gender accommodating</li> <li>Mass media and events</li> <li>ANC group meeting and individual in-home counseling</li> <li>Topics: benefit of breastfeeding, men's support</li> </ul>	<ul style="list-style-type: none"> <li>Assigned geographic areas                             <ul style="list-style-type: none"> <li>Intervention</li> <li>Comparison</li> </ul> </li> <li>Longitudinal: baseline after birth, four months, and six months</li> <li>Multivariate analysis</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>Exclusive breastfeeding at four and six months (24-hour recall, last week recall, since birth recall)</li> </ul>
<b>Susiloretni et al., 2013</b>	<ul style="list-style-type: none"> <li>Breastfeeding</li> <li>Couples, wife pregnant</li> <li>India</li> </ul>	<ul style="list-style-type: none"> <li>Gender accommodating</li> <li>In-home education of women, husbands, and mothers-in-law</li> <li>Posters, brochures, banners</li> <li>Topics: benefit of breastfeeding, men's support</li> </ul>	<ul style="list-style-type: none"> <li>Assigned health centers                             <ul style="list-style-type: none"> <li>Intervention</li> <li>Comparison</li> </ul> </li> <li>Longitudinal: baseline and 24 weeks</li> <li>Multivariate, survival analysis</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>Exclusive breastfeeding at 24 weeks</li> </ul>
<b>Brasington et al., 2016</b>	<ul style="list-style-type: none"> <li>Maternal health</li> <li>Pregnant women (or new infant) and their families</li> <li>Egypt</li> </ul>	<ul style="list-style-type: none"> <li>Gender accommodating</li> <li>Home visits</li> <li>Group sessions</li> <li>Community events</li> <li>Topics: maternal and newborn care, child nutrition, family support</li> </ul>	<ul style="list-style-type: none"> <li>Assigned geographic areas                             <ul style="list-style-type: none"> <li>Intervention</li> <li>Comparison</li> </ul> </li> <li>Cross-sectional: baseline and 14 months</li> <li>Multivariate, time x treatment analysis</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>Antenatal care visits</li> <li>Use of iron folate</li> </ul> <p><b>No differences (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>Skilled birth attendant</li> <li>Exclusive breastfeeding</li> <li>Fed child three or more dietary groups</li> </ul>

**Table 2: Detailed Findings, Effects of Gender-Integrated Interventions for Improving Maternal Health** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>Kamiya et al., 2013</b>	<ul style="list-style-type: none"> <li>• Kamiya et al., 2013</li> <li>• Maternal health</li> <li>• Pregnant women and their families</li> <li>• Bangladesh</li> </ul>	<ul style="list-style-type: none"> <li>• Gender accommodating</li> <li>• Home-based education</li> <li>• Community fund (low SES)</li> <li>• Transport referral slips</li> <li>• MH service improvement</li> <li>• Topics: pregnancy care, family support for pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned geographic areas                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Comparison</li> </ul> </li> <li>• Cross-sectional: baseline and 18 months</li> <li>• Multivariate, time x treatment analysis</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Antenatal care visits (any visits, at least three visits)</li> </ul> <p><b>No differences (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Skilled birth attendant</li> <li>• Received EmOC services</li> </ul>
<b>Sharma et al., 2016</b>	<ul style="list-style-type: none"> <li>• Maternal health</li> <li>• Pregnant women and family members</li> <li>• Nepal</li> </ul>	<ul style="list-style-type: none"> <li>• Gender accommodating</li> <li>• Group sessions, women and husbands</li> <li>• Incentives (e.g., baby blanket) for completing four ANC visits</li> <li>• Topics: pregnancy care, danger signs, delivery, postnatal care</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned geographic areas                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Comparison</li> </ul> </li> <li>• Cross sectional: baseline, two years, and five years</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Any ANC and three or more ANC</li> <li>• Iron and folic acid supplements</li> <li>• Attend post-natal care</li> </ul> <p><b>No differences (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• ANC in first trimester</li> <li>• Skilled birth attendant or facility delivery</li> </ul>
<b>Turan et al., 2011</b>	<ul style="list-style-type: none"> <li>• Maternal health</li> <li>• Pregnant women and men</li> <li>• Eritrea</li> </ul>	<ul style="list-style-type: none"> <li>• Gender accommodating</li> <li>• Separate group sessions for women and men</li> <li>• Topics: ANC, danger signs, birth preparations, referrals, fistula, skilled birth attendant</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned geographic areas                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Comparison</li> </ul> </li> <li>• Cross-sectional: baseline and two years</li> <li>• Time x treatment analysis</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Four or more ANC visits</li> <li>• Birth at health care facility</li> <li>• Initial ANC in first trimester</li> </ul> <p><b>No differences (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Made any birth preparations</li> </ul>
<b>Barry et al., 2014</b>	<ul style="list-style-type: none"> <li>• Maternal health</li> <li>• Pregnant women and family caregivers</li> <li>• Ethiopia</li> </ul>	<ul style="list-style-type: none"> <li>• Gender accommodating</li> <li>• Four in-home family meetings</li> <li>• Topics: complications referrals, helping newborn to breathe</li> </ul>	<ul style="list-style-type: none"> <li>• Cross-sectional survey, baseline and two years, intervention only</li> <li>• Multi-variate dose-response analyses</li> </ul>	<p><b>Improvements (over time)</b></p> <ul style="list-style-type: none"> <li>• Mean of CMNH package items received</li> </ul> <p><b>No differences (over time)</b></p> <ul style="list-style-type: none"> <li>• Skilled attendant or HEW at birth</li> </ul>

**Table 2: Detailed Findings, Effects of Gender-Integrated Interventions for Improving Maternal Health** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>Ensor et al., 2014</b>	<ul style="list-style-type: none"> <li>• Maternal health</li> <li>• Pregnant women and men</li> <li>• Zambia</li> </ul>	<ul style="list-style-type: none"> <li>• Gender accommodating</li> <li>• Community discussions</li> <li>• Emergency transport (encouraged men to drive)</li> <li>• Topics: ANC, skilled care, danger signs</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned geographic areas                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Comparison</li> </ul> </li> <li>• Cross-sectional: baseline and two years</li> <li>• Time x treatment and propensity score matching analyses</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Emergency transport</li> <li>• Skilled birth attendant</li> <li>• Contraceptive use post-birth</li> </ul> <p><b>No differences (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Four or more ANC visits</li> <li>• Post-natal care within six days</li> </ul>
<b>August et al., 2016</b>	<ul style="list-style-type: none"> <li>• Maternal health</li> <li>• Pregnant women and family members</li> <li>• Tanzania</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Home-based visits</li> <li>• Topics: ANC, danger signs, skilled care, BP/CR, help with chores, communication and joint decisionmaking</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned geographic areas                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Comparison</li> </ul> </li> <li>• Cross-sectional: baseline and two years</li> <li>• Time x treatment analysis</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Escorted wife to ANC, delivery</li> <li>• Share decisionmaking for delivery</li> <li>• Took three or more BP/CR actions</li> </ul> <p><b>No differences (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Facility delivery</li> </ul>
<b>MATERNAL HEALTH SERVICE</b>				
<b>Abuya et al., 2015</b>	<ul style="list-style-type: none"> <li>• Disrespect and abuse in maternity services</li> <li>• Facilities, providers, and communities</li> <li>• Kenya</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Policymakers: dialogue</li> <li>• Providers: training, coping with stress</li> <li>• Community: accountability and referral for women experiencing D&amp;A</li> </ul>	<ul style="list-style-type: none"> <li>• Cross-sectional surveys with women who delivered at facility at baseline and two years, intervention only</li> <li>• Direct observation</li> <li>• Multivariate analysis (women's self-report)</li> </ul>	<p><b>Improvements (over time)</b></p> <ul style="list-style-type: none"> <li>• Feeling humiliated</li> <li>• Physical and verbal abuse</li> <li>• Confidentiality violated</li> <li>• Detention</li> </ul> <p><b>No differences (over time)</b></p> <ul style="list-style-type: none"> <li>• Privacy violated</li> <li>• Abandonment</li> </ul>

**Table 3: Detailed Findings, Effects of Gender-Integrated Interventions for HIV**

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>INDIVIDUALS</b>				
<b>Mantell et al., 2015</b>	<ul style="list-style-type: none"> <li>• Condom use (female)</li> <li>• Young women, university students</li> <li>• South Africa</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Two one-on-one sessions</li> <li>• Topics: HIV prevention, partner negotiation (e.g., condom use), goal setting</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized women               <ul style="list-style-type: none"> <li>· Intervention</li> <li>· HIV education</li> </ul> </li> <li>• Longitudinal: baseline, two months, and five months</li> <li>• Time x treatment analysis</li> </ul>	<p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Number of unprotected vaginal intercourse occasions</li> <li>• Number of female condoms used</li> <li>• Percent vaginal intercourse used female condom</li> </ul>
<b>Wechsberg et al., 2010</b>	<ul style="list-style-type: none"> <li>• Condom use</li> <li>• Women, high-risk (use alcohol/drugs, sex work)</li> <li>• South Africa</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Two one-on-one sessions</li> <li>• Topics: HIV prevention, condom skills, violence prevention, partner negotiation, personal action plan</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned women               <ul style="list-style-type: none"> <li>· Intervention</li> <li>· HIV education</li> </ul> </li> <li>• HIV testing and referral</li> <li>• Longitudinal: baseline, two months, and six months</li> <li>• Multivariate analyses, all and HIV+, HIV-, status unknown</li> </ul>	<p><b>Improvements all (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Condom negotiation</li> </ul> <p><b>No difference all (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Condom use, three or six months</li> <li>• Communication w/partner, three months</li> <li>• Sexual coercion, three months</li> <li>• Improvements (for subgroups)</li> <li>• Condom use (HIV+ and status unknown)</li> </ul>
<b>Haberland et al., 2016</b>	<ul style="list-style-type: none"> <li>• IPV and HIV-related behaviors</li> <li>• Pregnant women</li> <li>• Kenya</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Individual counseling as part of ANC</li> <li>• Topics: IPV, power in relationships, HIV (post-test counseling)</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized women               <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Standard of care control</li> </ul> </li> <li>• Longitudinal: immediately after receiving counseling and one month</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Disclose IPV to provider</li> <li>• Felt more confident in how they deserved to be treated in relationship</li> <li>• Felt supported</li> </ul>
<b>Semeere et al., 2016</b>	<ul style="list-style-type: none"> <li>• Partner's VMMC</li> <li>• Pregnant women</li> <li>• Uganda</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• One counseling session, ANC</li> <li>• Topics: VMMC, negotiation</li> </ul>	<ul style="list-style-type: none"> <li>• Pre- and post-test surveys, intervention only</li> <li>• Multivariate analyses</li> </ul>	<p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Partner's VMMC</li> </ul>

**Table 3: Detailed Findings, Effects of Gender-Integrated Interventions for HIV** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>COUPLES, PRIMARY PREVENTION</b>				
<b>Villar-Loubet et al., 2013 and Jones et al., 2013</b>	<ul style="list-style-type: none"> <li>• Condom use, sexual risk behavior</li> <li>• Couples, pregnant woman</li> <li>• South Africa</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Four gender-concordant group sessions</li> <li>• Topics: communication skill building, HIV/STI, PMTCT, primary prevention, IPV, alcohol use</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized ANC facilities                             <ul style="list-style-type: none"> <li>• Intervention</li> <li>• Enhanced PMTCT</li> </ul> </li> <li>• Longitudinal: baseline, post-intervention, three months postpartum</li> <li>• Mediation analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Condom use (post-intervention)</li> <li>• Intimate partner violence</li> </ul> <p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Condom use (three months postpartum)</li> <li>• Sex with non-primary partner</li> </ul>
<b>Jones et al., 2009 and Jones et al., 2014</b>	<ul style="list-style-type: none"> <li>• Sexual risk behavior</li> <li>• Couples, HIV-seroconcordant and serodiscordant</li> <li>• Zambia</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Gender-concordant groups (three for women and three or one for men)</li> <li>• Topics: HIV prevention, partner communication and negotiation, condom skills</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized couples                             <ul style="list-style-type: none"> <li>• Variations of intervention</li> </ul> </li> <li>• Longitudinal: baseline, six months, and 12 months</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (over time)</b></p> <ul style="list-style-type: none"> <li>• Condom use</li> <li>• Positive communication</li> <li>• IPV</li> </ul>
<b>El-Bassel et al., 2014</b>	<ul style="list-style-type: none"> <li>• Condom use, HIV infection</li> <li>• Couples, high-risk (e.g., inject drugs)</li> <li>• Kazakhstan</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Five sessions (three single-gender group sessions, two couples counseling sessions)</li> <li>• Topics: perceived risk, HIV prevention, communication, condom skills, problem solving, gender roles, social support, triggers, overdose and response</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized couples                             <ul style="list-style-type: none"> <li>• Intervention</li> <li>• Wellness promotion</li> </ul> </li> <li>• Longitudinal: baseline, three months, six months, and 12 months</li> <li>• HIV testing and referral</li> <li>• Multivariate, multilevel time x treatment analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• HCV infection</li> <li>• Unprotected vaginal sex acts</li> <li>• Consistent condom use</li> </ul> <p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• HIV infection</li> <li>• Any STI</li> <li>• Needle sharing, unsafe injection</li> </ul>

**Table 3: Detailed Findings, Effects of Gender-Integrated Interventions for HIV** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>COUPLES PMTCT</b>				
<b>Mohlala et al., 2011</b>	<ul style="list-style-type: none"> <li>• HIV testing (PMTCT)</li> <li>• Pregnant women and their partners</li> <li>• South Africa</li> </ul>	<ul style="list-style-type: none"> <li>• Gender accommodating</li> <li>• Written letter of invitation for partner</li> <li>• Community sensitization in catchment area (intervention and control exposed)</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized women                             <ul style="list-style-type: none"> <li>• Intervention</li> <li>• Partner letter, pregnancy information session</li> </ul> </li> <li>• Longitudinal: one and 12 weeks</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Male attendance at ANC</li> <li>• HIV testing</li> <li>• Unprotected sex</li> </ul> <p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• IPV</li> </ul>
<b>Krakowiak et al., 2016; Ostoi et al.,</b>	<ul style="list-style-type: none"> <li>• HIV testing (PMTCT)</li> <li>• Pregnant women and their partners</li> <li>• Kenya</li> </ul>	<ul style="list-style-type: none"> <li>• Gender accommodating</li> <li>• Home-based education</li> <li>• Topics: pregnancy, facility delivery, breastfeeding, FP, HIV testing and counseling</li> <li>• HIV prevention, treatment, and PMTCT if HIV+</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized women                             <ul style="list-style-type: none"> <li>• Intervention</li> <li>• Partner letter, attend clinic</li> </ul> </li> <li>• Longitudinal: six and 14 weeks and six months postpartum</li> <li>• Bi-variate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Male HIV tested, couple tested together</li> <li>• Female knows male status</li> <li>• Serodiscordant couple identified</li> </ul> <p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Facility delivery</li> <li>• Exclusive breastfeeding</li> <li>• Contraceptive use</li> </ul>
<b>Byamugisha et al., 2011</b>	<ul style="list-style-type: none"> <li>• HIV testing (PMTCT)</li> <li>• Pregnant women and their partners</li> <li>• Uganda</li> </ul>	<ul style="list-style-type: none"> <li>• Gender accommodating</li> <li>• Invitation letter to the male partner</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized women                             <ul style="list-style-type: none"> <li>• Intervention</li> <li>• Leaflet on ANC for partner</li> </ul> </li> <li>• Tracked HIV testing</li> </ul>	<p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Male attendance at clinic</li> <li>• Male HIV testing</li> </ul>
<b>Theuring et al., 2016</b>	<ul style="list-style-type: none"> <li>• HIV testing (PMTCT)</li> <li>• Pregnant women and their partners</li> <li>• Tanzania</li> </ul>	<ul style="list-style-type: none"> <li>• Gender accommodating</li> <li>• Invitation letter to the male partner</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned women                             <ul style="list-style-type: none"> <li>• Intervention</li> <li>• Instruction to invite partner</li> </ul> </li> <li>• Tracked testing and longitudinal: baseline and third ANC visit</li> </ul>	<p><b>No difference (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Male attendance at clinic</li> <li>• Male HIV testing</li> </ul>

**Table 3: Detailed Findings, Effects of Gender-Integrated Interventions for HIV** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>Becker et al., 2010</b>	<ul style="list-style-type: none"> <li>• HIV testing (PMTCT)</li> <li>• Pregnant women and their partners</li> <li>• Tanzania</li> </ul>	<ul style="list-style-type: none"> <li>• Gender accommodating</li> <li>• Couples HIV testing at second ANC visit</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized women                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Individual testing at first ANC visit</li> </ul> </li> <li>• Tracked HIV testing</li> </ul>	<p><b>Negative outcomes (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Women’s receipt of HIV testing result</li> <li>• Among HIV+ women, intervention associated with use of sexual prevention measures and nevirapine</li> </ul>
<b>Stephenson et al., 2011 and Wall</b>	<ul style="list-style-type: none"> <li>• FP use</li> <li>• Couples, one or both HIV+</li> <li>• Zambia</li> </ul>	<ul style="list-style-type: none"> <li>• Gender accommodating</li> <li>• A: Information on methods</li> <li>• B: Model future planning behaviors (e.g., will, finances, pregnancy prevention)</li> <li>• C: Combination of A and B</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized couples                             <ul style="list-style-type: none"> <li>· One of three interventions</li> <li>· Control</li> </ul> </li> <li>• Drawn from cohort enrolled in study of couples counseling and testing, longitudinal data</li> </ul>	<p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Any contraceptive use</li> <li>• Among those using contraception at baseline, modeling video reduced incidence of pregnancy relative to control or informational video</li> </ul>
<b>GROUP</b>				
<b>Cowan et al., 2010</b>	<ul style="list-style-type: none"> <li>• HIV prevention, sexual behaviors</li> <li>• Youth</li> <li>• Zimbabwe</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Peer education, eight to ten months</li> <li>• Parent/community groups on adolescent SRH and parent-child communication</li> <li>• Provider training</li> <li>• Topics: HIV prevention, skills building, gender norms/roles, communication</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized communities                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Three-year delay intervention</li> </ul> </li> <li>• Surveys with 18- to 22-year-olds, four years after initial implementation, bio-marker for HIV, HSV-2, pregnancy (women only)</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Relationship control attitudes (women)</li> <li>• Gender empowerment (women)</li> </ul> <p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Sexual risk behaviors (had sex, number of lifetime partners, condom use)</li> <li>• HIV, HSV-2, Pregnancy</li> <li>• HIV service use</li> <li>• Relationship control attitudes (men)</li> <li>• Gender empowerment (men)</li> </ul>

**Table 3: Detailed Findings, Effects of Gender-Integrated Interventions for HIV** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>Kalichman et al., 2009</b>	<ul style="list-style-type: none"> <li>• HIV and GBV prevention</li> <li>• Men</li> <li>• South Africa</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Five sessions</li> <li>• Topics: consequences of violence and HIV, behavioral alternatives, role models, skills building, goal setting, meanings of masculinity, triggers</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized communities                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Single alcohol and HIV risk reduction session</li> </ul> </li> <li>• Longitudinal: baseline, one month, three months, and six months</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Attitudes toward women</li> <li>• Violence against women</li> <li>• Partner communication</li> <li>• HIV testing</li> </ul> <p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Sexual risk (unprotected sex, condom use, alcohol with sex, number of partners)</li> </ul>
<b>Lin et al., 2010</b>	<ul style="list-style-type: none"> <li>• HIV prevention</li> <li>• Women, rural to urban migrants</li> <li>• China</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Six sessions</li> <li>• Topics: HIV, goals, negotiation and decisionmaking, consensual relationships, empowerment</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned workplaces                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Attention comparison</li> </ul> </li> <li>• Longitudinal: baseline and four months</li> </ul>	<p><b>No difference (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Consistent condom use</li> </ul>
<b>Jemott et al., 2014</b>	<ul style="list-style-type: none"> <li>• HIV prevention</li> <li>• Men</li> <li>• South Africa</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Six-session group intervention, learning activities, and discussion</li> <li>• Topics: HIV, definition of manhood, protecting families and communities</li> </ul>	<ul style="list-style-type: none"> <li>• Matched and randomized communities                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Attention control</li> </ul> </li> <li>• Longitudinal: baseline and 12 months</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Condom use</li> </ul> <p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Anal sex</li> <li>• Multiple partnerships</li> <li>• Partner communication</li> </ul>
<b>Wingood et al., 2013</b>	<ul style="list-style-type: none"> <li>• HIV prevention</li> <li>• Women</li> <li>• South Africa</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Three sessions</li> <li>• Topics: gender, cultural pride, role of apartheid in disempowerment, HIV prevention, testing, dry sex, negotiation, condom skills</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized women                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Attention control</li> </ul> </li> <li>• Longitudinal: baseline and six months, bio-marker for STIs</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Unprotected vaginal sex acts</li> <li>• Relationship control</li> </ul> <p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• STI</li> <li>• Condom use</li> <li>• Self-efficacy for partner communication</li> </ul>

**Table 3: Detailed Findings, Effects of Gender-Integrated Interventions for HIV** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>Exner et al., 2009</b>	<ul style="list-style-type: none"> <li>• HIV prevention</li> <li>• Men</li> <li>• Nigeria</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Two workshops</li> <li>• Two check-ins (one and two months after last workshop)</li> <li>• Topics: HIV prevention, gender norms, GBV, dual method use</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned men               <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Half day workshop</li> </ul> </li> <li>• Longitudinal: baseline and three months</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Condom use with main partner</li> <li>• Unprotected vaginal sex</li> <li>• Egalitarian power dynamics</li> </ul> <p><b>No differences (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• HIV testing</li> <li>• Had non-main partner</li> </ul>
<b>Weiss et al., 2015</b>	<ul style="list-style-type: none"> <li>• VMMC</li> <li>• Men</li> <li>• Zambia</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Four sessions, partners could join</li> <li>• Topics: HIV, male and female condoms, sexual communication, skills building, role play for problem solving</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized HIV testing sites               <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Control</li> </ul> </li> <li>• Longitudinal: baseline post, six months, and 12 months</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• VMMC</li> <li>• Condom use among men who received VMMC</li> </ul>
<b>COMMUNITIES</b>				
<b>Wagman et al., 2015</b>	<ul style="list-style-type: none"> <li>• HIV and GBV prevention</li> <li>• Men and Women</li> <li>• Uganda</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Community mobilization: promote awareness, building networks, action, consolidation</li> <li>• Topics: attitudes, social norms, IPV, HIV, disclosure, communication, HIV testing</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized communities               <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Control (standard of care)</li> </ul> </li> <li>• Longitudinal: baseline, two years, and three years, biomarker for HIV</li> <li>• Poisson multivariate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Women’s report of physical and sexual IPV</li> <li>• HIV incidence</li> </ul> <p><b>No differences (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Women’s reports of emotional IPV</li> <li>• Men’s reports of IPV perpetration</li> </ul>

**Table 3: Detailed Findings, Effects of Gender-Integrated Interventions for HIV** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>Kyegombe et al., 2014</b>	<ul style="list-style-type: none"> <li>• HIV and GBV prevention</li> <li>• Men and women</li> <li>• Uganda</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Community mobilization: prepare community activists, strengthen connections and skills in community, reinforce change</li> <li>• Topics: HIV, gender norms, power imbalances, IPV, communication, HIV</li> </ul>	<ul style="list-style-type: none"> <li>• Matched and randomized communities                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Control</li> </ul> </li> <li>• Cross sectional: baseline and five years</li> <li>• Multivariate analysis, stratified by sex</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Protective behaviors (condom use, testing, concurrent partners) (men)</li> <li>• Communication and decisionmaking (men and women)</li> <li>• Participation in household tasks (men)</li> </ul> <p><b>No differences (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Protective behaviors (women)</li> </ul>
<b>Figueroa et al., 2016</b>	<ul style="list-style-type: none"> <li>• HIV and GBV prevention</li> <li>• Men and women</li> <li>• Mozambique</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Community dialogues, video profiles of “trendsetters”</li> <li>• Radio magazine</li> <li>• Topics: HIV, domestic violence, partner support</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized men and women                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Wait-list control</li> </ul> </li> <li>• Post-test only</li> <li>• Multivariate analyses</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Gender attitudes</li> <li>• Gender behaviors (e.g., household tasks)</li> <li>• Partner communication about HIV</li> <li>• Multiple concurrent partners</li> </ul>
<b>Wilson et al., 2016</b>	<ul style="list-style-type: none"> <li>• VMMC</li> <li>• Men</li> <li>• South Africa</li> </ul>	<ul style="list-style-type: none"> <li>• Gender accommodating</li> <li>• Four postcards, one addressing women’s perceptions of circumcised men</li> </ul>	<ul style="list-style-type: none"> <li>• Randomize men to receive one of four postcards</li> <li>• Track VMMC service use and uptake</li> </ul>	<p><b>No differences (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Men’s use of VMMC services</li> <li>• Men’s receipt of VMMC</li> </ul>

**Table 3: Detailed Findings, Effects of Gender-Integrated Interventions for HIV** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>MULTI-COMPONENT</b>				
<b>Saggurti et al., 2014; Raj et al., 2013</b>	<ul style="list-style-type: none"> <li>• HIV and IPV</li> <li>• Women at increased risk (husbands engaged in heaving drinking, women ever experience IPV)</li> <li>• India</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Six sessions, four individual counseling sessions and two group discussion sessions</li> <li>• Topics: HIV, IPV, problem solving, action plans, relationship conflict and its implications, social support, harm education</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized women               <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Control</li> </ul> </li> <li>• Longitudinal: baseline and four months</li> <li>• Multivariate time x treatment analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Marital conflict</li> <li>• Sexual coercion</li> <li>• Proportion unprotected sex with husband</li> </ul> <p><b>No differences (vs. control)</b></p> <ul style="list-style-type: none"> <li>• IPV</li> <li>• Number of vaginal sex acts with husband</li> <li>• Condom use with husband</li> </ul>

**Table 4: Detailed Findings, Effects of Gender-Integrated Interventions for Reducing or Mitigating Gender-Based Violence**

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>GROUPS</b>				
<b>Krishnan et al., 2016</b>	<ul style="list-style-type: none"> <li>• GBV and RH (generally)</li> <li>• Garment factory workers, majority women</li> <li>• India</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Posters, cartoons, leaflets</li> <li>• Plays, outreach, groups</li> <li>• Health camps (GBV services)</li> <li>• Topics: gender discrimination, types of violence, alcohol use/abuse and violence, SRH, social support</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned two factories                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Comparison</li> </ul> </li> <li>• Cross-sectional: baseline and 12 months</li> <li>• Multivariate time x treatment analysis</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Beliefs about gender equity</li> <li>• Acceptance of spousal abuse</li> <li>• Knowledge of where to seek GBV services</li> </ul>
<b>Devries et al., 2015</b>	<ul style="list-style-type: none"> <li>• Physical violence in schools (from teacher/staff)</li> <li>• Schools, teachers, and students ages 11 to 14</li> <li>• Uganda</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• School goal setting and plans</li> <li>• Student/staff-led face-to-face group activities</li> <li>• Supportive supervision, monitoring implementation</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized schools                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Control</li> </ul> </li> <li>• Cross-sectional: baseline and 12 months</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Reduction in students' experience of violence from school staff (in past week)</li> <li>• Staff reported use of physical violence (past week)</li> </ul>
<b>Miller et al., 2014</b>	<ul style="list-style-type: none"> <li>• GBV</li> <li>• Male student athletes ages 10 to 16)</li> <li>• India</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Coach-led activities/messages</li> <li>• Coach as role model</li> <li>• Topics: respect for women, GBV, positive bystander behaviors</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized schools                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Control</li> </ul> </li> <li>• Longitudinal: baseline and endline</li> <li>• Multivariate time x treatment analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Gender equitable attitudes</li> <li>• Negative bystander behaviors (e.g., laughing)</li> </ul> <p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Disapproval of violence against females</li> <li>• Positive bystander behaviors (e.g., intervening to stop violence)</li> <li>• Sexual abuse perpetration</li> </ul>

**Table 4: Detailed Findings, Effects of Gender-Integrated Interventions for Reducing or Mitigating Gender-Based Violence** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>Miller et al., 2014</b>	<ul style="list-style-type: none"> <li>• GBV</li> <li>• Male student athletes ages 10 to 16)</li> <li>• India</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Coach-led activities/ messages</li> <li>• Coach as role model</li> <li>• Topics: respect for women, GBV, positive bystander behaviors</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized schools                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Control</li> </ul> </li> <li>• Longitudinal: baseline and endline</li> <li>• Multivariate time x treatment analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Gender equitable attitudes</li> <li>• Negative bystander behaviors (e.g., laughing)</li> </ul> <p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Disapproval of violence against females</li> <li>• Positive bystander behaviors (e.g., intervening to stop violence)</li> <li>• Sexual abuse perpetration</li> </ul>
<b>O’Callaghan et al., 2013</b>	<ul style="list-style-type: none"> <li>• GBV mitigation</li> <li>• War-affected, sexually-exploited girls ages 12 to 17</li> <li>• Democratic Republic of Congo</li> </ul>	<ul style="list-style-type: none"> <li>• Gender accommodating</li> <li>• 15 sessions</li> <li>• Topics: stress management, dealing with feelings, cognitive coping</li> <li>• Three caregiver (e.g., parent) sessions</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized individuals                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Wait-list control</li> </ul> </li> <li>• Longitudinal: baseline and three months</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Trauma symptoms</li> <li>• Depression</li> <li>• Anxiety</li> <li>• Conduct problems</li> </ul> <p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Prosocial behavior</li> </ul>
<b>Green et al., 2015</b>	<ul style="list-style-type: none"> <li>• IPV</li> <li>• Women</li> <li>• Uganda</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Business training, \$150 start-up, supervision/ support, advice</li> <li>• Topics: business plans, budgets, record keeping</li> <li>• Variation: participation alone vs. with husband</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized villages                             <ul style="list-style-type: none"> <li>· Intervention</li> <li>· Wait-list control</li> </ul> </li> <li>• Longitudinal: baseline and 16 months for initial implementation</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Business ownership and income</li> <li>• Marital control</li> <li>• Quality of relationship</li> </ul> <p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Intimate partner violence</li> <li>• Autonomy</li> </ul>

**Table 4: Detailed Findings, Effects of Gender-Integrated Interventions for Reducing or Mitigating Gender-Based Violence** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>MULTI-COMPONENT</b>				
<b>Pulerwitz et al., 2015</b>	<ul style="list-style-type: none"> <li>• Intimate partner violence</li> <li>• Young men ages 15 to 24</li> <li>• Ethiopia</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Community engagement (CE)</li> <li>• Interactive group education (GE)</li> <li>• Topics: gender-equitable norms, violence prevention, sexual risk</li> <li>• Variation: CE and GE or CE only</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized sub-cities                             <ul style="list-style-type: none"> <li>• One intervention</li> <li>• Wait-list control</li> </ul> </li> <li>• Longitudinal: baseline and six months</li> <li>• Multivariate analysis</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Gender equitable attitudes</li> <li>• Perpetration of IPV (if partnered)</li> </ul>
<b>CHILD MARRIAGE</b>				
<b>Nanda et al., 2015</b>	<ul style="list-style-type: none"> <li>• Child marriage</li> <li>• Families of infant girls</li> <li>• India</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Bond given at birth of daughter, to be redeemed by the daughter at maturity if she did not marry before age 18</li> </ul>	<ul style="list-style-type: none"> <li>• Post-test data collected from sample of beneficiary and non-beneficiary households in selected villages across four districts</li> </ul>	<p><b>Improvements (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Currently in school</li> <li>• Never dropped out</li> <li>• Ever attended school</li> </ul> <p><b>No difference (vs. comparison)</b></p> <ul style="list-style-type: none"> <li>• Age at marriage</li> </ul>
<b>Amin et al., 2016</b>	<ul style="list-style-type: none"> <li>• Child marriage</li> <li>• Girls ages 12 to 18</li> <li>• Bangladesh</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• Weekly group meetings plus one of the following:                             <ul style="list-style-type: none"> <li>• Tutoring: math and English or computing and finances</li> <li>• Life skills training: gender rights, negotiation, critical thinking, decisionmaking</li> </ul> </li> <li>• Livelihood skills training</li> </ul>	<ul style="list-style-type: none"> <li>• Randomized villages to                             <ul style="list-style-type: none"> <li>• Intervention</li> <li>• Control</li> </ul> </li> <li>• Longitudinal: baseline and two years</li> <li>• Time x treatment analysis, controlled for demographics</li> </ul>	<p><b>Improvements (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Ever married (by age 18, at interview)</li> <li>• Enrolled in school</li> <li>• Earning income (life skills and livelihood)</li> <li>• Acceptance of violence</li> <li>• Acceptance of arranged marriage</li> <li>• Received treatment for RH problem</li> </ul> <p><b>No difference (vs. control)</b></p> <ul style="list-style-type: none"> <li>• Currently earning income (tutoring only)</li> </ul>

**Table 4: Detailed Findings, Effects of Gender-Integrated Interventions for Reducing or Mitigating Gender-Based Violence** (continued)

Source	Behaviors, Target Population, and Country	Intervention	Evaluation Design	Outcomes
<b>Erulkar et al., 2017</b>	<ul style="list-style-type: none"> <li>• Child marriage</li> <li>• Girls ages 12 to 17 and their families/communities</li> <li>• Burkina Faso, Ethiopia, and Tanzania</li> </ul>	<ul style="list-style-type: none"> <li>• Gender transformative</li> <li>• One or all of the following</li> <li>• Community dialogue around child marriage norms</li> <li>• School supplies for girls who remain unmarried and in school</li> <li>• Asset transfer (animal) for girls who remain unmarried and in school</li> </ul>	<ul style="list-style-type: none"> <li>• Assigned villages                             <ul style="list-style-type: none"> <li>· One of three or all interventions</li> <li>· Comparison</li> </ul> </li> <li>• Cross-sectional: at baseline and two years</li> <li>• Multivariate analyses stratified by age and country</li> <li>• Some analyses not done in all countries due to sample size or comparability issues</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced risk for marriage was significant for the following age/intervention groups</li> <li>• Community dialogue: 15- to 17-year-olds in Burkina Faso and 12- to 14-year-olds in Ethiopia</li> <li>• School supplies: 12- to 14-year-olds in Ethiopia</li> <li>• Asset transfer: 15- to 17-year-olds in Tanzania, 15- to 17-year-olds in Ethiopia</li> <li>• All components: 15- to 17-year-olds in Tanzania, 15- to 17-year-olds in Ethiopia</li> </ul>

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## The Interagency Gender Working Group (IGWG)

The Interagency Gender Working Group (IGWG), established in 1997, is a network of multiple nongovernmental organizations, the United States Agency for International Development (USAID), cooperating agencies, and the Bureau for Global Health of USAID. The IGWG promotes gender equity in order to improve global health and foster sustainable development.

