PROMOTING GENDER EQUALITY WITHIN FAMILY PLANNING PROGRAMS: AN ANALYSIS OF USAID PROJECTS

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ABSTRACT

Gender norms present barriers to contraceptive use and contribute to high rates of unmet need for contraceptives. In the developing world, complications arising from pregnancy and childbirth present the leading threat to the health and lives of women of reproductive age. Mortalities and morbidities resulting from unintended pregnancies are a significant public health issue. Meeting women's need for contraception could prevent 53 million unintended pregnancies, 15 million unsafe abortions, and 90,000 maternal deaths each year. International family planning programs actively address gender inequality as a means of decreasing unmet need for contraception. The United States Agency for International Development conducts family planning and reproductive health projects in more than 45 countries and positions gender equality at the center of its development work. This paper is a gender analysis of 19 United States Agency for International Development projects initiated between 2009 and 2015, and is based on publicly available project reports and website descriptions. Projects are classified using the Gender Equality Continuum Tool, case studies are reviewed, and common approaches to promote gender equality are discussed. Key findings, limitations, and promising paths forward are presented.

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PREFACE

This paper begins with a brief note on language and the challenges presented therein. Because language conveys powerful messages and remains subject to interpretation, I would like to present the reader with my rationale for using specific vocabulary within this paper. To group regions and countries, I have chosen to use the terms developing and developed in an effort to accurately report and synthesize data from multiple sources. To some, these labels imply a hierarchy between countries that is rooted in colonization and exploitation. The terms inaccurately represent countries and regions: developing overlooks the successes and functionality of some systems, while developed ignores the social problems and inefficiencies of others. This language is not ideal, but substituting with other terms presents the risk of inaccurately interpreting data.

Additionally, it is important to define the terms reproductive health and family planning, which I use at length throughout this paper. Reproductive health refers to the reproductive processes, functions, and system at all stages of life. Family planning is the practice of controlling the number and timing of children, and is one component of reproductive health. International reproductive health programs originated with a narrow focus on family planning, and have only recently expanded into a more comprehensive reproductive health approach. This transition is occurring slowly, however, and the term family planning continues to dominate international efforts and conversations. I have attempted to use the most accurate terms throughout this paper.

My interest in this topic arises from my work as a Peace Corps volunteer and my intrinsic questioning nature. Foundational work for this thesis began 15 years ago, when I first encountered the narrator of Margaret Atwood's (1985) *The Handmaid's Tale,* who repeatedly asserted that "context is all" (p. 187). I have sought to understand context in many obscure corners of this

beautifully messy world, with the help of countless amazing individuals who have touched my life and guided me along my path. Nasakilili mwani to all the amaamas ya Kapundu who face gender inequality daily, but taught me that smiles and laughter bridge cultural divides. Muchisimas gracias to all the mujeres poderosas de Guinea Grass who are finding their voices and their true selves, and continue to astonish me with their strength, resilience, and hope for the future.

Finally, many thanks are due. I would like to acknowledge Karen Hardee and Jill Gay, whose work has paved the way for this paper and whose encouragement gave me direction and confidence to venture into unknown territory. I am forever grateful to Dr. Terry, whose unwavering support, high expectations, and willingness to be human have been the perfect balance of everything I needed for the past three years. I am thankful to my family, who has accepted my constant state of stress, absence at family dinners, and unreturned phone calls with grace and love. And to my number one supporter, Coy, who has been my rock and without whom I would not have completed this: I love you so much. Thank you for standing by me and for picking me up every time I slumped onto the floor in a heap of tears, babbling about seemingly insurmountable gender inequalities. You are the very best tag-team partner.

LIST OF ACRONYMS

CBD	Community-Based Distribution
CHW	Community Health Worker
CSL	Commodities, Security, and Logistics Division
E2A	Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls Project
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender-Based Violence
GREAT	Gender Roles, Equality, and Transformations Project
HC3	Health Communication Capacity Collaborative Project
HPP	Health Policy Project
ICPD	International Conference on Population and Development
ICRW	International Center for Research on Women
IDEA	Informing Decisionmakers to Act Project
IGWG	Interagency Gender Working Group
MNCH	Maternal, Newborn, And Child Health
MSI	Marie Stopes International
NGO	Non-Governmental Organization
PEC	Policy, Evaluation, and Communication Division
PRB	Population Reference Bureau
PRH	Office of Population and Reproductive Health
PSI	Population Services International
PTA	Preventive Technologies Agreement Project
RTU	Research, Technology, and Utilization Division
SBCC	Social and Behavior Change Communication
SDI	Service Delivery Improvement Division
SEM	Social Ecological Model
SIFPO	Support for International Family Planning Organizations Project
UN	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization

1.0 INTRODUCTION

Gender norms present barriers to contraceptive use and contribute to high rates of unmet need for contraceptives in developing countries. Worldwide, 215 million women are estimated to have an unmet need for contraception, meaning that they want to delay or stop childbearing but are not currently using any method of contraception. Women with an unmet need for contraception account for a majority of unintended pregnancies, and rates of unintended pregnancies are disproportionately higher in the developing world. Unintended pregnancies result in unsafe abortions, maternal mortalities and morbidities, and infant mortalities. Meeting women's need for contraception could prevent 53 million unintended pregnancies, 15 million unsafe abortions, and 90,000 maternal deaths each year. This cannot be accomplished without addressing gender inequality and working to eliminate barriers to contraceptive use that result from gender and social norms.

For the past two decades, the international family planning movement has built its mission upon a human rights foundation, using unmet need for contraception as its primary indicator and addressing gender inequality as a core programming initiative. The United States Agency for International Development (USAID) has been a leader in the field of international family planning for several decades, and positions gender equality and women's empowerment at the core of all its development work. This paper is an analysis of the ways in which Washington, DC-based USAID reproductive health projects address gender inequality. Chapter 1 details the problem of

unmet need for contraception, describes international efforts to promote gender equality, and gives background information about USAID programming. In Chapter 2, the project identification method, eligibility criteria, and analytical approach are described. Chapter 3 presents case studies of projects, details the results of the gender analysis, and discusses common approaches used within projects. In Chapter 4, USAID internal policies are considered, intervention approaches are examined within the Social Ecological Model, and cooperative agreements with implementing partners are explored. Chapter 5 concludes the paper by discussing key findings, presenting limitations, and providing recommendations.

1.1 MATERNAL MORTALITY

Unintended pregnancies threaten women's health and lives. More than 80 million unintended pregnancies occur worldwide each year, resulting in unsafe abortions, maternal mortalities and morbidities, and infant mortalities (Mwaikambo, Speizer, Schurmann, Morgan, & Fikree, 2011). Developing countries bear a disproportionate burden of unintended pregnancies and subsequent mortalities and morbidities. In places where medical resources are scarce, facilities are under-resourced, and transportation is non-existent, unplanned pregnancies and complications during childbirth are matters of life and death. Even without health complications, unintended pregnancies have the capacity to compromise women's ability to access education, earn a living, and participate fully in society (Darroch, Sedgh, & Ball, 2011).

In the developing world, two-fifths of pregnancies among women aged 15-49 years are unintended (Darroch et al., 2011), and complications arising from pregnancy and childbirth present the leading threat to the health and lives of women of reproductive age (World Health Organization

[WHO], 2014). The maternal mortality ratio reflects the number of maternal deaths per 100,000 live births, and is recognized as an indicator of the overall health of a population, functionality of the health system, and status of women in a given society (MEASURE Evaluation, n.d.). In 2013, the maternal mortality ratio in developing countries was 230 deaths per 100,000 live births, compared to 16 deaths per 100,000 live births in developed countries (WHO, 2014). A total of 289,000 women died during pregnancy and childbirth in 2013, and 99 percent of maternal deaths occur in developing countries each year (WHO, 2014). Figure 1 depicts the global distribution of maternal mortalities, with Sub-Saharan Africa, Southern and Southeast Asia impacted by the highest maternal mortality ratios (WHO, 2015b).

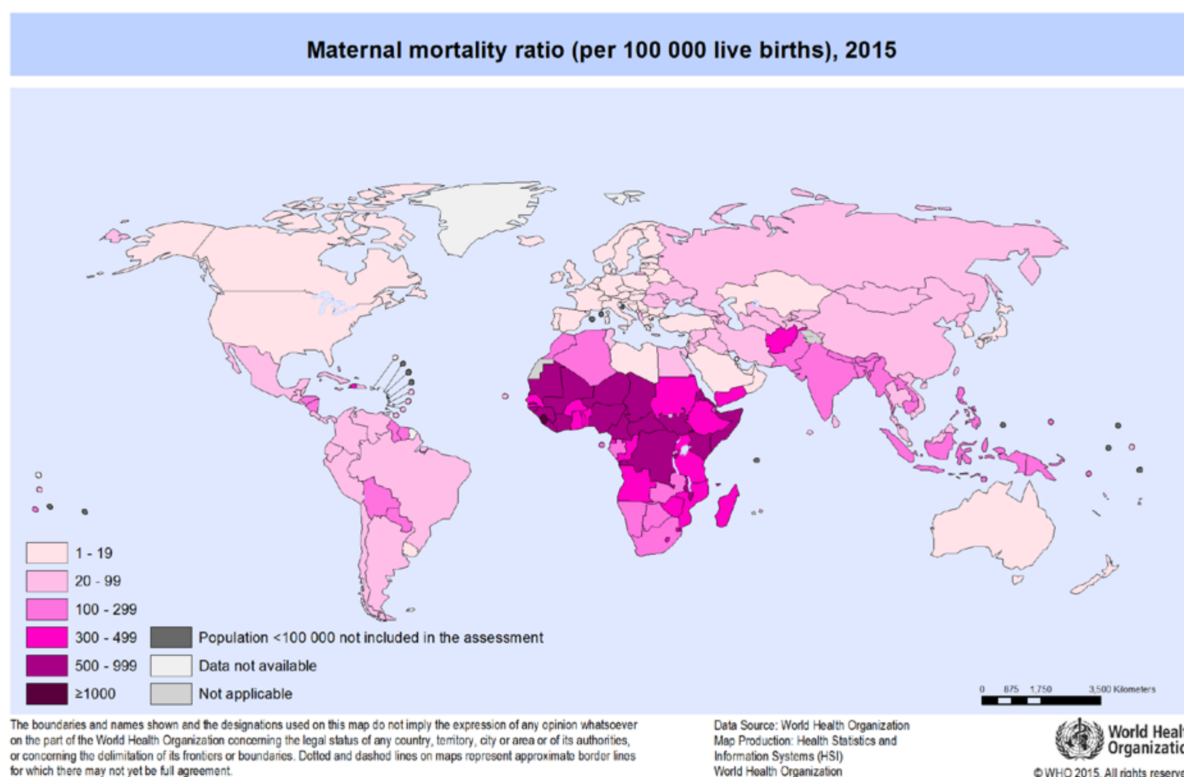
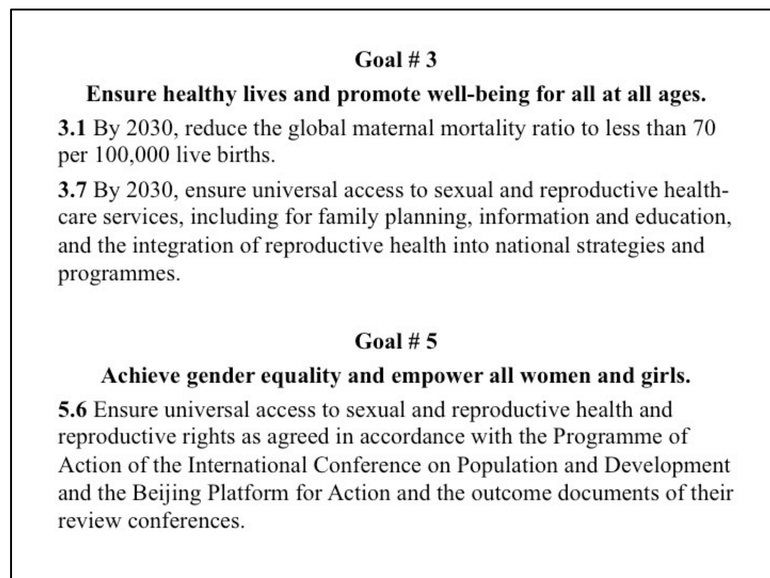


Figure 1: Global distribution of maternal mortalities

Maternal deaths are a significant public health problem and have garnered attention from international development organizations for several decades. The Millennium Development Goals (MDGs) were established in 2000 by United Nations (UN) member states and cooperating international organizations as a set of targets for addressing extreme poverty by the year 2015. These goals brought the situation of women worldwide into greater focus by dedicating Goal #5 to improving maternal health (UN, 2012). Goal #5 aimed to reduce the maternal mortality ratio by 3/4 and achieve universal access to reproductive health. In 2015, these ideals were included in the Sustainable Development Goals 3 and 5, which are detailed in Figure 2 (UN, 2015). Although these precise goals have yet to be achieved, the worldwide maternal mortality ratio has decreased by nearly 50 percent since 1990 (WHO, 2014). Much of this achievement has been attributed to programs that increase prenatal care, increase attendance of skilled health personnel at births, reduce rates of adolescent pregnancy, and increase usage of contraceptives and family planning methods (UN, 2012).



Goal # 3

Ensure healthy lives and promote well-being for all at all ages.

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Goal # 5

Achieve gender equality and empower all women and girls.

5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

Figure 2: Sustainable Development Goals

1.2 FAMILY PLANNING

Family planning, or the practice of controlling the number and timing of children, is a recognized method for decreasing maternal deaths and morbidities worldwide. This is commonly achieved through use of a contraceptive method such as an oral pill, implant, injectable, patch, vaginal ring, intrauterine device, condom, sterilization, or fertility tracking. Contraceptives are estimated to have the potential to prevent 32 percent of maternal deaths each year (Williamson, Parkes, Wight, Petticrew, & Hart, 2009). In 2008, an estimated 272,000 maternal deaths were prevented worldwide through contraceptive use (Jacobstein, Curtis, Speiler, & Radloff, 2013; Williamson et al., 2009). Use of contraceptives has also been associated with reduced rates of maternal morbidities, infant mortalities, and abortions, in addition to contributing to women's ability to realize their human rights to education, economic opportunities, and full participation in society (Jacobstein et al., 2013).

Despite the promising potential of contraceptives to improve maternal and infant health outcomes and realize social gains, these achievements are not equitably dispersed worldwide. The contraceptive prevalence rate is the percentage of women of reproductive age (15-49 years) currently using a contraceptive method (MEASURE Evaluation, n.d.). Although this measure often overlooks women who are not married or in a union, it is the most widely reported outcome for family planning programs at the population level (MEASURE Evaluation, n.d.). Contraceptive prevalence rates remain lower in developing regions and disproportionately lower in certain regions (Population Reference Bureau [PRB], 2012; Sedgh & Hussain, 2014; Sedgh, Hussain, Bankole, & Singh, 2007). Worldwide, the overall contraceptive prevalence rate is 63 percent, though this ranges from 72 percent in more developed countries to 34 percent in the world's least developed nations (PRB, 2013; PRB, 2012). Figure 3 shows global contraceptive prevalence rates,

and highlights low prevalence rates across much of Africa and other developing regions (WHO, 2015b).

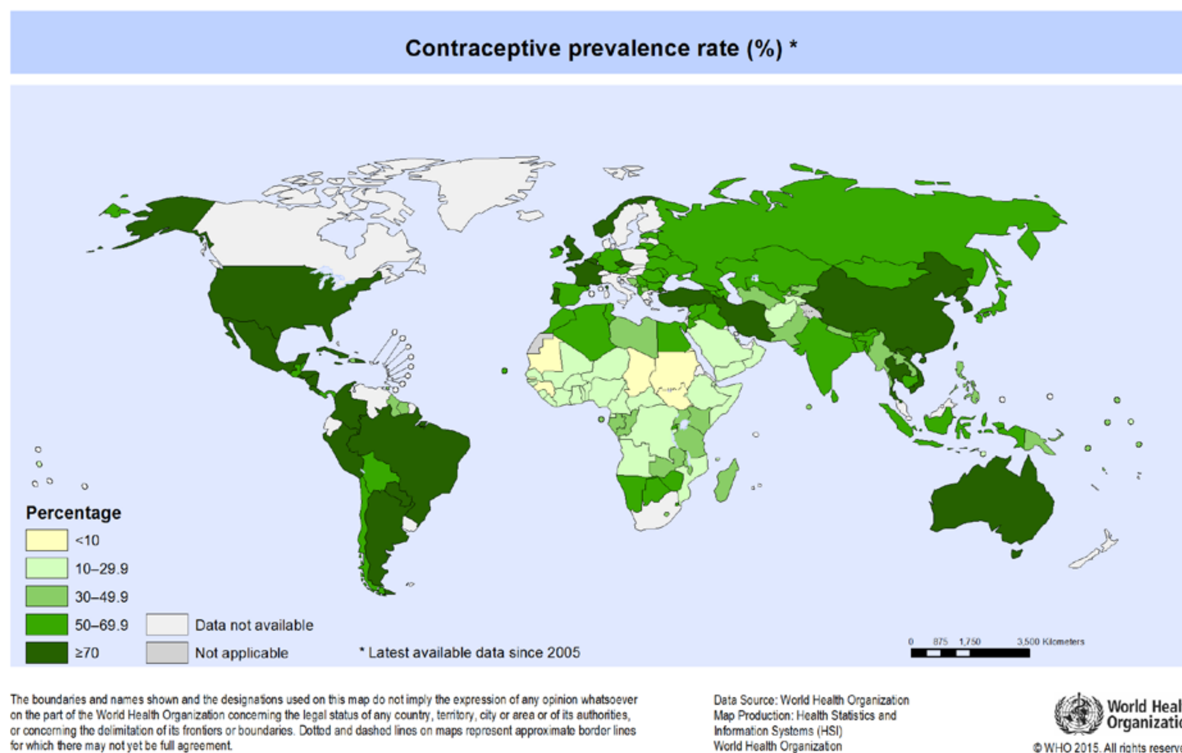


Figure 3: Global distribution of contraceptive use

Although contraceptive prevalence rates have risen substantially in many parts of the world, 215 million women are believed to have an unmet need for contraception (PRB, 2012). Women with an unmet need for contraception are those who want to delay or stop childbearing but are not currently using any method of contraception (PRB, 2012). Unmet need for contraception serves as an indicator for measuring progress toward Millennium and Sustainable Development Goal targets to achieve universal access to sexual and reproductive health. Women with an unmet need for contraception account for a majority (82 percent) of unintended

pregnancies, which are associated with unsafe abortion, delayed or no antenatal care, and overall health risks for women and infants (PRB, 2012). Meeting women's need for contraception could prevent 53 million unintended pregnancies, 22 million unplanned births, 15 million unsafe abortions, and 90,000 maternal deaths each year (PRB, 2012; PRB, 2009).

Contraceptive prevalence rates and unmet need for contraception are the key indicators used to contextualize the family planning environment in a given area. The Demographic and Health Surveys Program collects, analyzes, and disseminates population and health data in over 90 countries, including contraceptive prevalence rates and unmet need for contraception. Demographic and Health Surveys data highlight several common themes for contraceptive nonuse among women, including infrequent sex, fear of side effects/health risks, opposition to use (by woman, partner, or other), postpartum ammenorrhea/breastfeeding, sub-fecund, unaware of methods, and lacking access (Sedgh & Hussain, 2014). These reasons for contraceptive nonuse present at different levels across regions, as depicted in Figure 4, with fear of side effects/health risks, opposition to use, and infrequent sex most commonly cited (PRB, 2012). Knowledge of these reasons for nonuse has helped to shape family planning programs, but much is still unknown about their deeper significance.

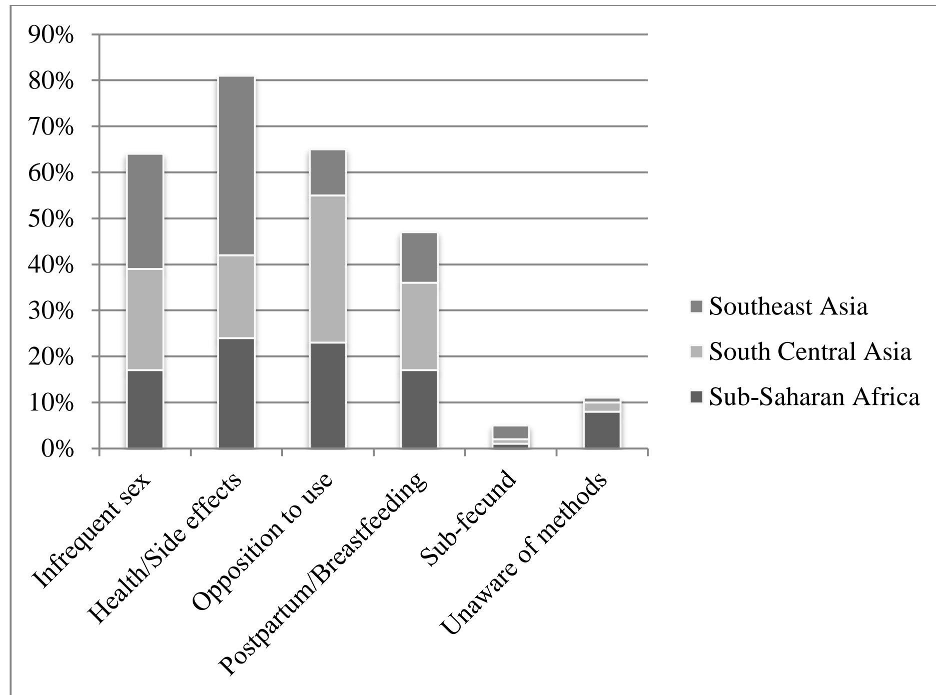


Figure 4: Reasons cited for contraceptive nonuse
(adapted from PRB, 2012)

1.3 GENDER INEQUALITY

The term *sex* refers to the biological characteristics of females and males, while *gender* signifies the socially constructed characteristics of women and men, such as norms, roles, and relationships (WHO, 2015a). Social definitions of what it means to be a woman or a man vary among and within cultures, and these gender norms can change over time. Gender inequality exists when women and men do not enjoy the same rights and opportunities across all sectors of society. In regards to health, gender norms influence access and control over resources needed to attain mental, physical, and social health and well-being (WHO, 2015a). Gender norms contribute to differences between women and men in social position and power, access to resources and services, and health-related behaviors (Mulralidharan et al., 2015). Gender inequality creates barriers to positive health

outcomes and is a contributing factor in morbidity and mortality rates for both women and men throughout the life course (Mulralidharan et al., 2015; WHO, 2015a).

1.3.1 Barriers to contraceptive use

Gender inequality contributes to unmet need for contraception (Feldman-Jacobs & Yeakey, 2011; McCleary-Sills, McGonagle, & Malhotra, 2012; Mulralidharan et al., 2015). A woman's ability to limit or space her childbearing is shaped by gender norms that play out across social ecological levels. The Social Ecological Model (SEM) explains an individual's behavior as an action that both affects and is affected by multiple levels of influence: individual, relationship, community, and societal (Centers for Disease Control and Prevention [CDC], n.d.). An explanation of the SEM as it pertains to contraceptive use is presented in the Table 1 below.

Table 1: SEM and contraceptive use

Social Ecological Level	Description	Examples
Individual	Biological and personal history factors influence behaviors	Age, education, marital status, history of abuse, HIV status, income
Relationship	Close relationships influence behaviors	Partner/spouse, family members, peers, close friends
Community	Settings in which social relationships occur influence behaviors	School, health clinic, church, market, workplace, neighborhood/village
Societal	Norms and policies create a climate that influences behaviors	Social and cultural norms related to gender, sexuality, childbearing, marriage, and decision-making. Policies impacting educational attainment, employment, land ownership, and human rights.

Gender norms are enacted through each of these levels, ultimately impacting an individual's position and power in society, access to resources and services, and health-related behaviors (Mulralidharan et al., 2015). Gender inequality undermines health (Greene & Levack, 2010) and presents barriers to contraceptive use at all social ecological levels.

Gender-related barriers to contraceptive use manifest from social and cultural norms related to gender roles and are carried out through multiple levels of the SEM simultaneously. Gender norms are enacted primarily at the individual and relationship levels, and reinforced through community interactions, social norms, and policies governing the larger society. Restrictive and inequitable gender norms negatively impact the reproductive health of both men and women. Gender-related barriers to contraceptive use are created and perpetuated by gender/social norms that:

- Encourage or require large family size through pro-natalist policies and/or social valuation of women and men based on the number of children they have;
- Perpetuate male child preference;
- Prohibit contraceptive use;
- Restrict women's education, movement, and/or access to money and resources;
- Encourage/accept child marriage;
- Condone violence against women;
- Require women to rely on men as providers/protectors and/or require men to make all household decisions;
- Deny women's knowledge/expression of sexuality and/or stigmatize women for expressing sexual desire;
- Encourage risk taking among men;

- Refute women's autonomy and decision-making and/or require women to seek permission from a man; and
- Disempower women in the presence of authority figures.

These inequitable gender norms create barriers to contraceptive use and contribute to unmet need for contraception.

1.3.2 The international family planning movement

Despite the prominent role of gender inequality in determining contraceptive access and use, the international family planning movement has only recently focused efforts on this issue. In the early 1900s, women's rights activists, including the well-known Margaret Sanger and Marie Stopes, organized birth control movements that arose from concern for the wellbeing of women, and advocated for women's rights and empowerment (Sinding, 2007). Several decades later, a separate movement emerged when fear of the potential consequences of rapid population growth prompted government leaders and international development agencies to invest in large scale distribution of contraceptives (Seltzer, 2002). In the 1960s, the birth control movement and population control movement merged, in spite of their divergent values (Sinding, 2007). The newly formed family planning movement secured large scale funding from international development agencies and was dedicated to non-coercive policies and programs (Seltzer, 2002). The overarching goals of the movement were to reduce population growth and increase standards of living, improve women's health and quality of life, and advance the rights of couples and women to plan their families (Seltzer, 2002).

By the mid-1990s, the vast majority of countries had adopted voluntary family planning programs into their maternal and child health or primary health care systems (Sinding, 2007).

Developing countries experienced a reproductive revolution over the course of a single generation: average fertility in the developing world fell from six children per woman to three children per woman, and contraceptive prevalence rates increased from less than 10 percent to over 50 percent (Seltzer, 2002; Sinding, 2007). Family planning programs were supported by government funding from many industrialized countries, as well as the World Bank and the newly formed United Nations Fund for Population Activities (UNFPA) (Sinding, 2007). US leadership played an influential role, with the US contributing over 50 percent of overall external funding for population and family planning programs from the 1960s to the 1990s (Sinding, 2007).

An important shift occurred during the 1990s, when the international family planning movement asserted its commitment to equality and human rights. The growing international women's movement was determined to reject the family planning movement's demographic targets and focus instead on improving the rights and health of individuals and respecting reproductive freedom (Sinding, 2007). In 1994, the International Conference on Population and Development (ICPD) launched a new set of goals intended to realize individuals' and couples' fundamental human right to control reproductive decisions (Seltzer, 2002). The ICPD Plan of Action called for adoption of a broader reproductive health agenda supplemented by social and economic policies aimed to empower women and strengthen their rights (Sinding, 2007). This shift toward human rights brought gender equality to center stage and led to women-centered objectives and the adoption of women's empowerment activities into family planning programs.

The ICPD Plan of Action urged governments to define family planning goals in terms of unmet need for contraception, which positioned women's rights and human rights at the core of the movement. The concept of unmet need for contraception bridged the divide between demographic targets for fertility reduction and the new human rights approach (Seltzer, 2002). In

the 1960s, surveys focusing on knowledge, attitudes, and practices (KAP surveys) about fertility levels and fertility preferences revealed that married couples desired fewer children, approved of family planning, and were interested in learning more (Seltzer, 2002). The surveys also found that many women wanted no more children yet were not using contraception; the discrepancy between a woman's preference for children and her contraceptive use was referred to as the KAP-gap (Seltzer, 2002). Known today as unmet need for contraception, this notion has long justified family planning programs in developing countries and inspired governments to initiate and sustain funding for these programs (Seltzer, 2002). Focusing on unmet need for contraception facilitates an intentional examination of gender inequality as it contributes to family planning knowledge, attitudes, and behaviors.

1.3.3 International development

The negative impacts of gender inequality became a pressing issue within the public health and development spheres by the late 1990s (Greene & Levack, 2010; UN, 2002). The crucial role of women's rights and equality within the family planning movement was firmly asserted at the ICPD. The following year, the United Nations World Conference on Women arrived at the Beijing Platform for Action, which declared gender mainstreaming as a global strategy for promoting gender equality (UN, 2002). In its 1997 resolution, the UN Economic and Social Council defined gender mainstreaming as

> …the process of assessing the implications for women and men of any planned action… It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring, and evaluation of policies and programs in all political, economic, and social spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality (as cited in UN, 2002, p. v).

Gender mainstreaming helped to establish the value and importance of gender considerations within all development work. This process moved the focus away from narrowly targeting women toward an agenda that included men and positioned gender equality as a development goal (UN, 2002).

The gender equality international development goals, together with the ICPD and Beijing Platforms for Action, reflect an international consensus in favor of questioning rigid gender norms and promoting gender equality in order to improve health outcomes (Greene & Levack, 2010). The MDGs declared gender equality as one of eight international development goals necessary to eradicate global poverty. The MDGs were adopted and agreed upon by all UN member states, and drove international development policy through 2015. The recently adopted Sustainable Development Goals continue to recognize and promote gender equality and women's and girls' empowerment through Goal #5. These goals set quantitative objectives and serve to unite international development efforts under a shared agenda.

An international commitment to gender equality encouraged the dissemination of evidence to support responsive programming. In its 2009 report, the WHO emphasized the role of gender inequalities in the allocation of resources and the strong association between gender inequality and poor health and reduced well being (WHO, 2009). The report highlights that, "across a range of heath problems, women and girls face differential exposures that are often poorly recognized" (WHO, 2009, p. 10). Reports and data helped facilitate the creation and implementation of gender equality policies and staff positions within key agencies. In further recognition of these issues, United Nations Women (UN Women) was established in 2010 as the entity dedicated to gender equality and the empowerment of women. UN Women advocates for the integration of gender and

women's empowerment into humanitarian efforts as a human rights imperative (UN Women, 2015).

Within this facilitative environment, gender mainstreaming has led to the purposeful incorporation of gender into development activities. A global strategy, international commitments, and extensive reporting show that gender equality programming is crucial, and challenge international development organizations to develop responsive policies and programs to address inequalities. In solidarity with the international development field's commitments, current family planning and reproductive health initiatives dedicate considerable attention to gender equality within programming and overall objectives.

1.4 USAID FAMILY PLANNING PROGRAMS

The United States government has been a prominent leader in supporting family planning programs in the developing world since 1965. Funding for international family planning programs is primarily administered through USAID under the Bureau for Global Health's Office of Population and Reproductive Health (PRH). USAID currently operates family planning and reproductive health (FP/RH) programs in more than 45 countries, making it the largest donor to family planning efforts and the largest purchaser and distributer of contraceptives internationally (Kaiser Family Foundation [KFF], 2015a). The objective of PRH projects is to expand sustainable access to high quality voluntary family planning and reproductive health services and information (KFF, 2015a). In fiscal year 2015, total US funds allocated to FP/RH programs amounted to $610 million.

The Bureau for Global Health is considered one of USAID's technical bureaus, and consists of three technical offices: PRH, the Office of HIV/AIDS, and the Office of Health, Infectious Disease and Nutrition (O'Hanlon, 2009). Each year, several bureau-wide projects are funded, in addition to a number of projects designated to each of the three offices. PRH administers FP/RH programming centrally, through the Washington, DC office, as well as by directing funding to field missions abroad. USAID is not an implementing agency, and conducts FP/RH work through contracts and grant agreements with cooperating agencies (O'Hanlon, 2009).

1.4.1 Policies and funding trends

The political environment under which USAID operates directly impacts its role in the global family planning movement. Political debates concerning the amount of funding and use of funds in family planning programs have resulted in legislation and restrictions that govern USAID programs. All family planning programs conducted by USAID are guided by the principles of voluntarism and informed choice and must adhere to several legislative restrictions related to abortion (USAID, 2016). The Helms Amendment prohibits the use of funds to pay for abortion procedures, while the Biden Amendment prevents funds from being used to pay for research related to abortion. The Tiarht Amendment prohibits the use of quotas and financial incentives in family planning projects, and the DeConcini Amendment requires funding recipients to offer a broad range of family planning methods and provide referrals for information about other services. A complete list of policies and amendments is outlined in Appendix A.

Although USAID has maintained its role as the largest bilateral donor to family planning programs worldwide, abortion restrictions and funding cuts ultimately undermine the agency's ability to achieve its global family planning goals. Political debate surrounding abortion began in

the early 1980s, when President Reagan initiated the Mexico City Policy, which prohibits recipients of US funds from performing or promoting abortion as a method of family planning (Barot, 2008; KFF, 2015b). Under the Mexico City Policy, international non-governmental organizations (NGOs) cannot provide abortion services while receiving US funds, even when abortion services are funded through other sources. The Mexico City Policy remained in effect until 1993, when President Clinton rescinded it. At the 1994 ICPD, the US pledged a significant increase in funding toward reproductive health; however, the Mexico City Policy was reinstated by President Bush in 2001 and accompanied by significant funding reductions under the Bush administration (Barot, 2008). In 2009, President Obama rescinded the Mexico City Policy and restored US funding to NGOs providing abortion services.

Bush administration funding decreases and restrictions for FP/RH programs were strongly criticized by many family planning advocates, including former USAID PRH directors, who argued the negative impacts of these policies in their 2009 report (Speidel, Sinding, Gillespie, Maguire, & Neuse, 2009). The former directors expressed concern over stagnant levels of funding, increased restrictions on funding, and the negative impacts of the Mexico City Policy, which they argue resulted in reduced family planning services, and increases in unintended pregnancies and abortions (Speidel et al., 2009). The funding decrease and restrictions introduced by the Bush administration were accompanied by a dramatic increase in HIV/AIDS funding which continued to overshadow all other USAID health programs for years to come (O'Hanlon, 2009). In response to these changes, USAID began shifting funds to field-based missions and decreasing funds to centrally managed programs with a focus on a handful of priority countries (O'Hanlon, 2009). A funding increase from the Obama administration enabled USAID to restore some of its focus to

central programs, but a continually uncertain economic climate and political divisiveness compromise the agency's ability to make substantial progress toward family planning goals.

1.4.2 Commitment to gender equality

Across sectors, USAID positions gender equality and women's empowerment at the core of all development work. Efforts to advance gender equality are governed by the USAID Gender Equality and Women's Empowerment Policy, while the Office of Gender Equality and Women's Empowerment provides oversight. USAID currently conducts a variety of gender programs in more than 80 countries (USAID, 2016). Although the most current agency-wide policy was only recently instated in 2012, USAID has funded and commissioned reports, toolkits, and guides related to gender since 1974 (Spevacek, 2012). The current policy and activities build upon these decades of experience to ensure that all strategies and interventions are informed by a gender analysis, and that indicators are in place to measure the gender impact of programs (USAID, 2016).

1.4.2.1 Interagency Gender Working Group

In 1997, two years after the US signed the Beijing Platform for Action, the Interagency Gender Working Group (IGWG) was established as a network comprised of international NGOs, cooperating agencies, and the USAID Bureau for Global Health (IGWG, n.d.-a). The IGWG focuses on education, advocacy, and the development of operational tools in order to improve reproductive health outcomes and foster sustainable development (IGWG, n.d.-a). The group consists of 60 to 80 active members and a technical advisory board that identifies priority areas and ensures that the IGWG continues to address issues of gender equity as they arise in the field of reproductive health (IGWG, n.d.-a). The IGWG promotes a critical reflection of gender and its

impact on reproductive health throughout all stages of the program cycle, and has identified a continuum of strategies to guide program design, implementation, and evaluation (IGWG, n.d.-a).

The Gender Equality Continuum Tool (see Figure 5) created by the IGWG enables users to evaluate the role of gender in programming, and encourages a focus on gender transformative interventions in order to positively impact both gender equity and reproductive health outcomes (IGWG, n.d.-a). Strategies are initially classified as either gender blind or gender aware, with the latter further distinguished as exploitative, accommodating, or transformative. The IGWG actively discourages both gender blind and gender exploitative interventions, and works to move programs toward gender transformative strategies. Gender accommodating projects work around existing gender differences and inequalities, while gender transformative projects encourage critical examination of gender norms and dynamics, strengthen more equitable norms, and/or change inequitable norms (IGWG, n.d.-a).

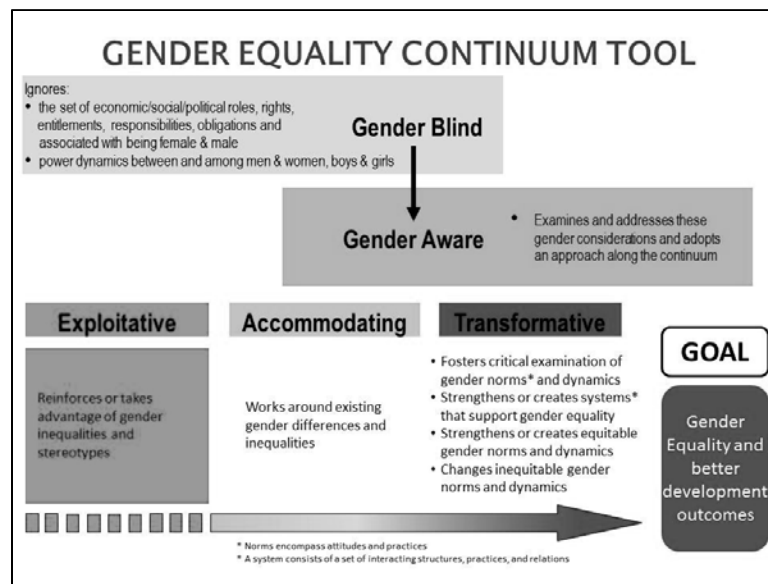


Figure 5: Gender Equality Continuum Tool

Retrieved from http://www.igwg.org/about.aspx. Reprinted with permission.

Since the IGWG's inception, USAID has commissioned the group to produce a number of gender-related reports, conduct trainings, and provide technical assistance for many of its cooperating agencies. USAID's longtime support of the IGWG further signifies the agency's commitment to gender equality. Together with the work of the IGWG, USAID's Office of Gender Equality and Women's Empowerment, the agency-wide policy, and a plethora of reports and resources, USAID is well situated to advance gender equality through development work in all sectors. As a leader in the field of family planning, USAID plays a crucial role in validating its commitment to gender equality within FP/RH programs and working to decrease gender-related barriers to contraceptive use for women and couples worldwide.

2.0 METHODS

This paper explores the ways in which USAID's Washington, DC-based FP/RH programs work to address gender-related barriers to contraceptive use. Users Guides to USAID/Washington Health Programs were examined to identify eligible projects. Project descriptions and activities were obtained through midterm and annual reports to USAID, and through details gathered from project websites. Projects were then analyzed and classified using the IGWG Gender Integration Continuum Tool.

2.1 PROGRAM IDENTIFICATION AND ELIGIBILITY

USAID annual Users Guides were obtained through Google internet searches and used to identify all centrally funded PRH projects between 2009 and 2015. The Users Guides contain brief descriptions of all projects within the Bureau of Global Health, including the project name, purpose, services, duration, geographic scope, and activity director contact information. Guides are divided into offices and subsequently into divisions. The organizational chart in Figure 6 illustrates how PRH and its four divisions are situated within the Bureau of Global Health. A new guide is created each year and distributed to all cooperating agencies.

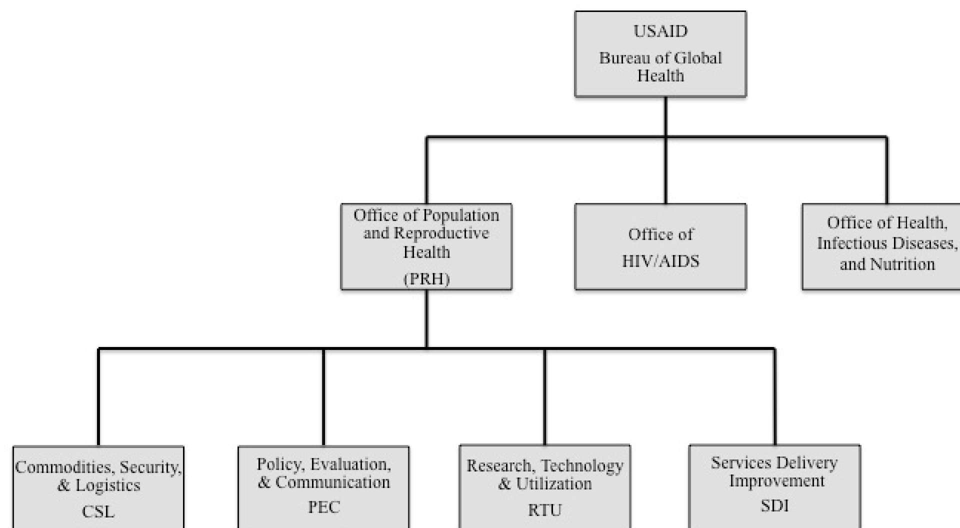


Figure 6: USAID PRH Organizational Chart

PRH conducted 63 unique projects between 2009 and 2015. Of these projects, the division of Commodities, Security, and Logistics (CSL) carried out four; Policy, Evaluation, and Communication (PEC) carried out 16; Research, Technology, and Utilization (RTU) carried out 22; and Services Delivery Improvement (SDI) carried out 21 projects. Projects initiated prior to 2009 were excluded from this analysis, as USAID had not yet implemented its formalized gender integration procedures. Thirty-seven projects commenced in 2009 or later: two CSL, seven PEC, 16 RTU, and 12 SDI. Projects without reports or detailed websites were excluded, as well as projects limited to biomedical research. One project was eliminated from analysis due to discontinuation, geographic relocation, and name change (Terikunda Jekulu in Mali became Tékponon Jikuagou in Benin). Nineteen projects remained eligible for analysis. The method used to determine project eligibility is detailed in Figure 7 below.

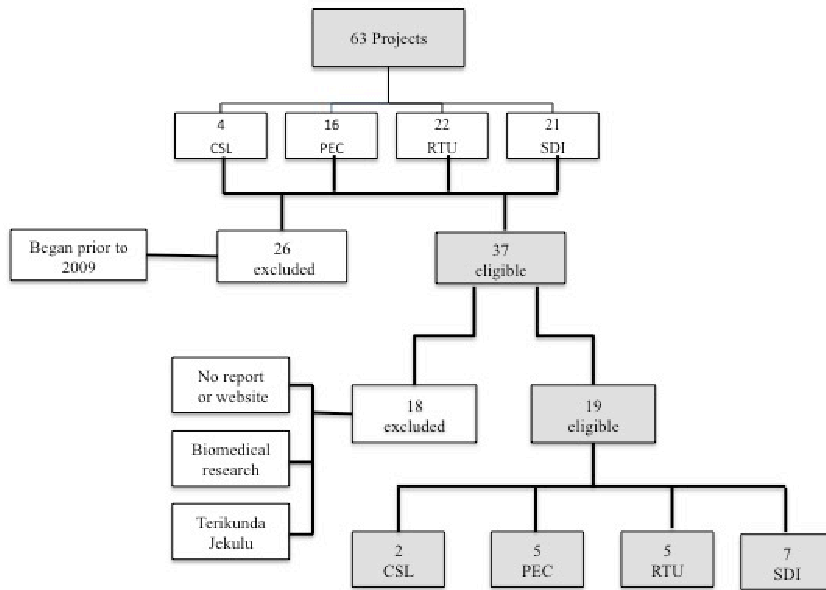


Figure 7: Project eligibility process

2.2 ANALYSIS

An online search was conducted using Google, the Development Experience Clearinghouse, and the Knowledge for Health website to locate project reports and detailed descriptions. Project information from reports and websites was analyzed using the IGWG Gender Equality Continuum Tool, shown in Figure 5 of Chapter 1.4.2.1 (see figure duplicated below). This continuum is intended to serve as a diagnostic tool or planning framework to assist with gender analysis. Project reports and websites were reviewed to classify each project as either gender blind or gender aware,

based on consideration of gender and approaches toward gender equality. Gender aware projects were further classified as exploitative in instances of reinforcing gender stereotypes, accommodating when they worked around existing gender inequalities, or transformative because they challenged or worked to change inequalities. Approaches to gender aware programming and topic areas were examined, and a listing of USAID's cooperating agencies was compiled and reviewed.

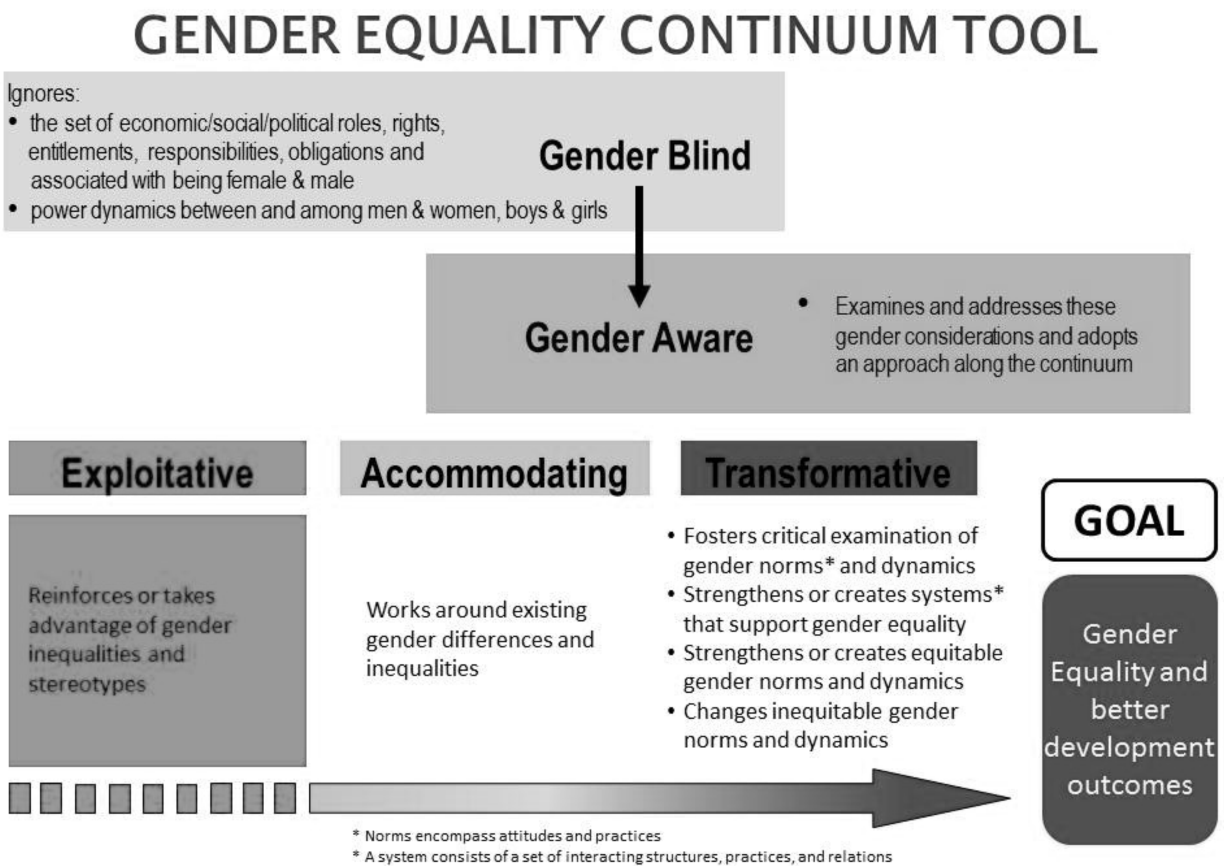


Figure 5 (duplicate): Gender Equality Continuum Tool

Retrieved from http://www.igwg.org/about.aspx. Reprinted with permission.

3.0 RESULTS

Nineteen total PRH projects were eligible for analysis. The CSL division carried out two projects: the DELIVER Project, and the Global Health Supply Chain. CSL projects promote the long-term availability of a range of contraceptives and reproductive health supplies, and strengthen global and country systems connecting product manufacturers to service sites. The PEC division managed five projects: Health Communication Capacity Collaborative (HC3), Health Policy Project (HPP), Informing Decisionmakers to Act (IDEA – two projects), and MEASURE Evaluation. PEC projects create the enabling environment for sexual and reproductive health by promoting effective sexual and reproductive health advocacy, policy, financing, and governance; collecting, analyzing, and evaluating data for evidence-based decision making; and developing and implementing communication efforts to influence attitudes, norms, and behaviors of beneficiaries and providers (USAID, 2015).

The RTU division coordinated five projects: Gender Roles, Equality, and Transformations (GREAT), Impact on Marriage: Program Assessment of Conditional Cash Transfers in India (IMPACCT), Preventive Technologies Agreement (PTA), Tékponon Jikuagou, and the Evidence Project. RTU projects aim to build scientific and empirical knowledge, and ensure its use in the design and implementation of FP/RH programs. The SDI division directed seven projects: Advancing Partners and Communities (APC), Capacity Plus, Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls (E2A), Leadership, Management, and Governance (LMG), Strengthening Health Outcomes through the Private Sector (SHOPS), and Support for International Family Planning Organizations (SIFPO – two projects). SDI projects improve access to and quality of FP/RH services through leadership, innovative

strategies, and best practices that improve performance and ensure sustainable delivery of family planning (USAID, 2015). A complete list of all 19 projects and the services provided by each can be found in Appendix B.

Contracts and grant agreements for the 19 projects were awarded to 50 agencies, with several agencies awarded agreements for multiple projects, and each project carried out in partnership by more than one agency. Of the cooperating agencies, 15 were awarded agreements for two projects, three agencies were awarded agreements for three projects, and one agency was awarded an agreement for five projects. Multiple cooperative agreements were awarded to Abt Associates, FHI360, Futures Group, Institute for Reproductive Health – Georgetown University, International Center for Research on Women, International Planned Parenthood Federation, Intrahealth International, Inc., John Snow, Inc., Management Sciences for Health, Marie Stopes International (MSI), Program for Appropriate Technologies in Health, Pathfinder International, Population Council, PRB, and Population Services International (PSI). A comprehensive list of cooperating agencies and projects is contained in Appendix C.

3.1 PROJECT EXAMPLES

Analysis of the projects revealed that all reflected some level of gender awareness. Extent of gender awareness differed between and within each project, ranging from gender accommodating to gender transformative programming aspects. Projects were categorized as gender aware based on findings of at least one aspect of gender aware programming discussed in a project report or on a website. Gender aware projects explicitly recognize the importance of gender differences, norms, and relations and their impact on health outcomes (IGWG, n.d.-b). These projects examine and

address gender dynamics through program design, implementation, and evaluation (IGWG, n.d.-b). This gender aware classification does not account for potentially gender blind components of these projects.

3.1.1 GREAT

The GREAT project was implemented in Northern Uganda by Georgetown University's Institute for Reproductive Health, Pathfinder International, and Save the Children. Designed as a set of participatory activities, GREAT engaged adolescents and adults in discussion and reflection in order to understand the processes through which social norms and attitudes about gender, reproductive health, and violence are transmitted (GREAT, 2015; USAID, 2013). GREAT intended to change social norms and attitudes to foster healthier, more equitable behaviors by focusing on transitional life stages for adolescents: puberty, onset of marriage, and initiation of childbearing (GREAT, 2015). The project spread ideas through various levels of the community via community action groups, radio drama, increased access to and quality of youth-friendly reproductive health services, and interactive lessons for community and school groups (GREAT, 2015). The GREAT project intended to change attitudes and behaviors related to gender equality, couple relationships, family planning, and gender-based violence (GBV) by engaging adolescents and the influential adults in their lives (GREAT, 2015).

Discussion and reflection activities were facilitated with community groups and school clubs using the GREAT Toolkit, and reinforced through the radio drama and community efforts. The GREAT Toolkit is a set of materials designed to help adolescents and adults learn, talk, and act to achieve their hopes and dreams through improving reproductive health, safety from GBV and equal opportunities for girls and boys (GREAT, n.d.). The Toolkit contains flipbooks for girls

and boys, activity cards for young, older, and married/parenting adolescents, a radio discussion guide, and a community game. The materials provide narratives and reflective questions as well as role-plays and other activities to facilitate discussion and challenge inequitable gender norms. The GREAT project's success in changing attitudes and behaviors has led District officials and community organizations to include GREAT Toolkit activities in their program budgets (GREAT, 2015).

3.1.2 E2A

E2A was implemented by Pathfinder International and partners in 14 African countries (E2A Project, n.d.). In the Democratic Republic of Congo, the project focused on community-based family planning programming, while simultaneously addressing gender equality and male engagement. E2A targeted areas where physical access to health services presented a significant barrier, and capitalized on the national commitment to family planning and maternal, newborn, and child health (MNCH) services (E2A Project, n.d.). By increasing the number of community-based distributors, creating linkages to health centers, and increasing health officials' capacity for supervision and support, E2A increased access to family planning services for rural communities. In addition, the project aimed to recruit sufficient numbers of women into community-based distributor roles and trained all community-based distributors to provide a range of family planning and MNCH services, including provision of injectable contraceptives. These efforts addressed gender-related barriers to contraceptive use by acknowledging constraints on women's mobility, changing inequitable norms that prevent women from being employed as community-based distributors, and circumventing stigma surrounding family planning use by offering integrated services in private settings.

In addition, E2A worked to increase awareness and demand for family planning through interpersonal communication and mass media, with a focus on male engagement (E2A Project, n.d.). The project solicited support from religious leaders and church programs to educate men about the benefits of family planning, and worked to change inequitable gender norms around women's role in personal and family health decision-making. Couples counseling and male engagement were cornerstones of the E2A project, and mass media strategies were also utilized to increase acceptance and use of family planning. E2A collaborated with multiple partners in an initiative to explore the use of text messaging and radio programs to spread positive family planning messages and dispel myths and misconceptions (E2A Project, n.d.). These aspects directly challenged inequitable norms preventing family planning use, and worked to create more equitable norms through male engagement interventions.

3.1.3 IDEA – PRB

The IDEA project, implemented by PRB, included a focus on strengthening the capacity of media to provide quality coverage of local FP/RH issues and gender disparities (Yeakey & Clifton, 2015). IDEA worked with local journalists in developing countries through workshops, study tours, and mentoring to increase their awareness and understanding of ways in which these issues impact national development (Yeakey & Clifton, 2015). The IDEA project conducted training activities for more than 700 journalists from 25 countries, resulting in 2,800 news stories and broadcast programs that reached a worldwide audience of millions (Yeakey & Clifton, 2015).

The Women's Edition network, a PRB program in its 21st year, builds the capacity of female reporters and editors to provide coverage of issues central to improving women's health and gender equity. An influential Women's Edition journalist and reporter in India highlighted the

benefits of a family planning program called the Honeymoon Package that successfully promoted birth spacing. Her reports helped to renew previously discontinued funding for the program and resulted in a proposal to extend the program throughout the entire state (Yeakey & Clifton, 2015). Journalists trained by the IDEA project and PRB have raised awareness of female genital mutilation/cutting (FGM/C) and abuse of women during labor and delivery, and have advocated in favor of justice for victims of rape. The media focused work of the IDEA project increases awareness of gender inequality within FP/RH, and challenges and helps to change inequitable cultural norms.

3.1.4 SIFPO – PSI

SIFPO was implemented by PSI in 13 USAID priority countries. An overarching goal of the SIFPO project was to positively impact the procedures and systems of cooperating agencies, which USAID anticipated would cascade down to local affiliates in developing countries (Castle & Hardtman, 2014). The gender aware approaches required by SIFPO did alter the work of PSI in this manner. SIFPO emphasized the strengthening of gender-sensitive family planning services targeting youth, which led to gender mainstreaming in all PSI service areas. The gender mainstreaming process within PSI was initiated by adapting and revising tools and indicators, and reinforced through trainings and the provision of web-based resources.

PSI developed gender indicators based on USAID and WHO standards, which were then incorporated into tools used across program areas (Castle & Hardtman, 2014). Family planning tools were adapted to reflect gender equitable goals and disseminated through PSI's online data sharing sites. In addition, a gender page was created on the PSI knowledge and information exchange site in order to engage staff worldwide in examining and responding to the ways gender

inequities, biases, and norms affect reproductive health (Castle & Hardtman, 2014). Gender indicators were also incorporated into client satisfaction tools and exit interviews.

After the inception of SIFPO, various gender awareness trainings were conducted with PSI staff domestically, abroad, and online. PSI conducted workshops for research staff in Washington, DC, which included values exploration exercises and training on gender analysis and gender integration throughout the program cycle. Additional trainings were provided for Washington, DC staff on the topic of GBV during research meetings and capacity building workshops. In collaboration with IntraHealth, PSI developed GBV research guidance consisting of ethical and technical guidance, information about qualitative and quantitative methods, and GBV indicators.

The gender-related resource development and training efforts of PSI have impacted the agency's program design and implementation. In Benin, gender sensitive resources helped improve organizational response to hotline callers experiencing GBV, and gender aware approaches influenced the interpretation and translation of research on no-scalpel vasectomy by highlighting the social and structural barriers faced by men (Castle & Hardtman, 2014). Gender mainstreaming within PSI encouraged an agency-wide critical examination of gender roles and dynamics, as well as efforts to create more equitable gender norms.

3.2 GENDER CLASSIFICATION OF PROJECTS

All project reports and websites indicated some level of gender awareness, ranging from gender accommodating to gender transformative. Four projects were classified as gender accommodating, including two CSL, one RTU, and one SDI project. The remaining 15 projects were classified as gender transformative: five PEC, four RTU, and six SDI projects (see Table 2). Projects were

classified as gender transformative based on findings of at least one aspect of gender transformative programming discussed in a project report or website.

Table 2: Gender classification of projects

	Project Name	Division
Gender Accommodating	DELIVER Project – Task Order 4	CSL
	Global Health Supply Chain – Technical Assistance	CSL
	Preventive Technologies Agreement (PTA)	RTU
	Strengthening Health Outcomes through the Private Sector (SHOPS)	SDI
Gender Transformative	Health Communication Capacity Collaborative (HC3)	PEC
	Informing Decisionmakers to Act (IDEA) - ASPEN	PEC
	Informing Decisionmakers to Act (IDEA) - PRB	PEC
	MEASURE Evaluation III PRH Associate Award	PEC
	Health Policy Project (HPP)	PEC
	Gender Roles, Equality, and Transformations (GREAT) Project	RTU
	Impact on Marriage: Program Assessment of Conditional Cash Transfers in India (IMPACCT) Project	RTU
	Tékponon Jikuagou	RTU
	The Evidence Project	RTU
	Advancing Partners and Communities (APC) Project	SDI
	Capacity Plus	SDI
	Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls (E2A)	SDI
	Leadership. Management, and Governance (LMG)	SDI
	Support for International Family Planning Organizations (SIFPO – MSI)	SDI
	Support for International Family Planning Organizations (SIFPO – PSI)	SDI

Projects classified as gender accommodating include programming that acknowledges the role of gender norms and inequities and adjusts or compensates in order to limit the harmful impact. These projects range in their acknowledgement of gender dynamics, and some openly advocate for gender transformative approaches while maintaining a gender accommodating program design or implementation. For instance, the DELIVER project neglects to mention the

term *gender* in its report or on its website, but does exhibit an aspect of gender awareness in its program evaluation by providing sex disaggregated data. The SHOPS project responds to women's preference for female health providers in Jordan by tailoring its efforts in order to work primarily with female providers. These projects are ultimately classified as gender accommodating because the core of their work focuses on adjusting to existing gender differences and inequalities.

Projects classified as gender transformative incorporate programs that foster a critical examination of gender norms, strengthen or create more equitable gender norms, or change inequitable gender norms. Projects in three divisions are classified as gender transformative, PEC, RTU, and SDI. Distribution of gender accommodating and gender transformative projects is shown in Figure 8. The variety of approaches and topics addressed by these projects is discussed in the following sections.

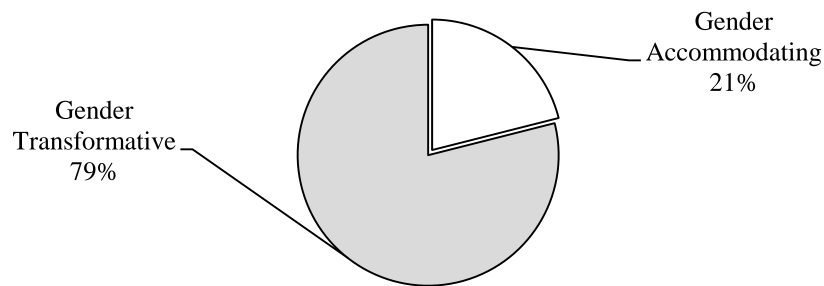


Figure 8: Gender awareness of projects

3.3 GENDER AWARE APPROACHES AND TOPIC AREAS

Nine projects integrated gender within the stated project purpose, seven emphasized gender as a key focus area or cross-cutting principle of the project, and three omitted gender from project descriptions. Gender accommodating and gender transformative projects employ a range of programmatic approaches and can be analyzed on a number of characteristics. This analysis classifies gender accommodating and gender transformative projects into five categories: data and research; education and communication; advocacy and policy; technical assistance and capacity building; and service delivery and program implementation. Projects frequently employed multiple approaches within gender aware programs.

3.3.1 Data and research approaches

Fifteen projects incorporated gender awareness into data and research approaches. Projects worked to compile and improve upon data collection that reflects gender dynamics and gender impacts. For instance, the DELIVER project provided sex disaggregated data on individuals trained, while MEASURE created and administers a Family Planning and Reproductive Health Database that defines gender indicators and provides instructions to incorporate these indicators in program design and evaluation (MEASURE Evaluation, n.d.). The Family Planning and Reproductive Health Database includes indicators that examine schooling, income, property, decision-making, mass media exposure, age at first marriage, laws pertaining to consent for marriage, reproductive health in sexual violence and rape situations, FGM/C, and male engagement in family planning. The IDEA – PRB project compiled gender related data and incorporated this data into resources

used for advocacy work: the World Population Data sheets include data pertaining to violence against women, early marriage, women's financial inclusion, and household decision-making.

Projects also employed a variety of research methods to accumulate data and build evidence to support gender awareness programming. The Evidence project, for example, aims to generate, translate, and use evidence to strengthen and support scale-up of gender transformative family planning approaches. The Evidence project has conducted research on normative aspects of contraceptive behavior and avenues for shifting inequitable norms, particularly in relation to unmet need for contraception, determinants of method choice, factors of discontinuation, and contraceptive switching patterns. Other projects, such as GREAT, IMPACCT, and Tékponon Jikuagou, were designed as research projects to investigate existing gender norms impacting sexual and reproductive health, and test various approaches to change inequitable norms. A number of projects involved research related to male engagement in family planning programs, and some examined the role of male social networks and religious leaders in determining family planning attitudes and behaviors. A complete list of programs and their data and research approaches is provided in Appendix D.

3.3.2 Education and communication approaches

Thirteen projects incorporated gender awareness into education and communication approaches. Projects employed education and communication platforms to reach individuals at the community level, and also to increase awareness and garner support from policymakers and program managers. Many of the education and communication efforts targeting the latter group included strategies that are discussed in the advocacy and technical assistance sections below. Projects working at the community level frequently used mass media campaigns and interpersonal

communication strategies to increase awareness, acceptance, and use of family planning methods and services. The GREAT project included a serial radio drama to promote equitable gender norms, while the Evidence project utilized religious sermons and community theater to promote positive views of family planning. IDEA – PRB increased media coverage of issues related to gender inequality, such as rape, FGM/C, and early marriage. The SIFPO projects worked to incorporate social franchising and mobile-health platforms to reach women with family planning services. A complete list of programs and their education and communication approaches is provided in Appendix D.

3.3.3 Advocacy and policy approaches

Twelve projects incorporated gender awareness into advocacy and policy approaches. These approaches involved education and awareness raising efforts, as well as policy consultation to create and adapt gender inclusive practices. Many of the education and awareness raising activities targeted national leaders and health program decision makers, and took the form of policy briefs, literature reviews, reference guides, and conference presentations. IDEA – ASPEN dedicated several sessions of its annual Ideas Festival to critically examining gender, and highlighted the intersection of gender with other humanitarian issues, such as food security and climate change. Capacity Plus promoted gender equality in human resources policies by incorporating gender sensitive language and practices into existing national policies. In Rwanda, the work of Capacity Plus led to a national law prohibiting GBV and gender discrimination in the workplace. The work of the LMG project in Benin facilitated the creation of a Ministry of Health gender policy and accompanying strategy document. A complete list of programs and their advocacy and policy approaches is provided in Appendix D.

3.3.4 Technical assistance and capacity building approaches

Fourteen projects incorporated gender awareness into technical assistance and capacity building approaches. Many of these approaches involved the creation and dissemination of reference and training resources, some of which also fall under the category of education and communication. For instance, HC3 manages a publicly accessible online library of social and behavior change communication (SBCC) resources, many of which address gender norms that impact family planning use. The MEASURE project created a guide for integrating gender into health program monitoring and evaluation plans, and the PTA project created a summary of evidence and recommendations for engaging men in HIV microbicide research trials. SIFPO – MSI published a gender and youth toolkit highlighting best practices in youth sexual and reproductive health programming.

Several of the projects conducted trainings and consultations at the national, institutional, and provider level. IDEA – PRB, for example, provided training for journalists and media personnel to increase coverage of issues related to gender inequality. The LMG project provided institutional strengthening for gender mainstreaming, as well as support to NGOs in developing GBV prevention programs and referral protocols. In Benin, the Tékponon Jikuagou project linked family planning providers to influential groups in order to bolster support for family planning and increase the reach of services. SIFPO – PSI involved youth in the training of healthcare providers and design of youth-friendly services in Liberia and Malawi in order to address high levels of unmet need for family planning among this demographic. A complete list of programs and their technical assistance and capacity building approaches is provided in Appendix D.

3.3.5 Service delivery and program implementation approaches

Twelve projects incorporated gender awareness into service delivery and program implementation approaches. Projects commonly addressed access to family planning services and supplies by providing community-based interventions, vouchers, and service integration. The SIFPO – PSI project integrated family planning into immunization programs as a response to cultural needs for covert contraceptive use. The SHOPS project and Capacity Plus utilized community health workers (CHWs) to educate and provide family planning services. The PTA project utilized mobile reproductive health units in South Africa to meet the needs of rural communities. Several projects also contributed to increasing the contraceptive method mix, with particular emphasis on long acting methods such as injectable contraceptives. The APC project worked to increase method mix and access, with an emphasis on community-based distribution (CBD) and injectable contraceptives. SIFPO – PSI promoted a no-scalpel vasectomy program in Benin, which sought to resonate culturally with existing gender norms.

Many of the projects also incorporated elements of interpersonal communication in order to decrease gender inequitable norms that prevent family planning use. The Tékponon Jikuagou project conducted reflective dialogue with participants that examined gender norms, and worked to reduce unmet need for contraceptives by promoting family planning use through male social networks. The GREAT project involved elements of community mobilization and engagement of village leaders and religious groups to promote gender equitable norms related to sexual and reproductive health. In Pakistan, the Evidence project worked with men's groups and religious leaders to promote positive views of family planning by focusing on healthy timing and spacing of pregnancies. A complete list of programs and their service delivery and program implementation approaches is provided in Appendix D.

3.3.6 Topic areas

In addition to applying multiple approaches, gender aware projects focused on a variety of topics within the field of FP/RH. The most common topic area addressed by projects was male engagement in family planning. Many projects also focused programming efforts on violence against women, including rape, FGM/C, workplace violence, and sexual harassment. A substantial number of projects addressed gender-related barriers by working to increase the contraceptive method mix, emphasizing availability of long acting methods such as injectable contraceptives. Multiple projects involved interventions to decrease access barriers by providing CBD through CHWs and mobile units. Additionally, numerous projects focused on women’s economic development and financial inclusion (see Table 3).

Table 3: Gender aware project topic areas

	Male engagement	Violence against women	Increasing method mix	Community-based services	Women's economic development	HIV prevention and services	FP integration into other health services
DELIVER			X				
Global Health Supply Chain			X				
PTA	X		X	X		X	X
SHOPS			X	X			X
HC3	X						
HPP		X				X	
IDEA - ASPEN							
IDEA - PRB		X			X		
MEASURE	X	X		X	X		
GREAT	X						
IMPACCT					X		
Tekponon Jikuagou	X						
Evidence	X					X	
APC	X	X	X	X	X		
Capacity Plus		X			X	X	
E2A	X		X	X			
LMG		X			X		
SIFPO - MSI		X		X		X	X
SIFPO - PSI	X	X	X				X
TOTAL	9	8	7	6	6	5	4

Table 3 continued

	FP decision-making and couple communication	Promoting girls' education	Reducing child marriage	Youth sexual and reproductive health	Religious leaders and faith-based networks	Family planning vouchers	Social franchising and market segmentation
DELIVER							
Global Health Supply Chain							
PTA							
SHOPS						X	X
HC3	X						
HPP							
IDEA - ASPEN							
IDEA - PRB	X	X	X				
MEASURE	X	X	X				
GREAT				X	X		
IMPACCT		X					
Tekponon Jikuagou					X		
Evidence							
APC	X	X	X			X	
Capacity Plus							
E2A					X		
LMG							
SIFPO - MSI				X		X	X
SIFPO - PSI				X			X
TOTAL	4	4	3	3	3	3	3

4.0 DISCUSSION

This analysis examines the ways in which USAID's Washington, DC-based reproductive health programs work to address gender-related barriers to contraceptive use. USAID's commitment to promoting gender equality is evidenced through the reproductive health projects analyzed. Gender equality is commonly referenced within project descriptions and purpose statements, and project activities reflect an inclusion of gender aware programming that works to combat inequalities and dismantle damaging gender norms. In fact, the vast majority of projects incorporate gender transformative approaches, which actively pursue the creation of equitable gender norms. The gender aware approaches discussed in this analysis align with USAID policy commitments and span a variety of approaches to reach a broad audience and create lasting impact.

4.1 USAID POLICIES AND PROCEDURES

The findings presented in the previous chapter reflect a clear commitment by PRH to USAID's Gender Equality and Female Empowerment Policy. The policy, implemented in 2012, attempts to streamline previous gender-related policies and procedures within the agency and outlines specific outcomes and indicators. The PRH projects included in this analysis incorporated these gender equality outcomes into project descriptions and areas of focus. By definition, the projects classified as gender transformative were closely aligned with the policy's goals to reduce gender disparities,

reduce GBV, and increase the capabilities of women and girls (USAID, 2012). Gender transformative projects encouraged critical examination of gender norms and dynamics, strengthened and created equitable gender norms and dynamics, and/or changed inequitable gender norms and dynamics. Fifteen of the 19 projects analyzed were classified as gender transformative and promoted the aims of the Gender Equality and Female Empowerment Policy. PRH has successfully operationalized this policy such that the intended outcomes are furthered by the office's project designs, implementation processes, and evaluations. There appears to be a consistent emphasis on adherence to the policy within PRH.

However, the commitment displayed by PRH toward USAID's Gender Equality and Female Empowerment Policy does not appear to be an organizational norm. A report published by Women Thrive Worldwide examined the implementation of this policy during its initial two years and found inconsistencies throughout agency bureaus, sectors, and missions (Young & Hart, 2014). Although the policy complements and reinforces various other USAID and US government initiatives, a lack of uniform guidelines creates an environment in which some bureaus, missions, and sectors adhere to the policy more than others (Young & Hart, 2014). Admittedly, the policy's outcomes were designed to be adapted by each sector or bureau and intentionally allow for flexibility, but this broad approach creates an opportunity for disengagement. Within this context, PRH's commitment to the policy is noteworthy and perhaps reflective of office leadership or meaningful overlap between the policy's goals and the current direction of the international family planning movement as a whole.

A lack of clear language to describe implementation of the policy is also visible within the Automated Directives System (ADS) Chapter 205: Integrating Gender Equality and Female Empowerment in USAID's Program Cycle (USAID, 2013a). Introduced in 2013, ADS Chapter

205 outlines agency-wide requirements for implementing various interrelated policies and strategies. The directive requires bureaus and missions to conduct gender analyses but does not outline a specific framework to be used for gender analysis. Rather, it simply provides a list of domains and descriptive statistics to be included in the analyses (USAID, 2013a). The vague language that allows for flexibility across agency offices also creates dependency upon bureaus and missions to establish ownership and display commitment to the policy.

In spite of the agency's expressed commitment to gender equality through policy reform and practice revision, challenges have arisen in USAID's operationalization of the policy. This may be partially attributed to the bureaucratic structure of USAID and the varying degrees of commitment across bureaus and sectors. Although the policy facilitated the creation of staff positions that focus on gender, these roles are limited and the leadership within each bureau, office, and mission ultimately influences commitment to gender equality. The 2012 policy draws upon the work of the Women in Development Office (established in 1974), a women in development policy paper (1982), and a Gender Plan of Action (1996) (USAID, 2012), but gender integrated efforts have yet to be evenly embraced throughout the agency. Such inconsistencies reveal the challenging nature of policy creation and operationalization within such a large bureaucracy, and highlight the sluggishness of the process.

4.2 GENDER AWARE PROGRAMMING AND THE SEM

In spite of the challenges inherent in operationalizing USAID's Gender Equality and Female Empowerment policy, PRH projects displayed a strong commitment to gender aware programming. Furthermore, projects exemplified a broad array of approaches tackling gender-

related barriers at all levels of the SEM. PRH's attention to activities at the individual, relationship, community, and societal levels demonstrates an institutional understanding of the ways in which a woman's contraceptive beliefs and practices affect and are affected by these multiple levels of influence. Working at multiple levels helps to ensure that gender equality advancements in family planning are both substantial and sustainable. Efforts to reduce gender-related barriers to contraceptive use at the individual level are less likely to have an impact when community interactions and national policy undermine gender equality. Likewise, policy efforts to reduce gender-related barriers may never be realized when individual, relationship, and community norms and interactions sustain and reinforce gender inequalities.

The projects frequently operated at multiple levels of the SEM simultaneously. A clearer distinction was obvious between projects geared toward the societal level than between those targeted at the individual, relationship, or community level. At the societal level, many projects focused on altering the policy environment in ways that supported gender equity or dismantled inequitable gender norms and dynamics. These efforts are important in creating a societal environment that decreases gender-related barriers to contraceptive use. Supportive policies and laws also promote gender equality at the community, relationship, and individual levels. Many of the projects that worked at the latter three levels of the SEM did so simultaneously and highlighted the interconnectedness of these levels and their impact upon contraceptive use. See Figure 9 for an overview of the gender aware approaches incorporated into projects.

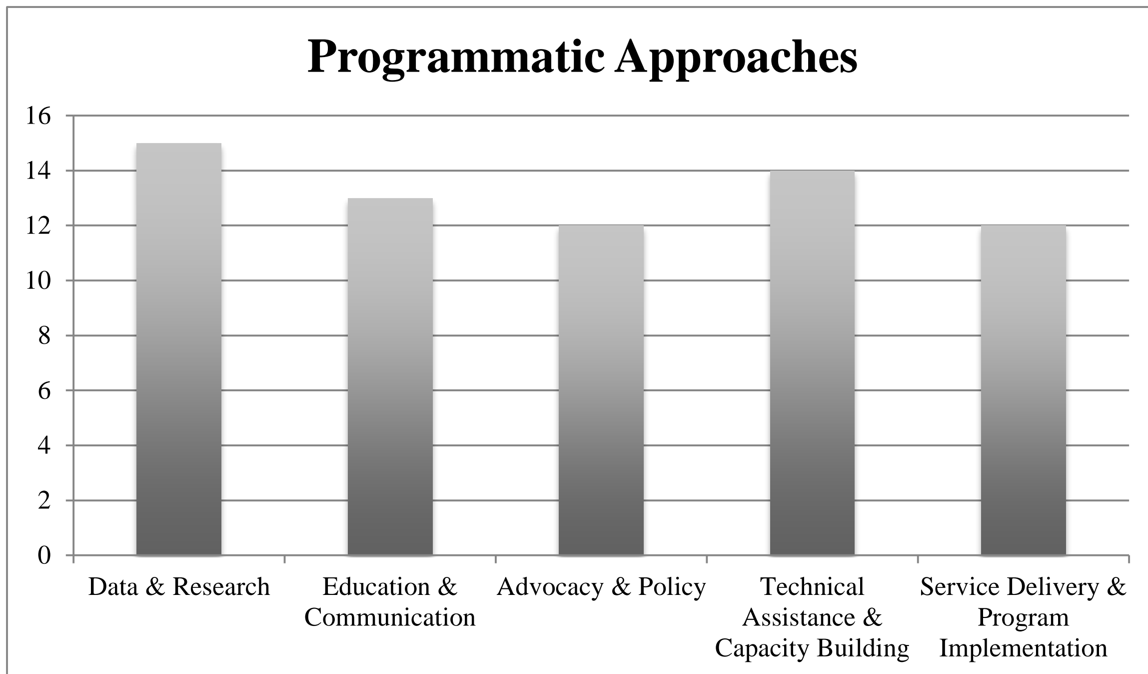


Figure 9: Gender aware approaches incorporated into projects

4.2.1 Policy level

Gender inequalities are embedded within a set of broader contextual factors that shape childbearing desires and options for women, couples, and society (McCleary-Sills et al., 2012). The policy environment strongly contributes to this set of factors and plays a crucial role in impacting contraceptive use. PRH project reports and websites indicated 12 instances of advocacy and policy approaches that reflected gender awareness. In some instances, these approaches led to dramatic changes such as the creation of national policies prohibiting GBV. By supporting data and research approaches, PRH projects also contributed to furthering a supportive policy environment. Data and research are commonly used to advocate for policy change, and project reports highlighted 15 instances of employing these approaches in gender aware programming.

USAID recognizes the importance of policy in both increasing access to contraceptives and decreasing gender inequalities that impact reproductive health. By effectively leveraging its prominent position within the international family planning movement, USAID has emphasized advocacy and policy to broadly impact gender equality and family planning. Research, advocacy and policy efforts are strategies that create lasting change beyond the scope of a five-year project. By focusing on these efforts, USAID can expand the reach of its projects to impact greater numbers of women and couples, while securing a foundation for gender equality that extends beyond each project's timeline.

Indeed, USAID's attention to policy and legislation aligns with international trends since the 1994 ICPD. Policy level approaches have been criticized for overlooking on-the-ground challenges of infrastructure, capacity, and resources that prevent the effective translation of these policies into service delivery (McCleary-Sills et al., 2012). However, USAID's incorporation of approaches at all levels of the SEM and attention to their interconnectedness suggest a more comprehensive approach to addressing gender inequality within FP/RH programs.

4.2.2 Individual, relationship, and community levels

Gender inequalities intersect social ecological levels and shape the attitudes, experiences, and social relations which influence a woman's ability to translate her childbearing desires into action (McCleary-Sills et al., 2012). USAID projects addressed gender inequalities at the individual, relationship, and community levels through education and communication approaches (13 instances), technical assistance and capacity building approaches (14 instances), and service delivery and program implementation approaches (12 instances). The nature of these projects

echoed the interconnectedness of these social ecological levels, and projects frequently employed activities that incorporated gender awareness into multiples levels at the same time.

4.2.2.1 Social and behavior change communication

Social and behavior change communication (SBCC) interventions represent a common approach through which many PRH projects incorporated various social ecological levels in addressing gender-related barriers to contraceptive use. These interventions acknowledge the role of social determinants of health, such as knowledge, attitudes, norms, and cultural practices in shaping an individual's overall health, and rely on communication platforms such as mass media, community-level activities, interpersonal communication, information and communication technologies to positively impact health (Johns Hopkins University, n.d.). As discussed in the previous chapter, a multitude of gender transformative projects employed such methods to change inequitable gender norms and strengthen or create equitable norms to support family planning use.

SBCC interventions acknowledge the interplay between multiple SEM levels and allow for interventions to tackle these levels simultaneously. For instance, many of the projects involved components that worked to increase accessibility for individuals, while simultaneously increasing social acceptance of contraceptives. E2A bolstered CBD of contraceptives and also focused on mass media and interpersonal communication activities to gain support for contraceptive use. The structure of such a project inherently considers the interplay between multiple SEM levels and the importance of addressing gender-related barriers at each level in order to bring about lasting change. This analysis revealed a strong commitment to SBCC interventions that demonstrates a thorough understanding of the SEM in relation to gender and contraceptive use.

4.2.2.2 Addressing inequitable gender norms

Gender norms and expectations may serve as barriers or facilitators to contraceptive use. Many aspects of PRH projects included activities that aimed to change inequitable gender norms that prevent women from using contraceptives. These activities frequently challenged social expectations related to womanhood and motherhood. Projects in Africa and the Middle East emphasized the healthy timing and spacing of children in an effort to redefine motherhood. These projects promote the acceptability of smaller families and challenge gender norms that attach value to both men and women relative to the number of children they produce. Creating such a drastic cultural shift requires collaborative efforts at multiple social ecological levels, and USAID frequently accomplished this through use of SBCC interventions.

USAID projects further challenged gender norms and expectations faced by adolescent girls. In parts of Asia and Africa, traditional marriage systems continue to serve as pathways to maximize fertility and encourage early childbearing among adolescent brides (McCleary-Sills et al., 2012). A young bride's status and security in her marital home is determined by whether or not she bears children soon after marriage, although early childbearing presents greater health risks and complications with pregnancy and childbirth (McCleary-Sills et al., 2012). USAID has engaged in various campaigns to delay the age of marriage in order to protect these young women. In addition, USAID recognizes the tremendous unmet need for contraception expressed by young couples, and projects are reflecting new emphasis on youth-friendly sexual and reproductive health services. Gender disparities in formal schooling also serve to limit young women's learning about sex and contraception, serving as yet another barrier to contraceptive use. Many of the projects incorporated activities to promote girls' education and address these gaps in women's knowledge.

Efforts to delay marriage and promote girls' education frequently employed activities at multiple social ecological levels in order to change inequitable norms.

Another area in which USAID projects addressed gender-related barriers to contraceptive use was through women's mobility and control of resources. In regions where women are not permitted to appear in public spaces, CBD and in-home programs can have tremendous impact on access to contraceptives. Throughout much of Africa, decisions regarding contraceptive use and distribution of finances are under the jurisdiction of men and community or religious leaders. In some instances, women may also fear the potentially violent repercussions of using contraceptives without permission. USAID projects worked to address these barriers by engaging men and religious leaders in family planning programming. Through increasing acceptance of family planning among males and preventing GBV, USAID projects attempted to address gender-related barriers to contraceptive use.

4.3 COOPERATING AGENCIES

Although all 19 projects were categorized as gender aware, certain agencies and entities expressed a stronger level of commitment to gender transformative approaches. In particular, IntraHealth, International Center for Research on Women, and IGWG facilitated many of the gender trainings and collaborated with many of the cooperating agencies to conduct gender analyses. Other agencies failed to mention gender in reports and on websites, or did so less often. Similar to the inconsistent commitment to gender equality across USAID bureaus and missions, it appears that agencies working in the field of FP/RH also differ in their attention to gender equality.

Gender integration, however, is a required component within USAID award solicitations (USAID, 2013a). As evidenced by the SIFPO – PSI project, a required focus on gender within programming has the potential to dramatically impact program design and service provision of an implementing partner/agency. Execution of this requirement provides the opportunity for USAID to significantly extend the reach of the agency's gender equality goals by influencing cooperating agencies to adopt gender aware policies and practices. Enforcing the inclusion of gender integration standards within solicitations and supplementing this with a requirement for specific outcomes and measurements in reports can strengthen the agency's progress toward gender equality goals. USAID should expect high standards of gender equality and female empowerment work from its implementing partners and do everything possible to support that endeavor.

Building the capacity of implementing agencies to promote gender equality through solicitation requirements also assists USAID in diminishing the negative impact of budget cuts within the agency. As discussed in Chapter 1.4.1, funding for reproductive health programs was dramatically reduced under the previous Republican administration. Given the current political climate and Republican control of the House and Senate, future budget cuts are certainly possible. Congress is required to approve USAID funding annually, and conservative Republican leaders have historically displayed a lack of support for reproductive health activities. Budget cuts are a real threat to recently established staff positions that serve to further the mission of the Gender Equality and Female Empowerment Policy. By ensuring that cooperating agencies are adopting gender equality policies and practices, USAID can continue to promote its vision in the face of budget shortcomings.

5.0 CONCLUSION

USAID's commitment to gender equality is evidenced through the gender aware approaches discussed in this paper, although the extent of this commitment would best be analyzed through a more in-depth analysis. Project literature, however, conveyed deliberate efforts on the part of PRH to operationalize the agency's gender-related policies. All 19 projects demonstrated programmatic approaches intervening at multiple social ecological levels to combat gender inequalities. Projects frequently addressed multiple levels simultaneously, and commonly used SBCC interventions to dismantle inequitable gender norms and/or create equitable gender norms. By requiring projects to focus on gender, USAID has the opportunity to impact program design and service delivery, as well as the internal structure of its cooperating agencies. Such capacity building of implementing agencies enables USAID to further its gender equality mission and diminish negative impacts of budget cuts within the agency.

5.1 LIMITATIONS

All information included in this analysis was obtained from publicly available reports and websites. The annual and midterm reports reviewed were those submitted to USAID, and thus are subject to the reporting bias of the implementing agencies. Likewise, websites highlighted successes of the projects and agencies and presented an overview of the work that aimed to elevate positive outcomes and efforts. The nature of this analysis, therefore, is not all encompassing and

does not reflect an in-depth gender analysis of any project discussed. This analysis examines the gender awareness of USAID-funded projects as publicly portrayed by the agencies involved.

The large geographic and programmatic scope of each project precludes a comprehensive analysis of every aspect. The extent of this analysis is limited to each agency or project's report of gender aware activities within any component of the project. While a few projects were limited to a single country, many carried out activities worldwide, and some reported work in as many as 30 to 40 countries. Similarly, most projects were comprised of multiple programs addressing both the enabling environment and service delivery for FP/RH programs. The majority of projects were also implemented by multiple cooperating agencies, contributing to the complexity of a thorough analysis. The Evidence project, for example, partnered with eight international agencies to carry out a broad range of activities in nine countries (Evidence Project, 2016). Its work was guided by a conceptual framework that focused on four overarching approaches intersected by four core principles (Evidence Project, 2016). The approaches were categorized as either supply side or demand side, and cross-cutting principles focused on equity, rights-based programming, gender transformative approaches, and capacity building. The immense scope of such a project is beyond the capacity of this analysis.

Another notable exclusion of this analysis pertains to projects classified as biomedical research and those carried out by the CSL division. Biomedical research projects were excluded from this analysis for the sake of narrowing its scope, although these projects meaningfully contribute to decreasing gender-related barriers by developing and improving upon a range of contraceptive methods. Both biomedical research and CSL projects seldom discussed gender considerations explicitly in reports and on websites. However, expanding the contraceptive method mix and securing access to these products works toward overcoming barriers that stem from fear

of side effects/health risks, opposition to use, and access. By reliably and consistently providing women with methods that can be used covertly, or that are perceived to be more safe/acceptable, these projects addressed gender inequalities that serve as barriers to contraceptive use.

5.2 THE PATH FORWARD

USAID family planning programs continue to make substantial contributions to the international family planning movement, and PRH projects have reported a notable commitment to gender equality. However, slow bureaucratic processes and conservative political climates, both domestic and abroad, limit the potential and scope of USAID projects. Building the capacity of international family planning organizations, as exemplified through SIFPO, suggests a positive direction for USAID projects. This format diminishes negative impacts of funding cuts for USAID, which might result in the elimination of staff positions and processes that currently facilitate gender equality initiatives within the agency. Because cooperating agencies are more likely to have local offices, employ local staff, and well informed about community resources and needs, this approach may also be a way for USAID to promote and conduct culturally appropriate work.

Building the capacity of cooperating agencies also enables USAID to circumvent restrictions on abortion. President Obama rescinded the Mexico City Policy in 2009, which enabled USAID to award contracts and grant agreements to agencies that provide abortion services. MSI and PSI, both of which provide abortion services, received cooperative agreements under SIFPO. The project was extended in 2015, and a cooperative agreement was awarded to a third party, International Planned Parenthood Federation, which also provides abortion services. Under SIFPO, USAID builds the capacity of these organizations, solidifies their commitment to

gender aware approaches, and strengthens their ability to provide a full range of FP/RH services. Thus, in the event that the Mexico City Policy is reinstated, the restrictions it imposes may have less negative impact on women's ability to receive abortion services.

In addition to SIFPO and other capacity building projects, biomedical research projects present additional opportunities to promote gender equality. Although these projects purport to address women's need for contraceptives through advancements in quality, safety, and new method development, it is necessary to examine the ways in which gender norms and dynamics impact women's acceptance of and preference for existing and emerging contraceptive products. Biomedical research projects would benefit from a gender aware approach that incorporates women's needs in new product design and quality improvement activities. Implementing agencies should be trained and held accountable for incorporating a gender aware lens into their research methods and reporting tools.

Utilizing resources within the agency would allow USAID to further advance its gender equality goals. For instance, rather than maintain the currently ambiguous language and instructions of the Gender Equality and Female Empowerment Policy, USAID should promote use of the Gender Integration Continuum Tool to conduct gender analyses. As exemplified in this analysis, this tool provides a structured framework for gender analysis and can be applied to myriad programs and projects. Additionally, data collected from various USAID projects must be used to inform future project design and family planning priorities within the agency. Demographic and Health Survey (DHS) data, such as contraceptive prevalence rates and reasons for nonuse of contraceptives, provides the foundational information guiding the international family planning movement. This data should be tied into project designs and used to determine priority countries. As discussed in Chapter 1, reasons for nonuse of contraceptives vary and present differently across

regions. USAID has an obligation to respond to unmet need for contraception by integrating evidence from the DHS and other projects into programs tailored to address unique needs in specific geographic regions.

Furthermore, addressing gender inequality as a barrier to contraceptive use requires a more comprehensive system of data collection. As is, the DHS collect information regarding contraceptive use from married women. This process must be expanded to include youth, unmarried women, and men in order to determine true family planning use and unmet need for contraception. Additionally, USAID must adhere to the ICPD recommendations to use unmet need for contraception as the ultimate measuring stick. When USAID graduates countries from family planning programs based on total fertility rates and modern contraceptive prevalence rates, the agency is countering ICPD recommendations and failing to meet the needs of women and couples. Graduation from USAID family planning programs must be contingent upon lowering rates of unmet need for contraception rather than increasing contraceptive prevalence rates.

Addressing gender inequality also demands an honest consideration of USAID's reputation in the international development sphere. The agency has been criticized for allowing ideology to govern its family planning programming, thus sacrificing the health and wellbeing of women and children across the globe. The same conservative politicians currently limiting women's access to a full range of reproductive health services domestically also have the power to dictate the budget and parameters of USAID's family planning programming abroad. In order to address gender inequality within family planning programs, domestic advocates must acknowledge the interconnectedness of local and global politics and organize efforts to benefit women worldwide.

Finally, USAID's success in addressing gender inequality through PRH projects requires a truthful assessment of the agency's processes and top-down approach. Promoting gender equality

necessitates substantial stakeholder input and a leadership team that is receptive to what is happening on the ground. Research projects such as GREAT are needed in many parts of the world to help understand gender and cultural norms and design appropriately responsive programs. Effective projects must be individualized, well researched, and culturally appropriate. Projects must address expressed reasons for contraceptive nonuse within the country or region, and must be implemented by carefully selected cooperating agencies that are well respected in the community. Addressing gender-related barriers to contraceptive use requires much more than a robust budget and broad reach: it is essential that the voices of women and couples are not only heard, but serve to inform future project design, implementation, and evaluation.

APPENDIX A: POLICIES GOVERNING US FAMILY PLANNING PROGRAMS

Policy	Principle	Description
Helms Amendment	Restrictions on Support for Abortions	No foreign assistance funds may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions (USAID, 2016).
Leahy Amendment	Restrictions on Support for Abortions	The term "motivate," as it relates to family planning assistance, shall not be construed to prohibit the provision, consistent with local law, of information or counseling about all pregnancy options (USAID, 2016).
Siljander Amendment	Restrictions on Support for Abortions	No foreign assistance funds may be used to lobby for or against abortion (USAID, 2016).
Biden Amendment	Restrictions on Support for Abortions	No foreign assistance funds may be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning (USAID, 2016).
Mexico City Policy (Global Gag Rule)	Restrictions on Support for Abortions	Requires foreign non-governmental organizations (NGOs) to certify that they will not perform or actively promote abortion as a method of family planning using funds generated from any source as a condition for receiving USAID family planning assistance (USAID, 2016). **Rescinded by President Obama in 2009**
Tiahrt Amendment	Voluntarism and Informed Choice	Prohibits use of quotas and financial incentives in family planning projects and requires provision of comprehensible information on methods. Prohibits denial of rights or benefits to individuals choosing not to use family planning (KFF, 2015b).
Kemp-Kasten Amendment	Voluntarism and Informed Choice	No foreign assistance funds can be made available to any organization or program which, as determined by the President of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization (USAID, 2016).
DeConcini Amendment	Voluntarism and Informed Choice	Funds shall be available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services (USAID, 2016).
Livingstone Amendment	Voluntarism and Informed Choice	In awarding grants for natural family planning, no applicant shall be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning (USAID, 2016).

APPENDIX B: PROJECT LIST AND DESCRIPTIONS

Division	Project Name	Services Provided
CSL	DELIVER Project - Task Order 4	"Improve and strengthen in-country supply chains: TO4 supports research, assessments, analyses, supply chain designs, and capacity building to ensure that in-country supply chains are able to meet the basic health commodity requirements of public health programs, and accommodate the growing need for, and influx of, supplies across multiple disease and health areas. Areas of expertise include product selection, forecasting, financing, procurement, quality assurance, distribution, inventory management, storage, logistics management information systems, and disposal. TO4 places renewed focus on end-to-end supply chain strengthening, and addressing key bottlenecks throughout the supply chain, particularly procurement, infrastructure, transport, and last mile distribution. Strengthen environments for commodity security: To strengthen country environments for commodity security, TO4 focuses on financing and resource mobilization, policies and regulations, market segmentation and market development, and advocacy and leadership. An overarching emphasis is to build local capacities to gather, analyze, and use quality data for decision making. While much of this work will directly focus on in-country environments, TO4 will also collaborate with and support partners at the global and regional levels to strengthen evidence-based global/regional advocacy for commodity security. Across all technical areas, TO4 will place new or expanded focus on capacity and skills transfer, research and innovation, leveraging partners, and knowledge management and communications" (USAID, 2011, p. 25).
CSL	Global Health Supply Chain - Technical Assistance	"Strategic Planning – Provide strategic planning and design assistance. • In-Country Logistics – Improve delivery of health commodities to service sites (including forecasting, supply planning, procurement TA, warehousing, inventory management, distribution, logistics management information systems, data collection, etc.) • Capacity-Building – Effective transfer of skills, knowledge, and technology for improved and sustained performance. • Enabling Environments – Strengthen enabling environments (financing, human resource, policy, governance and leadership) to improve supply chain performance. • Global Strategic Engagement – Global strategic engagement with partners for planning and implementation. Support global partners to utilize lessons learned and share best practices. • Advocacy – Continued awareness-raising and advocacy to improve availability of health commodities. • Coordination – Effective coordination with all USAID funded supply chain activities and within the IDIQ" (USAID, 2015, p. 24).

Division	Project Name	Services Provided
PEC	Health Communication Capacity Collaborative (HC3)	"HC3 will focus on strengthening in-country capacity to implement state-of-the-art health communication, including mass media, community-level activities, interpersonal communication, and new media. The project will provide tailored capacity strengthening to a range of indigenous partners, including governments, NGOs, creative professionals, and academics, with activities to develop individuals, organizations, and national systems. HC3 will also provide technical leadership in health communication that includes professional exchange, analysis of emerging trends, and development and dissemination of technical and operational guidance. The project will be characterized by a strong focus on implementation science, emphasizing rigorous evaluation, documentation, and diffusion of effective practices. The five core strategies employed by HC3 are: • Improving and sustaining health communication through a defined capacity improvement cycle based upon current best practices; • Facilitating increased capacity at the graduate and undergraduate levels among universities in Africa, Asia and elsewhere; • Supporting collaborative learning, exchange and capacity strengthening through regional "Market Places," including both virtual and physical centers; • Harnessing new media and igniting innovation to improve behavioral impact; and, • Building the evidence base for health communication through rigorous research and evaluation" (USAID, 2013b, p. 23).
PEC	Health Policy Project (HPP)	"Transferring skills to and building systems for the next generation of in-country policy leaders and champions will be the highest priority of HPP. Capacity building under HPP is seen as a process of jointly planned and focused support to identify, improve, and sustain institutional and individual competence and structures for effective policy, advocacy, and governance. HPP offers assistance to: • Support capacity building for development, costing, financing, and implementation of country-led plans, policies and/or Partnership Frameworks; • Strengthen partner country undergraduate, graduate, and continuing professional development programs in policy and governance; • Conduct regional and in-country trainings and provide technical assistance to develop data use, analysis, and modeling, as well as advocacy and communication, skills; and, • Create a grants mechanism to fund the implementation and scale- up of locally developed innovations and approaches" (USAID, 2011, p. 30).

Division	Project Name	Services Provided
PEC	Informing Decisionmakers to Act (IDEA) – ASPEN	"The IDEA-Aspen project uses the following approach: • Use high-level strategic access to national and global leaders to dramatically amplify new messages about the centrality of reproductive health to development; • Utilize select policymakers as champions and standard setters for their peers; • Link reproductive health more centrally to broader development goals including the environment, security, health, and economic development; • Engage new influential audiences and establish ongoing linkages with diverse non-health sectors; and, • Emphasize the power of personal narrative through the voices of influential policy spokespeople from developing and developed nations. Aspen engages these high-level policymakers primarily through three forums: the Population, Health and Development Track at the annual Aspen Ideas Festival; the Aspen Population and Health Roundtable Series in Washington, DC; and the Population Policy Dialogue Series in collaboration with the WHO in Geneva at the time of the World Health Assembly" (USAID, 2011, p. 31).
PEC	Informing Decisionmakers to Act (IDEA) – PRB	"The Population Reference Bureau IDEA project engages government organizations, NGOs, development networks, and other local institutions to build their capacity to design and implement effective FP/RH advocacy strategies. Under this award, PRB produces its World Population Data Sheets. It develops country-specific and global multimedia presentations to engage decision-makers on the benefits of FP/RH using advanced data-visualization technologies such as the Trendalyzer (bubble graph) software. It works with journalists to improve the quality and quantity of FP/RH issues in the media and to link FP/RH issues to population growth and development. Priority areas include: • Health and population data and information analyzed, synthesized and disseminated to engage relevant policy and advocacy audiences; • Capacity of media to provide quality coverage of key health and population issues strengthened; • Individual and institutional capacity to use information to influence policymakers improved; and, • Dialogue among population and health researchers, program implementers and policymakers expanded" (USAID, 2011, p. 32).

Division	Project Name	Services Provided
PEC	MEASURE Evaluation – PRH Associate Award	"The MEASURE Evaluation Phase III PRH Associate Award provides technical assistance, global leadership, and training to strengthen monitoring and evaluation of PRH programs. It also works to develop PRH monitoring and evaluation tools and methodologies, and to conduct PRH evaluation re search. In addition, the PRH Associate Award will facilitate and strengthen coordination of data collection, analysis, and dissemination of FP/RH data among PRH CAs and stakeholders, with the aim of providing guidance on best practices, promising innovations, and setting monitoring and evaluation standards" (USAID, 2009, p. 32).
RTU	Gender Roles, Equality, and Transformations (GREAT) Project	"This phased five-year project will be implemented by Georgetown University's Institute for Reproductive Health with partners Save the Children and Pathfinder International. The project will conduct formative research to identify opportunities to promote the formation of gender equitable norms, attitudes and behaviors among adolescents and the significant adults in their lives. The research design includes innovative qualitative methods, such as collecting life histories from young people at different stages of the life course and in-depth interviews with individuals nominated by youth as significant influencers in their lives. Using an implementation science framework, the project will then inform the development and testing of interventions during the second phase that: (1) impact gender norms to positively influence reproductive health outcomes, reduce gender-based violence, and improve gender equity, and (2) have the potential to catalyze wide-spread, sustainable movements to challenge gender inequities worldwide. In addition, the Responsible, Engaged and Loving (REAL) Father's Initiative focuses on the design and evaluation of an innovative mentoring program and community awareness campaign designed to reach young fathers (aged 16-25) to reduce the incidence of intimate partner violence and physical punishment of children. In order to address underlying causes of domestic violence, the intervention is designed to challenge the gender norms and sexual scripts that often trigger coercion and violence in relationships and to teach effective parenting, communication, and problem-solving skills" (USAID, 2011, p. 42).

Division	Project Name	Services Provided
RTU	Impact on Marriage: Program Assessment of Conditional Cash Transfers in India (IMPACCT) Project	"This five-year cooperative agreement awarded to the International Center for Research on Women (ICRW) provides a unique opportunity to evaluate an ongoing, government-run cash transfer program in Haryana, India. This Government program was started about 16 years ago where parents of newborn girls were give a bond to cash in when the girl turns 18 years of age and is still unmarried. Several other such programs have since begun in India. The Haryana program is the first to come to maturity in a couple of years, and presents an opportunity to do a large-scale research study to assess its implementation and impact. The findings of this project will greatly improve the evidence to date on conditional cash transfer programs and health impacts, which will then be applied to the Haryana program, other Indian government programs, and cash transfer programs around the world" (USAID, 2011, p. 43).
RTU	Preventive Technologies Agreement (PTA)	"The Project includes the following activities: • Developing and testing new or improved, microbicides and other reproductive health technologies, and providing technical assistance for the provision of these technologies • Assessing the acceptability and impact on users and programs of various microbicide products and reproductive health technologies • Developing and testing tools and strategies to improve integration of family planning and HIV/AIDS programs • Providing technical assistance to bilateral and other developing country programs to utilize state of the art research for service delivery improvement •Surveillance and testing of condoms and other commodities to ensure product quality" (USAID, 2009, p. 40).
RTU	Tékponon Jikuagou	"This six-year, phased project will be implemented by Georgetown University s Institute for Reproductive Health (IRH) in partnership with CARE International and Plan International. The methodology includes social network analysis to identify strategies to increase women s access to and use of family planning and reproductive health services. Formative research has found that deeply embedded social norms related to gender roles underlie unmet need for family planning. The goal is to create a social environment that enables married couples to achieve their fertility desires by fostering reflective dialogue and catalyzing discussion about social norms related to family planning, and diffusing information through formal and informal social groups, influential opinion leaders, and well-connected individuals. Based on this formative research, IRH and its partners will design and test interventions that activate key individuals within these networks in order to reduce negative determinants and strengthen positive influences on attitudes and behaviors" (USAID, 2015, p. 45).

Division	Project Name	Services Provided
RTU	The Evidence Project	"Through the EVIDENCE project, the Population Council and its partners: • Generate new evidence to increase the effectiveness of FP/RH programming. EVIDENCE will generate new evidence through rigorous research to address existing key FP/RH program issues of global significance, including developing and testing strategies to address these issues in a variety of contexts. In addition, EVIDENCE will have the capacity to design and conduct studies that respond to critical emerging issues, evidence gaps and country needs. • Synthesize and share evidence in order to accelerate scale-up of evidence-based improvements in FP/RH policies and programs. EVIDENCE will consolidate both new and existing evidence through syntheses, systematic reviews, case studies and other strategic analyses as well as package and disseminate lessons learned for use by key FP/RH audiences at global, regional, and country levels. • Provide technical assistance (TA) for application and use of evidence to improve FP/RH programming. EVIDENCE will provide TA that responds to program priorities at country and regional levels and builds capacity for generating and translating evidence into practice (e.g., TA to cost programs; to incorporate evidence into service delivery guidelines, tools and/or program plans; and to monitor and evaluate scale-up of high-impact FP/RH practices)" (USAID, 2014, p. 35).
SDI	Advancing Partners and Communities (APC) Project	"The project will accept all types of funding and addresses all health sector areas including family planning, HIV/AIDS, maternal and child health, and control of infectious disease. Advancing Partners & Communities is positioned to provide a wide range of technical services to Missions, some of which include: • Conduct assessments, introduce and promote innovative and high-impact strategies, and provide virtual or on-the-ground technical assistance to bilateral programs in the design of demonstration projects and national scale-up efforts of private and public-sector community family planning programs. • Provide technical and organizational capacity building services for local NGOs that will prepare them to implement and monitor effective programs and receive funding directly from USAID. • Provide Grant-making Services: Conduct fully open and targeted competitive solicitations; determine eligibility of awardees; prepare cooperative agreement documents for execution by USAID; execute actionable sub-awards; and execute sub-awards competed by an APS. • Provide Missions a wide range of grant management and oversight services for awards to local organizations: monitoring of progress and expenditures of programs, ensuring financial accountability of grantees, supporting program monitoring and evaluation, ensuring compliance with all USAID requirements, including branding and family planning requirements" (USAID, 2013b, p. 51).

Division	Project Name	Services Provided
SDI	Capacity Plus	“Project interventions focus on: • Fostering global leadership and advocacy to address the Human Resource for Health (HRH) crisis; • Enhancing HRH policy and planning, including strengthening HR management and information systems; • Improving HRH workforce development, including pre-service, in-service, and continuing professional development systems; • Strengthening HRH performance support systems to improve health worker retention and productivity; • Generating and disseminating knowledge to promote use of evidence-based HRH approaches. Two cross-cutting themes are promoting gender equity in HR policy and management and integrating faith-based organizations given their integral role in healthcare delivery in many countries” (USAID, 2011, p. 50).
SDI	Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls (E2A)	“E2A will work in partnership with USAID’s regional and country missions, host country partners, and international organizations to: • Introduction and large-scale implementation of family planning evidence-based practices; • Provide technical assistance to apply systematic approaches, monitor and evaluate scale-up; • Conduct youth and gender assessments, integrate youth and gender across service delivery interventions, and evaluate effectiveness of youth and gender approaches and models; • Introduce and test innovative service delivery approaches; • Provide technical assistance to support the integration of family planning into other health areas including FP/HIV and FP/MNCH and integration of family planning into non-health areas including workplace and environmental models; and, • Document and synthesize evidence of high-impact practices in family planning” (USAID, 2012, p. 53).

Division	Project Name	Services Provided
SDI	Leadership, Management, and Governance (LMG)	"The LMG Project interventions: • Foster global leadership and advocacy for improved leadership, management and governance capacity. • Strengthen the delivery of quality family planning and other health services through improved leadership, management and governance capacity; • Support the establishment and expansion of health managers as a professional cadre; • Develop and strengthen pre-service education in leadership, management and governance; • Develop and strengthen in-service leadership, management and governance education and training with Ministries of Health and local non-governmental and faith-based organizations; • Expand the awareness and use of tested tools, models and approaches to strengthen leadership, management and governance capacity throughout the public sector and civil society organizations; • Generate knowledge and conduct research to expand the knowledge base of the effect of enhanced leadership, management and governance capacity on health services outcomes in family planning, maternal and child health, HIV/AIDS and other health areas; and, • Develop and update indicators for tracking country-led leadership, management and governance processes and capacity building" (USAID, 2012, p. 52).
SDI	Strengthening Health Outcomes through the Private Sector (SHOPS)	"SHOPS builds upon decades of support for leadership in private health sector programming and on the work of its predecessor projects, Private Sector Partnerships-One (PSP-One) and Banking on Health, as well as projects such as Social Marketing for Change (SOMARC), AIDSMark, and Point-of-Use Water Disinfection and Zinc Treatment (POUZN). SHOPS' emphasis on exploring and advancing private sector innovations distinguishes this project from its predecessors. The SHOPS project offers a wide array of technical services available to Missions and their counterparts: • Conduct private sector health assessments; • Establish and facilitate public-private partnerships; • Implement social marketing programs (including pharmaceutical partnerships) for FP, zinc treatment, and other health products and services; • Conduct client-centered market segment analyses; • Promote behavior change through targeted health communications interventions; • Create financing mechanisms contracting, health insurance, voucher programs to improve access to affordable healthcare and products; • Improve policy and regulatory environments for the private sector in health; and, • Foster innovations and state-of-the-art private sector delivery and distribution models" (USAID, 2011, p. 56).

Division	Project Name	Services Provided
SDI	Support for International Family Planning Organizations (two projects)	"SIFPO leverages the comparative advantage and innovations of international family planning organizations to strengthen access to and use of high quality family planning services and commodities that are affordable and sustainable. SIFPO offers a wide array of technical services available to Missions and their counterparts, through two separate cooperative agreements. Awardees are working to: • Strengthen the delivery of quality family planning services to priority populations, specifically reaching those populations with high unmet need for FP with cost-effective interventions. • Quantify and disseminate quality assurance standards to strengthen FP program performance. • Increase organizational sustainability of country-level FP programs, through internal South-to-South support and technical assistance to improve capacity to capture revenue and become more self-sustaining over time, while still responding to the needs of underserved and marginalized groups. • Provide gender-sensitive FP services targeting youth strengthened so that youth and women, including young women, are able to access quality FP services that meet their needs. • Using vouchers, social franchising, social marketing and outreach strategies, SIFPO seeks to increase use of voluntary family planning including long-acting and permanent methods" (USAID, 2011, p. 54).

APPENDIX C: COOPERATING AGENCIES

Cooperating Agency	Project Name
Abt Associates	Capacity Plus
	SHOPS
African Medical and Research Foundation (AMREF)	LMG
African Population and Health Research Center	E2A
Aspen Institute	IDEA
Avenir Health	HPP
Axios	Global Health Supply Chain
Banyon Global	SHOPS
CARE International	Tékponon Jikuagou
Carolina Population Center – University of North Carolina at Chapel Hill	MEASURE
Center for Development and Population Activities (CEDPA)	HPP
Chemonics	Global Health Supply Chain
Engender Health	SIFPO
ExpandNet	E2A
FHI360	PTA
	APC
Futures Group	HPP
	MEASURE
IMA World Health	Capacity Plus
INDEPTH Network	Evidence
Institute for Reproductive Health – Georgetown University	GREAT
	Tékponon Jikuagou
International Center for Research on Women (ICRW)	IMPACCT
	SIFPO
International HIV/AIDS Alliance	SIFPO
International Planned Parenthood Federation (IPPF)	Evidence
	LMG
Internews	HC3
Intrahealth International, Inc.	Capacity Plus
	E2A
	SIFPO
Jhpiego	SHOPS

Appendix C continued

Cooperating Agency	Project Name
John Snow, Inc.	DELIVER Project
	APC
Johns Hopkins Bloomberg School of Public Health – Center for Communication Programs (CCP)	HC3
Johns Hopkins Bloomberg School of Public Health	LMG
Liverpool Associates in Tropical Health (LATH)	Capacity Plus
Logistics Management Institute (LMI)	Global Health Supply Chain
Management Sciences for Health (MSH)	HC3
	MEASURE
	Evidence
	E2A
	LMG
Marie Stopes International	SHOPS
	SIFPO
MedicMobile	LMG
NetHope	HC3
Ogilvy Public Relations	HC3
O'Hanlon Health Consulting	SHOPS
Partners in Population and Development Africa Regional Office	HPP
Program for Appropriate Technologies in Health (PATH)	Evidence
	E2A
Pathfinder International	GREAT
	E2A
Plan International	Tékponon Jikuagou
Population Council	Evidence
	SIFPO
Population Reference Bureau (PRB)	HPP
	IDEA
	Evidence
Population Services International (PSI)	HC3
	SIFPO
PricewaterhouseCoopers	Global Health Supply Chain
RTI International	HPP
Save the Children	GREAT
Stanford Program for International Reproductive Education and Services (SPIRES)	SIFPO
Training Resources Group	Capacity Plus

Appendix C continued

Cooperating Agency	Project Name
Tulane University	MEASURE
White Ribbon Alliance	HPP
Yale University Global Health Leadership Institute	LMG

APPENDIX D: PROGRAM APPROACHES

Table 4: Gender aware data and research approaches

Project Name	Data & Research
DELIVER	Provided sex disaggregated data on individuals trained.
PTA	Conducted research on female controlled HIV prevention methods (microbicide), research on male engagement in microbicide trials, research with female sex workers re: barriers to obtaining contraceptives, research on integrated services.
HC3	Conducted research re: women's role in FP decision-making and engaging men and boys as supportive FP partners. Completed secondary analysis of use of gender equity in health communication programs to increase contraceptive use.
HPP	Developed tools and methodologies for groups, program managers, and health officials to identify gender related barriers to services, as well as policy gaps.
IDEA – PRB	Compiled data on violence against women, CPR, early marriage, women's financial inclusion, household decision-making and published these indicators in World Population Data Sheets.
MEASURE	Created and maintains FP/RH database, which includes 6 indicators related to gender, with various measures for each. Women and girls' status and empowerment is a cross-cutting indicator in database (looks at schooling, income, property, decision-making, mass media exposure, age at first marriage, legal consent to marry). Indicators look at RH in emergency situations, sexual and GBV, FGM/C mutilation and cutting, male engagement in family planning. All of these indicators are defined so programs can use this as a resource and know how to measure and evaluate each indicator. For small grants program, funded research related to increasing women's ability to exercise reproductive control - community based approaches, and male and family involvement. For overall research, looked at dating violence and IPV in Haiti; women's empowerment and contraceptive choice in Africa; influence of child marriage on fertility choice.
GREAT	Project conducted research to understand process through which social norms and attitudes about gender, reproductive health, and violence are transmitted in Northern Uganda. Research aimed to identify opportunities to promote formation of gender equitable norms, attitudes, and behaviors among adolescents and significant adults in their lives.
IMPACCT	Project contributed to research on ability of conditional cash transfers to influence age of marriage.

Table 4 continued

Project Name	Data & Research
Tékponon Jikuagou	Project consisted of ethnographic research and was first social network analysis program in family planning.
Evidence	Aimed to generate, translate, and use evidence to strengthen and support scale-up of programs, particularly gender transformative ones, which are typically small in scope. Conducted research on normative aspects of contraceptive behavior and ways to shift norms. Including unmet need, determinants of method choice, factors of discontinuation, and contraceptive switching patterns.
APC	Conducted research in Iran related to contraceptive use and delayed childbearing impact on education and employment opportunities. Compile literature reviews and analyze data from other gender aware projects.
Capacity Plus	Conducted research on workplace violence and sexual harassment in Rwanda.
E2A	Conducted research on religious leader support for FP in Tanzania and faith based networks as part of efforts to increase male involvement in FP.
SIFPO – MSI	Conducted gender assessments to guide programming aimed at youth.
SIFPO – PSI	Incorporated gender indicators into tools used in all program areas. Indicators in client satisfaction surveys now include autonomy and gender of provider (to screen for coercion by parent, partner, or provider). Developed GBV research guidance.

Table 5: Gender aware education and communication approaches

Project Name	Education & Communication
SHOPS	Used behavior change communication and marketing strategies (incl. market segmentation) to increase access to and use of FP/RH services. Utilized CHWs to bring education into homes. India - mass media campaign and educational outreach to increase demand for injectable contraceptives.
HC3	Disseminates information and training resources to support partners in conducting social and behavior change communication (SBCC) activities around multiple topic areas, including gender
HPP	Created policy briefs and compiled literature reviews on topics such as violence against women, and scale-up of health programs that promote gender equality.
IDEA – PRB	Increased media training and coverage of gender inequality and damaging norms and practices like rape, FGM/C, and early marriage.
MEASURE	Published research briefs on male involvement in FP and CBD. Created guide to gender integration into health program M&E plans.

Table 5 continued

Project Name	Education & Communication
GREAT	Project consisted of a serial radio drama and interpersonal communication with community groups and activities in order to promote gender equitable norms and challenge inequitable norms.
Tékponon Jikuagou	Consisted of radio programs examining masculinity and challenging existing gender norms in order to increase acceptance of family planning practices.
Evidence	Religious sermons, community theater, and electronic media to promote positive views of FP.
APC	Compiled literature review on cultural barriers to male engagement in S. Asia. Studied role of couple communication in Malawi male involvement intervention.
E2A	Used interpersonal communication and mass media to increase awareness and demand for FP in DRC.
LMG	Created publications, documents, and training workshops to promote women in leadership. Created gender section on OVCsupport.net site (global knowledge sharing hub).
SIFPO – MSI	Used social franchising, mobile outreach, and M-health to reach women with family planning services.
SIFPO – PSI	Worked with MSI to increase social franchising for health.

Table 6: Gender aware advocacy and policy approaches

Project Name	Advocacy & Policy
Global Health Supply Chain	Carried out policy consultations to assist in developing and implementing policies regarding equitable access to health products regardless of gender, geography, or economic status.
HPP	Supports creation and dissemination of evidence for policy-making. Created multiple policy briefs to guide decision makers in areas impacting women. Works with government agencies, NGOs, women's associations, and others to strengthen advocacy capacity with a focus on improving women's health.
IDEA – ASPEN	Advocates for changing gender blind development work and focusing on women's rights to achieve development goals. Raises awareness of gender inequality and advocates for equality initiatives as focus of solutions. Aspen Ideas Festival has several sessions critically examining gender each year. Bring gender and RH into food security and climate change conversations and plans. Promoted FP/RH as cost effective intervention for health and development among ministers of health from low and mid income countries.

Table 6 continued

Project Name	Advocacy & Policy
IDEA-PRB	Created "Engage" presentations for decision makers on topics like FP and gender equality, girls' education, early marriage, and FGM/C. Publish World Population Data Sheets, which included special set of indicators assessing women's empowerment.
IMPACCT	Results showed that CCT was insufficient to change prevailing gender roles and expectations and may have even reinforced notion of girls as burden. Analysis will assist government and decision makers in future approaches.
Tékponon Jikuagou	Encouraged influential leaders to support and advocate for family planning practices.
Evidence	Uses research to make policy recommendations on gender transformative programming. Assist Uganda in operationalizing rights based family planning policy.
APC	Presented strategies for male engagement efforts based on literature review and other research.
Capacity Plus	Promotes gender equality in HR policy -Produced gender sensitive HR policies to be adapted to in country settings. Results of Rwanda study contributed to national law with specific articles prohibiting GBV and gender discrimination in the workplace. Based on Lesotho work, recommended policy and programmatic promotion of equitable division of HIV caregiving responsibilities among men and women.
LMG	Amplifies voices of women leaders as change makers in health sector through video and print publications. In Benin- supported MOH to develop gender policy and strategy doc by using gender audit.
SIFPO – MSI	Created gender and youth toolkit on best practices with youth.
SIFPO – PSI	Published program brief on sexual and reproductive health programs for youth, who have especially high levels of unmet need for FP.

Table 7: Gender aware technical assistance and capacity building approaches

Project Name	Technical Assistance & Capacity Building
PTA	Created summary of evidence and recommendations for engaging men in HIV microbicide research.
HC3	Compiles and makes available SBCC resources via online library. Collaborates directly with partners and conducts SBCC trainings.
HPP	Builds local capacity to integrate gender into family planning, reproductive health, HIV, and maternal health activities through direct technical assistance to local health institutions and national level leaders.
IDEA – PRB	Increased media training and coverage of gender inequality and damaging norms and practices like rape, FGM/C, and early marriage.

Table 7 continued

Project Name	Technical Assistance & Capacity Building
MEASURE	Provided technical assistance to USAID and created guide to gender integration into health program M&E plans.
GREAT	Trained providers to improve adolescent access to SRH.
Tékponon Jikuagou	Linked family planning providers to influential groups in order to bolster support for family planning and increase reach of services.
Evidence	Updated *What Works for Women and Girls* website as resource for programs worldwide. Provide technical assistance to government and ministry of health officials to operationalize rights based family planning policy. Assist in strengthening equitable gender norms by acknowledging, respecting, and protecting women's rights.
APC	Provides resources related to gender in the areas of: women and economic development (incl. conditional cash transfers); male engagement in FP; GBV; early marriage; and gender norms of healthcare providers.
Capacity Plus	Developed gender and human resource for health (HRH) orientation module for staff and adapted IGWG modules to HRH. Raised staff awareness of gender and GBV. Research in Rwanda resulted in MOH asking for further research and assistance in creating policy and training programs. MOL also asked for help in creating policy. Addressed worker shortage in rural areas and built capacity of workers. Gender discrimination and unequal opportunities impede efforts to develop, efficiently deploy, and fairly compensate health workforce.
E2A	Supports local efforts by providing gender sensitivity trainings, adopting practices to reduce gender inequalities, increasing women's participation, engaging men, and building capacity for gender equitable practices.
LMG	Provides institutional strengthening for gender mainstreaming. Work with NGOs to develop GBV prevention programs and referral protocols. In Honduras - supported NGOs in projects to prevent GBV, including 3-day workshops on topics related to FSW, MSM, transgendered individuals, and Garifuna. As a result, 8 capacity development plans developed by the NGOs and referral plan devised for NGOs to refer out GBV cases. In Ethiopia - technical support for MOH completion of gender training manual and gender directorate strategic plan. Also facilitated gender training of trainers.
SIFPO – MSI	Created gender and youth toolkit on best practices with youth.
SIFPO – PSI	Created youth friendly health services guide that discusses GBV and youth and encourages gender analysis when initiating a new youth friendly health services. GBV research guidance created. Involved youth in training of healthcare providers and design of youth-friendly services in Liberia and Malawi. Increased local capacity to lead and manage FP programs. Created e-learning course on social franchising (in partnership with MSI). On internal training site (Kix), created page on gender to train staff in examining and addressing ways gender inequities, biases, and norms affect RH. Conducted gender trainings with staff, as well as GBV trainings.

Table 8: Gender aware service delivery and program implementation approaches

Project Name	Service Delivery & Program Implementation
DELIVER	Project works to secure in-country supply of contraceptives in developing countries.
PTA	Mobile reproductive health units in South Africa; contribute to increased method mix by working on product quality and compliance (male and female condoms, lubricants, IUDs, oral pill, injectable, implant).
SHOPS	Bangladesh - integrated FP into maternity wards, which increased provision of long-acting and permanent methods. Jordan - community outreach by CHWs to educate, refer, and provide vouchers for women to select provider of choice.
GREAT	Project involved community mobilization and engagement of village leaders and religious groups to promote gender equitable norms.
IMPACCT	Used conditional cash transfers to attempt to enhance value of girls and change deep rooted norms and values. Intended to encourage keeping girls in school.
Tékponon Jikuagou	Conducted reflective dialogue with participants that examined gender norms, especially masculinity. Used male social networks to reduce unmet need - normative process. Used social networks to support FP use and reduce gender related barriers to use.
Evidence	FALAH project in Pakistan used men's groups, religious sermons, community theater, and electronic media to promote positive views of FP. Focused on healthy timing and spacing of pregnancies. Also focus on youth and work to identify structural barriers that prevent young women from seeking and accessing FP info and services.
APC	Guyana work on GBV, and promote gender equity through cross-cutting area, also have a stigma and gender officer on staff there. Work on method mix and access, including CBD and injectable contraceptives.
Capacity Plus	Lesotho- recruited men as CHWs in field of HIV to address worker shortage in a previously feminized field.
E2A	In DRC, increase awareness and demand for FP thru interpersonal communication, mass media, religious leaders, male engagement. Recruit equal #s of male and female CBDs and work to expand method choice like LARCs through CHWs.
SIFPO – MSI	Ghana - Kayeyi project focused on vulnerable and poor migrant market workers and provided them with FP and GBV services along with HIV prevention and testing. Increase variety of service delivery options to include mobile clinic outreach, social franchising, FP vouchers, FP/HIV services integration, youth focused services, and GBV.

Table 8 continued

Project Name	Service Delivery & Program Implementation
SIFPO – PSI	Integrate FP into immunization programs in order to respond to cultural need for covert contraceptive use. Created youth friendly services guide - changes gender norms that previously ignored needs of young men and women, denied their sexuality, and contributed to high unmet need for FP. Could also address high birth rates of married adolescents. Male involvement campaigns in Guatemala and Kenya. No-scalpel vasectomy program in Benin sought to resonate culturally with gender norms. Expanded FP access to vulnerable populations, and worked to expand method mix.

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