Changing gendered norms about women and girls at the level of household and community: a review of the evidence

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Background to the Women and Gender Equity Knowledge Network

The Women and Gender Equity Knowledge Network (WGEKN) of the WHO Commission on Social Determinants of Health was set up to draw together the evidence base on health disparities and inequity due to gender, on the specific problems women face in meeting the highest attainable standards of health, and on the policies and actions that can address them.

The work of the WGEKN was led by two organizational hubs – the Indian Institute of Management Bangalore (IIMB) and the Karolinska Institute (KI) in Sweden. The 18 Members and 29 Corresponding Members of the WGEKN represent policy, civil society and academic expertise from a variety of disciplines, such as medicine, biology, sociology, epidemiology, anthropology, economics and political science, which enabled the work to draw on knowledge bases from a variety of research traditions and to identify intersectoral action for health based on experiences from different fields.

Political briefing

The research question requested by the Women and Gender Equity Knowledge Network to guide this review was: "What is the effectiveness of household and community-level strategies and interventions in changing gender norms?" An extensive search strategy was developed to find key studies for review. Three key messages are derived from this review.

1. To change gender norms at the level of household and community, effective program design requires simultaneous multilevel (downstream-midstream-upstream) design that is carefully targeted to influence the underlying determinants of the problem. Single level programs have little effect on changing gender norms.

2. The status of women and girls and their opportunities are dependent on protective upstream legislation to ensure they have increased access to education, to reduce all types of violence and protect women and girls from discrimination and exploitation in labour markets. Strategies for increasing the levels of education of girls or raising their access to health services will have little or no effect on lessening the gender gap between men and women if they are not embedded in human rights frameworks that affirm, guide, and monitor violations of equal and universal rights.

3. Multilevel program evaluations are needed to measure:
   - change against indicators that assess investments to increase gender equity;
   - sensitivity of services and program delivery to gender equity and transformative social change particularly programs for men and boys; and
   - the impact of programs on the economic and human rights of women and girls.

Policies, programs and services intended to change gender norms will operate in a vacuum without the guidance of gender sensitive and rights sensitive country level protocols and indicators.

Executive summary

Gendered norms operate to restrict the rights, opportunities and capabilities of women and girls causing significant burdens, discrimination, subordination and exploitation. This review, developed for the Women and Gender Equity Knowledge Network of the WHO Commission on the Social Determinants of Health, sought to identify the best available research evidence about programmatic interventions at the level of household and community that have been effective for changing gendered norms to increase the status of women. The focus was on developing countries.

This review analyses existing intervention research around five key themes:

- Gendered norms in relation to education of women and girls
- Gendered norms in relation to violence against women and girls
- Female genital cutting
- Gendered norms in relation to economic empowerment of women
- Men and boys

A wide range of single and multiple databases were searched utilising database specific keywords such as women and girls; men and boys; household and community; intervention; gender norms. Key themes were identified: education of women and girls, economic empowerment of women, violence against women including female genital mutilation/cutting, and men and boys.

Program interventions are understood through a public health framework for analysis to identify their focus and the level at which they were targeted, and informed by upstream-downstream perspectives.

Types of interventions, levels of action, populations of interest and key outcomes from evaluations are identified. Evaluations are limited with little evidence or measurement of changes in gender equity and women's empowerment. Key findings are that targeting women and girls is a sound investment but outcomes are dependent on integrated approaches and the protective umbrella of policy and legislative actions.

Key findings are that the effectiveness of programmatic interventions to change gender norms at the level of household and community requires simultaneous multilevel (downstream-midstream-upstream) programs designed to influence the underlying determinants of the problem. All areas addressed in this review demonstrate that the status of women and girls and their opportunities are dependent on protective upstream legislation, whether to increase access to education, to reduce all types of violence and protect women and girls from discrimination and exploitation in labour markets. Strategies for increasing the levels of education of girls or raising their access to health services will have little or no effect on lessening the gender gap between men and women, whether rich or poor if they are not embedded in human rights frameworks that affirm, guide, and monitor violations of equal and universal rights.

Closing the gender gap requires nothing less than transformation of social and economic relations and gender norms. Multilevel program evaluations are needed to effect change, measured against indicators that assess investments and policies; sensitivity of services and program delivery to gender equity and transformative social change; and the economic and human rights of women and girls. Without gender sensitive and rights sensitive country level protocols and indicators to guide policies, programs and service delivery, interventions operate in a vacuum.

Background

This review was conducted to support the development of the Women and Gender Equity Knowledge Network's report to the WHO Commission on the Social Determinants of Health. This review sought to identify the research evidence on programmatic interventions[1] at the level of household and community that have been effective in changing gendered norms.

The review concentrated on learnings from sectoral and intersectoral interventions that illustrate a positive impact on changing gender norms through action to increase the status of women. Evidence was sought about successful interventions that have influenced one or more, of the social determinants of women's health such as raising women's economic independence or social status, enhancing their citizenship and providing the conditions for empowerment. This evidence synthesis takes account of the context-dependency of most interventions, while providing a back-drop on which policy decisions can be made.

The focus of the review was on developing countries. While gender refers to female and male issues, the focus of this review is on female gender issues based on the Beijing Platform for Action's goals which were about improving the status and lives of women and girls (World Bank 2005). The review takes account of the context-dependency of most interventions, while providing a back-drop on which policy decisions can be made.

Gendered norms

Gendered norms are powerful, pervasive attitudes about gender-based social roles and behaviours that are deeply embedded in social structures. Gender norms operate within families, communities, neighbourhoods and wider society, interacting to produce outcomes which are frequently inequitable and producing dynamics that are often risky for women and girls. Risks include violence against women and girls, discrimination, denial of education, illiteracy, poverty, economic and social injustice, honour killings, sexual assault and rape, female foeticide, subordination and exploitation, restrictions on women's physical mobility and education, and political disenfranchisement.

Dominant forms of masculinity operationalise gendered power relations but also sustain male risk-taking behaviour that impact on women including street and sexual violence, unsafe sexual practices and misogyny in cultures that deny women's rights (Karllson and Karkara 2004), and support for men to have multiple partners, or to maintain control over the behaviour of their female partners (Pulerwitz, Barker and Segundo 2004). Norms are perpetuated by social traditions that govern and constrain behaviours of both women and men, and by social institutions that produce laws and codes of conduct that maintain gender inequities. All countries, to some degree, experience tensions between emerging roles for women in society and expressions of their social, economic and political rights with traditional kinship concepts of women's roles. Such tensions are magnified in countries regarded as being in development.

Since the Fourth World Conference on Women (Beijing 1995), much progress has been made to overcome inequitable gendered norms, however, the effects of that progress have not been experienced evenly. Gender inequity is widely and deeply entrenched in individual and community attitudes and behaviours, societal norms, institutions and market economies with disproportionate inequities apparent among poor women (World Bank 2005; Grown, Gupta and Pande 2005). Inequities created by gendered norms affect

both women and men and create the necessity for gender analysis. Although male high risk behaviours also impact on male vulnerability to morbidity and mortality, they are not a focus of this paper.

Changing gendered norms and developing indicators of equality such as the Millenium Development Goals for the education of girls, promotion of gender equality and empowerment (UN 2005) are important but insufficient in terms of social justice and human rights. Women's rights are human rights but they are not supported consistently by governments. Strategies for increasing the levels of education of girls or raising their access to health services will have little or no effect on lessening the gender gap between men and women, whether rich or poor if they are not embedded in human rights frameworks that affirm, guide, and monitor violations of equal and universal rights. It is necessary to build a culture of women's rights that articulate the intrinsic value of girls and women and their rights to freedoms and opportunities. To deny women opportunities for land ownership, education, or social and economic participation is to create capability deprivation (Sen 2000) which is a form of social exclusion. The processes through which women are wholly or partially excluded, actively or passively, from full participation in labour markets, educational systems, and/or social participation, are discriminatory and a denial of rights. In turn, freedom from discrimination and economic participation are key determinants of mental health and wellbeing (VicHealth 2005). Discrimination, social exclusion and denial of rights are therefore conditions which cause gross social health inequities for women and require an ethical commitment by governments to change political realities that create health inequities and for renegotiation of social power relations (CSDH 2005), many of which are built on gendered norms perpetuated within households and communities.

Levels of public health interventions

It is useful to understand programmatic interventions in relation to the level at which they are targeted. The framework for public health interventions (Rychetnik and Frommer 2002) is useful for understanding where program efforts are focused:

- **Universal interventions** - approaches aimed at large groups or the general population, and often focused on risk factors or changing norms. Examples might include curricula delivered to all pupils in a school or community-wide campaigns, or changes in policy or legislation.
- **Selected or targeted interventions** - approaches aimed at those considered to be at a heightened risk, usually paying attention to social, economic and environmental factors and may include strategies to increase access to services including health, education and social support.
- **Indicated interventions** - approaches aimed at those who have a demonstrated problem, for example, programs for perpetrators of violence against women.

Analysis of interventions in this review is also informed by upstream-downstream perspectives, illustrated in Figure 1: *Framework for health promoting actions and capacity building*.

- Downstream interventions are those focused on change or support for individuals;
- Midstream interventions are those that focus at psychosocial levels including social marketing, whether in communities or populations more

broadly. Community action interventions which are directed at social change are moving upstream;

- Upstream interventions take a population focus and are also intended as umbrella protections or change mechanisms to support notions such as justice, rights and social change. Upstream interventions encompass institutional practices and organisational change to influence social (including gender) norms that create and reinforce social and health inequalities.

Figure 1: Framework for health promoting actions and capacity building

Downstream (individual) focus		Upstream (population) focus	
Communication strategies	Social marketing	Community development	Infrastructure, institutional & systems change
Health information	Health education	Engagement	Organisational change
Behaviour-change campaigns	Develop personal skills and individual capacity	Community action	Workforce development
		Advocacy	Policy
	Social support	Community/ institutional support	Legislation
			Organisational development
			Resources

Source: Keleher (2007)

Integrated or multilevel approaches in a program entail the use of a combination of interventions that are mutually reinforcing. Universal, selected or targeted interventions may be developed across the continuum from downstream to upstream, although indicated interventions are more likely to be situated towards the downstream.

Methods

The research question requested by the Knowledge Network to guide the search process was: "What is the effectiveness of household and community-level strategies and interventions in changing gender norms?" An extensive list of search terms was collapsed to a few keywords (women and girls; men and boys; household and community; intervention; gender norms) to frame the search strategy for relevant study populations. Criteria for inclusion were that impact evaluation data was reported in English, with reviews and major reports given preference over smaller studies.

The databases included in the search were included AMI (Informit), CINAHL, Cochrane, EconLit, ESRC Qualitative Data Archival Resource Centre, Expanded Academic ASAP (Gale), Health-Evidence.Ca, Health & Medical Complete, Health & Society, International Encyclopaedia of Social and Behavioural Sciences, MEDLINE, POPLINE, PsycINFO (Ovid), Sociological Abstracts, Taylor and Francis Online Journals, Web of Science (ISI). Grey

literature was sought through websites and direct contact with researchers in key organisations in a few instances.

The search revealed that randomised controlled trial research designs were almost never used, with descriptive research methodologies more common. Given the enormous literature available and the constraints of available time and resources, it was impossible to conduct quality ratings on individual articles on the many themes that arose from the research question. A very many of the papers found are in the form of reviews by UN agencies and NGOs that summarise whole suites of funded programs and their outcomes but do not provide information about actual evaluation design or measures. This made the task of 'counting' the number of included studies impossible.

Narrative (table) summaries and key themes were developed. The results are presented in terms of the scale of issues, interventions and outcome measures, and outcomes in the following themes:

- Changing gendered norms in relation to education of women and girls
- Changing gendered norms in relation to violence against women
- Changing gendered norms about female genital cutting
- The challenges of educating men and boys about gender equity
- Changing gendered norms in relation to economic empowerment of women.

Changing gendered norms in relation to education of women and girls

Change in gendered norms about education are directed universally at populations of primary and secondary girls, and targeted at specific populations of marginalised adolescents, and poor working women, indicated by their levels of economic, social and educational exclusion. The continuing need to work towards gender parity in education is supported by the Millennium Development Goals (UN 2005). Communities or regions with low total enrolments or low levels of literacy are targeted because indicators for achieving gender parity are not sufficiently robust to measure girls' actual levels of education or the relevance of the education they receive. Effectiveness of education is reflected over time particularly in employment and income data, and sexual and reproductive health including fertility control (UNICEF 2005a).

Of the 860 million people around the world who are affected by illiteracy, two-thirds are women who experience poorer health, larger families and few opportunities for any form of economic productivity. Girls' education is affected by negative perceptions that devalue their capabilities, values about female roles in public and private spheres, beliefs about relative costs to communities of educating females and expectations that males will be the primary income earners, heavy domestic schedules that place inequitable burdens on females, and distance from schools (Abane 2004; UNICEF 2004). Children with low levels of schooling assume the work burdens of adults prematurely, deprived of opportunities for learning outside the family. Where traditional gender norms dominate, millions of girls 'disappear' into early traditional marriages, hazardous labour or combat roles (UNICEF 2006), and girls who do attend school eventually take up gender-stereotyped roles (Lloyd and Grant 2004). Structural barriers include school fees, curriculum perceived as inappropriate for girls and lack of alternatives, lack of gender sensitivity, inflexibility of classroom programs and lack of safety (UNICEF 2004).

UNESCO (2003) has developed cross-cutting, targeted, multilevel approaches to poverty reduction via teaching both skills for life and work as well

as gender rights awareness for suppressed marginalized adolescent girls. Operating in Bangladesh, India, Nepal and Pakistan, the projects are founded on education and training with a strong rights framework. They have found that when girls are regarded not as a burden but as untapped potential for social and economic transformation, they are enabled to take greater control over their own lives to shape their own livelihood and contribute to the development efforts of their communities.

Girls' education has significant economic benefits. Psacharapoulos and Patrinos (2002) estimate that every year of schooling lost represents a 10-20% reduction in girls' future incomes. By contrast, countries can expect per capita annual growth in GDP of between 1-3 percentage points higher with more equal education levels with economic returns to primary education in the order of 5 to 15 percent for boys and slightly higher for girls (Psacharapoulos and Patrinos 2002) and in the 15–25 percent range for female secondary education (Herz and Sperling 2004). In a 72-country analysis as well as country studies in Uganda, Kenya and Zambia, reductions in HIV/AIDS infection rates are found to be related to literacy and girls' education and in a 63-country study, gains in women's education contributed more than any other intervention to reduce malnutrition between 1970 and 1995 due to more productive farming (Smith and Haddad 2000; Herz and Sperling 2004). In other words, girls' education leads to increased income for individuals and for nations as a whole with compounding economic and social benefits.

Widely replicated studies across comparative data bases have shown that an extra year of girls' education can reduce infant mortality by 5–10 percent, especially in low income countries; and in Africa, children of mothers who receive five years of primary education are 40 percent more likely to live beyond age five (Herz and Sperling 2004). Multi-country data show educated mothers are 50 percent more likely to immunize their children than uneducated mothers (Gage, Sommerfelt and Piani 1997), and cross country studies have shown that the education of women promotes the education of children (UNFPA 2002; Herz and Sperling 2004).

Education is the key to the fertility transition. A Brazilian study finding that illiterate women average 6 children each, compared to 2.5 children per literate women (UNESCO 2000). A 65-country analysis founds that doubling the proportion of women with a secondary education would reduce average fertility rates from 5.3 to 3.9 children per woman (Herz and Sperling 2004).

Primary education seems insufficient to provide women with the knowledge and skills to improve and sustain their own health or economic independence. At least some secondary education influences capacity for resistance and opposition to violence and genital cutting (Global Campaign for Education 2005), while more female secondary education is influential on later age at marriage, fertility control and smaller families, improved material care for children, reduced vulnerability to HIV/AIDS (Grown, Gupta and Pande 2005), women's empowerment, democracy, income growth, and economic productivity (Herz and Sperling 2004).

Investing in the education of girls and women is good economic policy, but the education must be empowering for girls by including curricula on women's rights, gendered norms about access to employment, finances, education and health care, and equity issues. Setting targets for parity in levels of education is meaningless unless countries also develop indicators for quality educational curricula that promote gender equity and the rights of girls. Both universal and

targeted programs should be supported to ensure to reach marginalised and suppressed younger and older girls and women in hard to reach communities.

Changing gendered norms in relation to economic empowerment of women and girls

Economic empowerment is 'economic change/material gain plus increased bargaining power and/or structural change which enables women to secure economic gains on an on-going and sustained basis' (Sudarshan 2003), or 'the expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control, and hold accountable, institutions that affect their lives (Narayan 2005: 5). Advances in the measurement and monitoring of empowerment (Charmes and Wieringa 2003; Narayan 2005) have emphasised the importance of multilevel interventions that seek to address the determinants of women's empowerment.

Women's capacity to participate in economic development is affected by widespread female malnutrition which is not simply the result of inadequate food availability or inadequate access to health services (UN 1997). In turn, female malnutrition is the result of complex gender norms about inferior status accorded to women, low levels of female education, and heavy burdens of work. In India, direct links are drawn between women's lack of empowerment and the high degree of malnutrition of women and children (Sethuram, Landsdown and Sullivan 2006) but there is a lack of sex-disaggregated nutrition data in many regions. Violence against women increases the risk of malnutrition in mothers and children, illustrating the connections between economic empowerment and other determinants of women's status.

Microcredit/microfinancing schemes are frequently built on assumptions that they are empowering by allowing women to contribute to household income and family welfare by establishing small businesses. However, they are rarely based on careful analysis of the gender relations involved, the dynamics of local economies, or the barriers to women conducting business in male dominated structures, networks and communities. Careful analysis of the gender relations involved reveal that women trying to enter markets face many hazards and constraints including increased violence, limits on their physical mobility, increasing responsibilities to provide a steady flow of cash and food for the household without changes occurring to inequitable intra-household relations and difficulties with extracting repayment when selling on credit (Johnson 2005). High turnover of group membership is a frequent result. Through a series of case studies, Johnson (2005) demonstrates the value of the ways in which microcredit schemes can be tailored to overcome obstacles and be designed to transform gender relations. She argues (2005: 244) that 'achievement of a "double bottom line" of both financial and social performance is therefore becoming both a necessity and a reality'.

PROGRESA is a nationwide anti-poverty program in Mexico involving the disbursement of cash transfers and incentives that are conditional on the household engaging in a set of behaviours designed to improve health, nutrition and education. The program has had significant impacts on women's empowerment and status, access to appropriate health services and school enrolment particularly among poor families (Adato, Briere, Mindek and Quisumbing 2000).

The Self-Employed Women's Association (SEWA) of India is a trade union reaching vast numbers of poor self-employed women. SEWA's approach is multi-level from the micro levels of skill building to institutional and legal reform and

capacity building to enable local organisations to increase their effectiveness and sustainability (SEWA 2005). SEWA's achievements have been remarkable utilising social protections and innovative services with rapid growth of 25-35 percent per year (Grown, Gupta and Kes 2005).

However, there are too few organisations working to counteract macroeconomic reforms. Although seemingly gender neutral, reforms have significantly disproportionate impacts on women and girls (Delahunty and Sud 1999), particularly women-led households whose livelihoods depended on access to now privatized resources (Mukhopadhyay and Sudarshan 2003; Van Hue 2006). Multi-country studies demonstrate the poor quality of employment that has been generated for women: 'although new employment may have brought women into the global market, it is on terms unequal with men and in conditions of work that have not, so far, created any change in their situation within the home or outside it. Those who have found work have been able to contribute to improving the economic situation of the household and reduce the intensity of poverty, but they have not been 'empowered' (Sudarshan 2003). Lack of legal protections and exploitative labour markets have created poverty traps for millions of women. Women with low status have weaker control over household resources, heavier demands on their time, less access to information and health services, poorer mental health, and lower self-esteem.

In Sub-Saharan Africa, more equal status between women and men would decrease child malnutrition in the region by nearly 3 percentage points—a reduction of 1.7 million malnourished children under three, while in South-Asia women's lower status is the strongest contributor to the costs of child malnutrition (Smith, Ramakrishnan, Ndiaye, Haddad and Martorell 2003).

Changing gendered norms in relation to violence against women and girls

Violence against women (VAW), described variously as intimate partner violence (or domestic) (IPV), female genital cutting, sexual violence and gender-based violence (GBV), are forms of discrimination committed on the basis of sex (UNGASS 1993). VAW is a clear violation of women's human rights including the rights to life, liberty and security of person, equality, equal protection under the law and freedom from all forms of discrimination. The WHO (2005, p 15) report on VAW in 10 countries found the proportion of women who had ever experienced physical or sexual violence, or both, by an intimate partner in their lifetime, ranged from 15% to 71%, with most sites ranging between 29% and 62% prevalence. VAW is a direct cost to development, both obstructing women's participation in, and contradicting the goals of development (Burton, Duvvury and Varia 2000). Women are dependent on their immediate social environment, their vulnerability related to 'impossible choices for women between security of shelter, economic dependence or continued abuse' (Bhatla, Duvvury and Chakraborty 2006: 4). Educational disadvantage and poverty render women and girls more susceptible to elevated risks of abuse (McCloskey, Williams and Larsen 2005). However, where violence continues to be tolerated in both school and family life, VAW will be difficult to overcome.

Evidence about outcomes of program interventions to prevent violence against women is seriously lacking (Jewkes 2002; Wathen and MacMillan 2003). There is emerging evidence about protective mechanisms for women against domestic and sexual violence. Women with more education are more highly valued because of employability and have more capacity to leave a relationship if it became abusive.

In a multi-site study in India and Sri Lanka, women's ownership of property was found to 'extend their capabilities, expand their negotiating power, and enhance their ability to address vulnerability' (Bhatla, Duvvury and Chakraborty 2006: 11). Multi-faceted responses are increasingly understood to be the most effective in changing social norms about men's control of, and access to, women's bodies. Embedding of rights frameworks that offer legal protections for women are becoming more widespread, as is recognition of the need for capacity building of staff in health, education and justice sectors to communicate that violence against women and girls is a serious offence and to become actively involved in prevention work (Jewkes 2002; WHO 2002; WHO 2005).

Thresholds for tolerating violence against women vary among and within countries. The development of a measurement scale for countries to assess the degree of tolerance and the degree to which gendered violence has become normalized would inform program interventions. The scale should include the attention paid to issues of gender in both policy proposals and debates on violence within countries.

Changing gendered norms about FGM/C

WHO estimates that about 130 million girls and women in some 28 countries have undergone some form of FGM/C[2] (Baumgarten, Finke, Manquet and von Roenne 2004) with the highest incidence found in Africa, western and southern Asia, and the Middle East. FGM/C is a deeply entrenched social convention through which girls and their families acquire social status and respect. Failure to perform FGM/C may bring shame and exclusion. FGM/C practices are based on gendered norms about women's social status, patriarchal family structures, honour, prestige, religious beliefs, beliefs about men's ownership of women and values about their economic dependence. Certainly, strong gender disparities within society lead to violations of women's rights but FGM/C appears to be part of a dense social and cultural fabric, from which the tradition can be extracted only with some difficulty, against tremendous resistance and perhaps, unpredictable damage to social integration (Gruenbaum 2001).

Upstream interventions, particularly legislation and the use of human rights instruments, are increasingly used to eradicate FGC practices. International pressure can be brought to bear on countries through for example, urging of countries to ratify the Protocol on the Rights of Women in Africa. However, legislation may lead to unintended consequences for some women and further entrenched adherence to the practice among communities where poverty, economic uncertainty, and social isolation threaten those who challenge norms about FGM/C (Martinez 2005). There is evidence that FGM/C practices may respond more readily to social change in gender norms than to legislation and policing. Indeed, in many communities, change has occurred not through acts of protest or suppression, but through   Multi-pronged education approaches have succeeded in changing attitudes and community-held norms (Gruenbaum 2001; UNICEF 2005b).

Effective programs have used multilevel interventions. The Senegal project (spearheaded by the NGO Tostan) has been so successful it is now an endorsed regional model by UNICEF. Its success involves public declaration of intent to abandon the practice; slow but steady human rights education program which encourages villagers to make up their own minds about FGM/C, literacy education, alternative employment for cutters, reproductive health and rights education classes that lift the taboo on talking about health problems associated with FGM/C and community decided alternative rites of passage (Mackie 2000). The model is being adopted in Guinea, Burkina Faso, Mali and Somalia.

Nonetheless, Gruenbaum (2001) argues that human and economic development, are necessary for creating propitious conditions for the abandonment of FGM/C which may be a relatively low priority where communities lack basic health care and education. Interventions to protect women from FGM/C have shown that simply affirming a stand against FGM/C is inadequate without close empirical scrutiny of the local, national and international politics that surrounds FGM/C and efforts to stop its practices. Other tactics such as providing alternative employment for the circumcisers or introducing alternative rites of passage require a comprehensive and multi-level approach to education, social mobilization and diffusion strategies to spread ideas and change attitudes (Mackie 2000).

Changing gendered norms among men & boys

Male behaviours that manifest in violence against women, unsafe sex, sexual assault and rape, inequitable gender relations and gender stereotypes, impact heavily on women and girls. Norms of male dominance, superiority and masculine honour are widespread, reinforced by large-scale militarisation of countries which has devastating impacts on women through economic upheavals, cultural dispossession, and poverty due to loss of lands or lack of employment (Becker 2003).There is wide agreement that men need to be part of the solutions to overcoming gender inequalities (Sternberg and Hubley 2005; Doniach and Peacock 2006) and many lessons have been learned from program development in the last 10 years. However, major challenges remain.

Program interventions are typically designed around group-work in a variety of community-based settings. They aim to effect change in knowledge, attitudes, and behaviour through: workshops that encourage men to take action in their own communities; the media to promote changes in social norms; collaboration between nongovernmental organisations and grassroots community-based organisations to strengthen their ability to implement programs; and advocacy for increased government commitment to promoting positive male involvement (International Women's Health Coalition 2003; Peacock and Levack 2004; Sternberg and Hubley 2005; Barker, Ricardo and Nascimento 2007). Programs have targeted both men and adolescent boys to interrupt the internalising of norms about traditional masculine roles.

Measures of change are focused on men's knowledge, attitudes and behaviours with regard to sexual and reproductive health, such as family planning and contraceptive use, safe sex, gender roles and relations, challenging men to examine masculinities, sexualities, power, and their manifestation in attitudes and behaviours that put women at risk.

Program interventions have achieved some change in terms of changing males' understanding about gender stereotypes but most program interventions are short term, and few have been evaluated systematically (Barker, Ricardo and Nascimento 2007). Combinations of intervention methods are proving more effective in achieving sustained behaviour change at least in the months that follow the intervention. Program H in Brazil and India, using quasi-experimental evaluation design, found evidence of behaviour and attitude change in young men who participated in group education activities. Stepping Stones in South Africa, through an RCT, has found reduced rates of violence against women (reported by women) in emerging evaluation data (Barker, Ricardo and Nascimento 2007).

Small scale impact evaluations are beginning to measure behaviour change among men. The Gender Equitable Men Scale (GEM Scale), developed by

the Instituto Promundo with support from the Population Council, is being used to measure the effects of group education and community programs on gender equitable behaviours and attitudes associated with the reduction of risk to HIV/AIDS (Pulerwitz, Barker and Segundo 2004).

However, evaluations have not yet been developed to measure how men's involvement in gender equity programs impact on women (UNICEF 2004). There has been substantial rhetoric about men's involvement but little evidence that programs are empowering for women, or that men were enabled to resist gendered social norms (Sternberg and Hubley 2005; Verma, Pulerwitz, Mahendra, Khandekar, Barker, Fulpagare and Singh 2006). Critiques argue that men and boys program interventions are narrowly cast in their approach, theoretically thin, relying on descriptive data and lacking in measures of effects on men or impacts on women (Sternberg and Hubley 2005). Both program interventions and evaluations are targeted in terms of men's pathological behaviour, with little acknowledgement of the cultural stereotypes of masculinity that emphasise physical strength, sexual prowess and male dominance in sexual encounters, and *machismo* (Verma, Pulerwitz, Mahendra, Khandekar, Barker, Fulpagare and Singh 2006). In some countries, men often gained more benefits from interventions than women so even though the interventions were designed to overcome gendered inequalities they can inadvertently increase the gender gap (Jacob, Abraham, Surya, Minz, and Singh 2006). Indeed, Sternberg and Hubley (2005, 394) ask if 'new, caring, sharing models of masculinity are being formed or are men learning more sophisticated ways to assert their dominance over women?'

While there are indications that men do want to be involved and that many men respond positively to well-designed programs delivered over time, behavioural education programs of themselves do not transform communities and societies in terms of social justice and rights. Yet, there is little evidence that men and boys program interventions take or advocate for, a social justice or human rights framework. Questions must be asked about the capacity of programs for social change if they operate in a policy and legislative vacuum. Policy, legislation, political and social justice leadership to ensure publicly accountable criterion of justice with regard to gender equality are critical (Unterhalter 2005).

A promising upstream action is the African Maputo Protocol on the Rights of Women in Africa with plans to have recourse for women to the African Court which has been adopted by at least 16 African countries since its introduction in November 2005 (Njoroge 2005). Tools to enrich women's empowerment include the Gender and Development Index (GDI) (Charmes and Wieringa 2003), and the Gender Empowerment Measure (GEM)[3]. These indexes focus on power and power relations as they impact on women but they do not measure gender inequality. The African Gender and Development Index (AGDI) is intended to be more sensitive to measurement of the gender gap (Charmes and Wieringa 2003).

Lessons learned – policy implications

The effectiveness of programmatic interventions to change gender norms at the level of household and community requires simultaneous multilevel (downstream-midstream-upstream) programs (WHO 2005) designed to influence the underlying determinants of the problem especially reinforcement of the rights of women and girls. Downstream strategies including the provision of basic primary health care are increasingly recognised as critical in addressing specific programs such as violence against women and general efforts to raise women's social status. However, social change occurs when downstream and midstream

programs are conducted in the context of broader systemic (upstream) efforts to increase gender equity.

All areas addressed in this review demonstrate that the status of women and girls and their opportunities are dependent on protective upstream legislation, whether to increase access to education, to reduce all types of violence and protect women and girls from discrimination and exploitation in labour markets. Strategies for increasing the levels of education of girls or raising their access to health services will have little or no effect on lessening the gender gap between men and women, whether rich or poor if they are not embedded in human rights frameworks that affirm, guide, and monitor violations of equal and universal rights. That there are continuing barriers to and denial of education to girls should be regarded as a global emergency. The integration of gender analysis and economic policy is necessary for positive effect on women and girls.

Closing the gender gap requires nothing less than transformation of social and economic relations and gender norms. Multilevel program evaluations are needed to effect change, measured against indicators that assess investments and policies; sensitivity of services and program delivery to gender equity and transformative social change; and the economic and human rights of women and girls. Without gender sensitive and rights sensitive country level protocols and indicators to guide policies, programs and service delivery, interventions operate in a vacuum.

References

Abane, H. (2004) 'The girls do not learn hard enough so they cannot do certain types of work.' Experiences from an NGO-sponsored gender sensitization workshop in a Southern Ghanaian community. *Community Development Journal*, Vol 39, No 1, 49-61.

Adato, M., de la Briere, B., Mindek, D. and Quisumbing, A. (2000) *The impact of Progresa on women's status and intrahousehold relations. Final report*. Washington, International Food Policy Research Institute.

Barker, G., Ricardo, C. and Nascimento, M. (2007) *Engaging Men and Boys to Transform Gender-Based Health Inequities: Is There Evidence of Impact?* The World Health Organization and Instituto Promundo in collaboration with the Men Engage Alliance.

Baumgarten, I, Finke, E., Manguet, J. and von Roenne, A. (2004) Intergenerational dialogue on gender roles and female genital mutilation in Guinea. *Sexual Health Exchange*, 3-4, 8-15.

Becker, H. (2003) The least sexist society? Perspectives on gender, change and violence among southern African San. *Journal of Southern African Studies,* Mar, 29(1), 5-23.

Bhatla, N., Duvvury, N. and Chakraborty, S. (2006) *Property Ownership and Inheritance Rights of Women for Social Protection – The South Asia Experience, synthesis report of three studies*. Washington, International Centre for Research on Women.

Burton B., Varia, N. and Duvvury, N. (2000) *Justice, Change and Human Rights: International Research and Responses to Domestic Violence,* ICRW/PROWID Project Synthesis Paper.

Charmes, J. and Wieringa, S. (2003) Measuring women's empowerment: an assessment of the Gender-related Development Index and the Gender Empowerment Measure. *Journal of Human Development*, Vol 4(3), 419-435.

Delahanty, J. and Sud, G. (1999) *Toward Participatory Economic Reforms in Africa: A Quest for Women's Economic Empowerment* (Canada, The North-South Institute).

Doniach, A. and Peacock, D. (2006) Masculinities in motion, In A. Jones (ed). *Men of the Global South (*London, Zed Books).

Gage, A.J., Sommerfelt, A.E. and Piani, A.L. (1997) Household Structure and Childhood immunization in Niger and Nigeria. *Demography,* 34 (2), 295-309.

Global Campaign for Education (2005) Girls Can't Wait: Why Girls' Education Matters and How To Make It Happen Now. *Reproductive Health Matters*, 13(25), 19-25.

Grown, C., Gupta, G., Kes, A. (2005) *Achieving Gender Equality and Empowering Women (UN Millennium Project)* (LLA, Stylus Publishing).

Grown, C. Gupta, G. Pande, R. (2005) Taking Action To Improve Women's Health Through Gender Equality and Women's Empowerment. *The Lancet,* 365, 541–43.

Gruenbaum, E. (2001) *The Female Circumcision Controversy: An Anthropological Perspective (*Philadelphia, University of Pennsylvania Press).

Herz, B. and Sperling, G. (2004) *What Works in Girls' Education: Evidence and Policies From The Developing World.* New York, Council on Foreign Relations. Available:
http://www.cfr.org/content/publications/attachments/Girls_Education_summary.pdf

International Women's Health Coalition (2003) My Father Didn't Think This Way: Nigerian Boys Contemplate Gender Equality. *Quality/Clidad/Qualite,* New York, Population Council.

Jacob ME; Abraham S; Surya S; Minz S; Singh D (2006) A Community Health Program in Rural Tamil Nadu, India: The Need for Gender Justice for Women. *Reproductive Health Matters*, Vol 14(27), 101-108.

Jewkes, R. (2002) Preventing Sexual Violence: A Rights-based Approach. *The Lancet*, Vol 360, 1092-3.

Johnson, S. (2005) Gender Relations, Empowerment and Microcredit: Moving on From a Lost Decade. *The European Journal of Development Research,* Vol 17(2), 224-248.

Karlsson, L. and Karkara, R. (2004) *Working with men and boys to promote gender equality and to end violence and boys and girls* (report of a workshop Kathmandu 2004). Save the Children Sweden-Denmark, Regional Program for South and Central Asia.

Keleher, H, (2007) Reframing health promotion. In H. Keleher, C. MacDougall and B. Murphy (eds). *Understanding Health Promotion* (Melbourne, Oxford University Press).

Lloyd C.B and Grant M.J. (2004) Growing up in Pakistan: the separate experiences of males and females. New York, Population Council, (Policy Research Division Working Papers No. 188) Website:
http://www.popcouncil.org/pdfs/wp/188.pdf

Mackie, G. (2000) Female genital cutting: the beginning of end. In B. Shell-Duncan and Y. Hernlund (eds). *Female Circumcision in Africa: Culture, Controversy, and Change* (Connecticut, Lynne Rienner Publishers, Inc: 253-282).

Martinez, S. (2005) Searching for a Middle Path: Rights, Capabilities, and Political Culture in the Study of Female Genital Cutting. *Ahfad* (Omdurman, Sudan) 22(1), 31-44.

McCloskey LA, Williams C and Larsen U (2005) Gender Inequality and Intimate Partner Violence Among Women in Moshi, Tanzania. *International Family Planning Perspectives*. 31(3), 124-130.

Mukhopadhyay S, Sudarshan RM (eds) (2003) *Tracking Gender Equity Under Economic Reforms: Continuity and Change in South Asia*. International Development Research Centre (IDRC), Canada.

Narayan, D. (ed) (2005) *Measuring empowerment: cross-disciplinary perspectives*. The World Bank.

Njoroge, A. (2005) *The protocol on the rights of women in Africa to the African Charter on human and peoples' rights.* Available: http://www.emmabonino.it/campagne/stopfgm/djibouti/njoroge.pdf

Psacharapoulos G, Patrinos H. (2002) *Returns to Investment in Education: A Further Update*. Policy Research Working Paper 2881, Washington DC7, World Bank.

Peacock D and Levack A (2004) The Men as Partners Program in South Africa: Reaching Men to End Gender-Based Violence and Promote Sexual and Reproductive Health. *International Journal of Men's Health*, 3(3), 173-188.

Pulerwitz, J., Barker, G. and Segundo, M. (2004) *Promoting Healthy Relationships and HIV/ST Prevention for Young Men: Positive Findings from an Intervention Study in Brazil,* Washington, Population Council/Horizons.

Rychetnik, L. and Frommer, M. (2002) *A Schema for Evaluating Evidence on Public Health Interventions, Version 4* (Melbourne, National Public Health Partnership). Available: http://www.nphp.gov.au/publications/phpractice/schemaV4.pdf.

Self-Employed Women's Association (2005) Annual Report. Ahmedabad. Available: http://www.sewa.org/Annual_Report/index.html.

Smith, L and Haddad, L. (2000) *Explaining Child Malnutrition in Developing Countries: a cross-country analysis. Research.* Report No.111. Washington DC: International Food Policy Research Institute.

Smith, L., Ramakrishnan, U, Ndiaye, A., Haddad, L and Martorell, R. (2003) *The Importance of Women's Status for Child Nutrition in Developing Countries.* Research Report 131, Washington, International Food Policy Research Institute.

Sternberg, S. and Hubley, J. (2005) Does men's involvement work? Evidence from evaluated interventions. *Sexual Health Exchange* 2005-2.

Sudarshan, R.M. (2003) Towards integration? Gender and economic policy. In S. Mukhopadhyay and R.M. Sudarshan (eds) *Tracking gender equity under economic reforms: Continuity and change in South Asia* (International Development Research Centre (IDRC): Canada, 364-385).

The World Bank (2005) *Improving Women's Lives: World Bank Actions Since Beijing*. The World Bank, Gender and Development Group.

UN General Assembly (1993) *Declaration on the Elimination of Violence Against Women*. Proceedings of the 85th Plenary Meeting, Geneva, Dec 20. United Nations General Assembly.

UN (1997) ACC/SCN (United Nations Administrative Committee on Coordination/Subcommittee on Nutrition). *Nutrition and poverty*. Papers from the ACC/SCN 24th Session symposium, Kathmandu. Nutrition Policy Paper Number 16. Geneva.

UN (2005) *The Millenium Development Goals Report*, UN Millenium Project.

UNESCO, (2000) *Women and Girls: Education, Not Discrimination*. New York.

UNESCO. (2003) *Education for All: Global Monitoring Report 2003/4*. Paris.

UNFPA. (2002) *State of World Population Report*. Downloaded 12 October 2006 http://www.unfpa.org.

UNICEF (2004) Strategies for girls' education. In *The state of the World's Children, Girls, Education and Development.* New York, UNICEF.

UNICEF (2005a) *Progress for children: a report card on gender parity and primary education.* Number 2, April.

UNICEF (2005b) *Changing a harmful social convention: female genital mutilation/cutting*. Florence, UNICEF Innocenti Research Centre.

UNICEF (2006) *The State of the World's Children.* New York, UNICEF.

Unterhalter, E. (2005) Mobilization, meanings and measures: reflections on girls' education. *Development*, 48(1), 110-114.

Van Hue, L.T. (2006) Gender, doi moi and mangrove management in northern Vietnam. *Gender, Technology and Development*, 10(1), 37-59.

Verma, R. Pulerwitz, J. Mahendra, V. Khandekar, S. Barker, G. Fulpagare, P. Singh, SK. (2006) Challenging and changing gender attitudes among young men in Mumbai, India. *Reproductive Health Matters*, 14(28), 135-143.

Wathen, C. and MacMillan, H. (2003) Interventions for violence against women: scientific review. *JAMA*, 289(5), 589-600.

WHO. (2002) *World report on violence and health*. Geneva, World Health Organization.

WHO (2005) WHO *Multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses*. Geneva, World Health Organisation.

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[1] The term *programmatic intervention* is used in this paper to refer to both short and longer term actions using multiple components.

[2] The practice of female circumcision has been variously referred to as infibulation, female genital mutilation, among other practices which are more recently referred to as female genital cutting (FGM/C).

[3] The GEM Scale should not be confused with the GEM.