

# **STOP AIDS NOW! Gender Development Project**

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**Research projects in Indonesia and  
Kenya: Summary of the endline reports**

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## List of abbreviations

4Cs	Citizens Coalition for Constitutional Change
ACK Eldoret	Anglican Church of Kenya Eldoret
CAI	Community Aid International
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
C-MEDA	Community Mobilization for Economic Development and Advancement
FGD	Focus Group Discussion
GDP	Gender Development Project
HSHC	Help Self Help Centre
IEC	Information Education and Communication
KANCO	Kenya AIDS NGO Consortium
KEFEADO	Kenya Female Advisory Organization
LBK-UB	Institute of Human Assistance of the Interfaith Community
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization
WIFIP	Women in the Fishing Industry Program
WSP-K	Women Shadow Parliament, Kenya
YWCAA	Young Women Campaigning Against AIDS

## Executive summary

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This report is a summary of the findings from studies done on the first phase of the Gender Development Project (GDP), which has been implemented in Kenya and Indonesia since early 2007. The purpose of the GDP is to stimulate the introduction of HIV prevention activities that incorporate gender issues and human rights, in order to reduce the vulnerability of women and girls to HIV. STOP AIDS NOW! counterparts focusing on HIV/AIDS, human rights and/or women's empowerment in Indonesia (Java and Papua) and Kenya were invited to form a coalition at the (sub)national level with the following three objectives. First, to carry out HIV prevention activities that integrate promotion of egalitarian gender attitudes, behaviours and norms and women's rights at the individual level; second, to take on community level activities such as awareness-raising campaigns and rallies; and third, to network together to coordinate lobbying and advocacy efforts.

Prior to the project activities carried out in 2008, baseline studies were conducted. After the intervention phase, from November 2008 to July 2009, endline studies were done. The purpose of these studies was to establish the status of knowledge, attitudes and perceptions of women in the research areas, and to measure impact of the activities. This report summarizes the findings of both endline studies and offers a preliminary analysis of cross-country differences, as well as some food for thought on what these results mean for the work of STOP AIDS NOW! on gender, HIV/AIDS and women's rights.

Six organizations in Indonesia (in Java only) and ten in Kenya participated in the research. The specific objectives of both baseline and endline studies were to collect, analyse and present information on: 1) knowledge of HIV and AIDS among primary and secondary beneficiaries; 2) intentional and actual condom use by women and girls; 3) gender-based attitudes, perceptions and beliefs; 4) power relations in the sexual and/or romantic relationships between men and women; and 5) forms of gender-based violence and how families and communities respond to it. Furthermore, the endline study sought to measure impact of the interventions.

The baseline research consisted of a questionnaire-based survey and focus group discussions (FGDs). At endline, primary beneficiaries – the persons directly involved in the interventions – participated in another survey and in FGDs, while secondary beneficiaries participated in FGDs or were interviewed individually. Secondary beneficiaries are partners, friends, fellow students, community members or other relations of primary beneficiaries, as defined by each participating organization.

In Java, the comparison of endline with baseline survey findings clearly suggests the largest impact of the GDP is in the field of HIV/AIDS knowledge. The number of people with low to fairly low knowledge has decreased almost three times, while the number of people whose knowledge is quite high has doubled. Some interventions have managed to affect one or more indicators, such as knowledge of particular ways of transmission or the physical manifestations of HIV and AIDS.

Participants in Java show variable acceptance of condom use, generally considering it a contraceptive and a means to protect extramarital sex. Even though the study did not show statistical change in relation to actual condom use, and many women remained hesitant, the change in intended condom use is fairly convincing. An increased number of women expressed their willingness to start using condoms in the future. The interventions seem to be relatively capable of making people more aware of the importance of condoms as protectors against HIV infection. This result is particularly noteworthy given the fact that several participants in the study had never seen or handled a male or female condom prior to the GDP activities, and were initially extremely hesitant to discuss or even countenance condoms.

The study in Java does not show a statistically significant change in gender-based perceptions, beliefs and attitudes and power relations between men and women. The intervention period covered in the research project in Java was quite short, however. Furthermore, some interventions appear to some extent capable to change the opinions of women who previously fully accepted the traditional gender role division. The results indicate powerful, rigid gender-based beliefs can be undermined. The analysis shows there is a great variety in attitudes towards traditional gender roles. With regards to unequal power relations between women and their partners, change was statistically less convincing. The only statistically significant change visible was in the number of women who thought that their partner was always controlling their movements. Nevertheless, it is likely some interventions made at least some of the women more aware of the unequal power relations that affect them. Related to unequal power relations is the increased likelihood that women suffer from gender-based violence. In general, the women in Java rejected domestic violence, even though there was some ambiguity in their answers. For instance, some women agreed with the statement that there are times when a woman deserves to be hit, and at the same time strongly rejected other violence-related statements.

In Kenya, there was little statistical change in HIV/AIDS-related knowledge and attitudes among women who attended GDP activities. That was not the case with condom use intentions. With regard to the latter, respondents at endline on average had significantly strong improvements in condom norms and attitudes, and also scored higher on self-efficacy, i.e., people's beliefs about their capabilities to actually use a condom. However, there was no statistical change in actual condom use.

The cross-sectional analysis of endline data suggests that overall, exposure to the interventions has led to significant and positive changes in the field of decision-making, control in relationships and gender norms and attitudes. Women in general thought they were in fairly equal relationships. With regards to gender-based violence, a majority of the women disagreed with the statements that measure acceptance of violence. Yet, 40% either condoned domestic violence under certain circumstances or acknowledged they had experienced it. Whether acceptance of violence has become higher or lower as a result of the interventions cannot be established, as this was not measured.

A comparison of the conclusions of both country reports shows that there is a striking difference in the level of change with regards to HIV/AIDS knowledge between Kenya and Indonesia: while in Kenya there has been little change due to the interventions, in Indonesia change in knowledge has been substantial and remarkable among all organizations except for one. With regards to condom intentions and use, it is clear that in Kenya the population is more likely to appreciate the role of condoms than in Indonesia. The analysis shows significant improvements in Kenya in condom norms and the belief in being able to use condoms. Nevertheless, even in Java there was a small increase in the number of women who expressed their intention to use condoms in the future, suggesting that the interventions were relatively capable of making some people more aware of the importance of condoms for HIV prevention. The beliefs and attitudes of men and women towards gender relations and inequality cannot be quickly and easily changed, these research studies show. Nevertheless, some of the results are encouraging. For instance, some Kenyan interventions seem to have produced significant change in relation to gender-based attitudes, and to a lesser extent, some Indonesian interventions may also have been capable of doing the same. It is likely the interventions in Indonesia made some women more aware of unequal power relations.

# 1 Introduction

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In the framework of the Gender Development Project (GDP), STOP AIDS NOW! has been partnering with 45 organizations in Indonesia and Kenya (51 organisations in 2007-2008) to implement small-scale activities around the themes of gender, HIV and AIDS, and human rights. The goal of the GDP is to add value to the HIV/AIDS and gender policies of the partners of STOP AIDS NOW! by identifying promising local level strategies and interventions for HIV prevention that integrate the promotion of egalitarian gender attitudes, behaviours and norms, and women's rights. The project seeks to reach this goal by bringing together faith-based, community-based and non-governmental organizations focusing on HIV/AIDS, human rights and/or women's empowerment. These organizations have collaborated to adapt, implement, and evaluate gender-transformative and rights-based HIV prevention strategies and interventions at the individual and community levels. They have also networked together to contribute to an enabling social and legal environment for women and girls.

This report is part of the evaluation of the first phase of the GDP (2007-2008). Prior to the interventions, baseline studies were done between October 2007 and March 2008. Following the activities, from November 2008 to July 2009, endline studies were conducted. Both research projects sought to establish the status of knowledge, attitudes and perceptions of women in the research areas, while the endline studies also sought to measure impact of the local interventions carried out. This report summarizes the findings of both endline studies and offers a preliminary analysis of cross-country differences, as well as some food for thought on what these results mean for the work of STOP AIDS NOW! on gender, HIV/AIDS and women's rights.

In Chapter 2, background information is given on the links between HIV, gender and women's rights; and some suitable approaches to address these links are presented. Chapter 3 describes the GDP and its research component, and Chapter 4 elaborates on the methodology used. In Chapters 5 and 6, the Indonesian and Kenyan results are given separately, while in Chapter 7, similarities and differences are analysed. Finally, in Chapter 8 some reflections are given on what type of analysis is still needed.

## 2 Background

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### 2.1 The links between HIV, gender and women's rights

A number of socio-economic inequalities produce and sustain the increased vulnerability of women and girls to HIV infection. Gender perceptions and norms that discriminate against women, grant them lesser social value, and put them in a position of subordination, lie at the root of these inequalities. These perceptions and norms are active in nearly all spheres of life, including sexual relations, where they contribute to produce power imbalances between men and women that put women at increased risk of contracting HIV. In particular, these power imbalances make it difficult for women and girls to negotiate safer sex or refuse sex, even if they have access to relevant information and condoms. Studies on HIV and the division of power in sexual relationships between men and women have found a direct association between lower power in sexual relationships and experiences of partner violence and inconsistent condom use.<sup>1</sup> Violence and condom use are both highly relevant since forced sex can be a direct means of transmission of HIV, and condom use is a predictor for HIV outcomes.

### 2.2 Appropriate responses

For addressing the link between gender inequality and HIV, three broad approaches have proven their worth. The first is transforming gender attitudes, behaviours and norms; the second is using women's rights as a framework; and the third is decreasing women's economic dependence and working towards their empowerment.

#### 1. Transformation of gender attitudes, behaviours and norms

According to public health experts, it is necessary to devise and implement strategies and interventions that address imbalances of power between men and women in their sexual relationships, and the obstacles these present for communication, safer sex negotiation, and HIV risk reduction. Research findings show that addressing gender attitudes, behaviours and norms in the context of HIV prevention can lead to improvements in reducing HIV risks, through for example increased condom use and reduction in partner violence.<sup>2</sup> Much of the evidence on transformation of gender attitudes, behaviours and norms comes from programmes focusing on men and masculinities, such as Programme H of Institute Promundo in Brazil.<sup>3</sup> For real change to take place, experts argue, more programmes need to work at the gender-transformative level, where attempts are made to both recognize and transform gender inequalities. The evidence from Programme H confirms that HIV/AIDS programmes focusing on changing gender perceptions and norms should include approaches that intervene beyond the level of the individual.<sup>4</sup> Working at the community level can provide support and sustainability for change. Community-oriented efforts can include a range of activities, from group discussions with leaders to broader level awareness raising and social marketing.

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<sup>1</sup> Pulerwitz, J., Measuring sexual relationship power in HIV/STD research, *Sex Roles: A Journal of Research*, April 2000.

<sup>2</sup> Pulerwitz, J., et al., *Promoting more gender-equitable norms and behaviours among young men as an HIV/AIDS prevention strategy*, 2006; Chege, *Interventions linking gender relations and violence with reproductive health and HIV: Rationale, effectiveness and gaps*, 2005; Wingood, G.M. & DiClemente, R.J., Partner influences and gender-related factors associated with non-condom use among young adult African American women, *American Journal of Community Psychology*, 1998, 26(1):29-51.

<sup>3</sup> Program H is just one of several programmes working with men and HIV around the world that have shown positive results in relation to gender perceptions and norms and reducing HIV risk. Others include: Stepping Stones of Action Aid/Strategies for Hope; Men's Action for Stopping Violence Against Women (MASVAW) in India; Men Working for the Movement against AIDS in Kenya; and the Men as Partners programme of Engender Health.

<sup>4</sup> Blanc, A., The effect of power in sexual relationships on sexual and reproductive health: An examination of the evidence, *Studies in Family Planning*, 2001, 32(3):189-213; Gupta, G.R., et al., *Integrating gender in HIV/AIDS programmes: A review paper*, 2001; O'Leary, A. et al., Association of negotiation strategies with consistent use of male condoms by women receiving an HIV prevention intervention in Zimbabwe, *AIDS*, 2003, 17(11): 1705-1707.

## **2. Women's rights as a framework for positive change**

In many places women and girls are not able to enjoy even their most basic human rights. The susceptibility of women to violence including rape, the low value of women and girls in society, and the socio-economic vulnerability of women, weakens their ability to protect themselves from HIV. The realization of the human rights of women and girls, including their reproductive and sexual rights, is essential for reducing the increased vulnerability of women and girls to HIV infection. Therefore, according to experts, interventions integrating gender and HIV/AIDS need to be rethought and redesigned using frameworks that promote the human rights of women and girls.<sup>5</sup>

## **3. Economic empowerment**

Women and girls consistently have disproportionate levels of poverty, and many are economically and financially dependent on male partners. This dependence limits the degree to which they are able to exercise agency in their relationships, sometimes pushing them to stay in abusive situations. This increases their chances of exposure to HIV.<sup>6</sup> It also puts them at times in the position of needing to solve their economic problems through sex work, again augmenting their HIV risk.<sup>7</sup> Therefore, increasing the income-generating capacity of women and girls – and the ability to decide how to spend their earnings – is an important component of HIV/AIDS programming.<sup>8</sup>

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<sup>5</sup> Royal Tropical Institute, *Operational guide on gender and HIV/AIDS: A rights-based approach*, 2005.

<sup>6</sup> Oxaal, Z. & Baden, S., *Gender and empowerment: Definitions, approaches and implications for policy*, Report No. 40 (Bridge), 1997.

<sup>7</sup> Dunkle, K.L. et al., Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa, *The Lancet*, 2006, 363:1415-21.

<sup>8</sup> De Bruyn, M., *Women, gender and HIV/AIDS: Where are we now and where are we going?*, Paper commissioned by Hivos, 2005.

## 3 About the GDP

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### 3.1 Set up of the project

Local partners in Kenya and Indonesia have been implementing the GDP since early 2007. These two countries were chosen because, first, STOP AIDS NOW! development projects must be implemented in countries where all STOP AIDS NOW!'s Dutch partners have counterparts; and second, implementing the GDP in a high-prevalence country (Kenya) and a low-prevalence country (Indonesia) provides for opportunities for cross-regional analysis and comparison. This second reason facilitates the linking and learning function of the Project, and may offer the possibility of replicating the good practices discovered in the high-prevalence country in the low-prevalence one. In Indonesia, the regions of Java and Papua have been selected because they are the areas with the highest HIV prevalence in the country.

STOP AIDS NOW! counterparts focusing on HIV/AIDS, human rights and/or women's empowerment in Java, Papua and Kenya were invited to come together and form a coalition at (sub)national level. In each project area, one local organization was selected to implement and manage the activities of the coalition and to function as a principle liaison with the project officer at STOP AIDS NOW! headquarters. The idea behind this overall process is to ensure the GDP stays true to Kenyan and Indonesian realities and needs, that decision-making is as 'bottom-up' as possible, and that local ownership is promoted. As part of the Project, participating organizations were also invited to take on HIV prevention activities at the local level that integrate gender transformative activities from an explicit women's rights framework. While STOP AIDS NOW! provided guidance on the methods to use—small, intensive discussion sessions as part of individual level activities on the themes of the Project, and public events for broader awareness—each participating organization could decide which types of activities to implement. Examples of activities include peer-to-peer training and peer education, workshops, trainings and focus groups. Local groups were not expected to develop new tools to give content to their prevention activities. Instead, they could draw from existing successful approaches such as Stepping Stones<sup>9</sup>, with appropriate adaptation to fit their circumstances and needs. Except for work at the individual level, counterparts have been expected to take on community level activities. These range from public efforts such as awareness-raising campaigns and rallies, to smaller interventions with key community actors, such as group discussions and trainings with community leaders from different social sectors. The Project has also encouraged counterparts to network together for lobbying and advocacy. This linking aspect of the GDP can contribute to creating an enabling social and legal environment for women and girls. It can also support the gender transformative work taken on at the individual and community levels. In addition, it can help strengthen civil society in Kenya and Indonesia by contributing to a cross-sectoral response to HIV/AIDS.

The Gender Development Project was designed from May through September 2006, during which period local partners were selected and invited. The first introductory workshops took place in December 2006 in Nairobi, and in February and March 2007 in Jakarta (Java) and Jayapura (Papua). In these workshops, staff members of local partners were trained on the GDP issues. Further, a needs assessment was done in each project area, and a coalition coordinator (lead organization) was chosen. Once the local structures were in place for operating the Project, local groups interested in participating were invited to submit proposals for HIV prevention activities that integrate promotion of gender equality and women's rights. During the design phase it was decided that local groups could integrate the GDP in what they were already doing, rather than having to take on the additional burden of adding an entirely new programme. Thus, local partners were asked to propose GDP activities that corresponded with or fit into their current programmes. Each organization was requested to implement interventions that suited their purpose, target group and culture most. As a result, GDP

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<sup>9</sup> Stepping Stones is a gender-transformative approach to HIV prevention, which was originally developed in Uganda in the 1990s and has since been adapted to many countries and cultures. Wallace, T., *Evaluating Stepping Stones: A review of existing evaluations and ideas for future M&E work*, 2006.

activities varied widely, ranging from HIV counselling and provision of legal services for cases of violence, to campaigning and advocacy activities.

The implementation phase (actual interventions) took place in 2008. Some organizations conducted their own workshops, while other organizations hired experts to train or inform their primary beneficiaries, or stimulated their participants to join existing activities of other organizations. While all organizations were instructed to pay equal attention to the three topics of the GDP – gender, HIV/AIDS and rights – some organizations focused more on one or two of these topics due to the nature of their previous work and interests.

Due to unforeseen circumstances, there was a delay in the implementation of the Project.<sup>10</sup> In addition, it was thought that a longer intervention period would be necessary to be able to effect and measure change in gender-based attitudes, as well as more direct HIV-prevention related indicators. It turned out to be difficult to conclude the GDP before the ending of the Theme-based Co-funding (TMF) cycle (2005-2008) through which it was financed. Thus, after a review of effectiveness of the GDP so far,<sup>11</sup> it was decided to prolong the project with another two years.

### **3.2 Research component**

To be able to establish the status of knowledge, attitudes and perceptions of women who participated in the local GDP interventions, two studies were carried out, one prior to the interventions (baseline study) and one after the interventions in the first funding cycle of the GDP (endline study). Six organizations in Java and ten in Kenya participated in both studies. For practical reasons, Papua was excluded as a study location.

The specific objectives of both the baseline and endline studies were to collect, analyse and present information on:

Knowledge of HIV and AIDS among primary and secondary beneficiaries

Intentional and actual condom use by women and girls

Gender-based attitudes, perceptions and beliefs on issues affecting women and girls

Power relations in the sexual and/or romantic relationships between men and women

Forms of gender-based violence and how families and communities respond to it.

Furthermore, the endline study sought to measure the impact of the interventions, and provide input for future work of STOP AIDS NOW!

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<sup>10</sup> For instance, the post-election violence in Kenya in the beginning of 2008 negatively impacted on the progress of the project.

<sup>11</sup> *Gender Development Project Review Report, Kenya and Indonesia*. STOP AIDS NOW!, November 2008.

## 4 Method

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Six of the fifteen local partner organizations in Java and ten of the twenty-four in Kenya were selected to participate in this research, as well as in the endline research. The other partner organizations only participated in the interventions. To be able to answer the study questions, the following method was used. The baseline research consisted of a survey and focus group discussions. The purpose of the survey was to establish the basic characteristics of the participants: their attitudes, perceptions and beliefs on issues affecting women and girls, power relations and gender-based violence; their level of knowledge on HIV and AIDS; and their intentions and practices with regard to condom use. In addition, focus group discussions were done to further discuss issues addressed by the survey, as well as provide more insight on selected topics.

After the intervention phase, an endline research was conducted in all the study locations, which consisted of individual interviews and focus group discussions with primary (the women and girls directly involved in the activities of the GDP) and secondary beneficiaries (for example, partners or family members of the women and girls participating in the GDP activities) and a questionnaire-based survey with primary beneficiaries. The purpose of the survey was to measure changes in knowledge, attitudes and practices of respondents since the baseline. The purpose of the interviews and focus group discussions was to verify the findings of the survey, and provide further insight on issues that could not be thoroughly covered by the survey.

During the interventions, the primary beneficiaries were instructed to spread their knowledge and share their opinions with others. Thus, the secondary beneficiaries are their partners, friends, fellow students, community members or other relations, as defined by each participating organization. At endline, all participating organizations conducted FGDs with at least one group of primary beneficiaries and one group of secondary beneficiaries. Further, a limited number of secondary beneficiaries were also interviewed, using a semi-structured questionnaire. In Indonesia, in general one person per organization was interviewed; in Kenya seven. The study tools used with secondary beneficiaries not only produced information on their attitudes and beliefs, but also tried to determine whether primary beneficiaries had shared their newly gained knowledge with their partners and friends. And if so, whether the secondary beneficiaries thought the information was useful, and whether they accepted or rejected the new knowledge.

For the survey, the same question lists were used in Indonesia and Kenya. Designed by STOP AIDS NOW!, the content of the questionnaire was partly based on three validated theories and scales: the Sexual Relationship Power Scale<sup>12</sup>, the Gender Equitable Male Scale<sup>13</sup> and the Theory of Planned Behaviour.<sup>14</sup> The survey questionnaires were self-administered in a group setting, which allowed for thorough explanation of the research and the questions, as well as for assisting those participants who could not read or write very well. Ideally, only women were present to make sure the participants felt comfortable in answering questions addressing sensitive issues.

For the FGDs, question guides were developed by the local research coordinators in Kenya and Indonesia. These guides could be adapted by the participating organizations. Thus, the focus of the FGDs could vary between organizations in each country as well as between Indonesian and Kenyan organizations. For example, the FGD guide in Kenya focused primarily on issues that were difficult to quantify, such as the role of men and women in the

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<sup>12</sup> Pulerwitz, J. et al., *Measuring Sexual Relationship Power in HIV/STD Research*, 2000.

<sup>13</sup> Pulerwitz, J. et al., *Promoting more gender-equitable norms and behaviours among young men as an HIV prevention strategy*, 2006.

<sup>14</sup> Fishbein, M. & Ayzen, I., *Belief, Attitude, Intention, and Behaviour: An Introduction to Theory and Research*. Reading, 1975.

family and community, and the safety and security of women and girls. Nevertheless, also (other) topics covered in the survey were discussed, so that the FGD findings could be used to verify information derived from the survey analysis.

The interview guides for partners, friends and parents explored the impact of the primary beneficiaries' involvement in the Gender Development Project on changing the way they relate to these friends or family members, as well as the understanding of these secondary beneficiaries of gender norms. The in-depth interviews with partners further explored specific gender-related decision-making and responsibilities in the home, for example, who decides on the number of children to have, who attends to the children's needs (change diapers, bathe or feed the children, etc.), who has more power between partners, and who has more say about when to have sex and when to use a condom.

#### **4.1 Differences in method between Indonesia and Kenya**

Given the freedom granted to the local research teams in both Java and Kenya to conduct the studies in their own manner, there were several differences in method used between both countries. First, the average number of participants per organization was much lower in Java than in Kenya. In Java, 65 questionnaires were analysed pre- and post-intervention, all of them filled out by participants in the interventions. In Kenya, 1.472 women participated in the baseline survey and 623 in the endline survey. Given these differences, the Kenyan data could be more thoroughly analysed, using various statistical measures. Second, in Indonesia only the questionnaires of those women who participated in the interventions were compared (N=65), while in Kenya analysis was done with a larger number of questionnaires, including those filled out by women who did not participate in the interventions. A third difference in methodology between the Indonesian and Kenyan studies was that in the Kenyan research project, the three constructs of gender-related attitudes, perceptions, beliefs and power relations (i.e., decision-making dominance, gender norms and control) were analysed and described separately, while in Indonesia, gender-related attitudes, perceptions and beliefs (decision-making dominance and gender norms) were taken together, while power relations (control) was dealt with separately. Finally, in the Indonesian report more analysis was done on impact per organization than in the Kenyan report. The structure of paragraphs 5.3 and 6.3 in this summary document thus differ considerably.

#### **4.2 Limitations of the methodology**

Important weaknesses of the methods used can be identified. First, the interventions took place for a short period of time, and this may have been too short to measure impact, especially with regards to changes in perceptions and opinions on gender and sexuality. Second, no analysis of success per type of intervention or type of organization (faith-based, community-based, etc.) has been done, so general statements about what type of interventions and/or organizations have been more successful cannot be made.

The Indonesian research project involved too few participants from each organization at both baseline and endline to warrant definite conclusions and generalizations about the impact per organization. In the Kenyan study, two methodological problems were identified. First, the endline data of four organizations turned out to be unsuitable for analysis, so the data collection had to be repeated. The questionnaires collected from these organizations in the first part of the endline study (January 2009) were replaced by the questionnaires collected in the repeat evaluation. Second, after comparison of endline with baseline data, it turned out that impact could not be reliably measured, since both groups of respondents did not consist of the same women, and a sizeable portion of women interviewed at endline did not participate in the interventions. According to the research team in Kenya, it proved difficult for the participating organizations to bring the same group of women together at endline as at baseline, because the election violence caused many women to be displaced. In addition, in an effort to improve their chances of having a positive impact some organizations decided to work with different beneficiary groups than at the beginning of the GDP. In the end, it was decided to put more weight on the endline results than on the comparison between these and

the baseline results, and instead to compare the answers of women who participated in the GDP with those of the women who did not. The researchers believe this cross-sectional analysis produced more reliable findings.

## 5 Indonesia

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### 5.1 HIV/AIDS and the position of women in Indonesia

According to the World Health Organization, Indonesia is at the concentrated stage of the HIV epidemic, but it is also one of the fastest growing epidemics in Asia.<sup>15</sup> The factors contributing to the spread of HIV include a widespread sex industry, high prevalence of sexually transmitted infections, low rates of condom use, rapid urbanization, high rates of migration, use of non-sterile needles and medical equipment, and injecting drug use. Although prevalence is currently low, there are fears that HIV may spread quickly. The two most affected islands are Java and Papua. Injecting drug use in the large cities of Java has become a significant transmission route.<sup>16</sup> In Papua, HIV is more closely related to poverty and migration, and the sex industry associated with both. Importantly, Papua, unlike the rest of the country, faces a generalized epidemic<sup>17</sup>.

Gender inequality and poverty are strongly connected to the spread of HIV. Even though the majority of people living with HIV are men, women are becoming increasingly vulnerable to HIV infection. Cultural norms related to sexuality, incorrect beliefs about AIDS and people living with HIV, and attitudes about condom use define how HIV/AIDS is perceived by Indonesian society. Taboos restrict discussions on sexual matters in public or private, yet this is starting to change in some instances. Cultural norms dictate that sex is strictly defined to take place in marriage. Sexual and reproductive health services are thus mainly aimed at married people and focus on reproduction. Young, unmarried people are not supposed to have sex, even though there is ample evidence that they do have sexual relationships. At the same time, the patriarchal nature of Indonesian society<sup>18</sup> condones extramarital affairs of men and thus actual sexual behaviour deviates from the cultural norm. In 2009 approximately 16% of the population had sex with a non-regular partner, and for more than half of these, some sort of payment was involved<sup>19</sup>.

There are low levels of HIV/AIDS knowledge across the Indonesian population (20.1% for women is the highest level report), and especially among young people aged 15-24 (14.3% have comprehensive knowledge). Incorrect beliefs about HIV and AIDS are still quite commonplace. For example, there is the idea that AIDS is a disease that only affects foreigners, men who have sex with men, sex workers and people who are 'promiscuous'. It is commonly believed that sex workers are the main vector of HIV and many prevention efforts are exclusively focused on them. However, condom use is problematic as clients of sex workers are often reluctant to use them. Last year, consistent condom use with female sex workers was 17%.<sup>20</sup> Condoms lack social acceptance in Indonesian society and are primarily linked to sex work and other high-risk behaviours, and to a lesser extent, to pregnancy prevention.

Indonesian traditions in general place women in the role of homemaker and caregiver.<sup>21</sup> This view has been in the past explicitly mentioned in government development policy. Women's participation in the development process, it is argued, must not conflict with their role in improving family welfare and the education of their children, and it includes a role as wife and mother among women's duties.<sup>22</sup>

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<sup>15</sup> National AIDS Commission Republic of Indonesia, 'Country report on the follow-up to the Declaration of Commitment on HIV/AIDS, Reporting period 2008-2009', 2009.

<sup>16</sup> UNAIDS/WHO, *Indonesia: Epidemiological fact sheet – 2004 update*, 2004; UNAIDS/WHO, *AIDS epidemic update*, 2005.

<sup>17</sup> UNAIDS, *Global Report*, 2010.

<sup>18</sup> Dzuhayatin, S. R., 'Islam, Patriarchy and the State in Indonesia', Emory University, 2003.

<sup>19</sup> UNAIDS Sex work and HIV, Indonesia, 2010.

<sup>20</sup> Ibid.

<sup>21</sup> Hulupi, M.E., Indonesian NGO works to stop violence against women in providing shelter, raising awareness and taking perpetrators to court, UNFPA: News, March 18, 2005.

<sup>22</sup> Wahidah Zein, B.S., Feminism in Indonesia: A movement between the West and the Muslim society, *Jurnal Studi Indonesia*, 1998, 8(2); Zulminarni, N., *Indonesia: In the middle of unsolved crisis*, National Reports: Indonesia, 2001 (see [www.onlinepolitics.org](http://www.onlinepolitics.org)).

Overall, violence against women is on the rise, though reporting is also on the rise. The response to violence against women is poor at various levels: discrimination exists throughout the justice system; violence at home is considered a family affair; and women lack knowledge of their legal rights.<sup>23</sup> Since 2004, the legal situation with regard to violence has improved, with a new law criminalizing marital rape and other forms of domestic violence, women-friendly desks in police stations, and a recent state policy of 'zero tolerance' of violence against women.<sup>24</sup>

## **5.2 About the GDP in Indonesia**

STOP AIDS NOW! has been partnering with 14 local organizations in Java and Papua to implement the Gender Development Project. Most organizations have chosen to incorporate or entrench GDP activities in their existing programmes. Before and after the intervention phase, research was done among six organizations. For practical reasons, these are all located in Java. A list of organizations, their choice of interventions and their primary and secondary target groups can be found in Appendix 1. The baseline study was done between November 2007 and March 2008, while the data for the endline was collected in November and December 2008.

### **5.2.1 Data collection and analysis**

Both baseline and endline studies consisted of a survey and focus group discussions, while the endline also included some in-depth interviews with secondary beneficiaries. The women participating in the surveys filled out the questionnaires in group settings, except for the respondents of Syarikat Indonesia, who were visited at home. In general, the data collector(s) read the questions one by one to make sure people who are unable to read could understand them. Then, each woman filled out the questionnaire on her own, whereas people who could not read and write very well were assisted.

All participating organizations in Java conducted FGDs with at least one group of primary beneficiaries and one group of secondary beneficiaries. Also, a limited number of secondary beneficiaries, one person per organization, were interviewed at endline about their knowledge, attitudes and perceptions and changes therein. The quantitative data was analysed in general and per organization, using Wilcoxon signed-ranks test in SPSS to determine the level of change, while the qualitative data were transcribed, checked and analysed.

### **5.2.2 Study participants**

The basic characteristics of the study population, as assessed by the baseline questionnaire, can be summarized as follows. Around half (48%) of the women were in a relationship, about two-thirds were married and one-third in a romantic and/or sexual relationship. Of those who were in a relationship, over half used some form of contraception. The IUD was the most common method (mentioned by 36% of the women), followed by the pill, condoms and injections (14% of the women each). The majority of respondents had secondary or even university education, about 10% had primary education and only a few were illiterate.

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<sup>23</sup> Diani, H., Domestic violence law 'still ineffective', *The Jakarta Post*, November 25, 2005; Hulupi, M.E., Indonesian NGO works to stop violence against women in providing shelter, raising awareness and taking perpetrators to court, UNFPA: News, March 18, 2005; Hussain, R., Looking into causes of violence against women, *The Jakarta Post*, June 24, 2006.

<sup>24</sup> Bureau of Democracy, Human Rights, and Labor, U.S. Department of State, *Indonesia: Country reports on human rights practices*, 2005.

Table 1. Number of respondents interviewed at baseline and endline by organization

Organization	Baseline	Endline
GAYa Nusantara	9	6
Mitra Wacana	18	16
Solidaritas Perempuan	17	15
LBK-UB	21	11
Syarikat Indonesia	12	11
Rahima	11	6
Total	88	65

## 5.3 Findings

### 5.3.1 Knowledge about HIV and AIDS

The comparison of endline with baseline survey findings clearly suggests that the largest impact of the GDP is in the field of HIV/AIDS knowledge. On the whole, there was a convincing increase in the number of respondents with correct knowledge on HIV and AIDS. The number of women with low to fairly low knowledge decreased almost three times, while the number of women whose knowledge is quite high doubled (Figure 1). Significant change was measured among respondents of all but one organization (Syarikat Indonesia) on at least two items on the list of HIV/AIDS knowledge-related survey questions (items 41-50, see Appendix 2). Out of these ten items, only one did not show significant change, namely 'A pregnant woman can pass on HIV to her unborn baby' (item 45). None of the organizations managed to change knowledge levels on this particular topic.

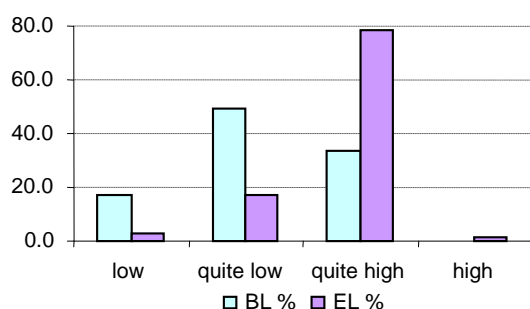


Figure 1. HIV/AIDS knowledge at baseline (BL) and endline (EL)

The intervention used by *Solidaritas Perempuan* – a series of seven monthly meetings for (prospective and former) female migrants – seems to be the most effective. In general, the number of respondents from *Solidaritas Perempuan* with high knowledge tripled in comparison to the baseline survey, which showed very low levels of knowledge of HIV/AIDS. More women than during the baseline correctly stated that someone cannot become infected with HIV by greeting, touching or sharing cups with a person living with HIV (items 42 and 43); and more women believed that someone can become infected by sharing syringes or razor blades with a person living with HIV (item 44). More women than before also recognized that a person can look healthy and yet is HIV infected (item 41) and that HIV infection is not restricted to people with high-risk behaviours such as men who have sex with men, sex workers and injecting drug users (item 46). The number of women who knew that there are treatments available for HIV tripled from four to twelve out of fifteen, a large majority.

Also the intervention done by *LBK-UB* seems to be rather effective in increasing the participants' knowledge on HIV/AIDS. For instance, all women but one answered the questions on ways of transmission (items 42-45) in the baseline survey incorrectly. These

same women knew the right answers to the same questions in the endline. The same is true for the statement that an HIV-infected person can look healthy (item 41). The baseline showed that the majority of participants already had a correct understanding of vulnerability, prevention and disease progression (items 46-49).

Even though the interventions implemented by Rahima, Mitra Wacana and GAYa Nusantara seem less effective than those of the two organizations mentioned above, there are still pointers for effectiveness in the statements that were answered correctly. For instance, young female teachers of Islam participating in the intervention by *Rahima* – a two-day training on gender and HIV/AIDS from an Islamic perspective – gained new knowledge on ways of transmission of HIV (items 42 and 43), one's vulnerability to infection (item 46) and the importance of having a good physical condition for people living with HIV (item 47). They had rather low knowledge levels before the intervention. The same is true for *Mitra Wacana's* respondents, high-school students who attended a series of five informal meetings including a three-day youth camp. The students had higher levels of knowledge after the intervention on physical visibility of HIV (items 41 and 48) and one particular way of transmission: sharing household utensils such as cups (item 43). Between ten and fourteen (out of sixteen) answered these questions correctly at endline, compared to five to six at baseline.

The results of the survey are confirmed by the information shared during the focus group discussions with primary beneficiaries. Participants generally identified the ways of HIV transmission correctly, even though some stated that people can also become infected through saliva exchange (e.g., through kissing). The focus group discussions also revealed that only a few participants had experienced cases of full-blown AIDS in their community. The knowledge of other people in their neighbourhood is still low, the participants stated, especially regarding the symptoms, ways of transmission and prevention of HIV and AIDS.

In terms of dealing with people living with HIV, the FGD participants generally stated that people with HIV should not be badly treated, humiliated or exiled. For instance, the participants of an FGD with primary beneficiaries conducted by Solidaritas Perempuan shared that they believe that people should be supportive to people living with HIV and that they should not be left by their loved ones or held in low esteem. However, the discussions sometimes showed some ambiguity between how people should respond to people living with HIV and how they actually did respond, as the following quote shows: *'The family treats her well and did not leave her. However, they did not know that she suffered from HIV/AIDS. That was because the doctor did not inform the family about the truth – that she was living with HIV.'* What might happen to this woman once her family finds out about her condition, remains unknown. Indeed, in Indonesia family support for people living with HIV remains unacceptably weak.<sup>25</sup> FGD participants of Syarikat Indonesia, which intervention yielded insufficient results on knowledge change, admitted that they were afraid of HIV because they thought it was highly contagious. One woman said that she avoided visiting the house of a person living with HIV, although she did visit this person before she knew of the HIV infection. She said she was afraid to shake hands with people living with HIV, however she also said that she would be supportive to any person who is seeking medical treatment.

The interviews and discussions with secondary beneficiaries – friends, partners, relatives, fellow students, etcetera of primary beneficiaries – showed that at a certain level, primary beneficiaries did share their new knowledge with their closest environment. Some participants of the focus group discussions with secondary beneficiaries said that the information they received was useful. For instance, a young man told that he had been able to take advantage of the information and felt glad to share it with his friends. Nevertheless, there were still some secondary beneficiaries who had incorrect views, as expressed during the FGDs and interviews.

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<sup>25</sup> National AIDS Commission Republic of Indonesia, 'Country report on the follow-up to the Declaration of Commitment on HIV/AIDS', Reporting period 2008-2009', 2009.

### 5.3.2 Intentional and actual condom use

Even though the general intention to use condoms remained low and many women showed hesitation, the increase in the number of participants who want to use condoms in their sexual relationships is fairly convincing. Figure 2 shows a decrease in the number of women with quite weak intentions to use condoms, and an increase in the number of women with quite strong and strong intentions to use condoms. Significant change can be seen especially on those items that focus on a change of feeling (feeling uncomfortable or bad about using or discussing condoms, versus feeling comfortable and good, items 28-31).

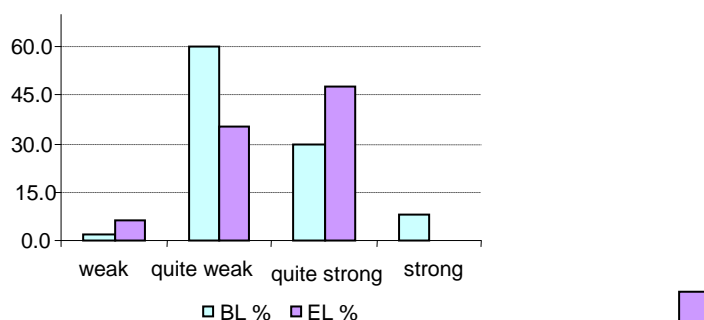


Figure 2. Intention to use condoms at baseline (BL) and endline (EL)

A large number of participants remained hesitant. For example, a large proportion of participants of *LBK-UB* did not change their opinion on the intention to use condoms in the future, despite their increased knowledge of HIV, including about the role of condoms in prevention. This is shown from the prominent number of women who remained uncertain on: a) their judgment of whether condom use is good or bad (item 30), b) whether their loved ones support or accept condom use (item 32 and 33), and c) whether condom use is beyond their control (item 37). Yet, the *LBK-UB* women also showed some positive changes, notably, in feeling comfortable and morally justified to discuss condom use with their sexual partners (items 29 and 31, from two to six and from two to seven out of eleven respectively), their confidence to use a condom (item 34, from three to seven) and the usefulness of condom use for themselves (item 36, from three to nine). It is important to bear in mind the beneficiaries with which *LBK-UB* works as part of the GDP are members of religious communities. Within this context the changes noted among the beneficiaries with regard to condom attitudes and intentions are perhaps more meaningful than they would be otherwise.

The participants who had the highest intention to use condoms and who felt the most comfortable to discuss and use condoms were the female college students and escort girls trained by *GAYa Nusantara*. The baseline showed none of them resisted condom use (item 27) and that all would feel (very) comfortable using a condom (item 28). Their views and opinions did not change much after being exposed to the intervention, a five-day meeting. Both baseline and endline data suggest that a high number of high-school students trained by *Mitra Wacana* were also fairly optimistic about future condom use. They felt that they would have the support of important others (family, friends, etc.) if they intended to use condoms, and they thought it would be actually expected from them to use condoms (items 32 and 33).

The female teachers of Islam trained by *Rahima* showed the strongest resistance to condom use at baseline and endline. Only one out of six at baseline thought it would be beneficial for them to use condoms (item 36) and none of them intended to start using condoms in the future (item 27). Given the background of the participants, teachers in Islamic boarding schools, this is not surprising. With regard to whether encouraging their sexual partners to use a condom would make them feel good and comfortable (items 29 and 31), the teachers differed in opinion. Some of them believed this would be a morally just thing to do and they would feel comfortable discussing the issue with their partners, while others felt the opposite.<sup>26</sup> Also the

<sup>26</sup> Based on feedback obtained from *Rahima* during a learning and exchange workshop outside the context of the research project described in this document, the teachers *Rahima* targets as part of the GDP initially found the very idea of handling or even looking at a condom reprehensible. According to *Rahima*, through the GDP activities, the

migrant women trained by *Solidaritas Perempuan* largely remained unintended to use condoms. Even so, some participants who previously had felt uncomfortable to discuss condom use with their partners, intended to use condoms following the intervention.

Surprisingly, after the intervention conducted by *Syarikat Indonesia* more women than before were reluctant to use condoms. It cannot be established from the data what the reason is for this negative development. Perhaps this was the first confrontation of the women with a condom demonstration which might have frightened them, or it was the first time they actually started thinking about how to address the issue with their partners. Nevertheless, seven out of eleven participants thought that condom use would be beneficial for them. Another positive result is the increased number of women who stated that they thought that using a condom would be easy for them.

Overall, as might be expected given the short intervention time, the change in intention to use condoms was not reflected in actual increased condom use. In the last six months prior to the surveys, there was no statistically significant change on the decision to use or not to use a condom during sex. Very few women had actually ever used condoms.

The focus group discussions support the findings of the survey that condom use is still problematic in Javanese society. Many people questioned the effectiveness of condoms for stopping the spread of HIV, and there was a resistance to accept condom use as it was commonly regarded as young people's 'ticket to free sex' (premarital sexual relations). From the interviews with secondary beneficiaries (all males), the resistance of men to use condoms seems to be connected to feelings of discomfort and the function of the condom, which was more recognized to prevent pregnancy and was related to whether the sexual relation is legal or illegal. For most men, condom use in marriage is unnecessary, as they consider pregnancy to be a natural consequence of the married state. It looks like there also is a belief that in legal marriage, sexual relations are by definition 'healthy', so that condoms are unnecessary. As an example, Badri, the husband of a woman who participated in the activities of *Solidaritas Perempuan*, said: *'I don't agree with using condoms that much. It is indeed necessary to prevent HIV. But for legal sexual relations, I don't think so.'*<sup>27</sup>

### 5.3.3 Gender-based attitudes, perceptions and beliefs

Generally, the baseline and endline surveys and FGDs documented varying views of participants with regard to the role of women in society and the family. These ranged from the acceptance of the traditional role of mother and housewife to an adoption of more egalitarian gender relations. Only a few women in each organization strongly agreed with the traditional views. Slightly more than half (55%) of the women who participated in the baseline study agreed with the idea that the most important role of women is to take care of their house and family, while 35% believed that it is the sole responsibility of women to attend to the children's needs. In contrast, a large majority of women believed that the role of fathers in the lives of their children should be limited, either during marriage or after divorce.

With regard to the roles of men and women in reproductive life, those who disagreed with the idea that pregnancy prevention is a woman's responsibility outnumber those who agreed (53% versus 40%, the rest was in doubt). However, an inconsistent pattern shows up with regard to the idea that a couple should decide together whether they want to have children. Almost all of the respondents (92%) disagreed that this should be a mutual decision. Stereotypical beliefs related to men's sexual role and their 'innate polygamous tendency' were rejected by the majority of respondents across the organizations. The idea that it should be the man who decides whether to have sex or not was opposed by more than half of all respondents. Finally,

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participants eventually felt more comfortable around condoms, and started opening the packages and exploring how condoms are meant to be used. Given the initial reactions, Rahima's results with the teachers are particularly positive.

<sup>27</sup> Heterosexual marriage is more and more seen to be a context presenting a high risk for HIV transmission. See, for example, the Kenya National AIDS Control Council's, 'Kenya National AIDS Strategic Plan 2009/2010-2012/2013: Delivering on Universal Access to Services', 2009, p. 21.

almost three quarters of the respondents disagreed with the statement that women need sex more than men do.

In general, the interventions carried out by the participating organizations show some, but statistically insignificant impact on gender-based attitudes, perceptions and beliefs (see Figure 3). Nevertheless, some interventions seem to be fairly capable to change the opinions of women who previously fully accepted the traditional gender role division. It also seems that some interventions have been significantly capable to change participants' stereotype views regarding the belief that women carrying condoms are easier convinced to have sex.

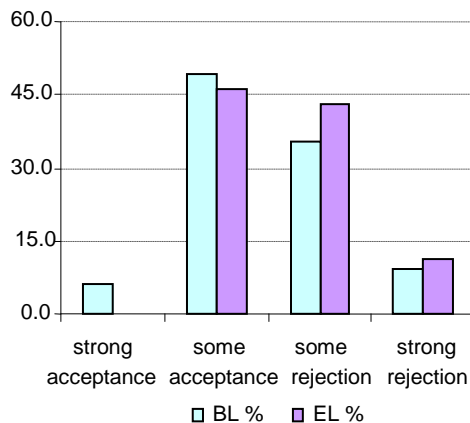


Figure 3. Attitudes, perceptions and beliefs about gender roles at baseline (BL) and endline (EL)

Based on a calculation of overall intervention effectiveness, the activities carried out by *Solidaritas Perempuan* can be considered as having the most impact overall. Statistically significant change occurred on three aspects of gender attitudes and beliefs. The most encouraging change took place on the view that a woman's most important role is to take care of her home and cook for her family (item 14). Before the intervention, thirteen out of fifteen participants interviewed at baseline had accepted this stereotypical role of women; after the intervention this number was halved to seven, indicating that more participants had become critical about the traditional role of women and more open-minded to alternatives. The second significant change took place on the view that it is a woman's responsibility to avoid getting pregnant (item 19). The figures clearly show that more women started to doubt this view, not only women who previously supported it, but also women who opposed it at baseline. The third change, a rather negative one, was visible in the increased number of women who strongly disagreed with the view that it is important that a father be present in the lives of his children (item 17). The baseline showed that thirteen out of fifteen women who participated in the intervention did not support this view. After the intervention, more participants than before strongly rejected this view, an unexpected outcome.

Participants of *GAYa Nusantara* had the highest levels of rejection of conventional gender stereotype roles, both at baseline and at endline. This rejection is seen in their attitudes towards the traditional duties of women, such as 'a woman's most important role is to take care of her home and cook for her family' (item 14, five out of six at baseline disagreed and all women at endline) and 'changing napkins/diapers, bathing, and feeding the children are the mother's responsibility' (item 15, half of the women agreed at baseline and five out of six at endline). It can also be seen in their rejection of the idea that it is the responsibility of women only to prevent pregnancy (item 19). Finally, all women rejected the idea that men should take the lead in sexual relationships and that men need other women (items 21-22). The comparison of baseline and endline data did not show many significant changes, except for women's opinion on whether women who carry condoms on them are easily convinced to

have sexual intercourse (item 18). After the intervention those women who previously agreed to the statement or showed hesitation, now strongly rejected it.

The participants of *LBK-UB*, women of different faith communities, showed the most resistance to the traditional division of labour within the household. At baseline, eight out of eleven women disagreed with the idea that a woman's most important role is to take care of her home and cook for her family (item 14) and all but one disagreed with the idea that changing diapers, bathing and feeding the children are the mother's sole responsibility (item 15). Like the women of GAYa Nusantara, the women of *LBK-UB* also showed fairly egalitarian views on sexual and reproductive life at baseline. For instance, six out of eleven of the women at baseline thought that it was not the sole responsibility of women to prevent unwanted pregnancy (item 19). Eight of the eleven also rejected the statement that it is the man who should decide whether to have sex (item 21). These views did not change significantly after the intervention.

In contrast with the religious women of *LBK-UB*, a majority of the women participating in the *Rahima* intervention, female Quran teachers at Islamic boarding schools, accepted the traditional division of labour within the household. Strikingly, a large majority agreed that taking care of the children should not be women's sole responsibility (item 15). And with regard to sexual and reproductive rights, a majority did not believe that women should be exclusively responsible for pregnancy prevention (item 19), that it should be the man who decides whether to have sex (item 21) and that a man needs more than one woman to fulfil his sexual desires (item 22). After the training provided by *Rahima* the views of the women on division of labour and sexual and reproductive rights did not change much.

The focus groups with primary beneficiaries confirmed that the traditional gender-based role division is still vibrant in Java. For example, primary beneficiaries involved in the FGD carried out by GAYa Nusantara said that women's roles are primarily in the domestic sphere. Meanwhile, men's roles are public in characteristic, and men tend to occupy important posts in companies and institutions, as well as in the community. Women involved in the activities of *LBK-UB* explained that since the harsh financial situation of many families forced many women to find a job, these women suffer from a double burden. Taking care of the house and family is still regarded a woman's exclusive job, although some women taking part in the FGD protested this gender-based perception. One *LBK-UB* woman shared her own experiences as follows: *'Men and women should be equal. There is no win and lose. Nobody presides over the other. But, men's understanding about gender is sometimes insufficient, so they think that men should be presiding over the women. ... It is like what I experience at home. Doing the chores is not solely my own responsibility, nor my husband's, nor my children's. It is ours. It depends on who has time to do it. If I have time, I will do the laundry. If my husband has time, he will do it. So will my children.'*

The primary beneficiaries of *Mitra Wacana* feel that gender-based discrimination dominates Javanese society. They recognized that women receive discriminatory treatment from school age. Boys and girls are treated differently, both at school and in the dormitories. For instance, boys have more liberties than girls. One girl compared the position of girls at her boarding school to porcelain: they *'should be strongly protected not to break'*. Secondary beneficiaries in majority adhered to traditional gender roles. In one FGD, a man explained that if women and men switch roles, it will end up in chaos. However, there are also opposing voices to be heard among secondary beneficiaries. For instance, Wiwik, a friend of a woman who participated in *Rahima's* intervention, said during her in-depth interview: *'I don't want to be the number two, because we have the same rights and obligations. Women are different only in nature. When I was a child, there was no difference in treatment between me and my little brother. Sometimes, before he died, I would ask my stepfather to sew my skirt. It was also common that he asked me to climb up the roof. Men and women are the same.'*

### 5.3.4 Power relations

In general, the interventions had statistically insignificant impact on perceptions on who has the power in the relationship (items 9-13) as well as on partner's control in actual life (items 1-8) (Figures 4 and 5).

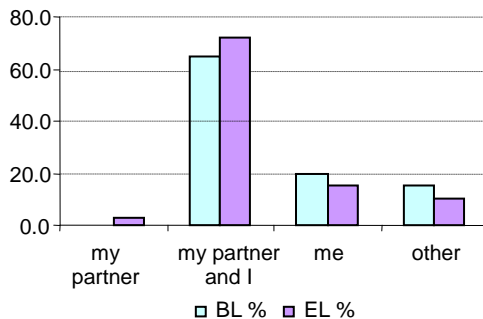


Figure 4. Power relations in romantic and sexual life at baseline (BL) and endline (EL)

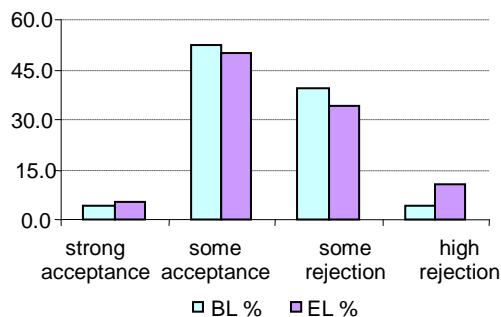


Figure 5. Attitude towards partner's control in daily life at baseline (BL) and endline (EL)

Women in a variety of communities felt actually in relatively powerful positions to express their opinions. However, in terms of decision-making, their partners remained in power, also with respect to sexual relations. In spite of the fact that some people felt slight changes in their relationship experiences, more equal relations did not appear. Nonetheless, some interventions seem to be able to make women more aware of the unequal power relations with their partners. Some women who previously had thought they had an equal relationship prior to the interventions, realized afterwards that it was their partners who had more decision-making authority.

The only statistically significant change that could be determined was in the number of women who thought their partner was always controlling their movements (item 7). Previously over 80% of the women felt their partner always wanted to know where they were. However, after the intervention phase, less than 30% of women felt this, and there was a sharp rise in the number of women who (strongly) disagreed. With regard to whether the power/control in the relationship is in the partner's hand, most of the respondents did not agree. For example, most women did not feel their partner is controlling what they are wearing (item 3), and they did not feel that they have to be quiet when they are together with their partner (item 4). When it comes to violence (item 6) a large majority believed they would not be beaten when they would do something of which their partner disapproves. Interestingly, the majority of respondents across organizations agreed with the idea that a woman should be disciplined by her partner (item 8). Exceptions are Solidaritas Perempuan and LBK-UB, where there is strong opposition to this view.

Even though the interventions in general showed insignificant change, there are still some interesting points to make. For instance, after the intervention of *Syarikat Indonesia*, slightly more women thought their partners control whom they can befriend (item 1). Perhaps the fact

that women talked about these power issues for the first time made them realize in what ways their partners influence their social life. The same is true for the partner's desire to always know where his wife is (item 7). Some women who previously did not feel restricted in their movements, probably realized their partner's influence after the intervention. It is likely that the intervention has at least made some people more aware of the unequal power relations to which they are subjected. This suggestion is confirmed by the change in answers to the question: 'In general, who do you think has more power in your relationship?' (item 11). Previously, six out of nine women who answered this question believed that the power in their relationship was equally shared. After the intervention two women changed their opinion, now convinced that their partner is more powerful.

A majority of *LBK-UB* women did not feel their relationship with their partner was unequal. For them, their partner does not really decide who they can spend time with (item 1) and what they should wear or not (item 3). The majority also felt that they are free to give their opinions while being together with their partner (item 4). Yet, their answers to other questions and statements show some ambiguity. For instance most of the women admitted that they rarely do what they want when they are together with their partner (item 5), and the majority also agreed with the statement 'my partner always wants to know where I am' (item 7). Interestingly, more women than before agreed after the intervention that it is important to have a partner who disciplines them. Apparently, the women do not see the ambiguity here, or the issue of discipline is not seen as strongly related to unequal power relations.

The unequal position of women in decision-making, as an indicator of equal power relations, is confirmed by the findings from the focus group discussion with primary beneficiaries. In general, the women believed that men are in charge of taking final decisions. Participants in an FGD done by *Syarikat Indonesia* found that in a decision-making process, women can have their own ideas, interests and plans, but it is men who decide whether women can implement them. For example, a man in the discussion group admitted he encouraged his wife to participate in the activities of *Syarikat Indonesia*. He believed that it would be a good experience for his wife to engage in social activities. Yet, he also reminded her not to share any family secrets in public. Another man admitted that his wife had asked for his permission to participate in the activities. The majority of participants agreed that men have more freedom to do what they want, including how to spend their income.

### 5.3.5 Gender-based violence

Although a law against domestic violence was passed in Indonesia in 2004, the effects of its implementation are yet to be seen. Society still tends to see domestic violence as a private issue. In general, the women who participated in the study in Java rejected domestic violence. However, there was some ambiguity. The statistical analysis showed the intervention carried out by *Syarikat Indonesia* was the only one that led to significant change in beliefs that justify violence against women. After the intervention, all women disagreed with the statements that women sometimes deserve to be hit (item 24), and that a man can hit his wife if she refuses to have sex with him (item 26). All but one disagreed with the idea that a woman should tolerate violence in order to keep her family together (item 25). Compared to the baseline, women seemed to be more adamant in their rejection of violence after the intervention: seven to nine out of eleven chose 'strongly disagree' rather than 'disagree' while answering the three violence-related questions, whilst only four to six women selected this category at baseline.

Except for one or two, the women participating in *Solidaritas Perempuan's* interventions strongly rejected domestic violence. They did not agree with the statements 'there are times when a woman deserves to be hit' (item 24); 'a woman should tolerate violence in order to keep the family together' (item 25); and 'it is OK for a man to hit his wife if she won't have sex with him' (item 26). The female high-school students of *Mitra Wacana* were divided in their opinions. Some of them condoned violence against women, while others were strongly against it. However, with regard to the question whether it is alright for a man to beat his wife if she does not want to have sex (item 26), fourteen out of sixteen at endline disagreed, against

twelve out of sixteen at baseline. The women participating in the *LBK-UB* intervention in large majority (eight to eleven out of eleven) disagreed with the three statements, both before and after the intervention. The *Rahima* women also rejected statements 25 and 26, but, interestingly, most of them (four out of six at endline) agreed with the statement 'there are times when a woman deserves to be hit' (item 24).

Some of the stories shared in the focus group discussions echo the traditional views of Indonesian society on gender-based violence. A woman participating in the intervention of *Rahima* gave the example of a bus driver who beat up his wife one day. His wife was said to be very materialistic and in debt. She was also apparently domineering: had a loud voice and talked a lot, while her husband was a rather calm person. The woman who told the story could not entirely blame the husband for beating his wife. *'His wife's behaviour was too much'*, she said. A woman participating in the FGD of *Syarikat* shared the interesting story of the wife of a *kepala dukuh* (hamlet chief), who attended a training to learn how to address domestic violence in his community, but did not spread the information she received to the other villagers. The suspected reason for that, the FGD participant said, was that the *kepala dukuh* was also beating his wife.

Some of the women participating in the FGD of *LBK-UB* admitted they found it very difficult to define what kind of action they can take to assist survivors. The fact that domestic violence takes place in a marriage makes it difficult for them to interfere; all they can do is give these women some advice. If women seek help at all, they go to their parents or close relatives. There is still a taboo in the community about talking about domestic violence in public. It should be kept within the family, as one woman in the *Rahima* FGD related: *'First, she wanted to go to the police. I said: You want to go to the police and tell about this? This is your own problem. You do not need to tell all people about that. You will have a bad reputation...'*

## 5.4 Summary and conclusions

### **From low to fairly high knowledge about HIV/AIDS**

The comparison of endline with baseline survey findings clearly suggests that the largest impact of the *GDP* is in the field of *HIV/AIDS knowledge*. Except for the respondents of *Syarikat Indonesia*, significant change was measured among respondents of all organizations on at least two items on the list of *HIV/AIDS knowledge*-related survey questions. The number of people with low to fairly low knowledge decreased almost three times, while the number of people whose knowledge is quite high doubled. The intervention implemented by *Solidaritas Perempuan* seems to be the most effective. The women taking part in the series of monthly meetings had low knowledge at baseline and moderate to high knowledge at endline.

Some interventions managed to affect one or more indicators, such as knowledge of particular ways of transmission and the physical manifestations of *HIV* and *AIDS*. The interventions were successful in making a growing number of people understand the myths they had taken for granted in relation to symptoms, spread, prevention and treatment of *HIV* and *AIDS*. There was an increase in the number of women with correct and accurate knowledge, even if clients of some organizations still considered *AIDS* a deadly disease.

As demonstrated by the FGDs, the women appreciated a need for non-discriminatory and supportive attitudes towards people living with *HIV*. Interestingly, virtually all participants had low knowledge of mother-to-child transmission of *HIV*. This raises the question whether this issue was properly addressed in the interventions.

### **Variable but low acceptance of condom use**

With regard to *condom use*, participants showed variable acceptance, generally considering it a contraceptive and a means to protect illicit (pre/extramarital) sexual intercourse. Overall, the change in intended condom use is fairly convincing: there was an increased number of women who expressed their willingness to start using condoms in the future. The participants who had the highest intention to use condoms were the female college students and the escort girl

trained by GAYa Nusantara, followed by the high-school students trained by Mitra Wacana. The women trained by the other organizations remained hesitant or reluctant to use condoms. Nevertheless, despite differences between organizations, there was a substantial number of women who did not feel guilty or uncomfortable about using condoms.

Given the short duration of the intervention period covered by the study it is not surprising that they did not lead to massive changes in the intention to use condoms and the actual use of condoms. However, the interventions seem to be relatively capable of making people more aware of the importance of condoms as protectors against HIV infection. This effect though was not followed by desired behaviours: in the last six months prior to the surveys, meaningful change in the use of condoms could not be observed.

### **Limited change of gender-based perceptions and beliefs**

As might be expected, the interventions were not significantly followed by changes in *gender-based perceptions, beliefs and attitudes* and in power relations between men and women. However, some interventions, such as those of Solidaritas Perempuan, seem to be fairly capable to change the opinions of women who previously fully accepted the traditional gender role division. In general, there is a sufficient indication that powerful, rigid gender-based beliefs can be undermined. Among others, this was shown by a growing number of women who accepted the notion that women can also carry condoms on them and that this does not mean they are 'prostitutes'.

In a patriarchal society such as Indonesia, gender-based perceptions, beliefs and attitudes are strongly internalized through a variety of social norms. Gender-based discrimination is widespread and women still occupy less important positions in society. Even when they do work, they are still responsible for keeping the house and taking care of the family. These ingrained beliefs are difficult to change with short-term interventions. Nevertheless, the analysis showed there is a great variety in attitudes towards traditional gender roles. Also, the answers were often inconsistent with each other, suggesting a large level of ambiguity.

### **More awareness about unequal power relations**

With regard to unequal power relations between women and their partners, change was statistically less convincing. Women in a variety of communities felt actually in relatively powerful positions to express their opinions. However, in terms of decision-making, their partners remained the final decision-makers, both in the public sphere, in day-to-day (financial) affairs and in sexual relations. For some women, however, it is likely that the interventions had at least made some of them more aware of the unequal power relations to which they are subjected. Some women who previously had thought they had an equal relationship, may have realized during the interventions their partners have more decision-making power.

The only significant change that could be determined was in the number of women who thought that their partner was always controlling their movements. Unfortunately, it is unclear from the survey data whether this change was due to the interventions, and if so, how it was produced. Did the behaviour of the husbands really change (becoming less protective/controlling), did the women perceive the questions asked by their husbands as less controlling, or is there another explanation?

### **Rejection of domestic violence**

In general, the women rejected domestic violence, even though there was some ambiguity in their answers. For instance, some women agreed with the statement that there are times when a woman deserves to be hit, while they strongly rejected other anti-violence statements. The statistical analysis shows the intervention carried out by Syarikat Indonesia was the only one that led to significant change in beliefs that justify violence against women. Compared to the baseline, the participants seemed to be more resolute in their rejection of violence after the intervention.

## 6 Kenya

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### 6.1 HIV/AIDS and the position of women in Kenya

The HIV prevalence in adults (15-49 years old) in Kenya is approximately 6%, around one million people. More women are living with HIV than men, and the majority of new infections is occurring among young women 15-24 years old. Since the late 1990s, HIV prevalence is declining in the country.<sup>28</sup> It appears the drop in prevalence can be attributed to behaviour change. Condom use with casual partners has increased and proportions of men and women with more than one sexual partner reduced by more than half in 1993-2003. More young men and women are delaying sexual debut.<sup>29</sup>

According to traditional culture, women are seen as property. This view of women facilitates practices such as wife inheritance and widow cleansing, both of which have been cited as contributing factors to high HIV transmission.<sup>30</sup> The view of women as property also facilitates violence against them. According to recent figures more than 90% of all violence in Kenya is committed against women.<sup>31</sup> Violence in the home is a serious problem. Figures from 2003 show at least half of all Kenyan women have experienced violence since the age of 15, with close family members among the perpetrators.<sup>32</sup> Rape rates are high, with one in every four women aged between 12 and 24 having sex for the first time through force.<sup>33</sup>

The response to violence is weak: fear, inhibitions about discussing sexual matters and discrimination on the part of the police keep women from reporting incidents; courts are ineffective; and facilities where abused women could seek assistance are largely unavailable, especially for women in rural areas.<sup>34</sup> A relatively new law, the Sexual Offences Bill, provides for rape survivors to receive free medical care and counselling in public institutions and also broadens the definition of a sex crime. Unfortunately, the law also includes a penalty of at least 15 years for 'deliberate' transmission of HIV.<sup>35</sup> Given the blame often cast upon women for supposedly 'bringing HIV into the community', it is possible that such a law would only serve to increase HIV/AIDS-related discrimination and violence against women.

Until the new constitution promulgated in August 2010, Kenyan constitutional law permitted discrimination in the area of family matters by letting a number of family issues to be decided or adjudicated by non-civic bodies. And this meant women's interests and rights were often trampled. For example, under customary law, some communities do not grant wives and daughters ownership over land or livestock. As a result, women rarely inherit land, livestock and other property in rural areas.<sup>36</sup> In Kenya overall, women own only five percent of land, yet many more women than men are (subsistence) farmers.<sup>37</sup>

### 6.2 About the GDP in Kenya

In the framework of the Gender Development Project, STOP AIDS NOW! has been partnering with 24 local organizations in Kenya. They are involved in different activities, including HIV

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<sup>28</sup> Kenya National AIDS Control Council, UNGASS 2006: Country Report – Kenya, 2006.

<sup>29</sup> Ibid.

<sup>30</sup> Wife inheritance is the practice of giving a widow in marriage to her deceased husband's brother or other close relative. Widow cleansing is a practice that dictates that widows, who are considered 'unclean', should have sex with a male relative of their deceased husband to purify themselves. Human Rights Watch, Q&A: Women's property rights in sub-Saharan Africa, 2006 (see [www.hrw.org/campaigns/women/property/qna.htm](http://www.hrw.org/campaigns/women/property/qna.htm)).

<sup>31</sup> Mulama, J., Int'l Women's Day: Sexual violence on the rise in Kenya, July 19, 2006.

<sup>32</sup> IRIN Africa, Kenya: Sexual and domestic violence prevalent, July 19, 2006.

<sup>33</sup> Muthaka, B. & Gathura, G., Rising AIDS cases linked to violence, *The Nation* (Nairobi), June 21, 2006.

<sup>34</sup> Ibid.; AFROL, Gender Profile-Kenya, 2006 ([www.afrol.com](http://www.afrol.com)); Amnesty International, Women in Kenya: Women's days, women's lives, *The Wire*, March 2002.

<sup>35</sup> IRIN Africa, Changing the law in Kenya to protect survivors, HIV-positive people, July 10, 2006 (see [www.irinnews.org](http://www.irinnews.org)).

<sup>36</sup> Mucai-Kattambo, V.W. et al., Law and the status of women in Kenya, in: Macharai-Kabeberi, J., ed., *Women, laws, customs and practices in East Africa – Laying the foundation*. Nairobi: Women & Law in East Africa, 1995.

<sup>37</sup> Government of Kenya, *Kenya Interim Poverty Strategy Reduction Paper 2000-2003*, 2000

prevention among youth, vocational trainings for orphans, poverty reduction, gender, youth development and human rights, civic education, micro finance, and community empowerment. Their target populations vary, including people living with HIV, women's groups and youth. A few organizations target both men and women.

Rather than creating new interventions on HIV/AIDS, gender and women's rights, most organizations incorporated or entrenched GDP activities in their existing programmes. Women and girls have been the primary beneficiaries of the activities, although all organizations incorporated men in their programmes. According to the representatives from the organizations, issues of gender and human rights have been successfully incorporated in several activities of the organizations that already had programmes addressing gender, youth or HIV/AIDS. Some organizations have modified their approach to incorporate GDP principles and methods, e.g., introducing participatory learning and action (debates and drama).

### 6.2.1 Data collection and analysis

Ten organizations were selected to participate in the research project. A list of organizations, their choice of interventions and their primary and secondary target groups can be found in Appendix 1. In August-September 2007, the organization Impact RDO trained eighteen representatives of these organizations on qualitative and quantitative data collection methods. Upon returning to their organizations, the representatives selected and trained a group of female research assistants to collect the data. This data collection took place between October and December 2007, prior to the start of the interventions. The endline evaluation was done in two phases. In phase 1 (January 2009) all the ten organizations participated in the collection of both quantitative and qualitative data, with the assistance of thirty research assistants trained by Impact RDO. In phase 2 (June-July 2009), four of the ten organizations participated in a repeat evaluation to improve the quality of data collected, because the data collected during the first phase were of questionable quality as a significant number of respondents had not participated in the GDP activities. These organizations were HSHC, 4Cs, KANCO and WSP-K. For this repeat evaluation, the same research assistants were used as for the first endline research. The researchers replaced the original questionnaires submitted by the four organizations with the new ones.

The total number of valid questionnaires was 623. In addition, 349 women participated in 34 FGDs during both phases of the endline and 84 secondary beneficiaries (men and women) were interviewed individually. Finally, representatives of the participating organizations were interviewed to explore how they had implemented the intervention(s).

The qualitative data were transcribed and analysed using *Atlas.ti* version 5.2. The quantitative data were analysed using SPSS version 15 and SAS version 9.1.3. First, factor analysis was done to find out which items in the questionnaire would significantly explain variance in the factors identified, i.e., the constructs that came out of the literature review such as decision-making, control in relationships, etc. Then, a bivariate regression analysis was conducted to analyse the relation between two variables (the outcome/dependent variable and the independent variable) and a multivariate regression was applied to measure the effect of various independent variables on the outcome variables—to be able to detect which specific variables had the most influence on the outcome variables. In this case, the outcome variables were condom use and HIV knowledge, as the researchers deemed it interesting to find out how other factors, like decision-making dominance, correlate with these variables.

The endline data were compared to the baseline data to assess whether there were any changes in perceptions and practices after the intervention, mainly because of doubts that emerged in the endline phase about the quality of the data collected at baseline. Finally, the endline data were cross-sectionally analysed, comparing those who participated in the GDP activities with those who did not<sup>38</sup>. Some 461 women (78.4%) reported attendance to the GDP

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<sup>38</sup> The women grouped as not having participated may actually have participated but may not have identified the activities as being part of the GDP specifically; activities done at the grassroots level were often not branded as GDP

activities while 127 participants (21.6%) reported non-attendance. Multiple linear regression was done to adjust for the effect of selected socio-demographic characteristics and to see the independent effect of exposure to the intervention on the factors of interest.

## 6.2.2 Study participants

The basic characteristics of the study population, as assessed by the baseline, can be summarized as follows. Over 70% of the respondents who filled out the baseline questionnaire were in some form of relationship, most of them married. Of the married women, 29% was in a polygamous union. The majority of the women had children. Of those who were using some form of contraception, about 35% used male condoms. Most of the participants (55%) had at least secondary education, however it turned out that the majority of the highly educated women came from only two groups: KANCO and WSP-K. Some 36% of the women were financially independent. A large majority identified themselves as being Christians, and there were small minorities of Muslim women and women who practice traditional religions.

*Table 2. Number of respondents interviewed at baseline and endline by organization*

<b>Organization</b>	<b>Baseline</b>	<b>Endline</b>
4Cs/KEFEADO <sup>39</sup>	103	82
ACK Eldoret	269	116
CAI	153	93
C-MEDA	66	55
KANCO	175	98
HSHC	53	23
WIFIP	139	69
WSP-K	464	42
YWCAA	50	45
	1472	623

As can be seen in Table 2, considerably fewer women participated in the endline than in the baseline. It is likely there would be differences in results in cases when socio-economic and demographic characteristics (e.g., age, education level) differ too much between both groups of respondents. A comparison of basic characteristics of the respondents shows that respondents interviewed at baseline were relatively younger. They and their partners were more likely than at endline to be better educated, to be in marital unions, to use contraception, and to be supported financially by husbands/partners. Also, it appeared that a significantly larger proportion of women interviewed at the baseline were Muslim compared to the endline. Respondents interviewed at the endline were more likely to be single and to support themselves with money from their own work.

Because of the differences in backgrounds of the two study populations, multiple regression analysis was done to control for the effect of those factors (age, education, marital status, religion and organizational affiliation) and to see the independent effect of the interventions. Also, the research team decided to conduct an extra cross-sectional analysis to compare people who participated in the interventions with those who did not participate (see footnote 38), using endline data only.

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or STOP AIDS NOW! activities, but were identified as falling under the egis of the local partner or even community based organizations working with a local partner in question.

<sup>39</sup> For the baseline, KEFEADO and 4CS partnered. The two organizations trained their research assistants separately but collected data together in two locations, a church and two youth groups. Endline studies were conducted separately.

## 6.3 Findings

### 6.3.1 Knowledge about HIV and AIDS

The baseline showed that most respondents already had sufficient knowledge of HIV/AIDS. More than 60% of the respondents answered the ten questions correctly. Some questions were even answered correctly by over 90% of the women. For instance, 91% of the women disagreed with the statement 'a person can get infected with HIV by greeting or touching a person living with HIV and/or AIDS' (item 42) and 94% knew that a person can become infected with HIV by sharing syringes or razor blades with a person living with HIV (item 44). Participants from all organizations had similar levels of HIV/AIDS knowledge and attitudes, except for participants from KANCO whose scores were significantly higher.

A comparison of endline data with baseline data shows no significant improvement of HIV/AIDS knowledge and attitudes among respondents. After controlling for organizational affiliation, only WIFIP had significant improvements in HIV/AIDS knowledge and attitudes. Following cross-sectional comparison of endline data no significant change could be found in HIV/AIDS knowledge between women who had attended GDP activities and women who had not. This suggests that the given interventions did not have much impact on the already high knowledge level of the participants.

The FGDs confirmed that knowledge levels in the communities were already relatively high. Although believed to be less informed than boys of the same age, respondents agreed that girls are rapidly increasing their HIV knowledge base. In schools, HIV/AIDS is taught as part of the curriculum, and the information is augmented by AIDS clubs and other peer-led programmes. In addition, information is also passed through the media, targeted talks and IEC materials (flyers, brochures and posters) in churches, health facilities, youth groups, during social events, and at voluntary HIV counselling and testing sites.

According to the participants, girls are more exposed to HIV than boys because their male partners often have several other sexual partners; girls are less educated and therefore less informed about HIV; they are poorer hence more open to sexual abuse by older and richer men; they look after sick family members who are infected; and they are exposed to rape and other forms of sexual violence. It was felt that to be effective, specific programmes should be implemented for and with girls in- and out-of-school, which should also involve boys and parents, where appropriate. The respondents thought it was important to involve parents and improve their communication skills for discussing sexual issues with their children. These skills are currently poor, which may contribute to the vulnerability of girls to HIV infection. Nevertheless, there was also acknowledgement of the fact that married women are vulnerable to HIV infection too. A respondent of YWCAA from Mukuru slums, Nairobi Province, said: *'Even you as a married woman, you are in the house settled [faithful] but your husband goes and meets with a 'dot com' [girl or young woman], sleeps with her and gets it [HIV], how will your staying at home help you? How will you say you can't be infected because you don't move [with men]? You will be infected. And then he will continue infecting other 'dot coms'. Many married women like some of us here live in fear of getting HIV from their husbands.'*

In-depth interviews with partners and other secondary beneficiaries suggest that the GDP positively impacted on HIV/AIDS knowledge and attitudes. Partners of women who participated in the interventions mainly noticed improvements in communication. They said that their wives and girlfriends were more confident and able to speak openly about their problems. Women also shared information about HIV and ways of transmission, and that led to more positive attitudes among the men about people living with HIV. Friends of the GDP participants said that they also noticed their friends had become empowered to talk freely about HIV and sex, without feeling shy or ashamed.

### 6.3.2 Intentional and actual condom use

The majority of women tended to agree with the statements that measure positive condom norms and attitudes. Over half of women interviewed at baseline stated that using condoms would make them feel comfortable or very comfortable, even though a sizeable proportion (about 48%) were either undecided or would feel uncomfortable or very uncomfortable using condoms. Close to 60% felt that encouraging their partners to use condoms would make them feel comfortable or very comfortable. In addition, the majority of women reported that most people important to them would want them to use condoms, and that it is expected of them to use them.

Variables collected to measure *self-efficacy on condom use* (items 34 to 37) included questions about whether participants felt confident to use condoms if they wanted to, whether they thought using a condom was easy and beneficial, and whether the decision to use condoms lies beyond their control. Self-efficacy is, according to the Theory of Planned Behaviour, an important determinant of actual condom use. The higher a person's belief is that he is capable of using a condom, the greater the chance that he will actually use it. The majority of the respondents (74%) at baseline agreed that they would be confident enough to use condoms if they wanted to (item 34), while 7% were undecided. A little over half of the respondents (58%) felt using condoms would be easy for them (item 35), and that using a condom would be beneficial for them (item 36).

Regarding *actual condom use*, respondents were asked how often they had used a condom during sexual intercourse in the past six months. Consistent use of condoms in the six months preceding the baseline survey was mentioned by 23% of the respondents; and 19% reported condom use in nearly all sexual encounters. Some 19% were undecided or rarely used condoms, and 39% reported never having used condoms in any sexual encounter in the six months preceding the survey.

A comparison of endline with baseline findings shows that participants interviewed at endline, on average, scored significantly higher on condom norms and attitudes, and also on self-efficacy. However, there was no significant improvement in condom use frequency. Multiple regression analysis did not find a significant positive association between the interventions and intended and actual condom use, even when the participants who self-reported that they had attended any GDP activities during the implementation period were compared to participants who reported that they had not participated.

After comparing endline results for those who participated in GDP activities and those who did not, it was demonstrated that women who had been exposed to the GDP activities on average scored significantly higher on all condom-related factors, except for actual condom use. Irrespective of participation in the GDP, women in polygamous unions and no start using condoms in the future. With regard to differences between the organizations, women trained by 4Cs, CAI and WSP-K felt significantly better able to use condoms effectively, and they also used more condoms compared to other participants. Women trained by C-MEDA and WIFIP had lower condom use scores than those mentioned before, however they felt more confident in using condoms than women trained by the remaining organizations.

The individual interviews held with secondary beneficiaries—partners, parents or friends of the women and girls who participated in the interventions—show that some, but not all, primary beneficiaries shared their new knowledge with friends and loved ones. Friends' discussions about sexual matters and HIV were more open and detailed than discussions between parents and children. As an example, a friend of a woman trained by KANCO was educated by her on the female condom: *'There was a demonstration about the male condom and then I was curious because I used to hear about the female condom, so she explained to me how it works and how it is used. There are certain myths about the female condom people would share. She clarified all those myths to me.'* n-marital romantic relationships, and women who practiced traditional religions, had slightly higher intentions to use condoms, and felt better able to use condoms. In addition, women under 40 years of age had better condom norms and attitudes, indicating that they may be more likely to

### 6.3.3 Gender-based attitudes, perceptions and beliefs

In general, the baseline showed that respondents tended to disagree with the statements that measure *control in relationships*: 55% of the women denied that their partners were telling them who to spend time with (item 1); and 65% rejected the idea that they should be rather quiet in the company of their partners (item 4). Further, 64% of women believed that they would not be hit by their partners when they act against their partner's wishes (item 6) and 60% disagreed with the statement that it is important to be disciplined (item 8). However, a relatively high percentage of women also tended to agree with some of these statements. For instance, 21% agreed that it is important for the partner to discipline them. Another relatively high percentage (50%) admitted that their partner would not let them wear certain things (item 3), and 61% stated that their partner always wanted to know where they were (item 7).

Regarding who has more say on *decision-making in a relationship* (item 9-13), the majority of the respondents reported that both partners have a say on: what they do together (65%); how often they see one another (55%); whether to use condoms (50%); and whether they have sex or not (51%). In contrast to this, the majority (56%) felt that their partners had more power in their relationship as opposed to themselves alone or both partners together.

Most participants tended to agree with the statements that measure *gender norms*. For example, 68% agreed that a woman's most important role is to take care of her home and cook for her family (item 14); 69% that changing napkins/diapers, bathing and feeding the children are the mother's responsibility (item 15); and 76% agreed that it is important that a father is present in the lives of his children, even if he is no longer with the mother (item 17). Participants tended to disagree with the statements that it is the man who should decide whether to have sex (63%); that a man needs other women (62%); that there are times when a woman deserves to be beaten (68%); and that it is OK for a man to hit his wife if she won't have sex with him (83%). Although a majority (56%) of respondents disagreed with the statement 'a woman should tolerate violence in order to keep her family together', there was still a relatively high percentage of women (39%) who agreed.

A comparison between baseline and endline data shows that in general, there were no significant differences in decision-making, control in relationships and gender norms between women who participated in the baseline and those who participated in the endline. However, after adjusting for organizational affiliation, significant change could be measured among women affiliated to two organizations: first, ACK Eldoret had significant improvements in *decision-making* and second, HSHC—which had improvements in the largest number of factors compared to any other group—had significant improvements in *gender norms*.

In contrast to the limited impact of the interventions suggested by comparison of endline data with baseline data, the cross-sectional analysis of endline data suggests that it is likely that exposure to the interventions has led to significant and positive changes in the field of gender-based norms, perceptions and attitudes. With regard to decision-making, regression analysis shows that younger respondents (under 30 years), women in romantic relationships (as opposed to married women), and women affiliated to ACK Eldoret, HSHC, WIFIP and YWCAA were more likely to have more equal relationships. Women with secondary education and women affiliated to 4Cs and KANCO had significantly higher control scores, indicating that they were better able to exercise power in their relationship. Finally, women under 30 years, who had received higher education and were in romantic relationships, and women affiliated to ACK Eldoret, 4Cs, CAI, KANCO and HSHC had significantly higher gender norms scores.

The findings from the focus group discussions and interviews supplement the findings from the survey. Topics discussed were among others the role division between men, women and children, and decision-making in the family and community. With regard to the latter topic, men were viewed by the FGD participants as key decision-makers at both community and home levels. Women were rarely mentioned as decision-makers in the community. In the home,

women only make decisions in the absence of their spouses, as one woman in the FGD by HSHC expressed: *'The wife makes the decisions when the husband is not there because at that time I am the husband and at the same time the wife.'* Often, male relatives are consulted when the husband is away. However, some participants at endline indicated that a few women are taking leading roles in the family as decision-makers because they have become economically empowered or manage single-parent households. For instance, an FGD participant from Mukuru Nyayo said: *'Mothers are the ones who decide since in this village, most women are single mothers and therefore they are forced to make many decisions.'* A few households are also sharing roles in decision-making concerning their children.

Women and girls who participated both in the interventions and in the FGDs reported improvements following participation in the GDP. Examples are better communication with children and spouses, awareness on their rights and increased financial independence for those women who managed to start their own small businesses. The women in general were satisfied with the topics discussed during the interventions, saying they were very beneficial for them. Some said they learnt a lot about their rights and how they can protect themselves, as one FGD participant from Dunga shared: *'It has been like an eye-opener for us because it has taught us that there are things we need not hide but share with each other.'* Some women said they felt empowered to fight for their rights and were no longer scared. Others said that they now understand that all children are equal and that boys are not superior to girls.

#### **6.3.4 Gender-based violence**

As we have seen in the previous paragraph, over 60% of the women surveyed at baseline stated that they would not be beaten by their partners when they do something their partners do not approve of and that they do not want their partners to discipline them. Even higher percentages of women (68% and 83% respectively) disagreed with the statements that there are times when a woman deserves to be beaten (item 24) and that it is OK for a man to hit his wife if she refuses him sex (item 26). Nevertheless, this leaves up to 40% of women who condone and/or experience domestic violence under certain circumstances. For instance, 39% of respondents agreed with the statement that 'a woman should tolerate violence in order to keep her family together' (item 25). It is important to note, however, that in Kenya, the research project did not measure change in attitudes towards gender-based violence. What follows describes qualitative data collected only at baseline.

The focus groups with primary beneficiaries yielded a wealth of information on the perceptions and practice of violence against women in Kenya. The safety and security of women was one of the main topics for discussion in the Kenyan FGDs. Most participants confirmed there was gender-based violence in their communities, the main problems being rape and wife-beating. Rape (by strangers and persons known to/or related to the woman) was repeatedly mentioned when questions on safety and security in the community were asked. Girls and women of all age groups are exposed to this risk. Rape does not only take place outside the home, as one participant from C-MEDA commented: *'Insecurity also is within our homes because you find that the man who you call your husband is the same person defiling your daughter.'* Most participants felt that the way some girls and women dress is responsible for their rape, as one of them expressed: *'You find that girls and women put on very tight clothes that expose their body and this is the main reason why they are being raped.'* This sentiment was repeated several times by participants from different groups. There was little empathy for survivors of rape, especially when the participants thought the women had contributed to it through dressing 'improperly' or other behaviours. Examples are accepting favours from men or drinking too much in bars. A participant from CAI said: *'Some go and get drunk and then those who bought her alcohol would demand to be paid back.'*

Wife- or girlfriend-beating was another frequently cited example of gender-based violence. A participant in an FGD done by YWCAA, blamed this on economic problems: *'You know, many men are unemployed, and they usually have many children and when they are asked for money by their wives, they don't admit that they don't have it, instead they resort to violence'*

*like wife-beating.*' Participants said it was difficult to identify the causes of domestic violence as most women do not disclose what happened to them and neighbours respect each other's privacy.

Other forms of violence against girls and women cited included forced marriage, female genital mutilation, denying education to girls, improper touching, incest, and widow inheritance. Interestingly, some participants also mentioned homosexuality, masturbation and unfaithfulness by male spouses as forms of gender-based violence. The participants recognized that gender violence also occurs in schools and they shared examples of girls who were raped by their teachers, even in day-schools. Sexual abuse, especially by teachers who take advantage of female students, is also rampant, as are incidences of abuse by fellow-students. Even though in a few cases perpetrators were arrested and sentenced, the participants felt very little or no steps are taken against them in the form of punishment. Some parents who know their child's rapist fail to report due to shame and others have been known to accept bribes in exchange for withdrawing cases against the perpetrators. A respondent from ACK Eldoret said: 'I can say that nothing has been done to the perpetrators of rape because when rape occurs and when they [the rapists] are arrested, they will soon be back home. The case will be thrown away unless the victim's family is well off and that is when justice will be done. But if it's someone poor, the perpetrator will come back because there will be no one to follow-up and see he goes to jail.'

Even though all women were deemed to be at risk of being violated sexually, those most vulnerable were identified as school girls, orphaned children, widows, single mothers, old women, women who abuse alcohol, illiterate women, business women and brewers of local/illicit beverages. Widows and single mothers were particularly cited as the groups most likely to be violated. They are considered easy targets, since in most cases there is no man in the house to scare off a rapist. Business women were also thought to be at greater risk, because they tend to return home late when it is dark, making it easy for criminals to ambush them; many also spend the night in hotels and become easy prey. Those less vulnerable to sexual violence were identified as working women, educated/empowered women, old women, and married women, in the latter case because the presence of a man is presumably providing them security. However, people also recognized that not all married women are out of harm's way since some are being sexually violated by their husbands. Some women were said to be aware of their daughters being molested by their spouses, but are unable to speak up or take any action against them because of fear, shame, or economic dependence.

As for seeking help after a sexual assault, the FGDs made clear that most victims fear coming out to seek help because of shame. Some do not report the incident for fear of being ridiculed by the police. However, some victims do go to the police, tell their family members, female friends or support groups, when available, which help them to get to the hospital where they can be treated, get tested for HIV, etc. Families have differing mechanisms for coping with violence against women and girls, the participants explained. Some families prefer to keep it a secret, others come out and seek treatment and/or legal action against the perpetrators. A KANCO participant from Rongai revealed: '*Some people say it's a family issue; let it remain there and not spread out. I saw one such case that happened but they just left it like that. They did nothing and it was a very small child.*' Domestic violence is considered by many as a private family matter and thus neighbours refrain from getting involved.

Participants shared that some communities have systems in place to fight gender-based violence, for instance traditional courts that punish perpetrators of rape and committees that discuss cases of wife-battering. In areas where support groups have been formed or where there are trained paralegals in the community, they are called upon to counsel and guide the survivors on coping and the process of seeking justice. Finally, communities where women's empowerment NGOs are active rely on these organizations to help the survivors. This role has been greatly appreciated, as one participant from 4Cs stated in an FGD: '*What has been done that has been effective is what you people are doing here today. Non-governmental*

*organizations have brought seminars in this community and they have taught the women on how to take steps (of staying safe).'*

One woman participating in an FGD done by WSP-K thought that the GDP had helped her to fight domestic violence in her own life. *'What we have learnt since the GDP came up... Family quarrels have gone down. Sometimes I was beaten by my husband, perhaps because I had wronged him, but now I know how to relate to him and even handle him... The gender project has also taught us how we can reduce quarrels and confrontations in the house.'* To most women, the key message was that husbands and wives should always discuss openly and agree on family issues.

## **6.4 Summary and conclusions**

The most successful organization in terms of change is HSHC, which had significant improvements in the largest number of factors compared to any other group. In the framework of the GDP the organization educated support group members on property succession planning and business skills, among others. The women who participated in the interventions of HSHC had improved gender norms, condom use norms and attitudes, and higher condom use efficacy.

### **Sufficient knowledge of HIV/AIDS**

The baseline showed that most respondents had sufficient knowledge of HIV/AIDS. A comparison of endline data with baseline data yielded no significant improvement in HIV/AIDS knowledge and attitudes among respondents. Also, the cross-sectional comparison of endline data shows insignificant change in HIV/AIDS knowledge between women who had attended GDP activities and women who had not. This suggests that the given interventions did not have much impact on the already high knowledge level of the participants. One exception is the intervention of WIFIP, which led to significant improvements in HIV/AIDS knowledge and attitudes.

### **Positive condom norms and attitudes but no change in condom use**

A majority of women already had positive condom norms and attitudes and they agreed that they would be confident enough to use condoms if they wanted to, and that using condoms would be easy for them (condom use efficacy). Consistent use of condoms in the six months preceding the baseline survey was mentioned by 23% of the respondents; and 19% reported condom use in nearly all sexual encounters. A comparison of endline data with baseline data shows that respondents at endline, on average, scored significantly higher on condom norms and attitudes, and also on self-efficacy. Some organizations, notably HSHC, C-MEDA, CAI and WSP-K, managed to increase the number of participants with positive condom norms and except for C-MEDA, these organizations also managed to increase condom use efficacy among their participants. After comparing endline results for those who participated in GDP activities and those who did not, it was demonstrated that women who were exposed to the GDP activities on average scored significantly higher on all condom-related factors, except for actual condom use. A number of reasons may lie behind the gap between increased intention to use condoms, and actual use. For example, perhaps the interventions have not been able to empower the women sufficiently to convince their partners to use condoms, perhaps different or longer interventions are needed to stimulate actual condom use, or lack of access to condoms due to low availability and the high price of condoms in Kenya, for example, have hampered actual use.

### **Traditional gender norms and fairly equal relationships**

In general, the baseline showed that respondents tended to disagree with the statements that measure *control in relationships*. Regarding who has more say on decision-making in a relationship, the majority of the respondents reported fairly equal patterns. Most participants also tended to agree with the statements that measure traditional gender norms, except for a few statements with which a large majority disagreed. A comparison between baseline and

endline data shows that in general, there were no significant improvements in decision-making, control in relationships and gender norms between those who ever attended GDP activities and those who did not. However, after adjusting for organizational affiliation, significant change could be measured for women affiliated to two organizations: ACK Eldoret had significant improvements in *decision-making* and HSHC had significant improvements in *gender norms*.

In contrast to the limited impact of the interventions suggested by comparison of endline data with baseline data, the cross-sectional analysis of endline data suggests that overall, it is likely that exposure to the interventions has led to significant and positive changes in the field of decision-making, control in relationships and gender norms and attitudes.

### **High level of acceptance of violence**

With regard to *gender-based violence*, even though a majority of the women surveyed at baseline disagreed with the statements that measure acceptance of violence, still 40% either condoned domestic violence under certain circumstances or acknowledged to have experienced it. The focus groups with primary beneficiaries confirmed that there is gender-based violence in the communities of participants. Rape stood out as a main security concern for all categories of women. Dressing style and alcohol consumption were viewed as contributing to young women's susceptibility to rape, while business women returning home late were also deemed at risk of rape. There was little or no empathy for rape survivors, especially when the participants thought the rape was a consequence of the victim's behaviour. Other forms of violence resulting in insecurity included wife-beating, early marriage of young girls, improper touching by teachers and male fellow-students, and gender discrimination.

As for seeking help after a sexual assault, the FGDs made clear that most victims fear coming out to seek help because of shame or fear of ridicule by the police. Little had been done to improve the security situation of women and girls.

Some communities have systems in place to fight gender-based violence, and in some areas there are support groups for victims and paralegals who can guide victims in the process of seeking justice. Some NGOs have also been educating people on the prevention of gender-based violence. Some participants felt that the violations had gone down since public awareness has increased, and especially because women were more informed and more cases were being reported, investigated and the perpetrators arrested and/or punished. People have become more informed and they are reaching out, and women know how to defend themselves better. This has helped to create more awareness on wife battering.

## 7 Comparison of country reports

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Which patterns arise when the conclusions of both country reports are being compared? First, it is striking that while in Kenya there was little change in HIV/AIDS knowledge levels due to the interventions, in Indonesia, change in knowledge was substantial and remarkable among nearly all organizations. This difference might be explained by the differences in original knowledge levels (at baseline) between both countries. In Kenya, being a medium-prevalence country with a long history of presence of HIV and AIDS in the community and a long-term response to the epidemic, people in general have higher levels of knowledge. After exposure to (yet another) HIV prevention effort, it is likely that people with already good knowledge do not gain many new insights. However, in Indonesia, a low-prevalence country with relatively smaller-scale HIV/AIDS responses, people with lower to moderate knowledge may profit most from the new information offered. The findings also suggest that participants in the GDP, both in Indonesia and in Kenya, are now more open to discuss HIV/AIDS as well as sexual relations.

With regards to condom intentions and use, it is clear that in Kenya the population is more likely to appreciate the role of condoms and make more use of them than in Indonesia. In the latter country, many men and women still consider condoms a family planning tool, or link them to pre- and extramarital sex. Only a few women actually (had) used condoms and there was a lot of doubt about the usefulness and morality of condom use, as well as one's ability to properly use them. Nevertheless, there was an increase in the number of women who expressed their intention to use condoms in the future, suggesting the interventions were relatively capable of making some people more aware of the importance of condom use for HIV prevention. In Kenya, women were less reluctant to use condoms. The majority of them had already positive norms and attitudes and felt that they would be capable of using condoms if they wanted. Even though there was no change in actual condom use, women who participated in the interventions were generally more likely to appreciate and feel confident about condom use than women who did not participate. Again, the differences between Kenya and Indonesia may be explained by the different stage of the Epidemic in both countries and the duration and intensity of HIV prevention efforts.

The beliefs and attitudes of men and women towards gender relations and inequality cannot be easily changed, as these studies show, especially through short-term activities such as the meetings, workshops and trainings that took place in the intervention phase. Nevertheless, some glimmers of hope can be distinguished in the results. First, some Kenyan interventions produced significant change in the field of decision-making, control in relationships, and gender norms and attitudes. To a lesser extent, also some Indonesian interventions may have been capable to do the same: specific ideas and opinions of participants have moved in more equal directions. It is likely that the interventions made some women more aware of the unequal power relations to which they are subjected. Second, the great variety in attitudes towards traditional gender roles as well as the inconsistencies in ideas (ranging from full awareness of gender inequality towards acceptance of the traditional positions) may offer an arena for transformation. There seems to be room for differing opinions, and thus space for change.

With regard to gender-based violence, the majority of participants in both countries rejected violence. Also here, there were inconsistencies in answers: a number of women agreed with several statements regarding acceptance of violence, while they strongly disagreed with other statements regarding rejecting violence. Again, this ambiguity may indicate a space for change.

As could be expected given the large diversity in interventions, strategies and methods used, and the different backgrounds of participants, some organizations were more successful than others. Solidaritas Perempuan and LBK-UB in Indonesia and WIFIP in Kenya seem to be most

effective in increasing the participants' knowledge on HIV/AIDS. Perhaps the type of interventions (a mix of communication methods and dialogues) chosen by Solidaritas Perempuan may explain its relative success. But the background of the participants may also play a role: the former and future migrant workers were relatively young (under the age of 45) and highly educated. The LBK-UB intervention seems to be rather effective in increasing participants' knowledge on HIV/AIDS and their intention to use condoms. With regard to condom use, women participating in the intervention experienced the largest changes in feeling comfortable and morally justified to discuss condom use with their sexual partners, condom use efficacy and the usefulness of condom use for themselves. The interfaith women were predominantly under the age of 35 and all of them had at least secondary education, which might provide an explanation. It is also possible that the type of interventions chosen by both organizations explains the success.

In Kenya, the intervention of HSHC seems to be the most successful in producing change among participants' attitudes toward gender equality and related concepts, support group members (women living with HIV) who learned how to protect their property rights. There was significant change in gender norms, condom use norms and attitudes, and condom use efficacy. Women participating in the interventions of CAI and WSP-K had better condom use norms and attitudes and improved condom use efficacy, and women participating in the interventions of C-MEDA also had better condom use norms and attitude scores, but no change in efficacy. The interventions of ACK Eldoret, a faith-based organization in Kenya, has significantly altered attitudes, behaviours and norms with regard to (power) relations between men and women. Perhaps its transformative approach on gender, HIV/AIDS, violence, female genital mutilation and women's rights was responsible for the success. Finally, Syarikat Indonesia's intervention led to significant positive change in beliefs that justify violence against women.<sup>40</sup> Compared to the baseline, the participants seemed to be more resolute in their rejection of violence after the intervention.

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<sup>40</sup> In Kenya, change in attitudes towards gender-based violence was not calculated.

## 8 Food for thought for future work

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This report and the two research projects it summarizes are only one part of the larger evaluation of the Gender Development Project. In 2010 results assessments were taken on with the participating counterparts to discuss progress and identify challenges and lessons learned, among others. A preliminary review in 2008 already showed that counterparts in general appreciated the GDP's flexibility and its approach. This approach has led organizations to realize the existence of the strong linkages between the three issues of HIV, gender and rights.

As we have seen, the GDP has led to increased knowledge on HIV and AIDS in Indonesia and a moderate increase in the intention to use condoms in both Java and Kenya. Furthermore, some changes can be noticed in the field of gender-based perceptions and norms among the participants of several organizations in both countries. The beliefs and attitudes of men and women towards gender relations and inequality cannot be easily changed in a short intervention period. Norms on how women should behave in relationships, the role imposed on them by tradition and culture, and the balance of power between men and women in relationships and in the community have been ingrained in people since their childhood. Changing these beliefs and ideas perhaps cannot be expected through a short intervention period. Nevertheless, the research studies show that there is space for transformation, given the differing opinions of women on fundamental ideas about the position of men and women in the family and the society. One can expect, therefore, that a longer intervention period (involving the most promising activities) would yield deeper results and change.

As could be expected, the fact that the GDP has used a highly flexible approach, allowing for a large diversity in interventions and strategies and participation of people of different backgrounds, has made it difficult to make decisive statements about what works and what doesn't. Which types of interventions implemented in the GDP are the most promising? Which strategies have been the most successful and why? What is the ideal length of a training? Is it better to have a three-day workshop than a series of meetings, or vice versa? If the latter is the case, how many consecutive meetings will do the trick? What type of trainers or moderators do we need, and what methodology should they use? What types of exercises are helpful? And in what way do background factors such as age, level of education or existing knowledge on HIV/AIDS and gender issues play a role? To be able to answer such questions, interventions need to be carefully studied, described and analysed in order to identify the factors that produced the accomplishments, or prevented them. The purpose of both research projects was to document the state of affairs with regard to gender inequality, violence, HIV/AIDS and condom use (intentions) and to measure change, if any. The researchers were not asked to identify good and promising practices and analyse the exact factors that led to the success. Consequently, the above questions cannot be answered with the data in the reports. An integration of the lessons drawn from the participatory results assessments done in 2010 in all project locations may help provide some answers.

## Appendices

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### 1. Appendix I - ORGANISATIONS PARTICIPATING IN THE RESEARCH JAVA, INDONESIA

**GAYa Nusantara** provides a national framework for contact, communication, information, education and research for and about communities with non-mainstream sexual orientations, i.e. lesbians, gay men, bisexual people and transgender people. In the framework of the GDP, GAYa Nusantara chose to involve female college students and escort girls as their primary beneficiaries. In a five-day meeting, the participants were trained on various issues related to gender and HIV/AIDS. They were divided into two groups: one of college students and one of escort girls. A series of discussions was carried out prior to this training. Of the ten girls that were originally selected to follow this intervention, only six could be included in the endline study, five of them college students and one escort girl. The secondary beneficiaries were defined as members of the community, i.e. friends and relatives of the primary beneficiaries.

**Mitra Wacana** is a women's resource centre that was established in 1996 in Yogyakarta with the aim to document and eliminate domestic violence. Among others, it raises awareness on gender inequality and discrimination of women among the general public and is active in lobbying and advocacy for policy change. In the framework of the GDP, female students in Sleman participated in the intervention, which consisted of a series of five informal meetings. In the first two meetings, the students learned about gender issues, sexual and reproductive health and HIV and AIDS. The third meeting was a three-day youth camp focusing on leadership training as well as issues raised during the previous meetings. During the fourth and fifth meetings, the students were stimulated to reflect on all what they had learned. Sixteen female students participated in the intervention and in the endline research. The secondary beneficiaries were friends and boyfriends of the students.

**Rahima** is a faith-based organization working for women's rights from an Islamic perspective. Twenty-two female teachers aged 20 to 40 working in Islamic boarding schools (*pesantren*) participated in the GDP intervention, a two-day training on gender, HIV/AIDS and sexual and reproductive health from an Islamic perspective. Six of them participated both in the baseline and the endline research. As it turned out to be difficult to find enough teachers to take part in the training and related research, it was decided to loosen the criteria and also allow kindergarten teachers to participate. The secondary beneficiaries were defined as the female students aged 16-20 of the teachers and the colleagues or close friends of the kindergarten teachers.

**Syarikat Indonesia** is a networking organization set up in 1997 to support the victims of the anti-communist conflict in 1965-1967, in which period communists and their families were prosecuted in Indonesia. The relatives of the former members of the communist party are still being discriminated in the country. In the framework of the GDP, a workshop was given in which the primary beneficiaries – women of the affected communities – were briefed on HIV and AIDS and gender equality. The information they received was then turned into *ketoprak* performances, a traditional Javanese art form. The shows, in which a part of the participants performed, were done for the local communities. Community members were thus the secondary beneficiaries. Eleven women participated in both the baseline and the endline study.

**LBK-UB**, the Indonesian acronym of Institute of Human Assistance of the Interfaith Community, was founded by leaders of five religions (Islam, Protestantism, Catholicism, Buddhism and Hinduism) with the aim to promote interfaith dialogue, democracy, educational programmes, community development, and local assistance to communities. For the GDP, female members of the interfaith community were selected, who participated in meetings on

gender issues and HIV/AIDS. Twenty-one young people from various religious groups received a training of trainers to become peer educators on these issues. Due to sampling problems, data from the surveys of only eleven of the twenty-one peer educators could be used for the endline report.

**Solidaritas Perempuan** is working on the islands of Java, Lombok and Sulawesi on gender equality. The organization is currently focusing on the families of migrant workers and prospective migrant workers. In the framework of the GDP, the primary beneficiaries were defined as female former and future migrant workers, who were reached with HIV prevention messages by various communication methods, including radio, IEC (information, communication and education) materials and community dialogue sessions. The intervention consisted among others of a series of seven meetings, once a month, during which topics such as migration, gender, reproductive health and migrant women's vulnerability to HIV infection were discussed. The women came from three villages in Bojonegoro district in Java. Fifteen of them participated in both the baseline and the endline study, so that their responses to the questionnaires could be compared.

## **KENYA**

**Help Self Help Centre (HSHC)** is an NGO working with (female) farmers in Central Province on management of natural resources and economic empowerment. In the framework of the GDP, HSHC educated people on property succession planning. Among others, support group members (women living with HIV) were trained on succession law in Kenya and succession planning – will-writing, inheritance and estate management. Also, women were trained on basic business skills to make them more economically independent. The secondary beneficiaries were men.

**YWCAA** (Young Women Campaigning Against AIDS) is an NGO operating in urban slums in Nairobi City. It is focusing on HIV prevention for youth and young women, especially out-of-school youth and single mothers. For this intervention, the primary beneficiaries were members of young women's groups – single mothers – while the secondary beneficiaries were their male partners/boyfriends. Approaches used were peer education and seminars on HIV/AIDS, gender and greater involvement of people living with HIV, using techniques such as video, role-plays, debates and self-reflection exercises.

**WIFIP** (Women in the Fishing Industry Program) is based in western Kenya, and operates within selected districts of Nyanza and Western provinces. The NGO is undertaking social and economic initiatives for women in the fishing industry through non-formal distance education and development programmes. The main targets for this intervention were women's groups, high school students and out-of-school youth, both male and female. In the framework of the GDP, IEC materials were developed, discussions were held at schools, and thematic/educative games and sports were organized for students, in which a particular theme such as HIV/AIDS or gender-based violence was integrated into the sports activity. Also, uptake of Voluntary Counselling and Testing was promoted.

**C-MEDA** – Community Mobilization for Economic Development and Advancement – is an NGO focusing on health, HIV/AIDS, poverty alleviation, agriculture and education. It is active in the Lake Victoria region and the urban and peri-urban areas of Kisumu. The primary beneficiaries of the GDP intervention were students and women's groups. They were trained on Participatory Education Theatre and developed educational skits, which were enacted at community forums where HIV/AIDS and human rights issues were discussed. In addition, school-based programmes on motivational talks facilitated by successful women were carried out.

**4Cs** (Citizens Coalition for Constitutional Change) is a non-governmental movement in Nyanza Province, which is promoting the development of a new constitutional order in Kenya.

In terms of targets for the intervention, the organization held workshops and conducted FGDs and trainings with the objective of promoting the rights of women to control their sexuality, in order to avoid cultural practices that lead to HIV infection, such as early marriages, coerced sex, rape and widow-cleansing rituals. The two approaches used were: 1) building the capacity of community theatre groups to articulate gender and HIV/AIDS in the context of human rights, and 2) facilitating workshops on HIV/AIDS and gender.

**KEFEADO** (Kenya Female Advisory Organization) is an organization based in Kisumu which main purpose is to promote gender equity, equal opportunity, and human rights. The specific emphasis is on empowering women and their families through innovative rights-based approaches. The GDP activities were implemented in two districts of Nyanza Province, targeting secondary schools. The approach used was to expand the space for communication and information on issues around gender, leadership and HIV/AIDS in the target schools through discussions, role-plays, theatre performances, and cultural analysis and debates. The students (boys and girls) were required to form youth clubs.

**CAI** (Community Aid International) is an NGO working in four provinces across the country. Most CAI programmes are child- and women-centred. The organization targets women groups and high-school girls. The objectives of the intervention were to provide life-skills development training for girls and boys, facilitate gender-sensitive debates and discussions at group and community levels, train women and women's leaders in leadership development, involve more women in gender and governance programmes, and introduce forums in schools to champion girls' rights.

**ACK Eldoret**, part of the Anglican Church of Kenya, is a faith-based organization responsible for the implementation of development programmes in the ACK diocese of Eldoret and Kitale, Rift Valley Province. In the framework of the GDP, the organization targeted women and girls from the congregation through women's and youth groups. The secondary beneficiaries were male partners and/or family members. A transformative approach on gender, HIV/AIDS, violence, female genital mutilation and women's rights was introduced, with young peer educators who were trained on how to use transformative exercises. They also included young men and parents in their programmes. The endline was done with women affiliated to two churches, St. James and St. Peter.

**KANCO** (Kenya AIDS NGO Consortium) is a national network of NGOs, community-based organizations and faith-based organizations involved in HIV/AIDS activities in Kenya. The main targets for this intervention were women and girls, while secondary beneficiaries included male partners and community leaders. KANCO organized a series of monthly debates on gender issues in the RAY youth centres in two regions, Mlolongo and Rongai. Issues discussed included increased vulnerability of women and girls to HIV, gender roles, wife inheritance as a form of gender violence, and human and women's rights. Both men and women participated in the discussions.

**WSP-K (Women's Shadow Parliament)** is an NGO that promotes women's involvement in political decision-making in Kenya. For this intervention, the organization organized FGDs with women and girls in Nyanza Province to promote their awareness and empowerment about sexual rights, and engaged provincial administration authorities and various leaders to discuss issues and practices that undermine women's autonomy, such as the culture of widow inheritance. Also, the media were used, in particular local radio stations that broadcast in various languages, to advocate women's rights. Data collection was done among women's groups and female students of a secondary school.

**2. Appendix II - ENDLINE QUESTIONNAIRE**  
**SECTION 1 – Background questions**

- A. Have you attended any of the gender development project activities?  
Yes  No
- B. Sex Male  → The questionnaire ends here  
Female<sup>41</sup>
- C. Age (in years): \_\_\_\_\_ Date of birth: \_\_\_\_\_
- D. Highest educational Level (completed) Primary  Secondary  University   
Other: \_\_\_\_\_
- E. What is your religion? Muslim  Christian  Traditional   
Other: \_\_\_\_\_
- F. What is your main source of income?  
Support from husband/partner  Support from other relatives   
Money from own work  Social service/welfare   
No income  Other: \_\_\_\_\_
- G. Relationship Status: Married Monogamous  Married Polygamous   
In a relationship  (sexual or romantic) Single  → Go to I  
Other: \_\_\_\_\_
- H. Duration of current relationship or marriage in years and/or months: \_\_\_\_\_
- I. Do you have children: Yes  No
- J. Do you use any form of contraception? Yes  No  (if No, go to L)
- K. If yes, what type of contraception do you use? (If single, go to M)  
Birth control pills  Condoms  Spermicides  IUD   
Injectables  Natural methods  Norplant  Tubal  
Ligation   
Other: \_\_\_\_\_
- L. What is the highest educational your spouse/partner has completed?  
Primary  Secondary  University  Other: \_\_\_\_\_
- M. Did you share any information from gender development activities with anyone?  
Yes  No
- N. If yes, with whom? My Children  Partner/Spouse

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<sup>41</sup> Or living in the social role of a female.

Others:

- O. Did you take part in the interview before the gender development project activities?  
Yes  No

### **SECTION 2 – Relationships**

*Scale: 1=strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree*

- 1 My partner tells me who I can spend time with.
- 2 Most of the time we do what I want.
- 3 My partner won't let me wear certain things.
- 4 When my partner and I are together, I am pretty quiet.
- 5 I have more to say about decisions than my partner does.
- 6 When I do some thing that my partner doesn't approve of, he hits me.
- 7 My partner always wants to know where I am.
- 8 It is important that my partner disciplines me.

*Scale: 1=my partner, 2=both of us, equally, 3=me*

- 9 Who usually has more say about what you do together?
- 10 Who usually has more say about how often you see one another?
- 11 In general, who do you think has more power in your relationship?
- 12 Who usually has more say about whether you use condoms?
- 13 Who usually has more say about whether you have sex?

### **SECTION 3 – Roles of men and women in the domestic and sexual sphere**

*Scale: 1=strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree*

- 14 A woman's most important role is to take care of her home and cook for her family.
- 15 Changing napkins/diapers, bathing, and feeding the children are the mother's responsibility.

- 16 A woman should have the final word about decisions in the home.
- 17 It is important that a father is present in the lives of his children, even if he is no longer with the mother.
- 18 Women who carry condoms on them are easily convinced to have sexual intercourse.
- 19 It is a woman's responsibility to avoid getting pregnant.
- 20 A couple should decide together if they want to have children.
- 21 It is the man who should decide whether to have sex.
- 22 A man needs other women.
- 23 Women need sex more than men do.
- 24 There are times when a woman deserves to be beaten/hit.
- 25 A woman should tolerate violence in order to keep her family together.
- 26 It is OK for a man to beat/hit his wife if she won't have sex with him.

#### **SECTION 4 – Condom use attitudes and beliefs**

- 27 I intend to use a condom when I have sex.  
(1=very likely, 2=likely, 3=undecided, 4=unlikely, 5=very unlikely)
- 28 I think using a condom would make me feel  
(1=very comfortable, 2=comfortable, 3=undecided, 4=uncomfortable, 5=very uncomfortable)
- 29 I think encouraging my sexual partner to use a condom would make me feel  
(1=very comfortable, 2=comfortable, 3=undecided, 4=uncomfortable, 5=very uncomfortable)
- 30 I think using a condom would make me feel  
(1=very good, 2=good, 3=undecided, 4=bad, 5=very bad)
- 31 I think encouraging my sexual partner to use a condom would make me feel  
(1=very good, 2=good, 3=undecided, 4=bad, 5=very bad)
- 32 I think most important people to me would want me to use a condom if I were to have sex.  
(1=very likely, 2=likely, 3=undecided, 4=unlikely, 5=very unlikely)
- 33 It is expected of me that I use a condom.  
(1=strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree)

- 34 I am confident that I could use a condom if I wanted to.  
(1=strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree)
- 35 For me, using a condom is  
(1=very easy, 2=easy, 3=don't know, 4=difficult, 5=very difficult)
- 36 For me, using a condom is  
(1=very beneficial, 2=beneficial, 3=undecided, 4=worthless, 5=very worthless)
- 37 The decision to use a condom is beyond my control.  
(1=strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree)
- 38 In the past six months, approximately how many times did you have sexual intercourse?  
None  If none, go to section 5  
1-5       6-15       16-25       More than 25
- 39 How frequently did you use a condom during sexual intercourse in the past six months?  
(1=always, 2=almost always, 3=undecided, 4=rarely, 5=never)
- 40 In the past six months, did you ever have sexual intercourse without a condom?  
Yes                       No

#### **SECTION 5 – HIV/AIDS knowledge and attitudes**

<i>Scale: 1=disagree, 2=agree, 3=don't know</i>
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- 41 A person can look healthy and yet is infected with HIV
- 42 A person can get infected with HIV by greeting or touching a person living with HIV
- 43 One can get HIV by sharing cups with people who have HIV
- 44 One can get HIV by sharing syringes/ razor blades with people who have HIV
- 45 A pregnant woman can pass on HIV to her unborn baby
- 46 Only prostitutes, homosexuals and people who abuse drugs get HIV
- 47 Keeping in good physical condition can delay progression from HIV to AIDS
- 48 Most people with HIV immediately show signs of being sick
- 49 Condoms reduce the risk of getting HIV
- 50 There is a cure for HIV and/or AIDS