

Interactive Workshops to Promote Gender Equity and Family Planning in Rural Guatemalan Communities

Results of a Field Test

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Acronyms

APAES	Association for HIV Prevention and Support for People Living with HIV
APROFAM	Asociación Pro Bienestar de la Familia de Guatemala
CBD	Community-based distribution
CI	Cognitive interview
ENSMI	Encuesta Nacional de Salud Materno Infantil (National Survey of Maternal and Child Health)
FP	Family Planning
GAFP	Gender Attitudes and Family Planning (Scale)
GEM	Gender Equitable Men (Scale)
IRB	Institutional review board
STI	Sexually transmitted infection
SBCC	Social and behavior change communication
TFR	Total fertility rate

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Executive Summary

This report describes an intervention project to test the hypothesis that the promotion of gender equity in the context of sexual and reproductive health will contribute to gender-equitable attitudes and strengthen the practice of family planning. A short-duration communication intervention by the USAID-funded C-Change project in rural Guatemala was designed to influence inequitable gender norms that constrain the practice of family planning. The study found that the intervention had a significant effect in changing both men's and women's inegalitarian gender attitudes. The effect in strengthening knowledge of contraceptives was also significant and the effect on contraceptive use was suggestive but not statistically significant. This study advances the potential to bring gender and reproductive health interventions to scale, as it tests a model that is short in duration and relatively cheap compared with models that have previously shown promise.

In Guatemala, as in many other countries, inegalitarian gender norms contribute to high fertility, short spacing between pregnancies, and non-use of contraceptives. Women's ability to make decisions about their own reproduction is limited by the fact that men have more decision-making power on issues of family planning and use of services (MSPAS et al. 2008; Netzer and Mesh 2008). Contraceptive use is lowest in rural areas inhabited primarily by indigenous, Mayan populations (ENSMI 2009).

The C-Change project sought to document the impact of a series of interactive workshops for couples, led by trained community-based mobilizers, and designed to alter gender attitudes and increase the use of contraception in Guatemala. Workshop sessions focused on the intersection of gender norms and family planning, gender equality, and healthy sexuality, and used a manual developed by C-Change that incorporated games, role plays, and other exercises.

The interactive, community-based workshops were conducted in 2011–12 in 30 communities in the rural highlands where indigenous people predominate. They were led by educators from the NGO Asociación Pro Bienestar de la Familia de Guatemala (APROFAM), which provides mobile reproductive health services in these communities and works to overcome barriers and increase access to family planning. Another local partner, the Association for HIV Prevention and Support for People Living with HIV (APAES) conducted the baseline and follow-up surveys. Ethical review was provided by the institutional review board (IRB) of the Guatemala Ministry of Health and the IRB of FHI 360.

Communities were randomly assigned to intervention and control groups, and interventions were delayed for the control group. The simultaneous recruitment of participants in the control communities served to minimize selection bias. A total of about 1,200 individuals were recruited for the workshops sessions—up to 40 participants in each session in the 30 communities. Mobile clinics were held in or near the 30 selected sites after the workshops.

Baseline and follow-up surveys were undertaken to measure changes in gender attitudes and contraceptive use, with contraceptive use defined as currently using one of the following methods: the pill, injectables, implants, condoms, spermicides, IUDs, or male or female sterilization. Changes among participants in the intervention group were compared with those among participants in the control group, where changes might be attributed to the Hawthorne effect or to extraneous factors. Gender attitudes were measured using the Gender and Family Planning (GAFP) Scale, which was developed for

this study and a similar one in Tanzania. This scale contains twenty items, three of which are drawn from the Gender Equitable Men (GEM) Scale (Pulerwitz and Barker 2008).

Results

Gender attitudes

In the baseline survey, women in both the intervention and the control groups had considerably higher gender equity scores than men. In the follow-up survey, the scores of both women and men in the intervention group increased. Men's scores registered a more dramatic gain, but remained slightly below the women's scores. In the control group, the men's mean score increased slightly, while the women's dropped by more than one point, to a level slightly below that of the men.

Although the scores of both women and men in the control group started at considerably higher levels than those registered by the intervention group, the follow-up survey scores of women in the intervention group exceeded those of women in the control group, and the scores of men in the intervention group nearly caught up with those of men in the control group.

A test based on a comparison of odds ratios, estimated with a mixed-effect logistic model, was conducted to account for the community-level randomization and repeated measures per participant. The differences in the levels of change in gender equity scores between the two groups are highly significant, both for men and for women. For the two groups of men, the difference reflects a higher rate of increase in the scores of the intervention group. This clearly suggests that the intervention had a positive effect on men's gender attitudes.

The significance of the differences among the two groups of women, however, are mostly due to the fact that the gender equity scores in the control group dropped between the baseline and follow-up surveys. A possible explanation is that the women thought about gender issues during the interval between the two surveys more than men did, and follow-up survey results are more reflective of their true attitudes. The scores for women in the intervention group might have dropped as well, had they not been influenced by the workshops.

Knowledge of modern contraceptives

Results of a similar test, based on a comparison of odds ratios estimated with a mixed effect logistic model, revealed that differences in the levels of change in contraceptive knowledge between the two groups were highly significant, providing strong evidence that the workshops had a substantial effect.

Participants received brochures on family planning methods from workshop facilitators that they appear to have read. They also seem to have become more active in seeking information about family planning. APROFAM reported a surge of interest in learning more about available contraceptive methods in intervention communities during and immediately following the workshops.

Use of modern contraceptives

Baseline levels of modern contraceptive use were moderately high: 54 percent in the intervention group and 56 percent in the control group. In the follow-up survey, these rates increased in both groups, but considerably more in the intervention group—11 percentage points—compared with 4 percentage points in the control group. The analysis excluded women who were pregnant at baseline or follow-up.

It should be noted that these increases in modern contraceptive use occurred over an interval of only 2 to 3 months. The large increase for the intervention group would have been remarkable even if it occurred over a year or more.

When the increase in modern contraceptive use was compared between the groups, the test was not statistically significant. The results suggest that the workshops may have influenced modern contraceptive use, but also that contraceptive use is increasing overall. It is possible that the 7 percentage-point difference in the increase in contraceptive prevalence between the two groups would have been significant had the sample sizes been larger.

Conclusions

The potential for this study to yield positive results was limited by its brief duration and the relatively small size of the sample. Nonetheless, overall findings confirm the hypothesis that the promotion of gender equity in the context of reproductive health will contribute to gender-equitable attitudes and the practice of family planning. The workshops had a significant effect on men's gender attitudes and, arguably, on women's gender attitudes, though the reason for the decline in equity points among women in the control group is open to debate.

While the effect of the interactive workshops on contraceptive use fell short of statistical significance, the effect on knowledge of contraceptive methods was large and statistically significant. The randomized design of the study, the use of phased interventions to minimize selection bias, and the statistical methods that control for the cluster effect all contribute to the robustness of these results.

Given the brevity of the intervention—four workshop sessions per individual over the period of only a month—these results are all the more impressive, as well as potentially scalable. By contrast, the highly successful and inspiring PROMUNDO Program H model for reducing inequitable gender attitudes and HIV risk behaviors among young men, as implemented in Brazil and India, entailed weekly sessions over a period of six months and stipends to ensure continued participation (Barker et al. 2004; Pulerwitz et al. 2006).

There is ample room to further refine this pilot communication intervention for promoting gender equity and family planning, expand it through APROFAM and potentially other organizations in Guatemala, and adapt and test it in other cultural contexts. The results of this study suggest that such efforts would be well worthwhile.

1. Introduction

This report describes an intervention study to test the hypothesis that the promotion of gender equity in the context of reproductive health will contribute to gender-equitable attitudes and strengthen the practice of family planning.

A short-duration intervention by C-Change was designed to influence inequitable gender norms that constrain the practice of family planning. Led by community-based mobilizers, the intervention engaged married couples in interactive workshops that focused on the intersection of gender norms and family planning. The study was endorsed by the Guatemalan Ministry of Health and approved by the institutional review board (IRB) in Guatemala and the IRB of FHI 360. The study found that the intervention had a significant effect in changing both men's and women's inequitable gender attitudes. Its effect in strengthening knowledge of contraceptives was also significant and its effect on contraceptive use was suggestive but not statistically significant.

Background

In many parts of the world, gender norms contribute to high fertility and closely spaced births by discouraging contraceptive use and constraining women from making decisions regarding the timing of their pregnancies and the size of their families. Gender norms also distance men, who have more decision-making power, from reliable family planning information and services.

For example, gender norms influence:

- the number and type of sexual partners that women and men are expected to have
- the situations in which couples are likely to have sex
- who has the power to determine when to have sex
- who decides whether to use condoms and other contraceptive methods
- the role of the violence (or its threat) in forcing women into sex

Increasingly, health and development interventions are designed to achieve the following goals:

1. Mitigate gender inequities and social structures that violate the rights of women and deprive them of opportunities to access resources that contribute to their own welfare and the welfare of their families.
2. Change concepts of masculinity associated with men's use of violence as a means of controlling others.
3. Address gender norms that disadvantage women at various phases in their life cycles.

Few published studies document the impact of communication interventions designed to alter gender attitudes related to health, and no study to date appears to have analyzed the effects of changing gender norms or attitudes on the use of contraception in medium- and low-income countries (Boender et al. 2004; Rottach et al. 2009).

2. Materials and Methods

Problem Statement

Although Guatemala has made significant progress in family planning in recent years, the country lags behind its regional neighbors. There are conspicuous gaps between indigenous and non-indigenous women related to contraceptive prevalence, fertility rates, and unmet need for family planning.

According to the 2008 National Survey of Maternal and Child Health, the fertility rate (TFR) in the country declined from 4.4 children per woman in 2002 to 3.6 in 2008 (MSPAS 2009). In that year, the TFR was 4.5 among indigenous women, compared to just 3.1 among non-indigenous women. That year, the contraceptive prevalence rate was only 40 percent among indigenous women, compared to 63 percent for non-indigenous women, and their unmet need for family planning was 30 percent—twice as high as among non-indigenous women (15 percent). Wide disparities in these indicators are also based on rural and urban residence and level of education.

Family planning programs have targeted the rural Mayan population for decades (Bertrand et al. 2001), but many indigenous people are suspicious of these programs. This is a legacy of the civil war that lasted over three decades (from 1960 to 1996), when 440 villages were annihilated and many indigenous people were killed. Survivors and their descendants have sometimes perceived government-run family planning programs as part of a ladino “plot” to diminish the indigenous population (Ishida et al. 2012).

As in many other countries, inegalitarian gender norms in Guatemala contribute to high fertility, short spacing between pregnancies, and non-use of contraceptives. Women’s ability to make decisions about their own reproduction is limited by the fact that men have more decision-making power on issues of family planning and use of services (MSPAS et al. 2008; Netzer and Mallas 2008).

Article 4 of Guatemala’s Constitution states that all human beings are free and equal in dignity and rights and that men and women, whatever their marital status, have equal opportunities and responsibilities. Notwithstanding, the 2011 Global Gender Gap report ranks Guatemala in position 111 among 134 countries and last among countries in the region with regard to gender equality (Hausman et al. 2011).

Guatemalan women do not have access to the same opportunities as men. The social roles assigned to women are very conventional, placing them at disadvantage when it comes to education and professional development. In addition, Guatemalan women carry a double or triple burden because men often take minimal responsibility for the upbringing and care of children and household chores.

Lack of discussion about gender roles and the social construction of masculinity impede change in attitudes and behaviors that place men and women at high risk for HIV, gender-based violence, and other health problems (WHO 2007).

Study Hypothesis and Objective

The study hypothesis is that the promotion of gender equity in the context of sexual and reproductive health will contribute to gender-equitable attitudes and strengthen the practice of family planning. A minimum level of access to contraceptive methods is required to test this hypothesis. This platform is

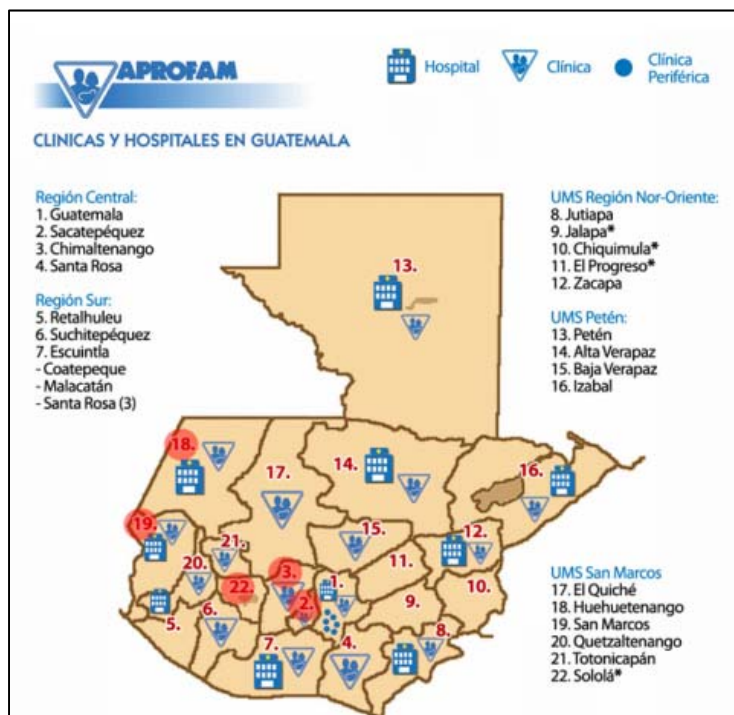
provided by the mobile clinic services and community-based outreach programs of Asociación Pro Bienestar de la Familia de Guatemala (APROFAM).

The objective is to test a strategy for increasing gender-equitable attitudes and promoting the practice of family planning in rural communities in Guatemala through interactive, community-based workshops.

Implementing Partners

The workshops were implemented by APROFAM, which was founded in 1964 to provide quality, integrated, sexual and reproductive health services. Annually, APROFAM's Rural Development Program delivers approximately 5,500 educational sessions on topics such as maternal and child health, family planning, and prevention of sexually transmitted infections (STIs) in hospitals, health centers, markets, cooperatives, and other public places. Personalized and confidential counseling are provided upon request after these talks, and in Mayan languages when appropriate. This program works in coordination with APROFAM's mobile medical units: teams of physicians and nurses who travel across the country to provide temporary and permanent family planning methods and other reproductive health services (Fig 1).

Figure 1. Where APROFAM Works in Guatemala



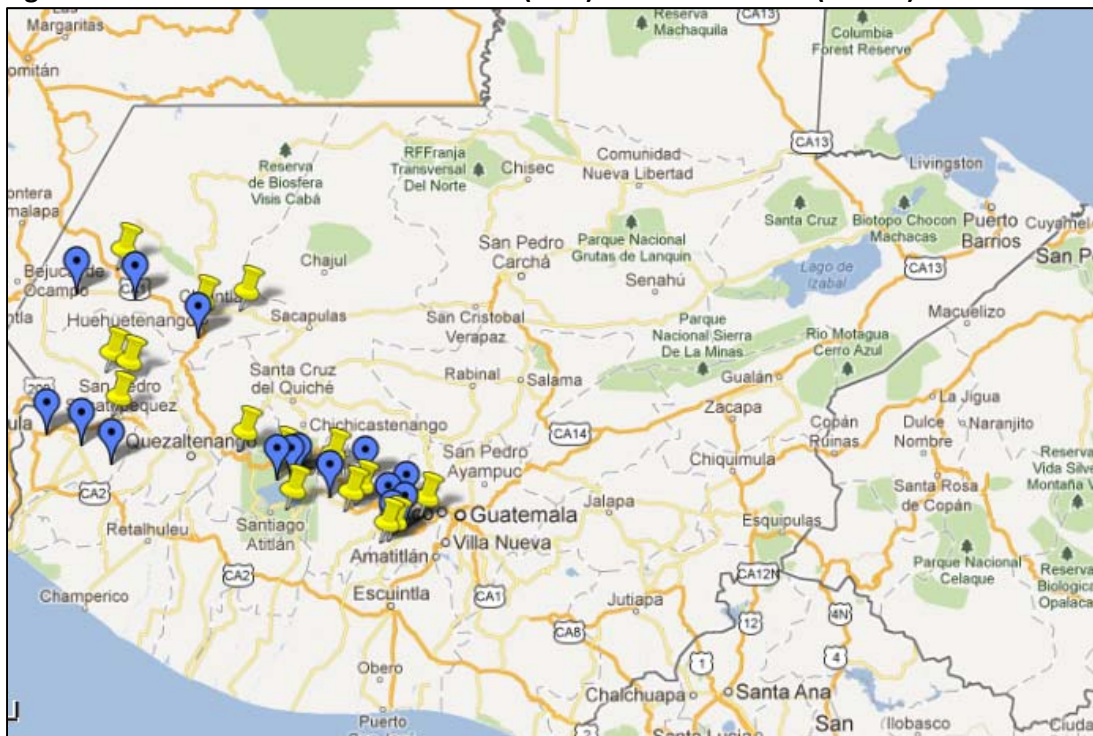
APROFAM's community-based distribution program includes a network of 3,400 female and male *promotores*, 55 educators (both women and men), and four field supervisors. The *promotores* carry out more than 100,000 visits per year in rural areas, providing personalized education and information on the different components of reproductive health, selling condoms and oral contraceptives at nominal prices, and referring pregnant women and children under age 5 to local health centers. They also identify and refer women interested in long-acting methods to mobile clinics.

Another important local partner was the Association for HIV Prevention and Support for People Living with HIV (APAES), which conducted the surveys to measure the effects of the workshops on gender attitudes and knowledge and use of contraception. This nongovernmental, nonprofit, service and humanitarian organization was founded in 1990. It focuses on education in formal and informal settings on prevention of HIV and other STIs, and its conducts research and evaluation.

Setting

The project was fielded in 30 rural communities in the western highlands, in the departments of Sacatepéquez, Chimaltenango, Sololá, Huehuetenango, and San Marcos. Communities were selected from rural areas where APROFAM provides mobile services and trains *promotores* to help overcome barriers and increase access to reproductive health services (Figure 2).

Figure 2. Distribution of Intervention Sites (Blue) and Control Sites (Yellow)



The study included communities speaking Quiché and Kakchiquel, two predominant Mayan languages. In aggregate, the communities had approximately equal numbers of indigenous and non-indigenous inhabitants. The latter were included in the study because they live in the same communities and face similar resource constraints as indigenous inhabitants.

Interventions

The interventions, conducted in March and April of 2012, consisted of a series of six interactive workshop sessions for couples—two for the men only, two for the women only, and two that both sexes attended together. This amounted to four sessions for each participant, held about one week apart. After the workshops, APROFAM mobile clinics were held in or near all 30 selected communities.

Participants were selected by APROFAM staff, based on the following criteria:

- They were known and respected within the community and able to communicate effectively with others.
- They individually agreed to attend, instead of one member of the couple making the decision.
- They lived within the community and had enough time to participate.
- They were married or in civil union.
- The women were between the age of 18 and 40 years. (In practice, some women in their 40s and 50s who expressed interest joined the workshops, as APROFAM staff felt it would be unfair to exclude them.)

The workshop sessions were led by trained facilitators, selected from among APROFAM's educators. Priority was given to those familiar with the communities in question and/or those who spoke the prevalent Mayan dialects.

The facilitators were trained to use a manual that incorporated games, role plays, and other exercises. These were designed to encourage gender-equitable attitudes and interest in family planning, as well as raise awareness of gender inequality and gender issues that function as barriers to family planning. The manual was developed by C-Change staff and consultants in two versions: one in Spanish for Guatemala workshops and an English version for similar workshops in Tanzania. Written materials on family planning methods were also given to workshop participants.

In most of the communities, the workshops were facilitated in Spanish, or a mix of Spanish and the local Mayan dialect. In a few, the facilitator used the Spanish manual but translated everything into the local dialect. Participants helped one another when they could not understand something being said or words written on flip-charts.

The four workshops sessions addressed the following topics:

1. Setting up the stage and exploring the concept of gender
2. Strengthening demand for family planning; encouraging responsible fatherhood (for sessions with men); discussing and negotiating contraceptive use with one's male partner (for sessions with women); and women's roles in initiating contraceptive use
3. Reproductive and sexual rights and effective, non-violent communication between men and women
4. Sexuality and the communication about sex, sexual pleasure, and family planning

An example from session 2 for women follows. The role plays addressing sex, family planning, and fear of pregnancy were designed to strengthen women's ability to negotiate contraceptive use with their partners.

Session 2, Workshop for Women

Ask six volunteers to play the role of three couples, with three women playing a husband or male partner, three women playing the role of a wife or female partner. Ask another volunteer to play the role of a baby of one of the couples. Ask them to take about 10 minutes to create one of the role plays outlined below. They will take turns acting out these role plays in front of the group. After each role play, ask the rest of the group to respond briefly to the discussion questions listed.

Role play 1: The man proposes sex, and but the woman is reluctant because she fears getting pregnant. She tries to convince her partner of the need for contraception. The man does not seem to care or does not have correct information about family planning.

Role play 2: The woman proposes sex, but the man is worried that she might get pregnant. He has no regular employment. He tries to convince her of the need for them to use contraception. She thinks he is not interested in having sex with her because he is having an affair with another woman. She also has a lot of misconceptions about contraception.

Role play 3: The man proposes sex, but the woman says the baby is in the room. He asks why she always wants to sleep with the baby, who is already 3 years old. As he tries to convince her to loosen her skirt, the baby starts crying. The man says he will find another woman to have sex with him. The woman responds by saying it is better if she accepts this, as she does not want him to go to another woman.

Discussion questions

- Is this dialogue realistic?
- Who is in control?
- Does the man seem to care whether his partner gets pregnant?
- Can the woman understand whether he wants her to get pregnant?
- Does the woman seem to care whether she gets pregnant?
- Can the woman understand whether she wants to get pregnant?
- Is there a risk of an unplanned pregnancy?
- Do they have a good relationship?
- What would make this situation better?

Men and women participants were initially shy, particularly in discussions of sexual matters. Facilitators felt that it was important that the initial sessions were held with same-sex groups, where shyness was more easily overcome. Participants commented that they had hardly ever discussed these topics with their partners—only with their friends, if at all. As the sessions unrolled, participants gained confidence and enjoyed the games, role plays, and opportunities to express their opinions. Laughter could be heard throughout the sessions.

A total of about 1,200 individuals were recruited for the workshops sessions—an average of 40 participants in each of the 30 communities. At each session, the mean attendance was 66 percent (395/600), not counting a few people who did not initially register but later asked to join. No one was turned away.

Some participants initially complained about the amount of time required to attend the workshops but, in the end, almost all said they were valuable. Many also stated that they would like to have more such

workshops on a wider range of topics, and that more men and women in their communities should have opportunities to be involved. The participants had many questions about sexuality and contraception, and they probably would have benefited from supplementary sessions focused on dispelling misinformation and answering the questions they had asked most frequently.

Project Design

Communities were randomly assigned to intervention and control groups, stratifying by department. First, APROFAM selected nine communities in each of five departments in the western highlands, based on the availability of an APROFAM educator familiar with the communities and/or speaking the local Mayan dialect who could be trained to facilitate the workshops. In each department, the nine communities were randomly selected into three groups: group 1 (intervention group), group 2, and group 3. There were a total of 15 communities in each of the three groups across the five departments.

Interventions in group 2 communities were delayed so they could serve as control sites. Group 3, where service statistics alone were to have been used to assess change in contraceptive use, was subsequently dropped because of time constraints.

In the remaining two groups, surveys were undertaken to measure changes in gender attitudes among workshop participants, comparing changes among participants in the intervention group with future participants in the control group, where changes might be attributed to the Hawthorne effect or to extraneous factors. The simultaneous recruitment of participants in the control communities was a strategy to minimize selection bias. In this way, participants would not be compared with groups of people who might or might not have been willing to attend the workshops (Table 1.)

Table 1. Project Design

	Intervention Sites	Control Sites
Months 1–3	<ul style="list-style-type: none"> • Facilitator training • Participant recruitment • Participant survey 1 	<ul style="list-style-type: none"> • Participant recruitment • Participant survey 1
Months 4–6	<ul style="list-style-type: none"> • Interactive workshops • Mobile clinics • Participant survey 2 	<ul style="list-style-type: none"> • Participant survey 2 • Mobile clinics
After Month 6		<ul style="list-style-type: none"> • Facilitator training • Interactive workshops

Gender attitudes were measured using the Gender and Family Planning (GAFP) Scale, which was developed for this study and for a similar study in Tanzania. The GAFP Scale (shown in Appendices 1 and 2) contains twenty items, three drawn directly from the Gender Equitable Men (GEM) Scale (Pulerwitz and Barker 2008). The rest of the items were constructed to reflect gender norms that influence family planning in the two countries by C-Change and the local project teams in Guatemala and Tanzania. Only a few items were too country-specific to be used in both settings.

Variables measuring gender attitudes and contraceptive use were compared at baseline and follow-up within each site, and levels of change between sites were then compared.

Data

Baseline and Follow-up Surveys

Surveys were designed to measure changes in gender attitudes among participants. Changes among the intervention group were compared with those in the control group, where such changes might be attributed to the Hawthorne effect or to extraneous factors.

Workshop participants were self-selected. They were recruited in the control group as well as in the intervention group to minimize selection bias. Workshops for the control group were delayed until after the follow-up survey.

Service Statistics

Levels of contraceptive adoption from mobile clinics were analyzed in communities where the workshop participants lived, prior to and following the workshops in the intervention group and during the same time interval before the workshops in the control group.

Cognitive Interviews

Cognitive interviews (CIs) were held with 30 indigenous women and 30 indigenous men between ages 18 and 40 in different sites in the rural highlands to avoid "contaminating" the intervention and control sites. Participants were recruited from two APROFAM clinics (in Chimaltenango and Antigua), an artisan market in Antigua, the national hospital in San Felipe, and two communities served by APROFAM in Solola.

The CIs aimed to explore in greater depth 11 statements used to measure gender attitudes in the baseline and follow-up surveys. These statements were considered most likely to contribute to a deeper understanding of the psychological and cultural context of the responses to survey questions.

The interview guide for the CIs consisted of a series of open-ended questions to be asked after reading each of the 11 attitudinal statements from the structured survey—a different set of questions for each survey statement. These were designed to shed light on how respondents understood the survey statements, as well as to explore thought processes and cultural factors that influenced their responses.

When the CI questionnaire was designed and the interviews conducted, the facilitator's manual had not been completed, and a subset of the gender-attitude indicators for the GAFP Scale had not yet been identified. Items unrelated to the contents of the workshop were discarded when the final GAFP Scale was completed. For that reason, many statements explored in CIs do not correspond to items in the GAFP scale. Nonetheless, CI findings related to all 11 items are summarized because their data may be useful for understanding some of the challenges of measuring gender attitudes, especially cross-culturally.

Recruitment and Training of Survey Interviewers

Survey interviewers with previous experience were recruited, several of whom spoke Quiché and Kakchiquel. A supervisor/editor hired by APAES assisted the coordinator of fieldwork, who led the training of interviewers and supervisors. Data collection instruments were in Spanish, and questions were translated into Mayan languages during this training.

Survey Data Collection and Processing

Before starting work in the communities, the study contacted municipal and auxiliary mayors and regional, district health, departmental, and police authorities, among others. Letters of introduction were provided, along with verbal explanations of the details of the study and the importance of their support. In advance of planned recruitment visits and participant surveys, APROFAM field staff discussed the project with community members and worked to establish interviewing schedules that accommodated people whose work made them unavailable for sessions during a weekday.

The APAES team conducted the baseline survey on the same day that participants were recruited into intervention and control groups, or shortly thereafter. The follow-up survey for the intervention group was conducted soon after the mobile clinics that followed the workshop sessions. The follow-up survey for the control group was conducted between the time the mobile clinics were held and the first day of their workshop sessions.

Survey data were double-entered using Microsoft ACCESS 2007. Comparison and cleaning programs were adapted specifically for this study using STATA 11.0.

Field supervisors were responsible for assuring the quality of the information collected, using the following strategies:

- *Direct supervision:* Using the guidelines described in the supervision manuals, the supervisors directly observed the administration of many interviews. They recorded the information from an interview on a separate survey form for comparison purposes.
- *Review of questionnaires:* At the end of each working day, all questionnaires were reviewed to make sure that their information was well recorded and correctly encoded.
- *Regular meetings with the field team:* These meetings served to monitor the progress of the data collection and modify strategies, as needed, to overcome the difficulty of locating respondents for follow-up surveys.
- *Editing:* All questionnaires were reviewed by field editors, who identified missing data, inadequate records, and improperly followed skip patterns.

Analysis of Survey Data

Statements reflecting norms and practices related to sexuality and family planning that were either equitable or inequitable were read to participants, who were asked whether they agreed, partially agreed, or disagreed with each statement. One point was given for each response that indicated an equitable attitude (as opposed to an inequitable or partially equitable attitude).

After all responses were tallied, points were summed to create a continuous gender equity score for each individual, at baseline and at follow-up. The individuals accumulating the greatest number of points were those who expressed the most gender-equitable attitudes.

SPSS v.21 and SAS v.9.3 were used to analyze the survey data. Variables measuring gender attitudes and contraceptive use were compared within each intervention and control site and levels of change were compared between the two surveys. First, bivariate statistical analyses were conducted. In the

multivariate analyses, the tests of significance were based on a comparison of odds ratios, estimated with a mixed effect logistic model to account for the community-level randomization and the repeated measures per participant.

Analysis of Service Statistics

In intervention sites, the study counted the number of contraceptive adopters at mobile clinics after the intervention and compared it with the number of adopters at these mobile clinics in the period 12 months prior to the intervention. In the control sites, data from the same time periods were analyzed.

Analysis of Cognitive Interviews

Each CI was assessed separately. Details illuminating the way each of the 11 statements was understood were noted, along with anything respondents said that contradicted or qualified their initial responses—agree/disagree/partially agree—when replying to follow-up questions. Other contextual details were noted that might explain what a respondent had in mind when responding to the initial statement.

Information related to each of the 11 statements was then consolidated and compared to identify patterns, and differences were noted in information provided by women and men.

3. Results

Survey Coverage

A total of 1122 interviews were completed in the baseline survey, and 603 individuals were re-interviewed for the follow-up survey. To qualify for the follow-up survey in the intervention sites, the potential respondent had to have been interviewed in the baseline survey and participated in at least one of the workshops. Using these criteria, it was possible to re-interview 55.4 percent (328) of the baseline sample.

Among those not interviewed, 10 percent had participated in the workshops but either refused a second interview or were not available for re-interview, and 35 percent did not participate in any of the workshops. In the control group, where workshops had not yet been held, 59 percent (275) of the baseline sample were re-interviewed in the follow-up survey.

Characteristics of the Survey Sample

The intervention group was slightly older, somewhat less educated, and had more children than the control group. All of these differences were statistically significant (Table 2).

Table 2. Selected Characteristics of Survey Participants at Baseline, by Group

Characteristic	Intervention Group (n=328)	Control Group (n=275)
Mean age***	30.7	28.6
Age groups*		
Less than age 20	(12) 3.7%	(14) 5.1%
Ages 20-24	(65) 19.8%	(74) 26.9%
Ages 25-34	(151) 46.0%	(132) 48.0%
Ages 35-44	(85) 25.9%	(49) 17.8%
Older than 44	(15) 4.6%	(6) 2.2%

Characteristic	Intervention Group (n=328)	Control Group (n=275)
Female	(187) 57.0%	(149) 54.2%
Male	(141) 43.0%	(126) 45.8%
Catholic	(165) 50.3%	(157) 57.1%
Evangelical	(126) 38.4	(84) 30.5%
Other	(37) 11.3%	(34) 12.4%
Mean # of years of schooling**	5.4	6.3
None	(51) 15.5%	(32) 11.6%
Primary (partial or complete)	(180) 54.9%	(132) 48.0%
Partial secondary	(51) 15.5%	(66) 24.0%
Complete secondary or some university	(46) 14.0%	(45) 16.4%
Not indigenous ethnic group	(148) 45.1%	(132) 48.0%
Indigenous ethnic group	(180) 54.9%	(143) 52.0%
Mean number of children***	3.1	2.2
Number of living children***		
None	(18) 5.5%	(9) 3.3%
One	(74) 22.6%	(91) 33.1%
Two	(58) 17.7%	(86) 31.3%
Three or more	(178) 54.3%	(89) 32.4%

Level of significance: * $p < .05$; ** $p < .01$; * $p < .001$**

The mean age of participants in the intervention group was 31 and was 29 in the control group. On average, men were two years older than the women.

Slightly more than half the respondents in the intervention group and just under one third among the control group reported that they had three or more living children. The average number of living children per couple in the intervention group was 3.1 and 2.2 in the control group. In addition, 10.1 percent of the women in the intervention group and 9.6 percent in the control group were pregnant. This difference is not statistically significant.

A little over 50 percent of the respondents in the intervention group and 57 percent of those in the control group were Catholic; 38 percent and 31 percent, respectively, were Evangelical. The remainder said they did not attend a particular church, with no significant differences between groups.

Slightly over half of the participants in both groups considered themselves to be indigenous (Mayan). Spanish was as predominant as native languages, spoken by 55 percent of the participants. Kakchiquel and Quiché were the respective languages of 15 percent and 12 percent, with no statistically significant differences between the two groups.

Gender Equity Scores

In the baseline survey, women in both the intervention group and the control group had considerably higher gender equity scores than men. In addition, men and women in the control group had significantly higher scores than their counterparts in the intervention group.

In the follow-up survey, the scores of both women and men in the intervention group increased. Men's scores registered a more dramatic gain, though these remained slightly below the women's. In the

control group, men's mean score increased slightly, while women's mean score dropped by more than one point, to a level slightly below that of the men.

Although the scores of both women and men in the control group started at considerably higher levels than scores registered by the intervention group, the follow-up survey scores of women in the intervention group exceeded those of women in the control group, and the scores of men in the intervention group nearly caught up with those in the control group (Table 3).

Table 3. Mean Scores on the GAFP Scale

Mean Score	Intervention Group				Control Group			
	Baseline		Follow-up		Baseline		Follow-up	
	Women	Men	Women	Men	Women	Men	Women	Men
Mean Score	14.7	13.5	14.9	14.6	15.3	14.7	14.5	14.7
Total (n)	(187)	(141)	(187)	(141)	(149)	(126)	(149)	(126)

Note: The lowest possible value on the scale is 0 and the highest possible value is 20.

The tables in Appendix 1 and Appendix 2 show considerable variation between baseline and follow-up scores was seen within the 20 individual components of the GAFP Scale. The control group showed a greater level of positive change on some variables; the intervention group showed greater positive change on others; and scores went down for some items.

Differences in the level of change—positive and negative “equity points”—were calculated by subtracting the mean scores of the control group from those of the intervention group. Negative numbers indicated that the intervention group had fewer equity points than the control group or that control group scores dropped by fewer points than the intervention group between baseline and follow up. Positive numbers show gains in equity points for the intervention group, relative to the control group.

While there was no item on which women or men in the control group gained 10 or more equity points relative to the intervention group, this was not true of men and women in the intervention group. For women in the intervention group, the greatest comparative gain in equity points was 26.5 points, for the statement: “You don’t talk about sex, you just do it.” If this gain was due to the intervention, sessions on couple communication could have had an impact. The second largest gain for women in the intervention group (11.6 points) was on the statement: “It is a man's responsibility to make sure his wife will not get pregnant if she does not want to.” These responses may have been influenced by sessions dealing with women’s rights and men’s responsibilities.

The next largest gain for women in the intervention group was on two statements addressing men’s and women’s roles in decision-making relating to fertility and contraception (10.8 points and 10.6 points). This theme was woven through several of workshop sessions. Close behind in gain (10.5 points) was the statement: “If your church says you should use only natural family planning methods, you should follow that,” an item reflecting the often patriarchal nature of the church in Guatemala. It is worth noting, however, that role of the church was not specifically referenced in workshop sessions, which emphasized personal responsibility and the benefits of family planning.

The greatest gains among men in the intervention group were on statements on mutual decision-making (23.3 points); contraceptive use and sexual pleasure (21.8 points and 18.8 points); and men’s responsibility to use condoms if a partner experiences side effects from contraceptive methods (14.5 points). The next largest gain was on the statement about following church teachings on the use of contraception (10.5 points).

Table 4 shows results of a test comparing odds ratios estimated with a mixed effect logistic model, adjusting for community-level randomization and repeated measures per participant.

Table 4. Mixed Linear Model Estimates of Intervention Effect on Equity Scores

Women (n=334)	Estimates	95% CI	P-value
Intervention group: Follow up–baseline	0.18	[-0.22,0.58]	0.370
Control group: Follow up–baseline	-0.79	[-1.23,-0.34]	0.001
Difference in difference	0.96	[0.36,1.57]	0.003
Men (n=267)	Estimates	95% CI	P-value
Intervention group: Follow up–baseline	1.10	[0.64,1.56]	<0.001
Control group: Follow up–baseline	0.00	[-0.49,0.49]	1.000
Difference in difference	1.10	[0.43,1.77]	0.002

The differences in the levels of change in gender equity scores between the two groups are highly significant, both for men and for women. For the two groups of men, the difference reflects a higher rate of increase in the scores of the intervention group. This clearly suggests that the intervention had a positive effect on men’s gender attitudes. The significance of the differences among the two groups of women, however, are mostly due to the fact that the gender equity scores in the control group dropped between the baseline and follow-up surveys.

A possible explanation is that the women thought about gender issues during the interval between the two surveys more than the men did, and the follow-up survey results are more reflective of their true attitudes. The scores for women in the intervention group did not drop—in fact, they rose slightly, arguably because their attitudes were influenced by their participation in the interactive workshops.

Cognitive Interview Results

CI data provided further insight into some of the indicators used in the baseline and follow-up surveys to measure gender attitudes. Interviews and follow-up discussions explored 11 survey items from a draft of the GAFF Scale, seven of which were also in the GEM Scale (Pulerwitz and Barker 2008).

CI findings illuminate various ways that survey respondents may have understood survey questions on gender attitudes and the reasoning behind their answers. The findings also highlight some of the differences between women’s and men’s perspectives on statements on gender norms in the GAFF and GEM scales.

However, in 76 cases out of 660 (60 respondents, 11 items), respondents either did not give a clear response to the statement or appeared to change their answer in the course of the follow-up discussions. In most cases where responses changed (32/55), participants reassessed the initial statement and understood it differently. The rest of the cases (23/55) involved initial misunderstandings of the initial statement.

Statements discussed in CIs and included in the final GAFP scale follow. (They are numbered and italicized.)

Role in the Family

1. *“A man should have the final word about decisions in his home.”* (GEM)

Women in the CI sample were about evenly split between agreeing and disagreeing with this statement. In contrast to survey findings, men’s attitudes expressed in CIs seemed more equitable, with about two-thirds disagreeing.

A large majority of the women appeared to understand this statement as implying that men should be the sole (not just the final) decision-makers and women’s opinions need not be taken into consideration at all. If all women had all understood the more moderate version of the statement, more women might have agreed with it.

This did not appear to be an issue among the men interviewed, but some who disagreed with the statement went on to say that the woman should have the final say only in matters related to housework or when the husband was not present. If the statement had been worded to convey decisions that are significant, men’s attitudes might have seemed less equitable.

When a follow-up question asked what it would be like if men and women made decisions together, both women and men indicated that this would be beneficial for couples. These results suggest that attitudes of men and women about decision-making roles elicited by the GEM/GAFP statements may seem somewhat less egalitarian than they are in reality. Both sexes endorsed the idea of mutual decision-making in principle, when asked directly.

Eleven respondents (six women and five men) changed their initial answers to this seemingly simple and straightforward statement in the course of the follow-up questions. The frequency with which initial answers were contradicted or changed was the second highest among the 11 statements discussed with CI participants. This may reflect respondents’ discomfort with the initial question, which did not give them a chance to directly state a preference for egalitarian decision-making.

Intimate Partner Violence

2. *“There are times when a woman deserves to be beaten.”* (GEM)

All but one woman and all men in the CI sample initially disagreed with this statement. During the discussion that followed, one woman agreed with it and three other women partially agreed with it. Several women indicated that if a woman spent too much time *“en la calle”* (on the street) they might provoke the husband to violence because he would suspect infidelity. About half of the women said that elderly people believed that there were times a woman deserved to be beaten. Many of the women said that men did not have the right to beat women and described intimate partner violence as a crime.

Although none of the men in the CI sample admitted to condoning intimate partner violence, quite a few spoke about the high prevalence of machismo in their society and said that intimate partner violence was not uncommon. None of these men admitted to having *machista* attitudes themselves. Many seemed to interpret the attitudinal statement as a question about their own behavior and

assumed that the interviewer disapproved of intimate partner violence. This may have inflated the number who said they disagreed with intimate partner violence.

Similarly, there may be somewhat more acceptance of intimate partner violence by women than was implied by their initial responses to the GEM statement. Alternatively, these women and men may have been portraying their own attitudes accurately but over-estimating the level of acceptance of intimate partner violence in the society.

3. *“A man can hit his wife if she refuses to have sex with him.”* (GEM)

All but one of the women and all of the men disagreed with this statement. As with statement 2 (above), about a third of the women and a sixth of the men later said that this often happened, and several mentioned cases they were familiar with or had heard about. Among 27 women, 11 said that elderly people (or “some” elderly people) would condone such violence.

Again, these results imply more acceptance of this form of intimate partner violence than indicated by the initial responses. Alternatively, the CI samples may have been unusually equitable in their gender attitudes compared with others in their society, or they may perceive a greater acceptance of intimate partner violence in their society than actually exists. In any case, interviewees indicated that they are aware that it is considered to be wrong and chose to represent themselves as condemning intimate partner violence.

4. *“A woman should tolerate her partner’s violence to keep her family together.”* (GEM)

Five of the men initially agreed with the statement, but this number dropped to four after some discussion. About a third of the women in the CI sample said they agreed or partially agreed. Upon further discussion, two women disagreed.

Four women in the sample stated outright that they had been victims of intimate partner violence, and three of them said they had managed to put a stop to it. The fourth said she had left her husband. A few women said that economic dependence causes women to tolerate intimate partner violence, and several also said that fear kept women from talking about it to others. Psychological and emotional violence were often mentioned. More than half the women said an abused woman should report the man to the police or other authorities.

All in all, this statement appears to have functioned relatively well in eliciting gender attitudes related to intimate partner violence and women’s ability to resist it. It may have been able to do this better than statements 2 and 3; here intimate partner violence is presented as a given and the focus of the question is on what the woman should do.

Sexual Double Standards

5. *“A man needs other women, even if things are going well between him and his partner.”* (GEM)

Women and men in the CI samples overwhelmingly disagreed with this statement—27 of 30 women and 28 of 30 men. Views expressed upon subsequent questioning were relatively consistent with these initial answers. However, about half of the women thought other women believed this to be the case. Many women also said that men thought so, and about half said elderly people thought so.

Half of the women also said that women sometimes think they need more than one man. Several added that this was not necessarily motivated by the need for sex; rather, they thought it was motivated by women's need for more affection or more money than their partners provided.

Most of the men disagreed with the initial statement, but appeared to be referring to themselves, rather than men in general. Many men later made statements indicating that other men did think they needed more than one woman. Consistent with the women's responses, more than half of the men said that some women needed more than one man; two said this was for economic support.

Many of the initial responses may have been intended to conceal a tendency to accept infidelity. It is also possible that the CI sample disproportionately represented people with more egalitarian attitudes and belief in fidelity. While the statement was intended to investigate the endorsement of a sexual double standard, the surprising implication of the CIs was that both men and women are seen as needing multiple partners.

6. "When a man is working away from home and has had sex with another woman, his partner should accept this situation."

Almost all of the women and men in the CI sample disagreed with this statement, even after further discussion. Three men misunderstood the statement or said they were unable to answer.

The most common reasons women gave for disagreeing were risk of STI infection and loss of respect. Asked what alternatives the woman had, most women said she should talk to her husband and tell him this was not acceptable. Only about a quarter of the women said she should leave him.

None of the women said that a man should accept it if the situation were reversed. Their remarks during the discussion suggested that this was even less forgivable than a man cheating on a woman.

Many of the men reportedly "looked astonished" when asked why the woman should not accept her husband's infidelity in such a situation. Most simply responded that this behavior was incorrect or not acceptable, and they felt the same way about female infidelity.

Unlike the women, most men said that the woman's best alternative was to divorce her husband. This difference probably reflects women's more pragmatic orientation in visualizing the pros and cons of the alternatives.

Responses to follow-up question about alternatives clarified that most women respondents were of the opinion that such a situation is unacceptable or morally wrong, but that women faced with it may not have good alternatives and may need to accept it in the end.

Although there was little variation in either women's or men's responses to the initial statement, it seems to have been relatively effective in eliciting gender attitudes. The missing piece is whether respondents think that the woman in such a situation ultimately has much choice. Although the statement appears to have been well understood, this survey question provides an incomplete picture of women's tolerance of gender inequity.

Sexuality

7. *“You don’t talk about sex, you just do it.” (GEM)*

People in the CI samples interpreted this statement in two different ways. Sizeable minorities—8 out of 26 women and 11 out of 29 men—took the statement to refer to what should happen: people should not talk about sex and should just have it. In these terms, three-quarters of the women and all of the men disagreed with the statement.

The rest of the respondents understood it as a statement of what people usually did. In these terms, less than a quarter of the women and a third of the men disagreed with it. Respondents who understood the statement in this way could have been projecting what they themselves do on others, not knowing what others do, or they could have formed impressions by talking with others.

These results are consistent with the finding that CI participants tended to view themselves as more equitable than others in their attitudes and behavior or wanted to present themselves as such. They tended to explain others’ failure to talk about sex as a function of shyness or fear of shame or embarrassment.

Several women said that it was inappropriate for a woman to talk about sex or that doing so would cause her partner to question her fidelity. Most of the men who appeared to be in favor of talking about sex indicated later that they favored nonverbal communication, not actual talking.

The ambiguities in this statement and the way it was interpreted by CI participants suggest that it is an inadequate tool for eliciting gender attitudes in Guatemala. In the follow-up survey, men's scores in both the intervention and control groups declined, while women’s scores rose slightly in the intervention group and dropped precipitously in the control group.

Family Planning and Contraception

8. *“The use of contraception allows a woman to have more than one partner.”*

This statement elicited a wide range of interpretations and rationales for agreeing or disagreeing, even more so than statement 7. Some women and many of the men interpreted it to mean that using contraception gave a woman permission to have more than one partner. Others understood it in the way intended: that contraception facilitates having more than one partner.

Distinct ways of thinking motivated the responses given by women who said they disagreed with the statement. Six said they did not believe that use of contraception gave a woman the right or permission to have more than one partner. Five said that women’s use of contraception was not predicated on having more than one partner. Four said they did not agree with contraceptive use. Two saw the statement as implying that the woman was using contraception without her husband’s knowledge, rather than as a joint decision of the couple. One woman disagreed with the statement because it seemed to imply that contraception increased sexual desire.

Three men who said they agreed with the statement saw having more than one partner as the main reason that women used contraception, but six did not see this as the main reason. This means that agreement and disagreement with the statement came from some people who had essentially the same

attitudes. It therefore does not adequately measure gender attitudes related to family planning in Guatemala.

9. *“Men should get angry if their wives ask them to use a condom.”* (GEM)

A large proportion of the women in the CI sample misunderstood the statement, which aimed to elicit opinions on whether a husband would be justified in getting angry if his wife asked him to use a condom. Several participants thought they were being asked whether they agreed or disagreed that a husband would become angry if his wife made this request. Others seemed to base their agreement or disagreement with the statement on other aspects of condom use, such as whether women like to use them or the desirability of joint decision-making.

In follow-up discussions, six women said making this request might cause a husband to assume that his wife was having an affair or that she suspected him of having an affair. When asked whether a husband would be angry if his wife asked him to use a condom, more than two-thirds of the women said he would be. When asked if this anger would be justified, half the women said yes. Initially, 11 of 25 of them had agreed or partially agreed with the statement.

Follow-up discussions also revealed that 16 of 27 men interpreted the statement in the way originally intended, and about two-thirds of this group disagreed with it. The remaining 11 men took the statement to mean that a man should use a condom when asked to do so by his wife. All but two disagreed when this interpretation was applied to the statement, arguing that condom use was unnecessary as well as a sign of infidelity.

Men who disagreed with this interpretation appeared to have the same attitude as those who understood and agreed with the intended interpretations. This suggests that the statement is unlikely to be a good indicator for use in future surveys to measure attitudes regarding gender and family planning in Guatemala.

It may be worth noting that the wording of this statement from the GEM Scale varied in some countries. Personalized versions for men and women used in some countries appeared in the study’s baseline and follow-up surveys: “I would be angry if my wife asked me to use a condom,” and “My husband would justifiably be angry if I asked him to use a condom.” At follow-up, men’s scores rose by several points in both the intervention and control groups, while women’s scores changed only marginally in both groups.

10. *“It is equally the responsibility of a woman and her partner to avoid getting pregnant.”*

All of the women in the CIs seemed to interpret this statement as intended, though two changed their answers after further thought. Among them, three initially disagreed with the statement and 27 agreed with it.

Four of the men in CIs either did not understand the statement as intended or did not have a clear position on the issue; they failed to provide coherent answers, including during follow-up discussions. Among the 26 men who understood the statement, 24 agreed with it—about the same proportions as the women.

In responding to a follow-up question on who had more power to decide whether a woman would get pregnant, slightly more than a third of the women and more than half the men said that both the woman and the man had the power to decide. Among those stating otherwise, more women said that the woman had the power to decide, and more men said that the man did. Similarly, more women said the woman had more ability to prevent a pregnancy, and more men said the man did.

Significant minorities of both men and women said their responses to the statement would differ if the man and woman were not in a long-term relationship. If the man and woman were single, some thought the responsibility should fall upon the woman, while others thought it should fall on the man. These results suggest that this type of statement would be better used to measure gender attitudes of women than of men and that responses would be more meaningful if the statement specified the relationship status of the couple. Given the variety of perspectives elicited by follow-up questions, variations on the initial statement appear to be needed.

In the follow-up survey, men's equity scores rose considerably in the intervention group and dropped considerably in the control group, while the scores in both groups of women dropped considerably. The most plausible explanation is that attitudes were rethought between the two surveys and workshops had different influences on the thinking of men versus women in the intervention group. It is possible that men in the intervention group began to think they should be more cautious about the possibility of pregnancy, whereas women may have remembered having had sex when hoping for a pregnancy.

11. "Sex is more exciting without contraceptives because the woman may get pregnant."

This statement generated considerable variation in responses—as many agreed as disagreed. Its wording apparently misled respondents initially, since a large number—seven women and five men—contradicted or changed their answers in the course of follow-up discussions.

Among the men who understood the statement as intended, the proportions agreeing and disagreeing were about the same. In contrast, half of the men seemingly did not pay attention to the words “because the woman may get pregnant,” and seemed to think they were being asked if sex was better without condoms.

Three women gave no initial response to the statement. Among those who did, five did not seem to have understood it as intended. A few women who understood and agreed with the statement later qualified their initial response by saying that sex was more exciting if the couple was trying to get pregnant.

When asked if there was ever a situation in which sex was more exciting with contraceptives, about a half the women but only a quarter of the men said yes. Most of the women (20/22) said that sex was more exciting for men without contraceptives. Almost as many men (18/22) said this was true for women.

This suggests that both women and men may choose to forgo contraceptive use because they believe their partners prefer to do so, though they themselves would prefer to have sex with contraception—a potentially important point to keep in mind in designing communication campaigns. The statement has considerable potential to shed light on gender attitudes and norms if used as part of a series of

questions that convey its intended meaning and nuances of the attitudes and norms explored. In any case, this item may be a better indicator of gender equity when used with men than with women, and where an “agree” response does not necessarily correspond to a gender inequitable attitude.

4. Impact on Knowledge and Adoption of Modern Contraceptive Methods

Knowledge of Modern Contraceptive Methods

Only about one-third of the men and two-thirds of the women in the intervention and control groups at baseline knew of five or more modern contraceptive methods. Differences in baseline knowledge between the groups were not significant.

Levels of knowledge of modern contraceptive methods increased among both women and men in both groups in the follow-up survey, perhaps in part reflecting a Hawthorne effect (i.e., some respondents may have learned the names of contraceptive methods from the survey itself), but increases in the intervention group were considerably greater than those in the control group.

From baseline to follow-up, the increase in the proportion of the intervention group who knew five or more modern contraceptive methods was 23 percentage points for women and 36 percentage points for men—more than double the baseline levels. Increases in the control group were 10 and six percentage points, respectively, for women and men (Table 5).

Table 5. Changes in Knowledge of Modern Contraceptive Methods, by Group and Gender

FP Knowledge	Intervention Group				Control Group			
	Baseline		Follow up		Baseline		Follow up	
	Women	Men	Women	Men	Women	Men	Women	Men
Knows less than 5 modern methods	35.3%	66.0%	12.3%	29.8%	32.9%	65.1%	23.5%	58.7%
Knows 5 or more modern methods	64.7%	34.0%	87.7%	70.2%	67.1%	34.9%	76.5%	41.3%
Total (n)	(n=187)	(n=141)	(n=187)	(n=141)	(n=149)	(n=126)	(n=149)	(n=126)

These findings suggest a substantial effect of the intervention: differences between the intervention and control groups relating to increased contraceptive knowledge were statistically significant at the $p < .01$ level for women and the $p < .001$ level for men.

Table 6 shows the results of a test, based on a comparison of odds ratios estimated with a mixed effect logistic model, to account for the community level randomization and the repeated measures per participant. The differences in the levels of change in contraceptive knowledge between the two groups are highly significant, providing more strong evidence that the intervention has had a substantial effect.

Table 6. Mixed Logistic Model Estimates of Intervention Effect on Family Planning Knowledge (n=601)

	OR	95% CI	P-value
Intervention group: Follow up—baseline	4.63	[3.12,6.87]	<0.001
Control group: Follow up—baseline	1.47	[1.00,2.15]	0.051
Difference in difference	3.16	[1.82,5.48]	<0.001

One factor explaining the increase in family planning knowledge in the intervention group is that the participants were given a brochure explaining the different contraceptive methods available. And during and immediately following the workshops, APROFAM *promotores* reported a surge of interest in learning more about available contraceptive methods by participants in intervention communities. It thus appears that participants were interested enough to read the brochures, and also became more active in seeking FP information.

Service Statistics on Contraceptive Adoption

Monthly data on services provided by mobile clinics from February 2011 to May 2012 were collected at intervention and at control sites to support an assessment of whether greater knowledge of contraceptive methods led to increased adoption by the intervention group, compared to the control group. These data were separated by group, then summed by each product or service and month. Charts were plotted to ascertain how the number of services provided or products distributed differed between control and intervention sites (Figs. 3 and 4).

Figure 3. Service Statistics from Mobile Clinics for the Control Group

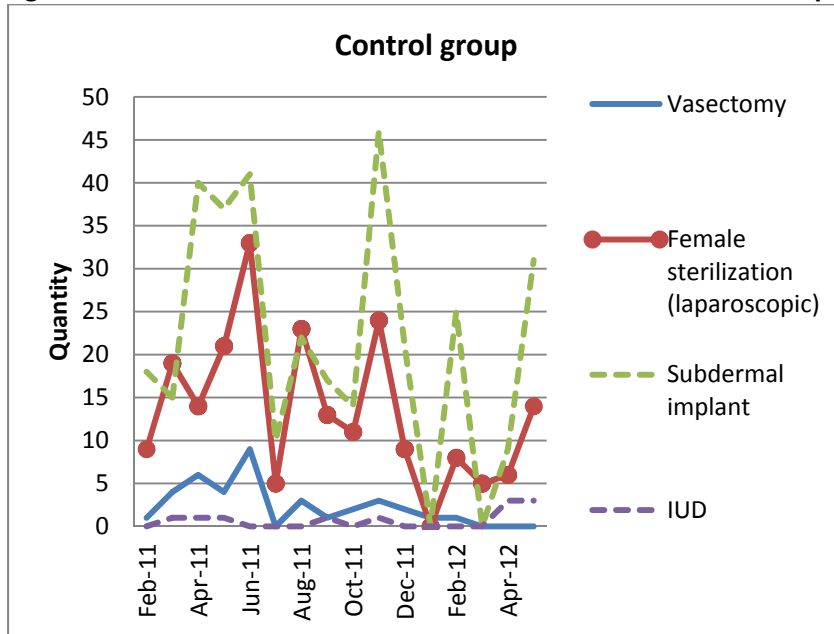
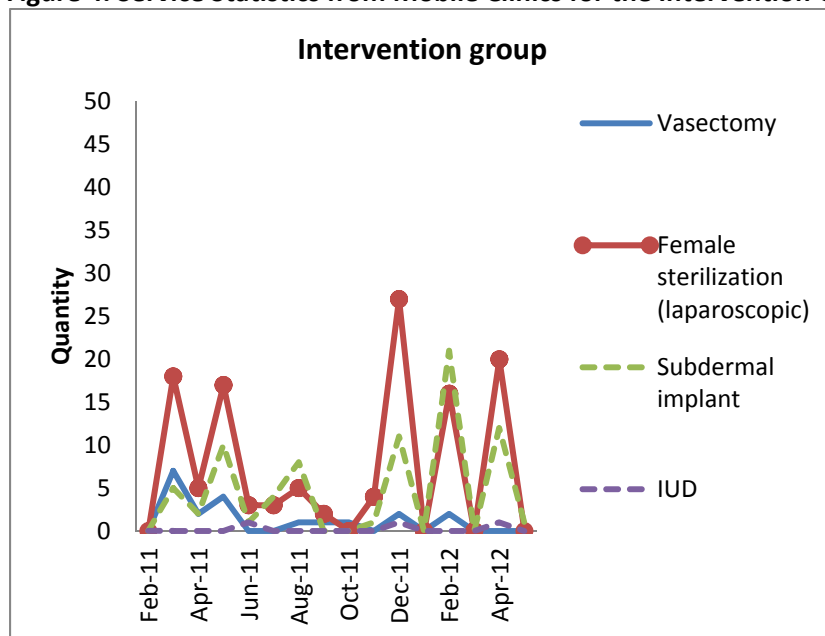


Figure 4. Service Statistics from Mobile Clinics for the Intervention Group



While some variation appeared month to month, the data did not show significant differences between the intervention and control sites.

To confirm initial impressions, ANOVA analysis was used to determine whether there was some statistical significance to the minor variation in the charts of mobile clinic data. Except for the data from September 2011, the calculated F value did not meet or exceed the calculated critical F value that was needed to discard the null hypothesis at a level of 90 percent certainty.

Data from the one month that showed a statistically significant difference reflected higher distribution numbers at control sites than intervention sites. Thus, it appears that there is no evidence of an intervention effect.

Data on Contraceptive Use from Surveys

Baseline levels of modern contraceptive use were moderately high: 53.6 percent in the intervention group and 56.2 percent in the control group.¹ Contraceptive use was defined as currently using one of the following methods: the pill, injectables, implants, condoms, spermicides, IUDs, or male or female sterilization.

In the follow-up survey, rates of modern contraceptive use increased in both groups, but considerably more in the intervention group—10.9 percentage points—compared with 4 percentage points in the

¹ Rates of modern method use for Guatemala as a whole reported in 2008 were 44.0 percent and 36.2 percent in rural areas (Ministerio de Salud Publica y Asistencia Social 2009).

control group (Table 7). This analysis encompassed women who were not pregnant, excluding women who were pregnant at baseline or at follow-up.

Table 7. Current Use of Modern Contraceptive Methods, Intervention and Control Groups

Intervention Group	Baseline		Follow up	
	No.	%	No.	%
Not currently using any modern method*	77	46.4	59	35.5
Using at least one modern contraceptive method	89	53.6	107	64.5
Total (n)	(166)	100%	(166)	100%
Control Group				
Not currently using any modern method	56	43.8	51	39.8
Using at least one modern contraceptive method	72	56.2	77	60.2
Total (n)	(128)	100%	(128)	100%

*Modern methods include tubal ligation, vasectomy, oral contraceptive pill, morning-after pill, IUD, injectable, implant, condom (male or female), or spermicide/gel/vaginal tablet.

It should be noted that these increases in modern contraceptive use occurred over an interval of only 2 to 3 months. The large increase in prevalence of modern contraceptive use in the intervention group—nearly 11 percentage points— would have been remarkable even if it occurred over a year or more. However, the rate of modern contraceptive use in the control group increased by 4 percentage points during the same period.

When the increase in modern contraceptive use^a was compared between the groups, the test was not statistically significant (Table 8). Again, the test was based on a comparison of odds ratios, estimated with a mixed effect logistic model, to account for the community-level randomization and the repeated measures per participant.

Table 8. Mixed Logistic Model Estimates of Intervention Effect on Contraceptive Use (n=292)

	OR	95% CI	P-value
Intervention Group: Follow up–Baseline	1.79	[1.06,3.03]	0.031
Control Group: Follow up–Baseline	1.24	[0.68,2.26]	0.472
Difference in difference	1.45	[0.65,3.22]	0.350

* Restricted to non-pregnant women

The results suggest that the workshops may have influenced modern contraceptive use, but also that contraceptive use is increasing overall. It is possible that the 6.9 percentage point difference in the increase in contraceptive prevalence between the two groups would have been significant had the sample sizes been larger.

5. Discussion

Gender Attitudes: Survey Findings

Notwithstanding the limitations of the gender attitudes questions, as suggested by the CI findings, the study results show a positive effect of the interactive workshops on gender attitudes. One might speculate that an even stronger effect could have been demonstrated had it been possible to measure gender attitudes more precisely.

Although the scores of both women and men in the control group started at considerably higher levels than scores registered by the intervention group, the follow-up survey scores of women in the intervention group exceeded those of women in the control group, and the scores of men in the intervention group nearly caught up with those in the control group. Differences in the level of change—positive and negative “equity points”—were calculated by subtracting the mean scores of the control group from those of the intervention group.

The differences in the levels of change in gender equity scores between the two groups were highly significant, both for men and for women. The significance of the differences between the two groups of women, however, was mostly due to the fact that the gender equity scores in the control group dropped between the baseline and follow-up surveys. For the two groups of men, the difference reflects a higher rate of increase in the scores of the intervention group. This suggests that the intervention had a positive effect on men’s gender attitudes. The conclusion regarding the effects of the intervention on women’s gender attitudes is less clear but, arguably, the effect was positive.

One possible explanation of the findings is that the women thought about gender issues during the interval between the two surveys more than men did, and the follow-up survey results were more reflective of their true attitudes. Thus, the attitudes of women in both groups may not have been as gender equitable as the baseline survey suggests, and those of the women in the control group therefore appeared to drop whereas, the scores for women in the intervention group rose slightly because of the influence of the workshops.

Gender Attitudes: Cognitive Interviews

In 76 cases out of 660 (60 respondents, 11 items), respondents either did not give a clear response to the statement or appeared to change their answer in the course of the follow-up discussions. In most cases where responses were changed (32/55), participants reassessed the initial statement and understood it differently. The rest of the cases (23/55) involved initial misunderstandings of the initial statement. While 76 out of somewhat fewer than 660 is not a large percentage, it could influence findings if these cases were not randomly distributed among the response categories.

Other findings raise questions about the face validity of GEM and GAFP scale indicators:

- In their interpretations of a statement, some respondents added information that influenced their answers. For example, some men assumed that “contraceptives” meant condoms, and some women assumed they would have no role at all in a decision if their husbands had the final say.

- In some cases, respondents focused on one clause in a statement and ignored an important qualifying clause.
- Some people interpreted two of the statements as asking what people should do (a question about their own attitudes), while others understood them as statements about what people do, or would do (a question about their perceptions of other people).
- A considerable number of people who shared the same attitude did not give the same response to two of the statements—some agreed and some disagreed—because they did not understand the statements in the same way.
- In several cases, all or almost all respondents disagreed with the statement but later said that there were many other people who agreed. It is possible that the sample was unusually egalitarian in their attitudes about gender or participants could have been concealing their true attitudes. It is also possible that they were making incorrect assumptions about other peoples' attitudes and behaviors.

In general, the CI results illustrate some limitations of the format used to measure gender attitudes in the GEM and GAFP scales, at least in the Guatemala context, where a statement was read and participants were asked whether they agreed, disagreed, or partially agreed.

It would be hasty to conclude that this format is not a useful way to measure gender attitudes, but the results suggest that one should be cautious about using such questions alone to conclude that an intervention failed to influence gender attitudes. It might be instructive to experiment with other formats that could be used to create scales for the measurement of gender attitudes. In this study, however, the findings on gender attitudes were positive despite the limits of the measures.

Knowledge and Use of Modern Contraceptive Methods

Analysis of the survey data showed a significant and substantial effect of the intervention on knowledge of contraceptive methods. The increase in the intervention group was more than 50 percent, nearly 29 percentage points. Knowledge also increased in the control group, perhaps due to a Hawthorne effect, but only by 8 percentage points.

One reason for this increase in contraceptive knowledge may have been that workshop participants were given a brochure explaining the different contraceptive methods available. And during and immediately following the workshops, APROFAM *promotores* reported a surge of interest in learning more about available contraceptive methods in intervention communities. It thus appears that participants were interested enough to read the brochures and also became more active in seeking out knowledge about family planning as a result of the workshops.

Service statistics from mobile clinics showed no effect of the interventions on adoption of modern contraceptive methods. In retrospect, it was unrealistic to imagine that there would be a measurable effect. For this to occur, changes in gender attitudes and interest in family planning would have had to spread from the workshop participants to the community at large. It is unknown whether such effects may eventually occur, but unrealistic to think they might have occurred within one or two months of the intervention.

The initial plan was to hold two or more mobile clinics at six-month intervals after the workshops, but project implementation was delayed by several months by staff turnover and other factors, leaving barely enough time to hold one mobile clinic in each site. Another factor limiting the ability to see an impact in service statistics is that there were some communities where no facility met the government's minimum standards for a mobile clinic site. In such cases, the mobile clinic had to be held at some distance from the intervention community, and the mobile clinic service statistics included clientele from several different communities.

The surveys provided a more accurate indication of the intervention's effects on contraceptive use because they included only workshop participants or, in the control group, people who had been recruited to later attend workshops.

The analysis showed a substantial increase in modern contraceptive use in the intervention communities: 10.9 percentage points in an interval of only 2 to 3 months. This is a large increase, and would be considered remarkable even if it occurred over a year or more. But as the rate of modern contraceptive use in the control group increased by 4 percentage points during the same period and the sample size was relatively small, when comparing the increase of modern contraceptive use between the groups, the test was not statistically significant. Results are suggestive that the workshops may have influenced modern contraceptive use, but contraceptive use is increasing overall. It is possible that the 6.9 percentage point difference in the increase in contraceptive prevalence between the two groups would have been significant had the sample sizes been larger.

Study Limitations

The potential for this intervention study to yield positive results was limited by the short time available for the interventions and the relatively small size of the sample. Also of concern is the sizeable percentage of the baseline samples lost to follow up (41 percent in the control group and 45 percent in the intervention group). Finally, because of time constraints, we were unable to modify the survey questions on gender attitudes based on the findings from the cognitive interviews. Had we been able to do this, the effects of the interventions on gender attitudes might have been even stronger.

Conclusions

Notwithstanding the above limitations, overall, study findings confirm the hypothesis that the promotion of gender equity in the context of reproductive health will contribute to gender-equitable attitudes and the practice of family planning. The workshops had a significant effect on men's gender attitudes and also on women's although the interpretation of the decline in equity points among the women in the control group is open to debate.

While the effect of the interactive workshops on contraceptive use fell short of statistical significance, the effect on knowledge of contraceptive methods was large and statistically significant. The randomized design of the study, the use of phased interventions to minimize selection bias, and the statistical methods that control for the cluster effect (caused by randomly assigning communities rather than individuals to the intervention and control groups) all contribute to the robustness of the results.

The results are all the more impressive given the brevity of the intervention—only four workshop sessions per individual, over the period of only a month—which contributes to its scalability. In contrast, the highly successful and inspiring PROMUNDO Program H model for reducing inequitable gender attitudes and HIV risk behaviors among young men, as implemented in Brazil and India, entailed weekly sessions over a period of six months, and stipends to ensure continued participation (Barker et al. 2004; Pulerwitz et al. 2006).

There is ample room to further refine this pilot communication intervention for promoting gender equity and family planning, expand it through APROFAM and potentially other organizations in Guatemala, and adapt and test it in other cultural contexts. The results of this study suggest that such efforts would be well worthwhile.

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Appendix 1. Women Reporting Equitable Responses on the GAFP Scale

GAFP Scale Statements	Intervention Group			Control Group			Diff Tx1 diff- Tx2 diff
	Baseline (n=187)	Follow up (n=187)	Diff btw follow up and baseline	Baseline (n=149)	Follow up (n=149)	Diff btw follow up and baseline	
You don't talk about sex, you just do it!	58.3	62.6	4.3	77.9	55.7	-22.2	26.5
Contraceptive use makes it easier for a woman to have more than one sexual partner.	90.4	92.0	1.6	94.6	94.6	0	1.6
My husband would justifiably be angry if I asked him to use a condom.	75.4	75.9	0.5	69.8	71.1	1.3	-0.8
In my opinion, a woman can suggest using condoms like a man can.	18.7	22.5	3.8	18.1	20.8	2.7	1.1
It is man's responsibility to make sure his wife will not get pregnant if she does not want to.	70.6	70.1	-0.5	77.2	65.1	-12.1	11.6
It is the responsibility of both the woman and her partner to avoid pregnancy.	90.4	90.9	0.5	89.9	90.6	0.7	-0.2
A man should not have sex without knowing if his partner wants to get pregnant.	69.0	68.4	-0.6	68.5	63.1	-5.4	4.8
If a woman does not want to get pregnant and is not using contraceptives, her partner should do so.	84.5	85.6	1.1	88.6	82.6	-6	7.1
Having sex without using contraception is more exciting because the woman can get pregnant.	48.7	40.6	-8.1	45.0	34.2	-10.8	2.7
Having sex using contraception is more exciting because you do not have to worry about pregnancy.	81.8	76.5	-5.3	75.8	75.8	0	-5.3

GAFP Scale Statements	Intervention Group			Control Group			Diff Tx1 diff- Tx2 diff
	Baseline (n=187)	Follow up (n=187)	Diff btw follow up and baseline	Baseline (n=149)	Follow up (n=149)	Diff btw follow up and baseline	
The man is the one with the power to impregnate, so he should decide whether to use contraceptives.	41.2	48.7	7.5	53.0	49.7	-3.3	10.8
It is the husband who should decide how many children to have, since he is the one who has to support them.	48.7	51.9	3.2	64.4	57.0	-7.4	10.6
A couple should decide together if they want to have children, and how many children they want.	93.6	97.3	3.7	96.0	94.0	-2	5.7
If a man gets a woman pregnant, the child is the responsibility of both.	96.8	93.0	-3.8	96.6	96.0	-0.6	-3.2
The woman has the right to decide to use contraceptives because she is the one who will get pregnant.	84.5	83.4	-1.1	84.6	81.2	-3.4	2.3
A man and a woman should decide together what contraceptive method they will use.	96.8	97.3	0.5	94.6	94.6	0	0.5
The woman can decide what type of contraceptive to use because she is the one who will use it.	80.7	88.2	7.5	82.6	83.2	0.6	6.9
If a woman experiences side effects from using a FP method, her husband or partner should help her find a method that suits her better.	94.1	94.1	0	97.3	96.6	-0.7	0.7
If a woman cannot use a FP method without side effects, her partner should use a method.	88.2	92.5	4.3	93.3	88.6	-4.7	9

GAFP Scale Statements	Intervention Group			Control Group			Diff
	Baseline (n=187)	Follow up (n=187)	Diff btw follow up and baseline	Baseline (n=149)	Follow up (n=149)	Diff btw follow up and baseline	
If your church says you should use only natural methods of family planning, you should follow that.	55.1	54.5	-0.6	63.1	57.7	-5.4	4.8

Appendix 2. Men Reporting Equitable Responses on the GAFP Scale

GAFP Scale Statements	Intervention Group			Control Group			Diff Tx1 diff- Tx2 diff
	Baseline (n=141)	Follow up (n=141)	Diff btw follow up and baseline	Baseline (n=126)	Follow up (n=126)	Diff btw follow up and baseline	
You don't talk about sex, you just do it!	51.1	48.2	-2.9	61.9	57.9	-4	1.1
Contraceptive use makes it easier for a woman to have more than one sexual partner.	80.9	80.1	-0.8	81.0	84.1	3.1	-3.9
I would get mad if my wife asked me to use condoms.	67.4	78.7	11.3	72.2	78.6	6.4	4.9
In my opinion, a woman can suggest using condoms like a man can.	24.1	19.1	-5	25.4	15.1	-10.3	5.3
It is man's responsibility to make sure his wife will not get pregnant if she does not want to.	68.1	65.2	-2.9	69.8	64.3	-5.5	2.6
It is the responsibility of both the woman and her partner to avoid pregnancy.	95.7	90.1	-5.6	93.7	92.9	-0.8	-4.8
A man should not have sex without knowing if his partner wants to get pregnant.	49.6	66.0	16.4	65.9	74.6	8.7	7.7
If a woman does not want to get pregnant and is not using contraceptives, her partner should do so.	78.7	86.5	7.8	81.0	88.9	7.9	-0.1
Having sex without using contraceptives is more exciting because a woman can get pregnant.	48.9	59.6	10.7	65.9	54.8	-11.1	21.8
Having sex using contraception is more exciting because you do not have to worry about pregnancy.	60.3	69.5	9.2	68.3	58.7	-9.6	18.8
The man is the one with the power to impregnate, so he should decide whether to use contraceptives.	45.4	54.6	9.2	45.2	56.3	11.1	-1.9
It is the husband who should decide how many children to have, since he is the one who has to support them.	52.5	70.2	17.7	65.1	59.5	-5.6	23.3
A couple should decide together if they want to have children, and how many children they want.	96.5	97.2	0.7	96.0	98.4	2.4	-1.7

GAFP Scale Statements	Intervention Group			Control Group			Diff Tx1 diff- Tx2 diff
	Baseline (n=141)	Follow up (n=141)	Diff btw follow up and baseline	Baseline (n=126)	Follow up (n=126)	Diff btw follow up and baseline	
If a man gets a woman pregnant, the child is the responsibility of both.	92.9	93.6	0.7	95.2	96.8	1.6	-0.9
The woman has the right to decide to use contraceptives because she is the one who will get pregnant.	64.5	65.2	0.7	78.6	69.8	-8.8	9.5
A man and a woman should decide together what contraceptive method they will use.	94.3	98.6	4.3	93.7	96.8	3.1	1.2
The woman can decide what type of contraceptive to use because she is the one who will use it.	60.3	64.5	4.2	66.7	73.0	6.3	-2.1
If a woman experiences side effects from using a FP method, her husband or partner should help her find a method that suits her better.	92.2	96.5	4.3	96.8	96.8	0	4.3
If a woman cannot use a FP method without side effects, her partner should use a method.	75.9	93.6	17.7	86.5	89.7	3.2	14.5
If your church says you should use only natural methods of family planning, you should follow that.	48.9	61.0	12.1	63.5	65.1	1.6	10.5



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