MIDTERM IMPACT EVALUATION OF THE REPRODUCTIVE HEALTH IN THE COMMUNITY (REPROSALUD) PROJECT

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ACRONYMS AND FOREIGN TERMS

CBOs	Community-based organizations
DFID	British Department for International Development
DHS	Demographic and Health Survey (ENDES in Peru)
FP	Family planning
IE&C	Information, education and capacity building
INEI	Instituto Nacional de Estiadísticas e Informática (National Institute for Statistics, Peru)
IR	Intermediate Results
MNISA	Ministerio de Salud (Ministry of Health, Peru)
OR	Odds Ratio
ReproSalud	Reproductive Health in the Community project
SO	Strategic Objective
USAID	United States Agency for International Development

CONTENTS

I. INTRODUCTION

Towards the middle of 1995, the non governmental organization Manuela Ramos received support from the United States Agency for International Development (USAID) to develop a new, long-term project, Reproductive Health in the Community (ReproSalud), the goal of which is to improve the reproductive health of rural and urban women of limited means and to empower them through adult education strategies and a small income generation component through community banks (with the loan of money) or product development (by providing materials).

In the first phase, which ran from 1995 to 2001, the project focused on the provision of information, education and capacity building (IE&C) to women (and a smaller number of men) in matters relating to reproductive health which they themselves prioritized through participatory appraisal and which essentially related to family planning, care during pregnancy and birth, and vaginal discharge and infections of the genital tract, amongst others. Through education, the project aims for women to achieve greater equity in their relationships with men, to have a greater awareness of their anatomy and of that of men, and to value and take care of themselves by making use of the health services. In the second phase (from 2001), with a more political focus, the main objectives are the promotion and defense of the rights of empowered women, such that they will be able to discuss and negotiate - on equal terms - with the ministry of health (MINSA)[1].

ReproSalud works with poor women living in isolated rural areas and peripheral urban areas in the departments of Huancavelica, Ancash, La Libertad, Puno Quechua and Aymara and Ayacucho. The project's activities in San Martín, Ucayali and Lima Este came to an end in the year 2000. In each department, following a careful selection process, community-based organizations (CBOs) fulfilling the requirements set out by the project (see section A1 of chapter two of this report) were chosen to become counterparts in the project with a 'winning' CBO. Given that the aim of ReproSalud was to reach as many beneficiaries as possible, the winning CBOs in turn selected 'sister' CBOs in what are termed 'associated' communities.

The originality of ReproSalud derives from the strategy of involving the community from the very outset: prioritizing the reproductive health problems which are of greatest concern to them, taking part in capacity building sessions and participating in

[1] Moreover, ReproSalud fulfils the CIPD (1994) mandate in at least two ways: Firstly, it aims to reduce the unmet need for family planning and other reproductive health services, using a different approach to that of traditional family planning programs. ReproSalud does not deliver services. It builds the capacity of and empowers women in CBOs such that they themselves may defend improvements in available health services. Secondly, the project, through various strategies including adult education, encourages women to overcome socio-economic, cultural and gender barriers which prevent them from taking decisions and actions to benefit their reproductive health, including an equitable relationship with their partners and a better use of available reproductive health services. Anna-Britt Coe, (2001).

negotiations with local and health authorities, amongst others. In this way the populations feel and treat the project as their own[2].

In its six years of field activities, until December 2001, the project had provided IE&C on reproductive health to some 123,000 women beneficiaries (amongst counterpart and associated communities) and to an additional number of 66,000 men living in the project's area of influence. This is a total of approximately 200,000 beneficiaries, either direct (those living in communities with winning CBOs) or indirect (those living in communities with associated CBOs). Of the total number of beneficiaries, 70 percent live in rural, mainly mountainous, areas, and 23 percent live in urban areas, in the periphery of cities of the departments where ReproSalud is working.

Several documents (see annex A) record the project results. This impact evaluation is centered on the analysis of quantitative achievements, by studying the indicators of the Results Framework for the Strategic Objective (SO) and for the Intermediate Results (IR) separated into the various issues (see annex B) on which an impact is expected. It is based on data collected by the project's Monitoring and Evaluation Unit prior to the start of the project and after a minimum of two years of work. Complementary information from the project's own monitoring system and from external sources was also added to put the findings into context.

Only part of the information available was used in this evaluation, specifically that relating to 25 counterpart communities with a control community to compare changes in the indicators and link them to the project. Reasons relating to the design of the sample and the development of the instruments used for data collection (both done in a gradual manner) resulted in the number of indicators analyzed being reduced from 46 to 33, although a further 6 were defined on this occasion from available data and added to the other 33. This evaluation is part of a more detailed evaluation that includes the project's process evaluation and its cost-effectiveness.

[2] For the Process Evaluation, which forms a part of the Midterm Global Evaluation of ReproSalud which also includes this Impact Evaluation, approximately 50 women from 12 communities in 5 departments were interviewed and expressed positive views on the project and the usefulness of what they had learned through capacity building for living their lives and for their relationships with their partners and families. (Reports were collected personally during fieldwork carried out between October and November 2001 in Ancash, Huancavelica and La Libertad).

II. METHODOLOGY

A. EVALUATION METHODOLOGY

Objective of the Evaluation

General Objective

To determine, pursuant to the Results Framework, the impact of ReproSalud on the target communities after a minimum period of two years from the start of IE&C activities in reproductive health and gender, and of income generating projects in the form of community banks.

Specific Objectives

- To compare the change in the indicators selected from the Results Framework in a sample of target communities and a sample of control communities.

- To analyze possible additional project impact on the indicators of the Results Framework if an income generation component, in this case community banks, is implemented in addition to the IE&C component.

Data Sources

Base Line and Midterm Evaluation Surveys

The Technical Monitoring and Evaluation Unit of the project carried out surveys (a base line survey at the beginning of the project, between 1997 and 1999; and a midterm evaluation survey after a minimum of two years, between 2000 and 2001) in a sample of women of reproductive age and of men aged between 15 and 59 from communities with counterpart (or winning) CBOs, a sample from communities with an associated CBO (where activities are carried out indirectly through the winning CBO) and a sample from comparison or control CBOs.

The information gathered is varied and abundant, but for the purposes of this evaluation only that relating to communities with CBO counterparts, for which a control community was also surveyed has been used.

Project Monitoring Information

The project keeps track of its activities by means of a data information system that is managed at the project's head office in Lima and allows progress in each department to be monitored through the information sent from the branch offices. This information was used without evaluation, on the assumption that the information provided by the system is

of a good quality. The total number of communities in the project, their location, total population, ranking of reproductive health issues by the women, as well as number of beneficiaries, both women and men, amongst others, were taken into account.

Project Related Documents

Additional information to that provided by the mentioned surveys was obtained from other project related documents, such as annual reports, evaluation reports, reports of field visits and supervisory reports. Information was also obtained from interviews with various actors taking part in the project both within the communities and at the project head office in Lima, as well as with persons carrying out the surveys and processing the information.

Official Documents on Reproductive Health and Population

Official documents prepared by the National Institute for Statistics and Information were used to place the findings of this evaluation into context; amongst them, the reports in the DHS (in all four of versions), country and district population projections, and the national census of 1993.

Evaluated Indicators

In accordance with the project objectives, the education component should result in an improvement in preventive health practices by women, including a greater readiness to attend health centers. The advocacy component should result in an increase in the negotiating capacity of women with health authorities, which it is expected will in turn result in an improved quality of attention and therefore in greater use of the services by women.

The above is represented in the Results Framework, which contains the SO of the project and the IRs with their respective indicators (see annex B). These are the key elements for evaluating achievements. Thus, achievement of the project objective is measured by the SO indicators which also measure the impact of the project; the achievements of the process are measured by the IR indicators.

Whilst reviewing the information collected and prior to its analysis, six new indicators were developed (see table 1) and tentatively numbered following the classification in the Results Framework, bearing in mind whether they related to the SO or to the IRs.

Table 1: Evaluation Indicators

Number	Indicator
SO: Women increase the use of reproductive health check-ups	
1.a	percent of women who have had 4 or more check-ups by health personnel during the last pregnancy occurring two years prior to the survey
IR 1: Women have more equitable gender relations with their partners and their families	
11.a	percent of women in a relationship who have spoken with their partner regarding the number of children they wish to have
IR 1.1: Women strengthen their capacity to bring about changes in their gender relations	
16.a	percent of women who know where to turn for help or advice in the event of physical aggression
IR 2: Women have a greater capacity to access reproductive health services	
24.	percent of women who have attended a health center for issues of reproductive health or family planning
IR 2.6: Women increase their knowledge regarding their reproductive health needs	
43.a	percent of women who have heard of Papanicolau or breast examination
43.b	percent of women who believe that it is difficult to get pregnant while breastfeeding

Evaluation Sample

The Monitoring and Evaluation unit of ReproSalud started its activities towards the end of 1997 and decided to carry out a base line survey in all (rather than in a sample of) the communities targeted to that date. Some of these communities were therefore surveyed when the project was already ongoing. As new communities were added to the project, it was decided that, given the costs involved, it was better to carry out surveys in a sample of 30 communities with counterpart CBOs for which control communities were set. Out of these 30 communities, 5 were dropped after the first subproject[3], leaving only 25 counterpart communities with their respective control communities. This evaluation is based on the data from such communities. All the departments, with the exception of Lima, are represented in the sample.

Prior to analysis of the indicators, the database was purged and weighted (to represent the universe of target communities bearing in mind their distribution by department, by urban and rural areas, and by age) for the purpose of obtaining consistent indicators. The process used is explained in section II.B of this report.

Population Surveyed

Prior to the start of the project, information was gathered relating to women of reproductive age and of men aged between 15 and 59 from a sample of households in communities with counterpart CBOs and in control communities. Surveys were also carried out in associated communities, but they are not analyzed in this report. The same households were surveyed in the midterm evaluation, and all the women of reproductive

[3] a subproject is a set of capacity-building sessions on an issue of reproductive health, with an approximate duration of 8 to 10 months.

age and men in the mentioned age group who were in the house at the time were interviewed, rather than only those who had been interviewed two or three years earlier in the base line survey. This was done on the principle that the project should have an impact not only on the beneficiary population, but also on the community as a whole.

There appears to be a great territorial mobility in the population, affecting mainly rural areas, and the communities in which ReproSalud works are no exception. Indeed, of the 3858 women of reproductive age interviewed in the midterm evaluation, 2612 had also been interviewed in the base line survey. This means that 32.3 percent of the original sample was replaced by new residents of the households and, obviously, of the community.

This factor must be considered when analyzing the change in indicators between the two surveys.

B. METHODOLOGY OF THE BASE LINE AND MIDTERM EVALUATION SURVEYS

Tools Used for Data Collection

- Household questionnaire to collect general information regarding the persons living in the household and the main characteristics of the home.

- Individual questionnaire for women of reproductive age (between 15 and 49 years) living in the selected household, to collect information on their demographic characteristics, attitude and behavior in relation to reproductive health, gender and family relationship issues, empowerment, participation in community based organizations and health care issues (e.g., awareness of the fertile period, awareness of symptoms of risk during pregnancy, number of prenatal check-ups, attendance at health centers, expenditure on health care, etc.).

- Individual questionnaire for men between the ages of 15 and 59 to collect information regarding their knowledge, attitude and practices on reproductive health, gender relationships, family relationships, work, etc.

- Area questionnaire to collect data regarding the population center and the area of influence of the community based organization participating in the project.

- Questionnaire for the head of the health center.

- Questionnaire for a member of the community who is also a member of the Local Health Administration Committee.

- Questionnaire for a community leader not a member of the Local Health Administration Committee.

This evaluation, the specific objective of which is to analyze project impact and the change in the indicators of the Results Framework before and after project implementation, used only the information collected in the household questionnaire and in the individual questionnaires for men and women[4].

A few comments should be made regarding the development of the individual questionnaires for women and men. As the definition of the sample framework was gradual, so was the development of the final version of these two tools. Indeed, nine questions were added to the first version, as the need for new indicators emerged, and so on thereafter. Some indicators were in fact defined at the start, but for the most part they were developed after the first version as a natural consequence of the gradual definition of the project[5].

New implementation issues and new target communities emerged, and with these the need to measure them by means of indicators. This resulted in the questionnaires being modified up to 14 times throughout the field work, such that one same questionnaire was not used for all the communities in the 2 surveys. Questions added at a later stage were applied to few of the communities in the midterm evaluation, and thus corresponding information for the base line survey is not available and cannot be compared[6]. As a result, it was decided in this impact evaluation to:

- Limit data collection to 25 communities with counterpart CBOs, which also have control communities, where the most complete version of the individual questionnaires was used. This greatly reduced the number of cases, and it was therefore not possible to obtain reliable data by department.

- Exclude associated communities from the evaluation, as they were very few in number and different versions of the individual questionnaires had been used.

- Reduce the number of indicators of the Results Framework from 46 to 33, eliminating those for which no base line information is available.

Sample

The communities making up the sample have in common the existence of one or more CBOs—groups which bring together women to carry out activities beneficial both to the community and to themselves.

[4] The information collected with the remaining tools described in section II.B of this report is valuable and varied. It should be analyzed and published in research reports to share the various aspects of the work and achievements of ReproSalud within the community with other institutions and development agencies.

[5] It took some time for ReproSalud to be consolidated, given that it is a new experience not only as regards methodology used and working strategies, but also given the fact that it works with remote rural communities.

[6] However, such data could be of use in the project's final evaluation.

The sample communities were classified in the following categories: a) 70 communities taking part in ReproSalud in which one CBO implements a reproductive health education sub-project and/or an income generation (community bank or product development) subproject after having been selected through tender by the project. They receive funding for their activities and technical support directly from ReproSalud; b) 17 associated communities, selected by the winning CBOs to also benefit from the project, but through an intermediary community; and c) 25 control communities where the project was not active and which are used to measure the impact and the results of the project.

Although details of these communities are given further on (section III.A), it should be pointed out that those working with ReproSalud were not selected randomly, but pursuant to certain criteria which set them apart from the other communities in the district. They were communities with better-organized CBOs, and probably with experience in development projects, although, judging from their poverty indicators, poorer than the control communities. This should be borne in mind when analyzing the results.

Sample Framework

This is formed by the communities, which were selected for participation in the project in 1997, 1998, and 1999. As CBOs were selected to take part, the communities in which they were based became part of the sample framework. This means that there was no predefined sample framework, but rather that it was gradually established as the project progressed, starting in 1996 as shown in table 2. Most of the communities (55 percent) were selected between the years 1998 and 1999.

Table 2: Communities Selected to Participate in ReproSalud

Department	Year of Selection					
	Total	**1996**	**1997**	**1998**	**1999**	**2000**
Total	*247*	*20*	*43*	*52*	*82*	*50*
Percent	*100.0*	*8.1*	*17.4*	*21.1*	*33.2*	*20.2*
Ancash	31	2	7	9	12	1
Ayacucho	35	2	8	6	14	5
Huancavelica	39	2	6	7	17	7
La Libertad	36	2	5	6	13	10
Lima Este	8	1	3	3	1	0
Puno Quechua	33	2	5	4	10	12
Puno Aymara	35	2	3	7	8	15
San Martín	15	2	4	7	2	0
Ucayali	15	5	2	3	5	0

Sample Design

The sample has the following characteristics:

- Gradual selection of the analysis unit for the sample (communities) in accordance with the gradual definition of the sample framework.

- Given the gradual selection of the communities, the base line survey was carried out in a period spanning years rather than months; the same is true for the midterm evaluation.

- Within the community, households of CBO members and households of nonmembers were selected randomly following a selection technique that is explained in section II.B of this report.

- Within selected households, all women of reproductive age and all men aged between 15 and 59 who were regular residents of the household were interviewed.

- In the midterm evaluation only communities which had received capacity building on at least two issues of reproductive health, i.e. which had carried out two sub-projects in a period of two or three years, were interviewed.

- No new sample was defined for the midterm evaluation: the same households as in the base line survey were visited and all women of reproductive age and men aged between 15 and 59 who were living in such households were interviewed.

Sample Selection

As has already been mentioned, the communities were included in the sample in a gradual manner, reaching a total of 70 communities with counterpart CBOs in a period of three years. The greater part of the sample (94.3 percent) was selected between 1997 and 1998 (although selection covered the period 1997 to 1999[7]). This bears no relation to the years in which a larger number of communities were included in the project, and which, as shown in table 3, was between 1998 and 1999. Only 4 communities were included in the sample in 1999 (5.7 percent), whereas 82 (33 percent) were added to the 115, which were already part of the project.

Table 3: Communities Selected for the Project and for the Sample Per Year

Communities	Total	1996	1997	1998	1999	2000
Total counterpart communities	247	20	43	52	82	50
Percent	*100.0*	*8.1*	*17.4*	*21.1*	*33.2*	*20.2*
Communities in the total sample	70		40	26	4	
Percent	*100.0*		*57.2*	*37.1*	*5.7*	
Communities in the sample for this evaluation	25			21	4	
Percent	*100.0*			*86.7*	*13.3*	

[7] The communities included in the project in 1996 and surveyed in the base line after intervention (a total of 36 communities) were excluded from the sample.

Collection of information in control and associated communities began in 1998. In this three-year period in which the sample was selected, both the criteria for selecting counterpart communities and the strategies for project implementation may have changed, such that the communities surveyed more recently have the benefit of the experience accumulated in previous years, i.e., since 1996. This could affect the results of the project, which might be better for such communities, and therefore alter the comparability of the data. It was therefore decided to carry out this evaluation with data from a sub-sample of communities interviewed for the base line in 1998 and 1999 (see table 4).

Given that intervention was gradual, all departments have different numbers of communities selected for the sample (see table 4). This means that the n sample by department (the number of communities in the sample per department) is not proportional to the N of intervention (number of communities with winning CBOs in the ReproSalud project area). This lack of a relationship, which is vital for the data to be truly representative, was solved by weighting the number of communities interviewed by department with the corresponding proportion of total counterpart communities in the project to December 1999. None of communities selected for the project since 2000 are part of the sample framework and thus neither are they part of the sample.

Table 4: Counterpart Communities Selected Between 1997 and 1999 Versus Communities in the Sample in 1998 and 1999

Department	Counterpart Communities			
	Sample Framework*		Sample*	
	Number	Percent	Number	Percent
Total	*170*	*100.0*	*25*	*100.0*
Ancash	28	16.5	4	16.0
Ayacucho	28	16.5	3	12.0
Huancavelica	30	17.6	5	20.0
La Libertad	24	14.1	2	8.0
Puno Quechua	19	11.2	2	8.0
Puno Aymara	18	10.6	4	16.0
San Martín	13	7.6	2	8.0
Ucayali	10	5.9	3	12.0

*excludes Lima East

Selection of Households

This comprised two groups:

1. Households of (women) members of CBOs

   In this case the size of the sample was determined with the formula of finite populations, since the number of members was known. In general, where CBOs had less than 40 members, all of them were interviewed. Where the CBOs were very small, there were few interviews: between 5 and 20 members, the only ones of

reproductive age[8]. By contrast, in large CBOs there were more the 80 interviews[9]. On average, members interviewed represented 50 percent of the total number of women interviewed, with the exception of La Libertad, where the average was 70 percent, and Ancash, where it was 58 percent. At this stage, households were selected as follows:

- The number of active members[10] of the CBO was determined on the basis of information provided by the president of the organization.

- Members who were under 15 and over 49 years of age were not interviewed.

- If, after discarding members outside the 15 to 49 age group, the number remaining was 40 or less, all of them were interviewed. If there were more than 40, the following formula[11] was used to calculate the size of the sample:

$$n = \frac{t^2 PQ / d^2}{1 + \frac{1}{N}(t^2 PQ / d^2 - 1)}$$, where

n = estimated size of the sample
t = distribution point related to a reliability level of 95 percent (1.96)
d = reliability interval (.10)
N = size of the population (160)
p = value of the indicator to be calculated

- Once the size of the sample was known, a random selection of member households was carried until the number to be interviewed according to the preceding formula had been reached.

The following were not interviewed:

- households of members who were absent during the interview period, and

- households of members living in another community, who do not participate in the organization and only receive foodstuffs.

[8] For example, in the Mothers' Group Antonieta Chu of CCPP Poloponta in the Zapatero district, Lamas province in the department of San Martín. Similarly, in the Mothers' Group Virgen de las Mercedes, of CCPP Huancha, San Marcos district in the province of Huari, department of Ancash, where 13 members were interviewed in the base line and nine in the midterm evaluation, this being the number of members of reproductive age. Likewise in the Mothers' Group Virgen del Rosario, of CCPP Ccachaccara, María Parado district of Bellido, Cangallo province in Ayacucho, where 21 members were interviewed in the base line and 16 in the midterm evaluation, this being the number of members of reproductive age in the CBO.

[9] For example in Vaso de Leche San Bernardo of the Acopalca community, Huari district, department of Ancash, where the number of interviews was 83 both in the base line and in the midterm evaluation. In the same department, in the Comité del Vaso de Leche Marcará of the CCPP Marcará, Marcará district, in the province of Carhuaz, where 72 members were interviewed in both surveys.

[10] those who attend meetings and take part in the activities of the CBO.

[11] Cochran, W. (1963). Sampling Techniques. NY: Wiley p. 75.

2. Households of non-CBO members

This was done in two different ways. In rural communities where it was possible to count the number of households the formula of finite populations was applied. Households were randomly selected. In urban communities a neighbor household to the member household was interviewed, and the sample was also randomly selected.

The procedure was as follows*:*

In small communities all households were counted and registered, taking care not to count any twice or to leave any out. From the register obtained sample households were selected as follows:

1. Occupation of the house was verified. If it was not occupied it was eliminated from the register.

2. In occupied households the persons living in it were identified. If a member of a CBO was living in the household it was also discarded, given that member households were selected separately.

3. The remaining households were numbered and those that were to form part of the sample were then randomly selected. The steps and criteria followed were the same as for selection of member households. The same formula was used.

4. In large urban communities 30 households located close to the CBO member household selected for interview were chosen. There was no set criteria for selection, and this varied according to the location of the member households. In some cases the household next to the member household was interviewed, in others the interviews were carried out in neighboring areas to that of the member household, and in others again the households of relatives of members were interviewed, since there was a greater probability that they would talk about what they had learned with their relatives.

The sample of men was taken from households of CBO members and non-members of the community. In each selected household all men between the ages of 15 and 59 were interviewed.

Weighting

The data collected were weighed or weighted following three criteria:

- The distribution by urban and rural areas of counterpart communities within each department.

- The proportion of counterpart communities in the department in relation to the to total number of counterpart communities within the project area.

- The distribution of the population by age in order for the sample to represent the structure of such communities as per the census of 1993, confirmed by the monitoring information of ReproSalud on the total beneficiaries in counterpart and associated communities. T he sample, which initially did not have the same 'shape' (see figure 1) as such sources, was matched to these, giving the structure shown in figure 2, and thereby correcting the age bias, which had apparently been produced on selecting the sample. The same procedure was used for wo men and men.

Figure 1: Age Structure in Sample Communities

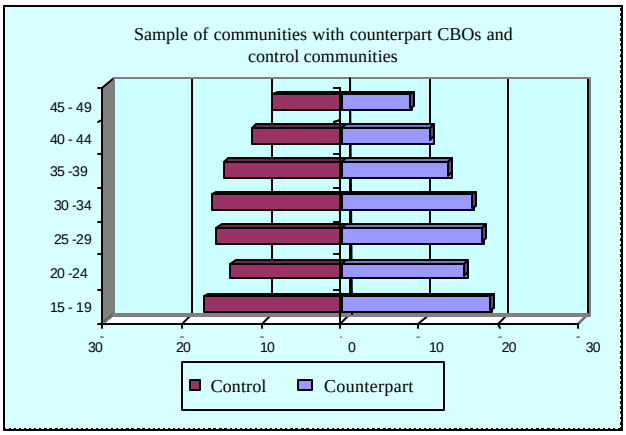
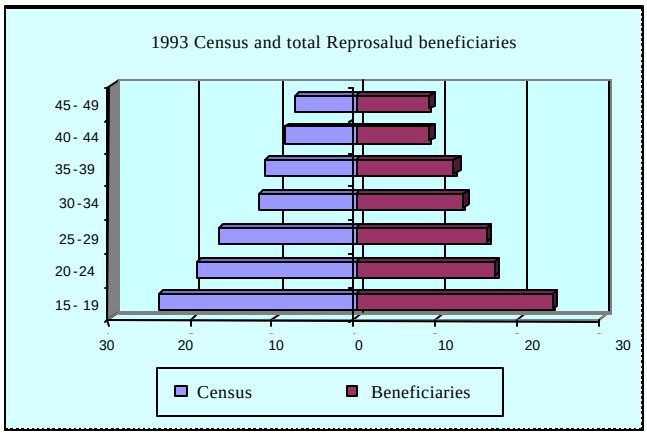


Figure 2: Age Structure in Sample Communities: Matched Sample



Process Used for Sample Weighting

Weight for each case in any urban area region:

$$[(N_{urbRegint} * N_{totsample}) / (N_{urbRegsample} * N_{totint})] * PAi$$

Weight for each case in any rural area region:

$[(N_{rurRegint} * N_{totsample}) / (N_{rurRegsample} * N_{totint})] * PAi$

Where:

$N_{urbRegint}$: Number of urban communities participating in ReproSalud in the department
$N_{totsample}$: Number of communities selected for the sample
$N_{urbRegsample}$: Number of urban area communities selected for the sample in the department
N_{totint}: Total number of communities participating in ReproSalud
$N_{rurRegint}$: Number of rural communities participating in ReproSalud in the region
$N_{rurRegsample}$: Number of rural communities selected for the sample in the department
PAi: Population age index for correcting the structure

Table 5 shows the number of cases of women interviewed, both weighted and unweighted, by department after applying the above formulas.

Table 5: Counterpart Communities: Weighted and Unweighted Sample of Women in the Base Line and Midterm Evaluation Surveys

Departments	Distribution of Cases by Percentage			
	Base Line		Midterm evaluation	
	Unweighted	Weighted	Unweighted	Weighted
Total	*100.0*	*100.0*	*100.0*	*100.0*
Ancash	17.3	16.4	19.8	18.2
Ayacucho	11.9	15.4	11.3	14.0
Huancavelica	16.3	12.3	15.6	12.3
La Libertad	5.9	8.8	5.9	8.9
Puno Aymara	20.4	17.0	18.7	15.7
San Martín	6.7	6.7	7.9	8.0
Ucayali	17.2	16.2	16.6	15.9
Puno Quechua	4.5	7.1	4.2	6.9

Control Communities

The decision to use controls was taken in mid-1998, and from then onwards a control community in which base line and midterm evaluation surveys were also carried out was selected for each of the communities participating in the project.

A control community is a community with no project intervention. It is a similar community selected in a somewhat experimental manner. As far as possible, it should have the same characteristics as participating communities: same height above sea level, literacy rate, population size, degree of urbanization, poverty level and an active community based organization. It appeared to be difficult to find similar communities, as shown in annex C. Indicators derived from the population census of 1993 (lacking a

more recent source) for the districts (for it is likewise not possible to obtain information by community) where ReproSalud communities and control communities were selected reveal differences, which are sometimes in favor of the counterpart communities and other times in favor of control communities. On the whole, it seems that the latter are less poor, less rural, and have a higher literacy rate than counterpart communities. For this reason, initial values for the Results Framework indicators are at times different from the values for the counterpart communities. These differences should be borne in mind when interpreting the results, since they could act to increase or decrease net gains in the indicators for each community, or affect the interpretation of the findings.

Table 6 shows examples of counterpart communities and their respective control community as a way of illustrating the differences between the two.

Table 6: Examples of Counterpart Communities and Corresponding Control Communities

COMMUNITIES											
COUNTERPART						CONTROL					
Department Province District	Community	Population	Illiteracy Percent	Rural Population Percent	Percent with an Unmet Basic Need	Department Province District	Community	Population	Illiteracy Percent	Rural Population Percent	Percent with an Unmet Basic Need
Ancash/Carhuaz						Ancash/Carhuaz					
Marcará	Marcará	7,704	64.3	87.1	60.9	Tinco	Tinco	2,514	38.3	68.3	68.3
Ayacucho/Cangallo						Ayacucho/Huanta					
Cangallo	Incaraccay	6,193	52.4	67.2	84.9	Santillana	Arahuay	6,395	73.4	88.2	80.3
Huancavelica/Huancavelica						Huancavelica/Tayacaja					
Huancavelica	Barrio Santa Ana	36,826	24.3	15.9	75.5	Pampas	Pampas	9,649	36.1	49.4	61.7
La Libertad/Otuzco						La Libertad/Sanchez Carrión					
Usquil	Chuquizon-guillo	24,203	38.9	91.7	75.1	Huamachuco	Chuquizon-guillo	37,708	47.0	53.1	77.2
Puno Quechua/Azangaro						Puno Quechua/Puno					
Arapa	Pucamoco	10,757	41.5	93.0	87.4	Coata	Sucasco-Tarizani	6,301	39.7	93.3	73.1
Puno Aymara/Yunguyo						Puno Aymara/Puno					
Yunguyo	Machacmarca	30,360	43.6	70.3	56.8	Acora	Chanchilla	29,420	36.9	93.0	67.5
San Martin/El Dorado						San Martin/Picota					
Shatoja	Shatoja	1,653	33.0	52.1	79.8	Tingo de Ponasa	Leoncio Prado	2,605	11.8	87.0	89.1
Ucayali/Coronel Portillo						Ucayali/Atalaya					
Masisea	Masisea	12,083	19.5	84.0	92.2	Sepahua	Sepahua	3,698	26.5	59.8	87.0

Sample Size

The number of cases interviewed, unweighted, and used in the analysis of the results presented in section III of this report are shown in table 7.

Table 7: Sample Size

Base Line				Midterm evaluation			
Community				Community			
Counterpart		Control		Counterpart		Control	
Women	Men	Women	Men	Women	Men	Women	Men
2,132	1,649	1,967	1,543	1,852	1,691	1,598	1,502

The characteristics of the sample by level of education, marital status, age and number of children, in the case of women, is shown in table 8.

Table 8: Sample Characteristics

Variable	Women		Men	
	Counterpart	Control	Counterpart	Control
Education	***100.0***	***100.0***	***100.0***	***100.0***
Uneducated	16.8	14.0	4.1	3.4
Primary	44.8	44.6	33.1	35.7
Secondary	33.1	36.4	53.6	51.9
Higher	5.3	5.0	9.2	9.0
Marital status	***100.0***	***100.0***	***100.0***	***100.0***
Single	33.2	26.7	45.1	44.2
Married	61.3	65.9	53.0	53.5
Divorcee/widow	5.5	7.4	1.9	2.3
Number of children	***100.0***	***100.0***	*na*	*na*
None	28.2	23.9		
1 child	15.0	15.4		
2 children	13.5	13.2		
3 children	10.5	13.9		
4 or more	32.8	33.6		

na=not applicable

III. RESULTS

This part of the report presents the project results measured by means of indicators from the ReproSalud information system at the head office in Lima and indicators from the Results Framework, calculated pursuant to information collected in the two household surveys carried out prior to the start of project activities (base line) and after two or three years (midterm evaluation).

A. PROJECT SCOPE AND CAPACITY-BUILDING ACTIVITIES: INFORMATION FROM THE REPROSALUD MACRO INFORMATION SYSTEM

Project Scope

Pursuant to its design, ReproSalud began its activities by selecting districts in 9 departments of the country[12] based on the following criteria:

- unmet basic needs,
- overall birth rate,
- population size and percentage of rural population,
- accessibility of the area,
- existence of community based organizations driven by and made up of women, and
- degree of security for implementing project activities, namely the absence of terrorism and/or drugs-related activities.

In each of the districts a general call for participating communities was made; however, selection was not random, since required criteria introduced from the start a certain degree of intentional selection. To participate in ReproSalud it was not sufficient for the communities to have a high level of unmet basic needs or for the average number of children per family to be high: they also had to be accessible, since the project aimed to maximize resources (achieve a balanced cost/benefit) and reach a larger number of beneficiaries (women and men), which automatically excluded the more remote communities.

Moreover, the communities which applied in response to the call were possibly those with better established community organizations and those which had very probably

[12] Lima East, Ayacucho, Ancash, Puno Quechua, Puno Aymara, Huancavelica, La Libertad, San Martín and Ucayali

taken part in other development projects (whether of other non-governmental organizations or of the Peruvian government). These factors differentiated them from other communities in the district and resulted in a process of self-selection totally outside the control of the project management. Although poverty and population indicators date back to 1993, it is true to state that the project works with very poor and remote communities, thereby meeting the objective of reaching the most deprived groups.

Counterpart communities, i.e, direct beneficiaries that were to receive funding for education and/or income generation activities, were selected following a detailed evaluation carried out by a Committee comprised not only by the women themselves but also by local authorities, personnel from the Health Directorates and personnel from ReproSalud. Given that the project aimed to reach through its activities a larger population than merely the women of communities with a winning CBO, each of them in turn selected a certain number of 'sister' communities, called associated communities, which would indirectly benefit from the education and information activities on reproductive health and gender.

From the start of the project and up to the end of the year 2000, ReproSalud has worked with a total of 247 counterpart communities, 80 percent of which are located in a rural area. This same percentage of distribution by area is true for the 2,528 associated communities, as shown in table 9.

Table 9: CBOs Participating in ReproSalud, by Type of Participation: 1996–2000

Department	Communities								
	Total			Counterpart			Associated		
	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
Total	*2,775*	*554*	*2,221*	*247*	*67*	*180*	*2,528*	*487*	*2,041*
Percent	*100.0*	*20.0*	*80.0*	*100.0*	*27.1*	*72.9*	*100.0*	*19.3*	*80.7*
Puno Aymara	524	30	494	35	4	31	489	26	463
La Libertad	484	97	387	36	9	27	448	88	360
Ayacucho	440	99	341	35	7	28	405	92	313
Huancavelica	422	62	360	39	8	31	383	54	329
Puno Quechua	249	52	197	33	6	27	216	46	170
Ancash	222	16	206	31	6	25	191	10	181
San Martin	183	73	110	15	12	3	168	61	107
Ucayali	174	55	119	15	8	7	159	47	112
Lima East	77	70	7	8	7	1	69	63	6

By department, although Huancavelica has the largest number of communities with counterpart CBOs (39), it does not have the largest total number of communities when associated communities are included. Puno, in the Aymara area, has 524 communities (versus 422 in Huancavelica), because 480 associated communities were added to its 35 counterpart communities. In Puno, each counterpart community has an average of 12 associated communities; whereas in the rest of the departments the average is 10.

Ayacucho and La Libertad are other departments with a total of more than 400 communities participating in the project, and, with the exception of Lima East where there were only 77 participating communities, the jungle departments San Martín and Ucayali have a smaller number of participating communities, whether counterpart or associated.

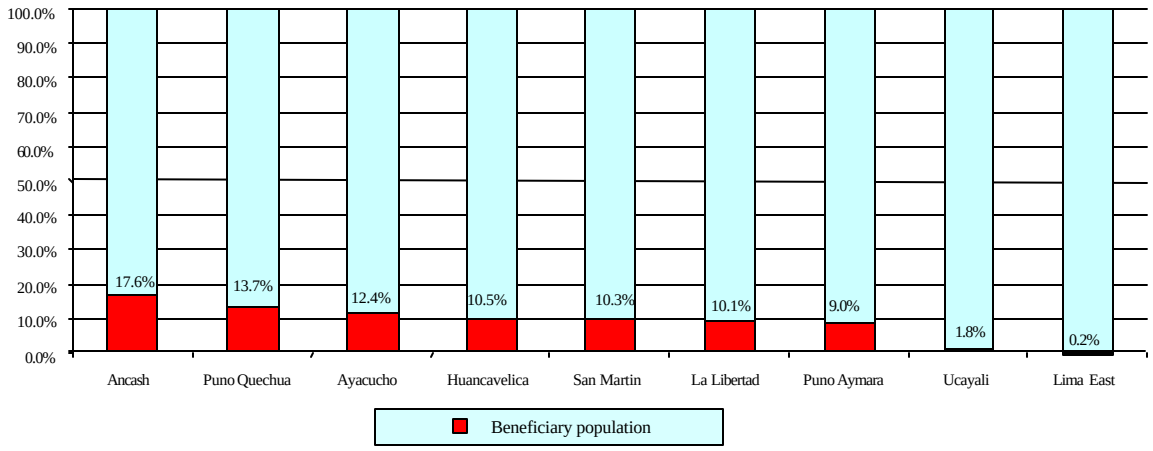
The number of beneficiaries, women and men, also varies by department, as shown in table 10. In its six years of activity, ReproSalud has offered capacity building to some 200,000 persons, both women and men, of which 124,000 are women.

Table 10: Beneficiary Population of the Project and Total Population of Participating Districts

Department	2001 population of districts participating in ReproSalud			Women beneficiaries			Total beneficiaries		
	1	2	3	4	5	6	7	8	9
	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
Total *(population)*	*100.0* *2,667,474*	*67.0*	*33.0*	*100.0* *123,917*	*31.1*	*68.9*	*100.0* *190,287*	*23.0*	*77.0*
Ayacucho	*100.0* *141,154*	*41.3*	*58.7*	*100.0* *17,470*	*26.9*	*73.1*	*100.0* *26,293*	*23.3*	*76.7*
Huancavelica	*100.0* *177,315*	*53.7*	*46.3*	*100.0* *18,580*	*19.9*	*80.1*	*100.0* *30,187*	*18.5*	*81.5*
Ancash	*100.0* *86,822*	*38.2*	*61.8*	*100.0* *15,273*	*14.4*	*85.6*	*100.0* *23,131*	*13.4*	*86.6*
Puno-Quechua	*100.0* *130,929*	*76.2*	*23.8*	*100.0* *17,962*	*22.2*	*77.8*	*100.0* *31,221*	*22.0*	*78.0*
Lima East	*100.0* *1,309,158*	*99.4*	*0.6*	*100.0* *3,266*	*93.3*	*6.7*	*100.0* *3,707*	*93.0*	*7.0*
Ucayali	*100.0* *354,321*	*91.5*	*8.5*	*100.0* *6,429*	*46.7*	*53.3*	*100.0* *8,180*	*45.4*	*54.6*
Puno-Aymara	*100.0* *212,910*	*17.0*	*83.0*	*100.0* *19,071*	*8.0*	*92.0*	*100.0* *29,111*	*7.0*	*93.0*
San Martín	*100.0* *73,218*	*91.8*	*8.2*	*100.0* *7,541*	*54.4*	*45.6*	*100.0* *12,105*	*54.0*	*46.0*
La Libertad	*100.0* *181,287*	*42.7*	*57.3*	*100.0* *18,325*	*23.2*	*76.8*	*100.0* *26,352*	*24.4*	*75.6*

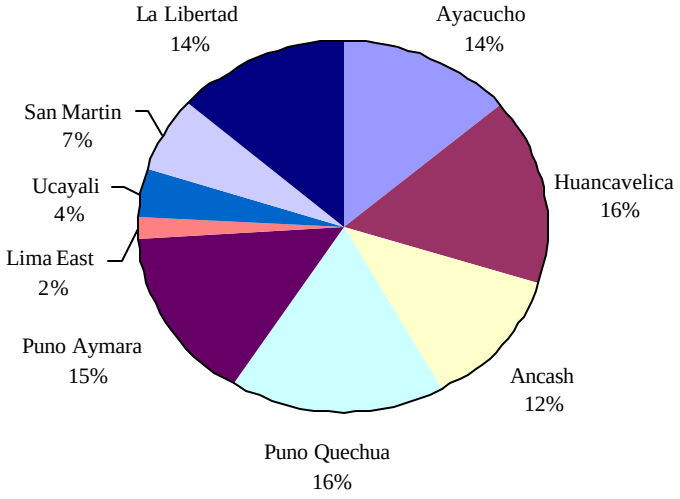
Considering participating districts by department to December 2000, ReproSalud has benefited 18 percent of the population of participating districts in Ancash, 14 percent in Puno Quechua, 12 percent in Ayacucho, and 10 percent in Huancavelica and San Martín, as shown in figure 2. The distribution of beneficiaries by area was provided by the project itself.

Figure 2: Percentage of ReproSalud Beneficiary Population as a Proportion of Total Population of the Participating Districts



Of total beneficiaries, more than 190,000, most are in Puno Quechua, Huancavelica and Puno Aymara, in descending order, each having just over 16 percent; Lima East has the smallest number of beneficiaries, as do the jungle departments as shown in figure 3.

Figure 3: Total Project Beneficiaries

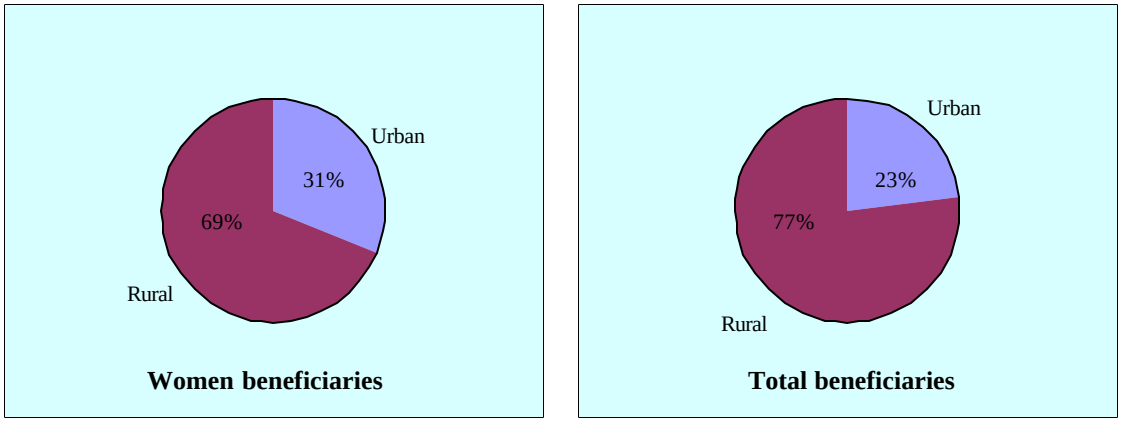


In order to determine the potential beneficiary population of the project if in an expansion phase it were to cover the total jurisdiction of participating districts, a sample exercise

was carried out. The projected population as calculated by the INEI[13] for these districts was taken and distributed into urban and rural areas, in accordance with the Population Census of 1993 (Table 10, columns 2 and 3), as a more recent source giving such data is not available. In any case, the bias in applying this to projected data for 2001 would underestimate the percentage of urban population, given that in the period 1993-2001 the urban population grew from 70 to 72 percent (INEI, 2001) and many small villages and settlements became part of the urban population.

In the event that the project were to expand to the total jurisdiction of all participating districts, ReproSalud would reach 2.7 million people, i.e. 10 percent of the national population (estimated at 26.3 million). If this were the case, 67 percent of all beneficiaries would be urban beneficiaries. This would not be in accordance with the target population of the project, which is rural population of limited means, as shown by the results to date. From the total number of current women beneficiaries (123,917) only 31 percent are from urban areas, the great majority being from rural areas. Similarly, of the total number of beneficiaries (almost 200,000 including men) just over one fifth are from urban areas (see figure 4).

Figure 4: Distribution of Beneficiary Population in Urban and Rural Areas



Participatory Appraisal Versus Capacity-Building Activities

ReproSalud worked through the modality of sub-projects consisting of IE&C (or income-generating) activities on an issue or issues of reproductive health which had been ranked in order of importance by participatory appraisal and which were to be given priority by the project. Capacity building was strengthened by the work of facilitators (a total of 8,424: 5,580 women and 2,844 men) with health workers from the health centers, who were requested to provide better care for women, whilst women were encouraged to attend the health center for receiving professional care.

[13] National Institute for Statistics, Technical Directorate for Population. Special Bulletin 14. Population projection by departments, provinces and districts: 1990-2020. July 2001. Internal document, not published.

Various reproductive health problems were mentioned in the participatory appraisal sessions, the most important being vaginal discharges, or 'white periods' as it is called by women. This was ranked as the most serious problem by 37 percent of all the communities participating in the project. This was especially so in Ucayali, where it was ranked first in 80 percent of appraisals, and in La Libertad, where it was also placed top of the list by 62 percent of CBOs (see table 11).

Table 11: Issues Mentioned in Participatory Appraisals

Department	Total	Discharge	Many children	Pain during delivery	Prolapse	Inflammation of the ovaries	Critical age	Ovarian and uterine cancer	Physical abuse	Retention of the placenta	Bowel inflammation	Others
Total Percent	*100.0*	*36.6*	*31.9*	*12.8*	*3.1*	*2.7*	*2.3*	*1.9*	*1.2*	*1.2*	*1.2*	*5.1*
Total	*257*	*94*	*82*	*33*	*8*	*7*	*6*	*5*	*3*	*3*	*3*	*13*
Ayacucho	35	14	12	4		3		1	1			
Huancavelica	46	11	11	11	2	1	4	1	1	2	2	0
Ancash	27	12	7	4		1				1		2
Puno-Quechua	36	9	20	5	2							
Lima East	9	2	4						1			2
Ucayali	15	12	1	1								1
Puno-Aymara	36	6	19	7				3				1
San Martin	19	7	2		4						1	5
La Libertad	34	21	6	1		2	2					2

The second most important problem of reproductive health as ranked by women in counterpart communities was the high birth rate, expressed as 'many children.' Almost a third of the women (32 percent) mentioned this. Indeed, it is the most important problem in the department of Puno in the two Quechua areas (in 56 percent of the communities) and in Aymara (53 percent), as well as in Ayacucho and Huancavelica for more than a third of the communities carrying out a participatory appraisal.

Pain during childbirth, complications in childbirth and problems relating to childbirth are the third most important issues of reproductive health affecting the population of reproductive age, according to 13 percent of the communities participating in the project. This is particularly so in Huancavelica, where it is considered serious by a quarter of the communities, which place it top of the list of all the problems affecting women's health, as well as in Puno Aymara and Ancash.

In this ranking of reproductive health problems, other issues were also classified as pressing, although by much smaller percentages than the three problems mentioned above. Amongst these are, in descending order of importance

- prolapse or rupturing of the uterus,
- inflammation of the ovaries,
- citical age,
- ovarian cancer and cancer of the neck of the uterus,
- physical abuse,

- retention of the placenta,
- bowel inflammation,
- miscarriage,
- death in childbirth,
- infidelity,
- abandonment,
- problems in the use of contraceptive methods,
- teenage pregnancies,
- problems following childbirth,
- complications in pregnancy, and
- vaginitis.

Educational material was developed for training, and as was evidenced on comparing the ranking of issues during participatory appraisal with those touched in the training, there was a perfect match between the needs of the women and the training afforded in most cases. There was only one exception in a community in Ucayali where, through the decision of the women, training was given on discharges instead of on physical abuse (the issue chosen during participatory appraisal) to avoid conflicts with partners.

B. PROJECT IMPACT: MEASURING ACHIEVEMENT OF THE STRATEGIC OBJECTIVE (SO)

The SO: "Women increase the use of reproductive health services" summarizes the project impact measured through practices and habits of reproductive health which will contribute to a better quality of life for women, and which are, essentially: care during pregnancy and childbirth by trained personnel, and the use of contraceptives.

Annex D shows the indicators of the Results Framework with their relevant measurements. The number of cases for each indicator is recorded, as is the statistical significance and relevant value for z; furthermore, an estimation of the Odds Ratio (OR)[14] is also given.

Care During Pregnancy and Childbirth by Trained Personnel

As is known, the aim of ReproSalud is to increase the use of reproductive health services, particularly of formal health services. This is the perception of the people working in the centers of MINSA, as evidenced in interviews carried out during visits to hospitals, health centers and health posts in project areas for the evaluation process carried out in the last quarter of 2001 (Shepard, 2002). Service providers stated that ReproSalud had built a bridge between the community and the centers with the community facilitators, allaying the fears of the population and their apprehension at 'being seen' by an 'unknown person'. It seems that training which emphasizes the need for women to attend

[14] The OR is the disparity value. It measures the influence of an activity within a group compared with a control group. An OR value greater than 1 shows an impact for the activity, and the size of same. A value below 1 means that the project had no impact.

professional health services had positive effects. Two key indicators measure this result: care during pregnancy and childbirth by trained personnel.

Care During Pregnancy by Trained Personnel

Prior to the start of the project, the percentage of pregnant women who went to trained health personnel for check-ups in counterpart communities was 55.6 percent; after two or three years this increased to 83.1 percent. The percentage also increased in control communities, but to a lesser extent (from 62.2 percent to 81 percent). Net gain in the former was 27.5 percentage points (significant to 5 percent, z = -7.240), while in the latter it was 18.8 percentage points (also significant to 5 percent, z = -5.114). See figure 5 indicator 1.a in Table 12.

Figure 5: Prenatal Care by Trained Personnel During the Last Pregnancy

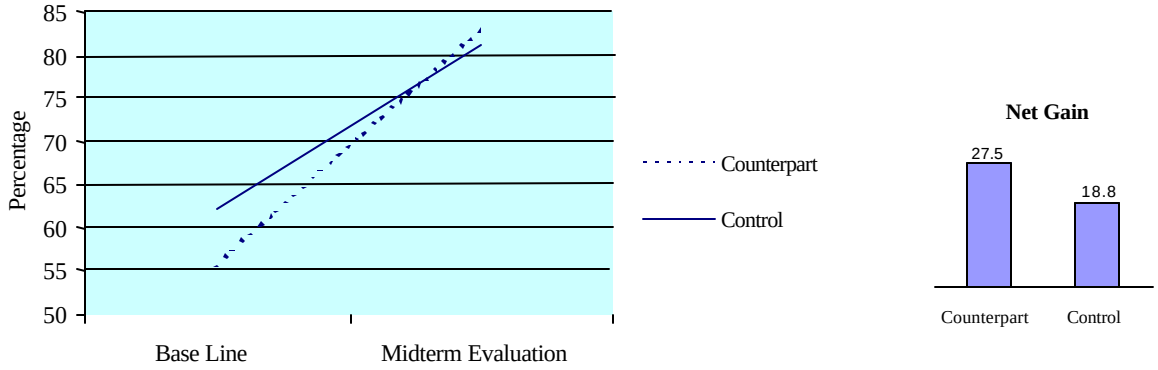


Table 12: Care by Trained Personnel during Pregnancy and Childbirth

N°	Indicator	Counterpart communities					Control Communities				
		Base Line	MTE*	Difference	z	Stat. Sig.	Base Line	MTE*	Difference	z	Stat. Sig.
1.a	Percent of women who had 4 or more controls by healthcare personnel during the last pregnancy occurring two years prior to the survey	55.6	83.1	27.5	-7.240	Sig 0.05	62.2	81.0	18.8	-5.114	Sig 0.05
2	Percent of women who had their last delivery, occurring two years prior to the survey, with trained personnel	36.1	48.0	11.9	-3.200	Sig 0.05	40.9	42.7	1.8	-0.494	

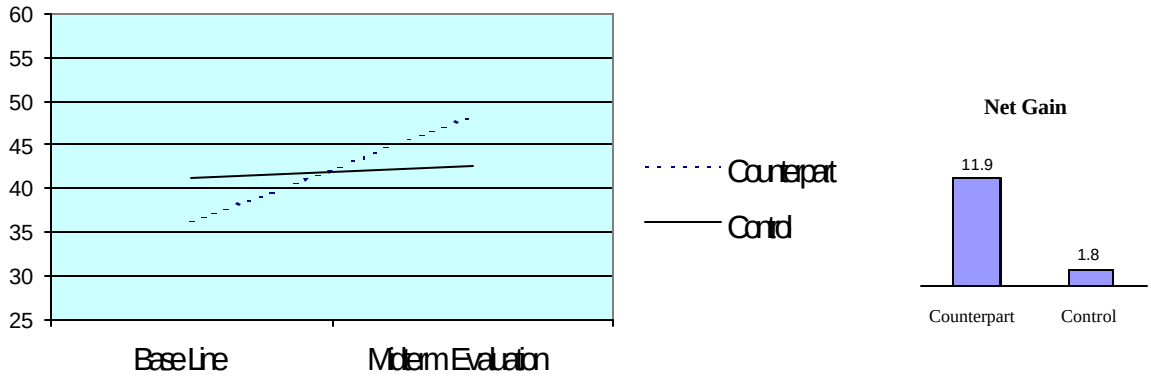
*Midterm Evaluation

Care During Childbirth by Trained Personnel

Professional care in childbirth underwent the same change. At the start of the project, a little over one third (36.1 percent) of women in counterpart communities gave birth with the aid of trained personnel, and after two or three years this increased to 48 percent. In control communities, however, this change was smaller (from 40.9 percent to 42.7

percent). Net gain in the former was therefore 12 percentage points; i.e., 6 times higher than in the latter (1.8 points). In the former, the change is significant to 5 percent, while in the latter it is significant to 10 percent (see figure 6 and indicator 2 of table 12).

Figure 6: Last Birth Attended by Trained Personnel



The improvements shown give a clear indication of the important impact of ReproSalud in two crucial aspects of care in reproductive health: pregnancy and childbirth. Lack of such care is an important cause of death in childbirth, especially in poor, rural areas.

Given that initial values for the indicators measured were different in the two types of communities, and particularly due to the fact that net gains in both are statistically significant, the OR (table 24, see footnote 14) was used to verify the probability that the dependent variable (the indicator) would exist in the presence of the activity. The value of the OR shows that as a result of the work of ReproSalud, care during pregnancy by trained personnel increased 15 percent more in counterpart communities, care in childbirth by trained personnel increased by 27 percent more.

Prevalence of the Use of Methods of Contraception

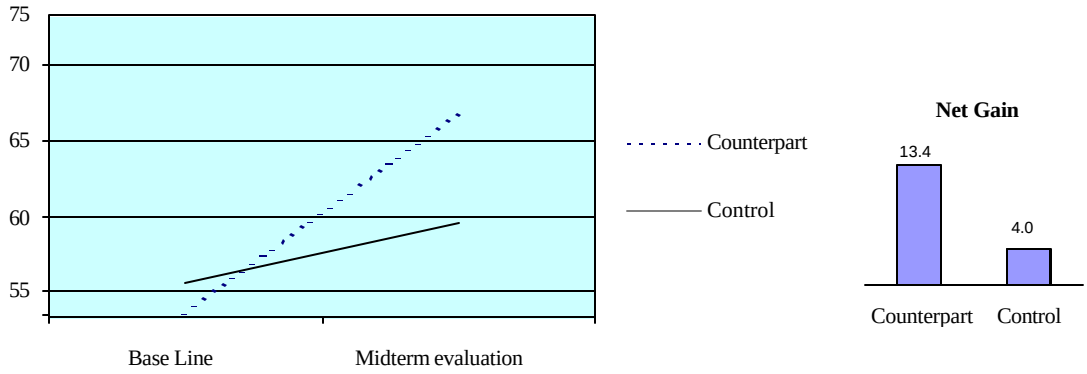
The use of family planning methods is an important indicator for evaluating the impact of ReproSalud for, on the one hand, it reveals the level at which information and access to services is available, and, on the other, it is the key to improving reproductive health, especially in remote communities.

Training and working strategies implemented by the project aim to: a) increase knowledge on the ways and means available to prevent unwanted pregnancies; b) inform potential users on the benefits and side effects of each method; and c) help the woman and/or partner to voluntarily choose the method which best suits their needs.

Data collected from the base line survey reveal that the use of methods of contraception increased by 13.4 percentage points (from 58.4 percent to 71.8 percent) in counterpart communities and by only 4 percentage points in control communities (from 60.6 percent to 64.6 percent). Although net gain was significant to 5 percent in both types of

communities, it is obvious that the intensity of change was greater in the former (see figure 7 and indicator 3 in table 13).

Figure 7: Percentage of Women in Relationships Who Use Some Method of Contraception



In this case, the relative change (which is obtained by dividing the value of the indicator in the second survey by the value in the first, table 24) in counterpart communities was 23 percent as opposed to 6.6 percent in controlled communities. These percentages show that use of contraception increased by 15 percent more in counterpart communities, due to project intervention.

Unmet Family Planning Needs

This variable was measured with two indicators: 1) unmet family planning needs as defined in the demographic and health surveys (DHS)[15] (ENDES in Peru), and 2) unmet needs including women in a relationship who do not wish to have more children or do not wish to have them soon and use the rhythm method but are unaware of the fertile days of the cycle. This last indicator has been defined and used in other studies[16] and is known as 'insufficient protection'. It affects many women who do not wish to have a (or another) child but are not adequately protected against becoming pregnant. It is estimated that in the year 2000 around 850,000 women in Peru were insufficiently protected (Ferrando 2001).

These figures show that the project has had a significant impact on this issue also, having reduced unmet family planning needs from 27 percent to 18 percent in counterpart communities (i.e., a drop of 9 percentage points), while in control communities the drop was from 26.1 percent to 21.1 percent (i.e. only 5 percentage points). Although in both communities the change observed is statistically significant to 5 percent, change is

[15] Includes women in a relationship who do not wish to have (more) children or wish to have them later (women who are not pregnant) but do not use any modern methods; or whose last pregnancy was unplanned or unwanted (pregnant women).
[16] The Alan Guttmacher Institute, 1994; Ferrando, D. 2001.

greater in the former (indicator 4.1 in table 13), with a relative drop of 34 percent in counterpart communities as compared to control communities.

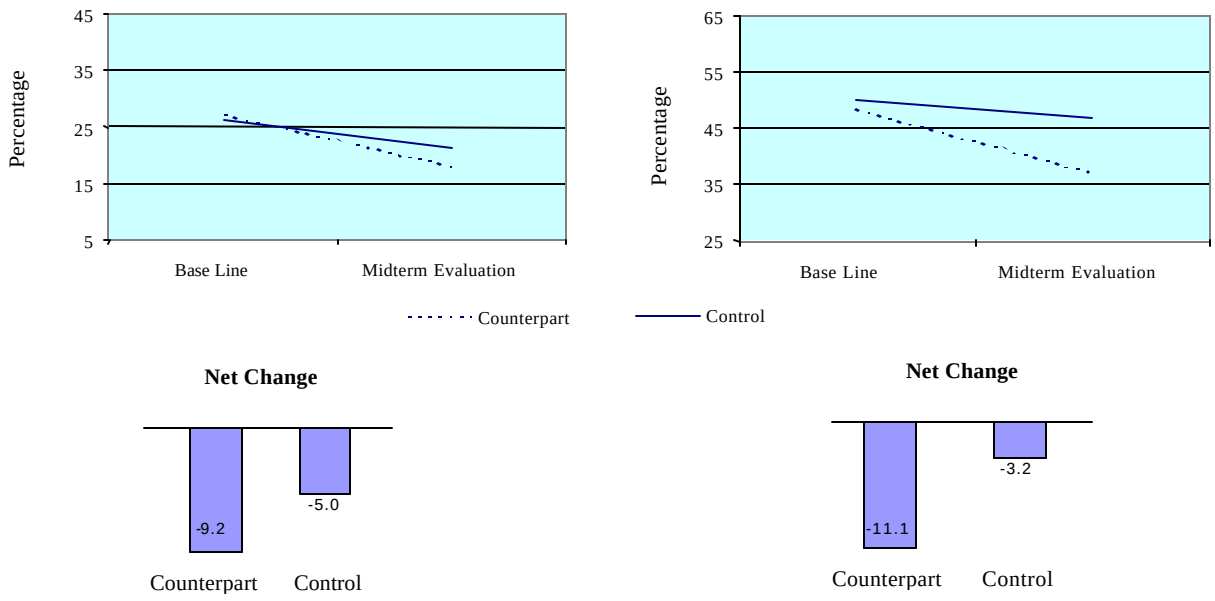
Table 13: Use of Contraception and Unmet Family Planning Needs

N°	Indicator	Counterpart Communities					Control Communities				
		Base line	MTE*	Difference	z	Stat. Sig.	Base line	MTE*	Difference	z	Stat. Sig.
3	Percent of women in a relationship who use a method of contraception	58.4	71.8	13.4	-6.071	Sig 0.05	60.6	64.6	4.0	-1.783	Sig 0.05
4.1	Percent of women in a relationship with unmet FP needs	27.1	17.9	-9.2	4.741	Sig 0.05	26.1	21.1	-5.0	2.525	Sig 0.05
4	Percent of women in a relationship with unmet FP needs. Includes users of the rhythm method who are unaware of the fertile period	48.4	37.3	-11.1	4.834	Sig 0.05	50.1	46.9	-3.2	1.379	Sig 0.10

*Midterm evaluation

As regards a wider definition of unmet needs (indicator 4 in table 13) the case is similar to that described above. The difference in improvement by communities is greater in counterpart communities (see figure 8). In counterpart communities insufficient protection was reduced by 11 percentage points (from 48.4 percent to 37.3 percent), while in control communities it was reduced by only 3 points (from 50.1 percent to 46.9 percent). This means that changes are significant to 5 percent in the former (z = 4.834) and to 10 percent in the latter (z = 1.379). In this case, relative reduction was 23 percent in counterpart communities, compared to 6.4 percent in control communities.

Figure 8: Women in a Relationship with Unmet Family Planning Needs



The balance of the relative reduction in unmet needs by type of community shows that project intervention resulted in an additional decrease of 18 percent for both indicators in counterpart communities (OR = 0.817 for indicator 4.1 and OR = 0.823 for indicator 4).

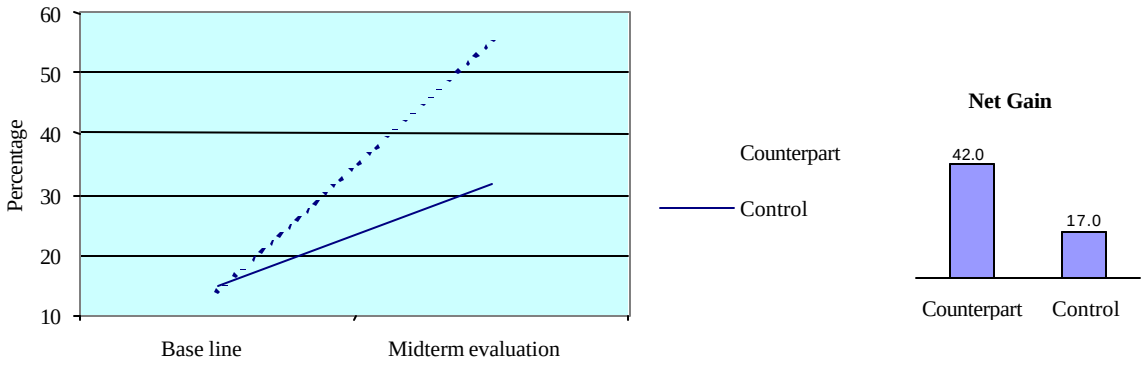
Awareness of the Different Aspects in the Use of Contraception

Within the Results Framework there are other indicators relating to the use of contraception which are analyzed below although they were not developed to measure the achievements of the Strategic Objective, but rather those of Intermediate Result 2.6: Women increase awareness of their reproductive health needs.

Awareness of Modern Methods

Given that this is basically a project for IE&C on reproductive health, another of the important aspects for ReproSalud is an improvement regarding knowledge and awareness of women regarding family planning methods, basically in order to reduce (and hopefully eliminate) their fears and prejudices surrounding certain methods, as a first step to increasing their use. Indeed, figure 9 shows an extraordinary improvement in awareness regarding methods, measured by the percentage of women in a relationship who know how at least one modern method works. This percentage increased fourfold in counterpart communities, from 13.5 percent to 55.5 percent between the base line survey and the midterm evaluation, resulting in a net gain of 42 percentage points, as compared with a gain of 17 percentage points in control communities, where the percentage increased from 14.9 percent to 31.9 percent.

Figure 9: Percentage of Women in a Relationship Who Are Aware of at Least One Modern Method of Contraception



The changes in this indicator are statistically significant in both types of communities. However, net gain in counterpart communities is almost two and a half times greater than in control communities (indicator 38 in table 14). In the ranking of indicators for the project, from that of greater effect to that of least effect (table 25), this indicator is in first place as showing greatest gain.

Table 14: Awareness of Methods of Contraception

N°	Indicator	Counterpart Communities					Control Communities				
		Base line	MTE*	Difference	z	Stat. Sig.	Base Line	MTE*	Difference	z	Stat. Sig.
38	percent of women in a relationship who are aware of at least one modern method	13.5	55.5	42.0	-24.410	Sig 0.05	14.9	31.9	17.0	-10.713	Sig 0.05
39	percent of users of rhythm method who are aware of the fertile days of the cycle	22.5	28.3	5.8	-1419	Sig 0.10	24.0	24.1	0.1	-0.027	
43b	percent of women who believe that it is more difficult to get pregnant if they are breastfeeding.	34.0	56.3	22.3	-10.477	Sig 0.05	30.9	46.9	16.0	-7.594	Sig 0.05

*Midterm evaluation

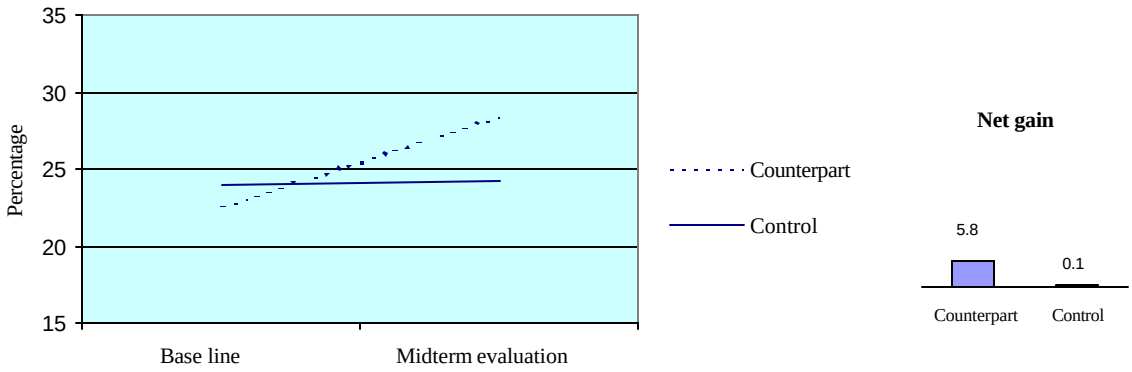
Awareness of the Fertile Period

Awareness of the fertile days of the cycle amongst users of the rhythm method showed a net increase of 5.8 percentage points (significant to 10 percent) in counterpart communities, rising from 22.5 percent to 28.3 percent, whereas in control communities it remained unchanged at around 24 percent (see figure 10 and indicator 39 in table 14). In the ranking of indicators for the project (see table 25) this indicator is fifth in order of impact.

Awareness on this issue must be strengthened, as it appears to be quite fragile. During the training sessions, participants (women and men) seem to assimilate the theory but forget

it after a short period of time if they do not have an opportunity to talk about the issue. In interviews with women beneficiaries and facilitators (both women and men) in five departments during the process evaluation (between October and November 2001) questions were asked regarding the fertile days of the cycle. Some women said that they knew about it but had forgotten what it was, others gave incorrect answers, and very few gave a correct answer[17]. Although the mentioned interviews are not representative, they do show that people are aware of the issue after a training session, but become confused later on and cannot remember it.

Figure 10: Percentage of Women Using the Rhythm Method Who Are Aware of the Fertile Days of the Cycle

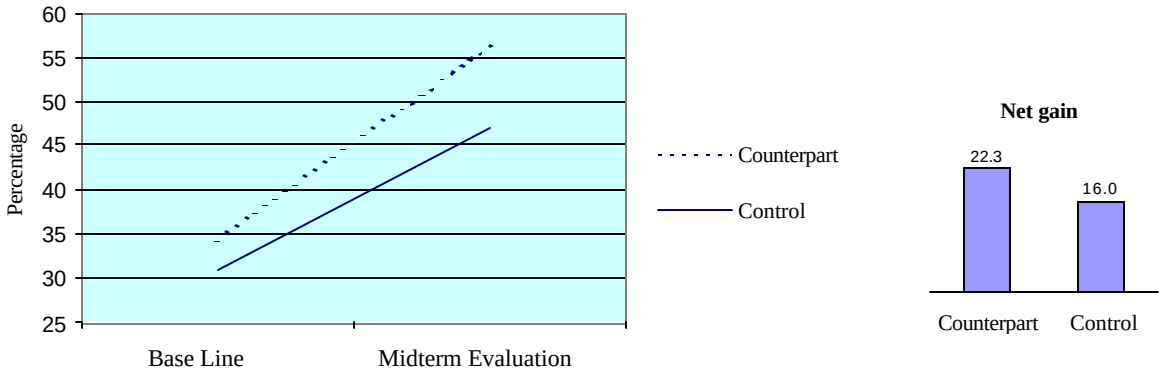


Perception Regarding Breastfeeding

Although this is more an opinion than actual knowledge, breastfeeding has been included in this section due to its association with the issue of contraception. The idea that while breastfeeding a child conception is difficult has experienced a significant positive change in counterpart communities (from 34 percent to 56.3 percent), but this was also the case in control communities, though to a lesser degree (from 30.9 percent to 46.9 percent). Thus, net gain was 22.3 percentage points in the former and 16 points in the latter (see figure 11 and table 14).

[17] As an anecdote, the wife of a ReproSalud facilitator, herself a facilitator, stated that she was expecting their second child because "the calendar failed". This fact does not necessarily show unawareness of the fertile period, but perhaps lack of willpower to avoid sexual intercourse on days when pregnancy is possible, or perhaps, male imposition.

Figure 11: Percentage of Women Who Believe It Is Difficult to Become Pregnant While Breastfeeding



A comparison of the value of this indicator in the midterm evaluation with that in the base line survey shows a relative change of 66 percent in counterpart communities as opposed to 52 percent in control communities (see table 24). Thus, the project achieved a 9 percent greater increase in awareness of this specific issue of reproductive health in the communities in which it was working.

On comparing the value of the OR (see tables 24 and 25) for the three indicators of table 14, it would appear that the possibility of the indicator existing because of the project decreases as the issues in consideration become more complex. As an example, the possibility of increasing the knowledge of how at least one modern method works is very high (92 percent), that of increasing awareness of the fertile days of the cycle is 25 percent and that of increasing the knowledge of the benefits of breastfeeding as a method of contraception is of only 9 percent.

C. INTERMEDIATE RESULTS

This section analyzes the indicators of the Results Framework for the Intermediate Results (IR) that the project must achieve if it is to attain its Strategic Objective[18]. Although there are three of these[19], only two will be evaluated: those relating to gender and to the use of health services. The third indicator, relating to empowerment of women and their participation in policy decisions, will not be evaluated[20,] although some

18 SO: Women increase their use of reproductive health services

19 RI 1: More equitable gender relationships of women with their partner and with their families
RI 2: Greater capacity and readiness of women in rural and peripheral urban areas to access reproductive health services in the formal sector
RI 3: Effective participation of women from CBOs in the process for developing policy proposals, adjustment and monitoring of reproductive health programs

20 since such issues are being given greater emphasis in Phase II of the project, which has been running for less than a year and has so far only an 'advocacy' base line.

empowerment indicators were identified as part of RI 1 and 2, which are analyzed in this section.

The IRs cover sub-results with indicators (see annex B) to measure progress and are duly numbered. However, to facilitate analysis and interpretation of the figures, they have been grouped in accordance with their relevance to issues of gender and family relationships, empowerment and use of services. Within this general classification they have been subdivided into indicators, which measure perception, knowledge, attitudes or practices. For this reason, the indicators are not shown in numerical order in the tables which follow, the original number of the indicator as per the Results Framework having been maintained. Annex 3 shows the indicators in numerical order. It also shows the number of cases per indicator, the statistical significance, value of z in each case and the value of the Odds Ratio.

Gender Relations

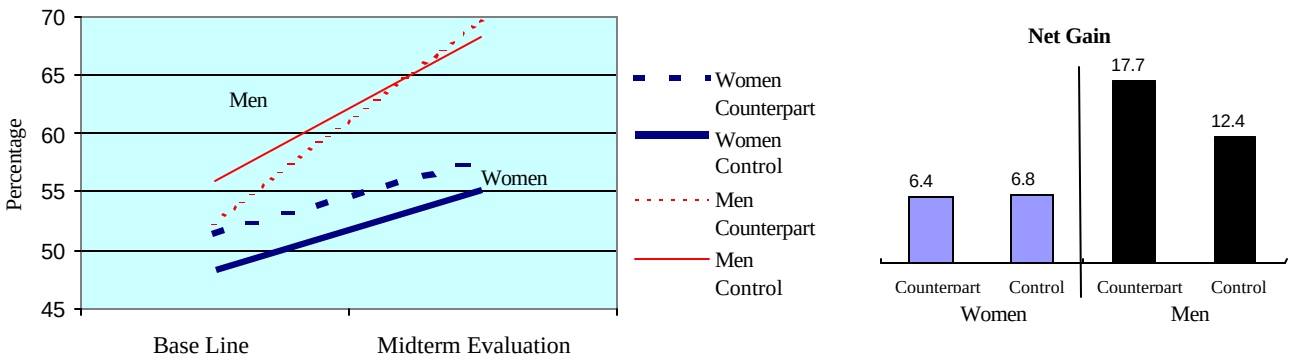
Perceptions

Perception of women and men regarding the importance of the work of women as compared to the work of men

Perceptions are ideas, opinions and beliefs held by people regarding things and events in life. Due to their very nature, they are dynamic and change according to social events and circumstances. They are therefore subject to change depending on external factors.

As regards perceptions on gender, the project would appear to have made no difference in counterpart communities as compared to control communities; if it did, this is not clearly reflected by the figures (see table 15). As an example, when it comes to assigning the same value to women's work as to men's work, the percentage of women who were of this opinion in counterpart communities increased by 6.4 percentage points (from 51.4 percent to 57.8 percent) and by 6.8 points (from 48.4 percent to 55.2 percent) in control communities. Net gain was practically the same in the two communities and statistical significance was also to 5 percent in both.

Figure 12: Percentage of Women and Men Who Believe that Work Done by Women Is as Important as that of Their Partners



However, amongst men this increase was slightly higher in counterpart communities as compared to control communities (17.7 percentage points as compared to 12.4 points), which implies a greater value attached by men to women's work[21] (see indicators 19 and 19.1 in table 15).

As regards the value attached to work in the home compared to the value attached to the work of men outside the home[22], both by men and by women, the increase has been greater in control communities, where it went from 30.2 percent to 42.5 percent amongst women and from 33.3 percent to 47.9 percent amongst men. In counterpart communities, however, it increased from 33.7 percent to 44.1 percent amongst women and from 36.25 percent to 47.4 percent amongst men. These percentages give a net gain in women's opinion of 12.5 percentage points in control communities and 10.4 percentage points in counterpart communities; figures for men's opinion are 14.6 percentage points and 11.2 percentage points respectively.

[21] Some non-exclusive explanations can be put forward on the difference in perception by men and women of women's work:

a) men have, in general, a higher level of education than women. In the sample being analyzed, the percentage of illiterate women is four times higher than that of men (16.8 percent as compared to 4.1 percent), whilst the proportion of those with secondary education is 33 percent and 54 percent respectively;
b) this higher level of education gives men a greater opportunity than women to access information and thus to be more in touch with the modern world. In such circumstances, they are better able to evaluate the importance of the work done by women. They have a more modern appreciation than women as regards their own work.
c) men have perhaps given an answer which does not reflect their real feelings in order to please the interviewer, whereas women have perhaps been more sincere in their replies.
d) women still have difficulty in realizing the value of their domestic chores and, generally, their own worth in society.
e) the work of ReproSalud with men, although involving a much smaller number than women, has had a positive effect. Of the total number of men interviewed in counterpart communities (1,773), 33 percent (581) had attended training sessions.

[22] The definition of this indicator is not clear: ' percent of women who believe that domestic work is as important as the work of their husband'. It should therefore be assumed that it refers to the value attached to the work of women in the home as compared to the work of men outside the home.

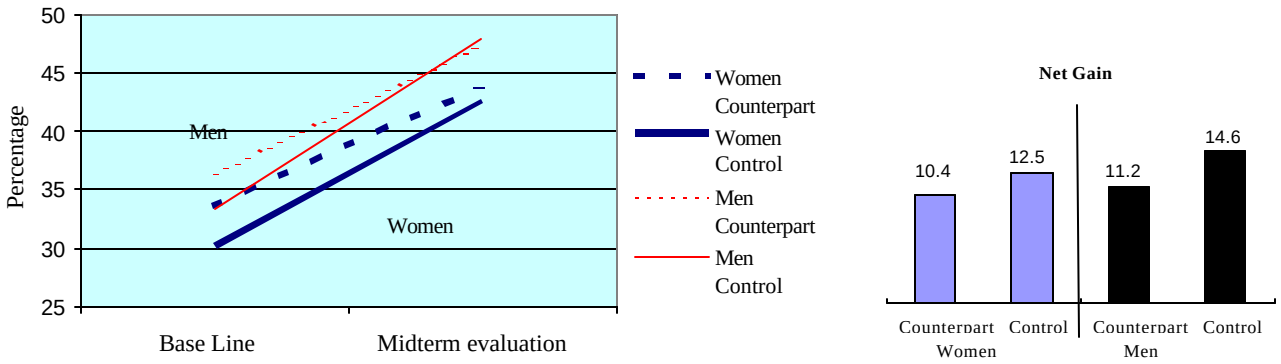
Table 15: Perception by Women and Men on the Importance of the Work of Women and Men and on the Level of Education to Be Received by Daughters and Sons

N°	Indicator	Counterpart Communities					Control Communities				
		Base Line	MTE*	Difference	z	Stat. Sig.	Base Line	MTE*	Difference	z	Stat. Sig.
Women's perceptions											
19	percent of women who believe that their work is as important as that of their partner	51.4	57.8	6.4	-2.522	Sig 0.05	48.4	55.2	6.8	-2.852	Sig 0.05
20	percent of women who believe that work in the home is as important as their husband's work	33.7	44.1	10.4	-4.339	Sig 0.05	30.2	42.7	12.5	-5.631	Sig 0.05
21	percent of women who believe that daughters and sons should study to the same level	86.7	91.9	5.2	-2.745	Sig 0.05	94.5	89.6	-4.9	2.957	Sig 0.05
Men's perceptions											
19.1	percent of men who believe that their work is as important as that of their partner	52.1	69.8	17.7	-5.987	Sig 0.05	55.9	68.3	12.4	-4.388	Sig 0.05
20.1	percent of men who believe that the work of their wife in the home is as important as the husband's work	36.2	47.4	11.2	-3.997	Sig 0.05	33.3	47.9	14.6	-5.393	Sig 0.05
21.1	percent of men who believe that daughters and sons should study to the same level	89.1	91.4	2.3	-1.077		91.6	90.9	-0.7	0.325	

*Midterm evaluation

The percentages and differences for each type of community in the two measuring surveys are shown in table 15 (see indicators 20 and 20.1), whilst the opinion trend in men and women by community type is shown in figure 13.

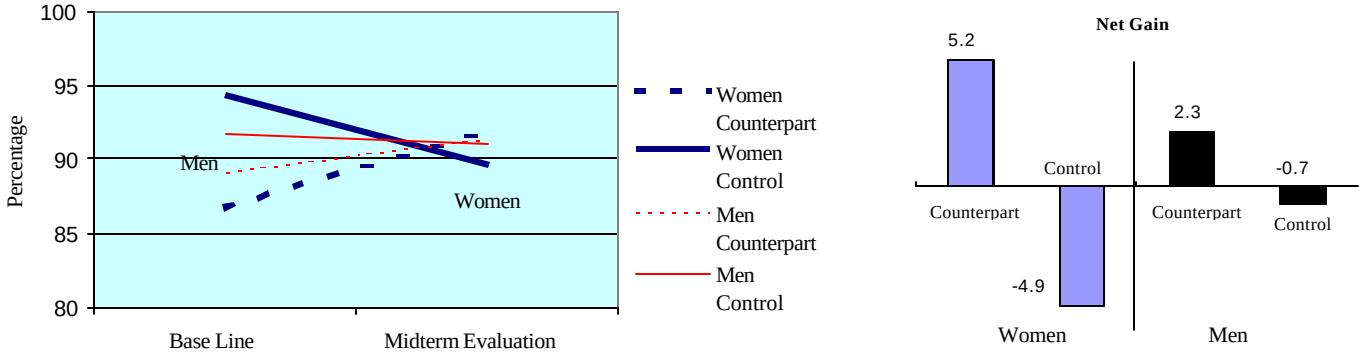
Figure 13: Percentage of Women and Men Who Believe that Housework Is as Important as the Work of the Husband



Perception of Women and Men on the Rights of Daughters and Sons to Be Educated to the Same Level

The positive opinion on the same rights to education of daughters and sons increases slightly in counterpart communities (see figure 14) and decreases slightly in control communities. Net gain of women's opinion in favor of the same rights to education of girls and boys was of 5.2 percentage points in the former and a drop of -4.9 points in the latter. As regards men's opinion, figures were 2.3 points and -0.7 points respectively (see indicator 21 and 21.1 in table 15).

Figure 14: Percentage of Women and Men Who Believe that Daughters and Sons Should Study to the Same Level



According to these figures, it also appears that women attach greater importance to the education of their daughters than do men. The percentage of women who believe that daughters and sons have the same right to education is 5.6 percent as opposed to 2.3 percent of men, probably because they wish better social and financial opportunities for their daughters than they have themselves[23]. The project has had a positive impact (albeit as yet a small one in men) on an important aspect relating to the lives of their daughters: the same rights to education as sons. However, the decline observed in control communities would warrant an explanation that does not fall within the scope of this evaluation.

The balance in partial changes by type of community summarized in the OR shows that as regards the value attached to women's work the project does not improve women's perception of this and affords only a slight improvement in men's perception. As regards the rights to education of daughters and sons, the project has had a slight impact on the favorable perception amongst men (3.4 percent) and a much greater impact amongst women (11.8 percent).

[23] the majority of women in counterpart communities are either illiterate (17 percent) or have only received primary education (45 percent).

Perception of Men Regarding Physical Abuse and Forced Sexual Relations

Changes in the opinion of men regarding physical abuse of women and sexual violence took place in both counterpart and control communities, although changes were slightly greater in ReproSalud counterpart communities, where there is a greater awareness by men that women should be respected and should not be forced into having sexual relations against their will.

Prior to the start of the project, the percentage of men in counterpart communities who believed that women should not by physically abused under any circumstances was 57.4 percent, and this increased to 64 percent after two or three years. In control communities the change was from 58.8 percent to 63 percent. These changes give a net gain of 6.6 percentage points in the former (statistically significant to 5 percent) and 4.2 percentage points in the latter (significant to 10 percent) (see indicator 17 of table 16 and figure 15a).

Table 16: Men's Perceptions Regarding Physical Abuse of Women and Forced Sexual Relations

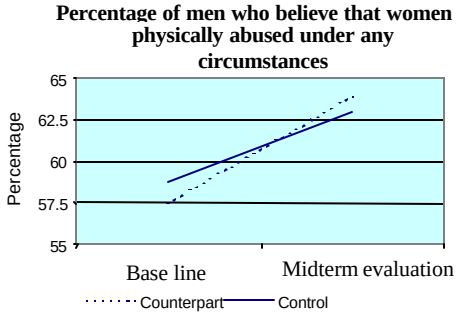
N°	Indicator	Counterpart Communities					Control Communities				
		Base line	MTE*	Difference	z	Stat. Sig.	Base line	MTE*	Difference	z	Stat. Sig.
17	percent of men who believe that women should not be physically abused under any circumstances	57.4	64.0	6.6	-2.531	Sig 0.05	58.8	63.0	4.2	-1.557	Sig 0.10
18	percent of men who believe that men have no right to demand sexual relations against the wife's will	84.6	91.5	6.9	-3.981	Sig 0.05	88.8	91.8	3.0	-1.831	Sig 0.05

*Midterm evaluation

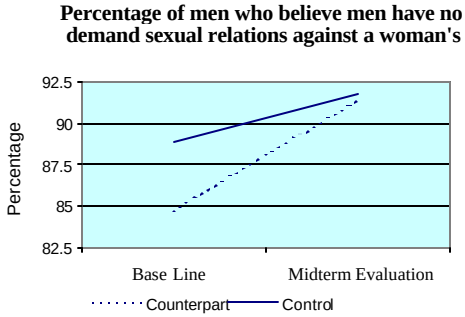
The proportion of men who believe that men have no right to demand sexual relations against a wife's will also increased in both counterpart and control communities, to a somewhat greater degree in counterpart communities. Thus, net gain in counterpart communities is 6.9 percent, more than double that in control communities (3 percent). See figure 15.b and indicator 18 in table 16.

Figure 15: Men's Perceptions Regarding Physical Abuse of Women and Forced Sexual Relations

15a



15b



However, a comparison of the partial changes (see table 24) by type of community on the basis of the base line and midterm evaluation values of the indicators shows that the project had little impact on the positive practices of men in their relationship with women. With regard to control communities, the project only achieved an increase of 4 percent in the percentage of men who believe that women should not be physically abused under any circumstances, and of 4.6 percent in the percentage of men who believe that men have no right to demand sexual relations against their wife's will.

This modest impact of the project on gender opinions and attitudes should be analyzed in the light of the social changes that took place throughout the country in the second half of the 1990s. Subsequent to the International Conference on Population and Development (UNFPA, 1994) at the end of 1994, discussions on gender equity became a fashion, this being the main theme of the Conference.

Given the wide-reaching effects of the said Conference, which emphasized gender equity, especially in matters of sexual and reproductive health, there emerged a current of opinion which has created a favorable environment not only for openly discussing the issue but also to endeavor to overcome obstacles and modify old customs which go against the right of women to be respected and appreciated. Issues of sexual and reproductive rights, as well as gender issues, are currently high on the agenda of social and political leaders, and are also widely discussed in the media and in mass productions which are broadcast on local radio and television, thereby contributing to a positive change in public opinion, even in the more remote communities, regarding a more equitable perception of gender relations, without the need for specific intervention, although it does appear that changes on certain issues are slightly greater when such intervention takes place.

Practices

Given the foregoing external variable which tends to put perceptions regarding gender issues on an equal footing amongst counterpart and control communities, from a project

point of view it is of greater interest to measure practices in the relations between women and men, and the way in which these are consolidated in counterpart communities.

In general, some changes can be seen in the behavior of women within the home and in their communication with their partner in communities where the project is working, whereas in others these changes have not taken place.

One example is that some decisions are being made jointly by the couple. Of the six indicators selected for measuring this issue (see table 17), three bear relation to the main focus of the project: that women should have the same decision-making capacity as their husband or partner within the home.

Table 17: Gender Practices of Women and Men

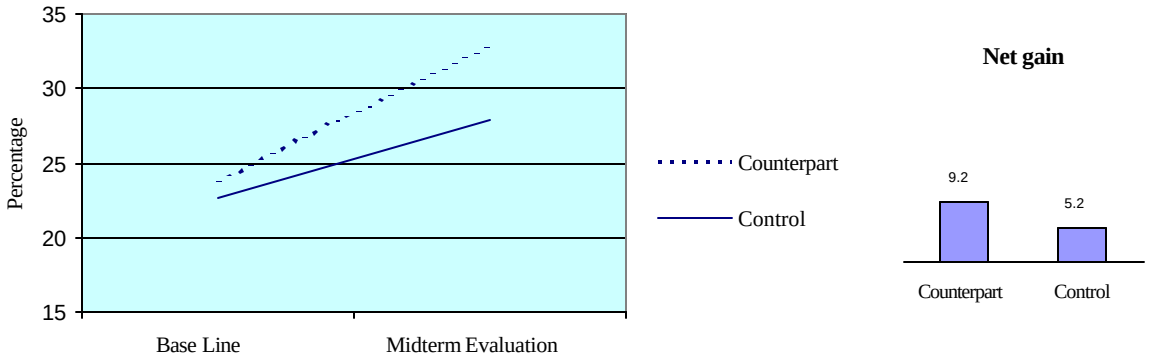
N°	Indicator	Counterpart Communities					Control Communities				
		Base line	MTE*	Differ-ence	z	Stat. Sig.	Base line	MTE*	Differ-ence	z	Stat. Sig.
Women's practices											
7	percent of women in a relationship who decide together with their partner on sexual relations, methods of contraception and number of children	23.7	32.9	9.2	-4.431	Sig 0.05	22.6	27.8	5.2	-2.588	Sig 0.05
9	percent of women who carry out one or more tasks in the home together with their partner	23.2	46.7	23.5	-10.775	Sig 0.05	18.6	37.9	19.3	-9.392	Sig 0.05
11	percent of women in a relationship who decide jointly with their partner on the level to which daughters and sons should be educated	57.4	64.0	6.6	-2.798	Sig 0.05	57.8	58.0	0.2	-0.084	
11.a	percent of women in a relationship who have talked with their partner regarding the number of children they wish to have	67.8	72.6	4.8	-2.273	Sig 0.05	69.3	74.0	4.7	-2.241	Sig 0.05
13	percent of women in a relationship who have talked with their partner on FP in the last 12 months	15.2	20.3	5.1	-2.908	Sig 0.05	11.4	14.1	2.7	-1.757	Sig 0.05
Men's practices											
5	percent of women in a relationship whose partner helps when children are ill	38.7	44.7	6.0	-2.527	Sig 0.05	30.0	35.3	5.3	-2.338	Sig 0.05

*Midterm evaluation

As an example, the percentage of women in a relationship who decide together with their partner on sexual relations, methods of family planning and number of children has increased more in counterpart communities (from 23.7 percent to 32.9 percent) than in control communities (from 22.6 percent to 27.8 percent) (indicator 7 in table 17). This resulted in a net gain of 9.2 percentage points in the former as opposed to 5.2 points in the latter. These changes are significant to 5 percent in both communities.

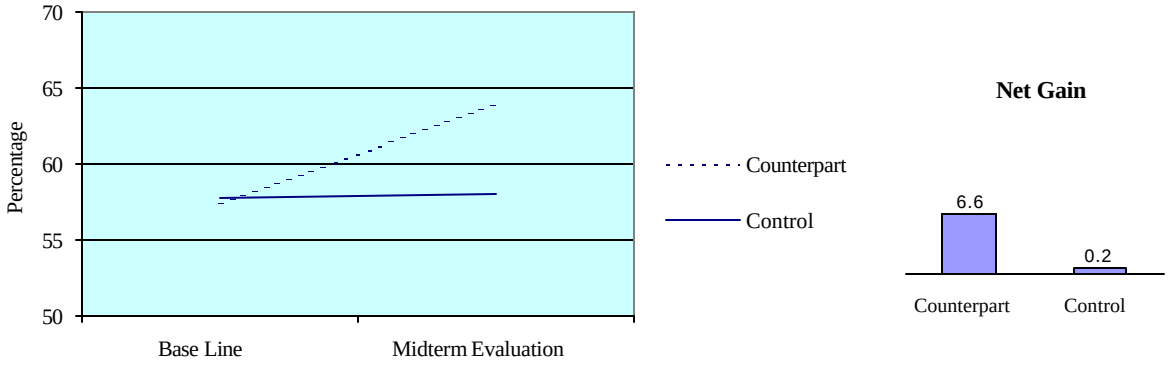
The relative change in counterpart communities was 39 percent and 23 percent in control communities. The balance of these changes shows that the project resulted in an improvement of 13 percent more in counterpart communities.

Figure 16: Percentage of Women Who With Their Partner Jointly Decide Regarding Sexual Relations, Contraception, and Number of Children



A positive change can also be seen in counterpart communities regarding joint decisions on the education of children (a positive change was also seen regarding perceptions on this same issue). Prior to the start of the project, the situation was the same in both types of communities, but the project has made a difference in counterpart communities, where the percentage of women who decide together with their partner on the education of their children increased from 57.4 percent to 64.0 percent (a net gain of 6.6 percentage points), this difference being statistically significant to 5 percent (z = -2.798). However, in control communities this percentage did not change, staying at around 58 percent (a net gain of 0.2 points) (figure 17 and indicator 11 in table 17). Thus, project activities resulted in an additional increase of 11 percent in the proportion of women in counterpart communities who take decisions together with their partner regarding the level of education for their daughters and sons.

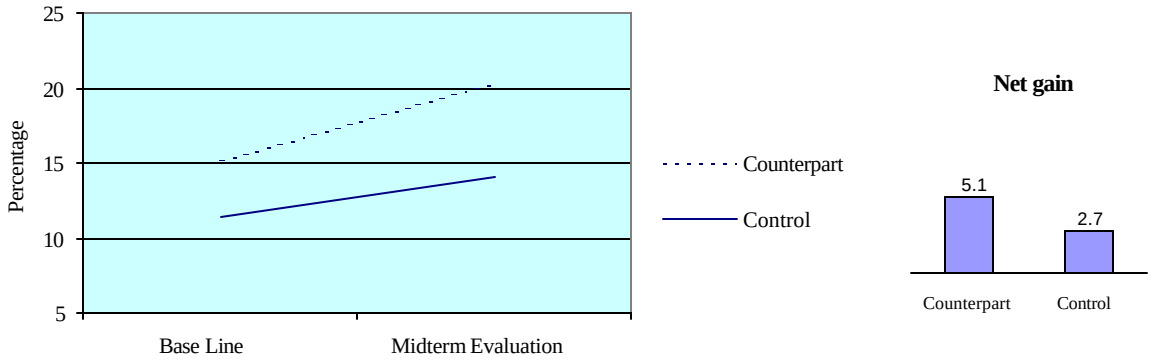
Figure 17: Percentage of Women Who With Their Partners Jointly Decide on the Level of Education for Their Daughters and Sons



Furthermore, a greater increase can be seen in counterpart communities in the percentage of women in a relationship who have talked with their partner on family planning in the

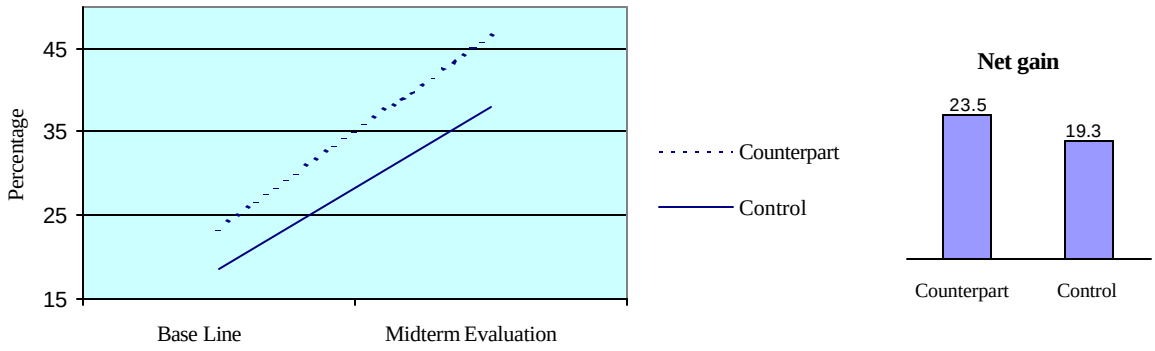
last 12 months (from 15.2 percent to 20.3 percent) as compared to control communities (where the percentage changed from 11.4 percent to 14.1 percent) (indicator 13 in table 17). This difference in intensity of change (see figure 18) resulted in a net gain in the former (5.1 percentage points), which was almost double that of the latter (2.7 points), although in both types of communities these increases are significant to 5 percent. On this issue, the increase due to the project in counterpart communities is 8 percent.

Figure 18: Percentage of Women Who Discussed Family Planning with Their Partner in the Past 12 Months



As opposed to these results, which show a positive impact of the project, there are others that are not as encouraging. As an example, the proportion of women who carry out one or more household chores together with their partner (figure 19), which, though showing a slightly greater increase in counterpart communities (23.5 percentage points) than in control communities (19.3 points), the intensity of change was essentially the same for both types of communities (indicator 9 in table 17). Thus, the project does not appear to have had a significant impact in counterpart communities regarding the percentage of women who have the help of their partner for the household chores (OR = 0.988).

Figure 19: Percentage of Women Who Carry Out One or More Household Chores Jointly with Their Partner



The same is true for the percentage of women who have talked with their partner on the number of children they wish to have. As can be seen in table 17 (indicator 11.a), given that increases were the same for both types of communities (4.8 percentage points), the

difference prior to and after project activities remained the same in each, resulting in parallel lines for the indicator trend, as can be seen in figure 20.

Figure 20: Percentage of Women in a Relationship Who Have Discussed with Their Partner the Number of Children They Wish to Have

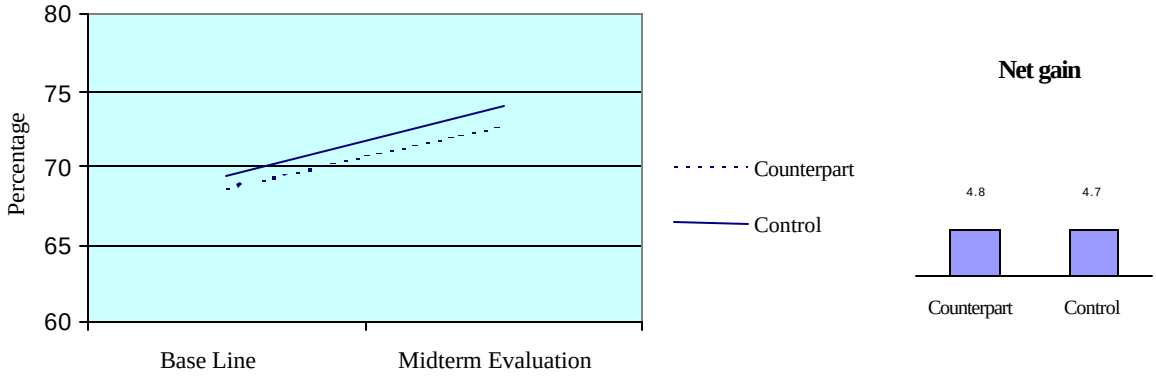
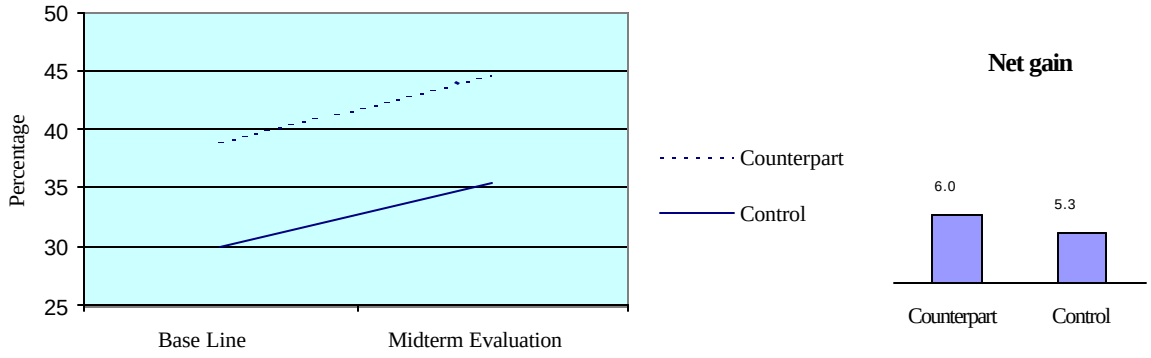


Table 17 has three indicators that measure the same issues in a different way, and their results appear to be contradictory. According to indicator 7, the percentage of women who decide together with their partner on sexual relations, use of contraception and number of children has increased by 9.2 percent between the base line and the midterm evaluation. According to indicator 11.a, the percentage of women who have discussed with their partner the number of children they wish to have has increased by only 4.8 percent and, finally, the percentage of women who have talked with their partner on family planning has increased by scarcely 5 percent. It seems to be a contradiction that a larger number of women decide on these issues when the percentage of those who talk about them has not increased in the same proportion. This confusion would be due to the manner in which indicator 11 is made up, since it summarizes three indicators (women who decide on sexual relations, or on contraception, or on number of children), whereas the other two (indicators 11.a and 13) each measure a single issue. For a more correct interpretation of the results, and in order to avoid apparent contradictions, indicator 11 should be divided into three separate indicators.

The behavior of men in the household as regards caring for the children when they are ill has not changed. The percentage of husbands or partners who help their wife in looking after the children when they are ill has increased in both types of communities, slightly more in counterpart communities (by 6 percentage points) than in control communities (5.3 points) (indicator 5 in table 17), but this does not differentiate the communities, as is confirmed by an OR value = 0.982, which indicates that project activities have not changed the behavior of men on this particular issue. This similar degree of change is shown in figure 21, which shows the parallel trend in both lines.

Figure 21: Percentage of Women in a Relationship Whose Partner Helps When the Children Are Ill



This similarity in the change in behavior of parents in the communities surveyed could be due to the work done by MINSA, and project activities cannot be isolated from this. One of the strategies of public policies on healthcare is the involvement of the family in the treatment and care of ill persons.

The erratic results of the indicators in table 17, some of which show better results in counterpart communities whereas others remain at the same level and are similar to control communities, could be due, as has been said, to the fact that these were anyway different from counterpart communities. Furthermore, a third of the population interviewed in the midterm evaluation was new to the community and, lastly, control communities may have been subjected to activities which have not been reported and which could influence the opinions and practices of the population living in such communities.

Family Relationships

There is only one indicator in the Results Framework that can be used to measure this issue, and that is the one shown in figure 22 and table 18 relating to the percentage of women who have talked with their children over 12 regarding relationships and family planning in the 12 months prior to the interview. This percentage more than doubled in counterpart communities (from 7.1 percent to 16.0 percent), but then so did it in control communities (from 3.9 percent to 10.4 percent). The net gain of 8.9 percentage points in the former and 6.5 points in the latter is of no real significance, since the intensity of change was greater in control communities, where the percentage of women who have talked with their children regarding relationships and family planning multiplied by 1.6 percent, whereas in counterpart communities this was only 1.25 percent. The value of OR = 0.845 shows that the project has not contributed in this respect.

Figure 22: Percentage of Women in a Relationship Who Have Discussed Relationships and Family Planning with Their Children in the Past 12 Months

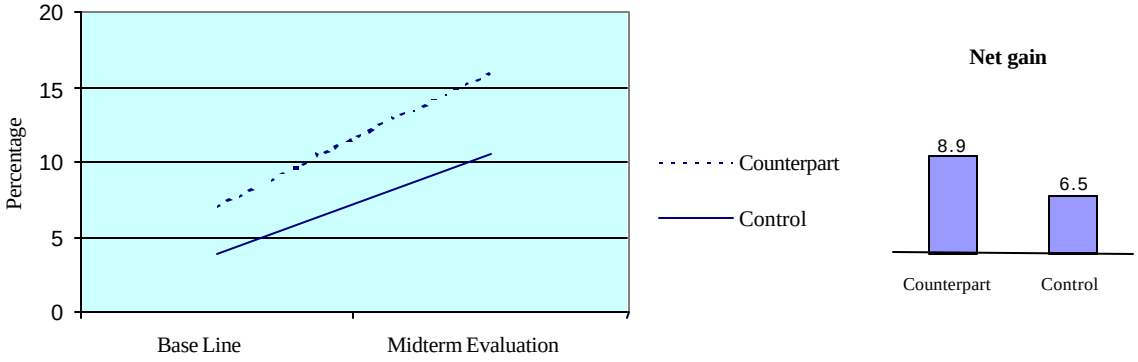


Table 18: Family Relations

N°	Indicator	Counterpart Communities					Control Communities				
		Base line	MTE*	Difference	z	Stat. Sig.	Base line	MTE*	Difference	z	Stat. Sig.
16	percent of women in a relationship who have talked with their children about relationships and family planning in the last 12 months	7.1	16.0	8.9	-3.893	Sig 0.05	3.9	10.4	6.5	-3.352	Sig 0.05

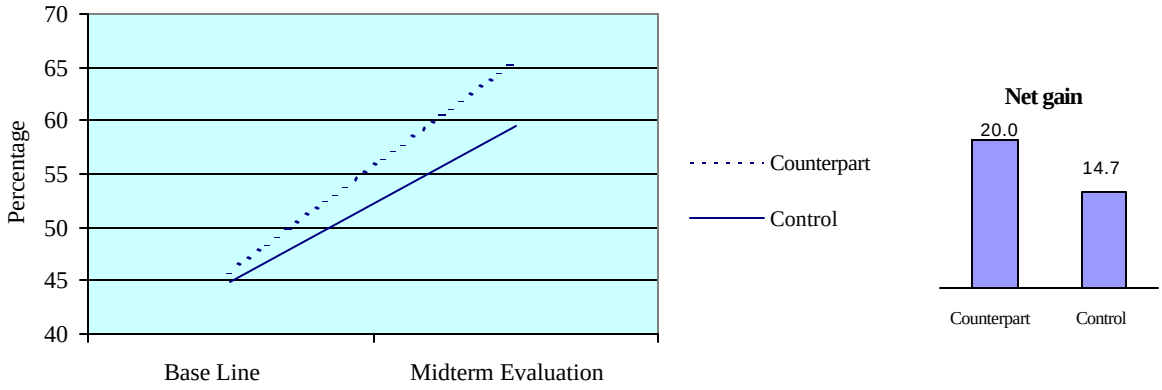
Empowerment

As regards empowerment practices, counterpart communities show interesting achievements, although some of these could contain some of the initial bias of self-selection of the communities. Although counterpart communities were quite poor, they were nevertheless better organized and, to a certain extent, had better information and knowledge on issues of gender and empowerment (which is the reason why they had stronger CBOs) than their controls in the area where control sample was selected.

Knowledge

In accordance with the figures available, the project has improved the information available to women regarding where to go to seek help if they are physically abused (see figure 23). In counterpart communities this figure rose from 45.6 percent to 65.6 percent, while in control communities it rose from 44.8 percent to 59.5 percent (indicator 16.a of table 19). Thus, net gain for knowledge was 20 percentage points in the former and 14.7 points in the latter, both significant to 5 percent. The balance of relative changes in each type of community shows that where project activities were carried out the knowledge of women in the counterpart communities who know where to seek help if they are physically abused increased by 8.3 percent more than in control communities (table 24).

Figure 23: Percentage of Women Who Know Where to Seek Help of Advice in the Event of Physical Abuse

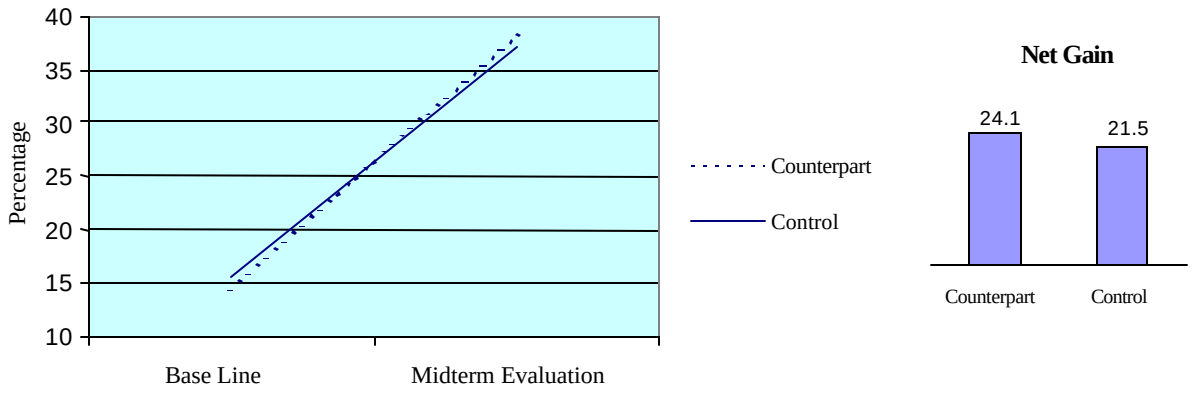


Attitudes

This increase in knowledge results in an increase in readiness to act accordingly. Following project activities, more than double the number of women in the project counterpart communities would be prepared to go to the police or to the authorities in the event of physical abuse by their husband (from 14.3 percent to 38.4 percent). This percentage also doubled in control communities (from 15.7 percent to 37.2 percent) and, in both, the change in the indicator is significant to 5 percent.

Net gain is greater (24.1 percentage points) in counterpart communities than in control communities (21.5 points), as is the intensity of change, although the almost parallel lines in figure 24 seem to indicate differently (see the base line and midterm evaluation percentages in table 19, indicator 14). In counterpart communities, the initial percentage of women who would go to the police to seek help multiplied by 1.69, while in control communities it increased by multiplied by 1.37 (table 24). The difference in these figures shows that as a result of project activities, the proactive attitude of women to defend themselves increased 13 percent more in counterpart communities.

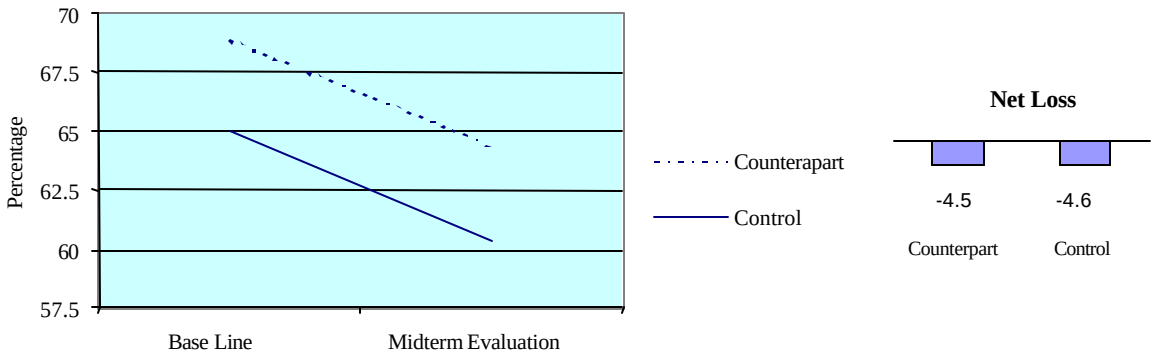
Figure 24: Percentage of Women Who Would Seek Help from the Police/Authorities in the Event of Physical Abuse by Their Husband



Perceptions

As regards perceptions on the issue of empowerment, the percentage of women who agree that women should take precautions in order not to have children even if their partner opposes this has decreased, as shown in figure 25, both in counterpart communities (from 68.9 percent to 64 percent) and in control communities (from 65 percent to 58.7 percent), net loss being the same in both types of community, approximately -4.5 percentage points (indicator 12, table 19).

Figure 25: Percentage of Women Who Agree that Women Should Take Precautions in Order Not to Have Children Even if the Husband Disagrees



This opinion could be attributed to the fact that during training sessions issues regarding communication with the partner and the importance of taking decisions jointly were emphasized. But this decrease also occurred in control communities where ReproSalud did not carry out any training, perhaps as a result of the work carried out by MINSA through its Family Planning Program, which emphasizes the fact that the decision on the use of contraception should be taken by the couple. The value of OR = 1.006 shows that project intervention has had no impact on this issue in counterpart communities as compared to control communities.

Table 19: Empowerment

N°	Indicator	Counterpart Communities					Control Communities				
		Base line	MTE*	Difference	z	Stat. Sig.	Base line	MTE*	Difference	z	Stat. Sig.
Knowledge											
16.a	percent of women who know where to seek help or advice in the event of physical abuse	45.6	65.6	20.0	-10.983	Sig 0.05	44.8	59.5	14.7	-7.737	Sig 0.05
Perceptions											
12	percent of women who agree that women should take precautions in order not to have children even if the husband disagrees	68.9	64.4	-4.5	2.071	Sig 0.05	65.0	60.4	-4.6	2.056	Sig 0.05

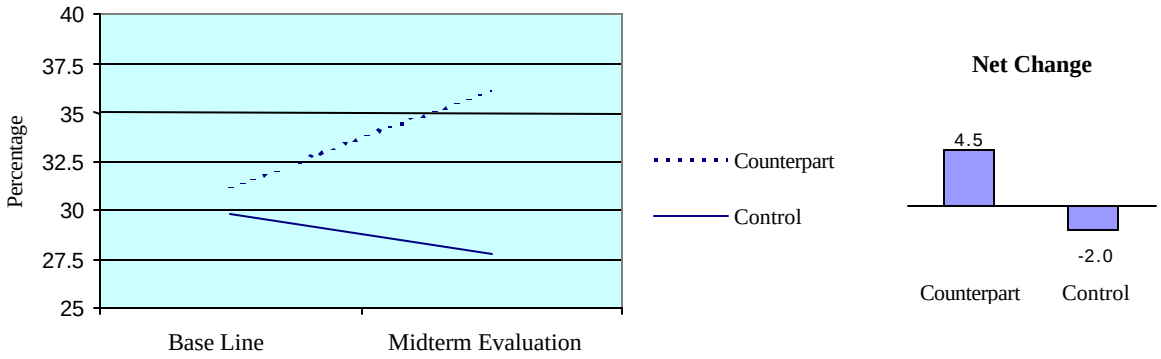
N°	Indicator	Counterpart Communities					Control Communities				
		Base line	MTE*	Difference	z	Stat. Sig.	Base line	MTE*	Difference	z	Stat. Sig.
Attitude											
14	percent of women who would go to the police/authorities for help in the event of physical abuse by their husband	14.3	38.4	24.1	-12.015	Sig 0.05	15.7	37.2	21.5	-10.691	Sig 0.05
Practices											
6	percent of women in a relationship who decide what to spend the money they themselves earn on	31.6	36.1	4.5	-2.596	Sig 0.05	29.8	27.8	-2.0	1.158	
12.1	percent of women who do not have sexual relations by force or persuasion	50.6	64.0	13.4	-5.852	Sig 0.05	55.4	58.7	3.3	-1.435	Sig 0.10

*Midterm evaluation

Practice

By contrast, as regards practices on issues of empowerment, the project has had a significant impact. As an example, the percentage of women who decide what to spend the money they themselves earn on increased in counterpart communities from 31.6 percent to 36.1 percent and decreased in control communities from 29.8 percent to 27.8 percent) (figure 26 and indicator 6 in table 19). Net gain in the former was 4.5 percentage points, and net loss in the latter was 2 percentage points. The project contribution is ratified by the value of OR = 1.225, which gives the project an increase of 23 percent more in the percentage of women in counterpart communities who decide what to spend the money they earn on.

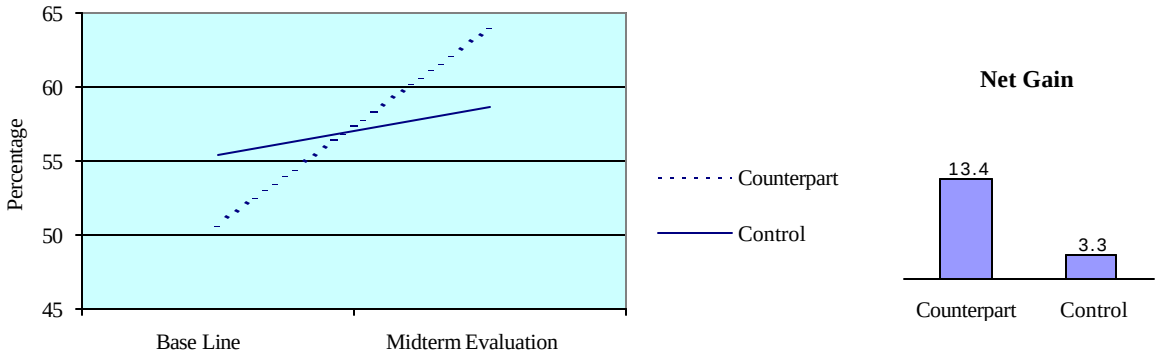
Figure 26: Percentage of Women Who Decide How to Spend the Money They Earn



The project seems to have had the same impact as regards understanding of the right of women not to be sexually abused by their partner, and this is shown by the increase in the percentage of women who do not have sexual relations by force or persuasion. In project communities this figure increased from 50.6 percent to 64 percent, while in control communities it increased only from 55.4 percent to 58.7 percent (indicator 12a in table

17). Net gain of 13.4 percentage points and 3.3 percentage points respectively is eloquent and reveals an important aspect of the self-respect that women in communities where ReproSalud is working have for themselves. These results are probably indicative of a capacity for negotiation with their partners on issues of sexual relations. This is confirmed by the balance in partial changes (table 24) in the two types of communities, which attributes to the project activities an additional positive increase of 19.4 percent for this indicator in counterpart communities.

Figure 27: Percentage of Women Who Do Not Have Sexual Relations by Force or Persuasion



Use of Health Services

Some indicators which reveal a greater use of health services were discussed in Section B.1 of Part Two of this report when analyzing achievements of the Strategic Objective. There now follows an analysis of additional indicators on the opinions and attitudes of women as well as on their practices in relation to the use of health services.

Perceptions Regarding the Quality of Health Services

Perceptions regarding health services were inquired about by asking women whether they thought that the service provided by the nearest health center, assuming that this is the one they attend, is good (or very good). The figures show that in general women from control communities have a more 'generous' perception of the quality of the health services when replying regarding the attention they themselves or somebody they were accompanying had received (see figure 28). I ndeed, this percentage grew from 52.8 percent to 69.7 percent, while in counterpart communities it grew from 45.5 percent to 56.2 percent (indicator 26 in table 20). As a result, net gain in control communities was 16.9 percentage points, while in counterpart communities it was 10.7 points.

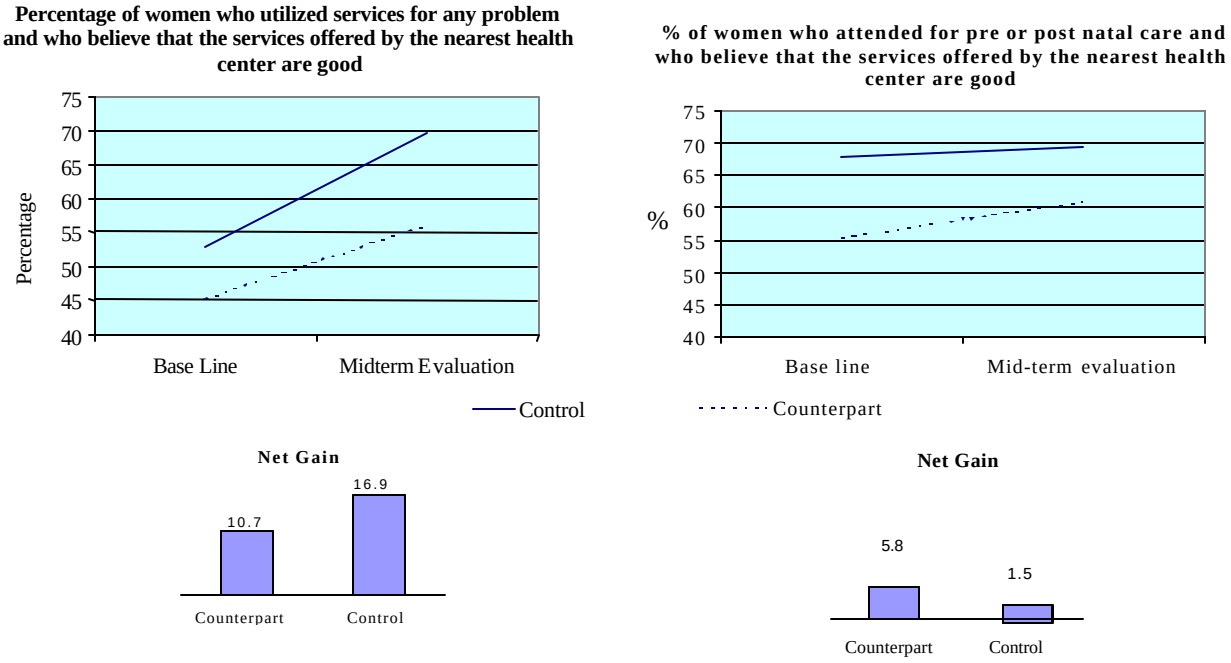
Table 20: Perception Of Women of Reproductive Age Regarding Quality of the Health Services

N°	Indicator	Counterpart Communities					Control Communities				
		Base line	MTE*	Difference	z	Stat. Sig.	Base line	MTE*	Difference	z	Stat. Sig.
Perceptions											
26	percent of women who believe that the services afforded by the nearest health center are good (or very good)	45.5	56.2	10.7	-5.107	Sig 0.05	52.8	69.7	16.9	-8.397	Sig 0.05
27	percent of women who have attended a health center for pre and post natal care and believe that the services afforded by the nearest center are good (or very good)	55.4	61.2	5.8	-1.450	Sig 0.10	67.8	69.3	1.5	-0.389	
Attitudes											
29	percent of women in a relationship who would attend a health center in the event of potentially dangerous problems	42.6	71.6	29.0	-11.111	Sig 0.05	36.8	62.2	25.4	-10.678	Sig 0.05

*Midterm evaluation

When the same question is made to women who attended a hospital, health center or health post for their own care for either pre or post natal check-up, it is observed that the positive change in the percentage of women with a favorable opinion of the health services they received was greater in counterpart communities (from 55.4 percent to 61.2 percent) than in control communities (from 67.8 percent to 69.3 percent). These increases resulted in a net gain of 5.8 percentage points in counterpart communities and 1.5 points in control communities (indicator 27 in table 20).

Figure 28: Women's Use of Health Services



These findings could be valued for their aspect of empowerment coupled with a sophistication in the critical judgment of women on the services they receive. Since they were trained on what to expect from the service, it is possible that on replying regarding the quality of the services afforded by health centers they may have given a more objective evaluation of what they received (indicator 26, table 20).

Furthermore, the greater increase in counterpart communities of the positive perception of health services amongst women who attend for pre or post natal care (indicator 27 in table 20) would imply an effective improvement in the health services as a result of the work carried out by the Health Ministry to afford quality care in mother-and-child services[24], and this may have been strengthened by the facilitators of ReproSalud, who approached the service providers in an attempt to improve client relations.

The OR value for indicator 26 (0.936) shows that the project had no impact, although if the theory of sophistication of the critical judgment of women is to be used, this measurement might not necessarily be negative for the project. On the other hand, OR = 1.081 for indicator 27 shows an additional increase, attributable to the project, of 8 percent in counterpart communities regarding the positive perception on the quality of service amongst women who attended for pre or post natal care.

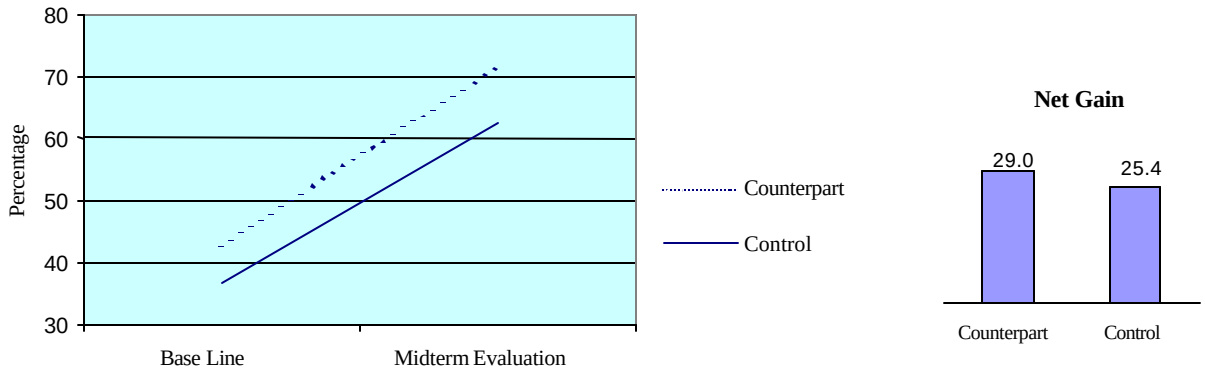
Attitudes: Readiness of Women to Attend Health Centers

In general, whether a women attends a health center for her own treatment or for accompanying another person, after a minimum of two years of project activities the figures show that almost 60 percent of women in counterpart communities and almost 70 percent in control communities are of the opinion that the services are of a good quality. Accordingly, their readiness to attend a health center is positive and has increased considerably, from 42.6 percent to 71.6 percent amongst the former and from 36.8 percent to 62.2 percent amongst the latter. In both, the increase is significant to 5 percent. Net gain is 29 percentage points in counterpart communities and 25.4 percent in control communities (see table 20, indicator 29, and figure 29).

The intensity of change was, however, greater amongst women in control communities, where in the midterm evaluation the percentage of those who would attend a health center increased by 76.4 percent as compared to the base line, while in counterpart communities it increased by 60.5 percent. The OR value of 0.936 shows that the project had no impact on this indicator.

[24] MINSA is committed to increasing coverage and improving the quality of reproductive health and family planning services, and for this it has the support of international aid agencies such as the US Agency for International Development USAID, the United Nations, the British Department for International Development DfID, the World Bank and the Interamerican Development Bank, amongst others.

Figure 29: Percentage of Women in a Relationship Who Would Visit a Health Center for High Risk Problems



Practices Relating to Health

The purpose of ReproSalud is to instill in the population positive practices relating to healthcare and to boost women's appreciation of themselves and their self-confidence. The aim is to encourage them to seek professional help for their physical healthcare needs and thereby achieve the necessary balance between physical and mental health, which will contribute to an increased quality of life. It is hoped that women will care not only for their children, their partner or their parents, as they have been doing for centuries, but that they will also care for themselves.

Spending on Health and Visits to Health Centers

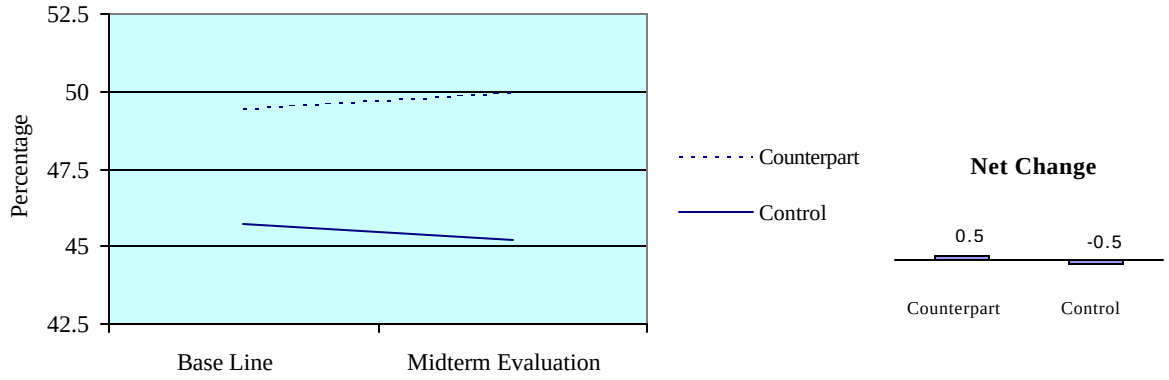
The project selected various indictors to measure these practices in the population and monitor their consolidation as project activities are implemented. The results likewise show that the project had no impact on this issue. As an example, both in counterpart communities and in control communities the percentage of women spending on healthcare in the last 12 months has remained virtually unchanged, at about 50 percent in counterpart communities and 45 percent in control communities (indicator 33 in table 21 and figure 30). The difference between the two surveys is not significant in either community, and although the increase in counterpart communities and the decrease in control communities might perhaps suggest a better situation in the former, the change is minimal and makes little difference between the two types of communities. This is confirmed by the OR value = 1.021, which attributes to the project a positive impact of only 2 percent for this indicator.

Table 21: Professional Health Care

N°	Indicator	Counterpart Communities					Control Communities				
		Base Line	MTE*	Difference	z	Stat. Sig.	Base Line	MTE*	Difference	z	Stat. Sig.
Practices											
33	percent of women who spent on healthcare in the last 12 months	49.5	50.0	0.5	-0.273		45.7	45.2	-0.5	0.241	
24	percent of women who attended a health center for issues of reproductive health or family planning	26.3	42.2	15.9	-9.187	Sig 0.05	22.5	39.7	17.2	-9.851	Sig 0.05

*Midterm evaluation

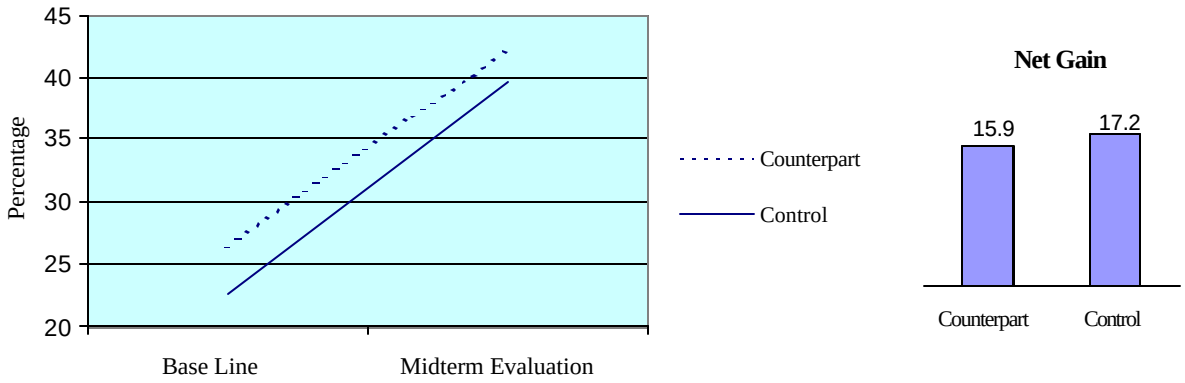
Figure 30: Percentage of Women Who Spent Money on Healthcare in the Past 12 Months



The percentage of women who have attended a health center for reproductive health or family planning issues has increased slightly more in control communities (from 22.5 percent to 39.7 percent) than in counterpart communities (from 26.3 percent to 42.2 percent), and thus net gain is 17.2 percentage points in the former and 15.9 percentage points in the latter (figure 31). The change observed in the two types of communities is statistically significant to 5 percent (indicator 24 in table 21). The value of OR = 0.909 shows that the situation both before and after project implementation was the same in the two types of communities.

It appears that the work of the MINSA through its community workers, mobile clinics and regional fairs, events which gather a large number of clients for the centers, has been more effective in control communities than in counterpart communities, and this has neutralized the work of ReproSalud, the impact of which it has not been possible to isolate with the indicators provided.

Figure 31: Percentage of Women Who Have Visited a Health Center for Family Planning or Reproductive Health Services



Differences could also be due to the fact that women did not receive a good response when they sought professional attention for genital tract infections or other reproductive health problems, as was noted during the interviews in the process evaluation. At the time, many women complained of the waiting time, of the high cost of the service, of the price of medicines, and especially of not receiving the results of the Papanicolau examination.

These findings are in stark contrast with the notable increase in the use of health services for pre and postnatal check-ups, as discussed in section III.B of this report.

Treatment of Vaginal Discharge (or 'White Period')

As has been mentioned, discharges were reported as the main reproductive health problem for women in 36.6 percent of the participatory appraisal exercises. This is just over a third of the communities taking part in the project; in Ucayali it was considered to be the most important problem faced by women in 80 percent of the communities, in 62 percent of the communities in Ayacucho and in 54 percent of the communities in Huancavelica.

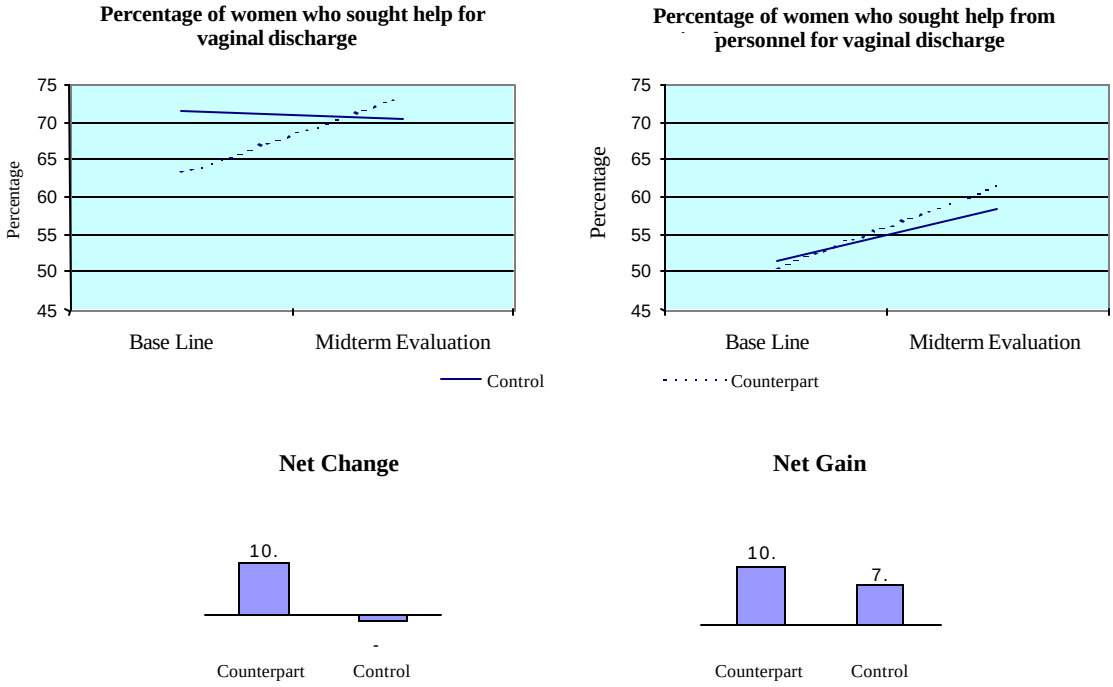
Given these findings and the suffering expressed by the women themselves, the project aimed to target this problem by explaining how and why it occurs, how it can be prevented, how it should be treated and especially by trying to persuade those who suffer from it to attend a health center in order to seek professional help.

The figures show the percentage of women who were attended by trained personnel and those who were attended by 'traditional' doctors. Project results on this issue are significant and reflect the efforts made to concentrate activities on it. Indeed, the percentage of women who sought help for vaginal discharge[25] in counterpart communities rose from 63.2 percent to 73.4 percent while in control communities it fell

[25] Amongst those women who said they suffered from this problem.

from 71.5 percent to 70.5 percent. Thus, net gain was 10.2 percentage points in the former and -1.0 points in the latter (figure 32). The value of OR = 1.178 shows that as a result of project activities the percentage of women who sought help for discharges increased by 18 percent more in counterpart communities.

Figure 32: Women's Health Seeking Behavior for Vaginal Discharge



The percentage of women who sought the help of trained personnel experienced a smaller increase, from 50.6 percent to 61.4 percent in counterpart communities (a net gain of 10.8 points) and from 51.4 percent to 58.4 percent in control communities (a net gain of 7 points) (indicator 30.a in table 22). The balance of the partial changes by type of community shows that in counterpart communities the project increased the number of women who sought the help of trained personnel for vaginal discharge by almost 7 percent more, OR = 1.068.

These figures show that women in counterpart communities are more worried if they have vaginal discharge and deal with this by seeking help either through formal or informal health services. For these women, it is also valid to attend a traditional doctor or herbalist, who can help improve external symptoms, although not necessarily cure the problem. It is a legitimate wish to resort to traditional medicine, although probably not effective in the case of abnormal (i.e. non-physiological) discharges caused by bacteria, fungi or virus which require specific treatment through antibacterial, antifungal or antiviral preparations. Home remedies or traditional medicine may be effective in the case of normal physiological discharges such as occur, for example, after menstruation and during pregnancy.

Table 22: Help for Problems of Vaginal Discharge

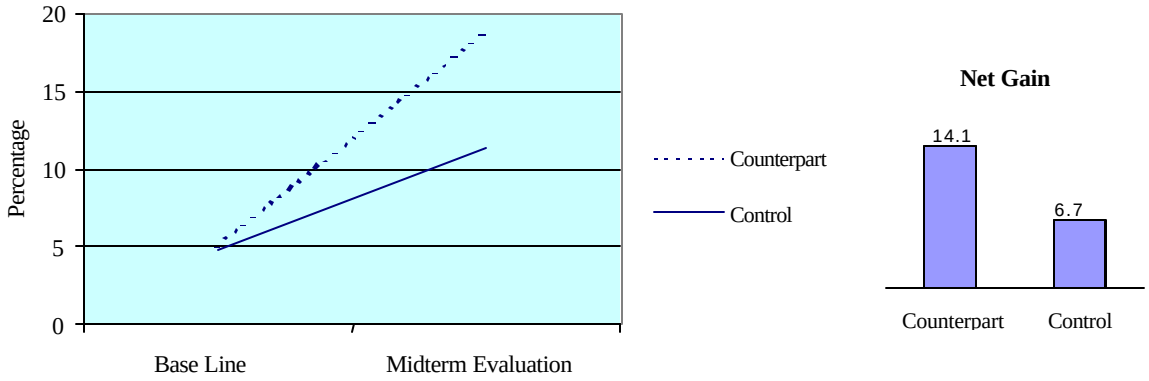
N°	Indicator	Counterpart Communities					Control Communities				
		Base line	MTE*	Difference	z	Stat. Sig.	Base line	MTE*	Difference	z	Stat. Sig.
30	percent of women who sought help for vaginal discharge	63.2	73.4	10.2	-2.673	Sig 0.05	71.5	70.5	-1.0	0.257	
30.a	percent of women who sought help from trained personnel for vaginal discharge	50.6	61.4	10.8	-2.669	Sig 0.05	51.4	58.4	7.0	-1.637	Sig 0.10

Self Care

The objective of ReproSalud was not only to encourage women to attend formal health services, but also to use other means of improving health, including self-care. The assumption is that even by simply confiding a problem to a neighbor or family member this might eventually lead to professional help after a chain of events or persons which would ultimately lead to a health center. Prior to a specific practice of self-care as indicative of change towards improvement of the quality of life of women, the project aims to increase the knowledge of women regarding health-related issues.

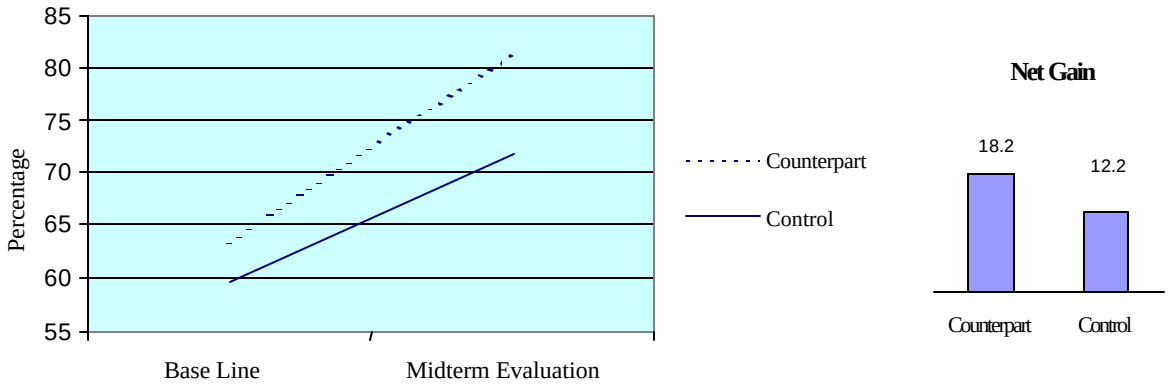
On the basis of this assumption the indicators of table 23 were developed, the values of which show that the project has improved the information available to women in counterpart communities on issues relating to reproductive health. In particular, the percentage of those who know how discharges are transmitted has increased from 4.9 percent to 19 percent, a net gain of 14.1 percentage points. By contrast, in control communities this increase was smaller, from 4.7 percent to 11.4 percent, a net gain of scarcely 6.7 points. As can be seen in figure 33 and in table 23, the two types of community start from a similar percentage of around 4.7 percent, but after project activities the lines diverge to give a significant difference on the second survey in favor of counterpart communities. As a result, the gain attributable to the project regarding knowledge on the way in which discharges are transmitted is quite high, namely 60 percent.

Figure 33: Percentage of Women Who Know How 'White Period' Is Transmitted



There is also an increase in knowledge of the Papanicolau exam or of breast examination amongst women in counterpart communities of 18.2 percentage points (from 63.2 percent to 81.4 percent), while in control communities there was an increase of 12 points (from 59.6 percent to 71.8 percent) (indicator 43.a in table 23 and figure 34). Project contribution to the increase of this indicator was 7 percent.

Figure 34: Percentage of Women Who Have Knowlege of the Papanicolau or Breast Examination



The percentage of women capable of identifying risk symptoms during pregnancy and after childbirth which would warrant seeking medical attention has shown a similar increase (net gain of 26.6 percent) in both types of communities, as shown by the parallel lines in figure 35. However, on analyzing the base line and midterm evaluation values for each type of community, it can be seen that partial change was much greater in control communities (203 percent) than in counterpart communities (137 percent). Thus, the balance of partial changes gives an OR value = 0.782, showing that the project had no impact on this issue. Indeed, this indicator is the one of least impact for the project as per the ranking shown in table 25.

Figure 35: Percentage of Women in a Relationship Who Are Able to Recognize Risk Symptoms During Pregnancy and After Childbirth

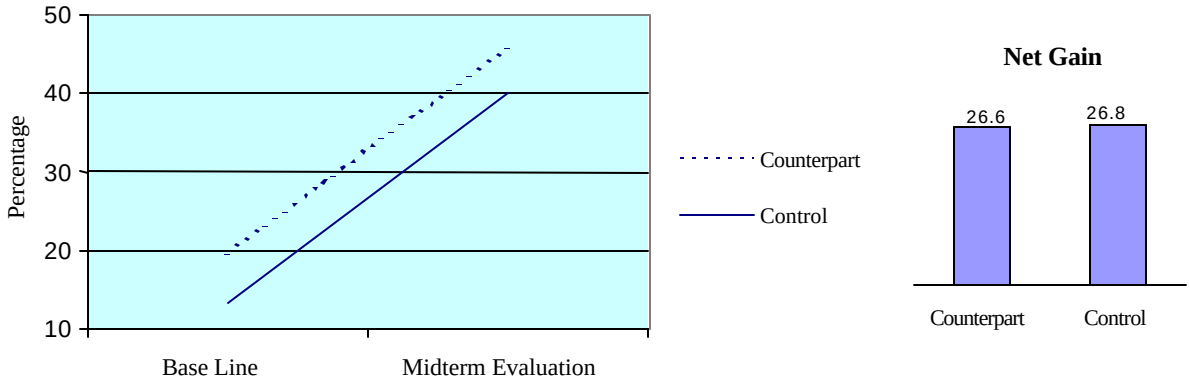


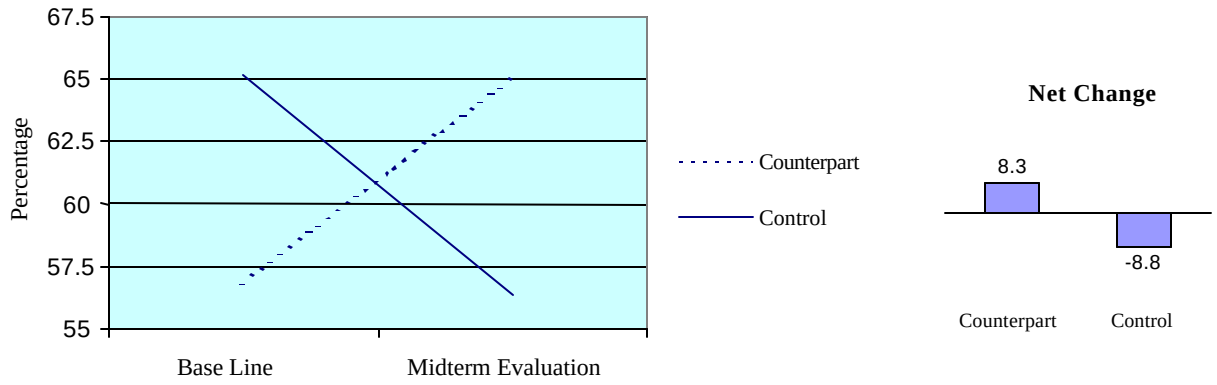
Table 23: Self Care

Nº	Indicator	Counterpart Communities					Control Communities				
		Base line	MTE*	Difference	Z	Stat. Sig.	Base line	MTE*	Difference	z	Stat. Sig.
Knowledge											
40	percent of women in a relationship who can recognize symptoms of risk during pregnancy and after childbirth	19.4	46.0	26.6	-12.428	Sig 0.05	13.2	40.0	26.8	-13.40	Sig 0.05
43	percent of women who know how 'white period' is transmitted	4.9	19.0	14.1	-10.568	Sig 0.05	4.7	11.4	6.7	-5.448	Sig 0.05
43.a	percent of women who have heard of Papanicolau or breast examination	63.2	81.4	18.2	-11.037	Sig 0.05	59.6	71.8	12.2	-6.732	Sig 0.05
Practice											
32	percent of women who look after their health to feel good	56.8	65.1	8.3	-4.368	Sig 0.05	65.2	56.4	-8.8	4.741	Sig 0.05

*Midterm evaluation

There is a project indicator that has also been developed to measure the increase in positive appreciation of women's health within the household and within the community (RI 2.2). This relates to healthcare as a way to 'feel good.' It is difficult to explain the figures, which show an increase in counterpart communities (from 56.8 percent to 65.1 percent) and a drop in control communities (from 65.2 percent to 56.4 percent) (see figure 36).

Figure 36: Percentage of Women Who Maintain Their Health to Feel Good



It is possible that the women interviewed did not understand the question, although it could also be that women in counterpart communities learnt to appreciate themselves through their training and do indeed look after their health to 'feel good' or to 'be healthy'. However, the decrease in control communities would require an explanation.

D. SUMMARY OF CHANGES IN THE INDICATORS OF THE RESULTS FRAMEWORK

This section aims to summarize the findings in respect of achievement of the SO and the IRs, which are shown in table 24, where the indictors are numbered as in the original version. The six indicators created for this evaluation have been included, as have the base line and midterm evaluation values of each indicator and the value of the OR.

Net gains, as described and shown in section III.B and C of this report, measure the change in percentage points between the base line and the midterm evaluation and give a good indication of the benefits to counterpart communities of project activities. However, they do not show how different such gains are in respect of what they might have been in control communities, particularly given the fact that such communities are different from project communities. For this reason, this section attempts to give a more sophisticated analysis, using relative changes/increments (obtained by dividing the value of the indicator in the midterm evaluation by the value of the indicator in the base line) and explaining the strength of the relationship between such changes and the project by the value of the Odds Ratio, or disparity factor (table 24).

According to these figures, the SO of the project, namely that women increase their use of reproductive health services, has been achieved. Indeed, the indicators defined for measuring its achievement showed a favorable change in the direction of the project's mission in the project communities. The relative increase in professional care during pregnancy was 50 percent in project communities (as compared to 30 percent in control communities), that of professional care during childbirth was 33 percent (as compared to only 4 percent in control communities) and prevalence in the use of contraception was 23 percent (as compared to 7 percent). The reduction in unmet family planning needs was 34 percent (as opposed to 19 percent).

The values of the OR confirm this. Under equal conditions, the OR values would be 1, but in the presence of project activities anything over one can be attributed to such activities. Thus, the project has achieved that professional care during childbirth and the use of contraception have each increased by 15 percent more in counterpart communities, and professional care during childbirth has done so by 27 percent more. The unmet demand for family planning has also been reduced by 18 percent more in counterpart communities than in control communities.

As regards IR 1, which aims for women to have more equitable gender relations with their partner and with their family, the project achievements can be clearly seen in three of the six indicators. In the communities where ReproSalud is working, 23 percent more women than in control communities decide what to spend the money they earn on, 13 percent more decide together with their partner on sexual relations, methods of contraception and number of children, and 11 percent more decide together with their partner on the level of education for their daughters and sons.

In the light of these results, the project did not produce any changes in indicators, which measure the participation of men in household chores. Thus, project communities and control communities are equal in terms of the percentage of women whose partner helps when the children are ill, in the percentage of women who carry out one or more household tasks together with their partner, and in the percentage of women who have talked with their partner regarding the number of children they wish to have. This last factor is not consistent with the increase in the percentage of women who decide together with their partner on, amongst other things, the number of children (indicator 7 in the Results Framework).

Table 24: Relative Change Between The Base Line and the Midterm Evaluation for Each Indicator of the Results Framework, and Calculation of the Odds Ratio Values

Indicators	Communities						Odds Ratio
	Counterpart			Control			
	Base Line	MTE	Relative Change	Base Line	MTE	Relative Change	
SO: Women increase their use of reproductive health services							
1.a percent of women who had 4 or more check-ups by trained personnel during the last pregnancy occurring two years before the survey	55.6	83.1	1.495	62.2	81.0	1.302	1.148
2. percent of women whose last delivery, two years before the survey, was under the care of trained personnel	36.1	48.0	1.330	40.9	42.7	1.044	1.274
3. percent of women in a relationship who use some method of contraception	58.4	71.8	1.229	60.6	64.6	1.066	1.153
4. percent of women in a relationship with unmet family planning needs (includes users of the rhythm method who are unaware of the fertile days of the cycle)	48.4	37.3	0.771	50.1	46.9	0.936	0.823
4.1 percent of women in a relationship with unmet family planning needs	27.1	17.9	0.661	26.1	21.1	0.808	0.817
IR 1: Women have more equitable gender relations with their partner and with their family							
5. percent of women in a relationship whose partner helps when the children are ill	38.7	44.7	1.155	30.0	35.3	1.177	0.982
6. percent of women who decide what to spend the money they earn on	31.6	36.1	1.142	29.8	27.8	0.933	1.225
7. percent of women who decide together with their partner on sexual relations, methods of contraception and number of children	23.7	32.9	1.388	22.6	27.8	1.230	1.129
9. percent of women who carry out one or more household tasks together with their partner	23.2	46.7	2.013	18.6	37.9	2.038	0.988
11. percent of women who decide together with their partner on the level of education for daughters and sons	57.4	64.0	1.115	57.8	58.0	1.003	1.111
11.a percent of women in a relationship who have talked with their partner regarding the number of children they wish to have	67.8	72.6	1.071	69.3	74.0	1.068	1.003
IR 1.1: Women strengthen their capacity to bring about changes in their gender relations							
12. percent of women who agree that women should take precautions even if their partner disagrees	68.9	64.4	0.935	65.0	60.4	0.929	1.006
12.1 percent of women who do not have sexual relations by force or persuasion	50.6	64.0	1.265	55.4	58.7	1.060	1.194
13. percent of women who have frequently talked with their partner regarding FP in the last 12 months	15.2	20.3	1.336	11.4	14.1	1.237	1.080
14. percent of women who would seek help from the police/ authorities in the event of physical abuse by their husband	14.3	38.4	2.685	15.7	37.2	2.369	1.133
16. percent of women who have frequently talked with their children regarding relationships and family planning in the last 12 months	7.1	16.0	2.254	3.9	10.4	2.667	0.845

Indicators	Communities						Odds Ratio
	Counterpart			Control			
	Base Line	MTE	Relative Change	Base Line	MTE	Relative Change	
16.a percent of women who know where to seek help or advice in the event of physical abuse	45.6	65.6	1.439	44.8	59.5	1.328	1.083
IR 1.2: Increase in the positive attitudes of men in their relati onship with their wife and their family							
17. percent of men who believe that women should not be physically abused under any circumstances	57.4	64.0	1.115	58.8	63.0	1.071	1.041
18. percent of men who believe men have no right to demand sexual relations against their wife's will	84.6	91.5	1.082	88.8	91.8	1.034	1.046
IR 1.3: Women increase their knowledge on gender issue							
19. percent of women who believe their work is as important as that of their partner	51.4	57.8	1.125	48.4	55.2	1.140	0.986
19.1 percent of men who believe that their work is as important as that of their partner	52.1	69.8	1.340	55.9	68.3	1.222	1.097
20. percent of women who believe that work in the home is as important as the work of their husband	33.7	44.1	1.309	30.2	42.7	1.414	0.926
20.1 percent of men who believe that the work done by their wife in the home is as important as the work of the husband	36.2	47.4	1.309	33.3	47.9	1.438	0.910
21. percent of women who believe that daughters and sons should have the same level of education	86.7	91.9	1.060	94.5	89.6	0.948	1.118
21.1 percent of men who believe that daughters and sons should have the same level of education	89.1	91.4	1.026	91.6	90.9	0.992	1.034
IR 2: Women have a greater capacity to access reproductive health services							
24. percent of women who have attended a health center for matters of reproductive health or family planning	26.3	42.2	1.605	22.5	39.7	1.764	0.909
RI 2.1: Women increase their capacity as end users of formal health services							
26. percent of women who believe that the services afforded by the nearest health center are good (or very good)	45.5	56.2	1.235	52.8	69.7	1.320	0.936
27. percent of women who have attended a health center for pre and postnatal check-up and believe that the services of the nearest center are good (or very good).	55.4	61.2	1.105	67.8	69.3	1.022	1.081
IR 2.2: Increase in the positive appreciation of women's health in the home and in the community							
29. percent of women in a relationship who would attend a health center in the event of risk symptoms	42.6	71.6	1.681	36.8	62.2	1.690	0.994
30. percent of women who sought help for vaginal discharges	63.2	73.4	1.161	71.5	70.5	0.986	1.178
30.a percent of women who sought help for vaginal discharges from trained health personnel	50.6	61.4	1.213	51.4	58.4	1.136	1.068
32. percent of women who care for their health to feel good	56.8	65.1	1.146	65.2	56.4	0.865	1.325
33. percent of women who spent on their health in the last 12 months	49.5	50.0	1.010	45.7	45.2	0.989	1.021
IR 2.6: Women increase their knowledge on their reproductive health needs							
38. percent of women in a relationship who know how al least one modern method works	13.5	55.5	4.111	14.9	31.9	2.141	1.920
39. percent of women using the rhythm method who are aware of the fertile days of the cycle	22.5	28.3	1.258	24.0	24.1	1.004	1.253
40. percent of women in a relationship who can recognize pre and post natal symptoms which imply risk	19.4	46.0	2.371	13.2	40.0	3.030	0.782
43. percent of women who know how 'white period' (vaginal discharge) is transmitted	4.9	19.0	3.878	4.7	11.4	2.426	1.599
43.a percent of women who have heard about Papanicolau or breast examination	63.2	81.4	1.288	59.6	71.8	1.205	1.069
43.b percent of women who believe that it is difficult to get pregnant while breastfeeding	34.0	56.3	1.656	30.9	46.9	1.518	1.091

As regards IR 1.1, which aims for women to strengthen their capacity to bring about changes in their gender relations, the figures show important achievements in some indicators, and a modest or no impact in others. As regards the former, in counterpart communities project activities have increased the percentage of women who do not have sexual relations by force or persuasion by 19 percent more, and the percentage of women who would seek help from the authorities in the event of physical abuse by their husband by 13 percent more. A modest impact can be seen in the increase in the percentage of women who have talked with their partner about family planning[26] (8 percent more than in control communities) and in the percentage of women who know where to seek help or advice in the event of abuse, which also increased by 8 percent more. The project had no impact on the percentage of women who agree that women should take precautions even if their partner disagrees, nor in the percentage of women who have talked with their children on relationships and family planning.

The achievements in IR 1.2, which aims to increase the positive attitudes of men in their relationship with women and with the family, are small. Project activities have increased the percentage of men who believe that women should not be physically abused under any circumstances and the percentage of those who believe that men have no right to demand sexual relations against their wife's will by scarcely 4 percent.

Achievements in IR 1.3, which aims to increase the knowledge of women on gender relations, have been modest for two indicators: the percentage of women who believe that daughters and sons should study to the same level, which due to project activities increased by 12 percent more in counterpart communities, and the percentage of men who believe that the work they carry out is as important as that of their partner, which increased by 10 percent more in counterpart communities. Achievements were small (3 percent) in the increase in the percentage of men who believe that daughters and sons should be educated to the same level. The project has had no impact on the increase in appreciation of the work of women by women nor, and this seems contradictory[27], on the percentage of men who believe that the work of their wife in the home is as important as the work of the husband. It appears that men value the work of women if this takes place outside the home.

It is not possible to reach a conclusion on IR 2, which aims to increase the capacity of women to access health services, since no indicators have been identified in the Results Framework to measure this. This evaluation developed one indicator, but it may perhaps not be the most appropriate. According to this indicator, the project has had no impact in counterpart communities as compared to control communities in the percentage of women who have attended a health center for issues of reproductive health or family planning. These findings are not consistent with the significant increases in prenatal care and care during childbirth by trained personnel, nor with the likewise significant increase in the use of contraception, which were discussed in relation to the SO.

[26] although this figure is not consistent with the better achievement in indicator 7 which measures, among other things, having talked with their partner regarding methods of contraception.

[27] since the project had a moderate impact on the percentage of men who believe that their work is as important as that of their partner

As regards IR 2.1, which aims to increase the capacity of women as end users of formal health services, the results of the indicators which measure the valuation of the quality of the health services in the nearest health center are difficult to interpret, since they appear to be more suited to measuring empowerment, in which case they show a positive impact of the project.

IR 2.2, which aims to increase the positive appreciation of the health of women within the home and within the community, shows significant achievements in two cases. Thanks to project activities, the percentage of women who look after their health to feel good increased by 32 percent more in project communities than in control communities, and the percentage of those who sought help for vaginal discharge problems increased by 18 percent more. However, the percentage of women who sought help for this reason from trained health personnel increased by only 6.8 percent more. The project has not affected the percentage of women who would attend a health center in the event of symptoms implying risk, and has had very little effect on the percentage of women who have spent on healthcare in the last 12 months.

Lastly, achievements for IR 2.6 which aims to increase the knowledge of women regarding their reproductive health needs, have been generally quite significant, with the exception of the percentage of women in a relationship who recognize pre and post natal symptoms implying risk, which has not been affected by the project. Results for other indicators are, however, quite surprising. Particularly so is the percentage of women who know how at least one modern method of contraception works, which increased due to project activities by 92 percent more in counterpart communities than in control communities; the percentage of women who know how 'white period' is transmitted, which increased by 60 percent more; and the percentage of women who are aware of the fertile days of the cycle, which increased by 25 percent more. In the ranking of indicators, from greater to smallest impact of the project, these three are first, second and fifth, respectively (Table 25). The project has had a modest impact on the percentage of women who have heard about the Papanicolau examination or breast examination, which increased by 7 percent more through project activities, and in the percentage of women who believe that while a mother is breastfeeding it is difficult for her to get pregnant.

As has been seen, the SO of ReproSalud has been fulfilled, since the indicators created for measuring it have increased significantly. Achievements in the IRs are varied, with a significant increase in some indicators, a moderate impact in others, and a modest impact in a few. There are also certain indicators on which the project has had no impact.

As regards fulfillment of the SO (which is measured essentially with the indicators on use of health services), the increase in the use of contraception and the reduction in unmet family planning needs are consistent with the achievements in the relevant indicators: for example, the enormous increase in the percentage of women who know how at least one modern method works, in the percentage of women who are aware of the fertile days of the cycle, in the percentage of women who do not have sexual relations by force or persuasion, and the increase, to a slightly lesser degree than for the foregoing indicators,

of the percentage of women who believe that it is difficult for a women to become pregnant while breastfeeding, among others. However, the indicators proposed for measuring this do not easily explain the significant increase in care of pregnant women and during pregnancy and childbirth by trained personnel.

Indeed, pursuant to the ranking of indicators, from greater to smallest project impact, as shown in table 25, two indicators on which the project has had no impact are: the percentage of women who have attended a health center for reproductive health or family planning issues, and the percentage of women who would attend a health center in the event of symptoms of risk. Furthermore, project impact is minimal on the percentage of women who have spent on healthcare in the last 12 months, although this could be explained by the fact that care during pregnancy and childbirth is free in public health centers.

Table 25: Indicators from the Results Framework Ranked in Order of Impact (Greatest First) as Measured by the Value of the Odds Ratio

Indicators	Net gain, in percentage points, between the base line and the midterm evaluation		Odds Ratio
	Counterpart	Control	
Odds Ratio from 1.199 to 1.999			
38. percent of women in a relationship who know how at least one modern method works	42.0	17.0	1.920
43. percent of women who know how 'white period' (vaginal discharge) is transmitted	14.1	6.7	1.599
32. percent of women who look after their health to feel good	8.3	-8.8	1.325
2. percent of women whose last delivery, occurring two years before the survey, was under the care of trained personnel	11.9	1.8	1.274
39. percent of users o f the rhythm method who are aware of the fertile days of the cycle	5.8	0.1	1.253
6. percent of women who decide what to spend the money they earn on	4.5	-2.0	1.225
4.1 percent of women in a relationship with unmet family planning needs	-9.2	-5.0	0.817
4. percent of women in a relationship with unmet family planning needs (includes users of the rhythm method who are unaware of the fertile days of the cycle)	-11.2	-3.2	0.823
Odds Ratio from 1.100 to 1.198			
12.1 percent of women who do not have sexual relations by force or persuasion	13.4	3.3	1.194
30. percent of women who sought help for vaginal discharge problems	10.2	-1.0	1.178
3. percent of women in a relationship who use some method of contraception	13.4	4.0	1.153
1.a percent of wo men who had 4 or more check-ups with trained health personnel during their last pregnancy occurring two years before the survey	27.5	18.8	1.148
14. percent of women who would seek help from the police / authorities in the event of physical abuse by their husband	24.1	21.5	1.133

Indicators	Net gain, in percentage points, between the base line and the midterm evaluation		Odds Ratio
	Counterpart	Control	
7. percent of women who decide together with their partner on sexual relations, methods of contraception and number of children	9.2	5.2	1.129
21. percent of women who believe that daughters and sons should have the same level of education	5.2	-4.9	1.118
11. percent of women who decide together with their partner on the level of education for their daughters and sons	6.6	0.2	1.111
Odds Ratio from 1.050 to 1.099			
19.1 percent of men who believe that their work is as important as that of their partner	17.7	12.4	1.097
43.b percent of women who believe that it is difficult to get pregnant while bre astfeeding	22.3	16.0	1.091
16.a percent of women who know where to seek help or advice in the event of physical abuse	20.0	14.7	1.083
27. percent of women who have attended a health center for pre and post natal check-up and believe that the services afforded by the nearest center are good or very good	5.8	1.5	1.081
13. percent of women who have frequently talked with their partner regarding family planning in the last 12 months	5.1	2.7	1.080
43.a percent of women who have heard of Papanicolau or breast examination	18.2	12.2	1.069
30.a percent of women who sought help from trained health personnel for vaginal discharge ('white period')	10.8	7.0	1.068
Odds Ratio from 1 to 1.049			
18. percent of men who believe that men have no right to demand sexual relations against their wife's will	6.9	3.0	1.046
17. percent of men who believe that women should not be physically abused under any circumstances	6.6	4.2	1.041
21.1 percent of men who believe that daughters and sons should have the same level of education	2.3	-0.7	1.034
33. percent of women who spent on healthcare in the last 12 months	0.5	-0.5	1.021
12. percent of women who agree that women should take precautions even if the partner disagrees	-4.5	-4.6	1.006
11.a percent of women in a relationship who have talked with their partner regarding the number of children they wish to have	4.8	4.7	1.003
Odds Ratio less than 1			
29. percent of women who would attend a health center in the event of symptoms implying risk	29.0	25.4	0.994
9. percent of women who carry out one or more household tasks together with their partner	23.5	19.3	0.988
19. percent of women who believe that their work is as important as that of their partner	6.4	6.8	0.986
5. percent of women in a relationship whose partner helps when the children are ill	6.0	5.3	0.982
26. percent of women who believe that the services afforded by the nearest health center are good (or very good)	10.7	16.9	0.936
20. percent of women who believe that work in the home is as important as that of their husband	10.4	12.5	0.926
20.1 percent of men who believe that work done by women in the home is as important as the work of the husband	11.2	14.6	0.910
24. percent of women who attended a health center for issues of reproductive health or family planning	15.9	17.2	0.909
16. percent of women who have frequently talked with their children on relationships and family planning in the last 12 months	8.9	6.5	0.845
40. percent of women in a relationship who recognize some pre and post natal symptoms which indicate risk	26.6	26.8	0.782

It is very likely that the results are affected by variables which are difficult to control, given the lack of equivalence between counterpart and control communities, by the internal migration which affected both types of communities, and by other factors which have not been detected and which should be investigated and considered in future evaluations of the project.

IV. PROJECT IMPACT AND RESULTS: COMPARING COMMUNITIES WITH EDUCATION ACTIVITIES AND COMMUNITY BANKS WITH COMMUNITIES WITH EDUCATION ACTIVITIES ONLY

As explained, ReproSalud also aims to strengthen the economic capacity of women through an income generation component working in two areas: community banks and product development (the former entails a small financial loan, and the latter the provision of materials). This is done on the assumption that if women have the financial means for paying for health services, they will have a greater readiness to attend health centers to seek professional help.

The income generation component also aims to empower women by improving their decision-making capacity and their ability to negotiate issues relating to their own lives, such as reproductive health, both on a domestic level (within the family) and a social level (with local authorities and health personnel). The empowerment of women sought by the project is a key element in the sustainability of its results and for its ultimate expansion.

The benefits of the microcredit component mainly reached communities in Ucayali, San Martín, Puno and La Libertad, given that the CBOs and the women of these departments who applied for loans met the requirements set down for them. Beneficiary communities were initially among the 247 counterpart communities of ReproSalud, and had the same IE&C activities as the rest. The community bank component subsequently became a special project independent from ReproSalud.

Given that these are two similar experiences, with economic activities in one of the cases to differentiate them, it is of interest to measure the impact in each in order to determine whether provision of financial support does in fact add to the achievements of the education activities.

There are several problems of a diverse nature which restrict the possibilities for making such a comparison and reaching categorical conclusions, amongst them:

- The analysis is centered on communities having CBOs with community banks (hereafter referred to as banks), since there are very few (36 in total) with product development activities: Puno Aymara (9), Ayacucho (9), Ancash (5), Ucayali (4), Puno Quechua (5), San Martín (2) y Lima East (2).

- There are a total of 487 CBOs with banks, located in 53 districts (it was not possible to obtain information at community level). The base line and midterm evaluation surveys were carried out only in 8 communities having CBOs with banks, but control communities where only education activities

were carried out were found only for four of these: two in Puno Aymara and 2 in La Libertad.

- Given the foregoing, it was decided to carry out a trial study where the sample was reduced to 4 communities with banks[28] and 4 control communities[29] (see Annex 4). The results are therefore not representative of what might have occurred in the total number of communities with a component of community banks and should be considered to give an indication of rather than a categorical conclusion.

- Lastly, the impact evaluation of ReproSalud using household surveys was not designed to measure any additional results of the project deriving from income generation activities to complement education activities. Figures might contain biases that are difficult to identify and, what is worse, difficult to control. It could well be, for example, that women beneficiaries of the banks component are in a better socioeconomic position and have greater empowerment.

- The findings and trends observed in the indicators which are analyzed hereafter could serve to develop a specific evaluation for this issue.

The format of this section is the same as that of section III.B and C of this report. It includes an analysis of the project impact and of the IRs. The three tables in annex F give a list of the indicators that were evaluated listed as per the Results Framework. The figures included the values of each in the base line and in the midterm evaluation, the number of cases, the statistical significance, including the value of z, and the value of theOR.

A. PROJECT IMPACT. ACHIEVEMENT OF THE STRATEGIC OBJECTIVE

Professional Care During Pregnancy and Childbirth

Care during pregnancy by trained personnel has had a very similar increase in communities with banks and in those with only the education (IE&C) component, as shown by the two parallel lines in figure 37. Net gain between the base line and the midterm evaluation was 25.9 percentage points and 24.1 percentage points respectively. In the former, the percentage rose from 41.7 percent to 67.6 percent, while in the latter it rose from 49.1 percent to 73.2 percent. For both groups the differences between the two measurements is statistically significant to 5 percent (indicator 1.a of table 26).

[28] with a sample of 186 women in the base line and 146 in the midterm evaluation
[29] with a sample of 258 women in the base line and 212 in the midterm evaluation

Figure 37: Prenatal Check-ups by Trained Personnel During the Last Pregnancy

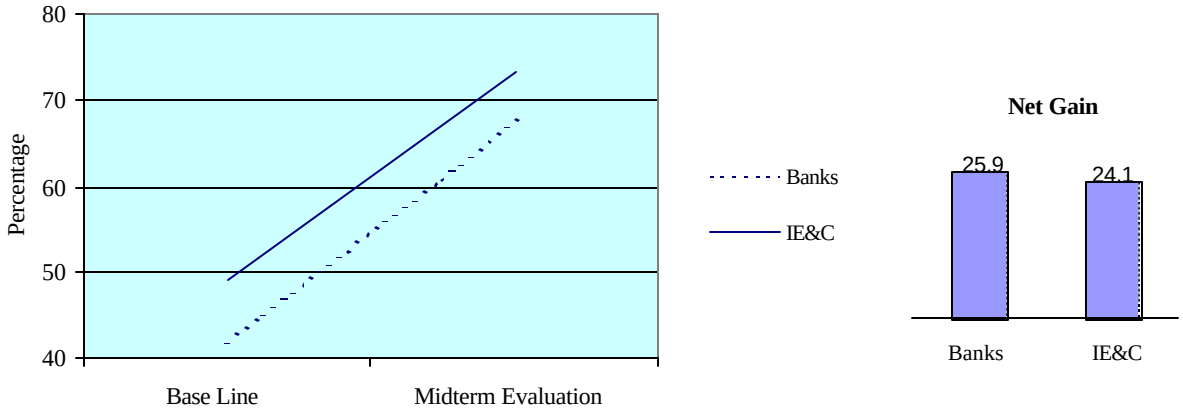
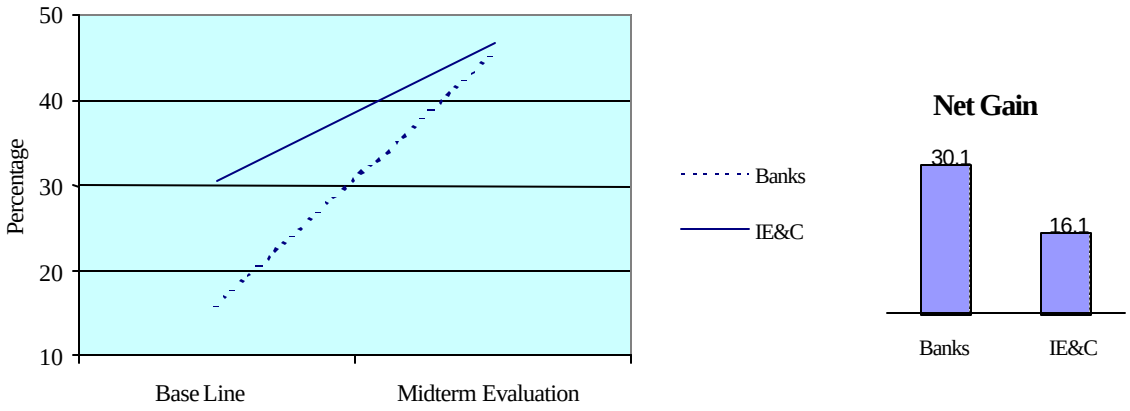


Table 26: Care in Pregnancy and Childbirth by Trained Personnel

N°	Indicator	Communities with Banks					Communities with IE&C				
		Base line	MTE*	Difference	z	Stat. Sig	Base line	MTE*	Difference	z	Stat. Sig.
1.a	percent of women who had 4 or more check-ups by trained health personnel during the last pregnancy occurring two years prior to the survey	41.7	67.6	25.9	-2.174	Sig 0.05	49.1	73.2	24.1	-2.362	Sig 0.05
2	percent of women whose last delivery, occurring two years prior to the survey, was attended to by trained health personnel	15.6	45.7	30.1	-2.950	Sig 0.05	30.6	46.7	16.1	-1.699	Sig 0.05

On the issue of professional care in childbirth a greater achievement can in fact be seen in communities with banks as compared to those with only the IE&C component (see figure 38). Net gain in the former was 30.1 percentage points, just under double the amount in the latter (16.1 points) (indicator 2 in table 26). The percentage of women whose last delivery was attended to by trained health personnel in communities with banks almost trebled (a net gain of 30 percentage points) in the period between the base line and the midterm evaluation (from 15.6 percent to 45.7 percent), while in control communities the increase was only 16 points (from 30.6 percent to 46.7 percent).

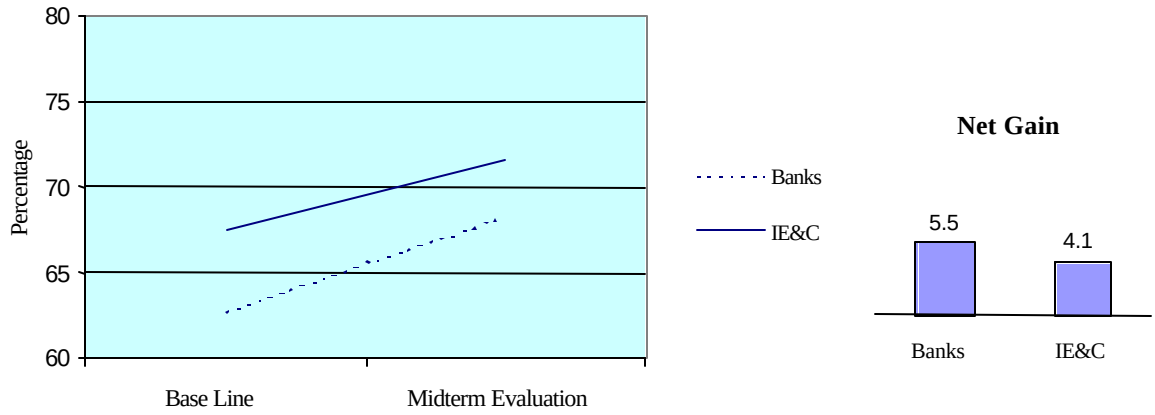
Figure 38: Last Delivery Attended by Trained Health Personnel



Prevalence in the Use of Methods of Contraception and Unmet Family Planning Needs

The indicators relating to family planning vary greatly. On the one hand, prevalence of use increases in both types of community (figure 39), but net gain between the base line and the midterm evaluation is only slightly higher (5.5 percentage points) in communities with banks than in communities with IE&C (4.1 points). Table 27 shows the percentages for the base line and the midterm evaluation measurements of indicator 3. Statistically, both communities have remained unchanged after two or three years of project activities. In this case, the project only increased the possibility that women in communities with banks may use contraceptives by 2.5 percent more (OR = 1.025) (see table 1 in annex F).

Figure 39: Percentage of Women in a Relationship Using Some Method of Contraception



Analysis of unmet family planning needs, which is a way of measuring the use of family planning methods as compared to the demand for them, shows a favorable change in communities with banks. The reduction was much higher in these communities than in communities with only IE&C, as shown in figure 40 and table 27 (indicators 4 and 4.1). Indeed, unmet family planning needs measured in the traditional way, as is done by DHS, decreased by 7.6 percentage points in the former communities as compared to 0.5 in the latter. This decrease from 23.5 percent to 15.9 percent in communities with banks is significant to 10 percent.

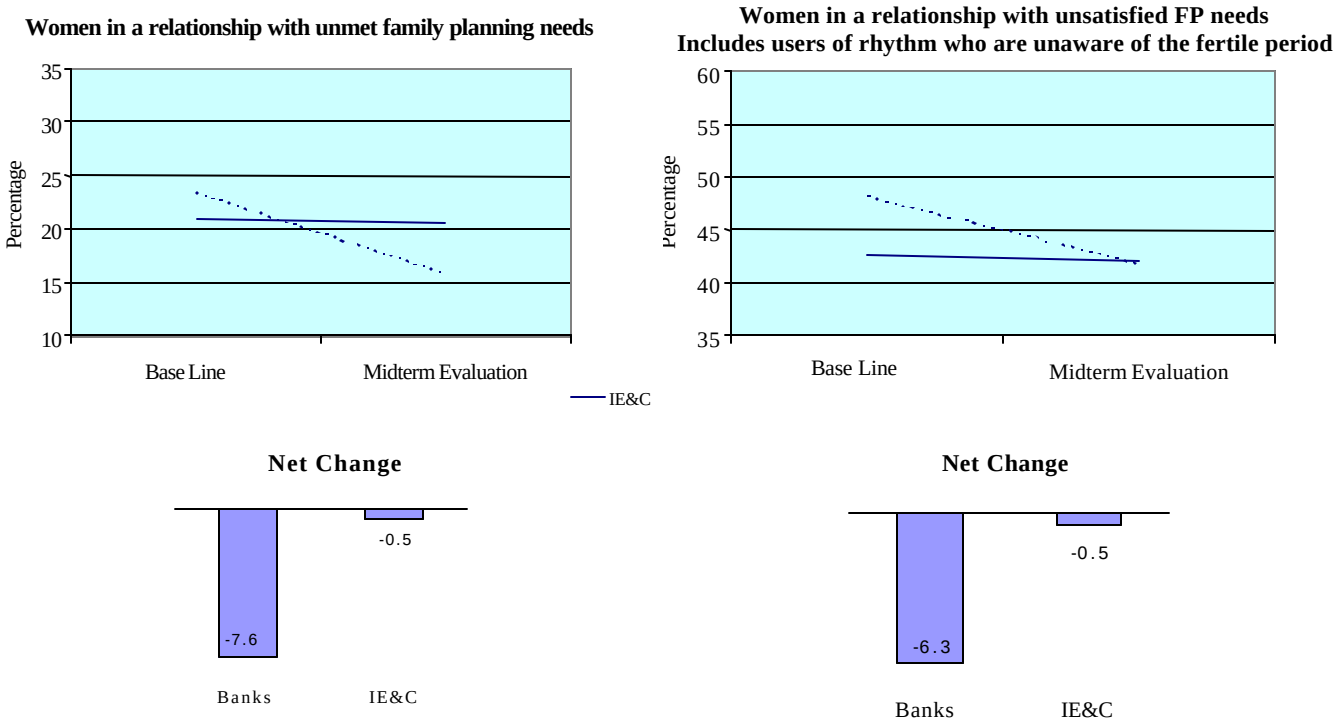
Table 27: Use of Contraception and Unmet Family Planning Needs

N°	Indicator	Communities with Banks					Communities with IE&C				
		Base line	MTE*	Difference	z	Stat. Sig.	Base line	MTE *	Difference	z	Stat. Sig.
3	percentage of women in a relationship who use some method of contraception	62.7	68.2	5.5	-0.819		67.5	71.6	4.1	-0.726	
4.1	percentage of women in a relationship with unmet family planning needs	23.5	15.9	-7.6	1.336	Sig 0.10	21.0	20.5	-0.5	0.101	
4	percentage of women in a relationship with unmet family planning needs (includes users of the rhythm method who are unaware of the fertile period)	48.3	42.0	-6.3	0.895		42.6	42.1	-0.5	0.082	

*Midterm evaluation

Insufficient protection (which includes women who do not wish to have more children or who do not wish to have them soon and use the rhythm method but are not aware of the fertile period) dropped by 6.3 percentage points in communities with banks and by 0.5 points in communities with IE&C, again showing a more favorable situation in the former. The values of OR = 0.697 for indicator 4.1 and OR = 0.888 for indicator 4 show a greater impact of the project in communities with banks.

Figure 40: Women in a Relationship with Unmet Family Planning Needs



Awareness of Certain Aspects in the Use of Methods of Contraception

The knowledge of how at least one modern method of contraception works has increased dramatically in communities with banks (48.9 percentage points) in the period between the base line and the midterm evaluation, from 6.1 percent to 55.0 percent. It should be noted that the initial value (6.1 percent) increased by a factor of 8 to reach 55 percent at the time of the midterm evaluation. In communities with IE&C increase was also significant (net gain of 31.5 percentage points), though less dramatic (from 25.8 percent to 57.3 percent) (indicator 38 in table 28). The value of OR = 4.060 shows an excellent impact of the banks project.

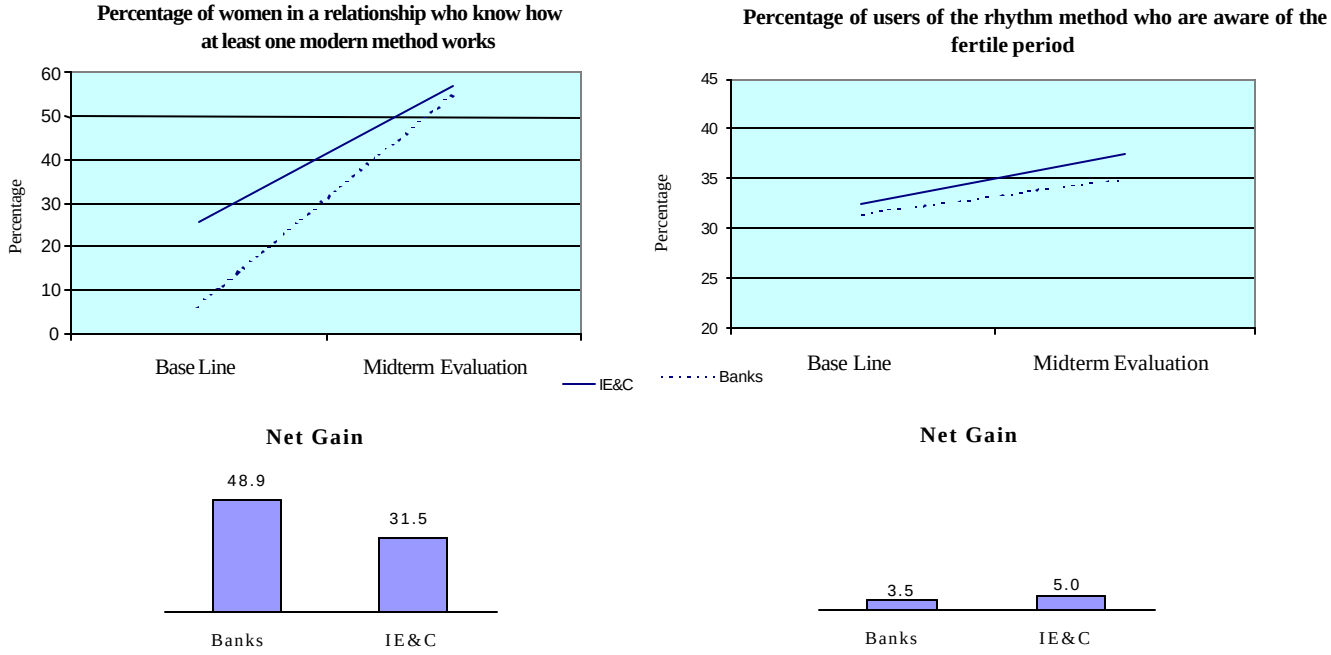
Table 28: Awareness of Methods of Contraception

N°	Indicator	Communities with banks					Communities with IE&C				
		Base line	MTE*	Difference	z	Stat. Sig.	Base line	MTE *	Difference	z	Stat. Sig.
38	percentage of women in a relationship who know how at least one method of contraception works	6.1	55.0	48.9	-9.893	Sig 0.05	25.8	57.3	31.5	-6.936	Sig 0.05
39	percentage of users of the rhythm method who are aware of the fertile period	31.4	34.9	3.5	-0.311		32.4	37.4	5.0	-0.475	
43.b	percentage of women who believe that it is difficult to get pregnant while breastfeeding	39.0	57.2	18.2	-2.751	Sig 0.05	39.2	60.7	21.5	-3.910	Sig 0.05

*Midterm evaluation

By contrast, the percentage of women using the rhythm method who are aware of the fertile period and the percentage of women who believe that it is difficult to get pregnant while breastfeeding, has increased slightly less in communities with banks than in those with only IE&C (see table 28, indicators 39 and 43.b and figure 41). The OR values for these indicators are less than one, which shows that the project had no additional impact in communities with banks.

Figure 41



Analysis of the indicators for project impact which measure achievement of the SO seem to suggest, albeit in an inconclusive manner given the previously mentioned limitations with regard to representativity of the figures (and probably because women of communities with banks enjoy a better social position), that the microcredit component provides additional improvements to some indicators relating to the use of formal health services. In particular, there is a greater increase in communities with banks in the percentage of care in childbirth by trained health personnel, and a greater decrease in unmet family planning needs, but this does not seem to bear much relationship to the increase in the use of contraception, which is only slightly higher than in communities with IE&C. As regards indicators for measuring awareness of methods, the banks component appears to add greatly to the increase in knowledge of how at least one modern method works, but it does not contribute to increased awareness regarding the fertile days of the cycle, nor regarding the benefits of breastfeeding as a method of contraception.

B. INTERMEDIATE RESULTS (IRS)

Gender Relations

Perceptions

A somewhat odd result appears in communities with banks, in that on gender issues they seem to systematically show a decrease as compared to the same opinions in communities where only education activities were carried out. This worsening of opinion on issues, which shows awareness of gender equity concepts, could be due merely to chance or be brought about by the mentioned limitation of the information available, despite the figures shown in table 29.

As an example, the percentage of women who believe that daughters and sons should be educated to the same level decreased in communities with banks from 96.7 percent to 78.7 percent (a net loss of -18 percentage points), and that of men dropped from 95.7 percent to 93.5 percent (a net loss of -2.2 points) (see figure 42). It seems surprising that the favorable opinion of men on the same rights of education for daughters and sons does not drop as much as does that of women. This would merit a more in-depth analysis of the differences of opinion between the sexes, complementing the figures obtained in household surveys with information from other sources, such as, for example, an ethnographic analysis.

Figure 42: Men's and Women's Belief About Children's Education Level

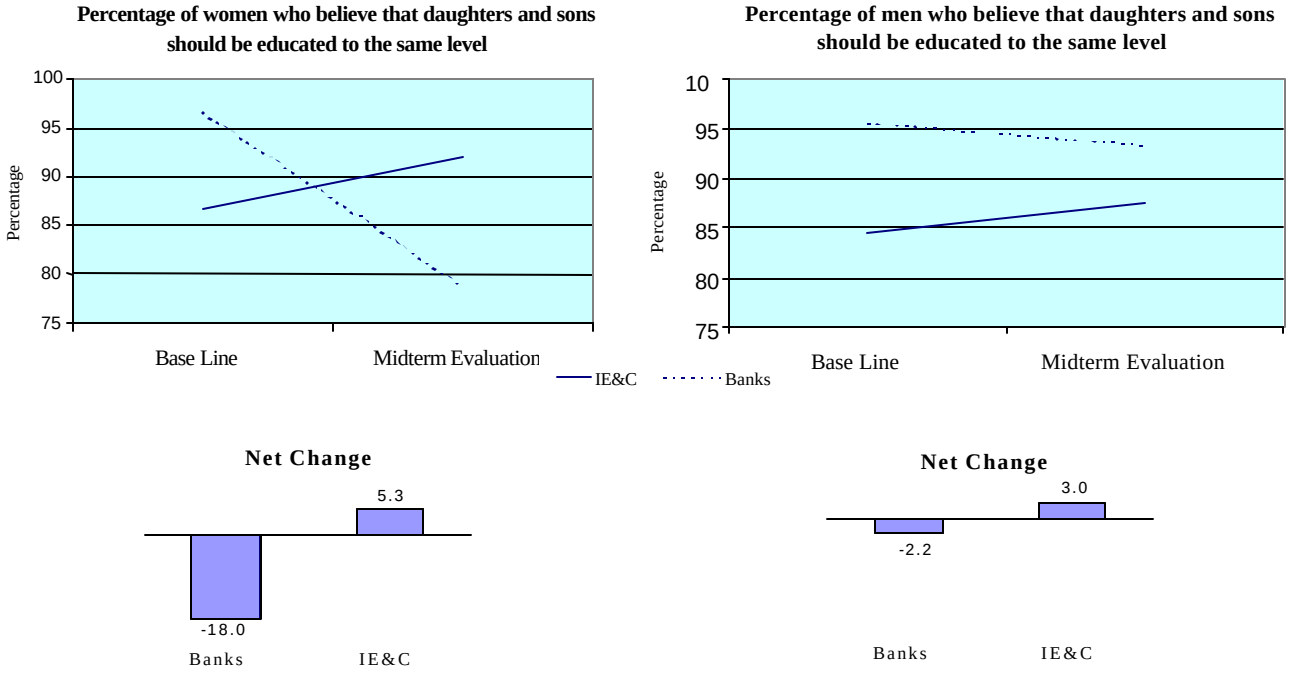


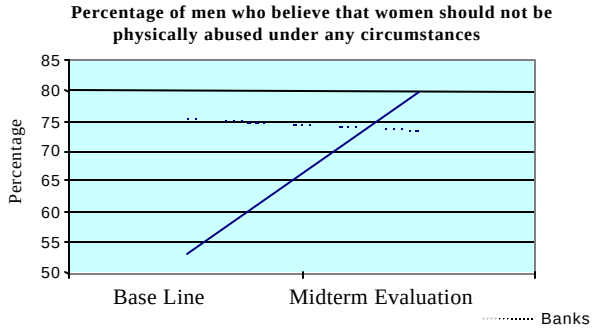
Table 29: Perceptions of Women and Men on Various Aspects of Gender Relations

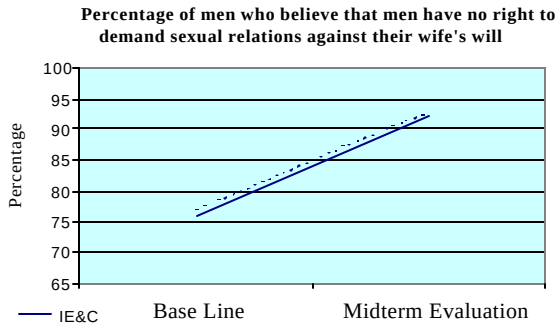
N°	Indicator	Communities with Banks					Communities with IE&C				
		Base line	MTE*	Difference	z	Stat. Sig.	Base line	MTE*	Difference	z	Stat. Sig.
Perceptions of women											
21	percentage of women who believe that daughters and sons should be educated to the same level	96.7	78.7	-18.0	2.929	Sig 0.05	86.5	91.8	5.3	-1.096	
Perceptions of men											
21.1	percentage of men who believe that daughters and sons should be educated to the same level	95.7	93.5	-2.2	0.429		84.5	87.5	3.0	-0.441	
17	percentage of men who believe that women should not be physically abused under any circumstances	75.5	73.3	-2.2	0.338		53.1	79.7	26.6	-3.688	Sig 0.05
18	percentage of men who believe that men have no right to demand sexual relations against their wife's will	76.8	93.0	16.2	-3.007	Sig 0.05	76.0	92.4	16.4	-2.619	Sig 0.05

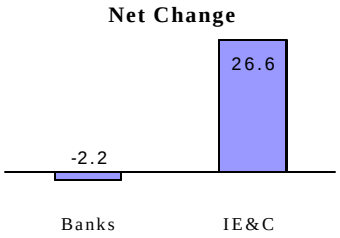
*Midterm evaluation

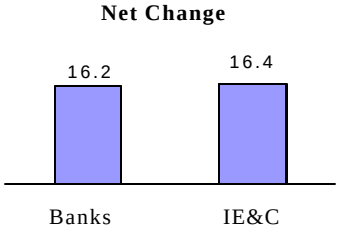
On the perception of men regarding respect for women, the situation deteriorates further. In communities with banks the percentage of men who believe that women should not be physically abused under any circumstances dropped by 2.2 percentage points, while in communities with IE&C it increased by 26.6 percentage points (indicator 17 in table 29). The percentage of men who believe that men have no right to demand sexual relations against their wife's will increased by practically the same amount (16 percentage points) in the two types of communities (indicator 18 in table 29 and figure 43).

Figure 43: Women's and Men's Beliefs about Forced Sexual Relations









From the results regarding perceptions on gender issues, it could be concluded that the banks component makes no additional contribution to the education component. Indeed, in some indicators it seems to have a negative impact, canceling out any capacity building activities. Once again, it should be pointed out that the trends described could be due to chance or to the lack of representative figures.

Practices

A similar result to that obtained for perceptions can be seen in the indicators, which measure practices. In communities with banks, there is either a smaller improvement than in IE&C communities, or a drop in the period between the two surveys, as shown in table 30. This is the case, for example, of the percentage of women in a relationship who carry out one or more household tasks together with their partner: an increase from 26.3 percent to 38.6 percent in communities with banks, compared to an increase from 33.1 percent to 67.2 percent in IE&C communities. Thus, net gain in the latter was more than double (34.1 percentage points) that in the former (12.3 percentage points). The same is true for the percentage of women who have talked with their partner regarding the number of children they wish to have: net increase in communities with banks was 2.5 points as compared to 10.4 percentage points in communities with IE&C only, almost five times greater. This change in some of the mentioned indicators is shown in figure 44.

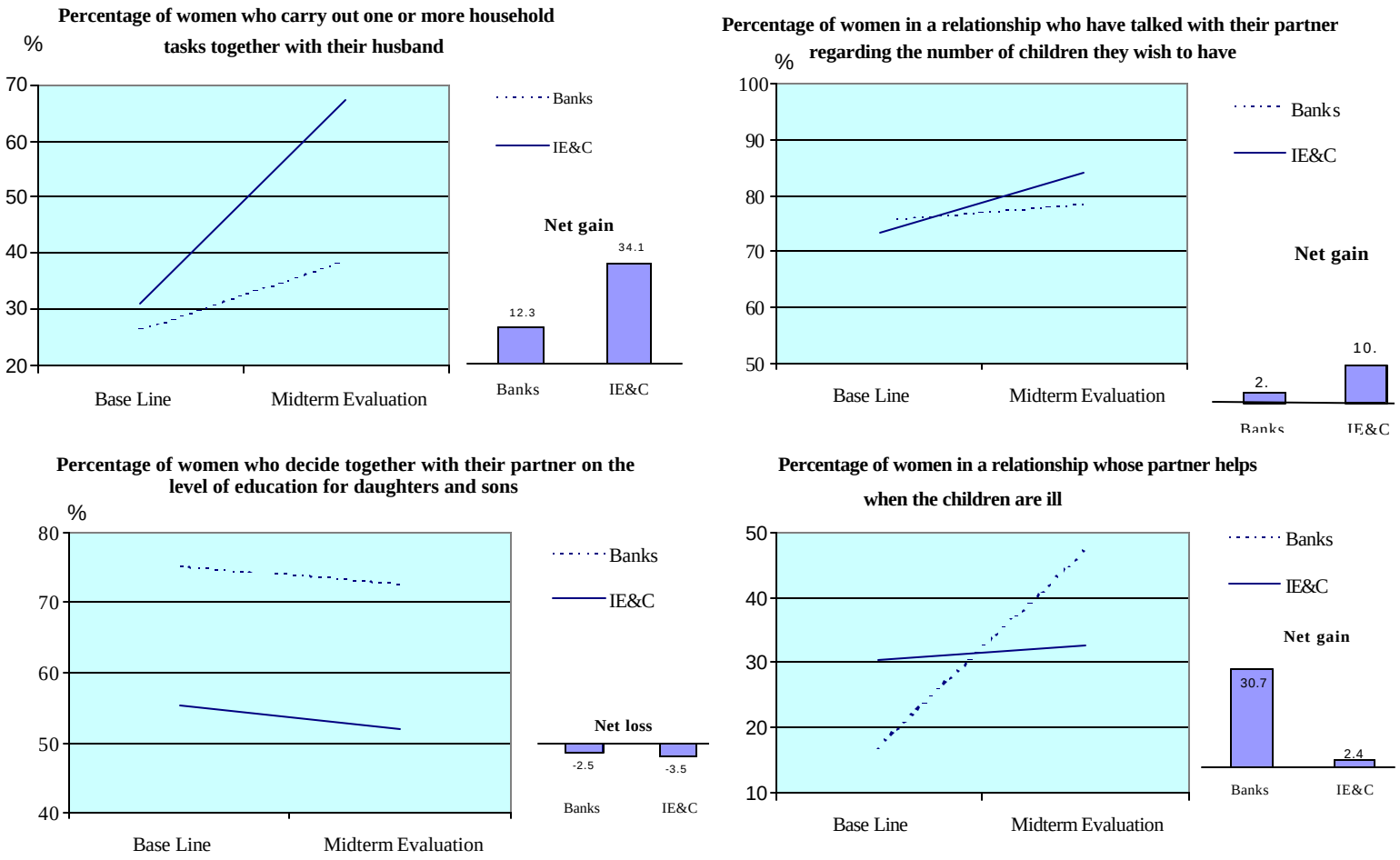
Table 30: Practices of Women and Men Regarding Gender Issues

N°	Indicator	Communities with Banks					Communities with IE&C				
		Base line	MTE*	Difference	z	Stat. Sig.	Base line	MTE*	Difference	z	Stat. Sig.
Practices of women											
7	percentage of women in a relationships who decide together with their partner on sexual relations, methods of contraception and number of children	22.2	30.6	8.4	-1.348	Sig 0.10	28.2	38.7	10.5	-1.804	Sig 0.05
9	percentage of women in a relationship who carry out one or more household tasks together with their partner	26.3	38.6	12.3	-1.879	Sig 0.05	33.1	67.2	34.1	-5.577	Sig 0.05
11	percentage of women in a relationship who decide together with their partner on the level of education for daughters and sons	75.2	72.7	-2.5	0.377		55.4	51.9	-3.5	0.549	
11.a	percentage of women in a relationship who have talked with their partner on the number of children they wish to have	75.8	78.3	2.5	?		73.5	83.9	10.4	-2.036	Sig 0.05
Practices of men											
5	percentage of women in a relationship whose partner helps when children are ill	16.7	47.4	30.7	-4.454	Sig 0.05	30.3	32.7	2.4	-0.338	

The care of children who are ill by men has improved significantly in communities with banks, the percentage increasing from 16.7 percent to 47.4 percent, while in communities with IE&C it increased from 30.3 percent to 32.7 percent. Thus, net gain was 30.7 percentage points in the former and 2.5 points in the latter (see figure 44). For the group

of indicators in table 30, only indicator 5 shows a greater impact of communities with banks.

Figure 44



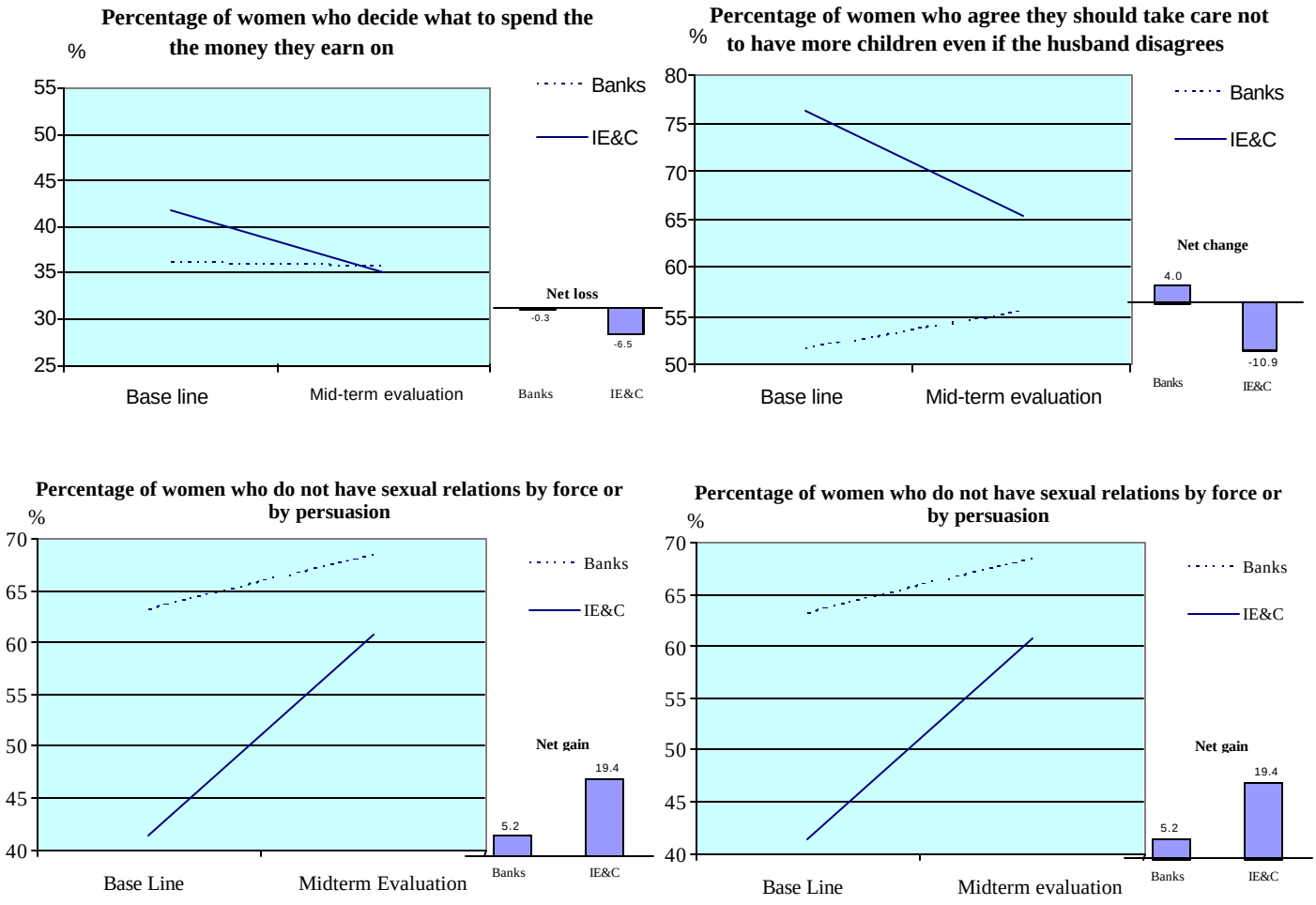
In general, the changes discussed here, and the figures themselves, would require a more in-depth analysis to explain unexpected behaviors, particularly on gender issues which are the basis of ReproSalud and which showed significant achievements when comparing counterpart communities with control communities in section III.C of this report.

Empowerment: Knowledge, Attitudes, and Practices

The indicators for empowerment also show erratic results in communities with banks: a) some increase significantly, such as for example the percentage of women who would seek help in the event of physical abuse by their husband, which goes from 19.5 percent to 43.2 percent (a net gain of 23.7 percentage points) compared to an increase from 18.5 percent to 35.7 percent (a net gain of 17.2 points) in communities with IE&C; b) others increase less than in control communities. This is the case in the percentage of women

who do not have sexual relations by force or persuasion, which increased by only 5.2 points, while in communities with IE&C it increased by almost 20 points, and c) some remain unchanged, although it could be said that they decrease slightly in the period between the base line and the midterm evaluation. As an example, the percentage of women in a relationship who decide what to spend the money they earn on, which remained unchanged at a value of around 36 percent at both surveys (see figure 45). However, it should be pointed out that in communities with IE&C the decrease was greater (6.5 percentage points).

Figure 45: Women's Empowerment



The figures for each indicator and the changes between the base line and the midterm evaluation are shown in table 31. The values of the OR (table 1 of annex F) for the first three indicators of the table show that the banks component results in an improvement of 26 percent for indicator 12, of 15 percent for indicator 14 and of 18 percent for indicator 6. Only indicator 12.1 shows a better improvement for communities with the education component only.

Table 31: Some Indicators of Perceptions, Attitudes, and Practices Relating to Empowerment

N°	Indicator	Communities with banks					Communities with IE&C				
		Base line	MTE*	Difference	z	Stat. Sig.	Base line	MTE*	Difference	z	Stat. Sig.
Perceptions											
12	percentage of women who agree that women should take precautions even if the partner disagrees	51.7	55.7	4.0	-0.569		76.4	65.5	-10.9	1.978	Sig 0.05
Attitude											
14	percentage of women who would seek help from police/authorities in the event of abuse by their husband	19.5	43.2	23.7	-3.685	Sig 0.05	18.5	35.7	17.2	-2.624	Sig 0.05
Practice											
6	percentage of women in a relationship who decide what to spend the money they earn on	36.2	35.9	-0.3	0.056		41.5	35.0	-6.5	1.434	Sig 0.10
12.1	percentage of women who do not have sexual relations by force or persuasion	63.4	68.6	5.2	-0.777		41.3	60.7	19.4	-3.149	Sig 0.05

*Midterm evaluation

Use of Health Services

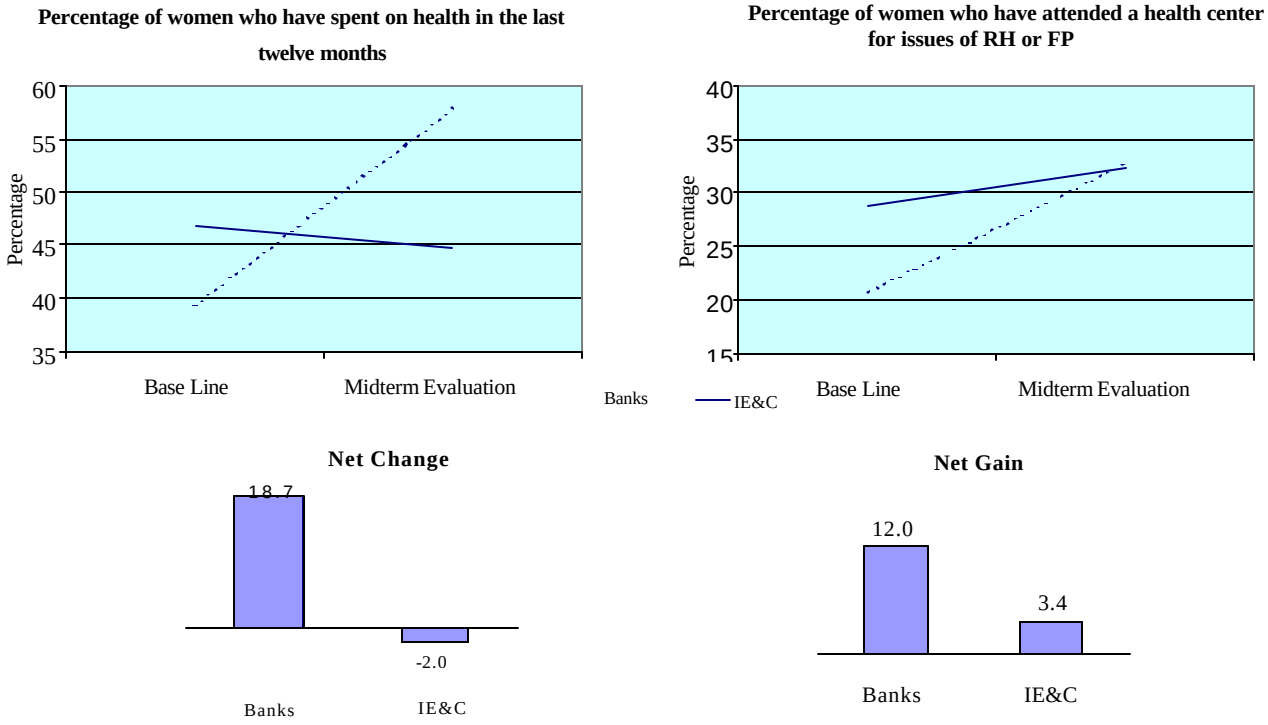
The assumption that women would tend to use health services more often if they had the financial means to cover the cost of treatment and medicines, which was taken into account for including a community bank component in the project, would appear to be true. Indeed, the two indicators selected for analyzing this aspect show significant positive changes between the base line and the midterm evaluation, as shown in table 32. As an example, the percentage of women who spent on their health in the last 12 months increased in communities with banks from 39.2 percent to 57.9 percent (a net gain of 18.7 percentage points), while in communities which had only the educational component this percentage decreased by 2.0 points (from 46.8 percent to 44.8 percent) (see figure 46).

Table 32: Indicators for the Use of Services

N°	Indicator	Banks					IE&C				
		Base line	MTE*	Difference	z	Sig. Stat.	Base line	MTE*	Difference	z	Stat. Sig.
33	percentage of women who spent on health in the past 12 months	39.2	57.9	18.7	-3.387	Sig 0.05	46.8	44.8	-2.0	0.433	
25	percemtage of women who attended a health center for an issue of reproductive health or family planning	20.8	32.8	12.0	-2.472	Sig 0.05	28.8	32.2	3.4	-0.798	

In the same way, the percentage of women who attended a health center for an issue of reproductive health or in order to receive information and/or services on family planning, also increased four times more in communities with banks (from 20.8 percent to 32.8 percent, a net gain of 12 percentage points) than in communities which had only the IE&C component (from 28.8 percent to 32.2 percent, a net gain of 3.4 points).

Figure 46



In general, the indicators on the use of health services, both those just described and those for care in childbirth by trained personnel, show that adding to the education component a component to financially benefit women improves their good practices towards health and their readiness to attend a health center for professional care in the event of problems related to reproductive health, and possibly also in other cases. These findings are, however, not conclusive and would warrant a more in-depth analysis and an explanation for unexpected and at times contradictory results.

V. CONCLUSIONS

The information provided by a sample of women of reproductive age reveals that in the communities where ReproSalud is working there is a general tendency towards improved health practices as compared to communities where there were no project activities.

According to the information collected, the SO of the project has been met because women are making greater use of the health services. This results in a significant increase in prenatal care and childbirth attended by trained personnel and in the prevalence of contraception, as well as in a reduction of the unmet demand for family planning in the project's counterpart communities as compared to those where there was no project intervention. Net gain/variation prior to project intervention and after an average of three years in counterpart communities is significant for the mentioned indicators and is evidence of the contribution that ReproSalud has made to reproductive and maternal health to complement the work carried out by the Peruvian government.

When ReproSalud began, Peru was undergoing important social changes, especially as regards health issues, and this is still the case, though to a lesser extent. MINSA, with the support of external aid organizations[30], concentrates its efforts on improving the quality of mother-and-child healthcare and its coverage by the government institutions; as well as on increasing dissemination of information and services on contraceptive methods within the framework of the National Family Planning Program. It is possible that because of this several indicators also show significant improvement in control communities, which is graphically represented by parallel lines in the trend for such indicators in both types of communities.

As regards gender issues, empowerment and the use of health services the achievements of the project vary and separate comments are provided for each IR. But it can generally be stated that women beneficiaries[31] in remote communities or in peripheral areas in some cities of the project's area of influence have absorbed the knowledge they have obtained and are transforming it into positive attitudes and assertive behavior which contribute to improve their negotiating capacity on a domestic and social level.

As regards IR 1, the aim of which is for women to achieve gender-equitable relationships with their partners and families, the project has made significant inroads on women's empowerment. The percentage of women deciding on the use of the money they earn and taking decisions jointly with their partners regarding sexual relations, methods of contraception, number of children and the level of education for daughters and sons has

[30] The United Nations, the United States Agency for International Development USAID, the Inter-American Development Bank, the World Bank, the Japanese Development Agency, the British Department for International Development (DFID), the Spanish International Development Agency, amongst others.

[31] Women for whom this was the first opportunity to hear about such matters went from an initial stage of uneasiness (given that these are issues which, in their culture and in their minds, were 'taboo') to one of satisfaction and subsequent gratitude (and there is ample verbal evidence of this) for having been given knowledge and information which has had a positive effect on the way they live their lives.

increased. However, the project has failed to increase male participation in household tasks.

As regards IR 1.1, which aims to strengthen the capacity of women to bring about change in their gender relations, the percentage of women who do not have sexual relations by force or persuasion has increased significantly, as has that of women who are willing to go to the police or to the authorities if they are assaulted by their partners. Moderate success has been achieved in improving communications between women and their partners on family planning, and in raising awareness of where to go for help or advice if they are physically abused. The project has made no impact on its target communities as compared to control communities regarding favorable attitudes to women exercising the right to protecting themselves against an unwanted pregnancy even when their partner is not in agreement, nor in the percentage of women who have talked with their children on relationships and family planning.

The project has achieved modest success as regards IR 1.2, the aim of which is to increase positive attitudes of men in their relationships with women and with the family. The percentage of men who believe that women can under no circumstances be physically abused, and of those who believe that men have no right to demand sexual relations with a women if she does not wish it, changed little in project communities as compared to control communities.

As regards IR 1.3, the aim of which is to increase women's knowledge on gender equity, the project had a significant positive impact on the percentage of women who believe that daughters and sons should be educated to the same level and on the percentage of men who believe that the work they carry out is as important as that of their partner; there was a low impact on the percentage of men who believe that daughters and sons have the same rights to education; but there has been no change in the value attached by women to women's work nor in the positive appreciation by men of women's work within the home. The latter seems to suggest that men appreciate women's work more when this is done outside the home.

These low achievements of the project in respect of gender perceptions should be analyzed in the context of the changes that are taking place on such issues generally within society. The Cairo Conference has given rise to a current of public opinion, which favors discussion and positioning on equity relations among the sexes, the rights of women and empowerment, and these issues have become frequently discussed topics, even on local radio and television programs. This would explain why perceptions on gender amongst project communities and control communities are similar, implying that no specific intervention is necessary to achieve positive change. However, the project has speeded up these changes to a considerable extent.

It is difficult to reach a conclusion on IR 2, which aims to build women's capacity to access health services, given the lack of indicators within the Results Framework to measure such results. The only available indicator, which was developed for this evaluation (and which may not be the most suitable), shows that in project communities

the percentage of women attending a health center for matters of reproductive health or family planning has not been any higher than in control communities. This seems to contradict the significant achievement reported under the indicators for the SO.

As regards IR 2.1, which aims to increase the capacity of women as end users of health services, the project has moderately increased positive opinion on the quality of the service of women who attended health centers for prenatal and post-delivery care, but it has not had the same effect on those attending for any other complaint or those who went to accompany somebody else.

As regards intermediate Result 2.2, which aims to increase the positive appreciation of women's health within the home and within the community, the project has had a significant impact on the percentage of women who take care of their health in order to feel good and of those who sought help complaining of vaginal discharge. It has had a low impact on the percentage of women who have invested in their health, and has had no impact on the willingness of women to attend a health center for alarm signals that might be indicative of risk.

The project's success is clear on studying the indicators for IR 2.6, the aim of which is to increase women's knowledge of their reproductive health needs. In fact, there has been a surprising increase in the knowledge of how at least one of the modern methods works (this being the most important indicator out of the 39 analyzed) and how vaginal discharge is transmitted (second in importance), and a moderate impact on the percentage of women who use the rhythm method and are aware of the fertile days of the cycle (fifth in order of importance). There is a slight impact on the percentage of women who have heard of Papanicolau or breast examination and on the percentage of those with an opinion on the contraceptive advantages of breastfeeding. The project has had no effect on the level of knowledge on complications in pregnancy and birth that are indicative of risk.

Figures in relation to achievement of the SO of the project are conclusive. The increase in the use of contraception and the reduction in the unmet demand for family planning are consistent with the very significant increase in the knowledge of how at least one modern method works, with the moderate increase in the knowledge of the fertile days of the cycle and with the percentage of women who do not have sexual relations by force or persuasion. But the significant increase in prenatal and birth care by trained personnel is not so well supported, since the project has had no impact on indicators such as the percentage of women attending a reproductive health or family planning center, or in the percentage of women attending a health center due to conditions which might be indicative of risk. It is very possible that other indicators not included in the Results Framework could support such achievements, and the project must therefore focus on identifying these.

As regards the additional impact of the project if an income generation component is added to the education component, results are not conclusive in that the analysis was based on limited data. Apparently, the activities of microcredit would provide an

improvement in the outcome of the project in matters relating to health care, as well as in the willingness to use formal care services. A larger increase in prenatal and birth care by trained personnel is observed in communities where a community bank exists, as compared to those where only educational activities are carried out. A greater use of contraception and a greater reduction in unmet family planning needs is also observed. However, as regards perceptions on gender and empowerment, not only does the microcredit component not have an added impact on the educational component, but rather it seems to have a negative effect on this. The positive and negative results of this section would merit a more in-depth study with more representative and better quality data.

VI. RECOMMENDATIONS

1. Evaluate the relevance of the indicators as regards the IRs they were developed to measure. Some examples:

   - IR 1.2 aims to measure the increase in positive attitudes of men in their relationships with women and with the family; however, three proposed indicators (17, 18 and 18.1) measure opinions and perceptions, rather than attitudes.

   - The same is true for IR 1.3, which aims to increase women's knowledge on gender issues; with the exception of indicator 23, all indicators measure opinions and ideas, rather than knowledge.

   - As opposed to this, IR 2.2, which aims to increase the positive appreciation of women's health within the home and within the community, which should be measured with an indicator on perceptions, has three indicators which measure practices.

   - The indicators measuring opinions on quality of the health services do not seem to be the most relevant for measuring IR 2.1: improving the capacity of women as end users of formal health services. To a certain extent they measure empowerment, but even this is not clear.

2. Create new indicators to measure IRs and to complement those which already exist (some have been suggested in Table 1), taking into account the information obtained in the last version of the individual questionnaire given to women of reproductive age and to men between the ages of 15 and 59.

3. Review the phrasing and definition of some of the indicators in the IRs of the Results Framework, such as:

   - Define the number of times which an event must take place for it to be considered 'very frequent' in indicators 13, 13.1 and 16.

   - Fix the period for care by trained personnel in the last pregnancy and/or birth (indicators 1, 1a and 2) at two years prior to interview, rather than three years.

   - Re-phrase indicator 20 to compare work in the home with that carried out outside the home, or women's work in the home compared to men's work outside the home. At present the indicator compares 'work in the home to work done by your husband'.

   - Rephrase or change indicator 32. It is possible that the question on which it is based may not be understood by women. The indicator can be developed with

a set of questions, asking in what way or ways women look after their health; then asking whether they attend a center for a medical examination Papanicolaou test or breast examination), how often they go, and thereby finding out why women look after their health.

- Divide indicator 7 into three sub-indicators to learn on what issues (sexual relations, family planning, or number of children) women have been able to take decisions jointly with their partner and thus achieve a more equitable gender balance.

- Re-phrase indicators 26 and 27 such that women's opinion on the service refers to the center the woman actually attends for help rather than to the nearest center. It is very possible that women do attend the nearest center, but this should be specified in the indicator.

4. In the eventuality that USAID should request that the project provides the indicators specified in the Project Paper (Number 527–0355, August 1995, page vi) for measuring achievement of the objectives and intermediate results of ReproSalud, review the document and structure a reply. In fact, only a few of the indicators specified in that document can be obtained, the rest being very difficult if not impossible to obtain. The Paper quotes: "At the goal level, project success will be measured by such indicators as total fertility, maternal mortality, infant mortality, chronic malnutrition and sexually transmitted disease prevalence. At the subgoal level, success will be measured by percentage of women participating in decision-making at the local level; percent increase in women-controlled organizations at the community level and percent expansion of economic opportunities for women.

   At the purpose level, project success will be measured by contraceptive prevalence, contraceptive failure, contraceptive discontinuation, length of birth intervals, duration of exclusive breastfeeding, use of prenatal care, births attended by trained personnel, prevalence of genital tract infections and prevalence of iron-deficiency anemia."

5. The information available on ReproSalud, collected by means of the instruments described in Part One of this report, as well as through project monitoring, is plentiful, varied and diverse. It should be analyzed globally and by regions and published in investigative reports such that the various aspects of the work of ReproSalud and its achievements within the communities may be shared with other organizations and development agencies. Even the interviews carried out in the households, on the basis of which this evaluation was carried out, have scope for detailed analysis at department level if the 70 counterpart communities are included in the database, and at a global level by comparing counterpart communities with associated and control communities in order to study the aggregate effect of the activities in accordance with the type of community participation in the project.

ANNEXES

ANNEX A

DOCUMENTS REVIEWED

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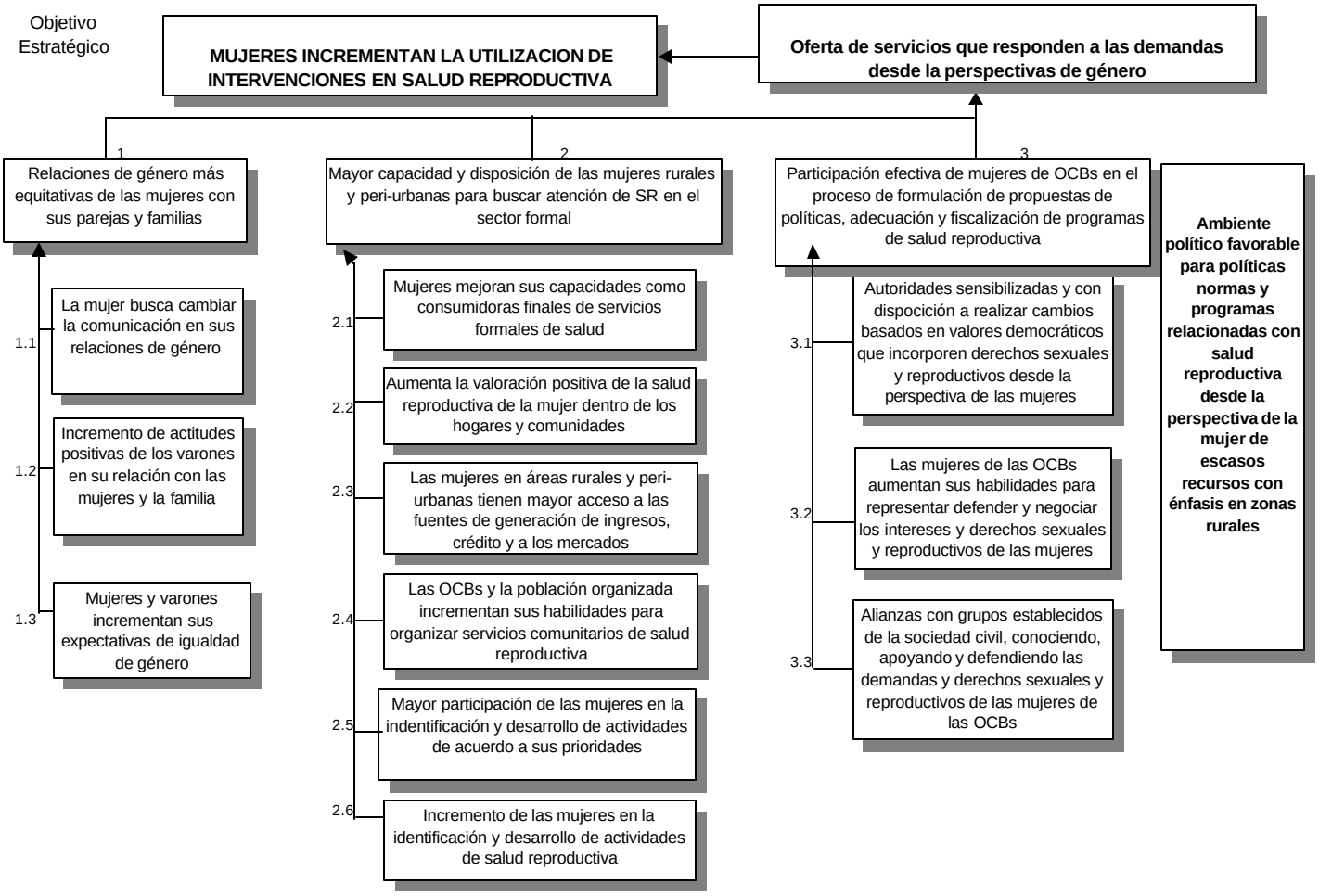
ANNEX B

RESULTS FRAMEWORK

MARCO DE RESULTADOS



Indicators	Net increase, in percentage points, between the baseline and the midterm evaluation		Odds Ratio
	Intervention	Control	
Odds Ratio from 1.199 to 1.999 VERY SIGNIFICANT			
38. percent of women who know how at least one modern contraceptive method works	42.0	17.0	1.920
43. percent of women who know how RTIs are spread	14.1	6.7	1.599
32. percent of women who take care of their health in order to feel well	8.3	-8.8	1.325
2. percent of women whose last delivery, occurring within the last two years, was performed by a healthcare professional	11.9	1.8	1.274
39. percent of women using the rhythm method who know the fertile days of their cycle	5.8	0.1	1.253
6. percent of women who decide how to spend the money they earn	4.5	-2.0	1.225
4.1 percent of women with an unmet need for family planning	-9.2	-5.0	0.817
4. percent of women with an unmet need for family planning (including those who use the rhythm method and are unsure of their own fertile days)	-11.2	-3.2	0.823
Odds Ratio from 1.100 to 1.198 SOMEWHAT HIGH			
12.1 percent of women who state their unwillingness to be forced or convinced to have sex	13.4	3.3	1.194
30. percent of women who have sought treatment for symptoms of RTIs (or vaginal discharge)	10.2	-1.0	1.178
3. percent of women who use some method of birth control	13.4	4.0	1.153
1.a percent of women who had at least 4 prenatal visits to a healthcare professional during a pregnancy occurring within the last two years	27.5	18.8	1.148
14. percent of women would go to the police/authorities if their partner abused them	24.1	21.5	1.133
7. percent of women who make joint decisions with their partner about sexual relations, birth control methods, and number of children	9.2	5.2	1.129
21. percent of women who believe that their sons and daughters should reach the same level of education	5.2	-4.9	1.118
11. percent of women who make a joint decision with their partner about the educational level their children should reach	6.6	0.2	1.111
Odds Ratio from 1.050 to 1.099 MODERATE			
19.1 percent of men who believe that the work they do outside the home is as important as the work their partner does outside the home	17.7	12.4	1.097
43.b percent of women who believe that while a women is breastfeeding it is dificult for her to become pregnant	22.3	16.0	1.091
16.a percent of women who know where to go for help or advice if they are abused	20.0	14.7	1.083
27. percent of women who have gone to a healthcare facility for prenatal and postnatal care, and who believe that the services provided by the nearest facility are good (or very good)	5.8	1.5	1.081

Indicators	Net increase, in percentage points, between the baseline and the midterm evaluation		Odds Ratio
	Intervention	Control	
13. percent of women who have spoken with their partner about family planning more than 2 times in the last 12 months	5.1	2.7	1.080
43.a percent of women who have heard about Pap and breast exams	18.2	12.2	1.069
30.a percent of women who have gone to a healthcare professional due to discomfort related to RTIs (or vaginal discharge)	10.8	7.0	1.068
Odds Ratio from 1 to 1.049 LOW			
18. percent of men who believe that a man does not have the right to force an unwilling woman to have sex	6.9	3.0	1.046
17. percent of men who believe that it is never right to hit a woman	6.6	4.2	1.041
21.1 percent of men who believe that their sons and daughters should reach the same level of education	2.3	-0.7	1.034
33. percent of women who incurred a health expense in the last 12 months	0.5	-0.5	1.021
12. percent of women who agree that a woman should be able to decide to take care of herself even if her partner objects	-4.5	-4.6	1.006
11.a percent of women who have spoken with their partner about the number of children they want to have	4.8	4.7	1.003
Odds Ratio less than 1 PROGRAM HAD NO EFFECT			
29. percent of women who would go to a healthcare facility in the event of symptoms that are warning signs of risk	29.0	25.4	0.994
9. percent of women who share one or more household chore with their partner	23.5	19.3	0.988
19. percent of women who believe that the work they do outside the home is as important as the work done outside the home by their partner	6.4	6.8	0.986
5. percent of women whose partner helps care for the children if they become ill	6.0	5.3	0.982
26. percent of women who believe that the services provided by the nearest healthcare facility are good (or very good)	10.7	16.9	0.936
20. percent of women who believe that housework is as important as the work done outside the home by their partner	10.4	12.5	0.926
20.1 percent of men who believe that the housework done by their partner is as important as his own work done outside the home	11.2	14.6	0.910
24. percent of women who have gone to a healthcare facility for consultation regarding reproductive health or family planning	15.9	17.2	0.909
16. percent of women who have spoken with their children age 12 years and older about male-female relationships and family planning more than two times in the last 12 months	8.9	6.5	0.845
40. percent of women who can recognize some symptom of pregnancy or postpartum warning signs that indicate risk	26.6	26.8	0.782

ANNEX C

COUNTERPART COMMUNITIES VERSUS CONTROL COMMUNITIES

CUADRO COMPARATIVO DE COMUNIDADES CONTRAPARTE Y COMUNIDADES DE CONTROL

	CONTRAPARTE									CONTROL							
Departamento y Provincia	Distrito	Comunidad	*Estab. de Salud	Area	Nº de habi-tantes	Msnm (altitud)	% de analfa-betismo	% de población rural	Con una NBI	Provincia	Distrito	Comunidad	*Estab. de Salud	Area	Nº de habi-tantes	Msnm (altitud)	% de analfa-betismo
ANCASH																	
1 Carhuaz	Marcará	Marcará	C.S	U	7704	2726	64.3	87.1	60.9	Carhuaz	Tinco	Tinco	P.S.	U	2514	2588	38.3
2 Carhuaz	Shilla	Llipta	NT	R	3307	3910	84.2	76.8	77.6	Carhuaz	Amashca	Shapashmarca	NT	R	1816	2850	62.2
3 Huaraz	Tarica	Tarica	P.S	U	4743	2802	55.6	80.4	89.0	Carhuaz	Amashca	Amashca	P.S.	U	1816	2850	62.2
4 Carhuaz	Marcará	Paltash	NT	R	7704	2726	64.3	87.1	60.9	Carhuaz	Ataquero	Huellap	NT	R	1792	2719	64.7
AYACUCHO																	
5 Cangallo	Los Morochucos	Pampacangallo	C.S.	U	6909	3330	61.4	88.8	97.8	Víctor Fajardo	Colca	Colca	P.S	U	1513	2972	54.9
6 Huamanga	S Juan Bautista	Barrio las Américas	NT	U	20558	2800	26.1	2.4	57.9	Huamanga	Ayacucho	Barrio Covadonga	NT	U	82131	2746	21.3
7 Cangallo	Cangallo	Incaraccay	P.S.	R	6193	2577	52.4	67.2	84.9	Huanta	Santillana	Arahuay	P.S.	R	6395	3262	73.4
HUANCAVELICA																	
8 Huancavelica	Huancavelica	Barrio Santa Ana	H.A	U	36826	3660	24.3	15.9	75.5	Tayacaja	Pampas	Pampas	C.S.	U	9649	3276	36.1
9 Acobamba	Paucará	Paucará	C.S.	U	9270	3806	56.5	79.7	98.7	Tayacaja	Pazos	Pazos	C.S.	U	7501	3840	45.7
10 Huancavelica	Acoria	Pallalla	P.S.	R	22656	3167	57.2	95.7	97.1	Huancavelica	Vilca	Vilca	P.S	R	3305	3275	30.5
11 Angaraes	Lircay	Ocopa	NT	R	20045	3278	60.0	76.9	92.5	Tayacaja	Ahuaycha	Purohuay	NT	R	4393	3280	44.2
12 Angaraes	Anchonga	Anchonga	P.S.	U	5573	3298	74.6	94.5	99.9	Tayacaja	Salcabamba	Salcabamba	P.S.	U	5765	3073	53.0
LA LIBERTAD																	
13 Otuzco	Usquil	Ex hacienda Chuq	P.S.	R	24203	3018	38.9	91.7	75.1	Sanchez Carrió	Huamachuco	Chuquizonguillo	P.S.	R	37708	3169	47.0
14 Otuzco	Agallpampa	Yamobamba	NT	R	9656	3117	34.4	92.6	89.6	Julcan	Calamarca	Sicchal	P.S.	R	8057	3150	39.2
PUNO QUECHUA																	
15 Melgar	Ayaviri	Ayaviri Barrio Puno	H.A.	U	23281	4400	26.2	26.5	53.9	Canchis	Sicuani	Barrio San Andres	H.A.	U	51083	3554	33.5
16 Azangaro	Arapa	Pucamoco	NT	R	10757	3838	41.5	93.0	87.4	Puno	Coata	Sucasco-Tarizani	NT	R	6301	3814	39.7
PUNO AYMARA																	
17 El Collao	Ilave	Ancoamaya	P.S.	R	48054	3847	34.6	70.5	71.0	Puno	Acora	Marca-Esqueña	NT	R	29420	3867	36.9
18 Yunguyo	Yunguyo	Machacmarca	NT	R	30360	3826	43.6	70.3	56.8	Puno	Acora	Chanchilla	NT	R	29420	3867	36.9
19 Chucuito	Pomata	Barrio Pueblo Libre	C.S.	U	18891	3863	38.0	91.7	85.7	Moho	Moho	San Pedro de Moho	C.S.	U	20120	3882	35.6
20 Chucuito	Zepita	Izani Central Zona	P.S.	U	19085	3814	35.3	94.3	81.1	Puno	Acora	Santa Rosa de Yan	P.S.	U	29420	3867	36.9
SAN MARTIN																	
21 Lamas	Tabalosos	Barrio Partido Alto	C.S.	U	11086	1050	31.9	16.7	71.9	Lamas	Lamas	Lamas (Ancoallo)	H.A.	U	13651	809	28.0
22 El Dorado	Shatoja	Shatoja	P.S.	U	1653	700	33.0	52.1	79.8	Picota	Tingo de Pona	Leoncio Prado	C.S.	U	2605	400	11.8
UCAYALI																	
23 Coronel Portillo	Masisea	Vista Alegre de Pach	P.S.	R	12083	225	19.5	84.0	92.2	Coronel Portill	Masisea	Caimito	P.S.	R	12083	225	19.5
24 Coronel Portillo	Masisea	Masisea	C.S.	U	12083	225	19.5	84.0	92.2	Atalaya	Sepahua	Sepahua	P.S	U	3698	276	26.5
25 Padre Abad	Irazola	Monte Alegre	P.S.	U	13280	212	18.7	85.2	89.5	Padre Abad	Curimaná	Curimaná	P.S.	U	S/I	S/I	S/I

**** H.A. =Hospital; C.S.= Centro de salud; P.S. = Puesto de salud; NT = No tiene***
S/I = Sin información en el censo de población y vivienda 1993
UTEM 5/2/2002

ANNEX D

COMPARISON OF THE BASE LINE (BL) AND MIDTERM EVALUATION (IE) RESULTS FRAMEWORK INDICATORS

Indicators	Counterpart Community							Control Community							Odds Ratio OR
	BL	IE	Dif.	n BL	n IE	z	Signif	BL	IE	Dif.	n BL	n IE	z	Signif	
SO: Increased use by women of interventions in reproductive health															
1.a percent of women who had at least 4 prenatal visits to a healthcare professional during a pregnancy occuring within the last two years	55.6	83.1	27.5	372	261	-7.240	Sig (0.05)	62.2	81.0	18.8	312.0	294.0	-5.114	Sig (0.05)	1.148
2. percent of women whose last delivery, occurring within the last two years, was performed by a healthcare professional	36.1	48.0	11.9	465	279	-3.200	Sig (0.05)	40.9	42.7	1.8	425	321	-0.494		1.274
3. percent of women who use some method of birth control	58.4	71.8	13.4	1046	855	-6.071	Sig (0.05)	60.6	64.6	4.0	1076	823	-1.783	Sig (0.05)	1.153
4. percent of women with an unmet need for family planning (including those who use the rhythm method and are unsure of their own fertile days)	48.4	37.3	-11.1	1034	848	4.834	Sig (0.05)	50.1	46.9	-3.2	1071	818	1.379	Sig (0.10)	0.823
4.1 percent of women with an unmet need for family planning	27.1	17.9	-9.2	1042	855	4.741	Sig (0.05)	26.1	21.1	-5.0	1069	821	2.525	Sig (0.05)	0.817
RI 1: More equitable gender relations between women and their partners/families															
5. percent of women whose partner helps care for the children if they become ill	38.7	44.7	6.0	955	783	-2.527	Sig (0.05)	30.0	35.3	5.3	979	753	-2.338	Sig (0.05)	0.982
6. percent of women who decide how to spend the money they earn	31.6	36.1	4.5	1599	1389	-2.596	Sig (0.05)	29.8	27.8	-2.0	1540	1246	1.158		1.225
7. percent of women who make joint decisions with their partner about sexual relations, birth control methods, and number of children	23.7	32.9	9.2	1035	848	-4.431	Sig (0.05)	22.6	27.8	5.2	1067	817	-2.588	Sig (0.05)	1.129
9. percent of women who share one or more household chore with their partner	23.2	46.7	23.5	1045	855	-10.77	Sig (0.05)	18.6	37.9	19.3	1075	824	-9.392	Sig (0.05)	0.998
11. percent of women who make a joint decision with their partner about the educational level their children should reach	57.4	64.0	6.6	965	776	-2.798	Sig (0.05)	57.8	58.0	0.2	971	767	-0.084		1.111
11.a percent of women who have spoken with their partner about the number of children they want to have	67.8	72.6	4.8	1054	853	-2.273	Sig (0.05)	69.3	74.0	4.7	1074.0	820.0	-2.241	Sig (0.05)	1.003
RI 1.1: Strengthened ability of women to achieve equality in gender relations															
12. percent of women who agree that a woman should be able to decide use family planning even if her partner objects	68.9	64.4	-4.5	1039	855	2.071	Sig (0.05)	65.0	60.4	-4.6	1073	823	2.056	Sig (0.05)	1.006
12.1 percent of women who state their unwillingness to be forced or convinced to have sex	50.6	64.0	13.4	1040	852	-5.852	Sig (0.05)	55.4	58.7	3.3	1067	820	-1.435	Sig (0.10)	1.194
13. percent of women who have spoken with their partner about family planning more than 2 times in the last 12 months	15.2	20.3	5.1	1044	852	-2.908	Sig (0.05)	11.4	14.1	2.7	1074	822	-1.757	Sig (0.05)	1.080
14. percent of women would go to the police/authorities if their partner abused them	14.3	38.4	24.1	1037	854	-12.01	Sig (0.05)	15.7	37.2	21.5	1067	822	-10.691	Sig (0.05)	1.133

Indicators	Counterpart Community							Control Community							Odds Ratio OR
	BL	IE	Dif.	n BL	n IE	z	Signif	Bl	IE	Dif.	n BL	n IE	z	Signif	
16. percent of women who have spoken with their children age 12 years and older about male-female relationships and family planning more than two times in the last 12 months	7.1	16.0	8.9	396	381	-3.893	Sig (0.05)	3.9	10.4	6.5	388	289	-3.352	Sig (0.05)	0.845
16.a percent of women who know where to go for help or advice if they are abused	45.6	65.6	20.0	1607	1395	-10.98	Sig (0.05)	44.8	59.5	14.7	1549.0	1251.0	-7.737	Sig (0.05)	1.083
RI 1.2: Increase in positive attitudes of men towards equitable relationships with women and family															
17. percent of men who believe that it is never right to hit a woman	57.4	64.0	6.6	707	697	-2.531	Sig (0.05)	58.8	63.0	4.2	679	633	-1.557	Sig (0.10)	1.041
18. percent of men who believe that a man does not have the right to force an unwilling woman to have sex	84.6	91.5	6.9	706	697	-3.981	Sig (0.05)	88.8	91.8	3.0	681	633	-1.831	Sig (0.05)	1.046
RI 1.3: Increase in women's knowledge about gender equality															
19. percent of women who believe that the work they do outside the home is as important as the work done outside the home by their partner	51.4	57.8	6.4	730	813	-2.522	Sig (0.05)	48.4	55.2	6.8	997	786	-2.852	Sig (0.05)	0.986
19.1 percent of men who believe that the work they do outside the home is as important as the work done outside the home by their partner	52.1	69.8	17.7	476	620	-5.987	Sig (0.05)	55.9	68.3	12.4	612	571	-4.388	Sig (0.05)	1.097
20. percent of women who believe that housework is as important as the work done outside the home by their partner	33.7	44.1	10.4	804	855	-4.339	Sig (0.05)	30.2	42.7	12.5	1073	822	-5.631	Sig (0.05)	0.926
20.1 percent of men who believe that the housework done by their partner is as important as his own work done outside the home	36.2	47.4	11.2	561	698	-3.997	Sig (0.05)	33.3	47.9	14.6	682	633	-5.393	Sig (0.05)	0.910
21. percent of women who believe that their sons and daughters should reach the same level of education	86.7	91.9	5.2	610	492	-2.745	Sig (0.05)	94.5	89.6	-4.9	602	442	2.957	Sig (0.05)	1.118
21.1 percent of males who believe that their sons and daughters should reach the same level of education	89.1	91.4	2.3	385	386	-1.077		91.6	90.9	-0.7	370	320	0.325		1.034
RI 2: Increased capacity of women in use of reproductive health services															
24. percent of women who have gone to a healthcare facility for consultation regarding reproductive health or family planning	26.3	42.2	15.9	1606	1392	-9.187	Sig (0.05)	22.5	39.7	17.2	1549	1248	-9.851	Sig (0.05)	0.909
RI 2.1: Improved capacity of women as end users of formal health services															
26. percent of women who believe that the services provided by the nearest healthcare facility are good (or very good)	45.5	56.2	10.7	1260	1039	-5.107	Sig (0.05)	52.8	69.7	16.9	1550	968	-8.397	Sig (0.05)	0.936
27. percent of women who have gone to a healthcare facility for prenatal and postnatal care, and who believe that the services provided by the nearest facilityt are good (or very good)	55.4	61.2	5.8	271	344	-1.450	Sig (0.10)	67.8	69.3	1.5	314	271	-0.389		1.081
RI 2.2: Increase in women's health as a priority within the home and community															
29. percent of women who would go to a healthcare facility in the event of symptoms that are warning signs of risk	42.6	71.6	29.0	655	783	-11.11	Sig (0.05)	36.8	62.2	25.4	1005	786	-10.678	Sig (0.05)	0.994
30. percent of women who have sought treatment for symptoms of RTIs (or vaginal discharge)	63.2	73.4	10.2	392	247	-2.673	Sig (0.05)	71.5	70.5	-1.0	358	219	0.257		1.178

Indicators	Counterpart Community							Control Community							Odds Ratio OR
	BL	IE	Dif.	n BL	n IE	z	Signif	BL	IE	Dif.	n BL	n IE	z	Signif	
30a. percent of women who have gone to a healthcare professional due to discomfort related to RTIs	50.6	61.4	10.8	393	246	-2.669	Sig (0.05)	51.4	58.4	7.0	358	219	-1.637	Sig (0.10)	1.068
32. percent of women who take care of their health in order to feel well	56.8	65.1	8.3	1246	1393	-4.368	Sig (0.05)	65.2	56.4	-8.8	1535	1250	4.741	Sig (0.05)	1.325
33. percent of women who have incurred a health expense in the last 12 months	49.5	50.0	0.5	1608	1395	-0.273		45.7	45.2	-0.5	1549	921	0.241		1.021
RI 2.6: Increase in women's knowledge about their reproductive health needs															
38. percent of women who know how at least one modern contraceptive method works	13.5	55.5	42.0	1608	1395	-24.41	Sig (0.05)	14.9	31.9	17.0	1550	1251	-10.713	Sig (0.05)	1.920
39. percent of women using the rhythm method who know the fertile days of their cycle	22.5	28.3	5.8	239	214	-1.419	Sig (0.10)	24.0	24.1	0.1	306	233	-0.027		0.782
40. percent of women who can recognize some symptom of pregnancy or postpartum warning signs that indicate risk	19.4	46.0	26.6	1044	855	-12.43	Sig (0.05)	13.2	40.0	26.8	1076	823	-13.399	Sig (0.05)	0.782
43. percent of women who know how RTIs are spread	4.9	19.0	14.1	1193	1150	-10.57	Sig (0.05)	4.7	11.4	6.7	1007	921	-5.448	Sig (0.05)	1.599
43.a percent of women who have heard about Pap and breast exams	63.2	81.4	18.2	1608	1395	-11.04	Sig (0.05)	59.6	71.8	12.2	1550.0	1251.0	-6.732	Sig (0.05)	1.069
43.b percent of women who believe that while a women is breastfeeding it is dificult for her to become pregnant	34.0	56.3	22.3	1193	1001	-10.48	Sig (0.05)	30.9	46.9	16.0	1200.0	951.0	-7.594	Sig (0.05)	1.091

ANNEX E

SAMPLE OF COMMUNITIES WITH COMMUNITY BANKS AND WITH EDUCATION ACTIVITIES ONLY

Muestra de cominidades con bancos comunales y con intervención educativa únicamente

CUADRO COMPARATIVO BANCOS LINEA DE BASE Vs EVALUACION INTERMEDIA

	Nombre de la comunidad	LA LIBERTAD				Nombre del	PUNO AYMARA				TOTAL			
	con Banco	MUJ	Socias	HOMB	TOTAL	Banco	MUJ	Socias	HOMB	TOTAL	MUJ	Socias	HOMB	TOTAL
LINEA DE	BC Cielo Salpino	46	13	33	79	Bc 14 de Setiembre	69	22	63	132	115	35	96	211
BASE	BC Carmen del Rosari	26	11	31	57	Santa Barbara	45	12	43	88	71	23	74	145
TOTAL		**72**	**24**	**64**	**136**		**114**	**34**	**106**	**220**	**186**	**58**	**170**	**356**
EVALUACION	BC Cielo Salpino	38	11	32	70	Bc 14 de Setiembre	45	13	50	95	83	24	82	165
INTERMEDIA	BC Carmen del Rosari	29	14	32	61	Santa Barbara	34	10	39	73	63	24	71	134
TOTAL		**67**	**25**	**64**	**131**		**79**	**23**	**89**	**168**	**146**	**48**	**153**	**299**

CUADRO COMPARATIVO CONTROL DE BANCOS LINEA DE BASE Vs EVALUACION INTERMEDIA

	Nombre de la comunidad	LA LIBERTAD				Nombre del	PUNO AYMARA				TOTAL			
	con IE&C	MUJ	Socias	HOMB	TOTAL	Control	MUJ	Socias	HOMB	TOTAL	MUJ	Socias	HOMB	TOTAL
LINEA DE	Santa Rosa	71	30	40	111	Tomas Vargas	79	62	63	142	150	92	103	253
BASE	Santa Rosa de Lima	48	19	26	74	Micaela Bastidas	60	40	47	107	108	59	73	181
TOTAL		**119**	**49**	**66**	**185**		**139**	**102**	**110**	**249**	**258**	**151**	**176**	**434**
EVALUACION	Santa Rosa	52	22	36	88	Tomas Vargas	69	49	51	120	121	71	87	208
INTERMEDIA	Santa Rosa de Lima	46	13	27	73	Micaela Bastidas	45	30	34	79	91	43	61	152
TOTAL		**98**	**35**	**63**	**161**		**114**	**79**	**85**	**199**	**212**	**114**	**148**	**360**

ANNEX F

INDICATOR TABLES

Tabla 1: Comparison of the Indicators of the Base Line (LB) and the Midterm Evaluation (EI): Communities with Community Banks and with Education Activities Only

Indicadores	Bancos							IE&C							Odds Ratio
	LB	EI	Dif.	n LB	n EI	z	signif	LB	EI	Dif.	n LB	n EI	z	signif	
OE: MUJERES INCREMENTAN LA UTILIZACIÓN DE INTERVENCIONES EN SALUDREPRODUCTIVA															
1a. percent de mujeres que ha tenido 4 o más controles con personal de salud durante el último embarazo ocurrido dos años antes de la encuesta	15.6	45.7	30.1	45	35	-2.950	Sig (0.05)	30.6	46.7	16.1	62	45	-1.699	Sig (0.05)	1.087
2. percent de mujeres que atendió su último parto, ocurrido dos años de la encuesta, con personal de salud	41.7	67.6	25.9	36	34	-2.174	Sig (0.05)	49.1	73.2	24.1	53	41	-2.362	Sig (0.05)	1.920
3. percent de mujeres unidas que usa algún método anticonceptivo	62.7	68.2	5.5	118	88	-0.819		67.5	71.6	4.1	157	116	-0.726		1.025
4. percent de mujeres unidas con necesidad insatisfecha de planificación familiar (incluye a usuarias de ritmo que no conocen su período fértil)	48.3	42.0	-6.3	116	88	0.895		42.6	42.1	-0.5	155	114	0.082		0.880
4.1 percent de mujeres unidas con necesidad insatisfecha de planificación familiar	23.5	15.9	-7.6	115	88	1.336	Sig (0.10)	21.0	20.5	-0.5	157	117	0.101		0.693
RI 1: MUJERES TIENEN RELACIONES DE GÉNERO MÁS EQUITATIVAS CON SUS PAREJAS Y SUS FAMILIAS															
5. percent de mujeres unidas cuya pareja ayuda cuando los niños se enferman	16.7	47.4	30.7	102	78	-4.454	Sig (0.05)	30.3	32.7	2.4	76	98	-0.338		2.630
6. percent de mujeres que decide en qué se gasta el dinero que gana ella.	36.2	35.9	-0.3	186	145	0.056		41.5	35.0	-6.5	256	210	1.434	Sig (0.10)	1.176
7. percent de mujeres que decide conjuntamente con su pareja sobre relaciones sexuales, métodos anticonceptivos y número de hijos	22.2	30.6	8.4	117	85	-1.348	Sig (0.10)	28.2	38.7	10.5	156	111	-1.804	Sig (0.05)	1.004
9. percent de mujeres que hace una o más tareas en su casa conjuntamente con su pareja	26.3	38.6	12.3	118	88	-1.879	Sig (0.05)	33.1	67.2	34.1	157	116	-5.577	Sig (0.05)	0.723
11. percent de mujeres que decide conjuntamente con su pareja hasta qué nivel de educación deben estudiar hijas e hijos	75.2	72.7	-2.5	101	77	0.377		55.4	51.9	-3.5	148	104	0.549		1.032
11a percent de mujeres unidas que ha hablado con su pareja sobre el número de hijos que desean tener	75.8	78.3	2.5	118	88			73.5	83.9	10.4	157	114	-2.036	Sig (0.05)	0.905
RI 1.1: Mujeres fortalecen sus habilidades para conseguir cambios en sus relaciones de género															
12. percent de mujeres que está de acuerdo que la mujer decida cuidarse aún cuando la pareja se oponga	51.7	55.7	4.0	118	88	-0.569		76.4	65.5	-10.9	157	116	1.978	Sig (0.05)	1.257
12.1 percent de mujeres que no tiene relaciones sexuales obligada o convencida	63.4	68.6	5.2	118	88	-0.777		41.3	60.7	19.4	156	114	-3.149	Sig (0.05)	0.736

14. percent de mujeres que acudiría a pedir ayuda a la policía-autoridades si su marido la golpease	19.5	43.2	23.7	118	88	-3.685	Sig (0.05)	18.5	35.7	17.2	81	115	-2.624	Sig (0.05)	1.148
Indicadores	**Bancos**							**IE&C**							**Odds Ratio**
	LB	**EI**	**Dif.**	**n LB**	**n EI**	**z**	**signif**	**LB**	**EI**	**Dif.**	**n LB**	**n EI**	**z**	**signif**	
16a. percent de mujeres que sabe a dónde acudir a pedir ayuda o consejo en caso de ser golpeadas	65.6	71.8	6.2	186	146	-1.205		43.6	73.4	29.8	258	212	-6.494	Sig (0.05)	0.650
RI 1.2: AUMENTO DE ACTITUDES POSITIVAS DE LOS VARONES EN SU RELACIÓN CON LAS MUJERES Y LA FAMILIA															
17. percent de varones que cree que a la mujer no se le puede golpear en ningún caso	75.5	73.3	-2.2	94	86	0.338		53.1	79.7	26.6	98	79	-3.688	Sig (0.05)	0.647
18. percent de varones que cree que el hombre no tiene derecho a exigir relaciones sexuales cuando la mujer no quiere	76.8	93.0	16.2	95	86	-3.007	Sig (0.05)	76.0	92.4	16.4	50	79	-2.619	Sig (0.05)	0.996
RI 1.3: MUJERES INCREMENTAN EL CONOCIMIENTO SOBRE LA SITUACIÓN DE GÉNERO															
21. percent de mujeres que cree que las hijas y los hijos deben estudiar hasta el mismo nivel	96.7	78.7	-18.0	60	47	2.929	Sig (0.05)	86.5	91.8	5.3	104	73	-1.096		0.767
21.1 percent de varones que cree que las hijas y los hijos deben estudiar hasta el mismo nivel	95.7	93.5	-2.2	47	31	0.429		84.5	87.5	3.0	58	48	-0.441		0.944
RI 2: Mujeres con mayor capacidad para acceder a los servicios de Salud Reproductiva															
24. percent de mujeres que ha acudido a un establecimiento de salud para una consulta sobre salud reproductiva o para atención en planificación familiar	20.8	32.8	12.0	186	146	-2.472	Sig (0.05)	28.8	32.2	3.4	258	212	-0.798		1.410
RI 2.2: AUMENTO DE LA VALORACIÓN POSITIVA DE LA SALUD DE LA MUJER DENTRO DE LOS HOGARES Y LA COMUNIDAD															
33. percent de mujeres que realizó algún gasto en su salud en los últimos 12 meses	39.2	57.9	18.7	186	146	-3.387	Sig (0.05)	46.8	44.8	-2.0	258	212	0.433		1.543
RI 2.6: MUJERES INCREMENTAN EL CONOCIMIENTO SOBRE SUS NECESIDADES DE SALUD REPRODUCTIVA															
38. percent de mujeres unidas que sabe cómo funciona al menos un método moderno	6.1	55.0	48.9	186	146	-9.893	Sig (0.05)	25.8	57.3	31.5	258	212	-6.936	Sig (0.05)	4.060
39. percent de usuarias de ritmo que conocen los días fértiles del ciclo	31.4	34.9	3.5	40	31	-0.311		32.4	37.4	5.0	43	39	-0.475		0.963
40. percent de mujeres unidas que conoce algún malestar del embarazo y del post parto que indican situación de riesgo	16.1	45.5	29.4	118	88	-4.616	Sig (0.05)	30.1	56.9	26.8	153	116	-4.416	Sig (0.05)	1.495
43a. percent porcentaje de mujeres que ha escuchado sobre Papanicolau o el examen de mamas	64.7	73.7	9.0	186	146	-1.755	Sig (0.05)	77.6	87.5	9.9	258	212	-2.784	Sig (0.05)	1.010
43b. percent porcentaje de mujeres que piensa que mientras una mujer está dando de lactar es difícil que quede embarazada	39.0	57.2	18.2	132	100	-2.751	Sig (0.05)	39.2	60.7	21.5	184	150	-3.910	Sig (0.05)	0.947

Tabla2: Porcentaje de cambio neto para cada indicador del Marco de Resultados y estimaciones de los valores de Odds Ratio. Comunidades con bancos comunales y comunidades con IE&C

Indicadores	Bancos			IE&C			Odds
	LB	EI	Cambio relativo	LB	EI	Cambio relativo	Ratio
OE: Mujeres incrementan la utilización de intervenciones en salud reproductiva							
1a. % de mujeres que ha tenido 4 o más controles con personal de salud durante el último embarazo ocurrido dos años antes de la encuesta	41.7	67.6	1.621	49.1	73.2	1.491	1.087
2. % de mujeres que atendió su último parto, ocurrido dos años de la encuesta, con personal de	15.6	45.7	2.929	30.6	46.7	1.526	1.920
3. % de mujeres unidas que usa algún método anticonceptivo	62.7	68.2	1.088	67.5	71.6	1.061	1.025
4. % de mujeres unidas con necesidad insatisfecha de planificación familiar (incluye a usuarias de ritmo que no conocen su período fértil)	48.3	42.0	0.870	42.6	42.1	0.988	0.880
4.1 % de mujeres unidas con necesidad insatisfecha de planificación familiar	23.5	15.9	0.677	21.0	20.5	0.976	0.693
RI 1: Mujeres tienen relaciones de género más equitativas con sus parejas y sus familias							
5. % de mujeres unidas cuya pareja ayuda cuando los niños se enferman	16.7	47.4	2.838	30.3	32.7	1.079	2.630
6. % de mujeres que decide en qué se gasta el dinero ue gana ella	36.2	35.9	0.992	41.5	35.0	0.843	1.176
7. % de mujeres que decide conjuntamente con su pareja sobre relaciones sexuales, métodos anticonceptivos y número de hijos	22.2	30.6	1.378	28.2	38.7	1.372	1.004
9. % de mujeres que hace una o más tareas en su casa conjuntamente con su pareja	26.3	38.6	1.468	33.1	67.2	2.030	0.723
11. % de mujeres que decide conjuntamente con su pareja hasta qué nivel de educación deben estudiar hijas e hijos	75.2	72.7	0.967	55.4	51.9	0.937	1.032
11.a % de mujeres unidas que ha hablado con su pareja sobre el número de hijos que desean tene	75.8	78.3	1.033	73.5	83.9	1.141	0.905
RI 1.1: Mujeres fortalecen sus habilidades para conseguir cambios en sus relaciones de género							
12. % de mujeres que está de acuerdo que la mujer decida cuidarse aún cuando la pareja se oponga	51.7	55.7	1.077	76.4	65.5	0.857	1.257
12.1 % de mujeres que no tiene relaciones sexuales obligada o convencida	63.4	68.6	1.082	41.3	60.7	1.470	0.736
14. % de mujeres que acudiría a pedir ayuda a la policía-autoridades si su marido la golpease	19.5	43.2	2.215	18.5	35.7	1.930	1.148
16.a % de mujeres que sabe a dónde acudir a pedir ayuda o consejo en caso de ser golpeada	65.6	71.8	1.095	43.6	73.4	1.683	0.650
RI 1.2: Aumento de actitudes positivas de los varones en su relación con las mujeres y la familia							
17. % de varones que cree que a la mujer no se le puede golpear en ningún caso	75.5	73.3	0.971	53.1	79.7	1.501	0.647
18. % de varones que cree que el hombre no tiene derecho a exigir relaciones sexuales cuando la mujer no quiere	76.8	93.0	1.211	76.0	92.4	1.216	0.996
RI 1.3: Mujeres incrementan el conocimiento sobre la situación de género							
21. % de mujeres que cree que las hijas y los hijos deben estudiar hasta el mismo nivel	96.7	78.7	0.814	86.5	91.8	1.061	0.767
21.1 % de varones que cree que las hijas y los hijos deben estudiar hasta el mismo nivel	95.7	93.5	0.977	84.5	87.5	1.036	0.944
RI 2: Mujeres con mayor capacidad para acceder a los servicios de Salud Reproductiva							
24. % de mujeres que ha acudido a un establecimiento de salud para una consulta sobre salud reproductiva o para atención en planificación familiar	20.8	32.8	1.577	28.8	32.2	1.118	1.410
RI 2.2: Aumento de la valoración positiva de la salud de la mujer dentro de los hogares y la comunidad							
33. % de mujeres que realizó algún gasto en su salud en los últimos 12 meses	39.2	57.9	1.477	46.8	44.8	0.957	1.543
RI 2.6: Mujeres incrementan el conocimiento sobre sus necesidades de salud reproductiva							
38. % de mujeres unidas que sabe cómo funciona al menos un método moderno	6.1	55.0	9.016	25.8	57.3	2.221	4.060
39. % de usuarias de ritmo que conocen los días fértiles del ciclo	31.4	34.9	1.111	32.4	37.4	1.154	0.963
40. % de mujeres unidas que conoce algún malestar del embarazo y del post parto que indican situación de riesgo	16.1	45.5	2.826	30.1	56.9	1.890	1.495
43.a % porcentaje de mujeres que ha escuchado sobre Papanicolau o el exámen de mamas	64.7	73.7	1.139	77.6	87.5	1.128	1.010
43 b % porcentaje de mujeres que piensa que mientras una mujer está dando de lactar es difícil que quede embarazada	39.0	57.2	1.467	39.2	60.7	1.548	0.947

Table 3: Results Framework Indicators Ranked According to Greatest Project Impact Relative to the Odds Ratio Value

Indicadores	Cambio neto en puntos porcentuales entre la línea de base y la evaluación intermedia		Odds Ratio
	Bancos	IE&C	
Odds Ratio de 1.999 a +			
38. percent de mujeres unidas que sabe cómo funciona al menos un método moderno	48.9	31.5	4.060
5. percent de mujeres unidas cuya pareja ayuda cuando los niños se enferman	30.7	2.4	2.630
Odds Ratio de 1.999 a 1.199			
2. percent de mujeres que atendió su último parto, ocurrido dos años antes de la encuesta, con personal de salud	30.1	16.1	1.920
33. percent de mujeres que realizó algún gasto en su salud en los últimos 12 meses	18.7	-2	1.543
40. percent de mujeres unidas que conoce algún malestar del embarazo y del post parto que indican situación de riesgo	29.4	26.8	1.495
24. percent de mujeres que ha acudido a un establecimiento de salud para una consulta sobre salud reproductiva o para atención en planificación familiar	12.0	3.4	1.410
12. percent de mujeres que está de acuerdo en que la mujer decida cuidarse aún cuando la pareja se oponga	4.0	-10.9	1.257
Odds Ratio de 1.199 a 1.100			
6. percent de mujeres que decide en qué se gasta el dinero que gana ella.	-0.3	-6.5	1.176
14. percent de mujeres que acudiría a pedir ayuda a la policía -autoridades si su marido la golpease	23.7	17.2	1.148
Odds Ratio de 1.099 a 1.050			
1a. percent de mujeres que ha tenido 4 o más controles con personal de salud durante el embarazo ocurrido dos años antes de la encuesta	25.9	24.1	1.087
Odds Ratio de 1.049 a 1			
11. percent de mujeres que decide conjuntamente con su pareja hasta qué nivel de educación deben estudiar hijas e hijos	-2.5	-3.5	1.032
3. percent de mujeres unidas que usa algún método anticonceptivo	5.5	4.1	1.025
43a percent de mujeres que ha escuchado sobre Papanicolau o el examen de mamas	9.0	9.9	1.010
7. percent de mujeres que decide conjuntamente con su pareja sobre relaciones sexuales, métodos anticonceptivos y número de hijos	8.4	10.5	1.004
Odds Ratio menor que 1			
18. percent de varones que cree que el hombre no tiene derecho a exigir relaciones sexuales cuando la mujer no quiere	16.2	16.4	0.996
39. percent de usuarias de ritmo que conocen los días fértiles del ciclo	3.5	5	0.963
43 b. percent de mujeres que piensa que mientras una mujer está dando de lactar es difícil que quede embarazada	18.2	21.5	0.947
21.1 percent de varones que cree que las hijas y los hijos deben estudiar hasta el mismo nivel	-2.2	3	0.944
11a. percent de mujeres unidas que ha hablado con su pareja sobre el número de hijos que desean tener	2.5	10.4	0.905
4. percent de mujeres unidas con necesidad insatisfecha de planificación familiar (incluye a usuarias de ritmo que no conocen su período fértil)	-6.3	-0.5	0.880
21. percent de mujeres que cree que las hijas y los hijos deben estudiar hasta el mismo nivel	-18.0	5.3	0.767
12.1 percent de mujeres que no tiene relaciones sexuales obligada o convencida	5.2	19.4	0.736
9. percent de mujeres que hace una o más tareas en su casa conjuntamente con su pareja	12.3	34.1	0.723
4.1 percent de mujeres unidas con necesidad insatisfecha de planificación familiar	-7.6	-0.5	0.693
16.a percent de mujeres que sabe a dónde acudir a pedir ayuda o consejo en caso de ser golpeadas	6.2	29.8	0.650
17. percent de varones que cree que a la mujer no se le puede golpear en ningún caso	-2.2	26.6	0.647