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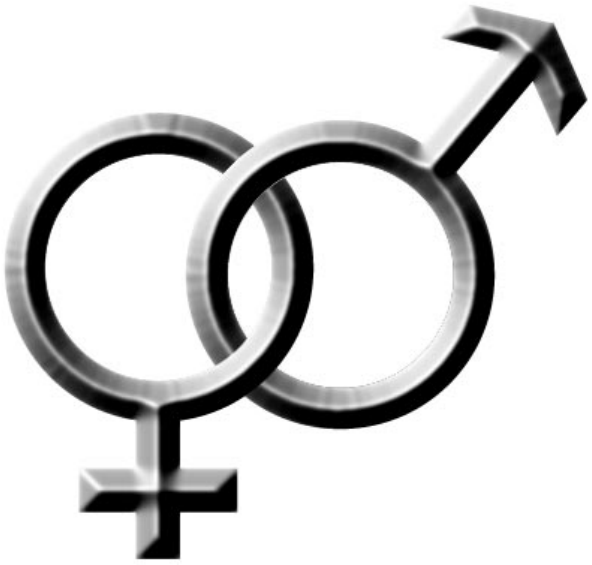

WORKSHOP ON GENDER, HEALTH AND DEVELOPMENT

Women
health and development

DIVISION OF HEALTH AND HUMAN DEVELOPMENT

PAHO wishes to acknowledge the contribution made by the Inter-American Commission of Women of the Organization of American States toward the publication of this manual.

Facilitator's Guide

WORKSHOP ON GENDER, HEALTH AND DEVELOPMENT: FACILITATOR'S GUIDE

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It is said that the most effective way to learn a subject is to have to teach it. The story behind the construction of this manual attests to this axiom. Almost three years ago, in March, 1994, the four members that then comprised a newly formed team of the Regional Program on Women, Health and Development at the Pan American Health Organization (PAHO) set out to convince PAHO colleagues that looking at health through a gender lens significantly contributes to our understanding of men's and women's health-illness processes and can improve the equity with which roles, responsibilities and rewards are distributed in health promotion and care.

We began by reviewing what others before us had done—in UN sister organizations, in multilateral and bilateral development agencies, and in non-governmental organizations. We looked at numerous gender training manuals, talked with many women who had spearheaded gender awareness efforts in these respective institutions, and received important advice from those who had, with mixed success, been responsible for implementing mechanisms to incorporate a gender perspective into their organizations' programming and planning.

The four of us approached these initial explorations with mixed feelings. We vacillated between great optimism, convinced that with energy and dedication and with help from the experts on gender training we could successfully undertake an effort to "engender" PAHO; and great anxiety, convinced that to undertake gender training at PAHO was a quixotic undertaking at best, and at worst was downright dangerous because it exposed our program to PAHO's technical staff, many of whom thought that "gender" was a straw man (or woman) and had little to contribute to the hard analysis needed to examine the interconnections between health and human development.

What our team did agree on was that as an isolated Program in the Organization, we alone could not ensure that a gender perspective was incorporated in PAHO's technical cooperation efforts. We needed partners and our partners had to be PAHO's technical programs: health services, water and sanitation, nutrition, reproductive health, mental health, occupational health, adolescent health, communicable and non-communicable diseases, health policy, health research . . . and so on. Sensitizing them to the ways in which gender, interacting with biology, can have protective or adverse outcomes on the health of men and women was of critical importance. There was no way of avoiding our need to embark on this effort to systematically expose our partners to concepts of gender equity and its practical applications.

The other point we all agreed on was that someone else had to conduct this process—someone who was an expert in gender and who had trained others in the application of the concepts to development work. We thought of many reasons why it had to be someone outside the Organization, all of them perfectly plausible. But the main reason was terror—both personal and professional. By hiring an expert from outside, if it went well, we could take the credit; if it went badly, we could more easily avoid the blame.

The results of the first attempt at gender and health training at PAHO was a two day session at Headquarters that lived up to our worst fears. Fortunately, we had carefully selected the participants among PAHO technical staff who were

"allies," men and women who believed gender had a significant impact on wellness and illness. After our first disappointment we brought them together to analyze the contents, the method, the dynamics and what went wrong.

It hadn't been the outside consultant—a person with many years of experience in gender and development training who had conducted many such successful sessions for international development organizations. Our own Program was responsible for this first truncated attempt—we had failed to assist the consultant in making the connection between gender, health and human development. The biological differences between the sexes and the implications of the interaction between biology and gender for health had not been incorporated sufficiently into the analysis.

Why was this first experience crucial to the Program? It forced us to acknowledge that to date there had been little work conducted in laying out a methodology for health planning professionals that made visible the linkages between gender, health and human development and helped health professionals gain confidence in applying that method to their areas of expertise. We also realized the importance to the success of our efforts of being thoroughly familiar with PAHO's technical cooperation programs. It was hardly fair to expect an outside consultant to know about PAHO "culture." Ultimately, we came to grips with the fact that regardless of how we felt about our capacity and knowledge, we ourselves had to design and implement the training package for PAHO. If we could not transmit in a logical and coherent manner the relationship of gender to the health and development of men and women, then we had no business being involved in technical cooperation in that field.

That should be the conclusion of this introduction, but it is really only the beginning. It took us 9 months to put a first draft of this manual together, after which we shared it with our focal points in PAHO's Offices of Representation in Latin America and the Caribbean. Their contributions served to enhanced the logic of the sequencing of the modules, adjust the length of the components and enrich the content. After incorporating their modifications and additions, we received our first request for the workshop from Cuba. The response to the seminar in Havana was exhilarating and gave us the confidence to continue—onto Belize, Barbados, Bolivia, Peru, Venezuela, Colombia, Paraguay, Costa Rica, Nicaragua, St. Kitts and Nevis, Honduras, El Paso and Geneva, for a session at WHO Headquarters.

Each country's experience has been crucial in the construction of this manual. Participants' suggestions have served to enrich our examples. Their constructive criticisms as well as their applause and encouragement have found their way into the spirit of the approach used throughout the sessions.

As we continue to learn more about the factors that affect women's and men's health, both biological and social, we will continue to improve this manual. The fact that it is joined together in loose leaf binder fashion speaks to our conviction that we must continuously improve upon it, add to some components and modify others.

Although the Regional Program for Women, Health and Development was directly responsible for this endeavor, many others have been part of its construction. We would like to thank Caroline Moser, pioneer in gender planning in development, for her initial guidance and continuous encouragement and conviction in the process we had chosen to undertake; Elizabeth Shrader Cox for her important contributions and positive reinforcement; Amelia Fort for her critical input at the beginning of the process; and Stephanie Urdang, whose ability as a trainer and as keen observer of human experience was invaluable to our growing awareness that people learn best when they are able to draw upon their own knowledge and experience and when they are actively involved in the discovery of new ways of looking at the world. Stephanie's influence is strongly reflected in the way the content of this workshop is communicated.

Within PAHO, a special thanks to Hernan Rosenberg who sat through numerous pilot sessions with us, challenging us to consider issues we hadn't addressed and not giving up until he and we were all confident we could convincingly respond to them.

We wish to note the efforts of Karen Sealey, Caribbean Program Coordinator, for her support in ensuring that this manual and the process of its construction reflected the needs of the English speaking Caribbean. Thanks also to all our PAHO colleagues at Headquarters who participated in the pilot sessions and gave their time and thought to this process and its contents.

In acknowledgements of this sort, it is often the norm to thank persons in key management positions of an organization who have somehow facilitated—or at least not impeded—these efforts. But our experience to date attests to the rarity of finding such an instrumental figure who takes the quest for gender equity in health as a personal and professional goal. George A.O. Alleyne, who for five years was directly responsible for the Women, Health and Development Program at PAHO, and who subsequently has become PAHO's Director, is such a person. The thinking that has gone into this manual, and the advances made by the Women, Health and Development Program at PAHO, have benefitted from his guidance, his challenges, and our many discussions and debates, but most of all, from his unflagging belief in the importance of women's health, and the incorporation of a gender perspective in the health and human development work of the Pan American Health Organization.

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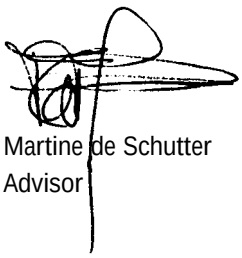

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WORKSHOP ON GENDER, HEALTH AND DEVELOPMENT

INTRODUCTION:

A training manual is much like a recipe book. Depending on the cook's personality, cooking style and the amount of experience, he/she might follow the instructions verbatim to the last ingredient, or add this or that to make it more interesting to the cook. Eventually the cook might totally dispense with the instructions, or might continue to experiment. One of the challenges of training and facilitating is to find one's own style and to explore different approaches. Use this training manual as a guide, a "recipe" book to be adapted and experimented with in terms of methodology. The basic ingredients will remain the same.

The manual, designed for conducting a workshop on GENDER, HEALTH AND DEVELOPMENT, incorporates a number of different training methods and approaches. In the following pages you can find some helpful hints in how to conduct training using these methods. We hope they will prove useful for both those new to training and those experienced, as you continue to develop and adapt your training to incorporate your own technique and approaches.

ADULT LEARNING:

There is a "question" that trainers like to pose in appropriate settings. "What is the difference between education and training?" And the answer is, "Would you like your daughter or son to be given sex education or sex training?"

There is a distinct difference between the two. In the case of this workshop, training is particularly suited to adult learning, as it is participatory, involves the learner, draws on his/her knowledge already gained over the years, while filling gaps in that knowledge. Skills are imparted through practice, a process to which trial and error is essential. When mistakes are made during training they enhance learning; when they are made on the job they can be costly.

Attention spans differ. They go up and down in waves. Each adult in a training setting experiences these waves unevenly. While the wave is at the peak for one, it is at the lowest ebb for another. If a piece of information is presented at the low ebbs, it will be washed over and not grasped. Training therefore needs to involve the participant in practical, hands on exercises, and the core messages to be repeated at regular intervals to ensure optimum comprehension.

Further, research has shown that adults respond differently to different ways of imparting knowledge, and retention differs according to the medium in which the learning took place. Thus participants will retain:

10 percent of what they read;
20 percent of what they hear;
30 percent of what they see;
50 percent of what they both hear and use;
70 percent of what they do.

To quote a Chinese saying:

"I hear, I forget. I see, I remember. I do, I understand."

Training can be very effective among adults because they tend to be self-directed, believing in and relying on their own personal experiences to provide critical resources. They learn best when the subject matter is highly relevant and can be applied shortly after the training takes place. In fact if the new skills are not used within a short time of the training, they are likely to atrophy very easily.

A trainer's task is often one of facilitating this process rather than providing knowledge, although substantive resource persons must be available. A trainer who also has the substantive knowledge is preferable but not essential and he/she can work closely with a resource person.

The following manual caters to adult learners' need to participate actively in the acquiring of skills rather than learning in a static atmosphere where knowledge is imparted in lecture form by an expert.

METHODOLOGIES:

Different methods are used in the sessions to vary the way material is learned and skills are acquired. Among these are:

PAIRS:

Participants are invited to pair off to introduce themselves, to discuss a point that arises during the workshop, to discuss a particular question prepared ahead of time and posed by the facilitator. If this is used a number of times during the workshop it is helpful to make sure the partners change for each exercise as this helps the participants to get to know each other better.

Advantage: It can be used more formally as in the introduction of the participants. It allows one-to-one communication that helps the building of group cohesiveness. It can be used spontaneously when a question arises that the facilitator feels is worth discussion. This is helpful when the question is a difficult one to answer for whatever reason. Participants are asked to pair off, discuss the question for a few minutes (3 - 5) (using a timer helps) and then offer their findings in plenary discussion. This allows participants to think through an issue and articulate it more effectively than if they were presented with the facilitator's viewpoint or thought about it on an individual basis.

Disadvantage: It can take time when used spontaneously and while it might be useful tool, it can play havoc with time control. It best be used sparingly for highest impact.

SMALL GROUP WORK:

This is very important for a participatory workshop and is a key training methodology.

It provides an important shift from the plenary and is one of the key ways to build understanding, awareness and skills.

It also allows those participants who are more reticent about asking questions in a large group a chance to voice their opinions.
In this manual small group work is used for the long exercise of project analysis and for shorter exercises such as working on brief cases.

Groups should be limited to no more than six participants in each. Such an arrangement provides sufficient variety but minimizes the time taken for presentation and feedback.

For the longer exercises break out rooms are needed, or a training room that is large enough for participants to be divided into groups at four tables so that they do not distract each other. This is important.

Because it is useful to have participants discussing points and exercises in small groups throughout the workshop, an effective lay out is to have up to six participants sitting at a table [see Training Room Set Up below]. Changing the participants at the tables each day will enhance interaction and learning.
This can be done each morning, asking participants on the left side of the table, for instance, to move by rotating clockwise to the next table. Have participants on the right side rotate anti-clock wise. Depending on how many are sitting at the table, it could be repeated once more.

The change in seating arrangements can also be planned the evening before the second day to ensure that different personality types and levels of knowledge and experience are spread throughout the room. In this case, ask participants to leave their name tents on the tables so that they can be rearranged.

Process: Pose questions for discussion (Group Task), and hand out cases if these are being used. Ahead of time, write the Group Task on a flipchart—one for each group if the task is long, and if they will be working in break out rooms. Inform participants of the total time they have for the group work, ask them to appoint a rapporteur and a recorder/notetaker to write their findings on a flipchart. Facilitators should circulate at the beginning to ensure they understand the exercise and should be available for clarifying questions.

Give time signals at a number of points, with the minimum of half-way and ten minutes and three minutes before the return to plenary.

Back in the plenary, ask the groups to volunteer to report back. Allow each group 5 minutes (or time appropriate to exercise) to present their findings. When the group's presenter has completed the report, ask other members of the group if they have anything to add. Ask the other participants for clarifying questions only (discussion will be held after all groups have presented). Continue this process for all the groups.

BUZZ GROUPS:

These are informal groups that can be set up spontaneously when an important but perhaps complex question is asked, and the facilitator does not want to become the "expert" or be put on the spot.
Ask the participants to form groups of three or four to discuss the question, and give them time to give their opinions. Time allotted should be brief: about five minutes.

Buzz groups can also be used intentionally as a break in a lecture. Think of questions to pose ahead of time, and write them on a flipchart.

Buzz groups and pairs are particularly useful after lunch on a hot day when attention will be flagging.

LECTURETTES:

Think about the lectures you have heard. It may be that many of them really kept your rapt attention throughout. But, how much do you remember from them? Were you involved or, rather, simply a passive listener aware of the length of time. This is the disadvantage of using lecture as a method for training. Captivating lecturers have a special talent that most of us do not have.

As we have seen, the attention span of adults peaks and ebbs, and this method of acquiring information can be disappointingly ineffective. Lectures tend to place the facilitator in the role of expert, to minimize the potential for participants to examine and draw on their own knowledge and experience.

However, there IS place for lectures in a training workshop.

- Lectures provide a contrast to the other methods utilized in the workshop.
- They enable the facilitator to present information in a short space of time, and if followed by exercises that re-entrench that information, they can be extremely useful.
- A well balanced workshop will limit the number of sessions that rely on lectures for the transmittal of information/knowledge.

Therefore in this manual you will find places in which lectures are delivered, as well as short lecturettes. The latter is much more preferable as it is short, so that the information is easier to absorb and is often a highly effective way of introducing a topic.

Delivering a Lecture/Lecturette:

Some useful tips in making your lecture/ lecturette as interesting as possible include:[1]

1 For further ideas and guidance, see: Eitington, J. *The Winning Trainer*. Houston: Gulf Publishing Co., 1989.

- Content:
  - State objectives up front
  - Personalize content—experiences, illustrations, laugh at self
  - Integrate anecdotes, humor, examples, metaphors
  - Try to grab attention with your openers
  - Repeat core messages in different ways
  - Sum up main points at the end

- Preparation:
  - Practice with tape recorder, mirror, video-camera
  - Over-prepare
  - Write salient points on flipchart and write cues in pencil

- Presentation techniques:
  - Use visual aids such as flipcharts, OHTs containing succinct information, written in clear, large type
  - Avoid notes or cue cards (e.g., use flipcharts as above)
  - Vary voice, tempo
  - Avoid standing in one place and "delivering"
  - Maintain eye contact, but with whole group. Don't focus on one or two participants
  - Speak in a clear strong voice, with a conversational tone
  - End on time!

- Involving participants:
  Perhaps the biggest key to a successful lecture is to involve the participants. For instance:
  - Encourage questions
  - Pose a question and have them break into pairs or buzz groups for 3 minutes to discuss and give responses
  - Use visual aids (Flipcharts/OHTs/ Handouts) [See page 10]
  - Provide a short reading assignment ahead of time
  - Ask for participants' experiences/ anecdotes to bear out a point
  - Turn a participant's question back on the group, e.g., "That's a great question. Discuss it in pairs for two minutes and lets see what you come up with."
  - Begin with a brainstorming.

BRAINSTORMING:

This method allows participants to give their ideas freely without prior thought. Innovative and useful ideas come from this method.

It entails the facilitator posing a question and asking the participants to call out their spontaneous answers. Nothing is censured. Everything is written up on the

flipchart, even repeats. The idea is to get as many ideas out in as short a space of time as possible. Participants will get into the rhythm of it quickly and enthusiastically. When the time is up, the facilitator then asks the group to categorize the responses into topic areas. Using color markers, each idea is given a letter in a different color. In the end, overlaps and repeats can be eliminated, and the ideas prioritized if wished. Group discussion follows during which some points might be emphasized, others discarded, until the sense of the group is achieved.

Some guidelines:

- Present a limited problem or question.
- The participants give one idea at a time.
- Record ideas on the flipchart.
- When recording, do not edit or comment.
- Only general comments allowed such as "Wow! we're getting a lot of good ideas," not praising one idea, or saying another is not to the point. This will stall the process as people get self-conscious.
- Keep the tempo quick.
- Ask participants not to self-censor. Tell them that some of the best ideas are the spontaneous, unfiltered ones. Comments that are critical are not allowed and evaluation of the ideas comes once the ideas have stopped flowing or the time is up.

This is a useful exercise as it is very involving, fun, and everyone is likely to contribute.

QUESTIONS:

Question/discussion time can be set at a specific time, e.g., at the end of a lecture, or during plenary feedback. In fact in a participatory training workshops, questions are key and need to be encouraged.

However there are inherent dangers: The participant who likes to hear his/her voice and asks constant questions, even when they are not relevant; the very relevant question that takes time to answer and so disrupts the timing of the session; the questions that turn into commentaries; the questions that turn into active debate. Training Workshops are marked by the need to cover a lot of material in a short time and questions can derail this. However, they are an intrinsic part of the participatory process.
The facilitator has to be firm about the time taken up in questions particularly when they are irrelevant.

- PARKING LOT: One way to get around this is to establish a "PARKING LOT" at the beginning of the workshop. Head a flipchart with these words, and stick it up on a visible wall. Right from the beginning of the workshop, tell participants that some questions might be answered later in the workshop, or

might be taking up too much time in a particular session. When this happens "park" the question on the flipchart so that you will be sure to answer it during the workshop. Some of the questions will cease to be as burning as the workshop continues, some will be answered, and those still floating at the end can be left to the participant's desire to have them answered. This is a useful mechanism for controlling time and allowing participants not to feel brushed aside.

- Refer Questions Back: Sometimes the facilitator is not sure how to answer a question; sometimes the question is key; the question comes at a time when concentration is flagging. If so, then refer the question back to the group and:
  - Commend the question and ask the participants to give their answers.
  - Move to pairs or buzz groups to consider the question.

- Dominating Participants: You will have to try and defuse persistent questioners:
  - Politely but firmly say that other participants need to be given a chance.
  - Park their questions, while praising their enthusiasm.
  - Suggest that you can talk to him/her later to clarify points, if you think other participants are not interested. Often, once in a one-to-one setting, the questioner will lose interest in his/her question.
  - Use humor to defuse any tension or resentment that might be building up among other participants who feel dominated.
  - Break into buzz groups more frequently.
  - Ensure that such dominators are moved from one small group to another, so that no group has to "live" with the participant for the whole workshop.
  - If the questioner is persistent and you are running short of time, ask the group as a whole to decide whether they would like to continue with this line of question which means losing some of the content of the session. This allows the participants to curtail the questioner, and not the facilitator.

VISUAL AIDS:

The Visual Aids used most commonly in this workshop are Overhead Transparencies (OHTs), Flipcharts and Handouts. A section at the end of the manual provides photocopy ready OHTs (to be copied onto transparency sheets) and Handouts. In addition, the content of the flipcharts have been placed all together to facilitate reproduction.

OHTs:

The advantage of these visual aids is that they can contain important information in a clear and neat manner. A whole lecturette can be presented with OHTs, or they can be used intermittently to stress a point and help participants retain the information as it is being both orally and visually presented.

When a lot of material is to be presented visually, OHTs are more useful than flipcharts. They are easy to carry around.

They can be handwritten or typed, and the typed OHTs can be highlighted with the use of different colored overhead projector pens.
Disadvantages include: passive interaction between participants and facilitator; the need to stare at a lighted screen; the facilitator can't move around.

- Use of OHTs:
  - Four or Five words per line; 5/6 lines per page
  - Large type
  - Use colors
  - Use diagrams/charts
  - Use stiff card to highlight one or two lines at a time; hide what isn't being focused on at the moment
  - Cardboard frames help the handling (sheets don't fly or slide away at critical moments) and you can write cues on the cardboard for the lecture.
  - Make sure you have an extra projector bulb on hand

FLIPCHARTS:

Flipcharts provide the opportunity to be more interactive.
They can be written on the spot; they can be dramatically highlighted with the use of color.
They can be pasted on the walls for later use, or to provide the opportunity to see a number of flipcharts at once, or to refer back to during a subsequent session.

- Use of FLIPCHARTS:
  - Prepare them ahead of time, including flipcharts to be used for brainstorming or responses from the plenary where only a heading is needed;
  - It is essential to write legibly in large letters (people at the back of the room have to be able to see them without straining);
  - Brighten up with colors: Underline alternate points with two different colors;
  - Stick a post-it or tape on the side of the flipchart so that it juts out, with the content and number for easy reference during the presentation;
  - Write cue points in pencil to dispense with cards or sheet of paper. Pencil marks cannot be seen by participants;
  - Separate sheets with a blank sheet if flipchart paper is thin enough so that the underlying flipchart shows through. Catch the two flipcharts sheets together with tape;
  - Stand to the side so that you don't turn your back to the participants;
  - Make sure you have plenty of fresh pens of different colors. Drying out pens are an irritation as they are hard to write with, and hard to see;
  - Use waterbased markers when possible, as some participants react to the strong smell;
  - Have plenty of masking tape around to stick the flipcharts to the wall. Tear off pieces of masking tape ahead of time and attach them in a row on the flipchart stand;

- Drawing a different color border around the flipchart enhances the presentation;
- It is useful to have as many as three flipchart stands up front, so that the facilitator can move between them, have more than one flipchart on display at the same time.

TRAINING ROOM SET UP:

The most common configuration is a deep "U" with participants sitting around the edge of the U and the facilitator standing up front in the gap. This is useful if the group is small, as the facilitator can move into the center and remain close to the group.

For larger groups—over 12 or 15—individual tables seating five to six participants so that they all face the front of the room is more effective. They can talk in quick buzz groups or work at their tables when undertaking a case study.

To ensure that they get a chance to work with different participants and benefit from a variety of input and experience, move the groups around each day. [See Small Group Work page 5]

TIME:

One of the most essential elements to a smooth running workshop—and often one of the most difficult—is a fanatical adherence to time.

Components need to be realistically timed so that facilitators do not get boxed in. Adjustments might have to made for larger groups, by cutting down some of the content of the sessions to allow for full interaction and participation.

The training room should be equipped with a large, visible clock.

It is important to get a balance of the need and desire for participants to contribute through questions, comments and anecdotes and the need to move on so that all the content can be covered effectively.

One of the best comments in the evaluation is that the time was too short—provided the workshop covered the material and was efficiently run.

During group work announce the time left at regular intervals. During lecturette, feedback sessions and other plenary activities, remind participants of the time available for the session. If they are very involved in a topic and are having difficulty grasping it and want to continue, stop and ask for their views about continuing longer. It might mean staying later. Participants need to make their own decision on this. Often they will opt for staying longer if they feel they are getting something worthwhile out of the session.

FURTHER READING:

Eitingham, J., *The Winning Trainer*. Houston: Gulf Publishing Co., 1989.

Silberman, M. *Active Training: A Handbook of Techniques, Designs, Case Examples, and Tips*. New York: MacMillan, 1990.

GENDER, HEALTH AND DEVELOPMENT AT A GLANCE

OBJECTIVES:

- To examine the difference between sex and gender
- To discuss the gender approach and its particular relevance to the area of health and human development
- To acquire skills and methodologies to enable participants to ensure that their work in health and human development is grounded in a gender approach

TARGET AUDIENCE: Health and Development practitioners responsible for development policy, programs and projects in health and human development

GROUP SIZE: 20 participants, to absolute maximum of 24; minimum of 12

METHODS: Highly participatory, including:

Lecturettes	Group/Plenary Discussion
Small Group Work	Videos
Case Studies	Question and Answer

DURATION: 14 hours (2 days)

TRAINERS: Minimum of two facilitators including: One facilitator who is experienced in conducting participatory workshops; one facilitator who is a specialist in Health and Development and familiar with the broad range of activities in health

TRAINING FACILITIES: One training room to comfortably accommodate entire group. Small break-out rooms, one per every 6 participants, or a room large enough so that work can be completed in small groups out of ear-shot of each other.
Training Room should have sufficient wall space for attaching flip charts

MATERIALS: Flipchart stands, flipcharts
Different Colored Markers
Masking tape (tape that does not mark walls)
Overhead Projector (with spare bulb)

SUMMARY OF WORKSHOP

MATERIALS (CONT):

VCR and Monitor
Stiff cards for name tents, either pre-printed or blank
Name tags (adhesive backed or pinned)
Note paper, pens/pencils

METHODOLOGY USED IN THIS TRAINING WORKSHOP:

The training manual is based on the premise that people acquire knowledge more effectively when encouraged to discover the facts for themselves and draw on their own work and personal experiences. It therefore uses participatory techniques to support this process of learning and allows for time to discuss, question, think and entrench knowledge through a variety of methods.

INTRODUCTION TO WORKSHOP

	MODULE: INTRODUCTION / OVERVIEW
Objectives	■ To provide participants with the framework of the workshop ■ To introduce the participants ■ To review the objectives of the workshop.
Core Message	The Workshop provides practical skills for incorporating a gender perspective in the participants' work
Expected Outcome	Participants will understand the relevance of the workshop within the context of PAHO's Strategic Orientations and Programs
Method	Lecturette Pairs Plenary Report Back
Materials	*Flipchart No. 1:* Introductions *Flipchart No. 2:* Workshop Objectives *Flipchart No. 3:* Expected Outcome Participant Binders (ring) or folders containing Workshop Agenda, Participant List, Objectives, Expected Outcome
Components	A.1: Introduction to Gender, Health and Development A.2: Participant Introductions A.3: Workshop Objectives and Expected Outcome
Time	A.1: 10 minutes A.2: 35 minutes A.3: 10 minutes Total: 55 minutes
Preparation	■ Introductory Lecturette: ■ Prepare Flipcharts (See Section: Flipcharts in Manual Copy or adapt as needed. Also, read section on preparing flipcharts in Guide to Facilitation in this manual.)

Preparation (Cont.)

- Prepare Participants' ring binders or folders to contain**)**
  - Agenda
  - Participant List
  - Objectives
  - Expected Outcomes
  - Background Reading
  - Module dividers, so that handouts can be filed in appropriate modules (if Ring binders used)
  - Holed paper for note-taking, to fit into binders

- Set up training room
  (See section on room setup in Guide to Facilitation, p. 12, in manual)

INTRODUCTION TO GENDER, HEALTH AND DEVELOPMENT

Method: Lecturette

Materials: Participants' Binders

Time: 10 minutes

Preparation: Review lecturette and customize as appropriate

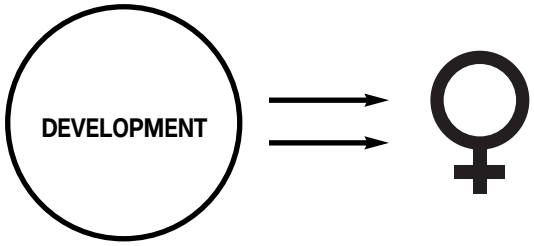
PROCESS

- WELCOME: Facilitator welcomes participants and introduces self. **[1 minute]**
- LECTURETTE: Facilitator explains: **[9 minutes]**
  - Workshop sponsored by the Regional Program on Women, Health and Development (WHD) of the Division of Health and Human Development of PAHO
  - History:
    - 1986: Program launched when XXII Pan American Sanitary Conference approved guidelines
    - 1987: First meeting of WHD Focal Points in Caracas. Agreement on need to promote national and subregional action plans to improve women's health
    - 1988: Latin American meeting in Cuba focussed on women's health and analyzed participation of women in health
    - 1988: "Health, a Bridge for Peace" strategy in Central America approved first subregional initiative for women
    - Program has continued to promote initiatives designed to advance understanding of interaction between biological and social factors and its impact on health

- The facilitator explains:

  During the last three decades, the problems of women and their participation in development have received increasing from bilateral and multilateral development agencies, including governmental and non-governmental organizations. This interest began with the so-called "Women in Development" or WID approach. WID grew out of the idea that women had been "outside" health and development processes and that, in order to integrate them, it was necessary to target efforts specifically to women that were designed to correct this situation. This approach focuses on women in isolation, with projects designed to generate income, improve the nutritional status of children and control fertility. The goal: more effective and efficient socioeconomic development through improvements in the conditions of women.

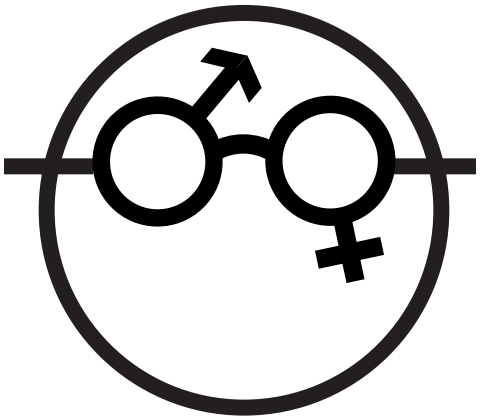
- Facilitator draws:



- It was later recognized that, far from being "outside" the development process, women had always been an indispensable part of this process. But they were invisible. We began to understand that women were not the "problem." Rather, the problem arose from inequitable gender relations which relegated women to a disadvantaged and subordinate position vis-a-vis men with respect to access to and control of resources that promote health and development.

- This new approach, called the "Gender, Health and Development" (GHD) approach, holds that inequity in the relations between men and women places one or the other sex at a disadvantage in terms of access to and control of the resources needed, for example, to protect health. The GHD approach holds that in order to balance these relations, the entire process of promoting health and development should be looked at through a gender lens.

- Facilitator draws:



- Today, our efforts are aimed at correcting this imbalance between the position of men and women in terms of access to and distribution of resources and benefits. We could say that we are looking for an ideal state of development in which gender relations are equitable. In most cases, women are in a position of socioeconomic disadvantage that negatively affects their health, and it is thus necessary to promote interventions that seek to improve women's disadvantaged situation. As a result, until equity is achieved, this requires a gender approach to give special focus to women's situations. As pointed out in the Human Development Report of the United Nations Development Program (UNDP): "No society treats its women as well as its men." However, there are instances in the health/disease process where men are at a disadvantage; it is necessary not to be blind to these cases. A gender approach must be applied to both men and women and where men are identified as being at a disadvantage or at risk, we must promote the necessary interventions that seek to improve their particular situations.

- New approach emerged, away from women as isolated population group to gender relations between sexes and their impact on health of women and men. This gender perspective allows for analysis and programming that addresses gender-based social inequalities.

- Why need for program on Women, Health and Development given that men generally die younger than women? Although longer, women's lives not necessarily lived in wellness and comfort.

- Scientific Research: Women everywhere suffer greater morbidity than men: higher incidence of acute conditions across the life-span and higher prevalence of chronic illness or short and longer term disabilities. Thus, their health and quality of life seriously compromised throughout life cycle.

- Use of health services: Are women favored because they are principal users? Women have higher morbidity, for one. But, due to social construction of gender, women seek care for others for whom they are responsible, and not necessarily for their own health needs.

- Women are not a vulnerable group. Women born with a biological advantage. Social construction of gender can be highly detrimental to men's health as well. Men die younger for several reasons including accidents, violence, cirrhosis, lung cancer, etc.

- Gender constructions involve protective and harmful factors for the health of both women and men.

- Gender approach related to PAHO's challenge to overcome social and economic inequities that are manifested in health profiles of men and women in the region.

- Training is a critical first step towards sensitizing professionals on interrelationship between gender and health and providing skills to incorporate the gender approach in their daily work.

PARTICIPANTS' INTRODUCTIONS/Icebreaker

Method: Pairs/Plenary

Materials: *Flipchart No. 1:* Introductions

Time:

5 minutes:	Interviews
30 minutes:	Plenary
35 minutes:	Total

Preparation: Prepare Flipchart No. 1

PROCESS

- Facilitator asks the participants to:

  Form pairs and interview each other, responding to the questions written on Flipchart No. 1 (text below) Each interview should take 2 minutes (4 minutes per pair).
  Note: Depending on time and size of group, both middle questions can be asked, or facilitator can choose one, depending on context.

Text of Flipchart No. 1

INTRODUCTIONS

- Your Name/Your Work
- When you were a child, what did you want to be as an adult?
- If earning a living was not an issue, what interests/ activities would you pursue?
- One expectation

- Time keeping: Facilitator first announces two minute mark and invites interviewers to switch partners and after 4 minutes, time up.

- During interviews, prepare a flipchart, headed "Expectations."

- Each participant is asked to introduce his/her partner. Co-facilitator writes responses to expectations on flipchart during plenary introductions and comments on responses, pointing out relevance to workshop, particularly in regard to expectations. (Facilitator later refers to these when presenting Workshop Objectives.)

WORKSHOP OBJECTIVES AND EXPECTED OUTCOME

Method: Facilitator presentation/questions

Materials:
Flipchart No. 2: Objectives (abbreviated)
Flipchart No. 3: Expected Outcome (abbreviated)

In Participant Binders: Objectives of Workshop
Expected Outcome

Time: 10 minutes

Preparation: Prepare Flipchart No. 2 and No. 3

PROCESS

- Facilitator introduces OBJECTIVES. Points to summarized objectives on flipchart as they are briefly presented.

Text of Flipchart No. 2:

WORKSHOP OBJECTIVES

- To examine the concept of gender
- To discuss the gender approach and its relevance to Health
- To acquire skills and methodologies to operationalize Gender Approach

COMPONENT A.3

Handout No. 1

WORKSHOP OBJECTIVES

- To examine the difference between sex and gender
- To discuss the gender approach and its particular relevance to the areas of health and human development
- To acquire skills and methodologies to enable participants to ensure that their work in health and development is grounded in a gender approach

- Facilitator presents EXPECTED OUTCOME of Workshop and points to the summary on flipchart.

- Points out which expectations on part of participants cannot be met in workshop and which will be.

Text of Flipchart No. 3:

EXPECTED OUTCOME

- Understand: Gender approach essential for health planning and sustainable human development

Handout No.2:

EXPECTED OUTCOME

- Participants understand that the gender approach is essential for health planning and sustainable human development

- Questions are invited.

- Facilitator introduces WORKSHOP AGENDA, pointing out that it comprises 7 modules plus an introduction. The methodology used is a participatory one based on the awareness that all participants have a wide range of experience and knowledge that will enhance the learning process. The workshop methodology will encourage their contributions. The process will include individual and group work with report back in plenary, plenary discussions, and case studies using actual PAHO or country projects, programs and/or policies. They will have a chance to apply what they have learned to analyzing and making recommendations to strengthen these projects, programs and policies.

MODULE 1

SEX AND GENDER

MODULE 1

SEX AND GENDER

OVERVIEW: MODULE ONE	
Objective	To understand the basic concepts underlying the definitions of sex and gender and examine the characteristics of the concept of gender.
Core Message	The characteristics that define what is masculine and feminine are largely culturally determined.
Expected Outcome	The understanding that gender is a social construction that defines the roles and relations of men and women, giving rise to different experiences, skills and needs.
Method	Brainstorming session Group Discussions/Lecturette Report back Lecturette
Materials	Flipchart No. 4: Women/Men Flipchart No. 5: Characteristics of Gender OHT No. 1.a: Sex/Gender OHT No. 1.b: Social/Biological OHT No. 1.c: Gender and Health Handout No. 3: Definitions of Sex/Gender (Copy of OHT No. 1.a)
Components	1.1: To be a Man or a Woman. What Defines Us? 1.2: Definitions of Sex and Gender
Time	1.1: 10 minutes 1.2: 20 minutes Total: 30 minutes
Preparation	■ Photocopy sufficient copies of Handout No. 3 ■ Prepare Flipchart No. 4: Women/Men ■ Prepare Flipchart No. 5: Characteristics of Gender

TO BE A MAN OR A WOMAN. WHAT DEFINE US?

Method: Brainstorming/Group Discussion

Materials: Flipchart No. 4: Women/Men

Time: 10 minutes

Preparation: Prepare Flipchart No. 4

PROCESS

- Facilitator draws a vertical line down the middle of the flipchart, and heads the one side "women", the other "Men," and poses the question: **"What are the characteristics of women and men?"**[1] to be answered in sequence. The facilitator encourages participants to randomly call out their answers without reflection, for a fast and dynamic interaction. Facilitator or co-facilitator fills in the flipchart, until it is full, without comment—unless childbirth and lactation are omitted, in which case, poses a question to ensure the inclusion of these biological functions.

Text of Flipchart No. 4:

MEN	WOMEN

- After contributions have concluded, facilitator then crosses out the headings, and replaces "men" with women, and "women" with men, (in order to reverse the assumptions) and poses the questions: **"Which characteristics could not be possible in any society?"** The facilitator will only need to underline "childbearing" and "breast-feeding" (or equivalent terms). These are the only characteristics which are biologically determined. All the rest are socially constructed.

- The facilitator then asks:

  What do these characteristics that you have identified as socially constructed have in common?

- Look for: change over time; differences between cultures; differences within cultures; learned behavior; historical. Point out that these are the key characteristics of gender. (See page 29 for further details of the key characteristics of gender).

1 If participants ask "In what society?" or "Should we say what is real or ideal?," facilitator can respond that the characteristics can be from any society, during any historical period, and can be either real or ideal.

DEFINITIONS OF SEX AND GENDER

Method: Lecturette

Materials:
Flipchart No. 5: Characteristics of Gender
OHT No. 1.a: Sex/Gender
OHT No. 1.b: Social/Biological
OHT No. 1.c: Gender and Health
Handout No. 3: Definitions of Sex/Gender (Copy of OHT No. 1.a)

Time: 20 minutes

Preparation: Photocopy Handout No. 3
Prepare Flipchart No. 5

PROCESS

■ Facilitator displays OHT No. 1.a with the following definition:

Text of OHT No. 1.a / Handout No. 3

DEFINITIONS
"Sex" refers to the biological differences between men and women **"Gender"** refers to roles that men and women play and the relations that arise out of these roles. They are socially constructed, not physically determined.

Flipchart No. 5

CHARACTERISTICS OF GENDER	
● Relational:	Socially Constructed
● Hierarchical:	Power Relations
● Changes:	Changes over time
● Context:	Varies with ethnicity, class, culture, etc.
● Institutional:	Systemic

■ The facilitator points to Flipchart No. 5, and says that what the participants have defined in the previous exercise is the difference between sex and gender. This emphasizes that there are very few characteristics that are biologically determined; most are socially constructed. The analytical category of gender has the following characteristics:

- **RELATIONAL:** It is relational because it refers not to women or men in isolation, but to the relationships between them and how these relationships are socially constructed.

- **HIERARCHICAL:** It is hierarchical because the differences established between women and men, far from being neutral, tend to attribute greater importance and value to the characteristics and activities associated with what is masculine and to produce unequal power relationships.

- **CHANGES OVER TIME:** Even though gender is historical, the roles and relations do change over time and, therefore, have definite potential for modification through development interventions.

- **CONTEXT SPECIFIC:** There are variations in gender roles and gender relations depending on the context: ethnic group, socio-economic group, culture etc., underlining the need to incorporate a perspective of diversity in gender analysis.

- **INSTITUTIONAL:** It is institutionally structured because it refers not only to the relations between women and men at the personal and private level, but to a social system that is supported by values, legislation, religion, etc.

■ NOTE: In presenting these gender characteristics, ideally the facilitator would ask participants to contribute their own examples. If time is short, facilitators can offer their own examples. The facilitator would want to provide examples that are relevant to the context/country of the workshop.

■ Facilitator shows Overhead Transparency No. 1.b:

Text of OHT No. 1.b

SOCIAL/BIOLOGICAL
● Emphasizing the social, does not exclude the role of biology ● Recognition of social factors is crucial to an analysis of this interrelationship in order to identify the differential disadvantages and/or advantages for men and women's health

■ And points out:

● The emphasis on social factors within the gender approach does not imply the exclusion of the profound influence of the biological element. On the contrary, this perspective provides for the examination of interactions between biological factors and factors in the social environment that lead to situations of relative disadvantage or advantage for one of the two sexes.

■ Facilitator shows OHT No. 1.c:

Text of OHT No. 1.c:

GENDER AND HEALTH
In HEALTH, advantage and disadvantage can be measured by: 1. Probability of maintaining health, or becoming ill or dying from preventable causes 2. Equity of access to and control of resources, responsibilities and rewards in health work

MODULE 2

GENDER ROLES, ACCESS TO AND CONTROL OF RESOURCES AND HOUSEHOLD STEREOTYPES

MODULE 2

GENDER ROLES, ACCESS TO AND CONTROL OF RESOURCES AND HOUSEHOLD STEREOTYPES

OVERVIEW: MODULE TWO		
Objective	To acquire steps for the analysis of gender roles and access to and control of resources.	
Core Message	Women and men perform multiple roles which may or may not be recognized in social or economic analyses. These roles give rise to differential access to and control of resources and to different exposure to risk or protective factors for health.	
Expected Outcome	Participants will be able to apply analytical concepts to: (a) make visible men and women's gender roles; and (b) identify how access to and control over resources for ensuring health are affected by these gender roles.	
Methodology	Case Studies (Brief) Group work/Plenary Reportback	
Materials	Handout No. 4:	Six Case Studies
	Handout No. 5:	24 Hour Day Chart
	Handout No. 6:	Definitions: Gender Roles
	Handout No. 7:	Definitions: Access and Control
	Handout No. 8:	Types of Resources
	Handout No. 9a:	Stereotype 1 (copy OHT No. 2a)
	Handout No. 9b:	Stereotype 2 (copy OHT No. 2b)
	Handout No. 9c:	Stereotype 2 (copy OHT No. 2c)
	Handout No. 10:	Case Studies: Scenarios 2
	OHT No. 2.a:	Stereotype/1
	OHT No. 2.b:	Stereotype/2
	OHT No. 2.c:	Stereotype/3
	Flipchart No. 6:	Definitions: Gender Roles
	Flipchart No. 7a:	Heading: PRODUCTIVE ROLES
	Flipchart No. 7b:	Heading: REPRODUCTIVE ROLES
	Flipchart No. 7c:	Heading: COMMUNITY MANAGEMENT ROLES
	Flipchart No. 8:	Definitions: Access and Control
	Flipchart No. 9a:	Economic Resources
	Flipchart No. 9b:	Political Resources
	Flipchart No. 9c:	Information/Education Resources

Materials (Cont.)	Flipchart No. 9d:	Time
	Flipchart No. 9e:	Internal
	Flipchart No. 10:	Three Questions for Conducting a Gender Analysis
	Flipchart No. 11:	Task For Health Crisis Case Study

Components	2.1: Daily Life and Gender Roles: The Work that Women and Men Do 2.2: Access and Control of Resources 2.3: Stereotypes 2.4: Health Crisis

Time	2.1: 70 minutes 2.2 35 minutes 2.3 15 minutes 2.4 30 minutes Total: 150 minutes

Preparation

- Look over Case Studies of Family Situations (Situation A through F). Choose among these which to use, depending on size of the workshop. Rewrite as necessary to make relevant to local conditions (e.g., in “situation A” the reference to "yuca" bread should be adapted to country realities).
- Make photocopies for each participant of Handouts Nos.4 through 10.
- Prepare Flipcharts Nos. 6 - 11.

DAILY LIFE AND GENDER ROLES: THE WORK THAT WOMEN AND MEN DO

Method: Small Group Work (Case Studies). Plenary Report back from groups, lecturette/plenary discussion based on cases.

Materials:
Handout No. 4: Six Case Studies
Handout No. 5: 24 Hour Day Chart
Handout No. 6: Definitions: Gender Roles
Flipchart No. 6: Definitions: Gender Roles
Flipchart No. 7a: Heading: PRODUCTIVE ROLES
Flipchart No. 7b: Heading: REPRODUCTIVE ROLES
Flipchart No. 7c: Heading: COMMUNITY MANAGEMENT/ POLITICS ROLES

Time:
25 minutes: Small Group work
45 minutes: Report back/Plenary Discussion
70 minutes: Total

Preparation:
Revise/Rewrite cases as necessary (see above)
Prepare flipcharts
Photocopy handouts

PROCESS

- Facilitator divides participants into four groups. Each group is assigned one of the case studies in Handout 4. Each participant receives a copy of Handout 5: 24 Hour Day chart.

- Facilitator explains:

  The cases are based on living arrangements similar to those which exist in the region. Each group should analyze how tasks and responsibilities are distributed and carried out in a given working day by the men and the women in that household. The 24-hour chart will facilitate the analysis.

  NOTE:

  - *The 24-hour chart is meant to facilitate discussion. However, it is easier, when using the chart, to focus on one adult male and one adult female within the family. The exercise can also be done without the chart, simply dividing a blank sheet down the middle lengthwise and, on one half, listing the activities and tasks carried out by the men, and on the other half, by the women.*

■ The facilitator circulates during exercise to make sure that the groups understand their task.

Text of Handout No. 4:

HOUSEHOLD / FAMILY SITUATION A

George and Hazel have lived together for a number of years. George, 52 years old, is a taxi driver and works the night shift; Hazel, 48 years old, works from Monday to Saturday in a factory. In order to increase household income, Hazel also makes yuca bread which she takes to work each morning to sell at lunch time. George's 75 year old mother, Ernestine, lives with them. Hazel has an unmarried son, Vincent, age 28, who lives with them and works in the informal sector selling music cassettes; George has a daughter, Alicia, aged 25, who is married, has small children and lives in the neighborhood.

HOUSEHOLD / FAMILY SITUATION B

Jane is the manager of a private company. She is Chairperson of the Committee of Women Managers in the capital. Her two children live with her; the oldest, Richard, is an 18-year old boy and the younger child, Rachel, is an 11 year old girl. She employs a domestic worker, Teresa, who works Monday to Saturday, from 8 in the morning to 7 at night.

HOUSEHOLD / FAMILY SITUATION C

Sam and Catherine Stevens live with their three children: a 12 year old girl, Marisa, and two boys, Frank and Tom, aged 9 and 7. Catherine is a graphic designer for an advertising company, Sam is a professor in the school of public health. Two nights per week and every other Saturday, Catherine goes to help her elderly parents who, because of their advanced age, are no longer able to do the shopping, clean the house, cook, etc. Sam participates actively in the Public Health Association.

Text of Handout No. 4 (cont.):

HOUSEHOLD / FAMILY SITUATION D

Elmer and May, aged 30 and 22, live with their four children in a rural community. The oldest daughter, Jean, is 8 years old, followed by two boys, Jim and Kevin, who are 6 and 3 years, and a 1 year old girl who is being breast-fed. The family lives on subsistence agricultural production which allows them to survive. Elmer and May supplement the family income, Elmer by harvesting produce and May by weaving fine baskets and selling them in the town market one hour away by foot; in addition, May is a health promoter in their community.

HOUSEHOLD / FAMILY SITUATION E

Teresa Martinez, age 38, lives in a poor urban community which has been built on the shores of a river inlet. During the day, she works in a canning factory. With her live her mother, Doña Zaida, age 54, who runs a sewing shop from home; her two sons, Raul, age 17, who is finishing high school and Conchita, age 14, who is also in school. Two years ago, Teresa's sister, Josefina, age 28, came to live with her. Josefina brought along her 10 year old son; Josefina works in the center of town as a street vendor, selling hot meals to passers-by. Teresa's husband, Jorge, is a migrant worker in the banana industry; he returns every two weeks on the weekends.

HOUSEHOLD / FAMILY SITUATION F

John Green is 45 and is the owner of a small dry goods store in a major city in the interior of the country. His wife, Frances, works in a hairdresser shop. Her father Ambrose, lives with them. He is 80 years old. John and Frances have two grown sons ages 27 and 22, respectively. The youngest, Stephen, helps his father in the store. The eldest has married and moved to the capital of the country.

Text of Handout No. 5:

HOUR	WOMAN	MAN
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
etc.		

- After 20 minutes, the participants reassemble in plenary.
- The aim of this part of the exercise is to categorize the roles identified on the 24 Hour Day chart into either Productive, Reproductive or Community Management. In order to ease this process, the facilitator distributes Handout No. 6 and displays Flipchart No. 6.
    - Facilitator points out that in our capitalist market-oriented economies, the roles than men and women play can be divided into three types:

Text of Handout No. 6:

DEFINITIONS

Productive:
Comprises the work done by both women and men for payment in cash or kind.

Reproductive:
Comprises the childbearing/rearing responsibilities and domestic tasks required to guarantee the maintenance and well-being of household members. It includes not only biological reproduction but also the care and maintenance of the persons who comprise the household.

Community Management Role:
Comprises activities undertaken at the community level to contribute to the development or political organization of the community. It is usually voluntary, unpaid work.

Flipchart No. 6:

DEFINITIONS OF ROLES

Productive:
Work done by both men and women for payment in cash or kind

Reproductive:
Childbearing/rearing responsibilities and domestic tasks

Community Management:
Community activities that are voluntary and unpaid which contribute to its welfare and organization

- The Facilitator points out:
  - Men and women's **Productive roles** comprise work done for payment in cash or kind.
  - Men and women's **Reproductive (or domestic) roles** include those tasks done to reproduce society, both physically and through passing on its system of values. The facilitator may comment that reproductive labor is the work done to ensure that workers can return to work the following day.
- Each group calls out the tasks/activities which their case's male or female household member per-

forms and indicates where it should be assigned on the flipchart. The facilitator fills in the flipcharts until all groups have reported back. For example, if a group reports that the woman in Situation A arises at 5 a.m. to make the yuca bread for sale at the local market, that task would be written on the PRODUCTIVE sheet, in the column under "WOMEN." If it is for home consumption it would be on the REPRODUCTIVE sheet. This process is continued until all groups have reported back.

NOTE:
It should be emphasized that not all human activities can be restricted to mutually exclusive categories (such as the activity in baking a pie). This is debated by economist and sociologists. Hence the facilitator should avoid the debate sidetracking the session. The division is a useful one in allowing us to conduct a gender analysis and to ensure that reproductive, and not only productive roles are visible in society.

- **Points to bear in mind:**

  The facilitator does not vocalize unless it is necessary for clarification, that reproductive labor comprises the childbearing/rearing responsibilities and domestic tasks undertaken by either sex, required to guarantee the welfare and survival of the individuals included in the home, for example: rearing, educating, feeding, looking after and nurturing household members and other tasks related to organizing and maintaining the home. Other activities to be included under reproductive roles include story telling and oral history (passing on social values).[1]

  Grey Areas: Participants might challenge some of the categorizations as being too fixed. Some activities might fall under both categories. For example, a woman cooks a pie and serves half of the pie to her family for supper and sells the other half in the factory where she works. Is this a reproductive role? A productive role? It is both. Other grey areas might be education (informal education which passes on value systems vs. formal school education) or subsistence farming (agricultural work performed solely to provide food for the table not for cash crops). What is important is to make visible the tasks men and women perform. Hence, grey areas are fine.

- When the participants have finished making their contributions, the facilitator asks:

  - **Can this be done** (pointing to the flip chart with the heading PRODUCTIVE ROLE) **without this?** (pointing to the flip chart with the heading REPRODUCTIVE ROLE).

- If a consensus is not present, ask those who answer "No" to argue their case to come to a consensus.

- The facilitator draws 2 diagonal lines across the two flip charts and writes the word "ECONOMIC" between the two lines.

1 Activities such as sleeping, eating, those associated with personal hygiene and leisure activities are not considered “roles.”

- The facilitator points out that:

  - Both these roles are **profoundly economic**. Without reproductive roles, productive roles could not be carried out, or would be critically curtailed. Who generally carry out the tasks, responsibilities and activities assigned under REPRODUCTIVE ROLES?

    The participants will probably indicate that the woman is the one who undertakes such tasks and responsibilities in most cases.

- The facilitator follows up:

  - However, in the formulation of the Gross National Product, only what is produced HERE is included *(point to flipchart with the heading PRODUCTIVE ROLE)*. The contribution that is made primarily by women to the national economy remains invisible because it is not considered "work" in the economic sense of the word, but seen as a part of their natural function derived from their role as reproducer of the human species.

- The facilitator also indicates:

  - The reproductive role is **less valued** socially because it is the work **"of women."** Many types of work in the area of production of goods and services, such as in the area of health and primary school education, have also been divided in accordance with gender roles. For example, the work of nurses and nurses aides, work for the most part carried out by women, is much less prestigious and well-paid than the work of a doctor, work that has been primarily carried out by men in our Western societies. Interestingly enough, in the countries which comprised the former Soviet Union, doctors are mostly female, and the medical profession is not a respected, sought-after profession, as it is in the West.

- Facilitator points to the flipchart paper with the heading **COMMUNITY MANAGEMENT AND POLITICS ROLE** and states:

  - There is a third useful category that can be said to be derived from the other two roles: the COMMUNITY MANAGEMENT AND POLITICS ROLES. Here again, there is a division of functions according to gender and we often find that women are responsible for carrying out community (management) work (attending to sick neighbors, participating in Parent-Teacher associations, involvement in church/religious activities), while **men are more likely to participate as community leaders** who negotiate with municipalities or other political authorities. This latter work is associated with status and is sometimes remunerated.

  - The Community Management Role has particular relevance for the health field. The **voluntary** participation of women in community activities, as health workers, active participants in vaccination campaigns (either to vaccinate their children or their animals) and as cooks in community kitchens, has been considered indispensable for the promotion of health. But this is based

on one assumption: **that women have free time**. This, as has been seen in the previous exercise, is not so. The type of community management work that women carry out is strongly associated with their reproductive role and with stereotypes that assign them certain types of work.

- Facilitator introduces the concept of MULTIPLE ROLES (sometimes known as double or triple role):

  Performing in a single day (sometimes simultaneously) two or three different roles. Given that reproductive roles are performed for the most part by women, multiples roles are more usually juggled by women.

  - Maintaining this balance has consequences in terms of time management and its effects on the person's mental and physical health. This is a burden that women therefore have to bear to a greater extent than men.

- Facilitator points out that:

  - The detection of gender roles makes **previously unrecognized work visible**. In general, in capitalist economies, only productive work, due to its exchange value, is considered "work;" reproductive work and community management work are not valued because they are considered "natural" and non-productive. **This has serious consequences for women, because it means that most of their work continues to be invisible and, therefore, undervalued.**

- The facilitator provides examples that underscore the burden that these multiple roles have on women. Such as:

  - Women carry out more fragmented tasks and have to divide their time between reproductive and productive tasks; in addition, the tasks of men are usually carried out in single blocks of time devoted to wage earning activities.

  - It is women who are responsible for domestic tasks, although men "help" them.

  - Women perform productive tasks in addition to their reproductive ones; men carry out productive tasks instead of reproductive ones.

  - Women have less leisure time and work more hours than men.

  - When the woman is head of a household, such as in Situation B, we see that the professional woman has to divide her time in order to perform the "male" and "female" role in the family.

  - When women leave to work outside the home, other women carry out the domestic activities.

- In order to underscore the essential need for gender roles analysis and gender responsive planning for sustainable health and development interventions, the facilitator emphasizes that:

- Gender roles/relations analysis is a critical step to ensuring development of gender responsive projects. It can safeguard a project from failure at best, or at the least, can minimize the degree of "harm" that is often inadvertently caused by invalid assumptions.

- Gender division of labor determines differential health risks and protective factors for men and women; therefore, planners can better respond with appropriate, varied and sustainable interventions.

- Planning that takes into account the multiple roles of women and values their work can: i) mitigate the economic dependence and subordination that contributes toward low self-esteem in women throughout their life cycle; ii) significantly lessen the stress inherent in carrying out these multiple roles and the fragmentation of their tasks, increasing their leisure time, and promoting physical, emotional and mental health.

- A gender approach to development can, therefore, better meet the needs of **both** men and women and enhance the well-being of the whole community.

ACCESS AND CONTROL OF RESOURCES

Method: Lecturette/Group Discussion

Materials:
Flipchart No. 8: Definitions: Access and Control
Flipcharts No. 9 (a) - (e): Resource Tables
Handout No. 7: Definitions: Access and Control
Handout No. 8: Types of Resources

Time: 35 minutes

Preparation:
Prepare Flipchart No. 8 and No. 9 (a-e)
Photocopy Handout Nos. 7 and 8

PROCESS

■ Facilitator indicates:

The fact that women and men are socially assigned different roles and responsibilities has direct implications for the level of access to and control over resources needed to promote their health.

This Gender Division of Labor has some fundamental characteristics:

- Different cultural values assigned to the roles depending on whether they are considered male or female roles.
- Different degrees of access to and control over household and social resources. These overall resources include those necessary for the promotion and protection of one's health as well as the health of others.
- It is entrenched through power relations, which in turn has impact on access to and control over resources.

■ *Facilitator presents the definitions of ACCESS and CONTROL and distributes Handout No. 7:*

Text of Flipchart No. 8
Handout No. 7:

DEFINITIONS: ACCESS AND CONTROL

Access
is the ability to USE a resource
Control
is the ability to DEFINE and make binding decisions about the use of a resource

■ Facilitator indicates:

The distinction between access to and control of certain resources is important because the ability to USE a resource does not necessarily imply the ability to DEFINE/DECIDE ON the use of that same resource and vice versa. For example, women or men may have access to the use of a condom to protect themselves from STDs but, at the time of sexual relations, may not have the ability to define or control condom use.

■ Facilitator shows Flipchart No. 9 (a), (b), (c), (d), and (e), the five-part resource table.

Text of Flipchart No. 9(a)

ECONOMIC RESOURCES

- work
- credit
- money
- transportation
- equipment
- food
- child care facilities
- facilities to carry out domestic tasks
- social security, health insurance
- housing
- health and supply services

Text of Flipchart No. 9(b)

POLITICAL RESOURCES

- position of leadership and mobilization of the actors in decision-making positions
- opportunities for communication, negotiation and consensus-building

Text of Flipchart No. 9(c)

INFORMATION / EDUCATION

- inputs to be able to make decisions to modify or change a situation, condition or problem
- formal education
- informal education
- non-formal education
- opportunities to exchange information and opinions

Text of Flipchart No. 9(d)

TIME

- hours of the day available for discretionary use
- flexible paid work hours

Text of Flipchart No. 9(e)

INTERNAL RESOURCES

- self-esteem
- self-confidence
- the ability to express one's own interests

■ Facilitator indicates that:

The capacity to have access to and control over resources develops and strengthens internal resources that can enhance personal development, hence these resources have been included. Handout No. 8 is distributed.

Text of Handout No. 8:

TYPES OF RESOURCES

ECONOMIC RESOURCES

- work
- credit
- money
- etc.

POLITICAL RESOURCES

- position of leadership and mobilization of the actors in decision-making positions
- etc.

INFORMATION / EDUCATION

- inputs to be able to make decisions to modify or change a situation, condition or problem
- formal education
- etc.

TIME

- hours of the day available for discretionary use
- flexible paid work hours

INTERNAL RESOURCES

- self-esteem
- self-confidence
- the ability to express one's own interests

■ **Other examples:**

INTERACTION BETWEEN GENDER AND ACCESS/CONTROL

Gender Implications for Women's Health: We tend to hear that women use health services much more than men. But that utilization can be hindered at different times by a lack of access to and control of the different resources:

- In order for a woman to recognize that she has, for example, a gynecological problem, she needs to have access to the information/education that allows her to identify the symptoms of a health problem. Access to information is a crucial element so that the woman can make the decision to go to the health services.

- Even when a woman recognizes that she has a gynecological problem, she may be too embarrassed or timid to mention it to the physician. In this case, the degree of development of internal resources would give her the self-esteem necessary to take action.

- A woman may need to obtain medical care. However, the decision to go to the doctor might not be made by her, because she depends on the approval of her husband, mother-in-law, parents etc. At this point, the woman must have control of economic resources. In this respect, the woman must be able to cover the cost of her visit and the type of health insurance that she has could be important.

  The woman may not have money to pay for transportation in order to get to the health service. Or she may not have someone with whom she can leave her children or her elderly and/or sick family members.

- The health care service's hours, the waiting time and the travel time can constitute other obstacles due to her lack of control over her time due to her reproductive responsibilities and roles.

■ **Implications for Men's Health:**

- Men may not have, for example, access to information on prostate cancer detection programs. In addition, they may be informed, but may decide not to have themselves checked, due to fear or embarrassment.

- A man may have control over sexual relations, but he may lack or have incorrect knowledge about sexuality and reproduction because he does not have access to adequate information. The lack of access to information can lead to sexual practices that expose both men and women to the risk of contracting sexually transmitted diseases.

■ **Differential Access to/ Control over Resources:**

- The analysis of the differential level of access and control that women and men have over resources is extremely important in developing and evaluating interventions. For example, there is a relationship between a woman's control over income and capacity to make household decisions and the educational and nutritional level of her children.

- In order to meet the development objective of enabling women to have greater control over household income, the intervention must include activities that strengthen women's ability to negotiate with others (companion, other family members) and to assert control. Access and control as a gender issue must be addressed in monitoring and evaluating the intervention, as a measure of whether the project achieved its initial objectives.

■ Facilitator sums up:

- **Gender** is institutionally structured in a social system that assigns male characteristics greater worth. The health system which reflects gender differentiated access and control, is a good example of this.

  Women's roles: The care of others, in particular, family members, is a predominant role for women in society. Even the productive roles they play tend to be extensions of their reproductive roles. This is particularly evident in the health care system where "caring for others" is viewed by society as women's "natural function." Hence, despite their central role, the nurses' work is valued less than that of medical doctors in our Western cultures.

  - ❍ Approximately 80% of the health care workers in the Region are women, but represent a small minority of decision-makers within the health care system.

  - ❍ The activities that nurses carry out and the time in which they do it, are controlled and often decided upon by physicians: this situation creates a feeling of lack of autonomy and decision-making power among nurses.

HOUSEHOLD STEREOTYPES

Method:	Lecturette	
Materials:	OHT No. 2.a	Stereotypes/1
	OHT No. 2.b	Stereotypes/2
	OHT No. 2.c	Stereotypes/3
	Handout No. 9a, b, c	Stereotypes 1/2/3 (copies of OHT No. 2.a, b, c)
	Flipchart No. 10	Three Questions
Time:	15 minutes	
Preparation:	Prepare flipcharts	

PROCESS

- Facilitator introduces the three main stereotypes prevalent among development practitioners which influence the design of development interventions:

- Facilitator displays **OHT No. 2.a** (illustration of couple and their children) and states:

  Assumption No. 1: The household consists of a nuclear family of husband, wife and two or three children.

- Facilitator asks participants to think of the communities they work in or know. Does the illustration reflect reality? What kinds of households are they familiar with?

  Points out:
  - Extended families are very common, covering three, sometimes four generations.
  - Many families consist of single mothers and children.

- Facilitator poses question:

  What is the percentage of *female headed households in the region*?

  Answer: In many areas of the Caribbean and Latin America, these are 40 percent or more. Globally, it is estimated that the figure is one-third.

- Facilitator displays **OHT No. 2.b** (drawing of couple with their divided tasks) and states:

Assumption No. 2: A clear division of labor exists within the household, in which the man as "provider" is involved in productive work outside the home and the woman as "housewife" and "homemaker" assumes the primary responsibility for reproductive and domestic work involved in the organization of the household.

■ Facilitator poses question:

How many women do you know have no involvement in productive labor?
When participants have made contributions, points out:

- Women are involved in considerable number in the formal labor market.
- Women dominate the informal labor market.
- The number of women who have to perform productive roles because of economic necessity is increasing.
- Women are increasingly qualified for jobs and careers that were formerly regarded as the domain of men, and work out of choice.
- Most women have no option but to balance their commitments to paid work with the unpaid work related to reproductive roles of caring for children and the home.
- Women's wages continue to be viewed as secondary or complementary to those of the "head of the house."
- The stereotype that women are passive recipients of their husband's productive efforts is born out in our region where women's access to social security comes through their husband's employment.

■ Facilitator shows **OHT No. 2.c** (drawing of couple) and states:

Assumption No.3: The household functions as a socio-economic unit in which all adults exercise equal access to and control of resources and decision-making capacity.

■ Facilitator indicates that:

This assumption is being questioned by the social and economic sciences for a number of reasons:

- Inequalities are prevalent in the distribution of family resources. It is a false assumption that the total wages earned will be pooled and adult members jointly will decide on the priorities and expenditure. It is widely recognized that male and female consumption patterns differ throughout the world. Women tend to apply resources to the family, men to their person or for consumer goods on which the livelihood of the family is not dependent - such as electronic goods or leisure time (drinks in the local bar). Within the family this translates into women having decision-making power over food and other domestic expenditures and men having more control over significant purchases or expenditures, such as land, a house, a car or smaller but important goods in lower income families.

- Even though women control the distribution of food within the family, they tend to follow cultural patterns which give preferential treatment to men (e.g., more protein because it is believed men need it because they are physically larger/have to work harder).
- Even in the reproductive sphere, it is evident that decisions about the number of children wanted or the use of contraceptives, for instance, are not in fact made by the women. And if they are, these may be made against the wishes of the husband and in secret (such as use of contraceptives). Evidence indicates that women are at a disadvantage in the exercise of their reproductive rights.
- **Implications for development practitioners:** The targeting of projects toward "the family" or "the household" presupposes a view of this institution as an economic unit that is closed and homogeneous among its members. This myth of the single family/unit should be dispelled and there should be in-depth studies on the wide variety of households that exist, a variety that has direct implications for the "internal economy" of each.

■ Facilitator summarizes the main points from this component:

- There are three important steps for conducting a gender analysis, and incorporating the findings of this analysis into effective and sustainable development planning.

  i) Analysis of the gender division of labor (productive, reproductive and community roles) and the social and power relations that arise out of them;
  ii) Analysis of access to and control of resources, and
  iii) Awareness of stereotypes in planning.

■ Facilitator displays Flipchart No. 10 and states that there are three critical questions to pose at all stages of health and development planning:

1. **Who does what, when, where and with whom? (ROLES)**
2. **Who uses what? (ACCESS)**
3. **Who decides who uses, what is used, and how? (CONTROL)**

Text of Flipchart No. 10:

THREE QUESTIONS FOR ANALYSIS OF GENDER

1. Who does what, when, where and with whom (ROLES)
2. Who uses what? (ACCESS)
3. Who decides who uses, what is used and how? (CONTROL)

HEALTH CRISIS

Method: Small Group Work/Plenary Report back

Materials: Handout No. 10: Case Studies: Scenario 2
Flipchart No. 11: Task For Health Crisis Case Study

Time: 15 minutes: Group Work
15 minutes: Plenary
30 minutes: Total

Preparation: Photocopy Handout No. 10

PROCESS

- Facilitator distributes Handout No. 10. Each group get the Crisis in Health scenario that matches the case they worked on previously.

Text of Handout No. 10:

Situation A, Part 2:

Ernestine, George's mother, fractures her hip. She has an emergency operation. After staying in the hospital, she comes home to convalesce.

Situation B, Part 2:

Richard, the oldest child has a motorcycle accident, needs rehabilitative therapy and rest for two months. Doctors are not sure he will recover completely.

Situation C, Part 2:

Sam is diagnosed with terminal lung cancer.

Situation D, Part 2:

May wakes up with vaginal bleeding and strong pain; she is hospitalized for an obstetric emergency due to spontaneous abortion. The hospital is an hour away by foot from the town where she lives.

Situation E, Part 2:

Jorge has an accident at work that cuts off his left hand. He is dismissed with minimal compensation and sent home.

Situation F: Part 2:

Frances' rheumatoid arthritis in her hands becomes so severe that she can no longer work as a hairdresser.

■ The facilitator displays Flipchart No. 11 which has the Task for the exercise, and explains:

Taking into account the gender roles analysis of each of your household cases worked on earlier, how will these roles, and the access to and control of resources, be affected by the health crisis each household faces.

Text of Flipchart No. 11:

Group Task

- How would the crisis affect the division of roles and responsibilities for the men and women over the short or medium term?
- How does the crisis affect women and men's access to and control over resources within the household?
- What household changes could ensure that the responsibility for dealing with this crisis situation does not fall primarily on one person?

Time allotted for the group work: **15 minutes**

■ In plenary session, each group presents its findings. Facilitator looks for and emphasizes: In a health crisis, a significant additional burden may be placed on women in the household. Another outcome may be, in the short run, a more equitable distribution of the responsibilities among the members of the household, a distribution which in the longer-term, may not be sustained.

MODULE 3

THE ORIGIN OF HEALTH NEEDS

MODULE 3

THE ORIGIN OF HEALTH NEEDS

OVERVIEW: MODULE THREE

Objective

- To understand how the interrelationship between biological, psychological and social factors generates specific health needs for women and men.
- To undertake a gender analysis based on this understanding so that interventions respond equitably to the health care needs of both sexes.

Core Message

To promote gender equity in health, it is important to identify specific health needs for each sex in order to respond to each.

Expected Outcome

The participants will be able to identify gender differences in health situations, conditions and problems.

Methodology

Lecturette
Buzz Groups
Small Group Work/Plenary Report Back
Plenary Discussion

Materials

OHT No. 3.a/b/c	Circles: Biology of Men and Women; Gender Constructions; Needs in Health
OHT No. 4:	Equity and need
OHT No. 5:	Origin of Male and Female Differences in Health/Illness Profiles
OHT No. 6:	HIV/AIDS and Biological Characteristics
Handout No. 11:	Copy of OHT No. 3 a/b/c
Handout No. 12:	Origin of Male and Female Differences in Health Profiles
Flipchart No. 12:	Group Task

Components

3.1	Differences in Health/Illness Profiles Between Women and Men
3.2	An Example of the Influence of Sex and Gender in the Health Profiles of Men and Women

Time

3.1	40 minutes
3.2	30 minutes
Total:	70 minutes

Preparation

- Photocopy Handout No. 11-12
- Prepare Flipchart No. 12

DIFFERENCES IN HEALTH/ ILLNESS PROFILES OF WOMEN AND MEN

Method: Lecturette
Buzz Groups
Plenary Discussion

Materials:
OHT No. 3.a/b/c: Interactions
OHT No. 4: Equity and Need
OHT No. 5: Origin of male and female differences in health
Handout No. 11: Copy of OHT No. 3 a. b. c.
Handout No. 12: Origin of Male/Female Differences

Time: 40 minutes

Preparations: Photocopy Handout Nos. 11 and 12

PROCESS

- The facilitator opens the discussion by saying:
  We all know that there are differences between men and women with regard to their physical and mental health. However, traditionally, the health sciences, particularly the medical profession, have focused on what they considered to be strictly biological differences between the sexes.

- Facilitator presents OHT No. 3.a, with biological circle.
  Facilitator continues, placing OHT No. 3.b directly over OHT No. 3.a:

  However, men and women also play different roles in different societies, and because of that they develop different skills and abilities. These roles, skills and abilities are valued differently, and it is usually those associated with masculine spheres that receive greater social recognition and are valued more highly than those associated with feminine spheres. This differential value has direct implications for the degree to which men and women have access to and control of resources. Collectively, these sexually assigned roles and responsibilities and the abilities, values and access to and control of resources that arise from them, give rise to gender inequities.

- Facilitator points to labels on the outside of the circle: (Culture/race/class)

  It is important to note that these gender constructions are strongly influenced by culture, by socioeconomic level and by age, and these all must be taken collectively into account when examining how gender influences health and health work.

■ Facilitator places OHT No. 3.c directly over OHT No. 3.a and 3.b:

If men and women are biologically different and, in different cultures, socioeconomic groups and generations, are shaped by different gender constructions, then we can also assume that men and women have different needs in health which must be understood so as to respond in an equitable and efficient manner to them.

■ Facilitator distributes copies of Handout No. 11 (copy of OHT No. 3 a, b, c). Points out that to attain equity in health it is necessary to identify and respond to different health situations, conditions and problems pertaining to each sex. Facilitator shows OHT No. 4, which defines equity and need.

Text of OHT No. 4

EQUITY AND NEED
● To attain equity in health, it is important to recognize that different groups have different needs that must be identified so as to adequately address them.

The gender perspective enables greater equity in interventions in health and increases the effectiveness of these actions.

■ The facilitator shows OHT No. 5: Origin of Male and Female Differences in Health Profiles, and notes that we can further understand the interaction of biological and social factors on health by examining specific health situations or problems.

Explains that this OHT shows the origin of the differences in health/ disease patterns between men and women.

Text of OHT No. 5/Handout No.12

ORIGIN OF DIFFERENCES IN HEALTH/ILLNESS PROFILES

BIOLOGICAL DIFFERENCES	SOCIAL DIFFERENCES
a) Anatomical/physiological; b) Anatomical, Physiological and Genetic susceptibilities; c) Anatomical, Physiological and Genetic resistances/immunities.	a) Roles and responsibilities; b) Access and control; c) Cultural influences and expectations; d) Subjective identity.

HEALTH SITUATIONS, CONDITIONS AND/OR PROBLEMS
1. Sex Specific; 2. Higher prevalence in one or other sex; 3. Different characteristics for men and women; 4. Generate different response by individuals/family/institutions depending on whether the person is male or female

- Covering the lower box of OHT No. 5, the facilitator displays the two charts in the upper part of the slide (biological and psycho/social differences), goes through them and explains:
  - Differences in health profiles between the sexes are based on an interaction between biological determinants and gender constructions.
- The facilitator then uncovers the lower box and asks participants for examples of these health situations/conditions/problems, and writes their contributions on a flipchart as they are called out.
- Facilitator adds any that are significant and missed by participants.

SOME EXAMPLES:

i. Sex Specific: Situations, conditions or problems exclusive to each sex:

♀ Pregnancy (in adolescence); Cervical cancer; Menopause; Maternal mortality; Prolapse of the uterus; Abortion (which can have consequences such as anemia, infections of the reproductive tract, prolapse of the uterus and urinary incontinence).

♂ Prostate cancer; hemophilia

ii. Different Prevalence: Situations, conditions or problems with different rates of prevalence in men or in women:

♀ Anemia due to iron deficiency, linked to women's loss of iron during menstruation , pregnancy and lactation and exacerbated by cultural practices that privilege men in intrahousehold distribution of iron-rich food; osteoporosis (8 times more in ♀ than in ♂), associated not only with biological factors but also with lifestyles; diabetes, hypertension and obesity, conditions which are more frequent in women than in men, and also in lower income groups; depression (two to three times more frequent in ♀ than in ♂ in all phases of life, related to personality types and experiences connected with types of socialization and differential opportunities for ♂ and ♀); sexual violence in childhood, adolescence and adulthood; excessive mortality due to cancer during adult age (associated less with the lethal nature of cancers in women than with limited access to medical technologies for early detection and treatment of cancers in their initial stages); varicose veins; urinary incontinence; arthritis; autoimmune disorders.

♀ Cirrhosis, associated with alcohol abuse; Schizophrenia; Lung cancer, associated with tobacco consumption; excessive mortality from violence, homicide and accidents (evident from the first year of life, associated with stereotyped masculine attitudes and behaviors such as aggression, risk-taking, excessive consumption of alcohol); Silicosis, associated with mining work; Hernias; Color-blindness

(20 times more in ♂ than in ♀); Coronary artery diseases which are biggest killers during years men are engaged in labor force; greater incidence of dyslexia, hyperactivity and stuttering.

iii. Different Characteristics: Situations, conditions or problems which have different characteristics for men or for women:

- Risk for shistosomiasis is greater for those women who come into more frequent contact with contaminated water, to wash clothes, for example;
- Sexually transmitted diseases (STDs) are "asymptomatic" for longer periods in women and have more severe consequences in women such as sterility and even death, in cases of pelvic inflammation;
- Nutritional deficiencies can cause maternal deaths in childbirth;
- Alcoholism and tobacco consumption have different health consequences for women, particularly during pregnancy;
- Sexual violence for women can cause unwanted pregnancy and STDs;
- Malaria during pregnancy is an important cause of maternal mortality, spontaneous abortion and stillbirths; particularly during pregnancy, malaria contributes significantly to the development of chronic anemia;
- Death with weapons (suicide or homicide) is more characteristic of men than of women;
- Women tend to be to a greater extent than men, victims of violent crimes perpetrated by intimate partners;
- In our societies, sexual "impotence" has more negative repercussions when it involves a man, than does sexual "frigidity" when it involves a woman. This is due to the great importance which is given to male sexual prowess which in many societies, is what defines "being a man." Being unable to perform sexually implies not being a "real man;"
- Lack of access to quality water supply affects women more than men because in many societies they are the main users of water and it is also they, and their children, who must fetch and carry water.

NOTE: In this section, one might also include sex differences in the perception of symptoms and in help-seeking behavior. In many societies, for example:

♂ only go to health services when an illness is in advanced stages;

♀ do not seek care from STD clinics because of social stigma that is associated with women that have an STD.

■ Facilitator points out: The last category (iv) is clearly gender based, i.e., important structural barriers to access to the resources and benefits of the health system derive from the roles that men and women play in society and the relations that arise from the value assigned to these roles.

iv. Responses by Individuals/Family/Institutions: Situations, conditions, or problems with different responses from the health sector in particular or society in general:

- Cardiovascular problems: the notion persists that these are typical men's diseases; as a result, symptoms are not recognized in women. Data indicate that cardiovascular diseases are one of the main causes of death, in some population groups the major causes of death, among women older than 49 years.

- Disfigurement for Leishmaniasis, schistosomiasis, leprosy, onchocerciasis generates greater rejection by society if the sufferer is female, given the connection between physical beauty and women's worth.

- Ratios of 1 to 300 for masculine/feminine sterilizations (despite the fact that vasectomy is a simpler, more economical and less invasive procedure than sterilization for women).

- Domestic violence toward woman is judged differently from public violence against strangers and there is a greater degree of social tolerance for violence towards women from their male partners than there is for other types of social violence. This tolerance is reflected in legislation on family violence in almost every country.

- The exclusion of women from clinical studies of pathologies affecting both sexes; consequently, therapies based on these studies may not be reliable for application to women, and may be hazardous for the female population. The consideration of the male body as the standard for clinical studies acts to limit the number of studies that focus on women's reproductive and non-reproductive health, and obfuscates the impact of certain medications or treatment at different stages of their life cycle.

- There has been low priority assigned to research of pathologies and treatments exclusively or primarily affecting women.

- Focus of family planning services on women have excluded men, with the result that men have limited access to such services. In addition, given the gender relations within a family, decisions about contraception need to include men, otherwise women can be prevented from using them by their partners/husbands.

- Differences by sex in the quality of care in health services: research in the United States of America, Canada, Australia, Sweden and some countries in Latin America shows that the quality of care received differs between men and women, and that this difference is inequitable for women (waiting time, over-medication, humiliating treatment).

■ Facilitator asks participants to quickly form groups of three and undertake the following brief task:

Buzz Group Task: What situations/conditions/problems in the categories are influenced or affected by gender?

Example: Although maternal mortality results from women's biological capacity to give birth, the fact that women die in childbirth from preventible causes is clearly influenced by the value society in general and the health sector in particularly places on women.

In processing the responses, the facilitator points out/sums up:

- Most of these, even though they are biologically specific to one sex or the other, and appear to be "gender neutral (to have no social or gender connotation) do so in terms of how and when they are reported and treated by the health system, and how persons presenting the symptoms of disease are treated by society.

- *It is important to begin the analysis from the perspective that all health issues have a gender base and challenge participants to look for what the gender implications are for each.*

Plenary Group discussion: Ask participants for examples of health conditions and lead a discussion to show the gender implications.

Some additional examples:

a) The fact that diabetes is more prevalent among women is derived from biology. However, because of women's nurturing role they are more likely to ensure that diabetic men in their families are fed right. Research indicates that women who have diabetes are less likely to feel comfortable with providing themselves with special food and adequate medical attention.

b) School-aged boys may be overdiagnosed as hyperactive in comparison to their female counterparts because of developmental differences between the sexes and the way these differences are addressed by the school system.

■ Facilitator emphasizes in summing up:

- Differences and disadvantages in the field of the health are manifested not only in the way health and disease are distributed in a population but also in the way health is promoted, disease is prevented and controlled, patients are cared for, and in the models adopted for structuring health and social security systems.

- Without fully appreciating the implications and impact of gender roles and relations, health practitioners will fail in their treatment of certain groups and individuals, and health planners will inadequately serve the total population.

AN EXAMPLE OF THE INFLUENCE OF SEX AND GENDER IN THE HEALTH PROFILES OF MEN AND WOMEN

Method: Lecturette
Small Group Work/Report Back

Materials: OHT No. 6
Flipchart No. 12: Group Task on HIV/AIDS

Time: 30 minutes

Preparation: Prepare Flipchart No. 12

PROCESS

- The facilitator emphasizes the fact that bio-psycho-social differences in health profiles for men and women naturally lead to differences in their respective response needs to particular conditions, situations, or problems.

- The facilitator addresses the group and says:

  Now that we have reviewed the differences in health profiles of men and women, for which sex disaggregated data is essential, let's look at how a gender perspective can anticipate the likelihood of a man or woman becoming ill and dying from a specific disease.

  Example of HIV/AIDS:

  - It is currently more prevalent among men. However, incidence of HIV is rising much more rapidly among women. Today, worldwide, women constitute 75 percent of the new cases of infection.

    Why? Gender analysis help provide reasons for this. It can also provide us with guidelines for designing interventions that respond adequately to health needs that are specific to men and women.

There are:

- different risk factors for the sexes
- different degrees of severity of consequences
- different responses from women and men, the health sector in particular or society in general

■ Facilitator shows OHT No. 6, which summarizes what will be presented below.

Text of OHT No. 6

HIV/AIDS: BIOLOGICAL CHARACTERISTICS

Women More Vulnerable because:

- Semen Highly Infectious
- Vaginal Mucous Membrane More Vulnerable
- Semen Remains in Vaginal Tract
- Age Factor: ↑ under 18; ↑ after menopause
- STD - HIV/AIDS link: ↑ Incidence for Women

■ Facilitator presents information on each factor, one by one. Asks participants to expand on each factors, correcting/expanding as needed.

RESPONSES:

Women are more vulnerable than men to HIV infection through heterosexual relations; studies show that women are two to four times more likely than men to be infected in this way. There are several explanations for this, including:

- *Semen Highly Infectious:* HIV needs live cells in order to be transmitted. The body fluids richest in cells are the most infectious. As a result, semen is more infectious because it has greater cellular content than vaginal fluids;

- *Vaginal Mucous Membrane More Vulnerable:* The epithelial quality of the vaginal mucous membrane is more vulnerable to infections than the penis;

- *Semen Remains in Vaginal Tract:* Semen remains in the vaginal or rectal tract for a longer period than do vaginal fluids on the penis; as a result, women's exposure time to the virus is greater in heterosexual relations;

- *Age Factor:* ↑ *under 18*; ↑ *After Menopause:* Age is an independent factor that increases susceptibility to HIV of women under 18 years and in the post-menopausal stage. This is because the vaginal mucous membrane in young women does not acquire a cellular density that acts as

an effective barrier until after 18 years of age; after menopause, the vaginal mucous membrane becomes thinner and weaker and is more vulnerable to HIV.

- *STD - HIV/AIDS link:* ↑ *Incidence for Women:* Women suffer more than men from sexually transmitted diseases which increases the risk of HIV infection through heterosexual relations. In many cases STDs are asymptomatic in women, which impedes early detection and timely treatment.

  Gender Perspective: However, biology alone does not explain rapid rise in women. Although there are important biological differences between women and men with respect to susceptibility to HIV, these biological differences do not explain the fact that women now constitute 75 percent of the new cases of infection. We have to consider the interaction between psychosocial and biological factors: a gender perspective allows us to understand how women, in addition to their biological risk for HIV, are psychosocially at greater risk than men because of those gender constructions characteristic to many societies.

■ **Small Group Work**: The facilitator divides participants into four (different) groups and displays flipchart with group task.

Flipchart No. 12:

TASK
1) Identify situations in which SOCIAL GENDER CONSTRUCTS INCREASE THE RISK OF CONTRACTING HIV FOR ONE SEX OR THE OTHER.
2) Include concrete experiences/observations of own societies/cultures/lives that provide evidence for 1).

Possible responses:

- *Social tolerance of male promiscuity:* the deep-seated idea that men have more urgent sexual needs by "nature," means that women as a group, and society in general, find it "forgivable" for these needs to be fulfilled indiscriminately;

- *Social assignment of greater value to what is masculine and the positive social support for female passivity and self-denial:* women internalize from the time they are very young the idea that it is "natural" for the man to be "worth more" and thus women, less. In many cultures, the qualities of the ideal woman include resignation, passivity and dependence. The psychological construct of feminine sexuality inhibits many women from questioning men in any area and particularly in the area of sexuality;

- *Lack of open communication on sexuality among partners:* a problem for many women is that, inhibited from inquiring about the sexual habits of their partners, they assume that they are faithful and, as a result, are not aware that they are at risk of contracting HIV and other STDs. In other cases, psychological denial mechanisms are also involved;

- *Male rejection of the condom:* rejection occurs more frequently in sexual relations of the man with his stable partner (use of the condom is associated with relations with prostitutes). In addition, the definition of masculinity is built around the idea of "taking risks" which implies that a "real man," will take a risk rather than take precautions. Also, women often reject condom use among their partners, because they associate its use with promiscuous sexual relations or prostitutes;

- *Female psychic construct based on economic and social subordination:* women may be aware of their vulnerability but may tend, because of gender constructions, to lack an internal locus of control that would enable them to reduce or eliminate the risk of their sexual relations. Men who do not want to use condoms generally will not do so, and women will not risk their relationship or male economic support, nor will they face the violence of a confrontation that this type of situation can cause. National AIDS Control Programs often assume that the strategies of prevention are equal for men and women, an assumption that is not reflected in reality, for example, in the control over the use of condoms;

- *Women have not been taken into account by the scientific community when carrying out clinical research on HIV/AIDS:* with the exception of prostitutes, women have been ignored for many years in efforts to prevent transmission of HIV and in research on AIDS. This is probably due to the fact that there was a much greater proportion of men than women affected in the countries that led international biomedical research. Accordingly, for years the natural history of HIV was defined and studied in men, without taking into account the fact that women are at greater risk for HIV/AIDS for the reasons we have seen here;

- *Prohibitions on access to sex education and contraceptives, including condoms:* among the multiple obstacles to the condom, there are religious prohibitions imposed by churches and the most conservative sectors of society; the male argument is based on the loss of sensitivity to sexual pleasure and the association of condom use with STDs and casual relations; in addition, there is a lack of adequate sex education and a lack of access to contraceptives and condoms, often justified with the argument that sex education promotes promiscuity in youth;

- *Age of Sexual Partners:* men have sexual relations with younger and younger women, particularly virgins, because of the belief that younger women are less likely to have contracted the virus. This is spreading the virus among increasingly younger women and girls.
- *Lack of health services for women with STDs or HIV which take into account gender-based needs:* generally, the health sector has not developed a satisfactory response for women suffering from STDs; this is one of the factors that significantly increases their biological susceptibility to HIV. Although women suspect that they may have STDs, they do not seek care because of the social stigma that the situation entails;

- *Sexual violence:* sexual violence against women, both public and domestic, increases the risk that women will contract STDs and HIV;

- *Fidelity and virginity:* both characteristics are considered culturally very valuable for women. In this context, women do not easily share their sexual history with their sexual partners, putting the couple at risk.

■ Report Back: Groups report back, one group at a time, with responses to Task No. 1 and one response to Task No. 2. Facilitator fills in any factors (above) that might have been missed.

MODULE 4

PRACTICAL AND STRATEGIC GENDER APPROACHES

MODULE 4

PRACTICAL AND STRATEGIC GENDER APPROACHES:

OVERVIEW: MODULE FOUR	
Objective	● To understand the concepts of practical and strategic gender approaches. ● To begin to apply the gender approaches and the accompanying mechanisms to promote empowerment, to addressing these needs in health.
Core Message	The Practical Gender Approach and the Strategic Gender Approach must be applied in conjunction, in order to ensure that all the health needs of men and women are equitably addressed
Expected Outcome	Participants will be able to distinguish between practical and strategic gender approaches to respond to these needs, and will begin to apply instruments to identify specific needs of men and women in health and development work.
Methodology	Plenary Discussion Lecturette Small Group Work/Plenary Reportback
Materials	OHT No. 7: Practical and Strategic Gender Approaches Flipchart No. 13: Definition of Empowerment Flipchart No. 14: Four Mechanisms of Empowerment Flipchart No. 15: Group Task Handout No. 13: PGAs/SGAs Handout No. 14a: Definition of Empowerment/Mechanisms of the Empowerment Process Handout No. 14b: Empowerment Continuum (adapted from Ronald Labonte) Handout No. 15(a): Promotion of Breast Feeding Handout No. 15(b): Detection and Control of Tuberculosis Handout No. 15(c): Community Based Intervention for Promotion of Mental Health of the Elderly Handout 15(d): Campaign to Stop Tobacco Addiction
Components	Introduction to Module Four 4.1 Practical and Strategic Gender Approaches 4.2 Empowerment Process 4.3 Health Interventions

OVERVIEW: MODULE FOUR (Cont.)

Time	Intro:	5 minutes
	4.1	20 minutes
	4.2	20 minutes
	4.3	50 minutes
	Total:	95 minutes

Preparation

- Prepare Flipchart Nos. 13 - 15
- Photocopy supporting document on the Continuum of Empowerment
- Photocopy Handout Nos. 13 - 15

INTRODUCTION TO MODULE FOUR:
Review of Modules 1 - 3:

PROCESS

- The difference between "sex" and "gender" was defined, emphasizing that the latter is socially constructed, is modified through time, and differs between social and cultural groups.

- Gender roles and responsibilities are assigned in every society. This has direct implications for the degree to which men and women, respectively, have access to and control over resources needed to protect their health.

- Health profiles of men and women are the product of an interaction between biological and psychosocial factors. Sex disaggregated data is crucial for identifying differences and similarities between the health profiles of men and women.

- The next step is to look at Gender Needs: If men and women are biologically different and have different gender roles, then they also have different gender needs in health. Identifying the health needs that arise out of different roles is critical to achieving equity in health policies, programs and projects.

COMPONENT 4.1

PRACTICAL AND STRATEGIC GENDER APPROACHES

Method: Lecture

Materials: Handout No. 13: PGAs/SGAs
OHT No. 7

Time: 20 minutes

Preparation: Photocopy Handout No. 13

PROCESS

- Facilitator points out that as development practitioners we need to be aware of the following:

  - Whether health needs for men and women are the same or different, gender roles and responsibilities must be considered for development interventions to respond equitably.

  - These gender based needs can be seen as twofold:

    (1) Those that improve the quality of life and in so doing meet the basic health needs of the people; and
    (2) Those that address the question of equity and self-determination and in so doing move towards a more equitable distribution of health resources in society.

  - Our ability to respond to these needs satisfactorily is helped in a significant way by distinguishing between two approaches, namely, the practical gender approach (PGA) and the strategic gender approach (SGA).

  - This dual approach is based on the assumption that:

    (1) The gender division of labor gives rise to an imbalance in the responsibilities for health care and promotion assigned to women and men;
    (2) The imbalance in power relations between women and men means different access to and control over resources to respond to health problems.

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A useful mechanism for ensuring that these assumptions are taken into account is the PRACTICAL GENDER APPROACH AND THE STRATEGIC GENDER APPROACH:

- **A Practical Gender Approach (PGA)** responds to the health needs of women and men within their socially accepted roles in society, without attempting to modify gender inequities. The practical gender approach improves the health condition of women or men because it identifies the roles and responsibilities of each sex and attempts to tailor the response to the present situation of women and men in specific contexts. Although PGAs are a key component to efficient responses, they do not directly address existing gender inequities. In fact, PGAs can even exacerbate existing gender inequities because, while they provide access to resources, they do not seek to increase control over them.

- **A Strategic Gender Approach (SGA)**, in addition to responding to the concrete health needs of men and women, is aimed at redistributing the roles, responsibilities and power between them, so as to reduce inequities that harm health and health seeking behavior.

■ Facilitator provides an example:

- **Practical Gender Approach:** Although both fathers and mothers are concerned about the immunization of their children, it is usually women who take them to the health services for this purpose. Thus, women and men share the need to have children immunized, but when we examine this need in the light of gender roles and responsibilities, women may feel the need for access to services at convenient times more than do men. Thus, we observe gender differences in health needs, caused by a division of labor that delegates the care of children as part of women's reproductive role. A PGA would be sensitive to women's need for accessible health services that offer a flexible schedule. This practical gender approach to the situation makes it easier for women to better fulfill their socially assigned role.

- **Strategic Gender Approach:** However, in addition to responding to the need to immunize children, the health services could aim toward a redistribution of gender responsibilities and roles, calling upon fathers to assume a share in the care of their children by bringing them to the services to be immunized. A strategic gender approach to such a health need might also include information and training sessions for fathers prior to the birth of children, on how to care for their newborn. As a result, men may become more comfortable in this role and hence more secure about being involved in the raising of their children, enhancing the potential for the responsibility for the health of children to be shared by men and women. This strategic gender approach could then contribute to building a society based on more equitable gender relations.

■ It is important to emphasize that PGAs and SGAs are not dichotomous. PGAs are essential to responding efficiently to health needs because they recognize that men and women have different gender roles and responsibilities which imply differential access to and control over resources necessary to protect health. For example, the absence of a Practical Gender Approach in the design of a project that incorporates a clinic could lead to the failure of the project if the hours of opening are

inconvenient to the women because of their domestic chores. However, with a PGA, women's roles and responsibilities would be taken into account, women would be consulted about their needs, and the flexible hours could lead to women having greater control over their available time. This would not necessarily change women's roles, but it would lighten the burden of those roles.

In the case of a project on HIV/AIDS prevention, a *Practical Gender Approach* would call for the use of condoms in order to help stem the tide of the epidemic. In certain cultural circumstances and contexts this might be sufficient. In some countries the reduction of new cases of HIV has been directly correlated to an increased condom use. Hence simply an information campaign and easy access to condoms can meet a gender need for both men and women.

On the other hand, culture dictates in many instances that men resist the use of condoms because they believe that it reduces sexual pleasure, and it is a challenge to their sense of manhood. A man would therefore not take kindly to a suggestion by a woman that he use one. A woman, even though she is aware that the use of a condom could save her life, has little power in the relationship to negotiate condom use. A threat by the man to leave her might be enough for her to not raise the issue at all. In some cultures, men are insulted if a woman suggests its use as he views this as lack of trust on the part of the woman. In other cultures, women are insulted if the man suggests its use, as she infers that he thinks she "sleeps around."

Hence in order for condom use to be successfully negotiated, the roles of men and women and the relations that arise from these roles have to be addressed. Only a Strategic Gender Approach will enable this process, and the WAY in which the project is designed and implemented might be very different for men and women given these different roles, relations and assumptions. Hence, a highly effective PGA for men to protect themselves from infection would ensure them access to condoms; however for women, PGAs in AIDS prevention, such as access to condoms, do not have the same impact because of gender roles that curtail women's ability to negotiate condom use with a male partner. In other words, a PGA might work for men, but is unlikely to work for women. An SGA would work for both, as it would change the gender relations, allowing women to assert their needs and for men to hear and respond to that assertion. However, because an SGA involves fundamental behavioral changes in power relationships, they are slow to take place.

■ Facilitator distributes Handout No. 13 and shows OHT No. 7.

Text of Handout No. 13:

PRACTICAL AND STRATEGIC GENDER APPROACHES	
A. PRACTICAL GENDER APPROACH	B. STRATEGIC GENDER APPROACH
● Responds to short-term needs.	● Tends to be a long-term strategy, as an integral part of sustainable human development.
● Responds to needs that are usually easily identifiable by users and suppliers.	● Responds to needs not always easily identifiable by people.
● Responds to biological requirements and specific health conditions.	● Targets inequities between women and men in responsibilities and power relationships.
● Gendered health needs met through provision of health goods and services.	● Needs identified through empowerment processes: the creation of awareness, increased self-esteem, education, strengthening organizations, political mobilization, etc.
● Tends to involve women and men as subjects of intervention.	● Tends to involve people as active subjects or empowers them for this.
● Can improve the health condition of women and men through the access to resources.	● Can improve the position of women by increasing their control over resources.
● Usually does not change gender roles and relations.	● Improves the balance of power between men and women in the use of health resources, through control over internal and external factors that affect the ability to protect health.

Text of OHT No. 7

PRACTICAL GENDER APPROACH	STRATEGIC GENDER APPROACH
● Short term response	● Long term strategy
● Needs more easily identifiable	● Needs less immediately identifiable
● Biological requirements and specific health conditions	● Targets inequities in power relationships
● Provides health goods and services	● Focuses on empowerment processes
● Involves women/men as passive subjects	● Involves people as active participants
● Improves health conditions	● Improves the position of women
● Gender roles and relations remain constant	● Improves balance of power relations

■ The facilitator points out:

Practical and Strategic Gender Approaches grow out of what has been generally recognized in the literature on gender and development as practical and strategic gender needs. These concepts came out of the women's movements in conjunction with various disciplines.

PAHO has adapted the concept of gender "needs" for application to health and development. We refer to practical and strategic approaches in order to underscore that in health the key to achieving gender equity is in HOW health projects, programs and policies are designed. However, it is worth emphasizing that since the concept originally grew out of the women's movement, as a result it logically targets needs and approaches identified by women rather than men, because of the continuing imbalance of power relations. Recent years have seen the formation in some countries of men's movements that have determined that gender constructions have also created role identity distortions that have been detrimental to their own health and well-being. We hope that as we are introducing this concept within the health sector, men will also help to identify their health needs and concomitant strategic gender approaches to improve their own health and well-being.

EMPOWERMENT PROCESS

Method: Lecture

Materials:
Flipchart No. 13: Definition: Empowerment
Flipchart No. 14: Four Mechanisms of the Empowerment Process
Handout No. 14a: Definition of Empowerment/Mechanisms of the Empowerment Process
Handout No. 14b: Empowerment Continuum (adapted from Ronald Labonte)

Time: 20 minutes

Preparation:
Prepare Flipchart Nos. 13 - 14
Make copies of Handout No. 14 (a) -(b)

PROCESS

- Facilitator recapitulates that:

Practical and Strategic Gender Approaches are not dichotomous concepts. In many cases, the two approaches overlap; they are neither static nor universal. The process of change that is implicit in the SGA implies personal and inter-personal conflicts and costs. SGAs are closely related to empowerment processes of individuals and of groups. This internal process that allows a person "the capacity to do or to act" is a critical element in the process of change.

Empowerment is not a new concept in public health, since it has been utilized a great deal in prevention and health promotion. It involves a process within individuals through which they develop the strengths and the skills that allow them to act toward a personal or collective good, either to improve their health in particular or to improve their quality of life (education, credit, work, etc.) in general.

A concept that facilitates the comprehension and implementation of strategic gender approaches is the "Empowerment Continuum" that comes from the health promotion field and was suggested by the Canadian, Ronald Labonte. Labonte utilizes this continuum to refer to the transformative process, not only in women but men, as well as in social classes, whereby the health sector's power over the population is turned into a new relationship of "joint power" shared by both.

Labonte defines Empowerment as: A process whereby individuals develop strength and skills to act toward a personal or collective good.

Flipchart No. 13:

EMPOWERMENT PROCESS
Definition A process whereby individuals develop strength and skills to act towards a personal or collective good

Labonte establishes different moments in the process of reaching this transformation or empowerment. We have adapted this author's suggestions and divide Labonte's continuum into Four Empowerment Mechanisms:

i) interpersonal encounters;
ii) support groups;
iii) community organization; and,
iv) political action coalitions.

These mechanisms are located along an "Empowerment Continuum," a concept that helps to clarify the use of the multifaceted concept of the strategic gender approach in health. The empowerment process is not a linear process, as we will see later. This continuum is useful in helping us to better understand how our interventions in health can facilitate or impede the empowerment of people.

In the specific case of gender, we can distinguish between men's and women's abilities to improve their health situation through a practical gender approach that makes the necessary resources more accessible to them; and, one which uses a strategic gender approach, which, in addition to responding to a concrete felt health condition or problem, includes elements that move towards greater equity in gender relations by enhancing the degree of control over needed resources to protect health. Increased access to resources is defined by many women as a form of empowerment. But, a clear distinction must be made between people's access to and control over resources; these are crucial concepts in the definition of empowerment.

■ Facilitator turns to Flipchart No. 14a of the Four Mechanisms of the Empowerment Process.

Text of Flipchart No. 14/Handout No. 14a:

EMPOWERMENT CONTINUUM

INTERPERSONAL ENCOUNTERS
● Facilitate self-validation through dialogue

SUPPORT GROUPS
● Facilitate opportunities to overcome isolation ("not only sufferer")

COMMUNITY ORGANIZATION
● Facilitate organization around common problems that go beyond personal interests

POLITICAL ACTION COALITIONS
● Facilitate social movements that go beyond limitations of community organization to achieve political/social change

Talking Points:
The four empowerment mechanisms through which health systems and services can initiate or strengthen a practical and strategic gender approach are:

a. ***Interpersonal Encounters:***
Can occur at the level of direct service, where health workers interact directly with users.

Labonte notes that the two pillars that allow services to be empowering are:

I. That they be offered in a supportive, non-controlling manner;

II. That they are not the limit of the services and resources offered by the agency.

This type of support respects the autonomy of the individual and seeks to understand the psychosocial and socio-environmental contexts of the problems. The health professional-user relationship is a horizontal one in which dialogue between them enhances a joint search for a solution to a health problem. Such a climate moves constantly towards a greater capacity by the individual to act upon both the symptoms and the roots of his/her distress. The user's relationship with services for managing a health problem at the individual level can facilitate personal empowerment.

e.g., Domestic Violence: A positive response from the health service can promote the development of personal empowerment in a woman as she develops a greater level of self-respect and progresses from a passive victim to an active subject. However, according to Labonte, individual care and crisis management does not have an impact on the structural problem of society's tolerance for violence against women.

b. *Support Groups:*

Personal empowerment requires opportunities for individuals to overcome their isolation and the "learned helplessness" it creates.

This, according to Labonte, can be accomplished through "group work" in which the individual recognizes that he/she is not the only one suffering from the problem and that, as a result, problems, diseases, etc. are not uniquely about themselves. Group work helps men and woman see their own experiences within a social context. However, the author points out that these groups, although very important for generating empowerment processes, can remain isolated from various forms of action and political organization designed to solve structural problems.

e.g., Domestic Violence: Self-help groups formed by abused women are an important source for promoting self-esteem and personal empowerment, but do not offer sufficient inputs to modify the structural conditions that tolerate violence.

c. *Community Organization:*

Support groups prompt people to organize around problems or situations that are specific to them.

Community organization, on the other hand, involves the process of organizing people around problems or situations that go beyond the particular interests of those involved. Support groups allay the particular and specific suffering of each of their members; community organizations try to confront the causes of such suffering. Both types of organization are necessary for generating processes of individual and collective change.

Community organization often involves conflict with other interest groups. According to Labonte, conflict, as the predecessor to fruitful negotiation, is a fundamental ingredient for achieving participatory democracy. However, community organization can remain local and parochial without having any effect on the control of resources at the macro level.

e.g., Domestic Violence: Recent decades have seen the emergence of non-governmental community organizations of activist women, offering refuge and comprehensive care to abused women (legal, psychological and physical support), in addition to sensitizing and building awareness of public opinion about the problem.

d. ***Political Action Coalitions:***

The formation of coalitions for political action provides elements for surpassing the limitations of community organizations.

The actions of such coalitions are generally directed toward higher levels of governmental decision-making, and they are called coalitions because action is carried out by a number of groups that unite to exert pressure for achieving a political change or a social reform.

Political Action Coalitions use advocacy as a means to achieve their goal.
Labonte defines advocacy as "taking a position on an issue," in this case, to initiate actions in a deliberate attempt to influence public policy choices. He notes that there are different ways in which health professionals and their agencies can support political action coalitions:

i) By being a resource to a process, providing information and advising groups on bureaucratic structures and their functions.

ii) By legitimizing the health concerns of the coalitions. This doesn't mean that the health agency takes the same position on the issue as the coalition, but it does involve taking a position on the health implications of health issues.

iii) By health professionals themselves taking positions on health issues. An organized, political voice of caring professionals may be crucial in moving towards more equitable and sustainable forms of gender sensitive social organization.

e.g., Domestic Violence: The health sector can legitimize the concerns of women's groups and acknowledge in policy statements that violence against women is a public health issue of growing severity. This way, it is easier for women's groups and other human rights groups to get Domestic Violence "on the agenda" of public and private sector decision-making fora. A case in point is the legitimacy that many governments have accorded to the issues raised by women's NGOs, illustrated by the growing number of NGOs present at intergovernmental fora.

HEALTH INTERVENTIONS

Method: Group Work

Materials: Handout No. 15a,b,c,d,: Health Interventions
Flipchart No. 15: Group Task

Time: 30 minutes: Group Work
20 minutes: Plenary
50 minutes: Total

Preparation: Photocopy Handout No. 15 (a) - (d)
Prepare Flipchart No. 15

PROCESS

- Facilitator distributes Handout No. 15, one health area to each group (Legislation to Promote Breast-Feeding, Program for Detection and Control of Tuberculosis, Design of Community Based Intervention for Promotion of Mental Health of Elderly and Campaign to Stop Tobacco Addiction (Handout Nos. 15a, b, c, d).

Text of Flipchart No. 15:

Group Task: HEALTH INTERVENTIONS

In your groups, read the General Findings pertaining to your topic and the issues to think about.

What practical gender approach (PGA) do you suggest for responding to the particular health needs of women and/or men?

Taking into account the different mechanisms of the empowerment process, how could the intervention selected above incorporate a strategic gender (SGA) approach so that it enhances the possibility of gender equity in health?

- Facilitators can use suggestions for possible responses following the description of findings and issues to think about for each health area.

Note: Facilitator should request each group to select one member who will provide an overview of the General Findings pertaining to the group's health area, by way of introducing the results of the group's discussion. In this way, all workshop participants have information on each health area.

Handout No. 15(a):

PROMOTING BREAST-FEEDING[1]

General Findings:

1. Scientific evidence and research have demonstrated the benefits of breast-feeding for child survival, health and nutrition, maternal health, and child-spacing. Breast-feeding currently saves 6 million infant lives each year by preventing diarrhea and acute respiratory infections alone, is responsible for 1/4-1/3 of the observed fertility suppression, and can provide high-quality nutrition at a fraction of the cost of high-risk substitutes.

2. WHO/UNICEF recommend that to ensure optimal maternal/child health and nutrition, the aim should be to enable all women to breast-feed their infants exclusively from birth for at least the first four months of life, and preferably for six months; and to continue breast-feeding, with the addition of adequate complementary foods, for up to two years and beyond.

3. In Latin America and the Caribbean, urban infants are not breast-fed as long as rural infants, and there is a rapid decline during the first three months in both groups. At 12 months of age, nearly half of the rural infants are still being breast-fed, but only 16% of urban infants apparently receive breast milk at this age.

4. Most studies on the subject show that breast-feeding decreases the case-fatality rate in children. In a case-control study in Brazil (Victoria et al., 1987), infants who received no breast milk were 14 times as likely to die of diarrhea as exclusively breast-fed infants.

5. The extent to which hospital personnel and hospital routines foster or discourage breast-feeding practices among new mothers is one of the principal determinants of the rate of initiation of breast-feeding (Winikoff & Baer, 1980; Winikoff & Castle, 1989). Providers should have received adequate training in the practical aspects of lactation management and understand the needs of women who are breast-feeding.

6. The great majority of women in Latin America and the Caribbean have breast-fed their children. However, the recommended practice of exclusive breast-feeding during the first four to six months is rare. In almost all countries the early introduction of liquids such as water, teas, juices and cow's milk is prevalent. For example, in Lima, 80% of children have received water before one month of age (Altobelli, 1991, Brown et al., 1989).

7. Women have positive attitudes towards breast-feeding in the majority of countries but supplement with other liquids almost immediately. Some authors indicate that this supplementing is due to a lack of motivation on the part of the mother to breast-feed, which also is a socially acceptable reason for the introduction of early weaning. However, one of the main reasons women give for supplementing breast milk with other liquids is their perception of not having enough breast milk to feed their children.

1 Sources: 1) Lactancia Materna en América Latina y el Caribe, Programa de Nutrición de la División de Promoción y Protección de la Salud, Organization Panamericana de la Salud; 2) Breast-feeding: The Technical Basis and Recommendations for Action, World Health Organization.

Handout No. 15(a) (cont.):

8. Data appear to show that employment outside the home does not influence the initiation or the continuation of breast-feeding. In many countries the rate of initiation and the duration of breast-feeding among women who work in the formal labor force is not significantly different from that of women who remain at home. Nevertheless, whether paid and working, or unpaid and working, all women have multiple roles which they often perform simultaneously. These multiple roles must be understood in seeking an explanation as to why women do not breast-feed exclusively and on demand for the four to six recommended months.

9. Mother support groups (MSGs) provide individual counselling, information, support and group discussions to enable women to practice breast-feeding and child care well. MSGs attempt to fill the void for a mother when breast-feeding is not the cultural norm and when she lacks family and peer support.

10. The promotion of breast-feeding has been framed as a health issue of importance to the infant and a moral imperative for the mother. However, an understanding of the obstacles women face in breast-feeding exclusively for four to six months must be grounded in the realities of their daily lives, including how decisions are made at the household and couple level. Breast-feeding is not only a "women's issue" but a social issue where other responsible parties include family members, particularly male partners, the social sectors, including education and health, and employers and policy makers.

<u>Issues to Think About</u>

1. Legislation that has been enacted in some countries to ensure that employers uphold women's right to breast-feed have backfired, and in some cases employers are reluctant to hire young married women.

2. WHO and UNICEF recommend that breast-feeding be continued beyond 6 months until two years of age, with the introduction of adequate complementary foods. How feasible is this in the light of gender roles and responsibilities?

3. There is little known about men's attitudes to breast-feeding and their view of the importance of this practice for the health of the child. Why is an understanding of male attitudes important to promoting breast-feeding? What might you expect to find (in attitudes as well as support practices to the lactating wife) in men in general in Latin America and the Caribbean?

4. Why would some women's groups take issue with the way breast-feeding traditionally has been promoted?

5. How might the emphasis society places on slimness and sexual attractiveness for women influence women's decisions as to whether or not to breast-feed?

For Facilitators

How could a breast-feeding promotion campaign incorporate a practical gender approach?

Information Resources:

- Offering information on how women must care for their mental and physical health, including eating properly while breast-feeding to help them to better fulfill their maternal role.

- Informing the male partner that women need additional food at this time, especially when promoting exclusive and prolonged breast-feeding.

- Sensitizing health care workers about the importance of breast-feeding and the need to support the mother as well as the child. Training should discourage practices such as immediate separation from the mother and infant, feeding of glucose water to test the patency of the esophagus and to calm crying babies, and provision of bottle and infant feeding formula.

- Address the needs of women who work in the labor force. To assist these women with breast-feeding, the following special target groups should be considered: child-care workers, occupational health nurses and women's groups. The mass media could be used to publicize existing policies affecting employed breast-feeding mothers and by showing elite professional women breast-feeding.

Material Resources:

- Address the need for private spaces in public places, not only in the formal labor force but also in recreational facilities.

In addition to having a practical gender approach, how could a breast-feeding campaign incorporate a strategic gender approach?

- By involving men in the design of promotional campaigns with messages which provide fathers with a way of becoming active in this process. For example, messages might propose that the father care for the other children and help with domestic chores so the mother can breast-feed. Other mechanisms could be developed so that the broader society shares responsibility for child-care.

- Formulate messages that breast-feeding is not a moral obligation. Promotion programs should include information for women who cannot or will not breast-feed. Because breast-feeding is a woman's choice, information should be made available on safe alternatives. The focus should be on informed decision-making so that women can weigh the importance of breast-feeding within the context of their everyday lives.

Handout No. 15(b)

DETECTION AND CONTROL OF TUBERCULOSIS[1]

General Findings:

1. In developing countries, men and women have similar TB notification rates until adolescence, after which males have higher notification rates. Some reasons for this that have been postulated are:

   a. Women may be less susceptible to TB infection during and after adolescence because hormonally mediated immunological differences protect them.

   b. Women may exhibit lower delayed type hypersensitivity (DTH) responses than males; males and females may have similar prevalence of infection but the degree of skin reaction in infected women is not large enough to be interpreted as a positive test during and after adolescence (this lower DTH reaction in women has been substantiated). It is not clear why older men have a higher risk of progression from infection to disease in comparison to women of older ages. Cellular immunity may diminish more quickly in men than in women and more men smoke and drink alcohol than women, which can weaken their immune system.

2. Women between the ages of 15 and 40 are almost twice as likely to progress from TB infection to TB disease than men of the same age, and men are more likely to progress from infection to disease after age 40. One of the possible reasons for women's rapid progression during reproductive years may be due to the stress of pregnancy. Some studies show that the risk of progression of infection to disease in women is particularly acute during post partum periods for women. A series of factors may account for this, including rapid hormonal changes, post partum descent of the diaphragm and reexpansion of the lungs, nutritional strain during lactation and insufficient sleep due to the demands of the new child.

3. Women have greater TB case fatality and mortality than men up until age 30.
   Some studies posit that this may be a consequence of decreased immune and nutritional status that may or may not be a result of complications during pregnancy. There may also be poorer levels of care provision for women, or women may arrive at the health services in more advanced stages of the disease. A study in Bolivia showed that the delay from the onset of symptoms to diagnosis was more than 6 months in the majority of women compared to 1 to 6 months in the majority of men. This diagnostic delay may account for some of the increased case fatality and mortality rates observed in women.

4. Passive vs. active case finding[2]: men have higher notification rates than women at all ages through passive case finding. Greater numbers of infected women are found than infected men through active case finding.

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1 Sources: Scientific publications based on results of research from 1966 to 1995 which describe relationship between sex, gender and the epidemiology of tuberculosis. We wish to thank PAHO's Regional Program on Communicable Diseases for this material.

2 Passive case finding refers to patients presenting to the health services of their own accord, whereas active case finding refers to random sampling conducted in a population to screen for TB, or to an entire population being screened for TB.

Handout No. 15(b) (cont.)

One reason for this may be that women going to health service for pre-natal or post-natal care are not being diagnosed for TB. Additionally, women may not seek care, despite their symptoms. Because men are more involved in the "public" sphere (military duty, formal employment), they are more likely to be screened for TB, whereas women who are more likely to be involved in domestic activities are not candidates for such screening.

5. HIV is strongly associated with TB and this may have a particularly severe impact on young women in developing countries because they are at increased risk for HIV infection at a time when they also appear to be at increased risk for progression to TB. Studies have found that the odds ratio for HIV infection in smear-positive cases for TB is significantly higher in females than males in the 15-34 year age group.

6. The impact of TB on family members is acute. As primary care givers of male family members that are infected, women are exposed to increased risk. While a woman takes care of others when they are ill, when she herself becomes sick there often is little support for her.

7. Worldwide, more disability adjusted life years (DALY) are lost due to TB than to HIV, other STDs or malaria. This burden must be viewed in the light of the added possibility of under-reporting in women.

Issues to Think About:

1. Why might the notification of infection in males during and after adolescence be higher than in females?

2. Why would there be such differences between men and women with respect to active vs. passive case finding? What difference might there be between men and women in terms of access (geographical, economic, cultural, etc.) to health services and, in particular, to TB diagnostic health services?

3. Why would women of reproductive age progress more rapidly from infection to disease than men in the same age cohort? Why would this reverse after 40 years of age?

4. Why would the case of fatality rates for women be greater than for males until age 30?

For Facilitators:

How could a TB detection and control program incorporate a practical gender approach?

Material Resources:

- Active case finding could be done by TB control programs for women attending maternal and child health care clinics.

Information/Political Resources:

- Health care workers and young women should be made aware of the elevated risk of progression from TB infection to disease in women's reproductive years, especially following a recent pregnancy.
- Health workers should be trained to detect and treat TB and to encourage young mothers to seek care for symptoms associated with TB.
- Health education efforts should be incorporated into MCH health programs and HIV/AIDS prevention and care.
- Health themes should be incorporated into school curricula and mass media campaigns to educate men and women about their specific risks, needs and opportunities in terms of TB prevention and control.

Material/Time Resources:

- Outreach strategies should be implemented for the detection and treatment of TB cases among women (all women, not only those that are pregnant) that do not come to maternal and child health care clinics.

In addition to having a practical gender approach, how could a TB detection and control program incorporate a strategic gender approach?

Information Resources:

- The school system and other youth organizations should work with young boys and girls to inculcate a value for human nurturing and the practical skills needed to take care of others.
- Together with community based women's groups, explore ways to raise awareness of the problem and support others in their group so that they make use of detection and treatment services.

Handout No. 15(c):

DESIGN OF COMMUNITY BASED INTERVENTION FOR PROMOTION OF MENTAL HEALTH OF ELDERLY[1]

General Findings:

1. Over the next three decades, the percent growth in the older population of Latin America will range from 25% in Uruguay to 282% in Costa Rica. The growth rate of the oldest old (persons 85 years and older) is higher than for all other ages in Latin America and the Caribbean.

2. Women live longer, on average, than do men.

3. Education in early life has a major effect on the well-being of the elderly. Illiteracy is almost always higher in older women than in older men.

4. In surveys of elderly persons living in communities, rates for dementia[2] are much higher in those with little education.

5. Societies have varied reactions to dementia in aging. Some societies are more tolerant than others, which can regard dementia as pathological.

6. Mental health problems can relate to lack of food. The World Bank estimates that 780 million people of all ages worldwide are energy deficient. The elderly, particularly women, are disproportionately poor and therefore more likely than the general population to be malnourished. Lack of food can lead to confusion and forgetfulness.

7. Studies show that the elderly can avoid some mental health problems if they stay active in society. Social changes associated with industrialization often isolate the elderly from their previous roles and increase dependency, resulting in loss of dignity, self-respect and weakening of filial support networks.

8. The burden of caring for the elderly falls predominantly on their children, mainly, their daughters.

9. There is a high prevalence of multiple coexisting physical conditions with age: incontinence, hip fracture, sensory loss. These influence mental health through the loss of self-esteem and independence. These conditions are more prevalent among elderly women than elderly men.

Issues to Think About:

1. Do elderly men and women have sex-specific biological needs that are derived from different immunological, genetic or physiological differences? Could this be associated with women's higher incidence of chronic dis-

1 Source: *World Mental Health: Problems and Priorities in Low-Income Countries*. Dejarlais, R.; Eisenberg, L.; Good, B.; Kleinman, A. New York: Oxford University Press, 1995.

2 Gradual loss of cognitive function resulting from diseases that appear late in life.

Handout No. 15(c) (Cont.)

eases and diseases such as urinary incontinence, diabetes, hypertension, etc.? How might these differences have an impact in the kind of information provided to health care workers and family members caring for the elderly and the elderly men and women themselves?

2. How might gender roles protect or increase the risk for men and women to suffer from these diseases that characterize the aging?

3. Given the importance of education and continued involvement in society to ensure the mental health of elderly men and women, how might a program be structured to respond to or enhance the different opportunities each sex has had for developing their intellectual and social abilities?

4. Given the preponderance of care of the elderly on female family members, what can the state do to promote more equitable distribution of the care of older persons within their families?

For Facilitator:

How could a program for mental health promotion for the elderly incorporate a practical gender approach?

Material Resources/Information Resources:

- Provide health care workers with information and training that will enable them to understand and deal with the developmental needs of elderly men and women, differentiating the needs that both sexes have due the interaction of biological makeup and gender roles.

Material/Internal Resources

- Provide material and emotional support to care givers of the elderly, recognizing that they have gender needs derived from their gender roles. This support should be aimed at those providing care in institutional settings and at those providing home based care to elderly family members.

Material Resources

- Make available community centers where elderly men can come together do conduct activities they enjoy, and women can do the same.

Internal Resources

- Devise programs in which the elderly men and women of the community have opportunities to interact and work with male and female youth, taking account of the learning/unlearning of gendered roles that might be stimulated by same-sex, cross-generational pairing, thus providing an opportunity for young and old men and women to gain self-confidence and a feeling of their own importance for others and for the community.

In addition to having a practical gender approach, how could a program for promotion of the mental health of the elderly incorporate a strategic gender approach?

- In the promotion of mental health for the elderly, one critical aspect is to ensure that earlier in their lives men and women are prepared for their older years. This entails having opportunities available (access) and being able to take advantage of these opportunities (control) to become educated, to participate fully in society, to feel that they are valued members of their communities regardless of their "occupations," and to have the knowledge of the components of healthy lifestyles that will provide greater protection from preventable illnesses that can accompany the aging process.

- Consequently, it becomes critical to empower young women in the direction of improving their education and having an active and satisfying life project beyond their reproductive role (and their reproductive years) that ensures their economic and psychological autonomy.

- For young men, it becomes critical to modify social values that continue to foster masculine dominance, the negation of a nurturing and caring role for men, and the sole importance of income-generating activities as proof of male self-worth.

Handout No. 15(d):

CAMPAIGN TO STOP TOBACCO ADDICTION

General Findings:

1. According to WHO, tobacco use is estimated to account for 3 million deaths per year, about half a million of which are among women. Slightly more than half of those women live in developed countries. The number of deaths is expected to rise dramatically from 3 to 10 million in the next 20 years. Only if there were to be a substantial fall in smoking prevalence among adolescents would the epidemic of tobacco-related deaths be moderated since the majority of these deaths will occur among youth and young adults of today.

2. The women most likely to smoke in developed countries are those on low incomes with low-status jobs or who are economically inactive. On the other hand, today, affluent and educated young women in Latin America are more likely to take up smoking than their lower income counterparts.

3. Studies from the United Kingdom show that spending on tobacco among low income households with children is higher than among low income households without children. The highest per capita expenditure on tobacco is among one-adult households with children. Qualitative studies of caring highlight the experiences that underlie the association between smoking, poverty and caring for children. Cigarettes were reported by mothers caring for children in low-income households as the way women coped when their children's demands became "too much to cope with." Within a lifestyle devoid of personal spending, cigarettes were the only item that women bought for themselves.

4. Studies in Latin America and in the United States show that girls are smoking for two very different reasons than boys are. Girls use cigarettes to control their weight and appear grown-up, neither of which are reasons boys give for smoking.

5. In Latin America, surveys show wide variations in the prevalence of smoking among women, from 3% in La Paz to 49% in Buenos Aires. Most reports of recent surveys indicate that prevalence among women is increasing, particularly in countries that have higher rates of urbanization.

6. In general, countries in which smoking was first taken up were the first to show a decline in the prevalence of smoking among women in certain age groups. However, recent data in the United States and Canada have shown higher rates of smoking among young women ages 14 to 19 years than among their male counterparts.

7. An Australian study (1995) of 60,000 students from grades 7, 9 and 11 indicates that teenage girls who smoke cigarettes regularly do so because it is a balm for depression and anxiety. A study in Chile found that girls who smoke score lower on measures of self-esteem than those who do not, which is not so for boys where self esteem is not a factor in boy's initiating and sustaining smoking.

8. For boys, the importance assigned to religion seems to play a key factor in whether or not they take up smoking, with a strong association between importance assigned to religion and not smoking (not the case in girls). For both sexes, the fact that friends smoke is strongly linked to the likelihood of initiating smoking. For girls, the belief that smoking is harmful is a deterrent to taking up smoking, but this is not the case for boys.

Handout 15(d) (Cont.)

9. For biological reasons, the consequences of tobacco use are different for both sexes. In women, smoking has particularly adverse consequences for their own health as well as the health of their children. For example, those who use oral contraceptives are more likely to suffer from cardiovascular problems later in life. Additionally, data collected in the United States indicates that the association between smoking and early menopause has generally been found to be highly significant. The public health implications of this association are derived from the adverse effect of early menopause on morbidity and mortality for several conditions, including the link between menopause and cardiovascular mortality, as well as between menopause and bone fracture.

10. Many women are becoming more aware of the dangers of smoking during pregnancy, but are unaware of the risks of smoking after delivery. Few regular smokers realize that their children are passively smoking. Children whose parents smoke have a tendency to suffer from a series of health problems in the first few years of life, especially respiratory illnesses and infections. There is a condition known as the "Monday morning syndrome," which occurs when children who have been inhaling smoke during the weekend develop otitis and respiratory infections on Sunday evening and have to see a doctor on Monday morning.

Issues to Think About:

1. Tobacco consumption in Latin America appears to be associated with gender relations. In population subgroups in which there is greater subordination of women, tobacco consumption is less than in subgroups in which there is greater gender equity. What do you think might be underlying this finding? How might messages be tailored to counteract this trend in women?

2. A study in Chile finds that knowing that smoking is harmful does not dissuade men from taking up the habit. What do you think might be underlying this finding? How might messages be tailored to counteract this trend in men?

3. If you were to receive a grant to study whether nicotine is more addictive in either sex, for biological reasons only, would you expect to find that it is more addictive in men, in women, or that it is equally addictive for both? Why would this type of study matter for smoking cessation programs?

4. In Canada, a smoking cessation program found dramatic gender differences in the ability of married men and married women to give up smoking. For married men it was much easier than for married women. Why do you think this was the case? How would you tailor a smoking cessation program with this in mind?

5. In the United States, President Clinton announced a series of policies to curb tobacco use in teenagers. Much of this had to do with banning the promotion and advertising of all tobacco products; revision of legislation regarding the sale of tobacco to minors to include stiffer penalties; and legislation banning tobacco sales through vending machines in places where children and teenagers might frequent. Taking gender considerations into account, which of these policies, in your estimation, will have greater effect in curbing smoking in girls? in boys? or will there be no difference? Why?

For Facilitator:

How could a smoking cessation and prevention program incorporate a practical gender approach?

Information/Education Resources:

- Based on sex and age disaggregated data, tailor smoking prevention pamphlets to men and women that provide them with information for each about the risks of smoking. This would include awareness of the different factors that influence smoking initiation in boys and girls, keeping in mind that generally for boys the health consequences do not seem to be a deterring factor.
- Aiming tobacco prevention campaign messages at women that convey independence from addiction as an image of the "woman in control of herself and her future."
- Aiming tobacco prevention campaign messages to men to convey that "real men who care for their family don't smoke."
- Working with church groups to form youth groups, particularly aimed at boys and young men, that coordinate activities such as sports clubs, etc.

Services (Material Resources):

- In smoking cessation programs, form support groups for women who smoke instead of counting on women to be able to get support from family members to stop smoking. For men support from wives and female companions has proven to be an important factor for smoking cessation. However, when trying to quit smoking, women appear to receive less support from family members than men do.

In addition to having a practical gender approach, how could a smoking cessation and prevention program incorporate a strategic gender approach?

Time Resources:

- In countries where the data indicates an association between cigarette smoking in women, isolation and caring for young children, form support groups with women to review how they might work together to care for one another's children. This would provide each with some free time during the week to pursue other interests. Additionally, the women could explore different ways of involving their male partners more in the care taking of their children.

Internal Resources:

- Work with young girls and boys in the primary schools to work on self esteem for both, keeping in mind that girls and boys have different developmental processes and that the content of the discussion sessions should be tailored to meet these variations. For example, work with girls could focus on the acceptance of body image, trying to break the desire for smoking as a weight control measure.

- Together with adolescent boys and girls, design programs to form peer counselors that assist others who have already initiated smoking or who are trying to give up smoking. This work should particularly be centered on youth who are out of school.

MODULE 5

DEVELOPMENT APPROACHES

MODULE 5

DEVELOPMENT APPROACHES

OVERVIEW: MODULE FIVE

Objective	Present information on the difference between the women, health and development approach and the gender, heath and development approach, and their respective relation to approaches used by multilateral, bilateral and national development agencies.
Core Message	Approaches that focus exclusively on women do not resolve gender inequity.
Expected Outcome	Participants will be able to recognize the different approaches to women that have been supported by various development models and will be able to identify the influence that these different approaches have on the treatment of women as a population subgroup within health and development policies, programs and projects.
Methodology	Lecturette Small Group Work/Plenary Feedback
Materials	OHT No. 8: Development Approaches (summary) Handout No. 16: Development Approaches Handout No. 17: Extracts from Policy Documents Flipchart No. 16: Group Task
Components	5.1 Approaches used by International Development Agencies 5.2 Equity and Efficiency
Time	5.1 20 minutes 5.2 30 minutes Total: 50 minutes
Preparation	■ Copy Handout No. 16-17 ■ Prepare Flipchart No. 16

APPROACHES USED BY INTERNATIONAL DEVELOPMENT AGENCIES

Method: Lecture

Material: OHT No. 8
Handout No. 16: Development Approaches

Time: 20 minutes

Preparation: Photocopy Handout No. 16

PROCESS

- Facilitator points out that:

  Any effort to understand the situation of women in our countries should investigate the effects that the theories and practices of the different models of development have had on women's condition and gender position. The elements of these models are incorporated in the strategies utilized in agencies such as PAHO when health programs and projects are formulated. One major development theory, the theory of modernism, continues to have a significant impact on the policies of cooperation agencies to date.

- Facilitator shows OHT No. 8 and explains that it is possible to distinguish 5 approaches to woman, gender and development that are utilized in development policies, programs and projects. The first three approaches derive directly from the theory of modernism. Facilitator, with the help of Overhead Transparency No. 8 presents those approaches, and distributes Handout No. 16.

Handout No.16

APPROACHES OF PROGRAMS AND PROJECTS DERIVED FROM MODERNISM

WID APPROACHES

EARLIEST WID APPROACH

Welfare approach ←←←←←←←← **Passive beneficiaries**

- To help the most vulnerable groups, including women;
- Sees women as passive recipients of development;
- Perspective centered on the family as unit, emphasizing the reproductive role of women;
- Views better child rearing as the principal contribution of women to development;
- Has a practical gender approach.

SECOND WID APPROACH

Anti-poverty approach ←←←←←←←← **Gender inequalities reflect poverty, not gender subordination**

- Attempts to ensure increased productivity of poor women;
- Women are poor because of economic limitations, not gender structured constraints;
- Recognizes the productive role of women;
- Emphasis on small income-generating projects;
- Has a practical gender approach.

THIRD WID APPROACH, NOW PREDOMINANT

Efficiency approach ←←←←←←←← **Women cushion impact of structural adjustment process**

- Women seen in terms of their ability to compensate for deterioration of public services;
- Rely on all three roles of women and their supposed free or flexible time;
- Women seen entirely in terms of delivery capacity and ability to extend working day; most popular approach with governments and multilateral agencies;
- Has a practical gender approach.

■ Facilitator points out that the next two approaches presented below were strongly influenced by networks and organizations of women in the northern and southern hemispheres. To date, they have had limited visibility within the programs and projects of development agencies.

Handout No.16 (cont.)

PROGRAM AND PROJECT APPROACHES ORIGINATING FROM WOMEN'S GROUPS

Equality approach ←←←←←←←← **Affirmative action to ensure women have active role in development**

- Women are the target population of programs and projects;
- By means of legislation, policies are designed to assure the incorporation of women in the paid labor force, in educational institutions and to ensure that their autonomy and rights are respected;
- Projects are designed to reduce inequality between men and women, especially with respect to the division of labor by gender, increasing the political and economic autonomy of women;
- Directed to any of the three roles (reproductive, productive or community);
- Has a strategic gender approach, through top-down state interventions giving political and economic autonomy to women in order to decrease their inequality.

Empowerment approach ←←←←←←←← **Defines empowerment as access to and control of the use of material/ economic resources, political, information/ education and time**

- Its origins in Third World women's grassroots organizations; Freire's theory has great influence on awareness of oppressed peoples;
- In health, it proposes a new relationship of "shared power" between the health sector and different groups of a population;
- Seeks to empower women through greater self-reliance: women's subordination seen not only in relation to men at the individual level, but also of predominant development models;
- Tries to serve the particular needs of men and women in their multiple roles, through mobilization from the bottom up as a way to confront different types of oppression;
- Bottom-up mobilization around concrete health needs in a manner that incorporates strategic gender approaches—can be a practical and strategic gender approach.

■ Facilitator distributes photocopy of Handout No. 16 to each participant and ends with the following observation:

- Projects prepared in agencies such as PAHO usually reflect a combination of approaches. This set of approaches can be utilized as an analytical tool to recognize and understand the relationship between gender, health and development, and policies, programs and projects directed to various populations.

Text of Overhead Transparency No. 8

Development Approach	Type	Characteristics	PGA/SGA
Welfare	WID/WHD	Modernization economic development model	PGA
Anti-Poverty	WID/WHD	Gender inequalities result of poverty, not gender subordination	PGA
Efficiency	WID/WHD	Women cushion impact of structural adjustment	PGA
Equality	GAD/GHD	Affirmative action to ensure women have active role in development	SGA
Empowerment	GAD/GHD	Access and control of the use of resources	SGA

EQUITY AND EFFICIENCY

Method: Small Group Work/Plenary Feedback

Materials: Handout No. 17: Policy Document Extracts
Flipchart No. 16: Group Task

Time: 30 minutes

Preparation: Copy Handout No. 17
Flipchart No. 16

PROCESS

- Facilitator distributes Handout No. 17: Policy Document Extracts, which contains extracts from policy documents from PAHO and other multilateral organizations. The participants are divided into groups of four (counting off so that the groups are different from those working on the Household Situations).

- Facilitator displays Flipchart No. 16 and asks participants to read the extracts and answer the following questions:

Text of Flipchart No. 16:

Task

Read the extracts and answer the following:

1) Do the selections reflect a PGA or a SGA or both?

2) Which Development Approach or combination of development approaches are reflected in the selections? Check against Handout No. 16.

Plenary discussion: Each group presents their observations one at a time, without initial comment. Ask groups to justify their answers. Ask other group members to comment on why a particular group's answer differs with theirs. The aim in this plenary discussion is to have the groups respond to each other and provide the justification for the correct answers. Facilitators adds comments only when needed.

NOTE: If insufficient time, this exercise should be conducted as a plenary discussion.

Text of Handout No. 17:

POLICY DOCUMENTS: EXTRACTS

- Investment in health and education for women produces significantly greater benefit to the society than similar investments in men because of the close correlation between the health, nutritional level and education of women and the health, educational level and productivity of future generations. These correlations are still greater when women have control over how resources are distributed within the home.

- Lack of access to credit, land, information and technology aggravates gender inequity. When women have access to credit, the effect on the well-being of the family and its members is notable. The provision of financial resources to women is related to improvements in the health levels of children.

- Women are more vulnerable than men to micronutrient deficiencies which damage health. Bad health and nutrition diminish productivity and the ability to take advantage of the gains from investments in education. Recent estimates suggest that the combined effects of only three types of deficiencies on morbidity and mortality—vitamin A, iodine and iron—could waste up to 5% of the gross domestic product, and that correcting these deficiencies would cost less than 0.3% of GDP in developing countries.

- Malnutrition of infants is related to poverty and the low educational level of mothers.

- Data from Brazil indicate that when women are given more control over resources, there is a greater impact on the anthropometric measures of their children, a greater level of nutrition in their families, and a greater proportion of the family budget devoted to the health and education of children, than when the man controls the resources.

- There is a critical connection between the provision of public health services and women's access to educational opportunities. A mother who has been taught to seek preventive care and timely treatment for her own illnesses and those of her children, particularly her daughters, will reduce expenditure for health care and in many cases will prevent premature death. Many of these services are cost effective and can be provided in primary health care centers.

■ Answers:

1. PGA : Efficiency
2. PGA : Anti-Poverty/Efficiency
3. PGA : Welfare/Anti-Poverty
4. PGA : Welfare/Anti-Poverty
5. PGA/SGA : Efficiency
6. PGA : Efficiency

MODULE 6

APPLYING THE CONCEPTS TO CASE STUDIES

MODULE 6

APPLYING THE CONCEPTS TO CASE STUDIES

OVERVIEW: MODULE SIX	
Objective	To apply the practical methodologies to case studies.
Core Message	The methodologies presented in the workshop assist in the identification and reduction of gender inequities in health.
Expected Outcome	Participants will successfully apply the concepts presented to case studies.
Methodology	Lecturette Question/Answer/Discussion Small Group work on Cases/Reportback Plenary/Facilitator Feedback
Materials	Handout No. 18: Case Study 1: Center for Integral Community Health Handout No. 19: Guide to Analyze Case Studies Handout No. 20: Worksheet: Case Study #1 Handout No. 21: Case Study 2: Improvement in Community Health Through Better Water Equality Handout No. 22: Worksheet: Case Study #2
Components	6.1 Applying the Concepts to Case Study 1 6.2 Applying the Concepts to Case Study 2
Time	6.2 90 minutes 6.3 60 minutes Total: 150 minutes
Preparation	■ Photocopy Handouts ■ Prepare flipcharts based on Handout Nos. 20 and 22

APPLYING THE CONCEPTS TO CASE STUDY #1

Method: Case Studies/Small Group Work
Plenary Reportback
Plenary/Facilitator feedback

Materials: Handout No. 18: Case Study: Center for Integral Community Health
Handout No. 19: Guide to Analyze Case Studies
Handout No. 20: Worksheet: Case Study #1

Time: 60 minutes: Introduction and Group Work
30 minutes: Plenary report/feedback
90 minutes: Total

Preparation: Ahead of time, assign participants to small working groups, providing a mix of experience, gender and personal style to ensure the best balance possible.
Write the names of each group on a flipchart.
Photocopy Handout Nos. 18, 19, & 20.
Prepare Flipcharts based on Handout No. 20.

PROCESS

- Facilitator distributes the first case study, "Center for Integral Community Health", the guidelines and the chart for facilitating the analysis and discussion of each case and explains the process, including the following points:

  - Introduce the case study that will be analyzed by all the groups and point out that we will focus on three groups in the case study, namely:
    1) The Intercommunity Coalition of Mothers (ICM)
    2) Women of childbearing age, and
    3) The Pro-Land Commission (PLC)

    Emphasizes that the first two groups are mutually exclusive.

    Explains that each working group will read the case individually bearing in mind the questions posed on the guideline. After 10 minutes the groups will discuss each question in turn and select a person to record the discussion.

  - The facilitator should prepare a flipchart based on same scheme used in Handout No. 20, and record answers groups provide during plenary feedback.

- Facilitator reads out the questions in the guide and invites clarifying questions.
- Facilitator reminds the groups they will have 60 minutes to complete the exercise. Circulates to ensure they do not spend too much time reading the case, and to ensure they understand the procedure.
- After 30 minutes, announce that they have 30 minutes left; repeat at 15 minutes and 5 minutes.

Text of Handout No. 19:

GUIDE TO ANALYZE CASE STUDY

I. PROJECT OBJECTIVES

a. What gender roles did the project target in its objectives and to what purpose?

b. What particular health needs of women and men did the project target in its objectives?

c. What development approach predominated in its objectives: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?

d. In the objectives, did it use a practical gender approach (PGA) or a strategic gender approach (SGA)?

II. IMPLEMENTATION AND IMPACT OF PROJECT

e. What gender roles did the project affect and how?

f. What particular health needs of women and men were affected and how?

g. What development approach actually predominated: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?

h. Did a practical gender approach (PGA) or a strategic gender approach (SGA) predominate in the implementation?

i. What changes occurred during the process of the project's implementation in terms of access to and control over one or more resources (material/economic, political, information/education, time, internal)? Discuss each target group in turn.

j. Referring to Labonte's Continuum of Empowerment, give an example of what elements of that continuum could have been incorporated, either in the project design or during its implementation, to respond more equitably and efficiently to the particular health needs of women and men.

- Back in plenary, each of the four groups reports back on their findings. Facilitator records answers on prepared flipchart. Asks for volunteers to go first; after their presentation, the next group volunteers until all four have been heard.

  Process:

  1) Group presenter reports the group's findings on first two or three questions (depending on number of groups);
  2) The other group members are asked to add points if they wish;
  3) Participants are invited to ask clarifying questions only;
  4) Facilitators ask clarifying questions and reserve general comments until the end, when comparisons can be made.

  This process is repeated until all groups have presented and all the questions have been answered.

- Facilitator invites any participant to comment on the content of the findings: anything that has struck them particularly, that they learned from another group, that they disagree with.

- Facilitator comments on the findings of all the groups, pointing out strengths and areas which could have been done differently for each group. Ensure that the focus has been gender.

  Time: Plenary work will take 30 minutes

Facilitator's Guide

- **Possible Responses for Case Study #1:**

  Although it is better that the participants identify them, some possible responses for the discussion in the plenary session are:

COMPONENT 6.1

PROJECT OBJECTIVES

a. What gender roles did the project target in its objectives and to what purpose?

- Women of childbearing age
  Reproductive role: improve their reproductive health and situation and the health of their children

- ICM
  Community management role: improve its ability to manage and develop a health plan

- PLC
  None

b. What particular health needs of women and men did the project target in its objectives?

- Women of childbearing age
  Need to improve the health of women and their children under age 6 through preventive and health care services.

- ICM
  None

- PLC
  None

c. What development approach predominated in its objectives: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?

- Welfare with empowerment elements

d. Did the objectives reflect a practical gender approach (PGA) or a strategic gender approach (SGA)?

- Both approaches: in addition to improving the health of women and children, it specifically proposed to train the Inter-Neighborhood Commission of Mothers to improve its ability to manage and develop a health plan.

IMPLEMENTATION AND IMPACT OF PROJECT

e. What gender roles did the project end up affecting and how?

- Women of childbearing age
  Reproductive role: it solved the problem of their sick children, but not that of their own health.

- ICM
  Community management role: it weakened its ability to negotiate.

- PLC
  Community management role: it strengthened their ability to negotiate and power.

f. What particular health needs of women and men were affected and how?

- Women of childbearing age
  Need to improve the health of their children; thus, it had an effect on women mothers because they had to invest less time and economic resources in caring for sick children. However, it had a NEGATIVE impact on the health needs of women themselves, by eliminating the focus on gynecological services in the Multi-service Center.

- ICM
  None

- PLC
  None

g. What development approach actually predominated: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?

- Welfare

h. Did a practical gender approach (PGA) or a strategic gender approach (SGA) predominate in its implementation?

- The project negatively affected the interests of the ICM because they lost power at the community management level to participate in preparation of the District Health Plan. Thus, the project did not really have an SGA because it did not balance inequity in the control of resources. Some may point out that the project's implementation was gender blind.

i. What changes occurred during the process of the project's implementation in terms of access to and control over one or more resources (material/economic, political, information/education, time)? Discuss each target group in turn.

- Women of childbearing age
  They had more access to time and material resources with regard to the health of their children. However, they remained as before with respect to access to gynecological services (material).

- ICM
  They did not have access or control of additional time to participate in the negotiations for preparation of the District Health Plan.

- PLC
  Had more access to and control of political and economic resources to achieve the necessary changes in the Integral Health Service; also, they had control of the use of their time because they could participate in the deliberations on the District Health Plan.

j. Referring to Labonte's Continuum of Empowerment, give an example of what elements of that continuum could have been incorporated, either in the project design or during its implementation, to respond more equitably and efficiently to the particular health needs of women and men.

- Needs of women and men
  Ensure greater response capacity at the Integral Health Service by including in the project budget adequate equipment for attending to greater complications. If not possible, be sure before starting the project that there is a clinic for referrals and discuss the possibility of its accepting cases from the service.

- SGA
  Start the project by strengthening the negotiating capacity of the women who comprise the ICM;

  Ensure that there is a childcare mechanism established in the community to make it easier for women from the ICM to participate in the procedures of the District Health Plan;

  After strengthening these women's ability to negotiate, prepare a women's strategy for involving male leaders from the five settlements from the outset in the discussion of the components of the Plan.

APPLYING THE CONCEPT TO CASE STUDY #2

Method: Small Group Work/Plenary Report/Feed back

Material: Handout No. 21: Case Study 2: Improvement in Community Health Through Better Water Quality
Handout No. 22: Worksheet: Case Study #2

Time: 30 minutes: Group Work
30 minutes: Plenary
60 minutes: Total

Preparation: Assign groups, changing composition from previous exercise.
Write names of groups on a flipchart.
Photocopy Handout Nos. 21 and 22
Prepare flipcharts based on Handout No. 22

PROCESS

- Facilitator asks the participants to divide up into their assigned group and read the case study "Improvement of Community Health Through Improved Water Quality" and makes reference to using the copy of Handout No. 19 which was handed out for the previous case study.
- Time for group work is 50 minutes. Follow the process for Component 6.1.
- Time for plenary session 30 minutes.
  - Possible Responses for Case Study #2:

    Although it is better that the participants identify them, some possible responses for the discussion in the plenary session are:

PROJECT OBJECTIVES

a. What gender roles did the project target in its objectives and to what purpose?

- Women
  Community management role: women were recruited to care for the latrines, learn about hygiene, water use and safe food preparation.

- Men
  Community management role: men were recruited to care for the wells and the hand pumps.

b. What particular health needs of women and men did the project target in its objectives?

- Women
  Need to improve the health of the community, particularly of women and children, by contributing to the diminishing of enteric diseases in children and skin diseases. It also sought to augment the water supply and diminish the time used to collect and prepare water for consumption.

- Men
  Needs were similar, but women stood to benefit more directly because improved access to a sufficient supply of good water would reduce the time spent on water fetching and preparation, and on the care of sick children.

c. What development approach predominated in its objectives: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?

- Welfare - it was a top-down approach where women and men were passive recipients of goods and services.

- Efficiency - it used men and, particularly women, to improve health conditions.

d. Did the objectives reflect a Practical Gender Approach (PGA) or a Strategic Gender Approach (SGA)?

- Neither because it did not assess the roles that men and women play in the community nor the way they lived their lives. It designed a project based on gender stereotypes and accentuated the roles and relationships of power of men over women.

IMPLEMENTATION AND IMPACT OF PROJECT

e. What gender roles did the project end up affecting and how?

- Women
  Reproductive role: they were better able to care for the health and wellbeing of their families because of their increased knowledge of hygiene and food safety. They also benefitted from the decrease in family illness, particularly of their children.

  Productive role: they became involved in the agricultural work needed to produce goods for market.

- Men
  Productive role: they were better able to engage in commercial transactions because their wives had extra time to devote to agricultural production.

  Community management role: men were trained in the care of the wells and the hand pumps.

f. What particular health needs of women and men were affected and how?

- Women
  The health of their children was much improved, and, although the case doesn't state this, we can surmise that the incidence of skin diseases also diminished in the community. However, the elimination of the need to fetch water may have had implications for their mental health and well-being, as this was the one moment of the day where they were able to control their time and engage in conversation with one another.

- Men
  We do not know, but we can assume that their health benefitted from the decrease in skin diseases and better hygiene.

g. What development approach actually predominated: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?

- Welfare - sees women as best vehicle through which access to others can be effective.

h. Did a practical gender approach (PGA) or a strategic gender approach (SGA) predominate in its implementation?

- The project emphasized a PGA because it tailored the intervention to help women do better what they were already doing, i.e., raising children and caring for their families, and it assigned to men those tasks that were stereotypically "masculine," i.e., maintenance of equipment (water wells and hand pumps). However, the project negatively affected gender equity as women once more became the mechanism through which health interventions are channeled so as to ensure project effectiveness. Moreover, it caused an alteration in the way in which the community, at least the women, interacted with one another, an outcome with possibly detrimental effects for women's mental health.

i. What changes occurred during the process of the project's implementation in terms of access to and control over one or more resources (material/economic, political, information/education, time and internal resources)? Discuss each target group in turn.

- Women

  They had more access to material resources with regard to the health of their children and other family members (water supply and quality water). They also had more access to information on hygiene, food preparation and the proper use of water. Their access to material resources was probably enhanced with their involvement in agricultural production. However, their access and control of their time was diminished. It is difficult to assess to what to what degree they had control over the additional material resources that came as a result of their increased involvement in agricultural production. We can surmise that the loss of access to the one group activity (water fetching and carrying) affected women's internal resources.

- Men

  They had access to information on the use and maintenance of the wells and the pumps. They were affected positively from having healthier families, and thus one might say that they had increased access to material resources (saved money on medicine and services). They also had increased access to such material resources because their wives became involved in agricultural production, which enabled the men to work more in commercial transactions. We can assume that the men had more control over time and over material resources as a result of the project, particularly over additional monetary rewards as a result of their wives' involvement in agricultural production, a task which the men used to have to do.

j. Referring to Labonte's Continuum of Empowerment, give an example of what elements of that continuum could have been incorporated, either in the project design or during its implementation, to respond more equitably and efficiently to the particular health needs of women and men.

- Needs of men and women

  Ensure that prior to the project's development, women's groups are fully involved in the description of their own activities, roles and responsibilities, to avoid "gender stereotyping" by project officers. In the case of this project, such stereotypes served to eliminate the only moment in a woman's day for respite, and made women solely responsible for tasks associated with reproductive roles (hygiene, food preparation). The way these tasks could have been distributed may have been an important opportunity to further the incorporation of men in caring and nurturing activities. In addition, it would have been important to draw upon existing community organizations, ensuring that these included women that were in touch with other women in the community. Such groups could act as an advisory group to the project to make certain that the interventions planned were acceptable to the community, for example, as in the case of the latrines. Such a group would also have been able to address women's interests in the way they wished to use their free time.

MODULE 7

APPLICATION OF GENDER ANALYSIS TO EXISTING HEALTH PROJECTS

MODULE 7

APPLICATION OF GENDER ANALYSIS TO EXISTING HEALTH PROJECTS

OVERVIEW: MODULE SEVEN

Objective	Using a PAHO document or one from the health sector in the country hosting the seminar, participants will conduct a gender diagnosis of the project, applying the analytical steps provided during the seminar, and will formulate an objective that reflects a gender perspective in health.
Core Message	Gender planning contributes to equity, efficiency and sustainability of health projects.
Expected Outcome	Participants will have successfully applied the concepts and methods presented in the seminar to an existing health project and will be able to formulate gender-sensitive recommendations on the basis of their diagnosis.
Materials	● OHT No. 3 (a/b/c): Circles from Module 3 ● OHT No. 9: Steps for a Gender Diagnosis ● Projects brought to workshop by participants for gender analysis ● Handout No. 23: Copy of OHT No. 9 ● Handout No. 24: Guidelines for Conducting a Gender Analysis for Projects
Components	7.1 Reviewing the Concepts 7.2 Project Work
Time	7.1 10 minutes 7.2 90 minutes Group Work 60 minutes Plenary Report back/Facilitator feedback Total: 160 minutes
Preparation	■ *Project/Program Document:* The participants will be invited in advance to send a copy of a project that they are involved in—design, implementation, monitoring, evaluation—to be used in the workshop in the final session. If progress reports or reviews are available, these should be sent with the document. They should be advised that this will provide them with valuable insights and constructive recommendations for strengthening the project from a gender perspective. These should ideally reach the workshop facilitators one week prior to the workshop.

OVERVIEW: MODULE SEVEN (Cont.)

Preparation (Cont.)

- In reality, some of the projects will arrive with the participants. These should be collected the first day.
- The facilitator can choose to have the whole group work on one project or chose several projects for small group work. This decision is based on whether it is a country based workshop, how diverse the participants are in terms of sector expertise, size of workshop, quality of projects.
- Each group should have a maximum of 7 participants. Groups should be selected on the basis of interest and knowledge of the particular sector.
- Groups can be preassigned or participants can voluntarily sign up for a project they would prefer to work on. The participants who brought the project should be in that group, and any others that are knowledgeable about the sector.
- Participants should be asked beforehand or at the start of the workshop to prepare a five-minute presentation on the project.
- Facilitators can assist by preparing a brief outline of the project.
- *Note: This workshop is not a place for discussions on the design of the project itself; however, the facilitators should, if possible, select projects that are well-designed. The discussion will be focusing on how to use the methodologies provided in the workshop to ensure that the gender perspective is incorporated/mainstreamed.*
- Have some extra copies of Handout No. 16 on hand for participants who may need them.

REVIEWING THE CONCEPTS

Method: Plenary Presentation

Materials: OHT No. 9: Steps for a Gender Diagnosis
Handout No. 23: Copy of OHT No. 9

Time: 10 minutes

Preparation: Copy Handout No. 23

PROCESS

- Facilitator reviews concepts and methodologies, inviting clarifying questions. OHTs No. 3 a, b, and c are presented again for review, and the facilitator summarizes:

  - In this seminar we have reviewed how biology and gender interact to protect men and women's health or conversely, place it at risk. The handout (23) will facilitate a more methodical approach to integrating a gender perspective in the design, monitoring and evaluation of health projects, programs and/or policies.

- Facilitator presents OHT No. 9.

  - All societies are characterized by a gender *division of labor*; this division is expressed in the multiple roles that women and men fulfill: productive, reproductive and community management roles. To analyze the division of labor, the following questions are posed: *who does what, how, where, when and with whom?*

  - Gender roles have *different social values* assigned to them. The gender division of labor and the assignment of value to each of these roles have important repercussions in terms of access and control. The analysis of access to and control over resources answers the questions: *who has what and who decides on what?*

  - In order to understand the critical interaction between biological differences between men and women and gender roles for designing equitable and efficient interventions in health, *data disaggregated by sex* is essential.

  - The interaction of biology and gender roles determines gender needs in health. The evaluation of the *particular needs of women and men* in the area of health is the basic tool for equitable and efficient planning. The evaluation of needs answers the question: *who needs what?*

- The analysis of gender roles, of access to and control of resources and of the particular health needs of women and men provide us with the elements that comprise a *gender diagnosis*. A gender diagnosis should be incorporated into the assessment or analysis that is usually carried out before initiating any project.

- On the basis of that diagnosis, the *objectives and expected outcomes* of a project or program are defined. To define objectives using a gender approach, two questions must be answered: *What and whose needs will be responded to, and what opportunities and obstacles are there in doing so?*

- Once needs are determined, the selection of the *practical and/or strategic gender approach* is defined through the answers given to the following questions: *How does one respond to the particular needs of women and men? What is proposed regarding access to and control of resources? Are there plans to reduce inequity in gender relations?*

■ Facilitator emphasizes further:

- The selection of a PGA or a SGA defines the degree of ownership of the project by the target group. An underlying assumption of the gender approach is that it is based on participatory development processes at all stages of project development and implementation. Participation of all the stakeholders as active participants should be, as far as possible, an integral part of a gender diagnosis. The key questions are: *who participates, in what, with whom, how, when, and to what end?*

- Participation is crucial not only in determining the strategy to be implemented, but it should be considered from the very beginning of the process of formulating programs or plans.

- The selection of a PGA or a SGA determines the dominant policy approach of the project: *welfare approach, anti-poverty approach, efficiency approach, equality or empowerment approach.*

■ Facilitator emphasizes that when initiating any project or program, these steps must be followed to incorporate a gender approach in the planning. However, these steps are not limited to the analysis and planning from a gender approach at the beginning of a project. The same steps should be used for monitoring and intermediate and final evaluations and, if necessary, the resulting redefinitions of objectives and implementation strategies.

Handout No. 23/OHT No. 9

STEPS FOR CONDUCTING A GENDER DIAGNOSIS

GENDER ROLES ANALYSIS	→	Who does what? How? Where? When? With whom?
ACCESS and CONTROL	→	Who has what? Who decides over what?
MEN'S and WOMEN'S NEEDS	→	What are the differences between men's and women's health profiles? Who needs what?
		Formulation of Objectives What needs will be met? Whose needs will be met? What opportunities exist to meet them? What constraints hinder meeting them?
POLICY APPROACHES (Welfare, Anti-Poverty, Efficiency, Equality, Empowerment	→	PGA? SGA? How are men's and women's needs met? Who has access to what? Who has control over what? Is reduction of gender inequity a goal? Who participates in what, with whom, How, where, when and to what end?

PARTICIPATORY

PARTICIPATION

PROJECT WORK

Method: Group Work
Plenary Reportback/Facilitator Feedback

Materials: Project (s)
Handout No. 24: Guidelines for Project Analysis

Time: 90 minutes: Group Work
60 minutes: Group Reportback/Facilitator Feedback
150 minutes: Total

Preparation: Copy Handout No. 24
Photocopy project(s)

PROCESS

- Facilitator introduces session:
  - Briefly outlines each project to be used in group work explaining that it does not necessarily include a gender approach. The task will be to make constructive recommendations to strengthen the project through incorporating a gender perspective. Handout Guidelines.*
  - Thank the participants for being willing to have their project used in this session.

* Facilitator may wish to add additions questions or modify those in Handout No. 24.

Text of Handout No. 24

GUIDELINES FOR PROJECT/PROGRAM ANALYSIS

I. Conduct the gender diagnosis, answering the following questions:

- What gender roles did the project target in its objectives and to what purpose?
- What particular health needs of women and men were affected and how?
- What development approach predominates in its objectives: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?
- Do the objectives reflect a practical gender approach (PGA) or a strategic gender approach (SGA) or both?
- Are any assumptions based on stereotypes evident in the project?

II. Identify the information that you would need to carry out an in-depth gender diagnosis.

III. Reformulate one of the project objectives and its indicators so that they reflect a gender approach.

IV. Develop a strategy to put into operation the reformulated objective identifying opportunities and/or obstacles in achieving the objective.

- Facilitator explains the group task: Guidelines will be handed out for each group to work with when analyzing and revising the project/program.
- Each group should select a rapporteur. Their findings should be recorded on the flipchart.
- Asks for clarifying questions
- GROUPS: The groups should be listed on a flipchart. Ensure that each participant knows which group they will be working in.
- Informs them that they have one and a half hours. They should assign a time keeper to ensure that all points are covered. Announcements of time still left will be made at intervals.

■ Back in plenary, each of the four group reports back on their findings and displays their flipchart. Facilitator asks for volunteers to go first; after their presentation, the next group volunteers until all four have been heard.

Process: 1) Group presentor reports the group's findings; 2) The other group members are asked to add if they wish; 3) Participants are invited to ask clarifying questions only; 4) Facilitator asks clarifying questions; 5) Facilitator invites the plenary to comment on the presentation, asking further questions, providing insights, making recommendations; 6) Facilitator then does the same and highlights positive aspects of the report while adding constructive input.

■ This process is repeated until all four groups have presented.

WORKSHOP EVALUATION

PROCESS

- Facilitator emphasizes importance of evaluations. These help the constant process of revision and redesign of the workshop, and so their open opinions and recommendations are highly valued and future workshop participants stand to benefit. These are taken seriously by the workshop organizers and facilitators. Names are not expected on the evaluation sheets.

  Distribute workshop evaluation forms. Allow 20 minutes.

- When all forms have been turned in, conduct a brief verbal evaluation, asking participants what was most useful, least useful; any particular comments they would like to make in general? In particular? Allow ten minutes.

- Facilitator thanks the participants. Mentions any learning and deeper understanding he/she experienced in the process of the workshop. Specific instances are best.

WORKSHOP EVALUATION **20 minutes**

Please assess each of the following components from 1 to 5, with 1 representing the lowest level of satisfaction and 5 the highest. Circle one:

1. Extent to which elements for gender approach were learned:

   1 2 3 4 5

2. Usefulness of instruments presented:

   1 2 3 4 5

3. Usefulness of the group exercises:

   1 2 3 4 5

4. Methodologies used to impart concepts:

   1 2 3 4 5

WORKSHOP EVALUATION (Cont.)

5. Facilitator(s)' handling of the subject:

   1 2 3 4 5

6. Mark with an "X" your evaluation of the length of the workshop:

   Too long

   Too short

   Just right

Please answer the following questions:

1. Which modules were most useful?

_____

_____

_____

2. Are there some modules that you would eliminate?

_____

_____

_____

_____

_____

3. Are there some modules that need to be reformulated and what recommendations do you have for this?

_____

_____

_____

_____

4. Do you think that the gender approach is appropriate for your specific work?

_____

_____

_____

_____

5. Do you foresee limitations or great difficulty in achieving its inclusion?

_____

_____

_____

_____

6. What strategy and what concrete activities do you suggest for achieving the inclusion of a gender approach in your daily work?

_____

_____

_____

_____

_____

7. How could the Program on Women, Health and Development support you in achieving its inclusion?

_____

_____

_____

_____

8. Would you recommend participation in this workshop to a colleague? Why?

_____

_____

_____

_____

9. Other observations

_____

_____

_____

_____

_____

_____

THANK YOU VERY MUCH!!!

It has truly been a pleasure to move forward with you
in building this new way of looking at health and human development.

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NOTE: We have not provided extensive bibliographical references on the subject of gender, health and development. These references are available through the Regional Information System on Women, Health and Development (SIMUS) database which uses the MICROISIS system (Version 3.07) developed by UNESCO and updated by the Latin American and Caribbean Center on Health Sciences Information (BIREME/PAHO). Information regarding gender, health and development is available upon request to the Program on Women, Health and Development (HDW) at PAHO. Request may be made via mail, telephone, fax or electronic mail.

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SAMPLE AGENDA

Gender, Health and Development Workshop

■ **DAY 1**

8:30 Introduction

- Introduction to Gender, Health and Development
- Participant Introductions
- Workshop Objectives and Expected Outcomes

9:30 Module 1: Sex and Gender

- To Be a Man or a Woman: What does that mean?
- Definitions of Sex and Gender

10:00 Module 2: Gender Roles, Access to and Control of Resources and Household Stereotypes

- Daily Life and Gender Roles: The Work that Women and Men Do - Small Group Work

10:30 Break

10:45 Module 2: Continuation

- Feedback from Groups
- Access and Control of Resources
- Household Stereotypes
- Health Crisis

12:30 Lunch

14:00 Module 3: The Origin of Health Needs

- Differences in Health Profiles between Women and Men
- An Example of the Influence of Sex and Gender in the Health Profiles of Men and Women

15:00 Break

15:15 Module 4: Practical and Strategic Gender Approaches

- The Concepts of Practical and Strategic Gender Approaches
- Empowerment Process
- Health Interventions

17:00 End of Day 1

FLIPCHARTS

COMPONENT A.2 **F1**

INTRODUCTION

- Your Name/Your Work
- When you were a child, what did you want to be as an adult?
- If earning a living was not an issue, what interests/activities would you pursue?
- One expectation

COMPONENT A.3 **F2**

WORKSHOP OBJECTIVES

- To examine the concept of gender
- To discuss the gender approach and its relevance to Health
- To acquire skills and methodologies to operationalize Gender Approach

COMPONENT A.3 **F3**

EXPECTED OUTCOME

- Understand: Gender approach essential for health planning and sustainable human development

COMPONENT 1.1

F4

WOMEN	MEN

CHARACTERISTICS OF GENDER

- Relational: Socially Constructed
- Hierarchical: Power Relations
- Changes: Changes over time
- Context: Varies with ethnicity, class, culture, etc.
- Institutional: Systemic

DEFINITIONS OF ROLES

Productive:
Work done by both men and women for payment in cash or kind

Reproductive:
Childbearing/rearing responsibilities and domestic tasks

Community Management:
Community activities that are voluntary and unpaid
which contribute to its welfare and organization

COMPONENT 2.1 F7a

PRODUCTIVE ROLE

COMPONENT 2.1 F7b

REPRODUCTIVE ROLE

COMPONENT 2.1 F7c

COMMUNITY MANAGEMENT ROLE

DEFINITIONS: ACCESS AND CONTROL

ACCESS
is the ability to USE a resource

CONTROL
is the ability to DEFINE and make binding decisions about the use of a resource

MATERIAL/ECONOMIC RESOURCES

- work
- credit
- money
- transportation
- equipment
- food
- child care facilities
- facilities to carry out domestic tasks
- social security, health insurance
- housing
- health and supply services

COMPONENT 2.2 **F9b**

POLITICAL RESOURCES

- position of leadership and mobilization of the actors in decision-making positions
- opportunities for communication, negotiation and consensus-building

COMPONENT 2.2 **F9c**

INFORMATION/EDUCATION RESOURCES

- inputs to be able to make decisions to modify or change a situation, condition or problem
- formal education
- informal education
- non-formal education
- opportunities to exchange information and opinions

COMPONENT 2.2 **F9d**

TIME RESOURCES

- hours of the day available for discretionary use
- flexible paid work hours

COMPONENT A.2 **F9e**

INTERNAL RESOURCES

- self-esteem
- self-confidence
- the ability to express one's own interests

THREE QUESTIONS FOR ANALYSIS OF GENDER

1. Who does what, when, where and with whom? (ROLES)
2. Who uses what? (ACCESS)
3. Who decides who uses, what is used and how? (CONTROL)

TASK FOR HEALTH CRISIS CASE STUDIES

- How would the crisis affect the division of roles and responsibilities for the men and women over the short or medium term?
- How does the crisis affect women and men's access to and control over resources within the household?
- What household changes could ensure that the responsibility for dealing with this crisis situation does not fall primarily on one person?

GROUP TASK

1) Identify situations in which SOCIAL GENDER CONSTRUCTS INCREASE THE RISK OF CONTRACTING HIV FOR ONE SEX OR THE OTHER.

2) Include concrete experiences/observations of own societies/cultures/lives that provide evidence for 1).

COMPONENT 4.2

F13

DEFINITION OF EMPOWERMENT

A process whereby individuals develop strength and skills to act towards a personal or collective good

COMPONENT 4.2

F14

FOUR MECHANISMS OF EMPOWERMENT

INTERPERSONAL ENCOUNTERS

- Facilitate self-validation through dialogue

SUPPORT GROUPS

- Facilitate opportunities to overcome isolation ("not only sufferer")

COMMUNITY ORGANIZATION

- Facilitate organization around common problems that go beyond personal interests

POLITICAL ACTION COALITIONS

- Facilitate social movements that go beyond limitations of community organization to achieve political/social change

GROUP TASK: HEALTH INTERVENTIONS

In your groups, read the General Findings pertaining to your topic and the issues to think about.

What practical gender approach (PGA) do you suggest for responding to the particular health needs of women and/or men?

Taking into account the different mechanisms of the empowerment process, how could the intervention selected above incorporate a strategic gender (SGA) approach so that it enhances the possibility of gender equity in health?

GROUP TASK

Read the extracts and answer the following:

1) Do the selections reflect a PGA or a SGA or both?

2) Which Development Approach or combination of development approaches are reflected in the selections? Check against Handout No. 16.

HANDOUTS

COMPONENT A.3 H1

WORKSHOP OBJECTIVES

- To examine the difference between sex and gender.
- To discuss the gender approach and its particular relevance to the areas of health and human development.
- To acquire skills and methodologies to enable participants to ensure that their work in health and development is grounded in a gender approach.

COMPONENT A.3 H2

EXPECTED OUTCOME

- Participants understand that the gender approach is essential for health planning and sustainable human development.

DEFINITIONS OF SEX AND GENDER

"Sex" refers to the biological differences between men and women.

"Gender" refers to roles that men and women play and the relations that arise out of these roles. They are socially constructed, not physically determined.

SIX CASE STUDIES

HOUSEHOLD / FAMILY SITUATION A

George and Hazel have lived together for a number of years. George, 52 years old, is a taxi driver and works the night shift; Hazel, 48 years old, works from Monday to Saturday in a factory. In order to increase household income, Hazel also makes yuca bread which she takes to work each morning to sell at lunch time. George's 75 year old mother, Ernestine, lives with them. Hazel has an unmarried son, Vincent, age 28, who lives with them and works in the informal sector selling music cassettes; George has a daughter, Alicia, aged 25, who is married, has small children and lives in the neighborhood.

HOUSEHOLD / FAMILY SITUATION B

Jane is the manager of a private company. She is Chairperson of the Committee of Women Managers in the capital. Her two children live with her; the oldest, Richard, is an 18-year old boy and the younger child, Rachel, is an 11 year old girl. She employs a domestic worker, Teresa, who works Monday to Saturday, from 8 in the morning to 7 at night.

HOUSEHOLD / FAMILY SITUATION C

Sam and Catherine Stevens live with their three children: a 12 year old girl, Marisa, and two boys, Frank and Tom, aged 9 and 7. Catherine is a graphic designer for an advertising company, Sam is a professor in the school of public health. Two nights per week and every other Saturday, Catherine goes to help her elderly parents who, because of their advanced age, are no longer able to do the shopping, clean the house, cook, etc. Sam participates actively in the Public Health Association.

Continued

SIX CASE STUDIES (CONT.)

HOUSEHOLD / FAMILY SITUATION D

Elmer and May, aged 30 and 22, live with their four children in a rural community. The oldest daughter, Jean, is 8 years old, followed by two boys, Jim and Kevin, who are 6 and 3 years, and a 1 year old girl who is being breast-fed. The family lives on subsistence agricultural production which allows them to survive. Elmer and May supplement the family income, Elmer by harvesting produce and May by weaving fine baskets and selling them in the town market one hour away by foot; in addition, May is a health promoter in their community.

HOUSEHOLD / FAMILY SITUATION E

Teresa Martinez, age 38, lives in a poor urban community which has been built on the shores of a river inlet. During the day, she works in a canning factory. With her live her mother, Doña Zaida, age 54, who runs a sewing shop from home; her two sons, Raul, age 17, who is finishing high school and Conchita, age 14, who is also in school. Two years ago, Teresa's sister, Josefina, age 28, came to live with her. Josefina brought along her 10 year old son; Josefina works in the center of town as a street vendor, selling hot meals to passers-by. Teresa's husband, Jorge, is a migrant worker in the banana industry; he returns every two weeks on the weekends.

HOUSEHOLD / FAMILY SITUATION F

John Green is 45 and is the owner of a small dry goods store in a major city in the interior of the country. His wife, Frances, works in a hairdresser shop. Her father Ambrose, lives with them. He is 80 years old. John and Frances have two grown sons ages 27 and 22, respectively. The youngest, Stephen, helps his father in the store. The eldest has married and moved to the capital of the country.

24 HOUR DAY CHART		
HOUR	**WOMEN**	**MEN**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
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23		
24		

COMPONENT 2.1 H6

DEFINITIONS: GENDER ROLES

PRODUCTIVE:
Comprises the work done by both women and men for payment in cash or kind.

REPRODUCTIVE:
Comprises the childbearing/rearing responsibilities and domestic tasks required to guarantee the maintenance and well-being of household members. It includes not only biological reproduction but also the care and maintenance of the persons who comprise the household.

COMMUNITY MANAGEMENT ROLE:
Comprises activities undertaken at the community level to contribute to the development or political organization of the community. It is usually voluntary, unpaid work.

COMPONENT 2.2 H7

DEFINITIONS: ACCESS AND CONTROL

ACCESS
is the ability to USE a resource.

CONTROL
is the ability to DEFINE and make binding decisions about the use of a resource.

FIVE TYPES OF RESOURCES

ECONOMIC RESOURCES

- work
- credit
- money
- etc.

POLITICAL RESOURCES

- position of leadership and mobilization of the actors in decision-making positions
- etc.

INFORMATION / EDUCATION

- inputs to be able to make decisions to modify or change a situation, condition or problem
- formal education
- etc.

TIME

- ours of the day available for discretionary use
- flexible paid work hours

INTERNAL RESOURCES

- self-esteem
- self-confidence
- the ability to express one's own interests

STEREOTYPES 1, 2 and 3

CASE STUDIES: SCENARIO 2

Situation A, Part 2:

Ernestine, George's mother, fractures her hip. She has an emergency operation. After staying in the hospital, she comes home to convalesce.

Situation B, Part 2:

Richard, the oldest child has a motorcycle accident, needs rehabilitative therapy and rest for two months. Doctors are not sure he will recover completely.

Situation C, Part 2:

Sam is diagnosed with terminal lung cancer.

Situation D, Part 2:

May wakes up with vaginal bleeding and strong pain; she is hospitalized for an obstetric emergency due to spontaneous abortion. The hospital is an hour away by foot from the town where she lives.

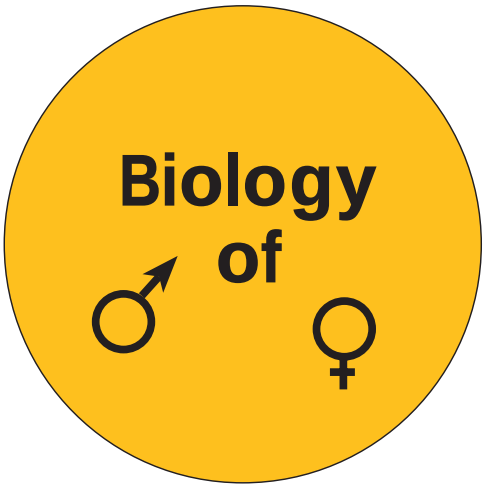
Situation E, Part 2:

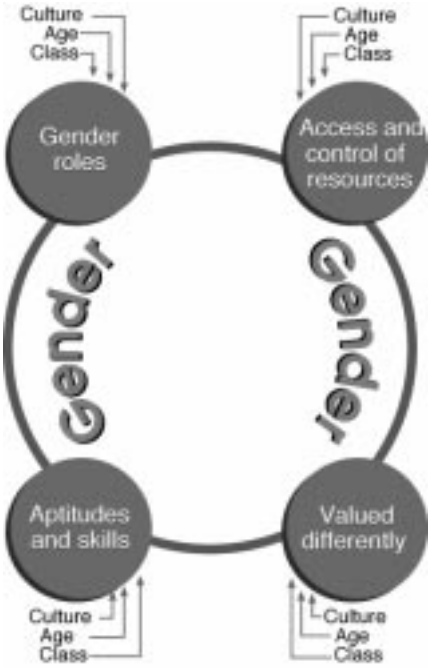
Jorge has an accident at work that cuts off his left hand. He is dismissed with minimal compensation and sent home.

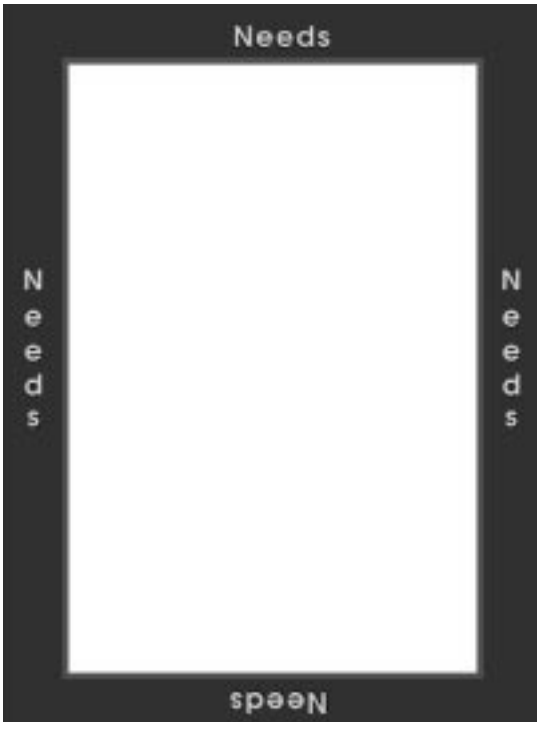
Situation F, Part 2:

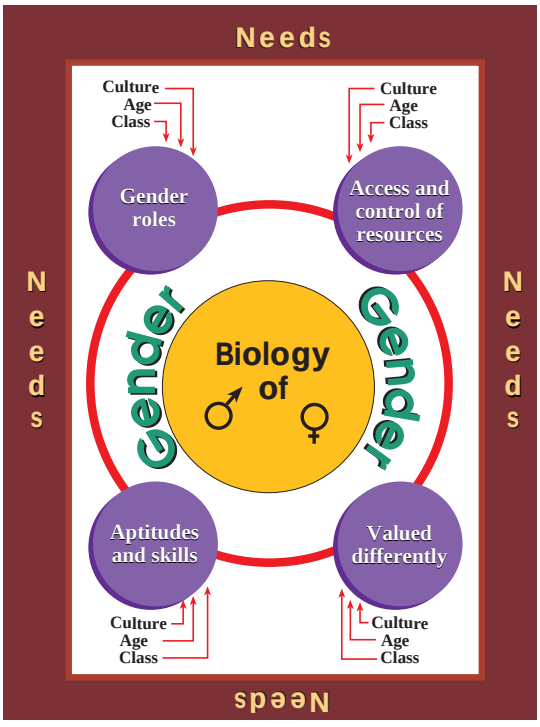
Frances' rheumatoid arthritis in her hands becomes so severe that she can no longer work as a hairdresser.

SOCIAL/BIOLOGICAL









ORIGIN OF MALE/FEMALE DIFFERENCES IN HEALTH PROFILES

BIOLOGICAL DIFFERENCES

a) Anatomical/physiological;
b) Anatomical, Physiological and Genetic susceptibilities;
c) Anatomical, Physiological and Genetic resistances/immunities

SOCIAL DIFFERENCES

a) Roles and responsibilities;
b) Access and control;
c) Cultural influences and expectations;
d) Subjective identity.

HEALTH SITUATIONS, CONDITIONS AND/OR PROBLEMS

1. Sex Specific;
2. Higher prevalence in one or other sex;
3. Different characteristics for men and women;
4. Generate different response by individuals/family/institutions depending on whether the person is male or female

PRACTICAL AND STRATEGIC GENDER APPROACHES

A. PRACTICAL GENDER APPROACH

- Responds to short-term needs.
- Responds to needs that are usually easily identifiable by users and suppliers.
- Responds to biological requirements and specific health conditions.
- Gendered health needs met through provision of health goods and services.
- Tends to involve women and men as subjects of intervention.
- Can improve the health condition of women and men through the access to resources.
- Usually does not change gender roles and relations.

B. STRATEGIC GENDER APPROACH

- Tends to be a long-term strategy, as an integral part of sustainable human development.
- Responds to needs not always easily identifiable by people.
- Targets inequities between women and men in responsibilities and power relationships.
- Needs identified through empowerment processes: the creation of awareness, increased self-esteem, education, strengthening organizations, political mobilization, etc.
- Tends to involve people as active subjects or empowers them for this.
- Can improve the position of women by increasing their control over resources.
- Improves the balance of power between men and women in the use of health resources, through control over internal and external factors that affect the ability to protect health.

DEFINITION OF THE EMPOWERMENT PROCESS

A process whereby individuals develop strength and skills to act towards a personal or collective good

MECHANISMS OF THE EMPOWERMENT PROCESS

INTERPERSONAL ENCOUNTERS

- Facilitate self-validation through dialogue

SUPPORT GROUPS

- Facilitate opportunities to overcome isolation ("not only sufferer")

COMMUNITY ORGANIZATION

- Facilitate organization around common problems that go beyond personal interests

POLITICAL ACTION COALITIONS

- Facilitate social movements that go beyond limitations of community organization to achieve political/social change

CONTINUUM OF EMPOWERMENT
Adapted from Ronald Labonte

Empowerment. contrary to popular thinking, does not emanate from the feminist movement. Moreover, it is not a new concept in public health, since it has been utilized a great deal in prevention and health promotion. It involves a process within individuals through which they develop the strengths and the skills that allow them to act toward a personal or collective good, either to improve their health in particular or to improve their quality of life (education, credit, work, etc.) in general.

A concept that facilitates the comprehension and implementation of strategic gender approaches is the "Empowerment Continuum" that comes from the health promotion field and was suggested by the Canadian, Ronald Labonte. Labonte utilizes this continuum to refer to the transformative process, not only in women but men, as well as in social classes, whereby the health sector's power over the population is turned into a new relationship of "joint power" shared by both.

Labonte defines Empowerment as: A process whereby individuals develop strength and skills to act toward a personal or collective good.

Labonte establishes different moments in the process of reaching this transformation or empowerment. We have adapted this author's suggestions and divide Labonte's continuum into Four Empowerment Mechanisms:

- **i)** interpersonal encounters;
- **ii)** support groups;
- **iii)** community organization; and,
- **iv)** political action coalitions.

These mechanisms are located along an "Empowerment Continuum," a concept that helps to clarify the use of the multifaceted concept of the strategic gender approach in health. The empowerment process is not a linear process, as we will see later. This continuum is useful in helping us to better understand how our interventions in health can facilitate or impede the empowerment of people.

In the specific case of gender, we can distinguish between men's and women's abilities to improve their health situation through a practical gender approach that makes the necessary resources more accessible to them; and, one which uses a strategic gender approach, which, in addition to responding to a concrete felt health condition or problem, includes elements that move towards greater equity in gender relations by enhancing the degree of control over needed resources to protect health. Increased access to resources is defined by many women as a form of empowerment. But, a clear distinction must be made between people's access to and control over resources; these are crucial concepts in the definition of empowerment.

Continued

LABONTE'S EMPOWERMENT CONTINUUM (CONT.)

The four empowerment mechanisms through which health systems and services can initiate or strengthen a practical and strategic gender approach are:

a. *Interpersonal Encounters:*
Can occur at the level of direct service, where health workers interact directly with users.

Labonte notes that the two pillars that allow services to be empowering are:

I. That they be offered in a supportive, non-controlling manner;
II. That they are not the limit of the services and resources offered by the agency.

This type of support respects the autonomy of the individual and seeks to understand the psychosocial and socio-environmental contexts of the problems. The health professional-user relationship is a horizontal one in which dialogue between them enhances a joint search for a solution to a health problem. Such a climate moves constantly towards a greater capacity by the individual to act upon both the symptoms and the roots of his/her distress. The user's relationship with services for managing a health problem at the individual level can facilitate personal empowerment.

e.g., Domestic Violence: A positive response from the health service can promote the development of personal empowerment in a woman as she develops a greater level of self-respect and progresses from a passive victim to an active subject. However, according to Labonte, individual care and crisis management does not have an impact on the structural problem of society's tolerance for violence against women.

b. *Support Groups:*
Personal empowerment requires opportunities for individuals to overcome their isolation and the "learned helplessness" it creates.

This, according to Labonte, can be accomplished through "group work" in which the individual recognizes that he/she is not the only one suffering from the problem and that, as a result, problems, diseases, etc. are not uniquely about themselves. Group work helps men and woman see their own experiences within a social context. However, the author points out that these groups, although very important for generating empowerment processes, can remain isolated from various forms of action and political organization designed to solve structural problems.

e.g., Domestic Violence: Self-help groups formed by abused women are an important source for promoting self-esteem and personal empowerment, but do not offer sufficient inputs to modify the structural conditions that tolerate violence.

c. *Community Organization:*
Support groups prompt people to organize around problems or situations that are specific to them.
Community organization, on the other hand, involves the process of organizing people around problems or sit-

Continued

LABONTE'S EMPOWERMENT CONTINUUM (CONT.)

uations that go beyond the particular interests of those involved. Support groups allay the particular and specific suffering of each of their members; community organizations try to confront the causes of such suffering. Both types of organization are necessary for generating processes of individual and collective change.

Community organization often involves conflict with other interest groups. According to Labonte, conflict, as the predecessor to fruitful negotiation, is a fundamental ingredient for achieving participatory democracy. However, community organization can remain local and parochial without having any effect on the control of resources at the macro level.

e.g., Domestic Violence: Recent decades have seen the emergence of non-governmental community organizations of activist women, offering refuge and comprehensive care to abused women (legal, psychological and physical support), in addition to sensitizing and building awareness of public opinion about the problem.

d. *Political Action Coalitions:*

The formation of coalitions for political action provides elements for surpassing the limitations of community organizations.

The actions of such coalitions are generally directed toward higher levels of governmental decision-making, and they are called coalitions because action is carried out by a number of groups that unite to exert pressure for achieving a political change or a social reform.

Political Action Coalitions use advocacy as a means to achieve their goal.

Labonte defines advocacy as "taking a position on an issue," in this case, to initiate actions in a deliberate attempt to influence public policy choices. He notes that there are different ways in which health professionals and their agencies can support political action coalitions:

i) By being a resource to a process, providing information and advising groups on bureaucratic structures and their functions.

ii) By legitimizing the health concerns of the coalitions. This doesn't mean that the health agency takes the same position on the issue as the coalition, but it does involve taking a position on the health implications of health issues.

iii) By health professionals themselves taking positions on health issues. An organized, political voice of caring professionals may be crucial in moving towards more equitable and sustainable forms of gender sensitive social organization.

e.g., Domestic Violence: The health sector can legitimize the concerns of women's groups and acknowledge in policy statements that violence against women is a public health issue of growing severity. This way, it is easier for women's groups and other human rights groups to get Domestic Violence "on the agenda" of public and private sector decision-making fora. A case in point is the legitimacy that many governments have accorded to the issues raised by women's NGOs, illustrated by the growing number of NGOs present at intergovernmental fora.

PROMOTING BREAST-FEEDING[1]

General Findings:

1. Scientific evidence and research have demonstrated the benefits of breast-feeding for child survival, health and nutrition, maternal health, and child-spacing. Breast-feeding currently saves 6 million infant lives each year by preventing diarrhea and acute respiratory infections alone, is responsible for 1/4-1/3 of the observed fertility suppression, and can provide high-quality nutrition at a fraction of the cost of high-risk substitutes.

2. WHO/UNICEF recommend that to ensure optimal maternal/child health and nutrition, the aim should be to enable all women to breast-feed their infants exclusively from birth for at least the first four months of life, and preferably for six months; and to continue breast-feeding, with the addition of adequate complementary foods, for up to two years and beyond.

3. In Latin America and the Caribbean, urban infants are not breast-fed as long as rural infants, and there is a rapid decline during the first three months in both groups. At 12 months of age, nearly half of the rural infants are still being breast-fed, but only 16% of urban infants apparently receive breast milk at this age.

4. Most studies on the subject show that breast-feeding decreases the case-fatality rate in children. In a case-control study in Brazil (Victoria et al., 1987), infants who received no breast milk were 14 times as likely to die of diarrhea as exclusively breast-fed infants.

5. The extent to which hospital personnel and hospital routines foster or discourage breast-feeding practices among new mothers is one of the principal determinants of the rate of initiation of breast-feeding (Winikoff & Baer, 1980; Winikoff & Castle, 1989). Providers should have received adequate training in the practical aspects of lactation management and understand the needs of women who are breast-feeding.

6. The great majority of women in Latin America and the Caribbean have breast-fed their children. However, the recommended practice of exclusive breast-feeding during the first four to six months is rare. In almost all countries the early introduction of liquids such as water, teas, juices and cow's milk is prevalent. For example, in Lima, 80% of children have received water before one month of age (Altobelli, 1991, Brown et al., 1989).

7. Women have positive attitudes towards breast-feeding in the majority of countries but supplement with other liquids almost immediately. Some authors indicate that this supplementing is due to a lack of motivation on the part of the mother to breast-feed, which also is a socially acceptable reason for the introduction of early weaning. However, one of the main reasons women give for supplementing breast milk with other liquids is their perception of not having enough breast milk to feed their children.

1 Sources: 1) Lactancia Materna en América Latina y el Caribe, Programa de Nutrición de la División de Promoción y Protección de la Salud, Organization Panamericana de la Salud; 2) Breast-feeding: The Technical Basis and Recommendations for Action, World Health Organization.

Continued

PROMOTING BREAST-FEEDING (CONT.)

8. Data appear to show that employment outside the home does not influence the initiation or the continuation of breast-feeding. In many countries the rate of initiation and the duration of breast-feeding among women who work in the formal labor force is not significantly different from that of women who remain at home. Nevertheless, whether paid and working, or unpaid and working, all women have multiple roles which they often perform simultaneously. These multiple roles must be understood in seeking an explanation as to why women do not breast-feed exclusively and on demand for the four to six recommended months.

9. Mother support groups (MSGs) provide individual counselling, information, support and group discussions to enable women to practice breast-feeding and child care well. MSGs attempt to fill the void for a mother when breast-feeding is not the cultural norm and when she lacks family and peer support.

10. The promotion of breast-feeding has been framed as a health issue of importance to the infant and a moral imperative for the mother. However, an understanding of the obstacles women face in breast-feeding exclusively for four to six months must be grounded in the realities of their daily lives, including how decisions are made at the household and couple level. Breast-feeding is not only a "women's issue" but a social issue where other responsible parties include family members, particularly male partners, the social sectors, including education and health, and employers and policy makers.

Issues to Think About

1. Legislation that has been enacted in some countries to ensure that employers uphold women's right to breast-feed have backfired, and in some cases employers are reluctant to hire young married women.

2. WHO and UNICEF recommend that breast-feeding be continued beyond 6 months until two years of age, with the introduction of adequate complementary foods. How feasible is this in the light of gender roles and responsibilities?

3. There is little known about men's attitudes to breast-feeding and their view of the importance of this practice for the health of the child. Why is an understanding of male attitudes important to promoting breast-feeding? What might you expect to find (in attitudes as well as support practices to the lactating wife) in men in general in Latin America and the Caribbean?

4. Why would some women's groups take issue with the way breast-feeding traditionally has been promoted?

5. How might the emphasis society places on slimness and sexual attractiveness for women influence women's decisions as to whether or not to breast-feed?

DETECTION AND CONTROL OF TUBERCULOSIS[1]

General Findings:

1. In developing countries, men and women have similar TB notification rates until adolescence, after which males have higher notification rates. Some reasons for this that have been postulated are:

a. Women may be less susceptible to TB infection during and after adolescence because hormonally mediated immunological differences protect them.

b. Women may exhibit lower delayed type hypersensitivity (DTH) responses than males; males and females may have similar prevalence of infection but the degree of skin reaction in infected women is not large enough to be interpreted as a positive test during and after adolescence (this lower DTH reaction in women has been substantiated). It is not clear why older men have a higher risk of progression from infection to disease in comparison to women of older ages. Cellular immunity may diminish more quickly in men than in women and more men smoke and drink alcohol than women, which can weaken their immune system.

2. Women between the ages of 15 and 40 are almost twice as likely to progress from TB infection to TB disease than men of the same age, and men are more likely to progress from infection to disease after age 40. One of the possible reasons for women's rapid progression during reproductive years may be due to the stress of pregnancy. Some studies show that the risk of progression of infection to disease in women is particularly acute during post partum periods for women. A series of factors may account for this, including rapid hormonal changes, post partum descent of the diaphragm and reexpansion of the lungs, nutritional strain during lactation and insufficient sleep due to the demands of the new child.

3. Women have greater TB case fatality and mortality than men up until age 30. Some studies posit that this may be a consequence of decreased immune and nutritional status that may or may not be a result of complications during pregnancy. There may also be poorer levels of care provision for women, or women may arrive at the health services in more advanced stages of the disease. A study in Bolivia showed that the delay from the onset of symptoms to diagnosis was more than 6 months in the majority of women compared to 1 to 6 months in the majority of men. This diagnostic delay may account for some of the increased case fatality and mortality rates observed in women.

4. Passive vs. active case finding2: men have higher notification rates than women at all ages through passive case finding. Greater numbers of infected women are found than infected men through active case finding. One rason for this may be that women going to health service for pre-natal or post-natal care are not being diagnosed for TB. Additionally, women may not seek care, despite their symptoms. Because men are more involved in the "public" sphere (military duty, formal employment), they are more likely to be screened for TB, whereas women who are more likely to be involved in domestic activities are not candidates for such screening.

1 Sources: Scientific publications based on results of research from 1966 to 1995 which describe relationship between sex, gender and the epidemiology of tuberculosis. We wish to thank PAHO's Regional Program on Communicable Diseases for this material.

2 Passive case finding refers to patients presenting to the health services of their own accord, whereas active case finding refers to random sampling conducted in a population to screen for TB, or to an entire population being screened for TB.

Continued

DETECTION AND CONTROL OF TUBERCULOSIS (CONT.)

5. HIV is strongly associated with TB and this may have a particularly severe impact on young women in developing countries because they are at increased risk for HIV infection at a time when they also appear to be at increased risk for progression to TB. Studies have found that the odds ratio for HIV infection in smear-positive cases for TB is significantly higher in females than males in the 15-34 year age group.

6. The impact of TB on family members is acute. As primary care givers of male family members that are infected, women are exposed to increased risk. While a woman takes care of others when they are ill, when she herself becomes sick there often is little support for her.

7. Worldwide, more disability adjusted life years (DALY) are lost due to TB than to HIV, other STDs or malaria. This burden must be viewed in the light of the added possibility of under-reporting in women.

Issues to Think About:

1. Why might the notification of infection in males during and after adolescence be higher than in females?

2. Why would there be such differences between men and women with respect to active vs. passive case finding? What difference might there be between men and women in terms of access (geographical, economic, cultural, etc.) to health services and, in particular, to TB diagnostic health services?

3. Why would women of reproductive age progress more rapidly from infection to disease than men in the same age cohort? Why would this reverse after 40 years of age?

4. Why would the case of fatality rates for women be greater than for males until age 30?

DESIGN OF COMMUNITY BASED INTERVENTION FOR PROMOTION OF MENTAL HEALTH OF ELDERLY[1]

General Findings:

1. Over the next three decades, the percent growth in the older population of Latin America will range from 25% in Uruguay to 282% in Costa Rica. The growth rate of the oldest old (persons 85 years and older) is higher than for all other ages in Latin America and the Caribbean.

2. Women live longer, on average, than do men.

3. Education in early life has a major effect on the well-being of the elderly. Illiteracy is almost always higher in older women than in older men.

4. In surveys of elderly persons living in communities, rates for dementia2 are much higher in those with little education.

5. Societies have varied reactions to dementia in aging. Some societies are more tolerant than others, which can regard dementia as pathological.

6. Mental health problems can relate to lack of food. The World Bank estimates that 780 million people of all ages worldwide are energy deficient. The elderly, particularly women, are disproportionately poor and therefore more likely than the general population to be malnourished. Lack of food can lead to confusion and forgetfulness.

7. Studies show that the elderly can avoid some mental health problems if they stay active in society. Social changes associated with industrialization often isolate the elderly from their previous roles and increase dependency, resulting in loss of dignity, self-respect and weakening of filial support networks.

8. The burden of caring for the elderly falls predominantly on their children, mainly, their daughters.

9. There is a high prevalence of multiple coexisting physical conditions with age: incontinence, hip fracture, sensory loss. These influence mental health through the loss of self-esteem and independence. These conditions are more prevalent among elderly women than elderly men.

Issues to Think About:

1. Do elderly men and women have sex-specific biological needs that are derived from different immunological, genetic or physiological differences? Could this be associated with women's higher incidence of chronic diseases and diseases such as urinary incontinence, diabetes, hypertension, etc.? How might these differences have an impact in the kind of information provided to health care workers and family members caring for the elderly and the elderly men and women themselves?

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1 Source: World Mental Health: Problems and Priorities in Low-Income Countries. Dejarlais, R.; Eisenberg, L.; Good, B.; Kleinman, A. New York: Oxford University Press, 1995.

2 Gradual loss of cognitive function resulting from diseases that appear late in life.

Continued

DESIGN OF COMMUNITY BASED INTERVENTION FOR PROMOTION OF MENTAL HEALTH OF ELDERLY (CONT.)

2. How might gender roles protect or increase the risk for men and women to suffer from these diseases that characterize the aging?

3. Given the importance of education and continued involvement in society to ensure the mental health of elderly men and women, how might a program be structured to respond to or enhance the different opportunities each sex has had for developing their intellectual and social abilities?

4. Given the preponderance of care of the elderly on female family members, what can the state do to promote more equitable distribution of the care of older persons within their families?

CAMPAIGN TO STOP TOBACCO ADDICTION

General Findings:

1. According to WHO, tobacco use is estimated to account for 3 million deaths per year, about half a million of which are among women. Slightly more than half of those women live in developed countries. The number of deaths is expected to rise dramatically from 3 to 10 million in the next 20 years. Only if there were to be a substantial fall in smoking prevalence among adolescents would the epidemic of tobacco-related deaths be moderated since the majority of these deaths will occur among youth and young adults of today.

2. The women most likely to smoke in developed countries are those on low incomes with low-status jobs or who are economically inactive. On the other hand, today, affluent and educated young women in Latin America are more likely to take up smoking than their lower income counterparts.

3. Studies from the United Kingdom show that spending on tobacco among low income households with children is higher than among low income households without children. The highest per capita expenditure on tobacco is among one-adult households with children. Qualitative studies of caring highlight the experiences that underlie the association between smoking, poverty and caring for children. Cigarettes were reported by mothers caring for children in low-income households as the way women coped when their children's demands became "too much to cope with." Within a lifestyle devoid of personal spending, cigarettes were the only item that women bought for themselves.

4. Studies in Latin America and in the United States show that girls are smoking for two very different reasons than boys are. Girls use cigarettes to control their weight and appear grown-up, neither of which are reasons boys give for smoking.

5. In Latin America, surveys show wide variations in the prevalence of smoking among women, from 3% in La Paz to 49% in Buenos Aires. Most reports of recent surveys indicate that prevalence among women is increasing, particularly in countries that have higher rates of urbanization.

6. In general, countries in which smoking was first taken up were the first to show a decline in the prevalence of smoking among women in certain age groups. However, recent data in the United States and Canada have shown higher rates of smoking among young women ages 14 to 19 years than among their male counterparts.

7. An Australian study (1995) of 60,000 students from grades 7, 9 and 11 indicates that teenage girls who smoke cigarettes regularly do so because it is a balm for depression and anxiety. A study in Chile found that girls who smoke score lower on measures of self-esteem than those who do not, which is not so for boys where self esteem is not a factor in boy's initiating and sustaining smoking.

8. For boys, the importance assigned to religion seems to play a key factor in whether or not they take up smoking, with a strong association between importance assigned to religion and not smoking (not the case in girls). For both sexes, the fact that friends smoke is strongly linked to the likelihood of initiating smoking. For girls, the belief that smoking is harmful is a deterrent to taking up smoking, but this is not the case for boys.

9. For biological reasons, the consequences of tobacco use are different for both sexes. In women, smoking has particularly adverse consequences for their own health as well as the health of their children. For example, those who use oral contraceptives are more likely to suffer from cardiovascular problems later in life.

Continued

CAMPAIGN TO STOP TOBACCO ADDICTION (CONT.)

Additionally, data collected in the United States indicates that the association between smoking and early menopause has generally been found to be highly significant. The public health implications of this association are derived from the adverse effect of early menopause on morbidity and mortality for several conditions, including the link between menopause and cardiovascular mortality, as well as between menopause and bone fracture.

10. Many women are becoming more aware of the dangers of smoking during pregnancy, but are unaware of the risks of smoking after delivery. Few regular smokers realize that their children are passively smoking. Children whose parents smoke have a tendency to suffer from a series of health problems in the first few years of life, especially respiratory illnesses and infections. There is a condition known as the "Monday morning syndrome," which occurs when children who have been inhaling smoke during the weekend develop otitis and respiratory infections on Sunday evening and have to see a doctor on Monday morning.

Issues to Think About:

1. Tobacco consumption in Latin America appears to be associated with gender relations. In population subgroups in which there is greater subordination of women, tobacco consumption is less than in subgroups in which there is greater gender equity. What do you think might be underlying this finding? How might messages be tailored to counteract this trend in women?

2. A study in Chile finds that knowing that smoking is harmful does not dissuade men from taking up the habit. What do you think might be underlying this finding? How might messages be tailored to counteract this trend in men?

3. If you were to receive a grant to study whether nicotine is more addictive in either sex, for biological reasons only, would you expect to find that it is more addictive in men, in women, or that it is equally addictive for both? Why would this type of study matter for smoking cessation programs?

4. In Canada, a smoking cessation program found dramatic gender differences in the ability of married men and married women to give up smoking. For married men it was much easier than for married women. Why do you think this was the case? How would you tailor a smoking cessation program with this in mind?

5. In the United States, President Clinton announced a series of policies to curb tobacco use in teenagers. Much of this had to do with banning the promotion and advertising of all tobacco products; revision of legislation regarding the sale of tobacco to minors to include stiffer penalties; and legislation banning tobacco sales through vending machines in places where children and teenagers might frequent. Taking gender considerations into account, which of these policies, in your estimation, will have greater effect in curbing smoking in girls? in boys? or will there be no difference? Why?

PROGRAMS AND PROJECTS DERIVED FROM MODERNISM

WID APPROACHES

EARLIEST WID APPROACH

Welfare approach →→→→→→→ **Passive beneficiaries**

- **To help the most vulnerable groups, including women;**
- **Sees women as passive recipients of development;**
- **Perspective centered on the family as unit, emphasizing the reproductive role of women;**
- **Views better child rearing as the principal contribution of women to development;**
- **Has a practical gender approach.**

SECOND WID APPROACH

Anti-poverty approach →→→→→→→ **Gender inequalities reflect poverty, not gender subordination**

- **Attempts to ensure increased productivity of poor women;**
- **Women are poor because of economic limitations, not gender structured constraints;**
- **Recognizes the productive role of women;**
- **Emphasis on small income-generating projects;**
- **Has a practical gender approach.**

THIRD WID APPROACH, NOW PREDOMINANT

Efficiency approach →→→→→→→ **Women cushion impact of structural adjustment process**

- **Women seen in terms of their ability to compensate for deterioration of public services;**
- **Rely on all three roles of women and their supposed free or flexible time;**
- **Women seen entirely in terms of delivery capacity and ability to extend working day; most popular approach with governments and multilateral agencies;**
- **Has a practical gender approach.**

Continued

PROGRAM AND PROJECT APPROACHES ORIGINATING FROM WOMEN'S GROUPS

Equality approach <-----> **Affirmative action to ensure women have active role in development**

- **Women are the target population of programs and projects;**
- **By means of legislation, policies are designed to assure the incorporation of women in the paid labor force, in educational institutions and to ensure that their autonomy and rights are respected;**
- **Projects are designed to reduce inequality between men and women, especially with respect to the division of labor by gender, increasing the political and economic autonomy of women;**
- **Directed to any of the three roles (reproductive, productive or community);**
- **Has a strategic gender approach, through top-down state interventions giving political and economic autonomy to women in order to decrease their inequality.**

Empowerment approach <-----> **Defines empowerment as access to and control of the use of material/ economic resources, political, information/ education and time**

- **Its origins in Third World women's grassroots organizations; Freire's theory has great influence on awareness of oppressed peoples;**
- **In health, it proposes a new relationship of "shared power" between the health sector and different groups of a population;**
- **Seeks to empower women through greater self-reliance: women's subordination seen not only in relation to men at the individual level, but also of predominant development models;**
- **Tries to serve the particular needs of men and women in their multiple roles, through mobilization from the bottom up as a way to confront different types of oppression;**
- **Bottom-up mobilization around concrete health needs in a manner that incorporates strategic gender approaches—can be a practical and strategic gender approach.**

POLICY DOCUMENTS: EXTRACTS

- Investment in health and education for women produces significantly greater benefit to the society than similar investments in men because of the close correlation between the health, nutritional level and education of women and the health, educational level and productivity of future generations. These correlations are still greater when women have control over how resources are distributed within the home.

- Lack of access to credit, land, information and technology aggravates gender inequity. When women have access to credit, the effect on the well-being of the family and its members is notable. The provision of financial resources to women is related to improvements in the health levels of children.

- Women are more vulnerable than men to micronutrient deficiencies which damage health. Bad health and nutrition diminish productivity and the ability to take advantage of the gains from investments in education. Recent estimates suggest that the combined effects of only three types of deficiencies on morbidity and mortality—vitamin A, iodine and iron—could waste up to 5% of the gross domestic product, and that correcting these deficiencies would cost less than 0.3% of GDP in developing countries.

- Malnutrition of infants is related to poverty and the low educational level of mothers.

- Data from Brazil indicate that when women are given more control over resources, there is a greater impact on the anthropometric measures of their children, a greater level of nutrition in their families, and a greater proportion of the family budget devoted to the health and education of children, than when the man controls the resources.

- There is a critical connection between the provision of public health services and women's access to educational opportunities. A mother who has been taught to seek preventive care and timely treatment for her own illnesses and those of her children, particularly her daughters, will reduce expenditure for health care and in many cases will prevent premature death. Many of these services are cost effective and can be provided in primary health care centers.

CASE STUDY 1: CENTER FOR INTEGRAL COMMUNITY HEALTH

The population of the District of Orange Creek is comprised mainly of migrants who have moved from interior parts of the country. Having set up their settlements around the periphery of a major city, they lack infrastructure and services. Most of the population in the District works in the informal sector of the economy.

Some of the communities in Orange Creek have organized commissions that focus primarily on issues related to property rights; these entities are comprised of men. Women have also organized themselves into mothers' clubs, and the focus of these groups revolves around their children's health.

In an effort to improve health conditions, particularly of women, an NGO secures funding for a project that targets five communities of the District. The selection of those communities is based on their degree of organizational capacity, as evidenced by the formation of two umbrella groups made up of leaders from the five communities: The Pro-Land Commission (PLC), which organizes around issues related to land tenure, and the Intercommunity Coalition of Mothers (ICM), a coalition which draws together women leaders from the different communities to catalyze initiatives of interest to all women that live there.

The NGO that proposed the health project already has been conducting adult literacy programs and supporting, through the ICM, educational programs for children. The ICM, in turn, has been running a children's soup kitchen for the past 4 years, and, after discussions with the NGO, agreed to participate in the health project.

The project proposed the execution of a pilot experience that could be replicated through a District Health Plan in other marginal urban communities of Orange Grove.

The project purpose is:

The health conditions and quality of life of the inhabitants of the district of Orange Grove improved as evidenced by a reduction in diarrheal diseases in children, and in women's morbidity.

Expected results include:

In the five selected communities of the District of Orange Grove:

1. In one year's time, an Integral Health Service Program with a focus on disease prevention and care through prenatal, pediatric and gynecological services is in place and functional for children under 6 and women of reproductive age.

2. The Integral Health Service is promoted through continuous dissemination of health information using printed material and loudspeakers.

3. Ambulatory services attached to the Integral Health Service provide immunization and prenatal care in the target communities and draw 75% of the population of expectant mothers and 95% of children under 6 years of age.

4. Women's organizations strengthened, particularly in the design, development, and management of a District Health Plan, in close coordination with the Municipal government of the area that encompasses all the communities in the Orange Grove District.

Continued

CASE STUDY 1: CENTER FOR INTEGRAL COMMUNITY HEALTH (CONT.)

SALIENT ACHIEVEMENTS OF THE PROJECT:

A1. According to the evaluation by the mothers, the ambulatory services attached to the Integral Health Services were highly effective for reducing infectious diseases in their children.

DIFFICULTIES OF THE PROJECT:

B1. A considerable number of the women that were treated in the ambulatory care services had to be referred to the Integral Services for follow-up. However, the Integral Services had little capacity to respond to these complications.

B2. From the outset of the project, the Integral Health Services faced financial sustainability problems. In an effort to address the financial situation, the focus, which had initially been children under 6 years and women of reproductive age, had to be expanded so as to include the general population. This expansion resulted in an increase in user waiting time, both for getting appointments with doctors and in the time users were kept waiting on the day of their scheduled appointment. It also increased delays in the delivery of laboratory results, and diminished the quality of professional-user interaction.

B3. With respect to community organization networking and negotiations, problems emerged concerning the determination of health priorities. The Pro-Land Commission (PLC) felt that one of the ways of resolving the financial viability of the Integral Health Services was by dropping the gynecological services, a cutback which was put into effect after heated discussions because of the opposition to this reduction by the Intercommunity Coalition of Mothers (ICM).

B4. In addition to this difficulty, the PLC, claiming its track record in negotiating with the authorities, were of the opinion that only their members could participate as community representatives in the formulation of the District Health Plan.

B5. Members of the ICM who wished to engage in these negotiations with the PLC were forced to dedicate more time to this process, time which they did not have because of their need to generate an income and to fulfill tasks involved in maintaining their households. The difficulties inherent in devoting the needed time to ensure that their views were taken into account in formulating the District Health Plan culminated in frustration and exhaustion for the members of the ICM, who gradually ceased to participate in the meetings to design the Health Plan.

NOTE: To facilitate a discussion of this case study, three groups will be analyzed: women of reproductive age in Orange Grove; the ICM; and the PLC. The first two groups are mutually exclusive.

GUIDE TO ANALYZE CASE STUDY

I. PROJECT OBJECTIVES

a. What gender roles did the project target in its objectives and to what purpose?

b. What particular health needs of women and men did the project target in its objectives?

c. What development approach predominated in its objectives: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?

d. In the objectives, did it use a practical gender approach (PGA) or a strategic gender approach (SGA)?

II. IMPLEMENTATION AND IMPACT OF PROJECT

e. What gender roles did the project affect and how?

f. What particular health needs of women and men were affected and how?

g. What development approach actually predominated: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?

h. Did a practical gender approach (PGA) or a strategic gender approach (SGA) predominate in the implementation?

i. What changes occurred during the process of the project's implementation in terms of access to and control over one or more resources (material/economic, political, information/education, time, internal)? Discuss each target group in turn.

j. Referring to Labonte's Continuum of Empowerment, give an example of what elements of that continuum could have been incorporated, either in the project design or during its implementation, to respond more equitably and efficiently to the particular health needs of women and men.

WORKSHEET: CASE STUDY NO. 1

a. PROJECT OBJECTIVES

ROLES	REP.	PROD.	G.M.
Women			
ICM			
PLC			

b. Health Needs

Women	
CIM	
CPT	

c. Development Approaches

Welfare Anti-Poverty Efficiency Equality Empowerment

d.

PGA? SGA?

Continued

WORKSHEET: CASE STUDY NO. 1 (CONT.)

e. PROJECT REALITY

ROLES	REP.	PROD.	C.M.
Women			
ICM			
PLC			

f. Health Needs

Women

ICM

PLC

g. Development Approaches

Welfare Anti-Poverty Efficiency Equality Empowerment

h.

PGA? SGA?

i.

	ACCESS					CONTROL				
	M/E	P	I/E	T	I	M/E	P	I/E	T	I
Women										
ICM										
PLC										

j.

CASE STUDY NO. 2: IMPROVEMENT OF COMMUNITY HEALTH THROUGH BETTER WATER QUALITY

In a rural agricultural area with small communities distributed along a river, the main impediment to health and development is a simple one: a limited water supply that is apt for human consumption. Health problems that emanate from this situation include enteric diseases, mainly in children, and a number of skin diseases. Household owners living near the river also have problems with water quality, and women must ensure that all water that is consumed is boiled. Women who live in dwellings further away from the river must walk 2 to 3 kilometers to reach this source, and, in addition to the water quality problem, they have the burden of carrying it back home.

It is known that there are underground aquifers in the area that could supply good water, a fact which propels the Department of Environmental Health (DEH) of the district that includes these communities to decide to construct wells, hoping that the wells will solve the problems of quantity, quality and transport. In addition, the DEH decides to construct latrines, taking care not to situate these in places where they might present hazards to the water quality.

On the basis of this description of the situation, the DEH implements the following project:

The project purpose is:

To contribute to the improvement of the quality of life of the target communities, in particular to the health of women and children.

The expected results include:

1. In each target community, at least one water well constructed and functioning, and the population in each instructed in the care of the wells and the hand pumps.

2. In each target community, at least one latrine constructed per 5 people.

3. In each target community, women are instructed in the use and care of the latrines, in personal and family hygiene, in the proper use of water, and in the safe preparation of food.

RESULTS OF THE PROJECT

A1. A well was constructed in each of the target communities.

A2. Eighty percent (80%) of the women of reproductive age in each community instructed in: personal and family hygiene; the proper use of water; the safe preparation foods; and, the care and use of the water wells.

CASE STUDY NO. 2: IMPROVEMENT OF COMMUNITY HEALTH THROUGH BETTER WATER QUALITY (CONT.)

A3. In so far as it was the women who transported and boiled the water and sought the firewood for this latter purpose, the construction of water wells for human consumption in their community was a real relief, as it alleviated the heavy burden that these chores constituted for them. Now the women found themselves with free time that they had not had previously.

A4. Children's continual diarrheal diseases diminished dramatically in only 3 months after having constructed the wells.

A5. Each community selected men to be trained in the care of the wells and the hand pumps.

A6. Shortly after having constructed the latrines, the men of the communities used them for storing their farming tools.

PROJECT DIFFICULTIES

B1. Women's free time was rapidly taken up in assisting the men in preparing their farm production for market. Subsequently, because the men were the ones who engaged in the commercial transactions, women were made responsible for the agricultural work. As a result, women saw themselves once again working very long hours at tasks that were equally demanding as those which they had to perform when they carried and prepared the water.

B2. The women who lived in the communities furthest from the river found another disadvantage to this new situation: the journeys back and forth to get water, a trip that had been undertaken by a group of women, had provided them with opportunities to exchange thoughts, feelings, joys and concerns; when the need to fetch and carry water ceased, so, too, did this only opportunity for daily interaction.

NOTE: The analysis should focus on the men and the women in the communities.

WORKSHEET: CASE STUDY NO. 2

a. PROJECT OBJECTIVES

ROLES	REP.	PROD.	M.M.
Women			
Men			

b. Health Needs

Women

Men

c. Development Approaches

Assistance **Anti-Poverty** **Efficiency** **Equality** **Empowerment**

d.

PGA? **SGA?**

Continued

WORKSHEET: CASE STUDY NO. 2 (CONT.)

e. PROJECT REALITY

ROLES	REP.	PROD.	C.M.
Women			
Men			

f. Health Needs

Women

Men

g. Development Approaches

Welfare Anti-Poverty Efficiency Equality Empowerment

h.

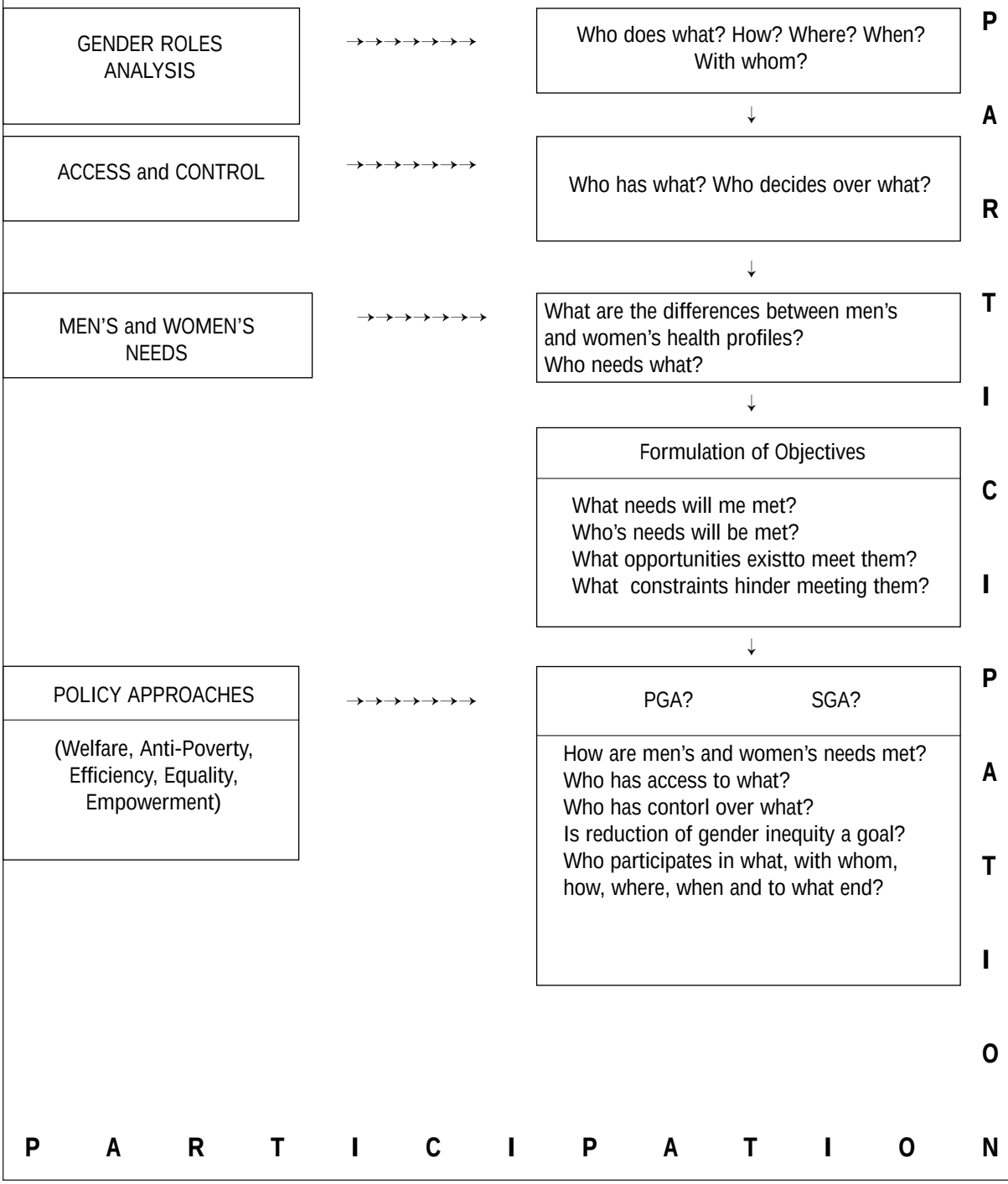
PGA? SGA?

i.

	ACCESO					CONTROL				
	M/E	P	I/E	T	I	M/E	P	I/E	T	I
Women										
Men										

j.

STEPS FOR CONDUCTING A GENDER DIAGNOSIS



GUIDELINES FOR PROJECT/PROGRAM ANALYSIS

I. Conduct the gender diagnosis, answering the following questions:

- What gender roles did the project target in its objectives and to what purpose?
- What particular health needs of women and men were affected and how?
- What development approach predominates in its objectives: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?
- Do the objectives reflect a practical gender approach (PGA) or a strategic gender approach (SGA) or both?
- Are any assumptions based on stereotypes evident in the project?

II. Identify the information that you would need to carry out an in-depth gender diagnosis.

III. Reformulate one of the project objectives and its indicators so that they reflect a gender approach.

IV. Develop a strategy to put into operation the reformulated objective identifying opportunities and/or obstacles in achieving the objective.

OVERHEAD TRANSPARENCIES

DEFINITIONS OF SEX/GENDER

"Sex" refers to the biological differences between men and women.

"Gender" refers to roles that men and women play and the relations that arise out of these roles. They are socially constructed, not physically determined.

SOCIAL/BIOLOGICAL

- Emphasizing the social, does not exclude the role of biology.

- Recognition of social factors is crucial to an analysis of this interrelationship in order to identify the differential disadvantages and/or advantages for men and women's health.

GENDER AND HEALTH

In HEALTH, advantage and disadvantage can be measured by:

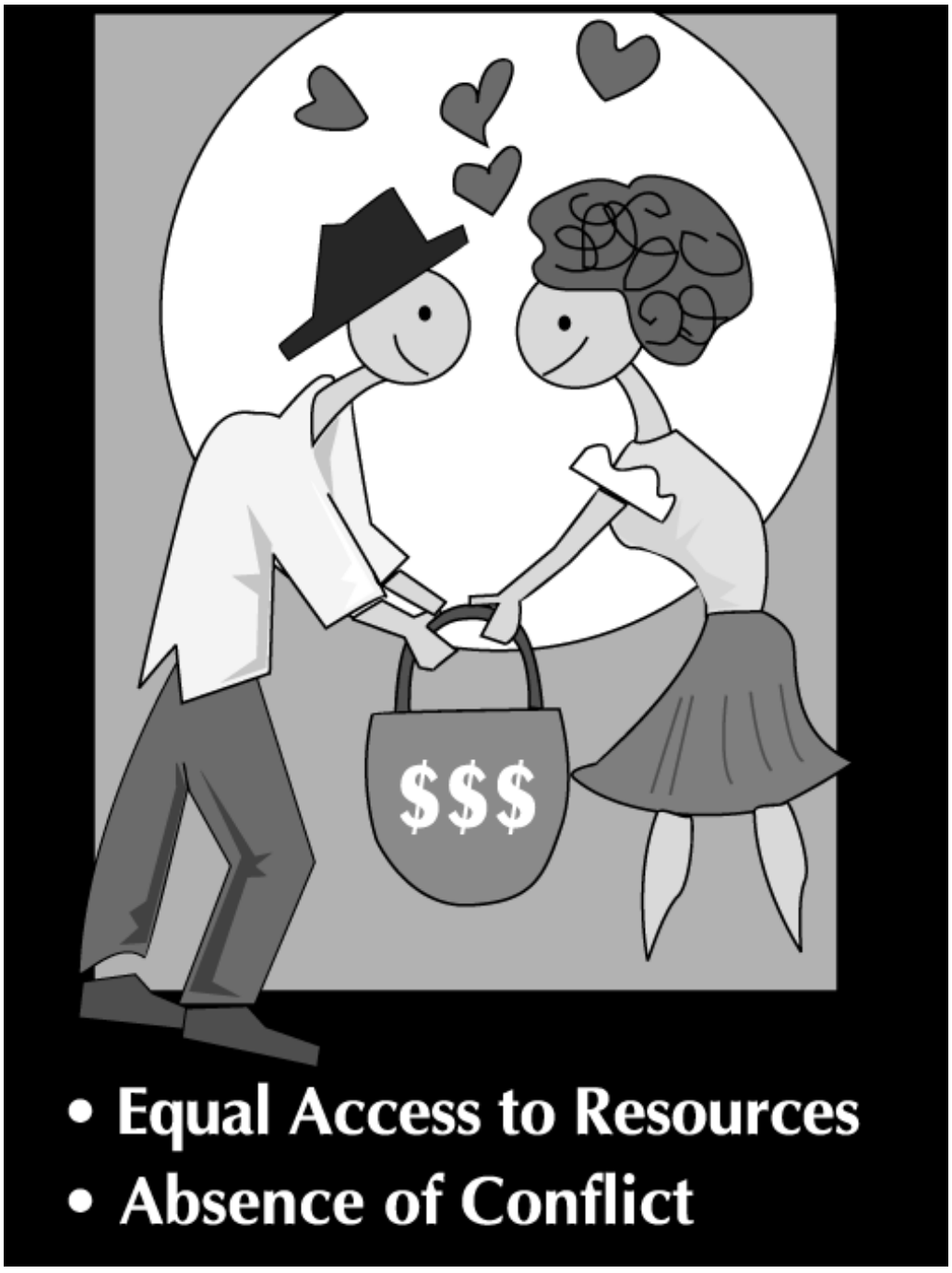
1. Probability of maintaining health, or becoming ill or dying from preventable causes.

2. Equity of access to and control of resources, responsibilities and rewards in health work.

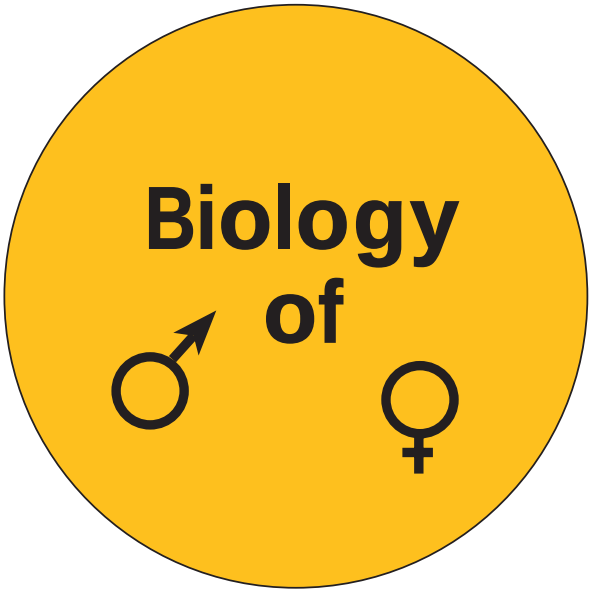
STEREOTYPE 1

STEREOTYPE 2

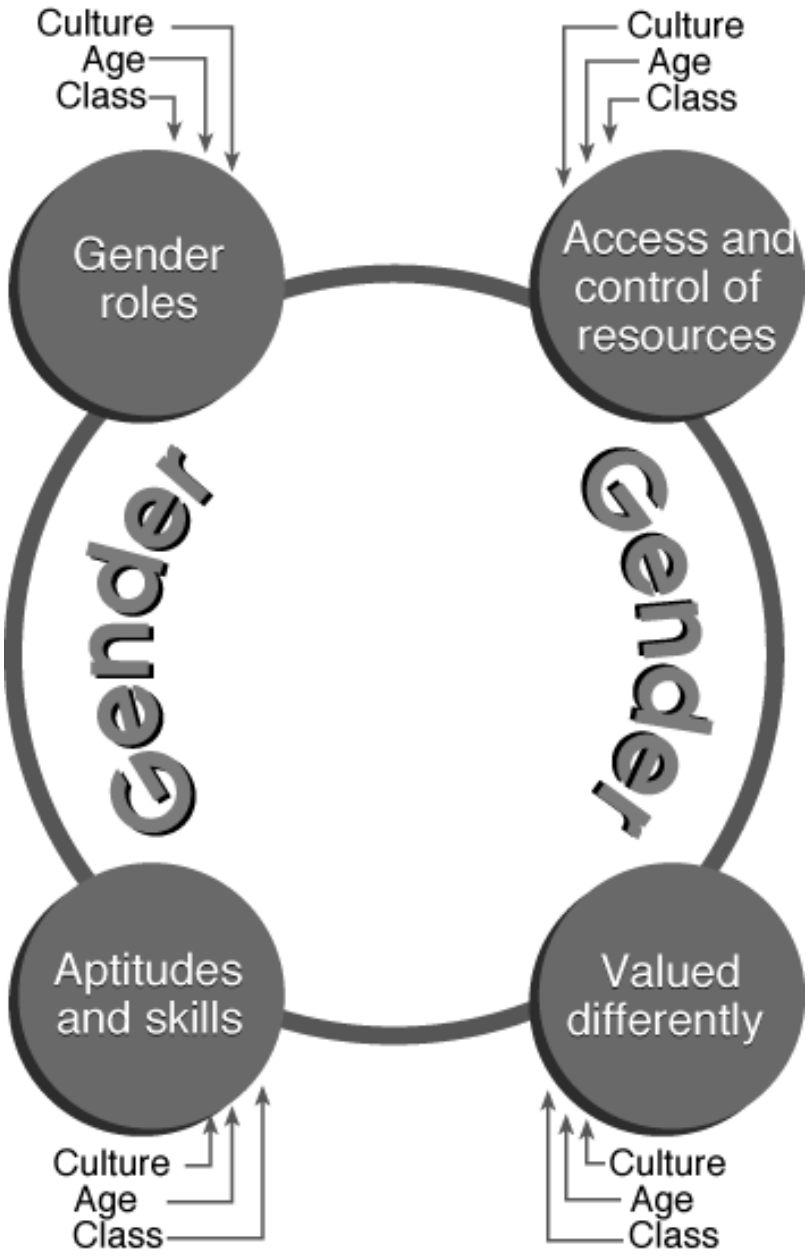
STEREOTYPE 3



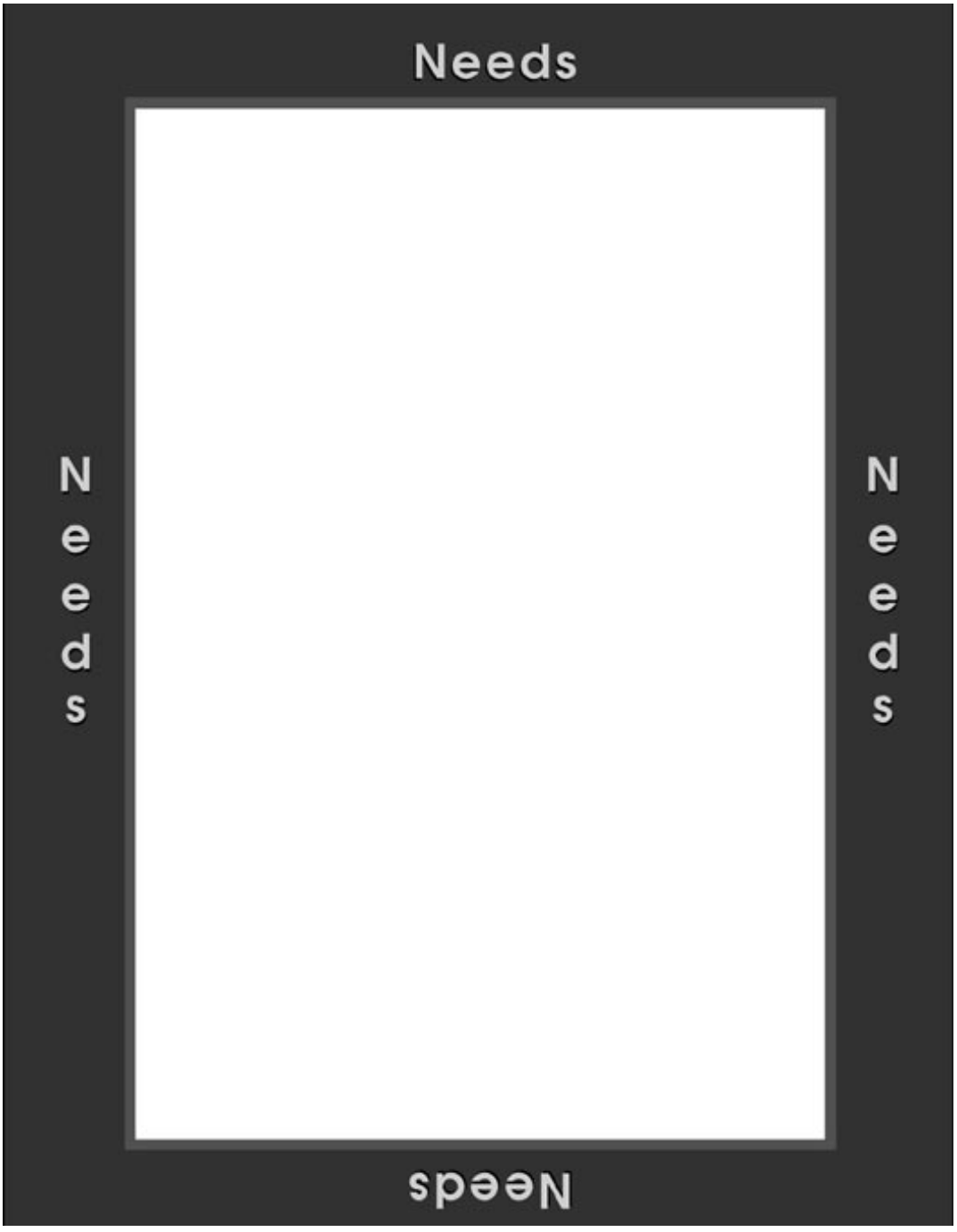
CIRCLES: BIOLOGY OF MEN AND WOMEN



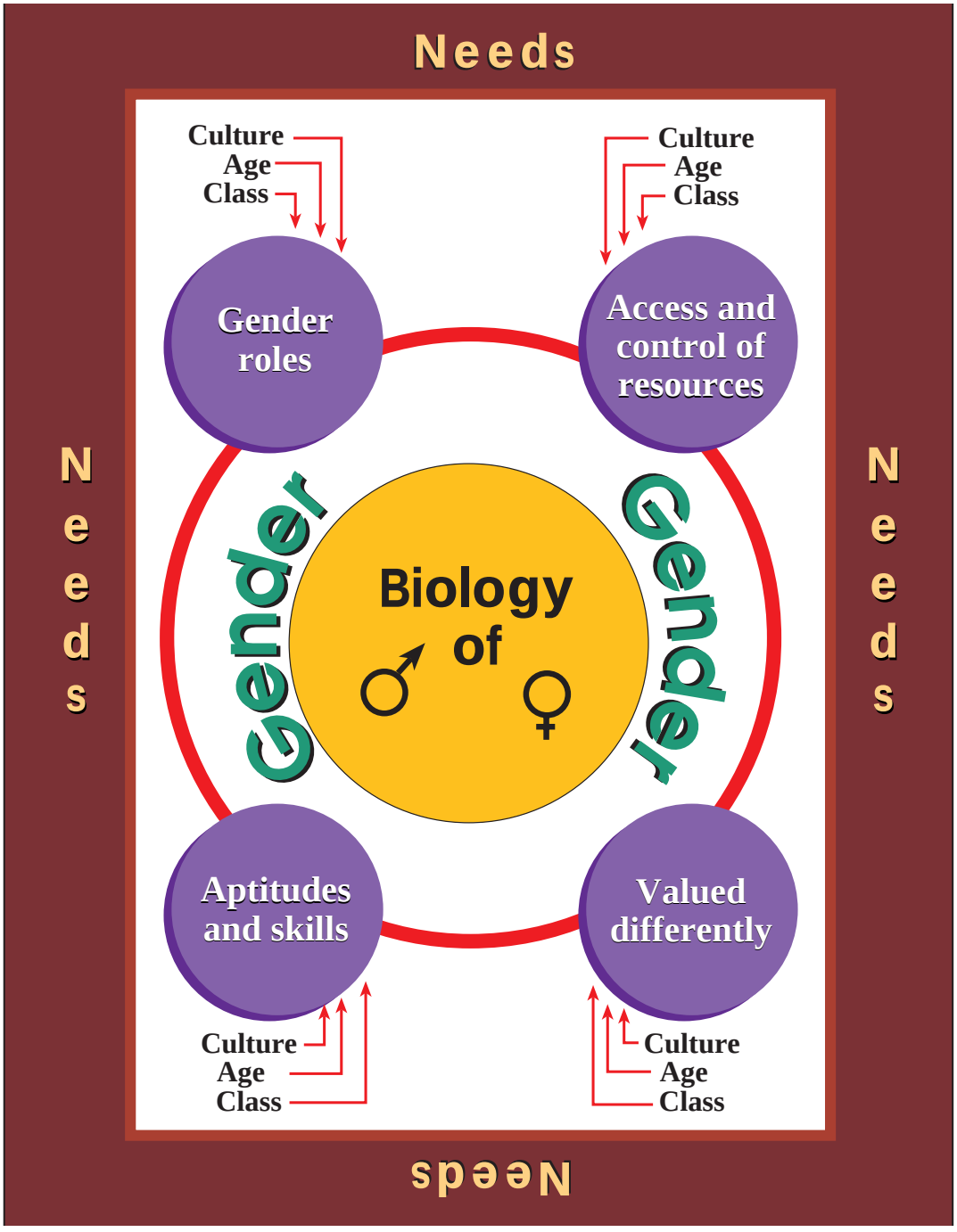
CIRCLES: GENDER CONSTRUCTIONS



CIRCLES: NEEDS



CIRCLES: NEEDS IN HEALTH



EQUITY AND NEED

To attain equity in health, it is important to recognize that different groups have different needs that must be identified so as to adequately address them.

ORIGIN OF MALE AND FEMALE DIFFERENCES IN HEALTH/ILLNESS

BIOLOGICAL DIFFERENCES

a) Anatomical/physiological;
b) Anatomical, Physiological and Genetic susceptibilities;
c) Anatomical, Physiological and Genetic resistances/immunities.

SOCIAL DIFFERENCES

a) Roles and responsibilities;
b) Access and control;
c) Cultural influences and expectations;
d) Subjective identity.

HEALTH SITUATIONS, CONDITIONS AND/OR PROBLEMS

1. Sex Specific;
2. Higher prevalence in one or other sex;
3. Different characteristics for men and women;
4. Generate different response by individuals/family/institutions depending on whether the person is male or female.

HIV/AIDS: BIOLOGICAL CHARACTERISTICS

Women are more vulnerable because:

- Semen Highly Infectious
- Vaginal Mucous Membrane More Vulnerable
- Semen Remains in Vaginal Tract
- Age Factor: ↑ under 18; ↑ after menopause
- STD - HIV/AIDS link: ↑ Incidence for Women

PGA / SGA

PRACTICAL GENDER APPROACH	STRATEGIC GENDER APPROACH
● Short term response.	● Long term strategy.
● Needs more easily identifiable.	● Needs less immediately identifiable.
● Biological requirements and specific health conditions.	● Targets inequities in power relationships.
● Provides health goods and services.	● Focuses on empowerment processes.
● Involves women/men as passive subjects.	● Involves people as active participants.
● Improves health conditions.	● Improves the position of women.
● Gender roles and relations remain constant.	● Improves balance of power relations.

DEVELOPMENT APPROACHES

Development Approach	Type	Characteristics	PGA/SGA
Welfare	WID/WHD	Modernization economic development model	PGA
Anti-Poverty	WID/WHD	Gender inequalities result of poverty, not gender subordination	PGA
Efficiency	WID/WHD	Women cushion impact of structural adjustment	PGA
Equality	GAD/GHD	Affirmative action to ensure women have active role in development	SGA
Empowerment	GAD/GHD	Access and control of the use of resources	SGA

STEPS FOR CONDUCTING A GENDER DIAGNOSIS

GENDER ROLES ANALYSIS	→	Who does what? How? Where? When? With whom?
ACCESS and CONTROL	→	Who has what? Who decides over what?
MEN'S and WOMEN'S NEEDS	→	What are the differences between men's and women's health profiles? Who needs what?
		Formulation of Objectives What needs will be met? Who's needs will be met? What opportunities exist to meet them? What constraints hinder meeting them?
POLICY APPROACHES (Welfare, Anti-Poverty, Efficiency, Equality, Empowerment)	→	PGA? SGA? How are men's and women's needs met? Who has access to what? Who has control over what? Is reduction of gender inequity a goal? Who participates in what, with whom, how, where, when and to what end?

PARTICIPATORY

PARTICIPATION