GENDER MAINSTREAMING IN HEALTH:

A PRACTICAL GUIDE

Pan American Health Organization

Regional Office of the
World Health Organization

Adapted from WHO manual "Gender Mainstreaming for Health Managers: A Practical Approach"

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Introduction

Why do public health workers need a packet on gender?

Contemporary public health mandates include addressing a wide range of determinants of health such as sex, gender equality, poverty and equity. This packet introduces gender concepts and focuses on the ways in which gender norms, roles and relations affect health outcomes and response. At the same time, it recognizes that gender is a cross-cutting issue that needs to be considered alongside other sources of health inequity, such as poverty, age, ethnic diversity and overall socio-economic development of the context in question. The packet also provides you with a basis for addressing these other forms of health-related discrimination.

Historically, a focus on women has remained dominant in much of the work on gender. However, since the 1990s, increasing attention has been paid to the ways in which men can contribute to improving gender relations as well as the ways that gender norms may negatively impact may negatively impact their lives and opportunities. While the last part of the 20th century has witnessed considerable improvements in the status of women and gender equality across both developed and developing countries, women and girls remain disadvantaged relative to men and boys in various ways. The disadvantaged position of women in society is internationally recognized as both a breach of human rights and a barrier to broader social development. It is also widely acknowledged that women's lower status has often become institutionalized through the structures which organize social life. Institutions tend to marginalize women in training, employment, policy-making, planning, implementation and monitoring. These very institutions also serve to perpetuate images and ideals of masculinity that are not always congruent with reality and may also serve to increase pressure and stresses on men who are either unable to, or are discouraged from fulfilling or assuming certain roles and responsibilities due to a changing, globalized world. This also happens in various settings – within the family, in schools, and in commercial, social and political institutions.

When it comes to health, gender roles, norms and relations can serve both as protective or risk factors for both women and men. However, women's disadvantaged social, economic and political status often makes it more difficult for them to protect and promote their own physical, emotional and mental health, including their effective use of health information and services. Although women live longer than men do, these additional years of life are often spent in poor health. Women experience avoidable morbidity and mortality as a direct consequence of gender-based discrimination. Men, on the other hand, often delay seeking health care longer than women and may even refuse to comply with treatment, for example for tuberculosis in some regions, because the treatment requires that they have to avoid alcohol consumption for the duration of the treatment. This obviously impacts upon their overall health status. Public health professionals are responsible for promoting and safe-guarding the health of the populations in which they work. This means that they must be able to identify those factors that put women and men at risk, and address them through effective interventions. Gender is one of those factors.

The steps towards achieving health equity goals, such as *Health for All* must begin from the basic acknowledgement that the 'All' being targeted are not the same. Inter-country and inter-regional differences and health disparities are widely recognized and recorded in health statistics and profiles. Public health workers at all levels need to recognize and identify differences within populations in their countries and address these differences in systematic and appropriate ways. This may mean that different interventions may be required

to facilitate the attainment of the highest possible level of health across the various groups within the population. It also often means that "business as usual" procedures are not the most effective ones to use. A new way of thinking, a new way of doing business is urgently needed to address global health inequities and to address the different health needs and problems of men and women, boys and girls.

This packet takes a gender perspective to achieving health equity and provides evidence to show how biological factors interact with gender norms, roles and relations (or socio-cultural factors) to affect the health of women and men and that of their communities. While health equity analyses typically focus on socio-economic disparities and responses, applying gender analysis methods to public health program, research and policies addresses *unnecessary, avoidable and unfair differences in health status[1]* beginning from the interaction of sex and gender as core determinants of health inequity. That is to say, that differences between and among women and men (i.e., age, ethnicity, socio-economic status, sexual orientation and region of residence) are incorporated into systematic gender analyses. This "added value" of gender analysis, therefore, enhances operational approaches to health equity.

In recognition of the role of gender-based differences and inequalities in the health of women and men, and in line with its long-standing concern with health equity, WHO adopted an internal Gender Policy in 2002 whose objective is to:

'...ensure that all research, policies, programmes, projects and initiatives with WHO involvement address gender issues. This will contribute to increasing the coverage, effectiveness, efficiency and, ultimately, the impact of health interventions for both women and men, while at the same time contributing to achievement of the broader UN goal of social justice.

Based on WHO's policy, inputs and approval of Members States, PAHO's Gender Equality Policy was adopted in 2005 with the following goal:

"The goal of the policy is to contribute to the achievement of gender equality in health status and health development through research, policies, and programs which give due attention to gender differences in health and its determinants, and actively promote equality and equity between women and men."[1]

This packet contributes to the implementation of both global and regional gender related policies. It furthers PAHO/WHO's efforts towards integrating gender considerations in all aspects of its work and in building country-level capacity to address gender inequalities in health. It supports the General Program of Work that outlines the WHO's strategic priorities until 2013, as well as the Health Agenda for the Americas and PAHO's related strategic Plan (2008/13).013).

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[1] Please note that integrating gender perspectives is used interchangeably with gender mainstreaming.
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For further information on the conceptual framework and approaches of health equity, see Braveman, P. and Tarimo, E. (2002). Social Inequalities in health within countries: not only an issue for affluent nations. Social Science & Medicine, 54: 1621-1635.; Tamburlini, G. (2004). Promoting Equity in Health. Health Policy and Development, 2(3): 186-191. See also reference list of this Packetfor further resources.

Tools for integrating gender into public health

In order to guide the process of examining the many ways in which gender-based differences and inequalities influence the health of women and men (what is known as conducting a *gender analysis*), a number of tools, guidelines and frameworks have been developed by a range of stakeholders in different development sectors. These are generically referred to as "gender analysis tools".

Usually formulated as questions, gender analysis tools guide one through a systematic process of examining the influence of gender-based differences and inequalities on health. Often, the reasons behind gender-based differences in health are neither explicit nor visible. This is why many health sector interventions remain gender-blind. Conducting a gender analysis is, in many ways, similar to tending a garden. What we see on the surface neither adequately reflects the complexity of the intertwining roots beneath, nor reflects the stronghold that these roots may have in the soil. With gender analysis, it is a similar process. We must examine things in a bottom-up manner, understanding realities of local populations before moving up to national and international levels to understand the root causes of how and why power, rights and access to important health-related resources are distributed unequally among internal groups.

This packet equips you with the tools for *gender gardening*, in order to detect where and why gender inequalities occur and to assist you in developing adequate and appropriate interventions.

The use of sound evidence to make decisions is very important in public health work. This is also the case with work on gender; especially when trying to decide whether or not gender and health issues are priority matters for the health sector. The packet includes such evidence – on women's and men's vulnerabilities due to gender norms – as described above. However, it is important to note that there is an evidence gap especially with respect to evaluation data on gender mainstreaming, and in relation to the ways that gender roles and norms affects men's health. While there is considerable and growing evidence of the ways in which gender affects women's health outcomes, there is less documented evidence on the ways that gender affects men's health outcomes. These gaps need to be addressed through adequate research and health-related data gathering.

This evidence gap does not mean that we cannot address and alleviate health inequities due to gender norms and inequality. We *do not* need more evidence to know that gender inequality, roles and norms-form an important social determinant of health. We *do* need to continue to strengthen the evidence base on the ways in which gender operates as a risk or protective factor in the health of both women and men at all ages, and conduct rigorous evaluations on the merits of gender mainstreaming in the health sector.

But while this type of data is being gathered, men and women, girls and boys all live in gendered environments and should not have to wait indefinitely for the health sector to consider and address their daily life conditions and opportunities through interventions designed to promote and safeguard their health. We can act now on the information we have, and this packet can help to get you started in the right direction. As public health workers, we need to address the gender dimensions of our work, and the process of integrating gender perspectives into public health work is a good way to start.

The role of this packet in the implementation of PAHO's Gender Policy

In support of the forthcoming Plan of Action for Integrating Gender Analysis and Actions into the Work of PAHO, and building on the implementation of PAHO's Gender Equality Policy (2005), this packet seeks to increase the capacity of PAHO staff, Ministry of Health and other development partners to develop gender-responsive plans, programmes and policies. In so doing, the packet also supports the development of core competencies and technical skills.

This training packet consists of background reading, handouts and worksheets that will be used throughout the accompanying workshop. It is based on a set of gender modules designed to provide concrete guidelines to enable you, as a public health professional, to integrate a gender perspective into your programs, interventions and policies. This facilitate you in ensuring that steps are taken both to promote gender equality and health equity, and to prevent or reduce negative impacts of ignoring gender on program outcomes.

The packet focuses on essential questions and stages of public health planning and program implementation and focuses on the development of usable and practical skills. If you would like more detail on gender analysis tools, we suggest that you refer, as a first step, to the *"Gender Analysis in Health: A Review of Selected Tools",* WHO, 2002. Gender and Ethnicity Team Members, in headquarters and country offices are also available to provide support.

Organization of the Packet

The packet adopts a modular, practical approach and is aimed at public health professionals in international, national or community based institutions. Modules are conceptually organized around answering the questions *"What do we know"* and *"What can we do"* about gender-based differences and inequalities through global and regional examples, case studies and evidence. These questions are asked related to designing, implementing and evaluating new and existing health programs, projects and policies. Each module contains additional resources or references that users may wish to consult, including web links when and where available.

Module 1: **Understanding Gender Concepts** provides an introduction to the concepts related to gender and health and aims to stimulate participants to get past politically correct discussions of gender and begin to grapple with the reasons *why* **public health professionals should address it. It is strongly recommended, even if facilitators or participants have some knowledge of gender that they begin with Module 1 to review basic terms and concepts to understand how they are operationalized and applied to public health.** Specifically, Module 1 defines key gender concepts and explores why and how gender inequalities affect health. Interactive learning activities to stimulate reflection on gender issues are included. For newcomers to gender, this module is essential so concepts that are often misunderstood are further clarified.

Module 2: **Understanding and Applying Gender Analysis** outlines what gender analysis is and highlights the importance of applying a gender analysis to the development, implementation and evaluation of new and existing programs, projects and policies. It describes the interrelationship between gender norms and roles and access to and control over resources. Activities are designed to give participants hands-on experience with the concepts explored.

Module3: **Integrating Gender in our Programs, Projects and Policies** introduces a tool to assist participants in applying gender to health programs and projects and explores ways that the results of a gender analysis can inform public health responses through different types of interventions. Group work in Module 3 builds on the learning from Module 2 and provides participants with the opportunity to develop a work plan for integrating gender in their work settings. This means that once participants have gone through the activities in the manual, they will have developed concrete skills that may be directly applied to their work.

It is important that Gender be seen in relation to other social determinants of health. The modules and tools in this packet focus on uncovering gender differences in health and on developing appropriate interventions in the health sector. However, gender cuts across other social factors that lead to inequities in health, such as socio-economic status, ethnicity, age or place of residence. Although it is not

mentioned explicitly in all activities, it is important that gender always be understood to be interacting with these other factors.

Adapting the Packet

The packet has been developed as a resource, and may require adaptation to certain contexts. Prepare your modules prior to the workshop. Use and adapt the material according to your facilitation style, the group (both in terms of who is attending the workshop and from where they come both professionally and geographically), and the information and resources available to you.

It is important to note that the modules are Regional in nature and the examples and evidence included tend to be Regional. When possible, or country-specific, or sub regional examples and data should be included. Facilitators are encouraged to use data that is most relevant for the group when possible. Use global and other comparative data or strategies provided in the packet when necessary to provide some contrast and let participants know how similar issues are represented in other parts of the world or region where appropriate. It is strongly *recommended to always* **use sex disaggregated** *data. When sex disaggregated data is not available, this should be stated and discussion generated with participants about the obstacles that lack of adequate data poses to gender analyses. Always link the material to local examples and issues.*

There is a lot of facilitator input which is required to explain concepts and provide background information. It is important that this is presented in an interactive and interesting manner – you may find the following tips useful.

Tips for Facilitators
- It is necessary to be familiar with the local context as well as with the concepts and applications of gender and health prior to facilitating a group with this manual. If gender is relatively new for you, take some time to think about how you feel about and understand the concepts. Learning about gender is a process and you will discover things along the way, from participants and yourself as you begin to reflect deeper on the issues at hand. Ask for support if you need it!
- Co-facilitation (or shared between 3-4 facilitators for different sections) has proven to be effective regardless of group size. This allows for increased diversity in delivery for participants and allows for better coverage of group work and overall logistical preparations.
- Read the additional materials suggested and look for regional or national examples of gender mainstreaming from countries or districts of the participants coming to the workshop so that examples are on-hand. This also acknowledges the excellent gender and health work happening in the countries of participants.
- Do not read the presentations word for word, but summarize the key points. In order to do this you will need to have read the material prior to the session.
- Talking points on several of the slides have been provided to guide you through the sessions if needed. These points may also be useful to clarify concepts during discussions.
- Ask participants to read the material to the rest of the group, when necessary, and try to ensure a mix of males and females when doing this.
- Use a blank sheet as a "parking lot" to record points that you would like to get back to
- Give participants an opportunity to read the material on their own, and ask questions. Refer to the participants' packet and remind them of additional reading that will enhance their outcomes.

- In addition to changing the mode of presentation, the key to avoiding boredom and maximizing learning is to apply the theory to practical examples, and to encourage discussion drawing on participants' experience.
- The workshop is intensive and requires concentration and focus to understand and apply the concepts.
- Counter-balance this with ice-breakers, singing and physical activity
- Be aware of the energy level of the group, and take breaks when energy level appears low.
- Gender work is often challenging – it is closely linked to participants' own values, beliefs and culture. We cannot assume that participants themselves are gender-sensitive or are convinced about the need for gender equality; be aware and sensitive to this.
- Avoid emotionally charged personal debates. Rather, use the other participants and the activities to highlight how and why gender discrimination impacts negatively on health and health services. **Remember, the focus of this workshop is to improve public health policies, programs and service delivery, not to confront or convert resistant participants!** The manual has been designed as a resource to encourage critical, analytical thinking, and even though some participants may have personal gender issues, the tools help to uncover gender issues in the context of health in an accessible and non-threatening manner.
- Use and adapt the course outline to suit your circumstances and the group. Timing depends on the size, level of the group, logistics such as travel, tea breaks and catering arrangements. Factor all these variables into your planning.
- The modules can be run in a flexible manner – if you are short of time, shorten activities or select which are most important. You can always go over the issues the shortened activity aimed to highlight if time is too short to include the full activity.
- Additional reading is provided in the participants' manual and reference lists at the end of this introduction. This is provided for the facilitator to read for background information.
- The participants' manual should be sent to participants in advance for preparation and contains worksheets, handouts and additional reading. In any case they should have it not later than the beginning of the training because there is reading homework after the work shop on each day.
- Modify the PowerPoint slides as necessary, including photos, images and data that will be most relevant and stimulating for the group of participants.
- Incorporate progressive evaluations and "checks" of participant understanding in between modules. This helps to ensure that objectives are met and provides facilitators with crucial input on areas that need revision.

PREPARATION for the introduction

Prior to beginning the workshop, facilitators should take some time to set up the room and display Greetings and welcome Flipchart for participants to see when they enter the room.

Materials to be prepared:
1. Flipchart: Greetings and welcome.
2. Flipchart: Participant expectations
3. Flipchart: Ground rules/Group Expectations (you may prepare a short list and then ask participants if they are in agreement and have anything to add to the list)
4. Flipchart: Parking Lot

Facilitator:

Step 1: Welcome everyone. Introduce yourself, and other facilitators. Ask participants to move around the room and greet each other. Encourage them to shake hands, look at each other, and greet and welcome the person in as many of languages they know, while moving around the room, specifically finding people they do not know.

Step 2: Ask participants to introduce themselves to the group, and to share their expectations of the workshop. Write their key expectations on flip chart and stick to wall, so that you may come back to them throughout, and at the end of, the workshop.

Step 3: Go over flipchart with suggested ground rules that will facilitate learning and sharing. Solicit additional rules from group (Could include: punctuality, cell phones off, laptops off, respect for all and their participation, no interruptions, conciseness)
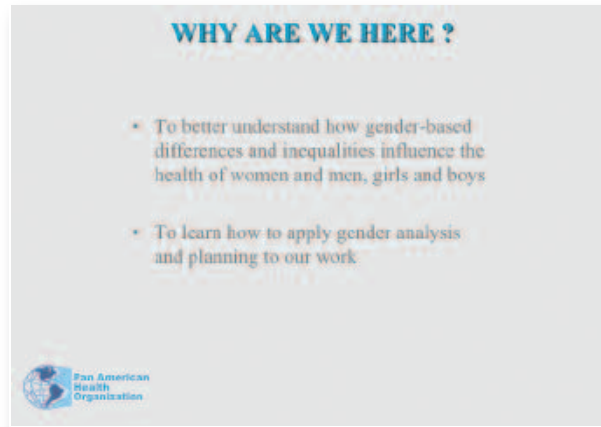
Flip Chart: Introductions	Tips for Facilitators
Ask participants to introduce themselves in the following manner: My name is... I work in...where I... One expectation I have for the workshop is...	• Gender issues are part of daily lives of everyone and affect us all, men and women, in our homes or workplaces, regardless of level of education, class, or position at work • They are not something that exists "out there" or for "other people" to "marginalized women or vulnerable communities". • This means that learning about gender can be challenging, because we have to think critically about our own lives, our own behavior, within our households, workplaces and communities. • Therefore statements by one person can be misinterpreted as value judgments by others. This is why it is important to set ground rules that will encourage openness and dialogue, learning and sharing.

WHY ARE WE HERE ?

- To better understand how gender-based differences and inequalities influence the health of women and men, girls and boys

- To learn how to apply gender analysis and planning to our work

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Facilitator:

Read the info on the slide and relate to expectations of participants.

Course Overview

MODULE 1: Understanding Gender Concepts

MODULE 2: Understanding and Applying Gender Analysis

MODULE 3: Integrating Gender in our programs, projects and policies

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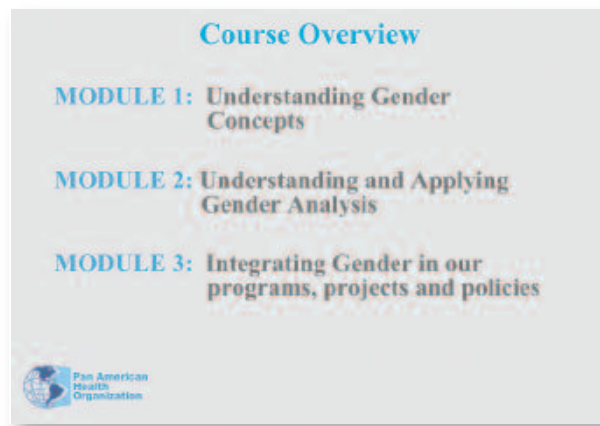
Facilitator:

Present the outline of the three modules:
During these days we will work together on understanding these three modules, which will provide us with the skills to carry out a gender analysis and develop a plan to improve our work at PAHO and with our partners to increase equity and efficiency.

MODULE 1: Provides an introduction to important gender concepts and aims to stimulate participants to get past politically correct discussions on gender and begin to really grapple with the reasons why public health professionals should address gender inequalities.

MODULE 2: Highlights the importance of conducting a gender analysis of programs, projects and policies. In this module you will learn how and why gender analysis is important for public health work.

MODULE 3: In this module you will be introduced to a tool/set of questions to consider when applying gender to health programs/projects and have the opportunity to apply this tool to a case study. Participants will also develop a basic workplan to integrate a gender perspective in their work and in the health sector. This means you will leave the workshop with something concrete.
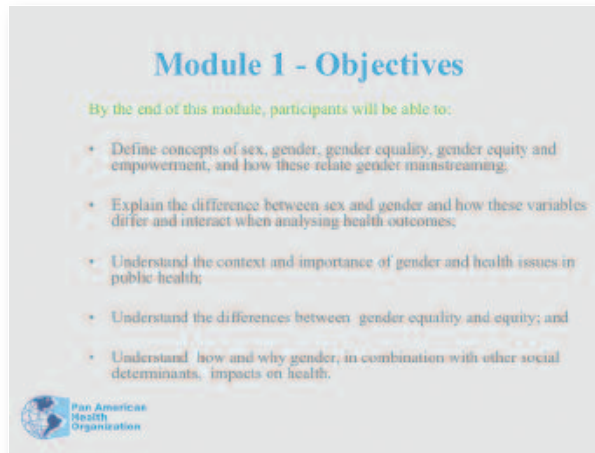
Module 1
Understanding gender concepts

Gender Mainstreaming in health, A practical guide

Module 1

Understanding Gender Concepts

Pan American Health Organization
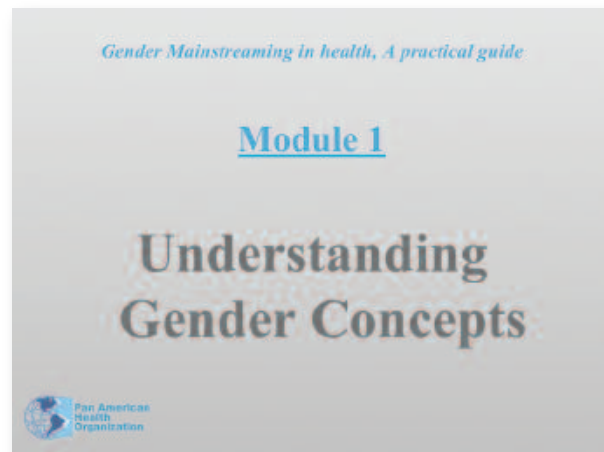
Facilitator:

Relay that Module 1 will outline key concepts that form the foundation for subsequent Modules. These include understanding the difference between sex and gender, and related gender discrimination and empowerment, unpacking the often confusing distinction between equality and equity, and making the linkages between gender and other determinants of health.

Facilitator:

Outline the objectives of Module 1, highlighting where participants'expectations and objectives converge. Identify additional expectations that can fit in, and note the others which fall out of the parameters of this module.
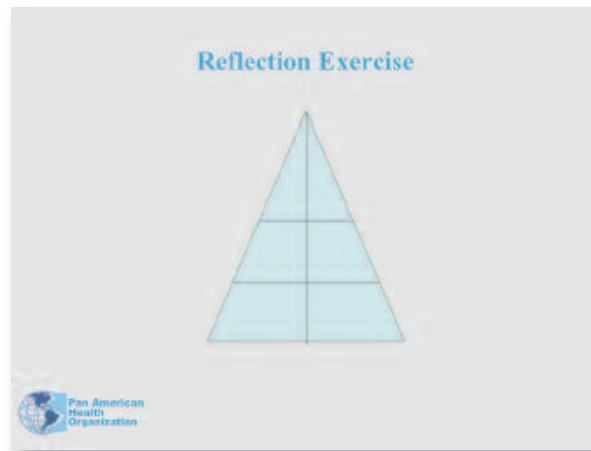
> **Facilitator tip**
> You can include these in a flip chart and locate on the wall, while noting related expectations. You may want to hang a blank sheet 9 parking lot- next to this to highlight/park important issues that can be revisited at a later stage.
>
> *Refer participants to the additional reading section at the end of the Module*

Objective: To reflect on the different ways we observe, analyze, and decide on a situation

Step 1: **Facilitator:** Show the triangle and ask the participants how many triangles they can see.

Step 2: Write the participant's responses on a flipchart:
- *How many people saw three triangles?*
- *How many saw more than three triangles?*
- *How many saw more than # triangles?*

Example: With 13 participants you could obtain the following results:
   3 triangles= 7 people
   5 triangles= 3 people
   7 triangles=2 people
   9 triangles=1 people

- Highlight the results on the flipchart and emphasize that if we are taking decisions by vote we should adhere to the decision of the majority. In this case we would assume that we saw three triangles. However, when we are taking decisions by consensus we allow everyone to participate and we can get different views in order to include and interpret each reality.

Step 3: **Facilitator:** Ask the participant who saw three triangles to point them out and then ask the same to the participant who saw more triangles. Then ask the participants if they agree with the last number cited.
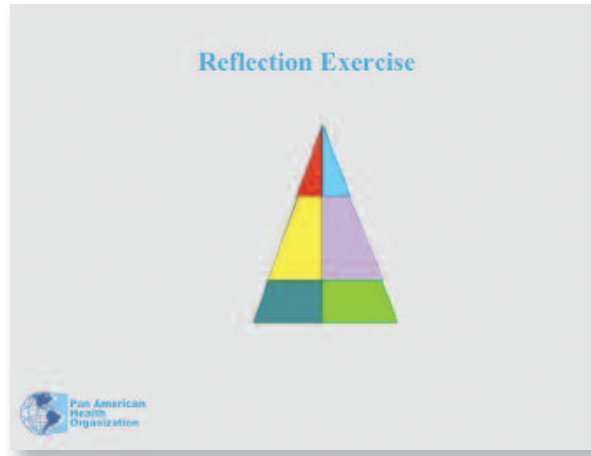
Click on the figure and count the number of triangles that come out from it in order to clearly demonstrate that there are 9 triangles.

Step 1: **Facillitator:** Encourage reflection with the following questions:

- What would have happened if we had taken the decision with the majority of votes?
- What happened when we let person A or B disclose that there were more triangles?
- How can we apply this reflection in the analysis with a gender perspective?

Step 2: **Facilitator:** Close the discussion by highlighting the importance of participatory and comprehensive analysis in which we listen to the voices of the different actors (community, women, men, elderly, young people, etc.), sectors, and organizations which are committed to and responsible for the topic. (Mention some such as: ministries of health, education, women etc., church and service providers)

Time 5 minutes: Need flipchart

Facilitator:

This activity will give participants an opportunity to define the difference between sex and gender.

PREPARATION: Prepare a flipchart with two columns, headed men and women

Facilitator:

Ask participants to share some characteristics related to men and women and list them in separate columns of the flipchart. Once you have filled the flipchart move to the next slide. You will come back to the next part of this activity after the definitions on sex and gender.

ACTIVITY

Time: 35minutes TOTAL
(Set up – 5 minutes; work in pairs –10 minutes;
Debrief – 20 minutes)

Prepare Flash Cards (follows slide) with questions and answers prior to session. Explain the process then carry out the activity

Step 1: Distribute cards randomly to participants, making sure there are an even number of questions and their answers. If there is an odd number of a participant, the extra person can join a pair or join the facilitator to form a pair.

Step 2: Instruct participants to read their card and find the person with the question or answer that goes with their card.

Step 3: Once the partner is identified, the pair can discuss for a few minutes and prepare to present their observations during plenary.

Discussion points should include answering the following questions:
a) *Did you know this fact before? Were you surprised by the fact?*
b) *What do you think is the reason for this fact?*
c) *Why does it affect women and men differently?*
d) *Why is this knowledge important for our work in public   health (e.g. in planning and implementing projects/programs, delivering services, educating clients and providers)?*

Step 4: Pairs can volunteer to present their flashcard situation and **limit their presentations to highlights** in order to keep on time, and record on flipchart key points.

Step 5: CONCLUDE the session by asking participants what the flashcards reveal about sex and gender.

Facilitator Highlights
From observations on flipchart highlight the following:
• Biological differences between women and men alone cannot explain the different disease patterns
• Some, but not all, different life circumstances and norms that apply to women and men affect their health outcomes.
• Non reproductive health conditions can affect women and men differently
• The differences in health outcomes presented in the flash cards can be mitigated or prevented
• The workshop seeks to address both the causes of these differences and how health workers can address them.
• It is helpful to keep the flashcard situations in mind as we go through the modules as examples and to enrich the discussions.

TRANSITION TO NEXT SLIDE

The facts from the flashcards and the discussion about why those facts exist have shown us why it is important to consider gender in today's public health context.

Tips for Facilitators related to the "Flash Card" activity

This is a warm up activity that is also designed to entice participants to engage with the subject matter from early on – especially those that are skeptical about the true relevance of gender in health issues.

It is not designed to discuss issues in an in-depth manner for each condition.

- Participants that are medical doctors or public health specialists may want to immediately dive into a discussion or debate on the flash card facts presented.
- Facilitators should be firm that this activity is to raise broad issues and stimulate discussion, and that there will be more time for discussion as the workshop progresses.
- Encourage participants to remember their points and to raise them in later discussions – especially when the modules refer to the flash card facts as examples or case studies.
- Remind participants that the focus of the training is not primarily about specific diseases or health conditions but rather, it is designed to build their skills at identifying the gender dimensions of health in order to improve health outcomes.
- If facilitators know their audience in advance, they may want to alter the content to topics out side the discipline in which the group currently works.
- This will allow for the group to brainstorm about a disease or health problem that they do not deal with on a daily basis, and will avoid lengthy technical debates on the health condition at hand.
- Facilitators are encouraged to use either **global or regional data** for this activity to avoid a detailed debate on the actual health condition at this early stage of the course. However, they should have more detailed local data for later use. This will require some advance preparation of the facilitator. It may be a good idea to keep this data available on a power point slide for easy reference if needed.

Activity Flash Cards with Questions and Answers

Flash card 1

Q: Does cardiovascular disease appear earlier in women than in men?

A: Cardiovascular disease tends to appear about 10 years earlier in men than in women.

Why?
Symptoms of cardiovascular disease are different in men and women and can be more "subtle" in women, often manifested in compounded heart damage before a cardiovascular event.
Sources: Regitz-Zagrosek, V. (2006). Therapeutic implications of the gender-specific aspects of cardiovascular disease. Nature Reviews Drug Discovery: 1-13.; Women's Health Victoria. (2005). Gender Impact Assessment: Cardiovascular Disease. Melbourne: Women's Health Victoria.

Flash card 2

Q: Do more men than women die from road traffic injuries?

A: Almost three times as many males die from road traffic injuries as compared to females. This is true even for young males under the age of 25 years.

Why?
There is no single rational for this discrepancy but a correlation between masculine socialized behaviour and risk taking is a factor. Also access to cars and mobility worldwide and alcohol abuse play a role in this discrepancy. *Source: Toroyan, T. & Peden, M. (eds). (2007). Youth and Road Safety. Geneva: World Health Organization. ; World Health Organization. (2002). Gender and Road Traffic Injuries. Geneva: World Health Organization.*

Flash card 3

Q: Do boys and girls have the same access to quality health care?

A: Boys and girls do not always have the same access to quality health care. For example, surveys conducted in Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand found that even when girls were vaccinated at comparable rates to boys, they were often not taken to a health provider or care facility for illness episodes.

Why?
Again there are multiple reasons for this. Factors such as social taboos (rape, violence, HIV/AIDS and others) play a role in this discrepancy. Also social norms including male preference and mobility issues often preclude girls from accessing equal healthcare.
Source: World Health Organization. (2000). Women of South-East Asia: A Health Profile. Delhi: Regional Office for South-East Asia.

Flash card 4

Q: Are women and men equally represented among new cases of HIV?

A: Globally, and in every region, more women (15 years or older) than ever before are now living with HIV. In sub-Saharan Africa, 59% of people (across all age groups) living with HIV in 2006 were women.

Why?
Women are more susceptible to infection during heterosexual intercourse due to a greater area of mucous membrane exposed during sex. In many cases worldwide men are allowed multiple partners which increases infection among spouses. Also violence (in all its forms) against women creates a greater vulnerability to infection. *Source: Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization. (2006). AIDS epidemic update. Geneva: UNAIDS.*

Flash card 5

Q: Do men and women die from tuberculosis at the same rates?

A: In 2002, nearly twice as many men died from tuberculosis as compared to women (1 055 000 and 550 000 deaths respectively).

Why?
It is important to stress that gender roles often preclude a fair assessment of female rates of tuberculosis but it is clear that men outnumber women. There is a need for further research into the reasons for this discrepancy. *Source: World Health Organization. (2005). Gender in Tuberculosis Research. Gender and Health Research Series. Geneva: WHO*

Flash card 6

Q: Do men and women experience violence in the same places and by the same types of perpetrators?

A: Women experience physical, sexual and psychological violence in their homes often from intimate partners, in conflict settings and in communities often by people they know. Sometimes they die from these situations, sometimes they remain in unsafe settings. Men, on the other hand, often experience violence at the hands of strangers and tend to die as a result of homicide by unknown perpetrators. *Source: García-Moreno, C., Jansen, H., Ellsberg, M., Heise, L., Watts, C., (2005). WHO Multi-country Study on women's Health and Domestic Violence against Women. Geneva: World Health Organization.*

Flash card 7

Q: Do many women around the world experience physical violence at some point throughout their lives?

A: Between 10% and 69% of women around the world report being physically assaulted by an intimate male partner at some point in their lives. In some countries, nearly 1 in 4 women may experience sexual violence by an intimate partner, and up to one-third of adolescent girls report their first sexual experience as being forced. *Source: García-Moreno, C., Jansen, H., Ellsberg, M., Heise, L., Watts, C., (2005). WHO Multi-country Study on women's Health and Domestic Violence against Women. Geneva: World Health Organization.*

Flash card 8

Q: Are there are male-female differences in lung cancer related mortality?

A: More men than women die of lung cancer. GLOBOCAN 2000 data reveals gender differences in lung cancer incidence, prevalence and mortality. In fact, while approximately 10 female deaths per 100 000 population were attributed to lung cancer, almost 31 male deaths were attributed to lung cancer. This is over three times more than for women!

Why?
For many years the marketing of Tobacco was aimed at men therefore lung cancers were predominantly male cases. Smoking as a culture includes rights of passage for young men and has historically been male centered. As smoking habits have changed over time the disparity between men and women is smaller that in the earlier half of the 20th century. *Source: World Health Organization. (2005). Gender in Lung Cancer and Smoking Research. Gender and Health Research Series. Geneva: WHO.*

Flash card 9

Q: Do women generally live longer than men?

A: In most countries women do live longer than men. While men's shorter life spans may be due to increased exposure to certain risk factors such as tobacco or alcohol use, road traffic accidents, homicide, suicide or cardiovascular disease, women's "extra" years are often spent in the shadow of disability or illness. *Source: World Health Organization. (2003). Gender, Health and Ageing. Geneva: WHO.*

Flash card 10

Q: Are adult women and men equally vulnerable to malaria infection?

A: Those at highest risk for malaria are infants and young children, pregnant women, and people living with HIV/AIDS. Pregnant women with malaria have an increased risk of abortion, stillbirth, premature delivery and low-birth-weight infants. Yet, it is estimated that less than 5% of pregnant women can access effective interventions for malaria management.

Men may sometimes have higher occupational risk of contracting malaria due to working in mines or fields at peak biting times. *Sources: Reuben, R. (1993). Women and Malaria – Special Risks and Appropriate Control Strategy. Social Science and Medicine, 37(4): 473-480.; Roll Back Malaria. (2003). Malaria in Pregnancy. RBM Infosheet No 4. Geneva: WHO.*

Flash card 11

Q: Were men and women affected in the same way by Hurricane Ivan in Grenada?

A: A review of deaths from Hurricane Ivan in Grenada showed that more men than women died as a direct result of the hurricane. Hurricane Ivan took the lives of twenty-eight persons, of which 30% were due to trauma to the head and chest, attributed directly to the hurricane. The majority or 69% of the victims were males, and 70 % of all deceased were over 60 years old.

Grenada has one of the highest total dependency ratios in the OECS region (94.8%) and a relatively high elderly dependency ratio of 31.8%. Persons over 65 years of age account for 16.3% of the population. It was not surprising therefore, that many of the deaths due to hurricane Ivan occurred among the aged, nor among elderly men, as there has been noticed a phenomenon in the OECS countries of the single headed male household living in somewhat lonely and precarious circumstances in old age.

A2: A review of the composition of the displaced population in shelters in Grenada, as a result of Hurricane Ivan, showed that there were more women than men

Male headed households account for some 52% of the households in Grenada and females 48%, but among the poor the situation is reversed, female headship accounts for 52% of the households. The living conditions and capacities of the head of household is important as it affects issues of inter-generational poverty , the life chances of children and the other dependents, such as the youth and elderly who live in the household. Female-headed households traditionally have an increased burden of care than their male counterparts, due to their inability to earn similar incomes, and the necessity to meet similar household needs with fewer resources.

The difficult situation of poor female headed households in the aftermath of hurricane Ivan was evident in the larger numbers of females in shelters than males and the larger number of children than adults. In one shelter in Bollieau, two women had between them some 22 children, which support the findings of the poverty assessment regarding the extremely large size of poor families. Disasters associated with natural events are fundamentally an issue of development and there are close links between poverty, low-income populations, and communities being disproportionately affected by natural hazards. *Source: OECS, Grenada: Macro-socio-economic Assessment of the Damages caused by Hurricane Ivan, October 2004 http://www.oecs.org/Documents/Grenada%20Report/GRENADAREPORT.pdf*

Flash card 12

Q: Are men and women affected by armed conflicts in similar ways?

A: Men and boys are often more likely than women to be recruited into or to join armed forces as active combatants with the possible risks to health that this role entails. It is important to remember that women and girls may also be combatants or be associated with fighting forces and that the impact on their well being may differ from that of their male counterparts depending on their roles. Women and girls are more likely than men and boys to experience sexual violence in conflicts which has implications for their physical and mental health and social well-being.

Why?

Civilian women and girls often bear the brunt of conflicts today. It is estimated that at least 65% of the millions displaced by conflict worldwide are women and girls. These women and girls face daily deprivation and insecurity. Many face the threat of violence, including sexual violence when they engage in daily tasks such as fetching water or gathering firewood. They lack access to health services that address the physical and mental consequences of conflict and displacement and may die in childbirth because basic reproductive health services are often not available. Violence against women -- including sexual violence -- is increasingly documented, particularly in crises associated with armed conflict. In these circumstances, women submit to sexual abuse by gatekeepers in order to obtain food and other basic life necessities. Rape is used to brutalize and humiliate civilians, as a weapon of war and political power and as a tactic in campaigns of ethnic cleansing. The violence and the inequalities that women also face in crises do not exist in a vacuum. Rather, they are the direct results and reflections of the violence, discrimination and marginalization that women face in times of relative peace.

Source: WHO, HAC Newsletter: Health in Emergencies, Issue 20 Focus: Women's Health,January 2004 available at: http://www.who.int/hac/network/newsletter/Final_HiE_n20_%20Jan_2005_finalpdf.pdf

Flash Cards to cut and distribute to participants

Questions:

Flash card 1

Q: Does cardiovascular disease appear earlier in women than in men?

Flash card 2

Q: Do more men than women die from road traffic injuries?

Flash card 3

Q: Do boys and girls have the same access to quality health care?

Flash card 4

Q: Are women and men equally represented among new cases of HIV?

Flash card 5

Q: Do men and women die from tuberculosis at the same rates?

Flash card 6

Q: Do men and women experience violence in the same places and by the same types of perpetrators?

Flash card 7

Q: Do many women around the world experience physical violence at some point throughout their lives?

Flash card 8

Q: Are there are male-female differences in lung cancer related mortality?

Flash card 9

Q: Do women generally live longer than men?

Flash card 10

Q: Are adult women and men equally vulnerable to malaria infection?

Flash card 11

Q: Were men and women affected in the same way by Hurricane Ivan in Grenada (Sept 2004)?

Flash card 12

Q: Are men and women affected by conflicts in similar ways?

Answers:

Flash card 1

A: Cardiovascular disease tends to appear about 10 years earlier in men than in women.

Flash card 2

A: Almost three times as many males die from road traffic injuries as compared to females. This is true even for young males under the age of 25 years.

Flash card 3

A: Boys and girls do not always have the same access to quality health care. For example, surveys conducted in Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand found that even when girls were vaccinated at comparable rates to boys, they were often not taken to a health provider or care facility for illness episodes.

Flash card 4

A: Globally, and in every region, more women (15 years or older) than ever before are now living with HIV.

Flash card 5

A: In 2002, nearly twice as many men died from tuberculosis as compared to women (1 055 000 and 550 000 deaths respectively).

Flash card 6

A: Women experience physical, sexual and psychological violence in their homes often from intimate partners, in conflict settings and in communities often by people they know. Sometimes they die from these situations, sometimes they remain in unsafe settings. Men, on the other hand, often experience violence at the hands of strangers and tend to die as a result of homicide by unknown perpetrators.

Flash card 7

A: Between 10% and 69% of women around the world report being physically assaulted by an intimate male partner at some point in their lives. In some countries, nearly 1 in 4 women may experience sexual violence by an intimate partner, and up to one-third of adolescent girls report their first sexual experience as being forced.

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Flash card 9

A: In most countries women do live longer than men. While men's shorter life spans may be due to increased exposure to certain risk factors such as tobacco or alcohol use, road traffic accidents, homicide, suicide or cardiovascular disease, women's "extra" years are often spent in the shadow of disability or illness.

Flash card 10

A: Those at highest risk for malaria are infants and young children, pregnant women, and people living with HIV/AIDS. Pregnant women with malaria have an increased risk of abortion, stillbirth, premature delivery and low-birth-weight infants. Yet, it is estimated that less than 5% of pregnant women can access effective interventions for malaria management.

Men may sometimes have higher occupational risk of contracting malaria due to working in mines or fields at peak biting times.

Flash card 11

A: A review of deaths from Hurricane Ivan in Grenada showed that more men than women died as a direct result of the hurricane. Hurricane Ivan took the lives of twenty-eight persons, of which 30% were due to trauma to the head and chest, attributed directly to the hurricane. The majority or 69% of the victims were males, and 70% of all deceased were over 60 years old.

Why?
Grenada has one of the highest total dependency ratios in the OECS region (94.8%) and a relatively high elderly dependency ratio of 31.8%. Persons over 65 years of age account for 16.3% of the population. It was not surprising therefore, that many of the deaths due to hurricane Ivan occurred among the aged, nor among elderly men, as there has been noticed a phenomenon in the OECS countries of the single headed male household living in somewhat lonely and precarious circumstances in old age.

A: A review of the composition of the displaced population in shelters in Grenada, as a result of Hurricane Ivan, showed that there were more women than men

Why?
Male headed households account for some 52% of the households in Grenada and females 48%, but among the poor the situation is reversed, female headship accounts for 52% of the households. The living conditions and capacities of the head of household is important as it affects issues of inter-generational poverty, the life chances of children and the other dependents, such as the youth and elderly who live in the household. Female-headed households traditionally have an increased burden of care than their male counterparts, due to their inability to earn similar incomes, and the necessity to meet similar household needs with fewer resources.

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Flash card 12

A: Men and boys are often more likely that women to be recruited into or to join armed forces as active combatants with the possible risks to health that this role entails. It is important to remember that women and girls may also be combatants or be associated with fighting forces and that the impact on their well being may differ from that of their male counterparts depending on their roles. Women and girls are more likely than men and boys to experience sexual violence in conflicts which has implications for their physical and mental health and social well-being.

Facilitator:

Have participants read each definition, then give an example of the distinction and ask participants for examples to increase understanding.

Facilitator emphasize that:
1. **Sex and gender are not mutually exclusive.** You cannot talk about gender without talking about sex. Example: Women but not men can bear children is an aspect of sex. The fact that, in most places, women but not men spend a great deal of time caring for children is an aspect of gender.
2. **The two are not always easily separated.** For example -- the fact that women spend more time caring for very young children may seem a "natural" outgrowth of the biological fact that women, and not men, lactate and thus, usually, need to be present to feed young children. But men can also display nurturing and affectionate qualities necessary for child rearing.
3. **To venture** further a field some evolutionary psychologists argue that certain behaviours are biologically programmed, such as women's nurturing children, men's aggression, as well as homosexual behaviours.

Our purpose here is not to separate the categories Sex and Gender -- especially because, in what follows, *both* categories will always be relevant. **Both of these have implications for health outcomes.**

Facilitator:

lead a guided discussion with the group going back flipchart on Men and Women Characteristics. Change the headings of the columns Men and Women. We will see that some qualities can still apply to the other sex, while others do not transfer because they are biologically determined. Here remind the participants of the definition of sex and gender.

Then lead a guided discussion on to the flash cards and previous activity:
1. What are the direct links between sex and health? What are the implications for health interventions?

The notion that, since "sex" is constant, or cannot be changed without surgical interventions. Health interventions need to be designed and implemented based on recognition of the sex-related or biological differences between men and women.

2. **What are the links between "gender" and men's and women's health? What are the implications for health interventions?**

Because gender issues affect men and women health behavior, vulnerability, access to health services, they should be taken into consideration in designing health policy and services.

3. **This may be a good opportunity to ask "Why is there such a focus on women when looking at gender issues in health?"**

Gender inequalities yield a disproportionate burden on women, due to their low status and related discriminations, and their disproportionate reproductive responsibilities in most societies. Also much health research has used men as the norm for cause, and manifestations of disease or drug clinical trials.

- Women's health has often been synonymous with reproductive health – largely ignoring health outcomes experienced outside reproduction (chronic diseases)
- However, we also know that social norms can impact negatively on men's health.

4. **EMPHASIZE that gender is often used as a politically correct way of saying sex, and is sometimes used interchangeably. However, in the health sector, it is important to acknowledge the distinction, as we cannot ignore biological factors anymore than we can ignore social factors that influence health.**

FACILITATOR TRANSITION NOTES

You have begun the process of uncovering the differences in the definition between sex and gender, between nature and nurture.

- **Sex** refers to those things that most people agree are the result of biological differences. It is usually **difficult to change** – unless through surgical interventions.
- **Gender** refers to those things that might reasonably vary from society to society, depending on that society's notion of masculine and feminine norms. It is usually **more difficult to change** – **and requires long term strategies.**
- Both sex and gender have implications for health outcomes – and the flash card activity gave us evidence of how those implications may play out in real life.

Facilitator Tips and Examples for Discussion on Gender and Sex

When asking participants to identify in which ways biological factors may affect males or females differently you can use the following as examples:

Anemia: Iron deficiency is linked to women's loss of iron during menstruation and pregnancy which contributes to anemia. However, hemophilia which is more common among men due to genetic reasons, often contributes to anemia in men.

Sexually transmitted infections (STIs): STIs are "asymptomatic" for longer periods in women and have severe consequences such as infertility and even death. On the other hand, most STIs are likely to be diagnosed earlier in men due to the presence of physical symptoms.

A man with an STI such as gonorrhea is more likely to seek health care earlier because the symptoms (such as pain on urination) appear within a few days from the time of infection.

The non-specific and asymptomatic nature of the symptoms of STIs in women, often results in their seeking health care late which subsequently results in more complications than in men. A painless syphilitic ulcer on the genitalia of a man is more likely to be noticed than a similar ulcer on the female genitalia. This influences their health seeking behavior

Osteoporosis: is 3 times more common in women than in men. Partly because women have a lower peak bone mass and partly because of the hormonal changes that occur at menopause and the effect of pregnancy which can alter calcium composition in a woman's body in the absence of appropriate diet and/or administration of calcium supplements.

Lifestyle issues such as diet, level of sun exposure and degree of weight-bearing activity (i.e., which reinforces bone strength) may also contribute to higher prevalence among women.

HIV: When transmitted through heterosexual relations, women are more vulnerable than men to infection. Their vulnerability relates to:

• The larger mucous membrane exposed during intercourse
• The length of time infected semen can remain in the vaginal tract (or a higher exposure to infectious fluids such as semen)
• The changes that occur in the vaginal mucosa as a result of the reproductive cycle or age
• Increased friction during sexual intercourse which may lead to lesions or tearing of the vaginal mucosa

Other examples could include cervical, breast or prostate cancer.
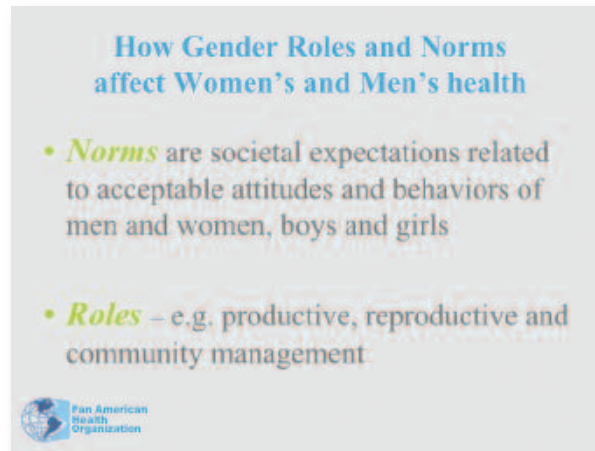
Facilitator:

Emphasize the following:
• Since gender attitudes and behaviors are learned, they can be changed.
• These perceptions are strengthened by tradition, customs, law, class, and ethics, on an individual and institutional level.

Step 1: **Ask participants to define the terms norms and roles on the slide.**
  • Note that **productive roles** are carried out by both women and men for payment in cash or kind (these tend to be most valued in most societies).
  • **Reproductive roles concern childbearing and related responsibilities, and domestic tasks;** tend to be attributed to women in most societies and are less valued than the productive roles. They include community activities that are voluntary and unpaid that contribute to a community's welfare and organization.

Step 2: **Use Handout 1.01(next page) on the effect of gender roles and norms on women's and men's health,** as a tool for discussion to further illustrate how gender roles and norms influence health.
  • **HIGHLIGHT** the main issues on the Handout,
  • Choose one to two examples, and suggest that participants read it properly after the session.
  • Encourage them to also think of their own examples, from their own contexts.

Handout 1.01: The effect of Gender Roles and Norms on Women's and Men's Health

Factors which influence health	Key questions:	Examples of how gender roles and norms influence health
How do gender roles and norms affect health outcomes generally?	• Why do different groups of men and women suffer from ill health? • Are there factors in the home, work environment that influence this (housing, water/sanitation, violence, social networks) health outcomes? • Are there structural conditions in society (physical environment, limited educational options, social welfare system, etc) that either promote or harm health?	• The risk for schistosomiasis is greater for women who come more in contact with water contaminated with the parasites, when washing clothes. • Disfigurement from leishmaniasis, leprosy, onchocerciasis generates greater rejection in many societies if the sufferer is female, given the connection between physical beauty and women's worth or ability to benefit from certain social protections
How do gender roles and norms affect responses to ill-health?	• How do local perceptions of health and illness, in addition to local norms concerning treatment affect women's and men's willingness/ability to accept illness and seek treatment? • Does women's and men's own perception of power affect their willingness/ability to admit to being ill and to seek treatment?	• Low levels of education among girls undermine their ability to acquire health information leaving them unable to seek and access appropriate health services, or use appropriate self-care. • Stereotypic masculine attitudes such as aggression, risk taking, excessive alcohol consumption are associated with cirrhosis, lung cancer and excessive mortality from violence. Requirements of stoicism often impede health seeking behaviour among men.
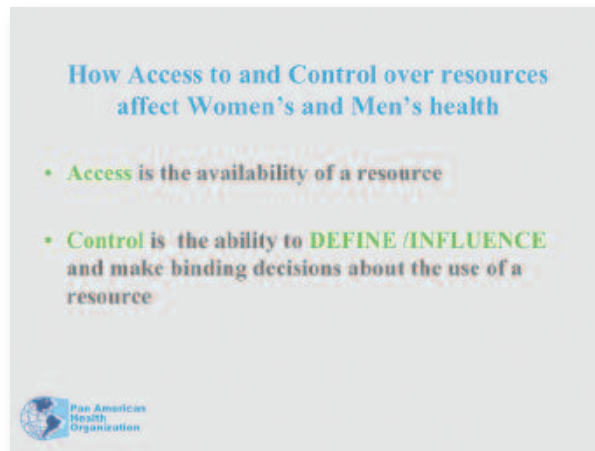
PREPARATION: Copies of Handout 1.02 (next page)

Facilitator:

Step 1: **Explain that ACCESS to and CONTROL over RESOURCES is an important component of** gender. Note the definitions of ACCESS and CONTROL on the slide above.

Step 2: **Referring to the handout, point out that there are different kinds of resources:** economic, social, political, information and education, time as well as internal resources.

Step 3: POINT OUT that access to and control over resources determines who uses services, the ease with which these services can be used, who decides which services to offer, how resources are used for prevention, care and maintaining health etc.

Step 4: REMIND participants that access to and control over resources will help reveal differences and also contribute to understanding how the these differences affect women and men in both positive and negative ways.

EXAMPLES:
Access: Lack of access to disposable income can prevent women from using available health care facilities that exist in the community

Control: Women and men may have access to the use of a condom to protect themselves from STIs but, at the time of sexual relations, may not have the ability to define or control condom use.

TYPES OF RESOURCES

Economic resources:
- money
- credit
- food
- transport
- land
- etc.

Social resources:
- community resources
- social networks

Political resources:
- position of leadership and decision making positions
- access to decision makers
- participation
- opportunities for communication-negotiation and
- consensus building

Information & education:
- formal and informal education
- opportunities to exchange information and opinions
- access to technology

Time:
- time available to participate in community, economic and leisure activities access health services

Internal resources:
- self-esteem, self confidence and ability to express own interests autonomy and empowerment

Essential questions regarding access to and control over resources:
Who uses what, the availability of services, ease in which services can be used, and response of the service to meet needs?
Who decides who can use the resources?
Who decides what resources can be used?
What is the broader legal, political and socio-cultural framework which supports power and control?
Are there differences between men's and women's control over resources that affects their own health?

Examples:
Access: Lack of access to disposable income can prevent women from using available health care facilities that exist in the community
Control: Women and men may have access to the use of a condom to protect themselves from STIs but, at the time of sexual relations, may not have the ability to define or control condom use.
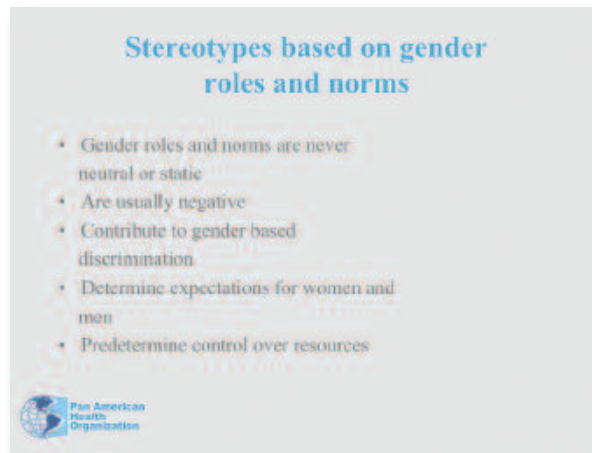
Facilitator:

POINT OUT that gender roles and norms are never neutral or static.
Women and men are usually expected to perform different tasks as adults and as children, and these roles may change depending on the context (country, culture, time, social class, age)

Step 1: Ask participants to give examples of gender roles and norms that have changed in their lives. If time is short, facilitator can offer own examples relevant to the sub-region country of the workshop.

Examples include: Their different roles as children and adults, the difference between their parents and grandparents and their roles, norms in their communities that have changed over time, control by a parent

Step 2: **Using these examples, point out that gender has the following characteristics:**
- **Based on relationships:** It refers not to women or men in isolation, but to the relationships between them and how the relationship is socially constructed.
- **Hierarchical:** The differences established between women and men, far from being natural, tend to attribute greater importance and to what is masculine and to produce unequal power relationships.
- **Change 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 in corporate a perspective of diversity in gender analysis
- **Institutional:** t 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, legislations, religion, etc.

Therefore: Gender roles and norms can be changed, although changing gender systems is often contested and requires short, medium and long term strategies in order to redress gender inequality that is often reinforced by these systems.

Step 3: **Point out that stereotypes are assumptions based on predetermined roles and norms**
Solicit examples of stereotypes that affect health. Examples include:
- Women's biological responsibility for childcare, resulting in men often being excluded from ante and prenatal care responsibilities.
- Health providers assume that family planning is a woman's responsibility, resulting in limited services for men and related non use of methods to protect their own and partner's health.
- Men are assumed to be perpetrators of violence, resulting in their being excluded or demonized in discussions related to gender based violence.
- Women considered complainers which lead to their symptoms not considered seriously.

Facilitator:

CONCLUDE: Gender stereotypes are usually negative in that they limit opportunities of women and men to fulfill their development and health potential - they should always be validated or refuted through consultation with the population in question to avoid erroneous assumptions.

POINT OUT: The same gender norms, roles and stereotypes that are harmful to women may play out differently for men and prevent them from realizing their full capacity to care, nurture and be responsible to their families and communities. Many societal norms encourage men and boys to engage in high-risk behaviors that harm both themselves and others.

Step 4: Gender roles, norms and stereotypes determine expectations for women and men, as well as their control over resources.

Solicit examples of gender-based divisions of labor and their possible health effects.

Examples include:
- Men tend to work on construction sites more than women due to the heavy physical demands. This may make them more vulnerable to work-related injuries.
- Women spend most of their productive years caring for children, the ill, elderly and disabled with no or low pay, or in the informal sector. This type of work excludes them from the pensions and benefits provided by formal employers
- Many women in developing countries are exposed to indoor air pollution at higher rates than men due to their labor related to food preparation and being within the home.

Facilitator:

CONCLUDE: Women and men are usually expected to perform different tasks as adults, and as children are raised or socialized into the expected behavior to carry out those tasks later in their life.

CLARIFY that "gender-based division of labor" refers to formal market and informal labor activities. This means it refers to *occupations outside of the home, as well as those tasks that men and women carry out in the community and household are often unpaid.*
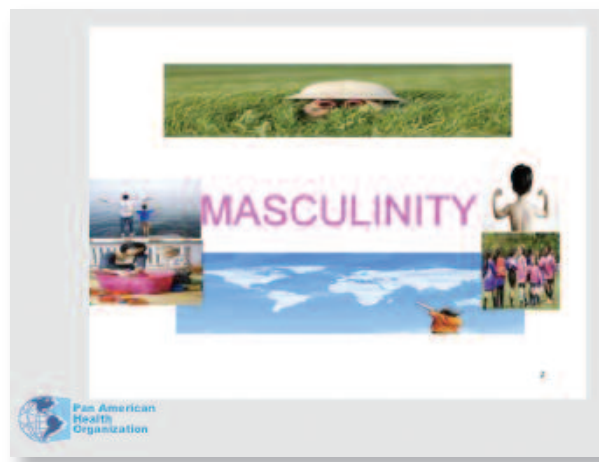
Facilitator:

Step 1: **Point out that in order** to have a better understanding of the gender relations, we need to look at the definitions of masculinity.

Notes for facilitator
As we have seen, gender refers to the socially constructed roles, expectations and definitions a given society considers appropriate for men and women. Sex refers to the biological and physiological characteristics that define men/ boys and women/girls.

Male gender norms are the social expectations and roles assigned to men and boys in relation to or in contrast to women and girls. These include ideas that men should take risks, endure pain, be tough or stoic or should have multiple sexual partners to prove that they are "real men".

Masculinity refers to the multiple ways that manhood is socially defined across the historical and cultural context and to the power differences between specific versions of manhood (Connell, 1994).[2]

Boys learn what manhood means by observing their families, where many see women and girls providing care giving for children while men are often outside the family setting working. They observe and internalize broader social norms, including messages from television, mass media and from which toys or games are considered appropriate for boys or girls. They also learn such norms in schools and other social institutions and from their peer groups, which may encourage risk-taking behavior, competition and violence and may ridicule boys who do not meet these social expectations. These social meanings of manhood are largely constructed in relation to prevailing social norms about what it means to be a woman or girl. At the same time, norms about manhood are constructed against the backdrop of other power hierarchies[3]

Global studies suggest that both men and women are placed at risk by specific norms related to masculinity. In some settings, for example, being a man means being tough, brave, risk-taking, aggressive and not caring for one's body. Men's and boys' engagement in some risk-taking behavior, including substance use, unsafe sex and unsafe driving, may be seen as ways to affirm their manhood.[4]

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[2] Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions: WHO
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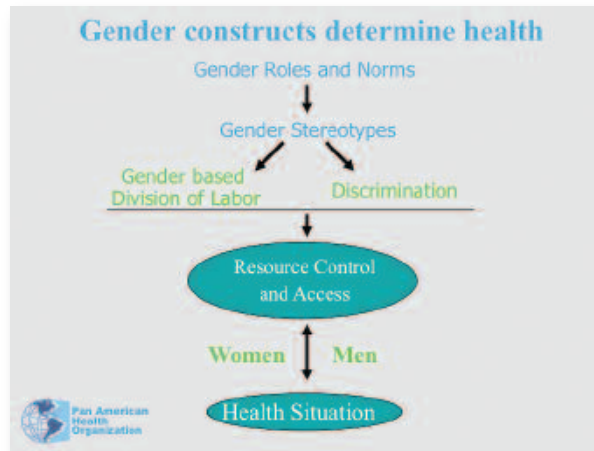
Facilitator:

Introduce the slide that includes several interesting concepts.

This slide shows how gender is socially constructed and that its components interlink to affect health. It shows how gender roles and norms result in the stereotypes that lead to the discrimination and division of labor that in turn influence women and men's behaviors and vulnerabilities that affect their health. It also shows how these interlinked gender variables determine women and men's control over the resources needed to access health services and information, as well to maintain optimal health.

TRANSITION TO NEXT SLIDE

Remind participants that there are no "right" or "wrong" gender norms but when these norms result in the mistreatment of one sex over the other, or a difference in power and opportunities, it can lead to discrimination and thus inequality and inequity in health

Facilitator:

Step 1: **Relate:** The first step to becoming "gender aware" begins with looking at the gender norms and roles and asking if they are really normal or fair, and explore their impact on health. Remind participants of flashcards that showed different health outcomes based on life conditions

Step 2: **ASK participants what Gender Equality means.**

Facilitator Talking Points:
- *Gender equality* refers to women having the same opportunities in life as men (and vice versa), including the ability to participate in the public sphere. **Emphasize that gender equality is not about making women and men the same, which is a common misconception.**
- It is about making sure that **women and men have the same chances to access and control socially valued goods, tools and resources.** An example of this might be to ensure equal access to a health care facility or to health insurance.
- What gender equality *is about:*
  - Being valued equally, regardless of sex.
  - Taking steps to ensure that women and men **have the same chances and opportunities in life** to gain access to and use resources such as water, education, housing, health care, employment, finances, technology, etc. (These are also called socially valued goods, tools and resources).
- What gender equality is *not about:*
  - making women and men the same;
  - giving one sex more authority over the other

Step 3: **ASK: what does gender equality in health means?**
- *Gender equality in health* means that women and men, girls and boys have equal conditions for realizing their full rights and potential to be healthy, contribute to health development, and benefit from the results. It is a human right of all to be able to live a healthy life. It is a human right of all to get the best ability and support to be able to live a healthy life.

- Despite this right, differences in risk exposure, vulnerability to disease, and mortality exist between men and women, boys and girls, as we saw in the activity with the flash cards. This is the reason why health care workers and planners need to pay attention to gender equality.
- Recognizing historical imbalances in the health system
- Making the health system more responsive to the health needs of women
- Equity of access, treatment and outcomes for men and women, girls and boys

> **MDGs Reminder: Gender equality is a condition for achieving all 8 MDGs,** as well as for empowering women as defined in Goal 3 of the MDG, in itself an essential component of gender equality, and therefore for achieving Goal 3 and all of the MDGs

Facilitator:

CONCLUDE: The *objective of gender equality* is to ensure that opportunities and chances are the same for both sexes. But this is not enough. Achieving gender equality broadly (including in health) will require specific measures that are designed to diminish existing inequalities between women and men. In some instances this can mean that more emphasis has to be placed on women, as we discussed earlier today. In other words, we may need to pay more attention to women. This is what we mean by *gender equality.*

Gender equity and health

3. What is gender equity?
- means fairness and justice in the distribution of power and social resources <u>according to the differential needs</u> of men and women, boys and girls.
- Removes barriers to access education, health services and politics.

Equity is the means ➡ equality is the result

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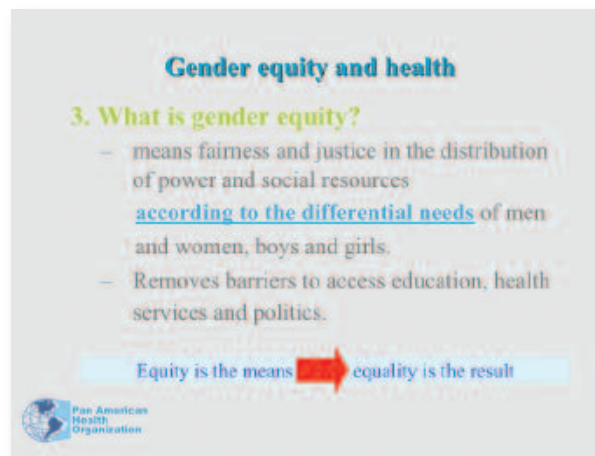
Facilitator Talking Points:
Gender equality refers to equal opportunity, while gender equity refers to fairness in distribution of goods and resources, which may include rectifying the imbalance between the sexes.

In other words, gender equity strategies are used to eventually attain equality. Equity is the means, equality is the result.

The goal of gender equity moves beyond equality of opportunity by requiring transformative change. It recognizes that women and men, girls and boys may have different needs, preferences, and interests and that to have equality of opportunity, it may be necessary to treat women and men differently and/or separately.

Conversely Gender inequity in health refers to those inequalities between women and men, in health status, health care, and health work participation which are unjust, unnecessary, and avoidable (PAHO Gender Equality Policy)

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Facilitator conclude with these points:
- In order to respond appropriately, it is important that public health workers understand the differences between equity and equality to enable them to develop fair and efficient responses, and incorporate strategies that address the differential needs and realities of women and men.
- A *gender equity approach* implies that all policies and interventions need to be scrutinized for their impact on gender relations. It requires a rethinking of policies and programmes to take account of men's and women's different realities and interests. It implies rethinking existing legislation on employment to account for women's reproductive work and their concentration in unprotected, casual work in informal and home based enterprises.
- Remind participants that this is what gender mainstreaming does – and therefore gender main-streaming strategies are part of gender equity.

</div>

Activity
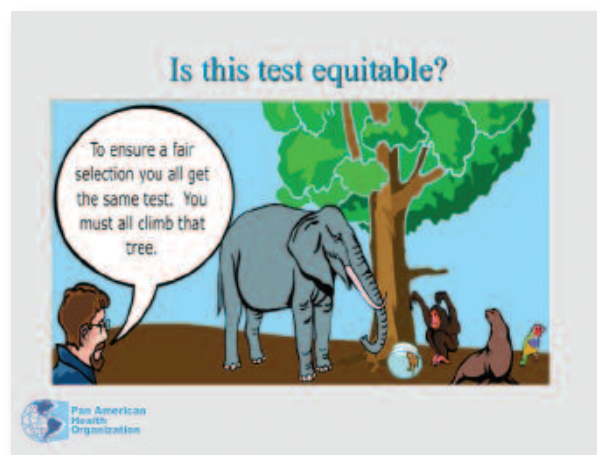
Facilitator:

Use this Cartoon Test to clarify the concepts of equality and equity by asking participants: This test is the same for all, but is it equitable?

Talking Points:
Even though all animals in the picture have the same opportunity to respond to the test (equality), it is unfair because they do not all have the same capacity to climb that tree (inequity)

Tips for Facilitators
- The differences between equality and equity are often difficult for new gender learners to understand. It is important to verify that the differences in the concepts are understood.

- It is good idea to solicit examples from the group as to what gender equality means and what gender equity means in a health context. This will engage them with the material and further their comprehension of the subject. Try to avoid merely reading the definitions off of the slides as this tends to lose the interest of participants.

Facilitator sum up sessions with the following points:
- Achieving gender equality is not a one-off goal. Progress can all too easily be eroded. Gender equality needs to be constantly promoted and actively sustained!
- It is important to remember that gender inequality, is based on wide-spread and often historic beliefs and traditions about women and men. These beliefs and traditions are often passed from generation to generation without any question as to their validity or their fairness. The beliefs and traditions may be embedded in laws, practices and social institutions. They often permeate organizational structures, *including health care systems.* This reinforces patterns of gender stereotyping, discrimination and limits opportunities available to men and women.

Empowerment

Facilitator:

Step 1: POINT OUT that empowerment women and also men is one of the most important strategies for achieving gender equality.

Step 2: ASK participants to give an example of how empowerment has resulted in a more successful health outcome

Step 3: Discuss the following
- EMPOWERMENT is an important concept when exploring gender-based discrimination, because it implies transformation –when a disadvantaged person gains more power through confidence, skills-building, and education.

Empowerment implies a new strength to overcome discrimination or exploitation:
- It often implies self-help or support from others who share, build and open up the potential to accesses power.
- In health it "empowers" men and women to participate in their own health-related decisions, and it places women and men at the centre of health programmes and policies. It provides them with the tools to attain and maintain optimal health.

CONCLUDE that only women, men and communities can empower themselves – But the health sector, and all of us that work in it, can support empowering processes to make a difference in men and women's control over their health.

Tips for Facilitators

- There may be confusion, even opposition, to saying *"gender norms can be changed"* as it may be understood that they *should* be changed. It is important to unpack such statements by emphasizing that integrating gender into public health programmes and policies is not about changing the roles and responsibilities of women and men for arbitrary reasons – nor is it about changing women and men themselves. Rather, it is about **changing behaviours and practices that are harmful, exploitative or discriminatory.**
- Remind participants that as representatives of the health sector, they have an obligation to promote and safeguard the health and well being of the populations in their context. This includes looking at those factors that may contribute to ill health, impact negatively on the quality of life circumstances and deny women and men the access to services, and to prevent or limit these factors. This means that when public health actors discuss changing gender norms – we are **referring to those harmful** gender norms that increase health risks for women and men.
- It may be necessary to take some time to discuss the fact that work on gender and gender equality is not about unravelling tradition, cultural or religious institutions as a form of militant activism. Depending on the audience, facilitators may **need to address the perception (and potential rejection) of gender work as an equivalent to radical feminism or Western impositions on differing cultural con texts and realities.** The following section provides an opportunity to discuss such misconceptions. Counter sceptical attitudes through open dialogue and the solicitation of concrete examples from participants.
- Finally, remind participants that in order to really be able to address the harmful ways that gender roles and norms affect health, they must understand the reasons why certain practices or beliefs are upheld and work in collaboration with women and men from the local population (including community leaders, etc.) to find acceptable solutions to address them. **Developing gender-responsive interventions will most likely not be effective if they are solely constructed in a meeting room at WHO, PAHO or MoH without consulting the very women and men whose health we are trying to promote and protect.** Women and men are important stakeholders in health; this means we must find ways to engage with them all.
- Building on the point above on consulting local populations, it is also important to remind participants that working across sectors and with multiple partners is the only way to achieve the common goals of social justice and improved health outcomes for men and women. Encourage them to take on a stewardship role by using health as a platform and entry point for addressing social inequalities and using their influence as health workers (whether service delivery, programmatic or political) to do so.

WHY WORK ON GENDER AND HEALTH?

1-International Mandates on Human Rights
2- International & Regional mandates on
   Gender Equality
3- Gender Mainstreaming define as strategy by
   ECOSOC
4- PAHO/WHO Gender Equality Policy
5- Research shows that Gender is an important
   Social Determinant of Health

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Facilitator:

Present the aim of this section with this slide: working on gender and health responds to international agreements

Facilitator Talking Point:
We will very quickly look at gender in the context of the international agreements that address gender equality, and the UN and WHO/PAHO response to these commitments. We will review these in the slides that follow.

1) Human Rights
2) International and regional mandates
3) ECOSOC mandate for mainstreaming gender
4) PAHO/WHO Gender Equality Policy
5) SDH: Social determinant of health

The Right to Health

- The Universal Declaration of Human Rights:
  Article 25: (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

- Health is considered a fundamental Human Right in WHO Constitution:
  The right to health applies to all human beings regardless of their race, color, sex, language, religion, political or other opinion, their social origin, property, birth or other status.

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Facilitator:

STATE that achieving gender equality and health equity are a part of the broader human rights agenda.

Step 1: EMPHASIZE the following:
- Achieving gender equality is a criteria for realizing human rights. Human rights cannot be realized without due attention to gender equality. It is important to emphasize that these are not competing agendas. They are in fact complementary – and need to work hand in hand.
- Addressing both gender equality and human rights increases the chances of attaining true health equity.

Step 2: Introduce the concept of "the right to health."
- Clarify that the right to health does not mean the right to be healthy – rather it refers to the right to mechanisms, institutions, etc that facilitate being healthy. For example, access to resources and information, health services, essential medicines, quality care, etc are part of facilitating the right to health.

Global/Regional Commitment

International attention to gender equality over past 20+ years

- 1975 I W C on Women- Mexico City
- 1979 Convention on the Elimination of all forms of Discrimination against Women
- 1980 II WC on Women- Copenhagen
- 1985 III WC on Women -Nairobi
- 1994 Inter-American Convention on Prevention, Punishment and Eradication of violence against women Belem de Para, Brazil
- 1994 International Conference on Population and Development (Cairo.)
- 1995 World Summit for Social Development (Copenhagen).
- 1995 IV World Conference on Women (Beijing.) UN Resolutions and P o A Gender issues
- ECOSOC resolution in 1996-97 endorsed and institutionalised Mainstreaming
- 2000, MDGs Gender equality and women's empowerment
- 2000 UN Security Council resolution on Women Peace and security
- 2005, PAHO Gender Equality Policy
- 2007, Health Agenda for the Americas™ to achieve health equity it is a must to promote gender equity" (Panama)

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Facilitator:

Step 1: **Provide a quick overview.** You can always refer to this slide which includes the International Commitments that most countries have made to gender equality including in health. Only select a few discussion points and encourage participants to review this slide on their own time, given the importance of these agreements

Facilitator Talking Points (optional depending on time)
- The UN Decades for Women over the past 20+ years has drawn global attention to women's rights and gender equality and the effects this has on many aspects of development, including health.
- **The four Global Conferences on Women,** started in 1975 in Mexico and resulted in the Agreement on the Beijing Platform of Action in 1995 which establishes lines of action, including health and gender based violence, to ensure women's rights, equality and participation. **It also established gender mainstreaming** as a way for governments and development agencies to achieve the platform's goals of attaining gender equality in all sectors. In response most countries and UN agencies, including WHO (2002) and PAHO (2005) implemented a gender equality policy and are obligated to report to the Secretary General annually. (Mention PAHO/GE's Best Practices in Gender Mainstreaming in Health)
- The commitment to gender equality and women's health issues dates back to 1979, when Member States ratified **the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which holds these states accountable for reporting on advances every 4 years.**
- **During the 90's,** known as the "Human Rights" decade, women's rights and gender equality became central to such groundbreaking commitments as the International Conference on Population and Development (Cairo, 1994), the World Summit for Social Development (Copenhagen, 1995), the Fourth World Conference on Women (Beijing, 1995) and UN ECOSOC Resolutions (1996 and 1997).
- **The LAC Region** was the first to define a regional and legal framework for preventing and addressing gender based violence 1994 through the Convention on Prevention Punishment and Eradication of violence against women was taken in Belem do Para. In 1993 PAHO had identified Gender Based Violence as a public health priority
- **Millennium Development Goals,** (MDGs) the internationally agreed framework for achieving development and health, established gender equality as essential for achieving all eight goals, as well as including it as a specific goal aimed at empowering women. While all eight goals affect health outcomes, three specifically focus on health and nine of the 17 targets relate directly to health outcomes. Gender and health are central to reporting on all MDGs.

PAHO/WHO Mandate

- WHO Gender Policy, 2002
- PAHO Gender Equality Policy, 2005
- WHO Strategy adopted by WHA 2007

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Facilitator:

Step 1: Mention that PAHO's Directing Council in September 2005 adopted the **Gender Equality Policy** that we have distributed to you (in the packet). This forms the basis for PAHO and Member countries commitment to mainstreaming gender in health.

Step 2: POINT OUT:
- This commitment and applies to all facets of its work including: technical cooperation, development of national policy frameworks and management of human resources.
- PAHO's policy is framed within the 2002 WHO Gender Policy and is in harmony with the decision, now being implemented across the UN system, that the integration of gender considerations/gender mainstreaming, must become standard practice in all policies and programs.
- The implementation of the Gender Equality Policy will contribute to increasing the coverage, effectiveness, efficiency and ultimately the impact of health interventions for women and men, while at the same time contributing to achieving the broader UN goal of social justice in the Americas.

Step 3: As members of the Gender, Ethnicity and Health Team, we hope you familiarize yourself with the policy, as we shall refer to it throughout the workshop, and it forms the basis for mainstreaming gender, achieving equality and improving efficiency in our work and Technical collaboration to member countries.

TRANSITION TO NEXT SLIDE GENDER MAINSTREAMING

Before showing slide, ask participants to define gender mainstreaming. Note down on a blank flipchart, or in your own notes, their answers for comparison with slide content afterwards.

Facilitator:

Step 1: Review participants' definitions of Gender Mainstreaming **(GMS)** and point to the common areas of the UN definition

Step 2: POINT OUT:
- GMS was first mentioned in the Beijing Platform for Action and then endorsed and institutionalised for all UN agencies and programmes in two consecutive ECOSOC resolutions.
- GMS **is often mistaken as a code word for 'women-only projects'.** This is not the case by its definition. Last year a rapid assessment was conducted by the Gender, Ethnicity and Health team with Family and Community Health colleagues showed that the majority of the colleagues equated gender with women issues.

- GMS addresses both **programme** issues, like how certain diseases or health problems affect women and men differently, as well as the **process** of how PAHO/WHO treats its workers (parity policies) and does business.
- It is important to remember that GMS is **a long term process with progressive rather than immediate results.** This does not exclude short term efforts to address immediate inequalities. In fact, this is often why there are women-targeted efforts as a way of addressing urgent gender gaps that are unfair.

Facilitator:

REMIND PARTICIPANTS that gender mainstreaming will have truly succeeded only when targeted program are no longer needed, and when these program are able to adequately address from the start women's and men's differential needs in a comprehensive way.

Gender mainstreaming is our collective duty –It is not the responsibility of one Office, Team, Department or Area. It is also not the responsibility of women only. The health of women and men is the responsibility of PAHO/WHO and its member governments.

Gender as a Social Determinant of Health
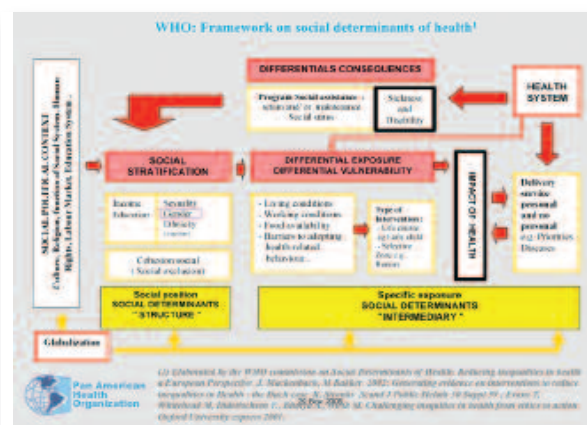
Facilitator:

Step 1: POINT OUT that Gender is included as determinant of health by the WHO Commission on the Social Determinants of Health (see reference in the manual).

Step 2: Quickly go over the points below, mention that we will again look at this slide and gender as a health determinant during module 2
- On the left side: understanding the context – social, political, including culture, religion, etc. - is fundamental in developing a Gender Analysis and in designing health programs, projects and policies.
- Gender as a structural determinant, combined with other social factors, produces differential exposure and vulnerability that impacts health.
- On the right side: the health system should be understood as an intermediary determinant of health.

Step 3: Addressing Gender as a Determinant of Health prepares us for the Power Walk activity that follows.

Exploring Social Determinants of Health and Gender

- Brief introduction relating gender with social determinants

- Participants are invited to gather in a larger space

- Every participants select one label to play a character

- Ask for several people to volunteer as observers

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Time: 60 minutes
(30 minutes set up and role play-30 minutes debrief)

Summary of Activity

This activity is a role play that allows participants to experience the ways that gender and other social determinants of health interact to affect the health of various assumed characters. The role play allows participants to take steps forwards or stay put, similar to what happens in a board game (such as checkers). At the end of the role play, the position of each "player" is analysed to unearth the interactions of gender and other social determinants of health.

The idea is to role play a range of characters (with a good sex balance) representing experiences vulnerabilities and privileges with respect to specific health behaviours and interactions with the health system.

The activity is preferably carried out in an open and fairly large space to allow for movement and can take a fair amount of time to finish. It can also serve as an energiser in that it gets participants moving around.

Role Play Instructions

FACILITATOR PREPARATION:
1. You will need a relatively large space for this activity.
2. Make cards for each character (see p.52), or make up diverse characters using local contexts.
3. Prepare a flipchart to record observations by three areas: front area, middle and back.
4. Write a card with questions for each observers (two or three):
   - What did you notice as people took steps forward, or remained still
   - Once they know who everyone is, where are the women and where are the men?
     What do theynotice about this pattern?
   - Who do they think is empowered and why?
   - What did you learn from the activity that is useful in your work?

Step 1: Distribute Roles
   - Randomly pass a card with a different character to each participant. We recommend the play should include a minimum of eight and a maximum of 12-15 participants. Some characters can be duplicated to reveal the difference in experience related to that character. Participants should not disclose their characters until asked at the end.
   - **Observers:** Assign two or three people to be observers and place them in strategic places to take notes on participant reactions (depending on the number of participants). They will be asked to report their observations to the group at the end of the activity.

Step 2: Power walk start up
   - Assemble participants in a horizontal line, as if they are about to begin a race.
   - Explain to participants that you will ask them a series of questions and that depending on the response of their assumed characters, they will move forward if the answer is yes, remain still if the answer is no, and take a small step for partial answers.
   - Agree on the size of steps that is considered "normal" for the activity and with respect to the space available.

Step 3: Power walk in Action
   - Read out statements from the provided list one at a time.
   - Participants will move or stand still silently according to their assumed character's response to the question.
   - After the last statement, participants remain in their places and reveal their assumed identity to the group. Note where they end up in the formation (front, middle or back)
   - Ask observers to share their observations, addressing the questions.
   - **Record the observations for each group (front, middle and back) on the flipchart for discussion, and for referral during Module**

Step 4: Power walk discussion and conclusion (see next page for discussion guide)

Power Walk feed back and discussion points

Step 1: Lead a discussion on the outcomes of the Power Walk and its connections with health interventions.
- Select a couple of characters from the front sections to describe their experience, and what it felt like to be in those positions. After the group has spoken on the "front row", tell them that these are the people we normally meet when we go to the community. **Often, these are the partners of PAHO/WHO** or MoH. Note these characters on the prepared flip and record their comments.
- Select a couple of characters from the middle sections to describe their experience, and what it felt like to be in those positions. Usually these are community organizations and workers (health and otherwise) – sometimes even including nurses and other health professionals (usually not doctors though). Remind participants **that these are also important partners for PAHO/WHO or MoH** that we must engage with when we want to reach the people at the back. **We also want them to be able to say yes more often to the Power Walk statements. Ask participants what strategies they think could help to do this.**
- Select a couple of characters from the **back sections** to describe their experience, and what it felt like to be in those positions. **Ask how they felt as they watched others moving forward.** If no one else points it out, say that the people at the back are usually the **direct beneficiaries of the programmes and policies that we develop** in collaboration with WHO or MoH – and usually the most difficult to reach. These are the women and men whose health we are supposed to promote and protect. Why are they at the back?

Step 2: Ask what the power walk tells us about the way in which we should develop health programmes and policies. What the different people need in order to participate effectively. How can the front group better respond to the different situations to improve health programming or policies?
- The front and middle sections often represent characters that are more privileged and have more decision-making power in the community and in the health system than those in the back sections (Woman suffering from a mental health disorder, NGO community worker visually impaired young man etc.) Often, the front characters are key gate keepers while those in the back sections are from marginalized groups.
- The back sections must be consulted for their needs to be understood and incorporated into plans, programmes and policies
- For optimal health outcomes, health equity and promotion of gender equality, there is a need to work with key characters that are represented in all three sections.

Step 3: Conclude by highlighting the following key points:
- Sex, age, ethnicity, sexual orientation and place of residence are all important determinants of health. When they interact with gender norms they often reduce the ability of characters (both women and men) to take a step forward in the Power Walk – or to safeguard their own health.
- It is not only the existence of health services (regardless of their quality) that ensures proper and effective access to, and use. Who you are, and the conditions of your life, make a difference to how you can interact with the health system and how the health system treats you.
- Furthermore, certain conditions of your life may mean that you have less social support for coping with disease and illness or less power to take decisions over your own body. These are all aspects that are uncovered when we pay attention to gender.
- The Power Walk not only allows people to identify marginalized groups and work out a strategy for including them in the process; it also clearly shows the power structure of the community – the subject of the role and pattern analysis that will come later.

Roles/Characters for Power Walk

Orphan girl (10 years old)	Poor rural grandmother looking after 4 grandchildren
Orphan boy (10 years old)	Woman living in rural Asia/Africa (aged 18 – 44 years)
Male sex worker	Illiterate woman (age 50 years)
Female sex worker	Illiterate man (age 50 years)
Staff member at WHO	Indigenous man a
Minister of Health	Professional man with 1 child
Female Community Health Worker	Professional woman with 1 child
Journalist for a local newspaper	Indigenous woman
70 year old woman living in a refugee camp	Teenage boy
Woman suffering from a mental health disorder	Man suffering from a mental health disorder
Primary school teacher	Dispenser / pharmacist
20 year old survivor of rape	15 year old girl, married to someone three times her age
20 year old male survivor of a traffic accident	HIV positive woman
NGO community worker	A policewoman
Gay man (aged 18-44 years)	Poor agricultural labourer x 2 (male and female)
Community nurse	Female Migrant worker
District Director of Health	Male Migrant worker
Domestic Workers (male or female)	Seasonal Workers (male or female)
Divorced woman with children	Divorced man with children
Visually impaired young man	Visually impaired young woman
Lesbian woman (aged 18-44 years)	A male doctor/female doctor

Questions/Statements for Power Walk

1. I know where to find the nearest health facility.
2. I feel respected by local health care workers.
3. I have a say in the way health services are organized and delivered in my community.
4. I can consult health services when and if I need to.
5. I have access to family resources if I need to pay for health care.
6. I can talk openly to local health care workers about my health problems.
7. I can talk openly to my family about my health problems.
8. Health programs in my area understand what my life is about.
9. I understand how to take medication given to me by my doctor. [Note: If participants feel that they would not even have access to medication, they should remain in the same place.]
10. I am allowed to be treated by a health care worker of the opposite sex.
11. I get to meet government officials.
12. I can read and understand the health information posters at the health facility.
13. If I get sick, I know I will be able to find the medicines I need.
14. I have access to micro-credit or other forms of earning money.
15. My opinion is important within my own ethnic or tribal group.
16. I have access to clean and safe drinking water.
17. I eat at least two full meals a day.
18. I can buy condoms.
19. I can negotiate condom use with my sexual partner(s).
20. I can refuse sex with my partner or spouse if I want.
21. I went to secondary, or I expect to go to secondary, school.
22. I can pay for treatment in a private hospital if necessary.
23. My opinion is respected is considered important by municipal or district health officials where I live.
24. I am not in danger of being sexually harassed or abused.
25. I do not feel judged by health care workers.

> **In Summary we have learned :**
>
> • The difference between sex and gender
>
> • The context for and importance of gender to our work in public health
>
> • The differences between gender equality and equity
>
> • How and why gender in combination with other social determinants influences health
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Facilitator:

Concluding Remarks:

- This module has provided the first step in exploring how gender can be included in your public health work. Without an understanding of the basic concepts of gender and health it is difficult to understand its applications.
- We have seen that gender is not only a women's issue or that women's health is not only affected by reproductive health interventions. This will enable you to use the following modules that focus more on the integration of gender on specific health areas of work.

> **MODULE ONE COMPLETED!**
>
> **Thank you for your participation!**
> **Don't forget the Evaluation & See you in Module 2**
>
> • A BIT ABOUT MODULE 2: You will learn about gender analysis and how to apply it to health issues, programs, projects and policies
>
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PREPARATION: Make copies of the learning form on the following page and disseminate to participants.

Facilitator:

NOTE:
- Congratulate participants for having completed Module 1
- You are now ready to move on to Module 2, where you will learn about gender analysis and how to apply it to health issues, programs, projects and policies
- Hand out copies of evaluation matrix to participants, and ask them to fill in the learning matrix and leave it on the facilitator's desk. These anonymous results will be aggregated to assess overall learning and shared before starting Module 2

See you in Module 2!

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Facilitator:

Prepare copies in advance to hand out to participants.

Now it is time for a progress check! Please fill out the following table, indicating by a check mark your responses to the following statements. This activity should be done anonymously. When you have finished with this work sheet, please place it on the facilitator's table.

I Know/Understand...	Not at all	Somewhat	Well
1. Why working on gender issues in public health is important.			
2. The difference between sex and gender...			
3. What gender is...			
4. What gender equality is...			
5. What gender equity is...			
6. What gender roles and norms are...			
7. What gender mainstreaming is...			

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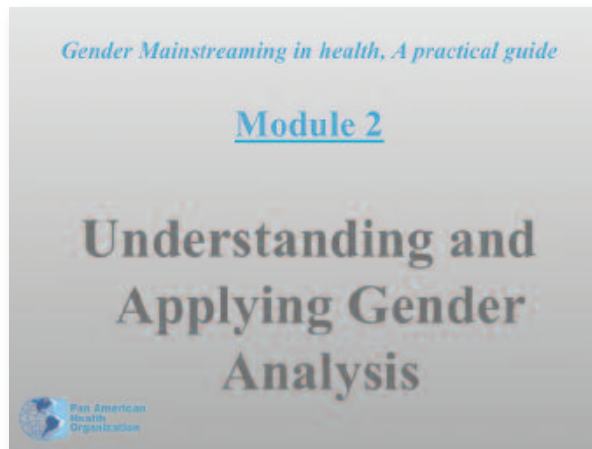
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Module 2

Understanding and applying gender analysis

Gender Mainstreaming in health, A practical guide

Module 2

Understanding and Applying Gender Analysis

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Facilitator introductory notes:
Before we discuss module 2, overview the objectives and what we will be covering today, let's do a Progress Check on the key concepts covered in module 1, as it is important to have a clear under-standing of these before moving on to how they may be applied.

Progress check of core concepts in Module 1

I know/Understand...	Not at all	Somewhat	Well
1. Why working on gender issues in public health is important.			
2. The differences between sex and gender.			
3. What gender is.			
4. What gender equality is.			
5. What gender equity is.			
6. What gender roles, norms are.			
7. What gender mainstreaming is.			

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Time: 10 minutes

Facilitator:

Aggregate results of Module 1 evaluation on this slide or flip chart and quickly review, before proceeding to Module 2. **More details in the box**

Facilitator Notes for module 1 Evaluation

Step 1: Go through completed participant worksheets and tally the checkmarks found in the "Somewhat" and "Not at all" columns. Consult Module 1 slides, talking points, trouble-shooting pointers and addi-tional reading from all three modules to prepare further explanations of the poorly understood concepts.

Step 2: With participants: Overview the flip chart summarizing evaluation results (or include in slide) and summarize those concepts that still remain unclear. Revisit these definitions/concepts using materials from Module 1. If there are no checkmarks in the "Somewhat" and "Not at all" columns, congratulate participants – and yourself!

If you get the impression that the understanding is less than optimal, approach affected indi-viduals privately and at their convenience for further explanation.

If the majority of participants have not understood the main concepts from Module 1 (and therefore the objectives were not met), the facilitator will need to go over the materials as appropriate. This may have time implications for

Step 3: Sum up by saying (if necessary based on the discussion during the activity):
Module 1 taught us some key gender concepts including how gender norms and roles are often hierarchical and often privilege one group over another leading to unequal power relations between the sexes.

MODULE 2: Objectives

By the end of this module participants will be able to:

- Understand gender analysis and explain why it is important in public health

- Understand what sex-disaggregated data is and why it is important in designing, implementing and evaluating health programs and projects.

- Understand how and why gender in combination with other social determinants impact upon health

- Use a gender analysis matrix to analyze a health problem or issue

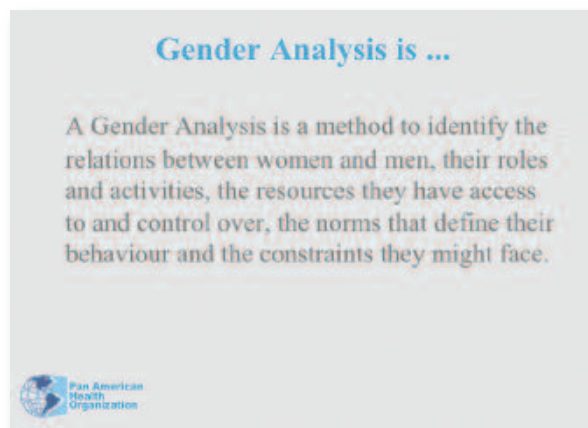Pan American Health Organization

Facilitator:

This module is designed to strengthen the capacity of health workers to conduct gender analysis so that gender-related issues are reflected in programming efforts.

Facilitator Notes

Go over the objectives of Module 2, stressing that the gender concepts that we learned in Module 1 will be applied in the analysis.

- We will define gender analysis and why it is important for health; discuss sex-disaggregated data and why it is important in gender analysis
- Understand what sex-disaggregated data is and why it is important in designing, implementing and evaluating health programs and projects.
- We will focus on three the principal elements for conducting a gender analysis, which are important in explaining gender disparities in health. These are:
    ° Biological differences between the sexes,
    ° Socio-cultural differences (gender roles and norms)
    ° Access and control over resources.
- We will outline the importance of doing a gender analysis to assist in sifting through the many other factors that influence health and uncover the issues which are gender related. This is vital to shape interventions.
- We will then review a tool for applying Gender Analysis to a health issue or problem - a Gender Analysis Matrix. The columns of the matrix are based on the factors discussed earlier and important public health considerations. We will discuss how the matrix can be used, practice using it, and explore different ways that we can use the findings.
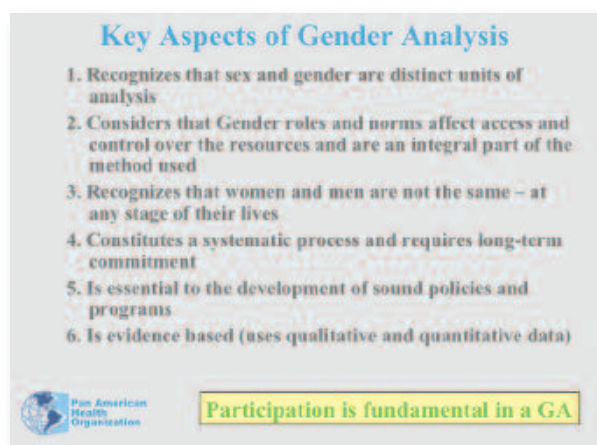
Gender Analysis is ...

A Gender Analysis is a method to identify the relations between women and men, their roles and activities, the resources they have access to and control over, the norms that define their behaviour and the constraints they might face.

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Facilitator:

As you can see by this definition, gender analysis considers the concepts we discussed in Module 1.

POINT OUT that Gender Analysis is a key instrument for mainstreaming gender in health polices and programs, as well as for monitoring and evaluating the differential impacts of these programs and policies

Key Aspects of Gender Analysis

1. Recognizes that sex and gender are distinct units of analysis
2. Considers that Gender roles and norms affect access and control over the resources and are an integral part of the method used
3. Recognizes that women and men are not the same – at any stage of their lives
4. Constitutes a systematic process and requires long-term commitment
5. Is essential to the development of sound policies and programs
6. Is evidence based (uses qualitative and quantitative data)

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Participation is fundamental in a GA

Facilitator:

Highlight the key aspects of gender analysis:
1. Sex and gender are distinct units of analysis: This means that **there should be no confusion between biologic and socio-cultural differences.**
2. **Women and men, boys and girls are not the same – at any stage of their lives, either by biology or by social factors.**
3. Gender Analysis is a **systematic process** and requires **long-term commitment. It is a central strategy in gender mainstreaming activities and improving efficiency and equality in health.**
4. Gender Analysis is **essential to the development of sound policies and programmes**
5. Gender Analysis is **evidence-based** – informed by data and information gathered from research, through consultations with diverse groups of women and men and standard health surveillance and monitoring

activities. This reminds us that we still need enforce the collection of data (quantitative and qualitative) dis aggregated by sex and variables that are necessary to perform a Gender Analysis

6. For better analysis of a health problem/issue, the process should include the participation of **members who truly represent the target groups, as well as** experts on the topic, and experts from different sectors and disciplines.

7. Gender Analysis is a multi-sectoral and multi-disciplinary process.

Activity

Why is Gender Analysis important to health and health outcomes?

PARTICIPANTS ACTIVITY

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Time: 15 minutes (optional)

Facilitator:

PREPARATION: Flipchart, cards for participants.
Aim of the activity: participants recap and understand why gender analysis in health is important

Step 1: ASK participants to imagine that they have to explain to their colleagues gender analysis and why it is important to their work. Allow five minutes for them to jot down three reasons/justifications.

Step 2: ASK for contributions and note these on a flipchart.

THEN, proceed to the next slide and read it aloud.

NOTE: Only use the presentation if you feel the group needs to re-visit these ideas and concepts which have previously been covered.

Why is Gender Analysis (GA) important to health and health outcomes?

Contributes to the understanding of:
- Differential health risk factors
- Exposures and manifestations of disease
- Differences in the severity and frequency of disease
- Responses of the culture, society and health to these problems

GA highlights differences in access:
- Health care and resources
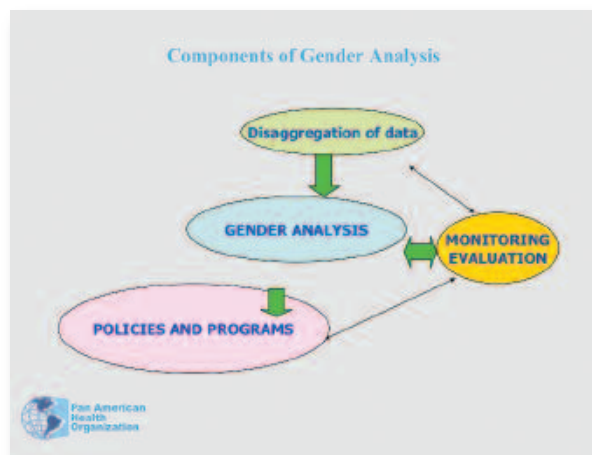- Information, transport, communication and services
- Decision- making process

GA recognizes the different contributions to care
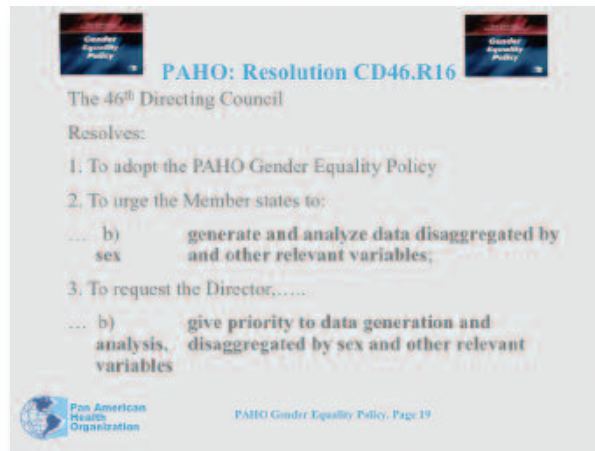- Formal, informal and unpaid care within home

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Facilitator:

Quickly REVIEW these points in relation to the participants contributions recorded on the flip chart (if previous activity was done)
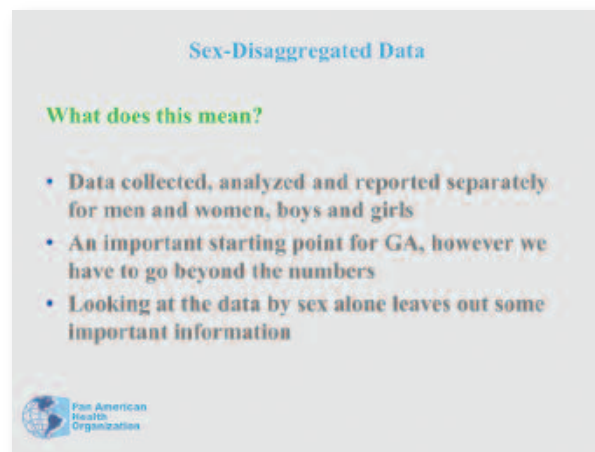

Components of Gender Analysis

Disaggregation of data

GENDER ANALYSIS

MONITORING EVALUATION

POLICIES AND PROGRAMS

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Facilitator:

POINT OUT how evidence and evaluation relate to Gender Analysis which ultimately results in improved policies and programs

Slide: PAHO: Resolution CD46.R16

The 46th Directing Council

Resolves:

1. To adopt the PAHO Gender Equality Policy

2. To urge the Member states to:

... b) generate and analyze data disaggregated by
sex and other relevant variables;

3. To request the Director,......

... b) give priority to data generation and
analysis, disaggregated by sex and other relevant
variables

Pan American Health Organization · PAHO Gender Equality Policy, Page 19

Facilitator:

Step 1: REFER to the PAHO Gender Equality Policy that urges PAHO and its Member States to give priority to disaggregating and analyzing data and the inclusion of gender analysis. Information is included in the slide.

Step 2: ASK THE QUESTION: What is sex-disaggregated data? Invite several responses to this question then move on to the next slide to confirm what it is.

Slide: Sex-Disaggregated Data

What does this mean?

• Data collected, analyzed and reported separately for men and women, boys and girls
• An important starting point for GA, however we have to go beyond the numbers
• Looking at the data by sex alone leaves out some important information

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Facilitator:

READ OUT THE SLIDE above, and then move on to show several examples of data on slides.

EXPLAIN that data are useful because they illustrate the similarities and differences between the situations of men and women and suggest some areas for further discussion and investigation (sometimes using qualitative methods such as in depth interviews and focus groups).

MENTION that looking at the data by sex alone, however, leaves out some important information; e.g. when we add ethnicity, age and socioeconomic status to the data we are better able to target programs, projects and policies.

The next few slides will show how data that has been disaggregated by sex show different health situations for men and women in some Caribbean countries.

(On its Website Learning Space the Module will have data from different countries and regions that can be included in this presentation).
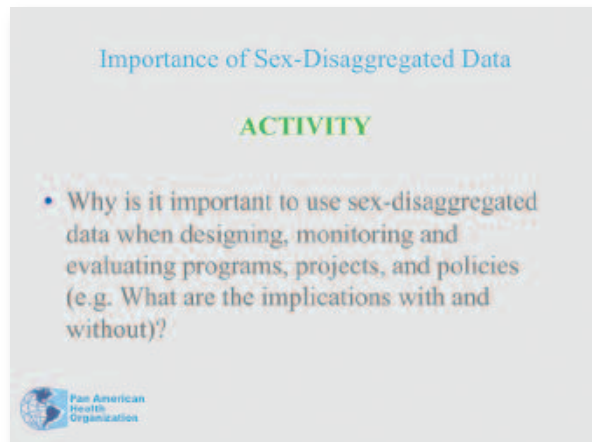

Facilitator:

Ensure that data disaggregated by sex in included in this slide and next 3 or 4 slides. It will allow participants to see why it is important to have data disaggregated by sex, and see the different health situation for men and women.

To assist you, data from different countries and regions will be posted on the Gender and health Capacity Building workspace in the Gender SharePoint: http://portal.paho.org/sites/ge/WS/GHCapacityBuilding/default.aspx

Importance of Sex-Disaggregated Data

ACTIVITY

- Why is it important to use sex-disaggregated data when designing, monitoring and evaluating programs, projects, and policies (e.g. What are the implications with and without)?

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TIME: 30 minutes   **PREPARATION:** Flipchart

Facilitator:

Activity process

Step 1: READ the question above to participants.

Step 2: GIVE the following example: *If you were developing a country-wide program to prevent the spread of HIV/AIDS and only had data for the total population without a breakdown by sex, how would it affect the design, implementation and impact of your program?*

ASK participants to write down their responses *then write a few on the flipchart. rama?*

Step 3: THEN ASK: If you were developing a country-wide program to prevent the spread of HIV/AIDS and had data for the total population broken down by age, sex and ethnicity, how would it affect the design, implementation and impact of your program?

ASK participants to write down their responses (give them about 3 minutes observing how long they write), then take some and write them on the flipchart.

Step 4: LEAD A DISCUSSION: about the differences between their responses to the program "with sex-disaggregated data" and "without".

CONCLUDE: SEX DISAGGREGATED data (both qualitative and quantitative) provide a better understanding of the situation of men and women, boys and girls you are "targeting". This assists in planning gender sensitive programs, projects and policies. It also is important to collect and use sex-disaggregated data when monitoring and evaluating health programs, projects and policies to analyze their different impacts

WITHOUT SEX-DISAGGREGATED DATA: e.g. Data with men and women rolled up together, do not provide the differences between them and thus cannot design appropriate and gender-sensitive programs, projects and policies.

WHO: Framework on social determinants of health[1]
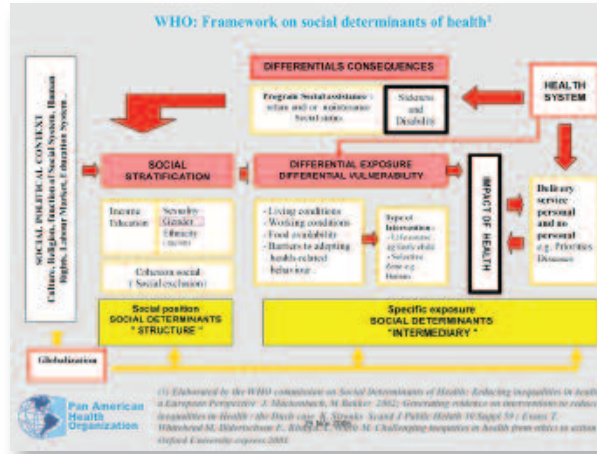
You will recall that we introduced the determinants of health in Module 1 and noted that gender was one of these.

Step 1: HIGHLIGHT the following points and remind participants of the Power Walk:
- On the left side: understanding the **context** – social, political, including culture, religion, etc.
- is fundamental in developing a Gender Analysis and in designing health programs, projects and policies.
- Gender as a **structural determinant**, combined with other social factors, produces differential exposure and vulnerability that impacts health.
- On the right side: the health system should be understood as an intermediary determinant of health.

Step 2: ASK the participants the following questions about these determinants.
- *What do we know about income in relation to its influence on health* (Research indicates that the wealthier are healthier)
- *What do we know about education's influence on health?* (The more educated are healthier, and make healthier choices regarding food, Activity, environments).
- *What do we know about gender and its influence on health?* (Women and girls in many cultures are not as valued and are disadvantaged compared to men, thus have less access to economic opportunities, decision making, control over resources in the home)
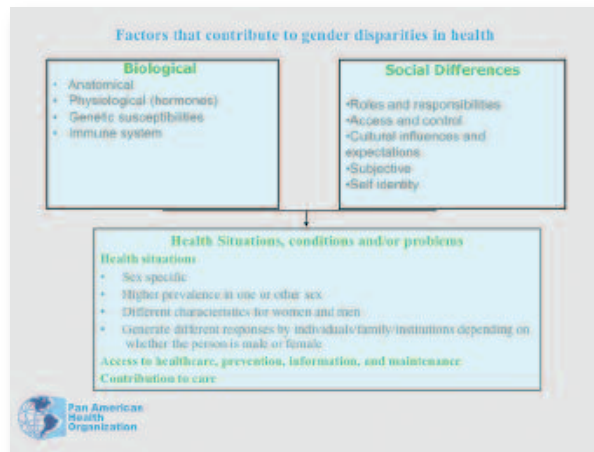
Facilitator:

In this section we will take a closer look at some key factors that contribute to gender disparities in health. We will incorporate much of the information you learned in Module 1

EMPHASIZE the following: Gender analysis of a health issue or problem contributes to a better understanding of differences between men and women, boys and girls in relation to: risk factors and exposure, disease manifestation, health-seeking behaviours, access to and use of health services and the health sector response, as well as impact on health.

REFER TO THE SLIDE that shows how interactions between **biological/physiological and socio-cultural factors** affect women and men's health situation, access to care, as well as their contribution to this care differently.

EXPLAIN: We are now going to look at each factor separately. We begin by unpacking biological differences. You will recall in Module 1, we discussed how biological differences between men and women (i.e. sex) contribute to health and health outcomes (remember the flashcards).

EXAMINING BIOLOGICAL Factors: Sex-specific conditions can be thought of in two main categories:

A) Reproductive and/or conditions related to hormonal changes, such as pregnancy, menopause, and sex specific organs; or cervical and prostate cancer
B) Genetic, physiological, hereditary conditions (or those transferred from parent to child through chromosomes) such as color blindness and hemophilia (tend to be more prevalent among men)

EXAMINING SOCIO-CULTURAL factors
Socio-cultural factors relate to gender roles and gender socialization that often result in gender inequalities, as was explained in Module 1.
• Unpacking socio-cultural factors is an important component of gender analysis.
• Similar signs and symptoms sometimes elicit different responses by women and men. Those differences in responses may be a result of gender norms, roles and inequalities and lead to different health-related behaviors and outcomes.
• The interaction between biological factors and socio-cultural factors is one way of explaining these differences.

EXAMINING HEALTH SITUATIONS (SEE HANDOUT 2.01, following this section)

Evidence and the Activities in Module 1 have shown us that the interaction of biological and social factors affect women and men's health situation differently. These affects may either be:

If there is time, participants may be asked to give examples of each.

• Sex specific, as in haemophilia for men, or pregnancy for women.
• Have a higher prevalence in one sex, such as iron deficiency anaemia in women, sexual violence among women, accidents among men.
• Have different characteristics and consequences for women or men, such as some sexually transmitted infections
• Generate different responses by individuals, families or institutions, such as stigma related to women living with HIV, sexual activities, violence.

We have also seen how these interactions through control over resources, affect women and men's **access to health services**, care, prevention, information and maintenance.

It also affects how women and men contribute to providing care and to what extent this contribution is recognized. Over 80 percent of health care is provided by women, either in the formal paid health sector, or in their homes and communities, where it is unpaid and largely unrecognized.

We will now look at some specific examples from...

Please use a local, national example here

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Please use several examples here, especially local examples, to illustrate factors that contribute to gender disparities in health.

Category	Women	Men
Sex Specific	Pregnancy (in adolescence); cervical cancer; menopause; maternal motrality; prolapse of the uterus; abortion (which can have consequences, such as anemia, infections of the reporductive tract, prolapse of the uterus and urinary incontinence	Prostate cance; hemophilia
Higher prevalence in one or other sex	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 (eight times more likely in women than in men 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 women than in men in all phases of life, related to personality types and experiences connected with types of socialization and differential opportunities for men and women); malaria in women pregnant for the first time; sexual violence (in childhood, adolescene and adulthood); excessive mortality due to cancer as adults (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, homicde and accidents (evident from the first year of life, associated with sterotyped masculine attitudes and behaviours such as aggression, risk -taking, excessive consumption of alcohol); silicosis (associated with mining work); hernias; colour-blindness (20 times more likely in men than women); coronary artery diseases (which are the biggest killers of men during the years they are engaged in the labour force); greater incidence of dyslexia, hyperactivity and stuttering.

Category	Women	Men
Differences in characteristics for men and women	1) Sexually transmitted infections (STI) are more easily transmitted to women and have more severe consequences in women, such as sterility and even death in cases of pelvic inflammation. 2) Nutritional deficiencies can cause maternal deaths in child birth. 3) Alcoholism an tobacco consumption have different health consequences for women particulary during pregnancy 4) Sexual violence for women can cuase unwatned pregnancy and STI. 5) Malaria during pregnancy is an important cause of maternal mortality, spontaneous abortion and stillbirths; particulary during pregnancy, malaria caontributes significantly to the development of chronic anemia. 6) Death with weapons (suicide or homicide) is more characteristic of men. 7) Women tend to be victims of violent crimes perpetrated by intimate partners more often than men. 8) In our societies, the repercussions of sexual impotence are more negative when it involves a man than does sexual frigidity when it involves a woman. This is due to the great importance given male sexual prowess in many societies. 9) Lack of access to quality water supply affects women more than men because in many societies women are the main users of water, and they and their children must fetch and carry it.	
Generate differences in response by individual/fam-ily/institution depending on whether the person is male or female	1) Cardiovascular problems; the notion persists that these are typically men's diseases; as a result, symptoms are not recognized in women. Data indicate that cardiovascular diseases are one of the main cuases of death among women over 49 years old 2) Disfigurement for Leishmaniasis, schistosomiasis, leprosy, onchocerciasis generates greater rejection by society if the sufferer is female, given the connection between phycial beauty and women's worth. However, enlarge-ment of the scrotum and testes by filariasis is more socially harmful to men than enlargement of the breasts for the same reason to women. 3) Ratio of 1 to 300 for masculine/feminine sterilization, even though vasec-tomy is simpler, more economical and less invasive than sterilization for women. 4) Schistosomiasis rates will be higher for women or men depending on the gender division of labour in the region.	

Category	Women	Men
	5) Domestic violence toward women 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 ther is for other types of social violence. This tolerance is reflected in legislation on family violence in almost every country. 6) The exclusion of women from clinical studies of pathologies affecting both exes means that therapies based on these studies may not be reliable for appliaction 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 dovus on women's health and obfuscates the impart of certain medications or treatments at different stages of their life cycle. 7) Cataracts and skin cancers are more prevalent in men in coastal fishing areas from the sun reflecting off the water. 8) Low priority has been assigned to research of pathologies and treatments exclusively or primarily affecting women. 9) Focus of family planning services on women has excluded men. with the result that men have limited access to such services. In addition, give the gender relations within a family, decisions about contraception need to include men. Otherwise, women might be prevented from using them by their partners/husbands. 10) Differences by sex in the quality of care in health services: research in Austalia, Canada, Sweden, and the United States, as well as some countries in Latin America, shows that the quality of care received differs between men and women. Quality of care for women was found to be unequal (i.e. waiting time, over medication and mistreatment).	

Recap: What can be achieved when GA is applied?

GA can deal with some of the root causes of gender discrimination and inequalities, such as:

- Gender stereotypes
- The different health needs of males & females
- A recognition of social factors affecting health
- Gender blind policies and programmes

And by dealing with above…

- **Improve** the quality of health interventions for efficiency and effectiveness
- **Improve** health information, documentation and use
- **Facilitate** empowerment, decision-making, informed choice, health rights and improvement of health

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Facilitator:

RELAY: Gender analysis contributes to addressing the specific needs of the most vulnerable groups. In addition, gender analysis enhances the effectiveness and efficiency in interventions.

Introduction to Gender Analysis Matrix

The Gender Analysis Matrix

Basic steps for this section:

- Introducing the matrix and its concepts
- How the matrix can be used
- Activity using the matrix

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TIME: 70–80 minutes:
Form groups (5 min): 45 -55 min in groups
including writing up group outputs on a flipchart;
20 min report back & debrief

PREPARATION: Hand out copies of
- Handout 2.02, *the blank GA Matrix*
- Handout 2.03, *"The Matrix: Gender Analysis of a health problem - Definitions"*.
- Handout 2.04, *"The Matrix: Gender Analysis of a health problem: the impact of different characteristics of gender on men and women's health – Context: HIV and AIDS"*

FLIPCHART

This next section will cover:
- An introduction to the gender analysis matrix and how it may be used
- An activity to demonstrate how it may be used.
- The purpose of this activity is to change the way we think about health issues/problems.

Facilitator:

Step 1: **SHOW the matrix without any boxes filled in slide. (Also handout 2.02)**
- **The matrix is a tool for analyzing a health problem or issue.** It assists us in uncovering the impact of sex and gender on men's and women's health situations, their access to and control over resources and health outcomes. acceso a los recursos y su control, y el impacto en la salud.
- The rows (along the left side of the matrix; e.g. health risks and vulnerability, etc.) provide a framework for conducting a more in depth Gender Analysis. The column headings (e.g. how do biological/physiological differences between sexes influence men's and women's?) are questions to ask related to the row headings (e.g. health risks and vulnerability).
- The GA matrix helps us to recognize similarities and differences relating to various health issues and problems for men and women, girls and boys. For example it reveals who is more likely to get ill, **when, where (under what circumstances),** why, and the **recognition, response and impact of a health issue/problem.**
- The definitions of the concepts (e.g. of health risks, vulnerability, etc.) are in **Handout 2.03 which you will review in your small groups in a few minutes.**

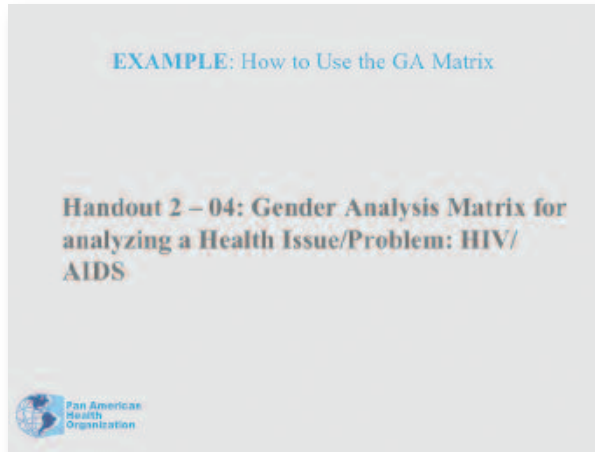Let's now look at how information is gathered for the GA Matrix.

How is the information gathered for the GA matrix?

Usually formulated as questions, the GA matrix guides a GA: The questions encourage an evidence-based approach

The **PURPOSE** of the **GA Matrix** is to put a gender lens on the way we think about specific health issues/problems, access and outcomes

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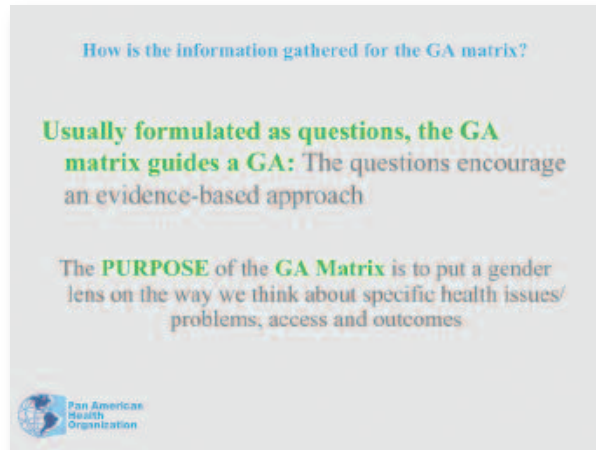
Facilitator:

Step 2: ASK: How is information gathered for the matrix?

- Usually as questions
- The GA matrix guides one through a systematic process of examining the influence of gender-based differences and inequalities on health.
- The questions also encourage an evidence-based approach, informed by data and knowledge from research and from consultations/engagement with women and men

We do not always have the answers, but by asking the questions we are beginning the process of unpacking the differences that emerge as a result of the Gender Analysis.

- For analysis to be meaningful, the analysis **must reflect local or contextual perspectives.** For example, Gender Analysis on Malaria in Chile may not necessarily yield the same priorities for action as it would if carried out in Haiti.
- It is important to remember from Module 1 that **gender factors are not static, they evolve.** This means Gender Analysis is not a one time event, but should carried out from time to time to keep up with community trends and disease patterns.

EXAMPLE: How to Use the GA Matrix

Handout 2 – 04: Gender Analysis Matrix for analyzing a Health Issue/Problem: HIV/AIDS

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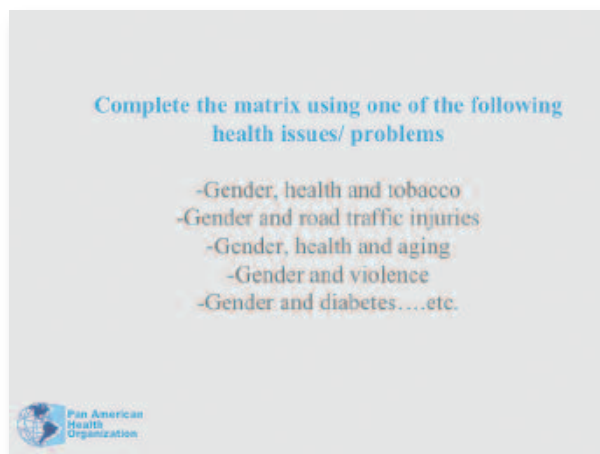
Step 3: HOW THE GA MATRIX MAY BE USED

Before we break into small groups let's walk through together the Gender Analysis Matrix using the example of the Health Issue/Problem HIV/AIDS.

WALK participants through handout 2.04.

Initially READ OUT some of the examples in each column, then ask other participants to read through others, encourage participants to add additional examples if they wish.

ASK if there are any questions about the use of the Matrix

THEN...

Complete the matrix using one of the following health issues/ problems

-Gender, health and tobacco
-Gender and road traffic injuries
-Gender, health and aging
-Gender and violence
-Gender and diabetes....etc.

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Step 4: SET UP THE GENDER ANALYSIS MATRIX ACTIVITY: 40 – 55 minutes
- **DIVIDE participants** into two to three small groups and invite them to choose from one of the health issues/problems listed on the following slide. To fill out the GA matrix provided.
- **REMIND participants** that the activity provides an opportunity to use the GA Matrix tool to analyze a particular health issue/problem in a certain context, using a gender lens.
- **REFER to The Matrix Gender Analysis of a Health Problem (Handout 2.04).** Explain that this is an example, and is not complete, either because the information was not available, or it was not relevant to the issue at hand.

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- REFER to the accompanying Handout 2.03 Gender Analysis Matrix Definitions if you are unsure about certain definitions of the concepts
- If you do not have hard facts/information, make assumptions based on your work experience, knowledge, trends and conventional wisdom. You may also use the date from the indicator booklet. Remember, the point of the activity is to use the Matrix, and learn about ways to analyze a health problem using gender dimensions, not to provide concise epidemiological information.
- Be creative, think out of the box!
- Have fun! Hopefully you will learn some new facts about particular health issues/problems and also learn new ways of looking at health issues/problems.
- At least 15 minutes to write up your completed matrix in a format that you can present on the flipchart.
- Ask for assistance at any point.

Step 5: Group Report Back session and debrief

This is often a vibrant, interactive session. Groups present completed Matrixes and get feedback on the process, challenges, and discuss adaptations and usefulness.

Facilitator tip
- **It is useful to have a programmatic/subject specialist linked to the topic chosen in the group** – or to provide ample data/information on the topic to be discussed. You need to get to know participants competencies prior to the activity, ensure that appropriate topics are chosen, and that the `specialists´ are evenly distributed in the group. The activity can still work without experts; participants just need to draw on their own public health knowledge/conventional wisdom.
- **Do not choose more than three topics,** as the feedback session is time-consuming and needs time for discussion and interaction. If participants are from one program, then choose that particular topic, and divide into groups where all the groups deal with the same topic. Depending on the composition/size/avail ability of experts in the group, you may also decide to have the same topic repeated in more than one group. In very small groups, participants can work in pairs.

Handout 2.02 Gender analysis matrix for use in analyzing a health issue or problem

Health Issue/Problem	Lenses of gender analysis	
	How do biological/physiologi-cal differences between sexes influence men's and women's:	How do gender norms/values affect men's and women's (boys' and girls'):
Health risks and vulnerability		
Ability to Access and use health services		
Health outcomes/consequences of health problem (e.g. economic, social)		

Health Issue/Problem	Lenses of gender analysis	
	How do biological/physiological differences between sexes influence men's and women's:	How do gender norms/values affect men's and women's (boys' and girls'):
Health risks and vulnerability	Risk can mean a **probability,** i.e. the risk of getting HIV/AIDS from an infected needle. Risk can mean an *f factor* that raises the probability of an adverse outcome, that is exposure, i.e. Increased risk for STIs following sexual violence against women; Risk can mean **consequence**; i.e. A boy who has experienced violence in the family could himself be a violent person; Risk can mean a potential **adversity or threat**, i.e. gender norms and roles that undermine pregnant women to seek health care increase the risk of maternal and infant moratlity. Vulnerability: Refers to factors that put an individual at increased risk. For example, although both women and men can be affected negatively by "gender", women's disadvantaged social, economic and political status further undermines their ability to protect and promote their own physical, emotional and mental health, including their effective use of health information and services.	

Health Issue/Problem	Lenses of gender analysis	
	How do biological/physiologi–cal differences between sexes influence men's and women's:	How do gender norms/values affect men's and women's (boys' and girls'):
Ability to access and use health services	Women's and Men's access to and use of health services are influenced by: • Distance to health care facility, hours of operation, cost of sevices, time involved • Community knowledge of available health serviced • How treatment options are communicated by the providers • Perceived quality of care • Knowledge/recognition of issues requiring care • Perceived severity with health services • Available options • Stigma associated with health conditions • Interference with daily tasks • Absence of a culturally sensitive approach	
Health outcomes/Consequences of HEalth Problems (e.g. economic, social, attitudinal)	The burden of a health problem and its outcome on an idividual and family influenced by: • Monetary costs • Duration of health problems • Stigma	

Health issue/Problem	How do biological differences between sexes influence men's and women's:	How do gender norms/roles affect women's and men's:	How do access to, and control over resources influence men's and women's:
Health risks and vulerability	• Women are more prone/vulnerable to HIV infection because of: ° Anatomical factors; e.g. physiology of genital tract ° Complication of pregnancy, with associated possibility of transfusion	• Women are more prone to HIV infection because of their inability to negotiate condom use • Women, especially young girls, find it difficult to purchase or procure condoms • Women who carry condoms are some times perceived to be promiscuous, rather than careful; men with condoms are seen as being careful and safe • Young girls with condoms are seen as being sexually active, which is a "negative" perception • Women are more likely to be victims of sexual violence, especially in wartorn areas, which puts them at greater risk of HIV infection • Male same-sex relationship in some countries are forbidden, ignored or stigmatized, leading to lack of health education and preventive measures, with increased risk for those infolved	• In some countries, information on sexual and reproductive health, including HIV, is not freely available, including via the internet, because of government censorship • More women than men experience poverty and more women than men are involved commerical sex work to access and control resources • Lack of security and breakdown in social order puts more women than men at risk of sexual violence • Men, who make up the majority of the prison population, are more at risk of HIV infection in that particular context.

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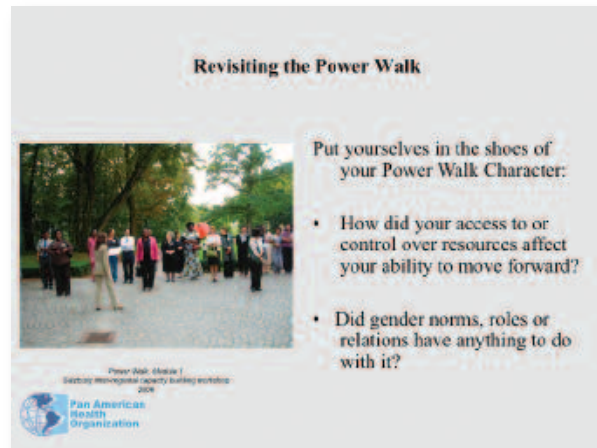| Health issue/Problem	How do biological differences between sexes influence men's and women's:	How do gender norms/roles affect women's and men's:	How do access to, and control over resources influence men's and women's:
		• Men are more likely to exhibit HIV risk behaviors, such as multiple partners a nd intravenous drug use	
Ability to access and use health services		• Adolecent girls may not be allowed to access sexual and reproductive helath inforamtion from health facilities and health workers, because they are not married and are not allowed to have sex • Lack of priavacy in health clinics keep more women away then men, since general knowledge of pistive HIV status is more devastating for women than men, in some societies • Sigma against men who have sex with men in some countries prevents or delays health-seeking behavior • Masculinity encourages young men to seek sex and multiple partners as conquest and being "macho"	• Women have a more difficult time negotiating with their male partners to go for an HIV test, than the other way around, because of the power differential in the relationship • Attitute that many health providers have towards women clients may impede access to preventive and curative services

Health issue/Problem	How do biological differences between sexes influence men's and women's:	How do gender norms/roles affect women's and men's:	How do access to, and control over resources influence men's and women's:
		• In some cultures men with HIV infection believe that sex with a virgin will cure them, thus putting young girls, even babies, at risk • In some cultures, women need permission from the male head of household to visit clinics • In communities where early marriage is practiced, younger women and girls are not able to seek health care due to health illiteracy and lack of experience	
Health Outcomes/Consequences of health problems (economic and social, including attitudinal)		• Women's roles as caregiver puts extra burden on them, putting their health at risk	• A diagnosis of HIV infection in a woman may result in abandonment y husband and family in many cultures

Power Walk Character Analysis:
This activity is designed to reinforce the understanding of the distinction between access to and control over resources – often challenging for participants.

Revisiting the Power Walk

Put yourselves in the shoes of your Power Walk Character:

- How did your access to or control over resources affect your ability to move forward?

- Did gender norms, roles or relations have anything to do with it?

Power Walk, Module 1
Salzburg intercoporeal capacity building workshop
2006

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Facilitator:

Step 1: **Recalling the Power Walk activity** from Module 1. Ask participants to put themselves back into the shoes of their character. (**Note:** If you have taken pictures during the Power Walk on Module 1 and have the time and facilities, replace the existing photos with one from your own workshop. Participants will be surprised – and it will help stimulate recall!)

Step 2: Remind participants that characters ended up in different positions during the power walk depending (to a large extent) on their access to, and control over, resources.

Step 3: Divide participants into groups (3 or 4 depending on number of participants) and ask them to choose one or two characters from among them.

The selected characters should have ended up in different groupings in the Power Walk (e.g., not two characters from the back group if it can be avoided) in order to demonstrate a range of responses.

Power Walk Character Analysis

Power Walk Statement	Key health-related resources required	Access to these resources?	Control over these resources?
I can consult health services when and if I need to			
I eat at least 2 full meals a day			

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Facilitator:

Display **slide** and distribute **Handout 2.2b (Power Walk Character Analysis), Page 25** to groups. Instruct participants that they are to reflect on two of the Power Walk Characters for the selected statements.
- ° They should first determine a few **key health-related resources** that the character requires to say "yes" to the statement.
- ° Secondly, consider whether or not the Character has **access to and/or control over the selected health-related resources.**
- ° You may need to refer or display **slide 2.15** on health related resources to guide the discussion.
- ° Give the group **15 minutes to brainstorm and then invite them to briefly present the differ ences between their characters to the larger group.**

- Discuss briefly why the responses are as such, and what (if anything) can be done about changing it so that characters can move forward in the Power Walk. Ensure that the discussion touches upon other cross cutting issues such as social class, ethnicity and age (e.g. youth).
- Remind participants that the Character Analysis is **based on interpretations of how the Character would respond.** In real life, they would need to have more information about the person, their circumstances and opportunities to better understand how access to and control over key health-related resources affects their health.

TRANSITION TO NEXT STEP IN THIS ACTIVITY

Summarize the Power Walk Character Analysis by referring to the diagram of the factors that influence health. Re-cap that biological and socio-cultural factors can influence access to and control over key resources. Different access and control issues can affect the health of women and men in different ways.

Remind participants that characters in the back section of the Pwer Walk face different barriers to taking a step forward and may require additional assistance to over-come them. One of the barriers could be gender-based discrimination, and one of the strategies is empowerment.

Handout Power Walk Character Analysis

Power Walk Statement	Key health-related resources required	Access to these resources?	Control over these resources?
Character 1:			
I can consult health services when and if I need to			
I eat at least 2 full meals a day			
Character 2:			
I can consult health services when and if I need to			
I eat at least 2 full meals a day			

## Handout Gender analysis group work guidance

You have one hour to conduct a gender analysis of a selected health problem. Use the following tips to guide you:

- Elect a rapporteur and a presenter.
- Use the GAQ to guide your discussions.
- Refer to Participant Notes for definitions, examples and Gender Analysis Tips as necessary.
- When evidence is missing, make assumptions based on your work experience, knowledge, trends and conventional wisdom.
- Remember – the point of the activity is to utilize the Matrix, and learn about ways to analyse a health problem using gender dimensions, not to provide concise epidemiological information.
- Time limited?
  - address at least one of the first three rows, and one of the last two rows to give you a chance to analyse both patient and health sectors' perspectives.
- Leave at least 15 minutes to prepare your presentation to the group.

Facilitator concluding remarks
- The three main gender factors that affect the health of men and women are, biological differences, gender roles and norms and access and control over resources. These should be analysed in relation to health risks and vulnerability, ability to access health services, health seeking behaviour, preventive and treatment options, responses to treatment and rehabilitation, experience with health services and health providers, health outcomes and consequences of the health issue or problem.
- Gender factors interact with biological differences between men and women and have an impact on their health status.
- Women and men may be exposed to differential risks of contracting a health problem because of gender roles and norms or because of gender based division of labour.
- Women often have limited access to resources than men, which are necessary for good health.
- Even when women have access to adequate resources they may not have the power and authority to make decisions. This increases their vulnerability.
- Gender analysis helps to clarify the differences between men and women in how they live, what they do, their access to control over resources, which they interact with, and the nature of these interactions and relations.
- Gender analysis of a health problem brings to light the ways in which these differences interact with biological differences to affect women's and men's health status, their access to and interaction with the health care system, and the social and economic consequences of ill-health.
- Gender issues evolve, are dynamic, and as such, they can be challenged and transformed. Gender analysis need to be adaptable, flexible and contextual.
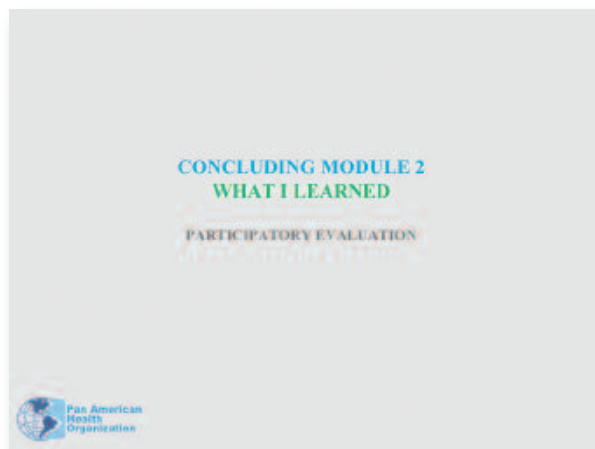
Time: 15 minutes

PREPARATION: Flipchart with 3 columns with headings: "what I liked (about the Module)", "Concerns I have," and "Suggestions for improving."

Facilitator:

ASK participants to include their reflections

Conclude the session by reflecting on what participants have learned from this Module.

You may also do a participatory evaluation with the group at this point on a flip chart.
Flip Chart is recommended: **3 columns or on 2 separate flipcharts with the headings:** "What I liked" (about this module); "Concerns I Have"; and "Suggestions for Improving" the module.

What I liked	Concerns I have	Suggestions for improving

(About 15 minutes)

Tips for facilitators: discussing progress and challenges
- While this activity is to serve as both a progress check and also a way for facilitators to gauge participant understanding, it is important that facilitators are mindful throughout modules of "trouble spots" for participants.
- Often, the reasons for why participants do not understand core concepts is because they are unrelated to concrete, practical examples. Try to stimulate local examples from the group, as well as from your own experience, to help you in clarifying concepts.
- This activity cannot be planned in advance as it responds directly to participant responses. The facilitator should be able to determine understanding by the end of Module 2 and try to prepare for potential gaps in comprehension based on this. Using local cases (regional, country or specific) are useful but require advance preparation.
- When comprehension of core concepts is fuzzy, it is often best to avoid repeating jargon-heavy wording. Revisit the facilitator talking points in Module 2 for ideas of ways to unpack core concepts and definitions for the progress check.
- Try to limit this activity to 45 minutes of recap from Module 2 – if there are still some puzzled expressions in the room, suggest that you speak at the break in order to not hold back other participants from proceeding. However, if the majority of participants have not understood the main concepts from Module 2 (and therefore the objectives were not met), the facilitator will need to modify the times used in Module 3.

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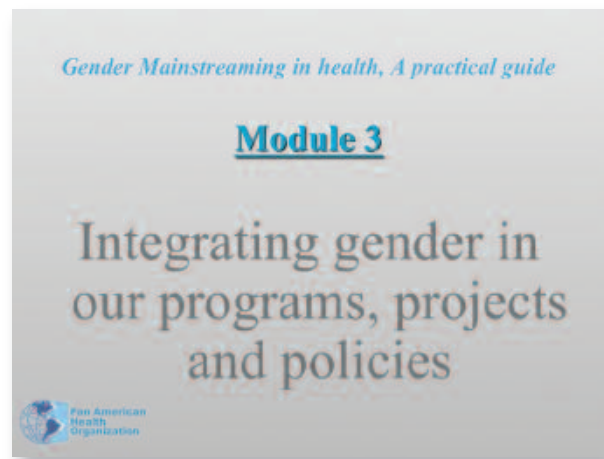
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Module **3** **Integrating gender in programs, projects and policies**

Gender Mainstreaming in health, A practical guide

Module 3

Integrating gender in
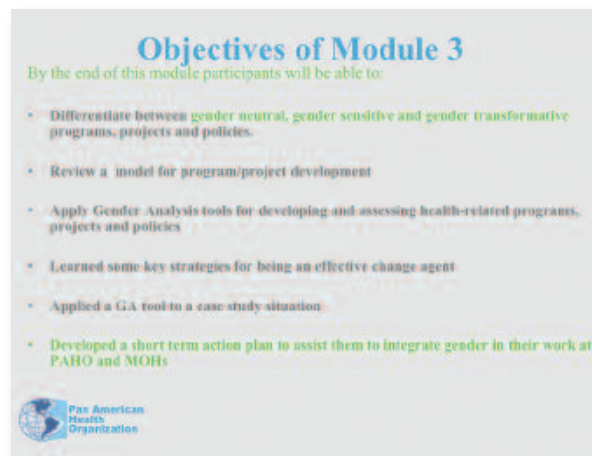our programs, projects
and policies

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Introductory notes:
In this module, we apply the results of a gender analysis to health projects or program in PAHO/WHO or at national levels. This analysis facilitates the promotion of equitable health programs and projects. In order to do this, key concepts relating to gender and program/project development need to be understood and applied. This module begins by explaining these concepts, which are then applied to a health program/project planning cycle. Once again, participants are given the opportunity to apply this learning using a planning tool for including the gender programming cycle.

TRANSITION TO NEXT SLIDE

Now that we are comfortable with the components of a gender analysis, let's look at how we can apply the results to our work.

Objectives of Module 3
By the end of this module participants will be able to:

- Differentiate between gender neutral, gender sensitive and gender transformative programs, projects and policies.

- Review a model for program/project development

- Apply Gender Analysis tools for developing and assessing health-related programs, projects and policies

- Learned some key strategies for being an effective change agent

- Applied a GA tool to a case study situation

- Developed a short term action plan to assist them to integrate gender in their work at PAHO and MOHs

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Facilitator:

Go over the objectives in slide and POINT OUT:

- This module is designed to build the capacity of health worker to apply gender analysis in programming efforts.
- Important gender and health concepts for including a gender perspective in policies and programs are outlined and the gender analysis matrix and their application are introduced and practiced.
- Gender analysis and interventions should be applied at different levels. In module 2, we practiced gender analysis and looked at some examples of how results of this analysis can help to produce improved outcomes from health interventions. In Module 3, we examine the issue more broadly, in relation to developing programs and projects. In other words, we look at how to achieve those improved outcomes we saw briefly in Module 2.
- In Module 3, we also look at ways of assessing existing programs or projects so that during the panning, implementation, and evaluation cycle, we can insert gender considerations and, ultimately, improve the outcomes. Simply put, we are attempting to ensure that interventions take into account potential health inequities that may arise from gender differences or gender-based inequalities.

Tips for facilitators
The learning outcomes of this session apply the concepts learned in Module 1 to specific health issues. In doing so, we need to explore the following:

1. The implications of different norms, roles, responsibilities and status of women and men within the community where the project or program is being implemented. We learned about these in Module 1 and applied them in the gender analysis of Module 2. We can see how important these concepts and issues are as we refer to them frequently. They form the basis of the majority of gender work – in health and in other sectors as well.
2. How a program, project or policy could accommodate these different roles – either through developing a new initiative, or in adapting an existing one.
3. The potential of the program, project or policy to improve the status of vulnerable groups of women and how the initiative will affect women and men in the long-term. This is about how the roles and norms for men and women may be changed in order to achieve better health outcomes for both (**gender transformation**).
4. The actual and possible contributions of men and women to the program or project.
5. The ways in which we can assess that the program or project is actually addressing gender issues through monitoring, evaluation, process and outcome indicators.

CONCLUDE by stating that this Module equips you with additional knowledge and tools to assist you in integrating gender into your work
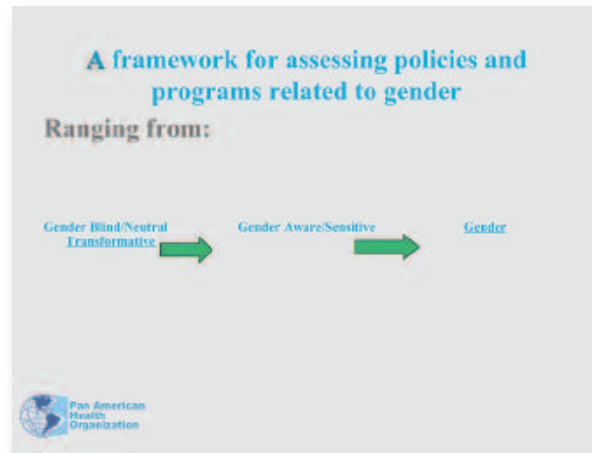
TIME: 30 minutes

Facilitator:

The aim is to understand the concepts and a framework for assessing and categorizing gender in policies and programs.

Facilitator Discuss:
- Often, we hear words such as "gender blind", "gender-sensitive" and more recently we have been hearing "gender-transformative". We need to aim for gender-sensitive and ultimately gender-transformative programs, projects and policies, as they actually do something about harmful gender norms.
- Gender and policy analysts have developed a useful framework to assess and address gender in policy and program development to ensure both sensitivity and transformation.
- These include approaches which range from ignoring gender, to trying to work within the limits imposed by gender norms, to outright challenging and changing these norms and roles.
- Over time a common language and continuum or framework has been developed for describing these approaches. These are: (a) Gender-blind/neutral; (b) gender-aware/sensitive; and (c) gender-transformative (we have condensed these from the WHO Model).

These terms will now be further explained.

Gender Blind/Neutral *Policies and Programs*

Category	Characteristics
Gender Blind/Neutral	• Ignore gender norms • Blind to differences in opportunities and allocation of roles and resources • Often ignore lack of opportunities/discrimination that underpin what appears to be fair practice
=When the effects of sex and gender are assumed to be irrelevant or neutral; (e.g. when terms such as labourers, farmers & caregivers are used)	Not intentionally discriminatory but may reinforce gender-based discrimination

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Facilitator:

EXPLAIN and define the concept/category using the slide and give the following examples of Gender Blind or Neutral Policies and Programs:

- A national tobacco control **policy** is developed by a group of experts without considering the reasons that men and women smoke and without basing their decisions on consultations with men and women they are targeting, or from data that is sex-disaggregated. It is a "one size fits all" policy. ASK participants, *Can you think of another example of a gender blind or neutral health program?*
- A Community-based AIDS care **program** says that the health care system cannot take responsibility for caring for people with AIDS, so home-based care must be instituted. No effort is made to find ways of involving men in home-based care. So, however unintentionally, the program puts the burden of care on women. ASK participants, *Can you think of another example of a gender blind or neutral health program?*

Gender Aware/Sensitive/Responsive Policies and Programs

Category	Characteristics
Gender Aware/Sensitive/ Responsive	• Consider gender issues, but does not do anything to change these • Gender responsive recognize differences in gender roles, responsibilities and access to resources and consider these when designing interventions
=When sex and gender are considered as important variables or issues in a given context (e.g. Policy, program, project)	*However,* do not address the root causes or try to change the underlying causes of gender differences or discrimination

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Facilitator:

EXPLAIN the concept using the slides and give the following examples of gender aware and gender specific policies and programs:

• Water supply **policy** establishes a mechanism to provide taps close to villages so that women will not have to walk as far to fetch water.
• Occupational health **policy** that protects women from working in places hazardous to the reproductive health. However, the policy may also not be gender-sensitive if it does not take into account damage to male reproductive functions from similar or other workplace exposures, and offer them protection as well.

Facilitator:

In between the examples, ask participants to provide examples from their context. Try and limit to two examples per type of programme or policy in the interests of time.

More examples:
• Workplace provides a child care facility for women with babies.
• Creation of separate examination areas in health facilities for men and for women to ensure privacy and comfort of patients.
• Organization of community participation events around the schedules of women and men and having these events in spaces where both women and men can attend.

Gender Transformative Policies and Programs

Category	Characteristics
Gender Transformative	**Recognize differences in gender roles, norms and access to resources**
= When an attempt is made to change the underlying causes of gender differences, roles, norms and sources of discrimination to improve the health of men or women, boys or girls	•Actively try to change these differences, so as to promote gender equality • Include renegotiation of the status quo and a shift in power relations • Most difficult but most desirable; take time ; require social change and effective change agents and strategies

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Facilitator:

EXPLAIN the concept using the slides and gives the following examples of gender transformative policies, programs and projects:

- A land **policy** removes restrictions on women's right to inherit land.
- An information, education and communication (IEC) **program** advocates for women and men about mutual respect and equal rights in sexual decision-making, as a means of promoting safer sex practices and helps both sexes empower themselves to be able to make better decisions.
- A co-educational youth club is established to promote physical activity among male and female youth.

REMINDER: in between the examples, ask participants to provide examples from their context. **ASK** *Are you aware of some gender transformative programs, projects and policies in your region?* If so what are the learning from them? Try and limit to two examples per type of programme or policy in the interests of time. **See handout 3.01:** *Example of gender sensitive and transformative programs*

Tips for facilitator
When discussing gender transformative strategies, emphasize that these strategies may be the most effective in addressing the harmful effects of gender norms on health outcomes for men and women. However, this type of strategy is often the most difficult to achieve, as it involves a direct re-negotiation of gender norms and roles. As we saw in Module 1 – and hopefully throughout the workshop, these traditional norms and roles are often perceived as normal, or obligatory due to socio-cultural rules.

GENDER SENSITIVE REPRODUCTIVE HEALTH PROGRAMS

A panel of international experts formed by the USAID defined gender-sensitive reproductive health programs as those that "actively involve women and men in prioritizing their own reproductive health needs, concerns and reproductive health intentions."

A USAID Gender Working Group subcommittee on program implementation identified a number of features of gender sensitive reproductive health programs including:

• Involve women and men in identifying, prioritizing and resolving their own RH needs
• In their design, include a participatory process (e.g. focus groups) to identify community needs
• Provide a broad range of services and interventions that meet women's and men's reproductive needs
• Involve women's partners & promote male responsibilities
• Address sexual health and needs for sex education
• Address domestic violence, physical and emotional abuse, and the threat of abandonment
• Address social, economic and physical barriers to access for women and men
• Recognize how gender affects male/female relationships and existing inequities

Source: www.fhi.org/en/fp/fppubs/network/v18-4/nt1846a.html

GENDER TRANSFORMATIVE PROGRAM

PROJECT EXAMPLE: Involving Men in Reproductive Health Issues and Programs– an easily accessible workplace project that would aim to understand men's Reproductive Health needs, provide them with relevant information and treat them as potential users of Family Planning services. Such interventions "create opportunities for men to support their partner's family planning (FP)/reproductive health (RH) goals"; increase men's access to RH services as they are geared to both men's and women's needs; increase men's awareness of Sexually Transmitted Infections and HIV/AIDS; and increase contraceptive access for couples who want male methods (e.g. condoms). an easily accessible workplace project that would aim to understand men's Reproductive Health needs, provide them with relevant information and treat them as potential users of Family Planning services.

Source: Interagency Gender Working Group, Exploring Gender Perspectives in Population and Health Programs: Workshop Findings and Recommendations, July 2002

Gender Scale/Continuum

| Category	–	+	++
Gender Blind/Neutral	✔		
Gender Aware/Sensitive/Responsive		✔	
Gender Transformative			✔

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Conclude this section by highlighting:

1. **Gender sensitive strategies** acknowledge the different norms and roles for women and men, and their impact on, access to, and control over resources. Such interventions make it easier for women and men to fulfil duties that are ascribed to their gender roles and that might impair their ability to access health care. A gender sensitive strategy, however does not attempt to reduce the root causes of gender inequality.

2. **Gender transformative strategies** require shifts in current power relationships and not only among women and men, but also among decision-makers. They require that local populations participate actively in policy and program development to maximize benefit and sustainable outcomes. Many decision-makers are not used to this. As we saw in Module 1, gender mainstreaming is about changing the process of who and what types of information inform decisions and how we do our work differently based on this.

3. Fully implementing gender transformative strategies is an important goal of gender mainstreaming – and is best conceived of in the long term. In order for them to be successful, they need to be complemented by gender specific short and mid term strategies.

CONCLUDE: We should aim for gender-sensitive and gender-transformative strategies, according to the context we are in and the resources we have to use for the program or project. The two strategies are complementary; or rather represent progressive stages.

The ideal is a gender aware/sensitive or transformative program, project or policy.

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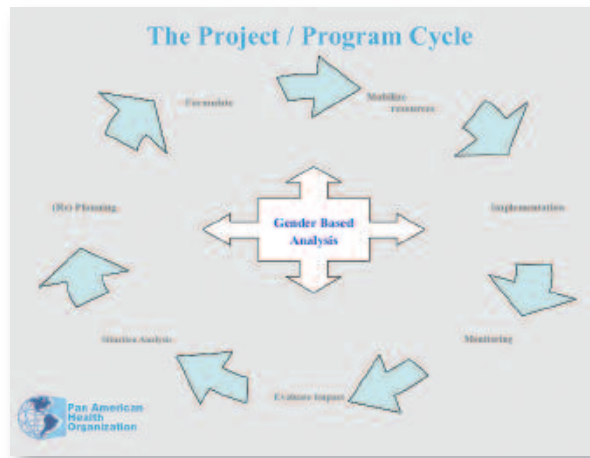
Facilitator:

NOTE

So we speak the same language, let's agree on what a program or project is:
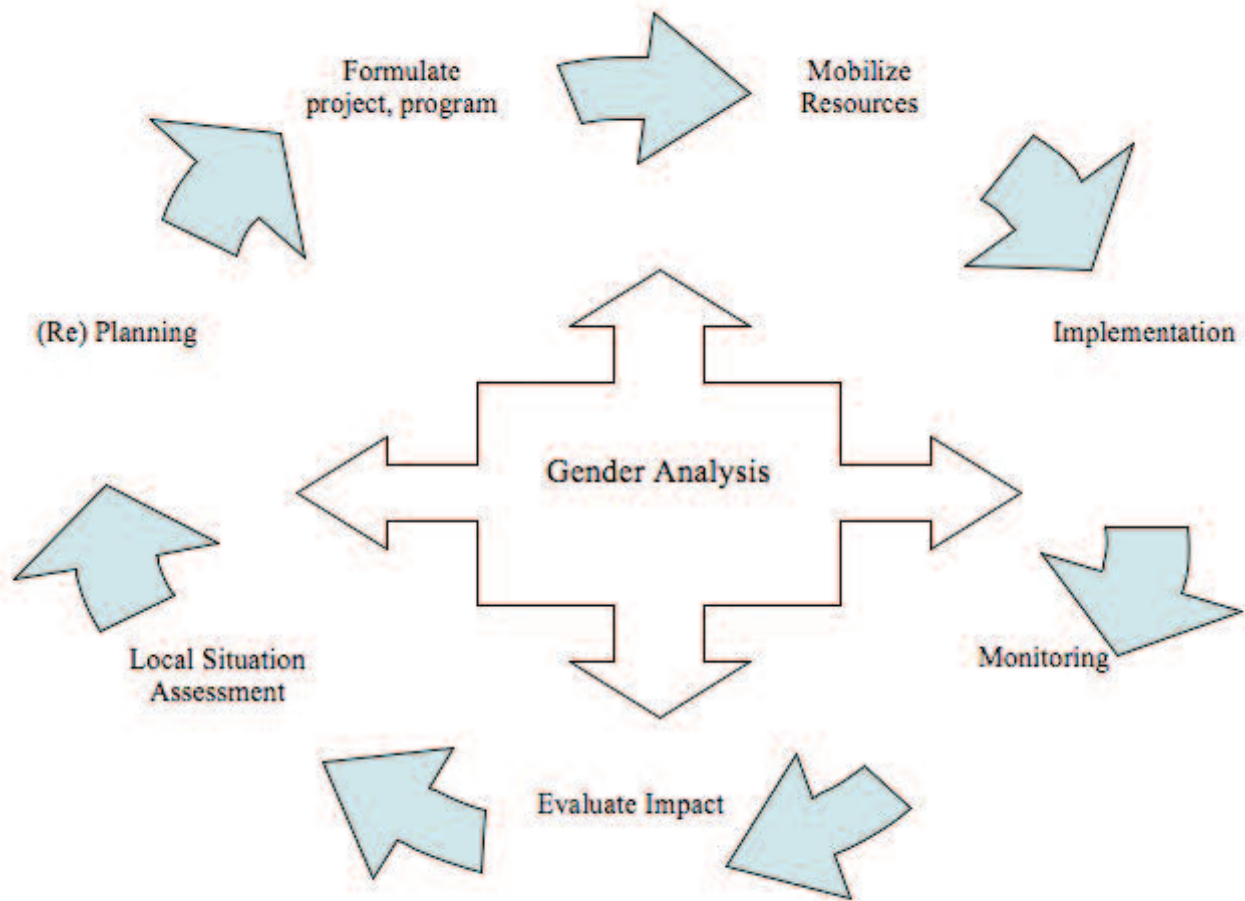
- A project is a **time-limited initiative** that focuses on a limited intervention and that has a beginning and end.
- A **program** has broader aims, is **on-going and continuous**.
- REVIEW a typical project/program planning cycle. Walk participants through the phases in the slide above (e.g. 1) Situation Analysis; 2) Planning ... 7) Evaluate Impact.

Facilitator:

REFER to **handout 3-02:** *Entry points for gender in Program/Project Development.*

- Ideally, a gender perspective should be integrated into all phases of program, project and policy development, beginning with the situation analysis phase, however a gender perspective may be included at any stage to fine-tune and enhance an existing program or project.
- A program or policy that is gender neutral or gender blind, does not have to be terminated or discarded. Throughout the program cycle, gender issues can be integrated to address gaps.
- It is also important to remember that decisions to include or exclude a gender perspective are not always made under ideal circumstances; and may exclude gender due to multiple factors (i.e., time and resources to consult all stakeholders). It is the role of gender and health advocates to enhance understanding and facilitate the inclusion of a gender perspective through dialogue and collaboration.

Handout 3.02: Entry points for Gender in Program/Project Development

Formulate project, program

Mobilize Resources

(Re) Planning

Implementation

Gender Analysis

Local Situation Assessment

Monitoring

Evaluate Impact

Source: Adapted from WHO/MSD/MDP/00.17

Gender sensitive indicators

Important use:
- Situation analysis, monitoring and evaluating of programs
- Measure results and changes towards gender equality
- Can be quantitative, qualitative process indicator (for GMS)
- Change over time

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Facilitator:

NOTE

Gender sensitive indicators are a key component for carrying out a situation analysis and for evidence based programming. They also measure progress towards more equitable health programs and impacts.

Indicator: Is a pointer, that can be a measurement, a number, a fact, an opinion or perception that points at a specific condition or situation, and measures changes in that condition over time. Indicators provide a close look at the results of initiatives and actions." (CIDA, 1997, Guide to Gender Sensitive Indicators)

Indicators *may be qualitative* (e.g.; perceptions of m, w, b and girls obtained through methods such as in-depth interviews and focus groups) *or quantitative* (obtained through surveys and based on statistics).

Gender Sensitive Indicators: Their usefulness lies in their ability to point to changes in the status and roles of women and men over time, and therefore to measure whether gender equity is being achieved." (Ibid)

- Gender-sensitive indicators can be constructed based on the following:
- Female share of a total (when it is evident that the total comprises the female and male share): 50% indicates gender equality
- Ratio between a female and a male characteristic: 1 indicates gender equality

REFER to handout 3.03 "Criteria for gender sensitive indicator." Quickly review these criteria.

CONCLUDE: The major limitation to gender-sensitive indicators is that they usually say very little about why gender relations have been shaped and how these have changed. Thus, indicators should be complemented by gender analysis with questions to examine the social relations between women and men and the social structures that reinforce gender inequality and inequity that affect health.

Resources on Gender Indicators:

- **Handout 3.04** *"Suggested process indicators for gender mainstreaming"*
- *"Engendering health statistics: contributing to reducing gender inequities in health" basic indicators to analyze gender equity in health"*
- *"Gender, Health, and Development in the Americas. Basic Indicators 2007"*

Handout 3.03: Criteria for Gender-Sensitive Indicators

Some criteria for selecting developing gender-sensitive indicators:
- **Conceptual relevance:** Indicators should point to conditions or determinants of health that impact upon gender equity.
- **Comparison to a norm:** Gender-sensitive indicators should involve comparison to a norm - i.e., the situation of men in the same country or that of women in another country. This enables the indicator to focus on questions of gender equality and equity rather than on the status of women.
- **Disaggregation:** Data should be disaggregated by sex. Where possible, data should also be disaggregated by age, socio-economic status, region of origin with the time period, geographical coverage and data sources all properly noted. As women's health status varies by ethnic and racial group, data should also be disaggregated along these lines.
- **Ease of access:** Data should be easy to use and understand; indicators should be described in easily understandable language and developed at a relevant level of the institutional capacities of the country at hand. A vaguely defined indicator will be open to interpretation.
- **Scope of availability:** Indicators should be available for the entire country.
- **Reliability:** Data should be relatively reliable and the user should be informed how the indicators were constructed.
- **Measurability:** Indicators must be about something 'measurable'. Concepts such as 'women's empowerment' may be difficult to define and measure. Proxy indicators, i.e., greater choice for women in accessing health care (a component of women's empowerment), should be used in place of less precise concepts.
- **Time frames:** Gender-sensitive indicators should be reliable enough to use as a time series. The time span of the indicator should be stated clearly.
- **International comparability:** Gender-sensitive indicators should be collected using internationally accepted definitions in order to allow for international comparison.
- **Measuring impact:** The indicator should measure the outcome of a situation, where possible.
- **Participatory development:** Indicators should be used and developed in a participatory process, involving input from all stakeholders
- **The number chosen should be small:** Gender-sensitive indicators should avoid 'over-aggregation': designing composite indices based on aggregation and weighting may obscure important information and value judgements. Where composite indices are devised, value assumptions of selection and weighting must be made explicit and the disaggregated components should be readily available.

Handout 3.04: Suggested process indicators for Gender Mainstreaming

Suggested Gender Mainstreaming Indicators	What does this Indicator tell us?
Proportion of staff, by sex and grade having ever attended a Gender Training Module or session.	This indicator tells us to what extent existing staff is, at least, gender aware.
Proportion of new staff, by sex and grade having attended a Gender Training Module or session.	This indicator gives us an idea of the exposure of new staff to gender issues in health through Gender Training Modules.
Number of consultations (meetings, teleconference, documentary analysis) for gender issues.	This indicator tracks departmental initiatives to mainstream gender into work.
Proportion of senior level staff, by sex and grade who have "knowledge of gender issues" included in their terms of reference.	This indicator tells us to what extent those in decision-making positions are expected to consider gender.
Proportion of technical work, programmes and research from identified AoW that address gender issues.	This indicator monitors attention to gender in WHO/MoH initiatives.
Proportion of priority AoW that include gender issues.	This indicator tells us to what extent gender is being mainstreamed into priority programmes.
Proportion of research activities that include sex, or gender "stratifiers", as variables of analysis.	This indicator reflects the extent to which gender is considered in departmental/Ministerial work.
Number of publications produced that highlight how women and men are differentially affected by the given condition.	Idem.
Proportion of dissemination activities, advocacy work based on analyses using sex-disaggregated data or gender "stratifiers"*.	Idem.
Percentage of budget allocated towards gender issues.	This indicator demonstrates, perhaps, the most concrete form of evidence that gender is being considered seriously at the highest levels.
Percentage of planned versus actual costs allocated towards increasing gender skills of the department/Ministry.	This indicator is more precise than the above and accounts for planned costs.
Percentage of panned versus actual cost allocated towards incorporating gender into departmental/Ministerial work.	Idem.

* That is to say, those indicators that allow for gender analysis. For example, sex and age, ethnicity, region of residence, level of education, employment status, ect.

TIME: 60 minutes

Facilitator:

ACTIVITY: Applying the Gender Analysis Matrix for programmes, projects or polices.

PREPARATION: REFER TO handouts that follow this section
Handout 3.05: *Gender Analysis Matrix for existing programs, project or policies*
Handout 3.06: *Explanations of concepts used in Gender Analysis Matrix*
Handout 3.07: *Applying the Gender Analysis Matrix tool in a malaria prevention and intervention*

Facilitator:

Step 1: EXPLAIN the matrix in the slide organizes the concepts we have discussed earlier and categorizes both programmatic areas and gender issues. This combination will help implement gender sensitive programs and projects.

Step 2: REFER to handout 3.06 *"Explanations of concepts used in Gender Analysis Matrix"* and quickly review program areas to familiarize participants.

Step 3: REFER to handout 3.07 **"Applying the Gender analysis Matrix tool in a malaria prevention and intervention"** and go through the matrix for one or two program cycle areas, so participants gain understanding of the process.

Step 4: ACTIVITY: applying Gender Analysis Matrix for planning (TIME 30 minutes)
Break into two or three groups and assign each group the case study of HIV in Belize, of which we have seen the data in Module 2. (Handout 3.08)

Instead of the HIV case study, participants could use theme they analyzed in module 2

NOTE

- The aim of this activity is for you to become familiar with using the Gender Analysis Matrix for planning a project or a program. The Planning Matrix can be found in Handout 3.05. "Analysis".
- READ over the Belize case study and based on this information design a project or program that addresses the HIV situation in Belize. Include key activities for each area of the matrix, indicating if these are gender sensitive or transformative.
- You may use the malaria example to guide you.
- REMEMBER: ideally most programs should combine activities that are gender sensitive/responsive, with ones that are transformative. You should aim to avoid activities that are gender neutral or blind.
- Use indicators whenever possible
- Use a flipchart and designate a reporter to record your contributions.

Step 5: After 30 minutes each group takes 5 minutes to highlight their activities
POINT OUT the common activities that are transformative.

Facilitator:

In addressing gender differences and discrimination in a health intervention, gender issues can be raised at each phase of the program/project. Even when a program is ongoing, gender analysis will help you to re-plan and integrate new and emerging gender considerations based on feedback from monitoring and evaluation.

When planning a program or project it is not necessary to use the matrix format, but it is useful to bear key questions in mind when planning new or revising existing programs. Your packets include a checklist for this purpose.

Handout 3.05: Gender Analysis Matrix for existing programs, projects or policies

Area of Work	Gender Blind/Neutral	Gender Aware/Sensitive/ Responsive	Gender Transforma–tive	Variable to consider for the analysis
Situation Analysis				Use multiple sources of data for the evidence Explore gender specific needs Disaggregate data by sex
Scope, design and planning-formulation (including vision and goal)				Use explicit statements to address gender Use gender specific actions Stakeholder participation in design Scope to show gender/sex differences
Resources mobilization				Need $ for gender issues–political will Communication and stakeholder support
Implementation				Easier if better planned Both sex involvement Pertinent data collection
Monitoring				Use gender-sensitive indicators
Impact Evaluation				Review success in mitigat-ing gender imbalance Have process and impact indicators
(Re) Planning				

Phases in Program/Project Cycle	Explanation and tips to integrate gender
Local situation analysis	Local situation analysis The term local situation analysis relates to activities that help to define the health needs and problems of the program's target group. This is done to capture a true picture of the health needs and problems and forms a starting point to develop effective interventions. A gender analysis should be part of the assessment of the local context. This is achieved by integrating gender specific needs which help to pinpoint gender issues that need to be addressed. Such information is useful for planning, re-planning, implementation and monitoring and evaluation. It is crucial that you have access to, and use, the right kind of information to ensure that you can adequately address gender in a situation analysis. This entails adequate data (i.e., disaggregated by sex), using multiple sources of data and information (i.e., quantitative, qualitative, NGO reports, etc) and consulting women and men in the area that are to benefit directly from your project, program or policy (i.e. through in-depth interviews, focus groups, etc).
Planning and project/program formulation including scope, vision and goal	Planning The planning process should be participatory and based on the best available evidence. It should take into consideration the different needs of women and men, girls and boys the program/project wants to engage (e.g. data gathered during the local situation analysis). The program/project should attempt to build on the assets (e.g. human, financial, infrastructure) and capacities (e.g. individual, community, organizational) to improve the health of m and w, g and boys. Program/project vision, goals and principles When developing or reviewing the goals/vision of the program/ project ensure that: • There is an explicit statement on its intentions to address gender issues which are gender sensitive and/or gender-transformative. • The intentions should relate to the program/project vision, goals, or principles with concrete actions identified. • The program design must actively promote gender equality, and must be appropriate, given the nature of the program. Scope • The scope should include stakeholder participation in the design, monitoring, and evaluation of the project and mechanisms envisioned to ensure the equal participation of women. • The scope reflects the ways sex and/or gender differences will be taken into account in the programme - regarding norms, values, roles and behaviours, biological differences between men and women, access to and control over resources.

Phases in Program/Project Cycle	Explanation and tips to integrate gender
Resource mobilization	• Resources include people, materials and money including time. There needs to be an understanding of available and unavailable resources to carry out the work on gender. This requires political support to access required resources. • Community support and mobilization are also important: Finding people who can support the work is important. For example, if the activities on gender require a lot of input from the community, as in malaria, HIV and TB programmes, community support and commitment can facilitate resource mobilization for the program or project by generating donor interest and establishing realistic outputs. • Stakeholders should be brought on board to understand and support gender initiatives. Such consultations and dialogue can raise awareness about the importance of including gender work, and elicit additional financial support to carry out gender related activities.
Implementation	• The inclusion of gender issues is easier during the implementation phase if the gender analysis findings (i.e. different needs of men and women, boys and girls) are clear and specific. • It is important to also consider the manner of implementation and methods used. For example, are men and women both involved in the project, program or policy on an equal basis? If qualitative data collection is involved, has adequate attention been paid to the life circumstances and gender roles and norms for women and men in that specific community that will facilitate their participation and reduce the risk of harm to them? • Address gender-sensitive health outcome indicators. See additional resources in this manual for further information.
Monitoring	• Monitoring provides continuous feedback during program/project implementation on whether gender integration in a specific health problem or condition is on course or requires redefining. Specific instruments or forms need to be developed for use to collect the relevant information. Indicators for monitoring must reflect the project's gender-related impact. Include process indicators to assess the progress of gender mainstreaming. See additional tips in Handout 3-07 in this manual for further information.

Phases in Program/Project Cycle	Explanation and tips to integrate gender
Evaluation	• Evaluation provides an opportunity to look back at all the work that has been done over a period of time, to determine the effectiveness of the programme or project. However, the evaluation framework should be set up and agreed upon on the "front end" of a project/program. • The evaluation needs to include problems and successes of the gender aspects uncovered in the gender analysis, with recommendations as to how this can be improved • The indicators for the evaluation system should similarly include input or process indicators as well as outcome indicators. All such indicators must be appropriate and adequate to the task of reflecting the project's gender-related impact. • Evaluations may also be external – by donors for example. They often have their own measures of success to use, many of which include gender.
(Re) planning	• Information collected from evaluation should be used to improve the health intervention and should shape ongoing and future planning. Decisions should include gender related activities to strengthen the effectiveness of the program/project.

| Programme or project area	Gender-blind/neutral	Gender Aware/sensitive/ specific	Gender- Transformative
Scope, design and planning formulation (including vision and goal)	Design a policy that aims to decrease the incidence of malaria among the poor.	Design a policy to decrease incidence and negative outcomes of malaria during pregnancy. Develop preventive measures for male farmers. Explore possibilities of reaching out to men through workplace-based treatment, malaria diagnosis and treatment facilities	Build women's as well as men's responsibility for malaria prevention and treatment. Include women at all levels in project planning, advisory committees and in community meetings, to challenge gender roles that restrict participation and decision power to men only
Resource mobilization	Raise money for a malaria intervention without allocating resources for addressing gender issues.		Ensure that funds cover transportation and time loss costs for volunteers who are often working without payment. Account for the "invisible" work of women in budgets (i.e., child care) to ensure their active participation. Include costs for participants in the study, trial, or project for compensation for time lost from paid work, travel and other related fees.

Programme or project area	Gender-blind/neutral	Gender Aware/sensitive/specific	Gender-Transformative
Implementation	Increase the number of bed nets that are produced, without addressing if men and women have equal access to use them.	Reduce or subsidize the cost of bed nets and insecticides to make them more accessible to women. Use diverse media to reach both men and women. Ensure that the information content corresponds with their different vulnerabilities and health-seeking behaviours.	Ensure that programme messages on appropriate care for childhood malaria address both fathers and mothers, thereby challenging the stereotype that only mothers are responsible for the care of children.
Monitoring	Examine if a project has increased the use of bed nets in the poor population.	Collect data on the proportion of women and men who have participated in community meetings regarding introduction of bed-nets. If their participation differs, examine if gender norms influence the participation of either sex. Accommodate gender differences to increase the participation of the under-represented sex.	Collect, analyse and report data disaggregated by sex and age to evaluate a program aiming to reduce malaria in a population. Conduct workshops with members of community decision-making structures to identify potential gender-related barriers and ways to address these.
Evaluation	Evaluate an increased household use of bed nets, without using sex disaggregated data.	Evaluate a decline in incidence of malaria among pregnant women.	Give information to key stakeholders and leaders on the consequences of failing to address gender issues within the programme context. Evaluate the proportion of women and men, girls and boys that are utilizing bed-nets regularly.

Handout 3.08: Case Study HIV in Belize

HIV is a critical public health issue in Belize, where HIV/AIDS reports from 1986 through 2005 have indicated that 3,360 individuals live with HIV, and 762 have developed AIDS, in a population of less than 300,000 . In 2005, HIV/AIDS ranked as the fourth leading cause of death with 2.4% of Belizeans living with HIV, 37% are women.
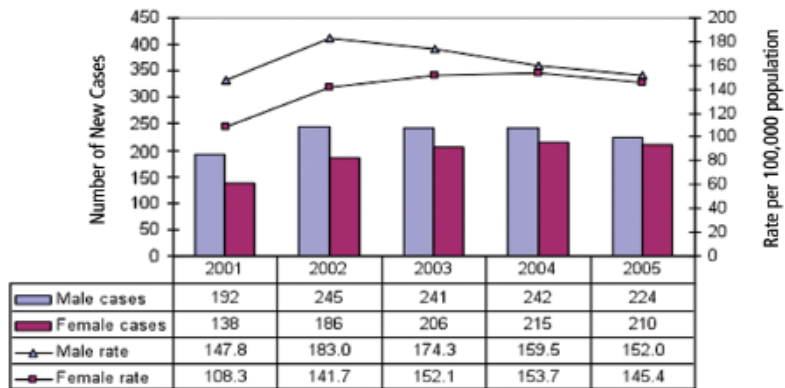

Figure 1: Number of New HIV Cases & Incidence Rates, Belize 2001–2005

	2001	2002	2003	2004	2005
Cases	330	431	447	457	434
Rates	128.2	162.5	163.3	156.7	148.7
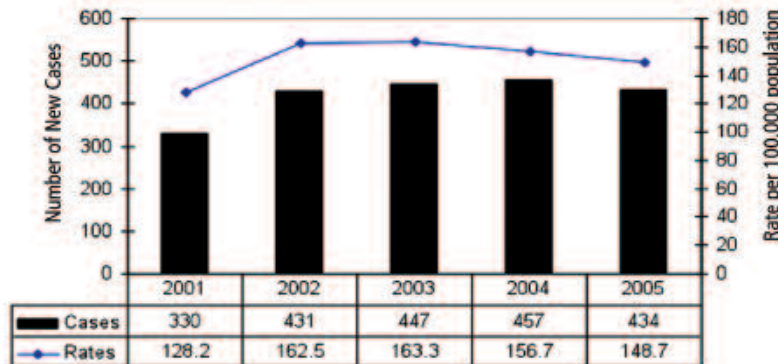
The number of newly confirmed cases of HIV infection increased 32% from 2001 to 2005, though the overall incidence appears to have peaked in 2003. These numbers of test result may not be representation of the whole population, since only 3-5% of the population gets tested.

While there has been a decline in HIV incidence for men from 2001-2005, women account for a growing number and proportion of newly identified cases of HIV infection in Belize. A **52% increase in the number of positive test results for women since 2001.** By 2005, the number of positive results among women was nearly the same as men.

Figure 2: Number of New HIV Cases & Incidence Rates by Sex Belize 2001–2005

	2001	2002	2003	2004	2005
Male cases	192	245	241	242	224
Female cases	138	186	206	215	210
Male rate	147.8	183.0	174.3	159.5	152.0
Female rate	108.3	141.7	152.1	153.7	145.4

The apparent increase in HIV infection among women may, in some part, be attributable to increased counseling and testing of women, which increased 60% from 2001-2005.
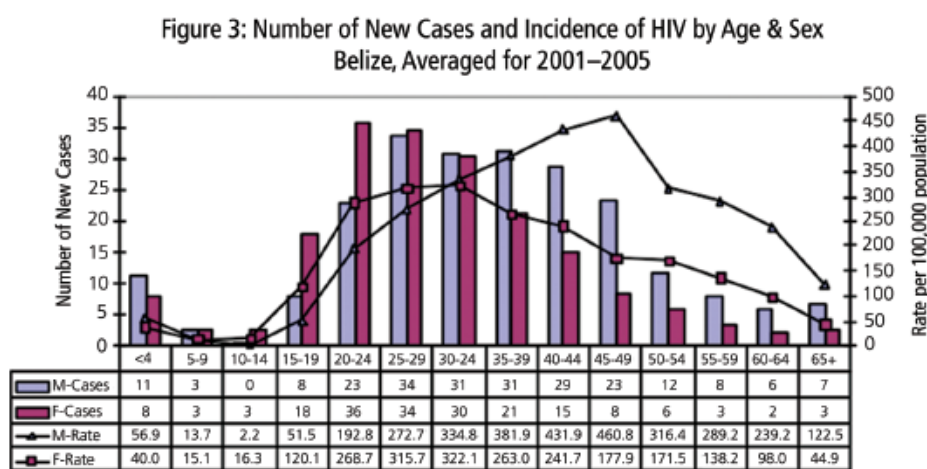
Women are in contact with health service providers more often, especially during pregnancy.

Since 2001, the prevalence of HIV/AIDS had increased 20% among Belizeans, which may be attributable to the increase in new HIV infections among women in recent years or to improved access to HIV/AIDS clinics.

Women's biological vulnerability to HIV is greater than men's because of the greater surface area of delicate vaginal tissue, which is compounded by women's greater vulnerability to forced sex and violence; affecting their ability to negotiate safe, or unwanted sex.

The implications of increasing HIV/AIDS among women are far-reaching, with serious consequences for themselves, for increasing the risk of transmission from mothers to their newborn or breast-feeding infants.

Figure 3 shows the average number of new HIV cases and incidence of HIV in Belize by sex and by age from 2001 to 2005.

Figure 3: Number of New Cases and Incidence of HIV by Age & Sex Belize, Averaged for 2001–2005

	<4	5-9	10-14	15-19	20-24	25-29	30-24	35-39	40-44	45-49	50-54	55-59	60-64	65+
M-Cases	11	3	0	8	23	34	31	31	29	23	12	8	6	7
F-Cases	8	3	3	18	36	34	30	21	15	8	6	3	2	3
M-Rate	56.9	13.7	2.2	51.5	192.8	272.7	334.8	381.9	431.9	460.8	316.4	289.2	239.2	122.5
F-Rate	40.0	15.1	16.3	120.1	268.7	315.7	322.1	263.0	241.7	177.9	171.5	138.2	98.0	44.9

As in other parts of the world, new cases of HIV have disproportionately been found among younger adults. However, looking at new cases of HIV by sex as well as by age reveals a **greater burden of HIV among female teens and young adults compared to males peers.**

Among men, the highest numbers of cases of HIV were found among those ages 25 to 34, while among women peak number of cases occurred at age 20 to 24. **HIV infections were more common among women than men throughout the 10-24 age range.** The risk of HIV appears particulary high for men aged 40-49, especially for their population size. Note that approximately 85% of new HIV infections among women occur in the childbearing years (15–49 years).

HIV detected in girls aged 10-14 is a particular concern if transmission is through sexual contact in this age group. Using this information and local knowledge about whether young girls are sexually active for economic reasons, or because of coercion, trafficking or some other reason, it is possible to develop public health initiatives specific to them.

Other information for the gender based analysis and Planning

Early initiation of sexual activity and the prevalence of STIs are recognized as major public health concerns relationg to HIV/AIDS in Belize. However, it is important to recognize distinct physical, social, and psychological vulnerabilities among women, particularly young women. Women, especially young women are more physiologically susceptical, girls generally reach sexual maturity earlier than boys, and more often have older partners (e.g. unprotected sex, multiple partners, IDU). Men are more likely to engage in behaviors and activities that place them at risk of HIV.

Gender roles and power inequalities between men and women limit women's espcially young women's ability to insist on safer sex practices. Women's greater unemployment, lower income greater likelihood of living in poverty and great marginalization also increase the liklihood that engage in high-risk activities such as injection drug use, placing them at risk of sexually transmitted infections. Sexual violence against women places them at risk for acquiring HIV and other STIs.

Questions to consider for Planning

Using the data separated by sex, health planners can ask: Have recent public health and public education initiatives contributed to the slightly declining incidence rates for men? Have recent initiatives been as successful for women?

Are there gender differences in the social stigma associated with HIV/AIDS? What would cause stigma for men? What would cause stigma for women? How do these factors influence women's and men's willingness to be tested?

Are there gender differences in access to anti-retroviral drugs? As women tend to should greater health costs, what are the implications for women? Treatment and expanded coverage of treatment improved considerably in 2004-2006, yet some segments of the population (poorer people) may still experience barriers to access. Are differences in access among women evident?

What gender relevant impacts may globalization have on HIV/AIDS? Consider trends in exploitation of women, human trafficking, tourism, migration, and other social changes.

What are the implication of HIV dection in young girls? Are there programs to protect them, as well as to prevent further transmission to other sexual partners or through pregnancy and birth? For instance there is evidence that younger girls are more likely to have sex by force. Many women of differenct ages are not able to negotiate protected and unforced sexual relations. Other women are vulnerable to HIV because they or their husbands have multiple sexual partners.

How can public health and public education initiatives be tailored to address the lives of women and girls in Belize, including thier responsibilities to family and communit?

What can be learned from successful initiatives in other countries to prevent further disease incidence in girls and women?
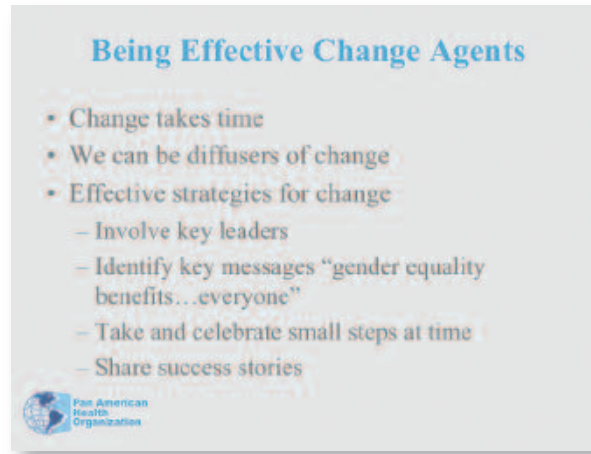
Facilitator:

POINT OUT that:

• We are all change agents in our own workplaces and mainstreaming Gender is about influencing our systems so they can move along the continuum from gender blind/neutral to gender sensitive and ultimately to being gender transformative
• We know from the research on change that change takes time and there are strategies to facilitate making change
• Everett Rogers, a communications theorist, determined that to diffuse innovation (e.g. trying to move an organization to be more gender sensitive/use gender analysis) the following strategies are recommended:

➢ Identify key opinion leaders in your workplace/community –who are perceived credible, trustworthy and are often charismatic/good speakers
➢ Engage them in your course by sharing your knowledge and tools about the importance of integrating gender and what the research demonstrates (Gender Analysis, promoting health and gender equality).
➢ Identify key messages; e.g. Promoting gender equality has been shown to improve health status and assist in reducing poverty; Gender is not only about women, it is about men and women, boys and girls having equal conditions for realizing their full human rights and potential to contribute to society
➢ Develop a short, succinct briefing note to assist you in communicating with opinion
➢ leaders; e.g. Gender Analysis: what it is and why it is important for our work in public health

Facilitator:

ASK

What other strategies can you think of that would facilitate these changes?

TIME: 30 minutes

Facilitator:

REFER TO:

Worksheet 3.9: *Building the Bridge Between the Workshop and my Work*
Handout 3.10: *Program Planning Matrix*
Handout 3.11: *Basic Questions*

Facilitator:

PREPARE ACTIVITY

You now have the tools and information, as well the motivation for being a change agent for mainstreaming gender in your health work.

The aim of this activity is for you to apply these to the actual design of a program/project that integrates a gender perspective.

Step 1: We suggest you form workgroups of the participants of your country to develop a preliminary strategy/plan that can be further developed, once you are back in your country.

Step 2: Use the **Worksheet 3.9** *"Building the Bridge Between the Workshop and My Work"* and **Handout 3.10** *"Program Planning Matrix"* to guide you in developing this strategy/plan/program. You may develop an overall gender mainstreaming strategy, or target specific programs, projects, or even phases of programming, that are realistic to implement in your country. Handout 3.11 "Basic Questions; does my program, project or policy consider gender" provokes further thought on integrating gender into your work.

In addition to the tools presented in this module, you can also use the tools included in your folder *"Gender health and development: Basic Indicator, 2007", "Useful gender checklists for policy and programs"* and the gender profiles of your country.

Step 3: We hope that you, as change agents, will develop this Strategy /plan/program more completely with relevant partners of the Ministry of Health, National Women's Ministry, from civil society and from PAHO, once back in your country.

1) **Identify a goal** of what you would like to achieve over the long run

2) **Identify some key objectives** or results you expect to achieve

3) **Identify a list of activities** you will undertake over to integrate Gender Analysis into your health word.

4) **Review** the activities keeping in mind the following criteria?
   • Realistic?
   • Within my sphere of influence?
   • Relevant to my public health work?
   • Of potentially high impact; e.g. do they address several gender dimensions?
   • Do they not require a significant influx of new resources?

5) **Identify Priority Areas for Action (e.g. Advocacy, Policy Development, Research, Communications, Organizational Change, Training)** – This can be done by theming the list of activities you developed above (clustering them).

6) Use **Handout 3.10** "Program Planning Matrix" to develop your plan

   A few other points to remember:
   • Begin your activities with an action verb
   • Keep in mind the criteria in step 2 above
   • Remember the key points related to change and being an effective change agent
   • Think about who inside and outside the organization will be able to support you; e.g. perhaps identify a colleague(s) from this workshop you will touch base with on a regular basis
   • Think about other resources you may need; e.g. financial; and others you may build on such as tools and handouts from this workshop.

7) **Reflect on your action plan** and think about the **Priority Area for Action** you think is most important for you to address to move forward/address gender in your work; **Write this down and Identify your goal for the next 3 months, 6 months and 12 months related to this particular issue.**

Handout 3.10: Program Planning Matrix
Goal (long run) _____

| Expected Results	Activities	Indicator	Time Line	Responsible

Handout 3.11: Basic Questions

Does my programme, project or policy[1] consider gender[2]?

This checklist is intended to be a quick way to identify how well program/projects/policies Ministries or Departments are doing in terms of integrating gender.

	Question	Yes	No
1.	Does my project demonstrate a clear understanding of the difference between sex & Gender?		
2.	Does my programme include sex as an important variable for the target population?		
3.	Does my target population include both women and men on purpose?		
4.	Does my policy consider the life conditons of the women andmen in the target population?		
5.	Has my project piloted methods/tools on both sexes?		
6.	Does my program consider fmaily or household dynamics and anticipate different consequences and opportunities for individual members of the household (e.g., intra-household allocation of resources?		
7.	Does my project include both male and female team members that have equal say in the direction of activities?		
8.	Is the evidence generated by, or informing, my program collected and reported by sex?		
9.	Is a male norm adopted as the "standard" in my project or program? (i.e., Is the definition of a disease based on the existence of symptoms that have been identified in male research subjects only? Does it assume that women have the same rights as men if such rights are essential to benefit from the program?)		
10.	Does the principles (such as inclusion criteria) of my project exclude one sex but assume that the conclusions are to be applicable to both sexes?		
11.	Do aspects of my policy exclude one sex in areas that are traditionally thought of being relevant for the other sex only (i.e., reproductive health issues in policies for men or paid work in policies for women)?		
12.	Does my policy treat women and men as homogeneous groups when outputs could have differential outcomes on sub-groups of women and men (i.e., poor verusus rich women, employed versus unemployed men, etc.)?		
13.	Does my program, thorugh its materials or publications, stereotype men as actors and women as being acted upon?		
14.	Does the language of my policy exclude one sex over the other?		

[1] Please note that the terms are used in the checklist interchangeably. Participants should respond according to the type of intervention on which they are currently working.
[2] Adapted from Abdool & Vissandjée (2003), Health Canada (2001, 2003), Horne, Donner & Thurston (1999).
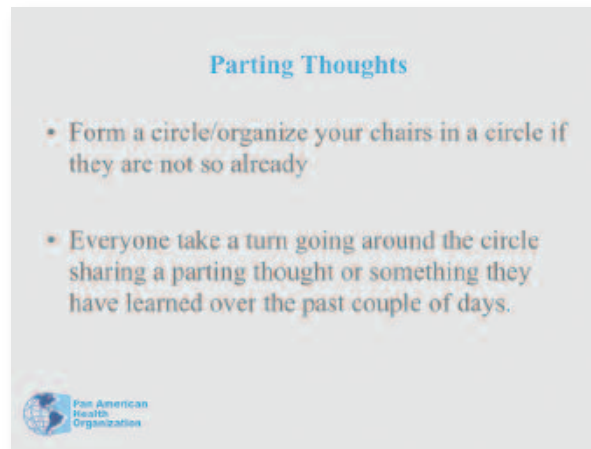
Facilitator:

- Congratulations! You have finished the workshop on "Gender and Health" and you have developed some preliminary plans that can be followed up once you return to your country.
- Our PAHO team will be available in supporting you in developing and implementing these plans.
- Before we fill out the evaluation forms of the course, we would like to collectively share some part

Activity

Facilitator:

Prepare Closing Activity
PREPARATION: Talking Stick
We will use a talking stick or talking stone to pass around the circle and only the one who holds it may speak and all others must listen. (20-30 minutes depending on the size of the group)

- Thank you, and again congratulations on being the agents for change on achieving gender equity in health
- Please fill out the evaluation form and leave it at the facilitator's desk.

Worksheet 3.12: Checkpoint: True or False?

Test yourself! Now that you have completed Module 3, try these questions out to see how you are doing in your gender discoveries. Answers are provided below.

Question		True	False
1.	A gender-neutral trategy recognizes the differences in power balance due to gender roles, norms and access to resources and actively tries to change these		
2.	In order to achieve sustainability but also short-term results on improved health outcomes, we need to use both gender-transformative and gender-specific strategies.		
3.	A program has boader aims than a project and is continuous rather than with a definite beginning and an end.		
4.	When designing a program/project it is essential to include women as well as men in the process since doing so ensures that the aim of the program will address gender issues.		
5.	All programs/projects should start with a gender analysis to make sure that gender issues that need to be addressed are identified.		
6.	When addressing gender differences and discrimination in health interventions, gender issues can be raised at each phase of the program cycle. In practice, gender needs to be considered during the local situation analysis, program/project formulation, scope and design planning, resouce mobilization, implementation, monitoring and evaluation. After having done all this, we can be sure that gende rhas been properly addressed.		
7.	In the material of a program/project it is right to depict men as actors and women as passive as this often reflects reality.		
8.	To reach out to men through a work-based treatment project of malaria is an example of a gender specific strategy.		
9.	When a disease has been identified to be more common fo one sex compared to the other, a comprehensive gender analysis considers how gender as well as control as access over resources impact on the specific health issue.		
10.	Gender is an important social determinant of health that needs to be considered and addressed in order to achieve better health outcomes for all.		

Module 3 References

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