

Guidelines for the Analysis of Gender and Health

**Liverpool School of Tropical Medicine
Gender and Health Group**

Preface

The Gender and Health Group at the Liverpool School of Tropical Medicine was established in 1995. This multi-disciplinary group emerged from:

- a growing interest in gender issues
- a desire for a clear practical and theoretical understanding of gender issues in health
- a desire to contribute practical knowledge and expertise to incorporating gender issues into health

The group aims to encourage the integration and application of gender analysis into all areas of the school's work, including teaching, research, consultancy, and human resources management.

In July 1996, the group organised a workshop to develop their understanding of gender issues and to consider how these issues could be practically incorporated into their work. The workshop investigated the applicability of existing gender planning guidelines to health projects and programmes. The consensus of the workshop was that existing gender analysis guidelines did not provide health policy makers, researchers or care providers with appropriate guidance for identifying relevant questions and issues to guide their work. The development of guidelines to be used in these areas became a primary focus of the group.

After a period of development work, a first version of the guidelines was circulated among health professionals in November 1996. The implications of a gender analysis for health policies were discussed at a second workshop in December 1996. Funding for the further development and practical application of the guidelines, conducting a systematic review and holding an international consensus workshop was then obtained from the Department for International Development (DFID) Seedcorn Fund. This work began in January 1998 and enabled the group to employ a full time research officer, Rachel Tolhurst.

The group's work has extended beyond the Liverpool School of Tropical Medicine as the network of professionals interested in gender issues in the health field continues to grow. The group held a symposium and a workshop at the Second European Conference on Tropical Medicine in Liverpool September 14-18, 1998. This brought together policy makers, researchers and health planners, including from a number of developing countries. The guidelines, a number of case studies and review findings were presented for discussion.

A critical literature review is also being undertaken to complement the guidelines, and to inform policy makers and practitioners of debates and developments in gender theory and practice relevant to health. The literature review will focus on approaches to gender and infectious diseases in developing countries. It will illustrate the theoretical and practical implications of different approaches to gender and health, analyse the guidelines used in this field and suggest areas for further development.

My own involvement with the Gender and Health group came about through my work as a consultant to the Liverpool School's DFID funded Health Sector Reform Programme. Health Sector Reform raises many gender issues, and the Programme has made resources (including my time) available to the group to pursue its work. A notable feature of the group is its gender composition, with more or less even numbers of women and men. This speaks to the

genuine commitment across the School to debate and dialogue in the area of gender and health.

In recent years, the significance of gender divisions in health has become increasingly recognised by international and bilateral donors, national governments, NGOs and the research community. Yet we have lacked practical frameworks which are relevant to the particular needs of the health sector. The development of these guidelines is an attempt to meet this challenge. The guidelines are offered in a spirit of enquiry about and engagement with gender issues in health. They are not meant to be a prescription to be followed mechanically. Rather, their aim is to stimulate researchers and those involved in policy and planning to address the hitherto often neglected gender dimensions of their work. For those concerned to do so, they offer at the same time a practical framework for incorporating gender into health projects and programmes. My colleagues and I hope that you will find them helpful in your work and we very much welcome your comments and feedback.

Acknowledgements

These guidelines are produced by the Gender and Health Group at the Liverpool School of Tropical Medicine. The process of developing the guidelines involved the input and expertise of all group members:

Korrie de Koning, Helen Derbyshire, Rumona Dickson, Grindl Dockery, Vicki Doyle, Charles Gilks, Julia Kemp, Tim Martineau, Janet Price, Bertie Squire, Hilary Standing, Peter Thomas and Rachel Tolhurst. For profiles and contact details see [Appendix 3](#).

The document was drafted in the final stages by Korrie de Koning, Rachel Tolhurst, Janet Price, Julia Kemp and Helen Derbyshire on the basis of discussion and inputs from the group. Case studies were contributed by Renu Khanna, Charles Gilks, Tim Martineau, and Bertie Squire.

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The links given below suggest sections which will be particularly relevant to groups of users and areas of health.

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Chapter 1 - Introduction

1.1 Why do we need Guidelines for Gender Analysis in health?

Gender differences and inequalities are a major cause of inequity in health and health care. There is increasing recognition amongst health care providers and researchers of the importance of considering gender issues in health policy, planning, practice and research both to reduce health inequities, and to increase the efficiency and effectiveness of health care services.

However, health policy makers and practitioners usually have little training in recognising and addressing gender issues. Although there is a range of materials available which offer general assistance in considering gender issues in development practice, few refer specifically to the issues which are most relevant to health. The Gender and Health Group at the Liverpool School for Tropical Medicine has developed these “Guidelines for Gender Analysis in Health” to offer such specific assistance to health professionals. The overall aim of the guidelines is to enhance the ability to understand and respond to gender issues amongst those involved in the planning, implementation, and evaluation of health care provision and health research.

1.2 What do the Guidelines include?

These Guidelines include:

Section 1

background information introducing concepts of gender and health and outlining the different ways in which gender affects health

Section 2

STEP 1: *a gender analysis framework* for conducting detailed situation specific gender analysis for use in health planning, implementation or research, comprising guidelines for constructing:

- Part 1: *Patterns of ill-health* (who gets ill, when and where)
- Part 2: *Factors affecting who gets ill* (why do different groups of men and women suffer from ill-health)
- Part 3: *Factors affecting responses to ill-health* (how are men and women’s responses to ill-health influenced by gender?)

STEP 2: guidelines for *gender sensitive planning*, comprising questions and examples which raise issues about the design, implementation and monitoring of health care systems and research. This chapter includes specific questions addressing:

- the formal health system
- epidemiological and clinical research projects

STEP 3: outlines possible *strategies for addressing gender inequalities* in health care provision and research with examples from policy and practice

Section 3

case studies illustrating the use of the guidelines and practical examples of the issues raised

1.3 How can the Guidelines be used?

The Guidelines have been designed for use at different levels of the health care system. Health policy makers, planners and managers as well as health practitioners and researchers should all find the Guidelines useful.

The Guidelines can be used in several ways by different groups of people:

- *individual professionals* as well as health care teams can use the Guidelines to develop their personal understanding of gender and health, to provide assistance in identifying gender issues in their own areas of work, and to assist in identifying strategies to address gender inequalities in their health service provision
- the Guidelines can be used for participatory analysis, planning and evaluation, actively involving *all people affected by health problems or activities*
- health researchers can use the Guidelines to consider the gender dimensions of their research area
- *health systems policy makers* can use the guidelines to identify gender issues in the design and implementation of health policy
- *health systems managers* at district or regional level, can use the guidelines to identify and prioritise issues and devise strategies to address them
- *gender trainers* can use and adapt the Guidelines and case studies for workshops in gender awareness and gender planning for health care professionals

Chapter 2 - Background Information

Chapter 2: Background Information: What is gender and how does it relate to health?

The aim of this chapter is to give a background to concepts of gender and health. The chapter begins with a basic introduction and then goes on to examine the concepts in more detail. The first three sections (2.1 - 2.3) are *essential* to understanding the guidelines. The following sections provide a broader context for understanding the relationship between gender and health.

2.1 What is gender?

SEX: refers to the biological differences between men and women.

GENDER: refers to the roles that men and women play and the relations that arise out of these roles, which are socially constructed, not biologically determined (Pan American Health Organization, 1997).

The term “*sex*” refers to the biological differences between women and men.[\(1\)](#)

The term “*gender*”, in contrast, refers to those characteristics of women and men that are socially and culturally determined - that is, the different behaviour, roles, expectations, and responsibilities all women and men learn in the context of their own societies. Because societies are different, and because every society develops and changes in its practices and norms over the course of time, gender roles and relations are not fixed and universal. They differ in different places and in every society they change over time.

- Gender roles are *socially constructed*. For example, the idea that “women’s place is in the home” while men should be the “breadwinners” is common in many societies. Whilst it is often contended in this context that it is “natural” for women to carry out domestic work such as cooking, cleaning and looking after children, and for men to carry out waged work or produce goods to sell outside the home, these are not fixed sex roles but gender roles, which are produced by the society in which they emerge.
- Gender roles and relations are held in place by ideology (underlying beliefs about the way society should be). For example:

Males and females are expected to have different characteristics. For example, boys are often expected to be ‘tough’ and discouraged from crying, while girls are expected to be ‘soft’, that is, more emotional. As adults, men are thought to be rational and intellectual while women are thought to be irrational and emotional.

- Gender is relational; that is, gender roles and characteristics do not exist in isolation, but are defined in relation to one another and through the relationships between men and women

- Gender roles and relations are unequal and hierarchical.

Whilst gender roles and responsibilities are different in different societies, gender roles and relations are rarely equally balanced. Women and men generally do not have equal access to resources such as money, information, power and influence. In almost all societies what is perceived to be masculine is more highly valued and has a higher status than what is perceived to be feminine; masculine attributes, roles and behaviour are usually given greater social and economic rewards. Gender is thus one of the principal sources of power and inequality in most societies. For example,

In many societies, the most powerful figures in the major institutions are men. For example, heads of state, head teachers, company managers, and health managers are more likely to be men than women. The assertive behaviour required in leadership is often associated with men. Domestic work (or 'women's work') is given a lower value than work performed outside the home. 'Housewives' are not directly paid for their work which is not seen as economically 'productive' and domestic labour outside the home, such as a cleaner's job, is poorly paid.

- Gender relations are institutional because they form a social system which is supported by values, rules, routine activities, and divisions of resources in all forms of social organisation, including families/households, communities, markets, states (and specific organisations such as health care systems).

(See levels of analysis in [Gender Analysis Framework](#))

For example:

Institutional rules include laws such as those which prohibit sexual activity outside marriage for women but not for men, or which allow men but not women to own or inherit property.

2.2 Why is gender relevant to health?

Gender differences in women's and men's roles and responsibilities, and gender inequities in access to resources, information and power, are reflected in gender differences and inequalities in women's and men's:

- vulnerability to illness
- health status
- access to preventative and curative measures
- burdens of ill-health
- quality of care

- because of the different roles women and men play in society, they are often vulnerable to different diseases. For example, a study in Zimbabwe found that

women's more frequent contact with water because they wash clothes and utensils, tends to expose them to a greater risk of schistosomiasis, although adolescent boys often have a higher prevalence and intensity of the disease than girls of the same age because they tend to play in rivers and canals (Chandiwana and Christensen, 1988 in (Vlassoff & Bonilla, 1994)).

- because women often have less direct access to resources, such as money, than men, they are often less able than men to take measures to protect themselves against disease. For example, women may have less power to use income to purchase preventative measures against malaria such as mosquito coils and nets (Agyepong, 1992b, Ettling et al 1989, and Okonofua, 1992 in (Tanner & Vlassoff, 1998)).

- men and women's different roles and perceptions of acceptable levels of discomfort lead to gender differences in willingness to accept that they are sick and to seek care. There is some evidence that women wait longer than men to seek care for illness partly due to their unwillingness to disrupt household functioning until they become incapacitated (Kaur, 1997). However, fulfilling male roles such as that of the 'breadwinner' may also lead to pressure on men not to accept the sick role in certain contexts because of the economic implications of this.

- the insensitivity of formal health services to cultural gender norms may reduce women's access to these services. For example a study in Guatemala found that women chose to be examined by local midwives rather than health personnel because they were allowed to keep their clothes on during the process (Kaur, 1997).

- because in the household and community caring for the sick is usually seen as primarily women's role, the illness of household members places a heavy burden on women (Abrahamsen, 1997; Dias, 1996; Hudelson, 1996; Rathgeber & Vlassoff, 1993; Vlassoff & Bonilla, 1994).

These differences are context specific; that is, they are particular to a certain time and place, and social, cultural, economic and political situation. Gender differences and inequalities often work to the disadvantage of women, sometimes to the disadvantage of men. Because gender differences and inequalities in any particular place combine with the effects of other forms of social division such as class and ethnicity, not all women or all men experience gender related health problems or issues in the same way.

Gender is therefore relevant to health because it affects equity in health and health care. The concept of equity suggests fairness, rather than necessarily equal treatment. A focus on equity in health aims to reduce avoidable or unnecessary unfairness or disadvantage in health and the provision of health services. This requires actively recognising and addressing the structures and processes that give rise to gender inequity.

2.3 What is the difference between Gender Analysis and Women's Health?

Historically, the discipline of *women's health* tended to focus on health problems specific to women because of their biological/sexual make up, such as maternity related problems, and those which relate to their child care role, such as maternal and child health.

Gender analysis, in contrast, is a way of looking at things, a way of understanding, that can be applied to all health issues, including women's health. Unlike women's health, it is not a body of knowledge or a discipline in its own right. Gender analysis seeks to recognise the ways in which gender roles, resources and perceptions impact upon women's and men's health, and to find ways to address inequities that arise from this.

Initially, gender analysis in health focused on the traditional "women's health" areas of concern, highlighting the fact that women's health problems were not only determined by their biology, but also by their socially determined gender roles, resources, perceptions and expectations.

Sexually transmitted diseases

Sexually transmitted diseases (STDs) are a health problem which affect women in specific ways due to their biological characteristics. Women are biologically more vulnerable to HIV infection. Some STDs may be asymptomatic in women so that they are unaware that they are infected. Untreated STDs increase the risk of infertility and of contracting HIV. STDs are clearly a "women's health" issue.

However, women's experience of STDs is also affected by gender roles, resources and perceptions in a number of ways. Women may lack information about STDs because norms of sexual behaviour often discourage women from gaining knowledge about their bodies (Seidel, 1993). Infertility often has a particularly negative impact on women because of pressures on them to bear children. Women's access to treatment for STDs may be limited, due to the social unacceptability of women presenting at clinics with STDs and their lack of access to money to pay for treatment. Women may have less power than men to take steps to protect themselves from HIV infection by insisting on the use of condoms (de Bruyn, 1992).

Gender analysis adds considerably to an understanding of women's experience of STD infection, and provides important information to enable health care providers to address women's needs effectively. Gender analysis also stresses that addressing the relationships between women and men would be an important way of responding to these problems.

More recently, work on gender and health has begun to focus on health problems experienced by women outside of reproduction, arguing for a holistic view of women's health, which recognises that women experience a wide range of health problems which are not determined by their reproductive functions. It is also beginning to bring into focus the health problems

experienced by men due to their gendered roles (such as mining, see Strategies: 5.3.1 Example 2).

In the context of development work, gender analysis seeks to understand more widely how women and men might be affected differently by any particular problem or intervention. In this context, gender analysis examines the ways in which gender roles, perceptions and access to resources causes women and men to be exposed to and affected by health problems and services differently and inequitably.

Increased understanding of the importance of gender issues in the health field has led to a focus on *mainstreaming gender* in health. This means the “integration of gender concerns into the analyses, formulation and monitoring of policies, programmes and projects with the objective of ensuring that they reduce inequalities between women and men” (Pan American Health Organization, 1997).

2.4 What is health?

2.4.1 Introduction

To recognise and address gender issues in health, it is important not only to understand what is meant by gender but also to consider the different understandings of health, illness and disease which inform how we explain and manage ill-health. These affect:

- how we view the causes of ill-health
- how we perceive the individual as responding, physically and psychologically, to these causes
- what we accept as appropriate action to take
- how we view those who are well or ill

The biomedical approach and the social understandings of health are two very different ways of understanding health and illness. These frameworks are often implicit and taken for granted in our approaches to health care. In practice, elements of these approaches are often found in combination, but it assists understanding to consider them independently.

2.4.2 The biomedical approach(2)

The biomedical approach distinguishes between:

- *disease*: a medical conception of physical pathology, indicated by a set of signs and symptoms
- *illness*: a person's experience of ill-health, indicated by a person's feeling of pain, discomfort and the like

The discipline of clinical medicine as we know it today began to emerge in Western Europe during the 18th and 19th centuries, as a result of new ways of looking at the body, determined by new developments in science. Prior to this, the ability of a doctor or healer to care effectively for and cure a patient was dependent primarily upon the history given by the patient. Physical examination and the localisation of pathology were of little importance, as

the physician's main task was to identify what 'species' of disease, or 'humoral' imbalance was present in the patient.

The 18th/19th centuries saw marked changes in understandings of the 'natural world', and of the relationship between the individual, the environment and disease. Research in the natural sciences was influenced by the work of scientists and engineers as they developed their understanding of mechanics, leading to the conception of the natural world in mechanistic terms. Medical scientists, as they discovered more about the human body through physical examination and dissection, also adopted a mechanistic model of the body. To identify the site and cause of bodily malfunctions (i.e. diseases), medicine developed mechanisms to measure, quantify and experiment on the human body, in a similar fashion to the quantifiable, mathematical norms of engineering. The focus was upon the individual biological body as the site of disease pathology.

Clinical medicine thus developed within an empirical framework; that is, based upon the analysis of measurable variables and experimental data drawn from the body. Only observable facts and phenomena were accepted as valid and true - anything stemming from theory or abstract reasoning was regarded with suspicion unless proven by reference to empirical data. Crucially, it was believed that it was possible to understand the body by focusing upon it in smaller and smaller units: what is known as reductionism. This was a process which, while massively increasing our depth of understanding of biology and pathological disease processes, led to the isolation of our understanding of the body, and thus of the patient, from surrounding historical, social, environmental and economic determinants of health and illness.

Germ theory

In germ theory, disease was held to be caused by 'external, specific, discrete agents' (Turshen 1989) - bacteria, for example, and the focus was upon how causative agents caused a specific set of signs and pathological lesions within the body, rather than upon the broad socio-economic conditions which led to the development of disease in particular groups of people.

The major response of biomedicine to illness has been the development of pharmacological tools that will cure or prevent the development of disease.

In summary, biomedicine:

- is focused upon the disease process within the individual patient
- attempts to understand ill-health through an ever more detailed scientific examination of disease causing agents and biological responses
- responds to illness by developing drugs and vaccines to treat, cure and prevent diseases, but pays limited attention to the socio-economic and cultural determinants of health and illness.

The biomedical model has attained a dominant position in formal approaches to health and health care in the world today. Western or allopathic medicine is used, though in modified form, by many government health systems and by international agencies (although traditional and indigenous health systems still provide a high, if not the greater proportion of health care

across the world). However, the biomedical approach can be criticised in a number of ways(3):

- Because medicine is treated as a science, it is assumed it is *possible to be completely objective* and rational about ill-health. Issues such as doctor:patient relationships, or the socio-economic context of the patient and doctor are regarded as variables to be controlled for or managed, rather than necessary aspects of understanding the illness process.
- *It fails to provide a clear analysis of or response to the underlying causes of ill-health* that moves beyond the individual to social, economic and political factors. It assumes people have free choice about their lifestyle, and that if they have unhealthy habits, they are equally free to change them. Connections between ill-health, lifestyle and socially differentiating factors such as gender, race, class and age are noted rather than used for their explanatory powers.
- *Medicine is regarded as an absolute good*, its failure to lead to good health for all lying not in the model itself but in the failure to provide enough of it to go round, or to provide the right delivery mechanisms.

Biomedicine has developed as a *highly gendered discipline*; that is, its structures and practices both reflect and reproduce gender norms, roles and relations. For example, power relations within medicine have developed around a divide in which treatment and cure are the preserve of the doctor and are masculine roles, whilst care and nurture are handled by the nurse, as feminine roles. (See Chapter 2.6)(4)

2.4.3 Social Understandings of Health

The World Health Organization has offered a definition of health that goes beyond the biomedical model and argues that health is:

'A state of complete social, psychological and physical well-being and not merely the absence of disease'.

Implicit within this definition is the notion that health is not purely a physical phenomena, but is influenced by socio-cultural, economic and psychological factors.

There are a whole range of alternative understandings of health and illness that very broadly adopt this understanding of health. Some have developed as indigenous systems over centuries e.g. acupuncture, whilst others have emerged more recently, partly in response to criticisms of the biomedical approach. One group of related analyses may be loosely referred to as models of the *social production of health and illness*. These argue that health and illness are produced through social as much as biological processes, and are products of the way in which society is organised.

The focus of these analyses is not so much upon morbidity or mortality caused by specific diseases, but rather upon the correlation between socio-economic divisions and burdens of health and illness. National and international data have consistently shown similar patterns of inequalities in health and illness in relation to economics, with those who are most

economically deprived carrying the heaviest burdens of ill-health (Townsend & Davidson, 1982).

It is argued that patterns of health and illness are determined by societal relations of production and reproduction, specifically by class relations. It is these relations that are argued to result in the broad correlation between socio-economic situation, life chances and health(5). There are, further, more specific effects of these relations. For example, the effects of production on health include:

- *the negative health consequences of work practices* such as exposure to dangerous chemicals, risky mechanical procedures, the stress of overtime, shift work and production line working
- *the environmental effects of producing goods and services* such as pollution from industries, deforestation for raw materials, and the negative health effects of goods per se: for example, tobacco and alcohol.

More recent social analyses in health have moved beyond a focus on economic relations to look at other dynamics of social organisation such as gender and race. The patterns of health inequalities here are less clear-cut. For example, gender analyses of health in European countries show broadly that men have higher overall mortality rates, whilst women have higher rates of chronic long term health problems. These patterns are altered by factors such as economic status, marriage and age, indicating the need for locally specific analyses to understand how social-economic factors determine patterns of health and illness.

Further, these models, whilst offering broad statistical correlations between health/illness and socio-economic conditions, have only recently begun to map out more clearly the micro-level processes through which poverty, gender, race and other aspects of inequality affect health. In relation to poverty and gender, for example, analyses have begun to address the processes that lead to limitations on choice, and that influence behaviour and decision making, thus affecting health chances. For example, recent work has examining the 'bio-psychosocial' causality of disease has found that the stress associated with poverty affects the hormonal and immune systems, leading to an increased vulnerability to disease.

Social understandings of health also address the role of health care systems in producing and managing health and illness. They are seen not as apolitical institutions but as systems with particular sets of ideologies and beliefs that influence how health and illness is addressed, who gains access to care and who benefits and loses out from health initiatives.

2.4.4 Summary

This section has offered brief overviews of two broad approaches to analysing health and illness. These are by no means the only models available for understanding health and illness, but they are two that will be of relevance in conducting a gender analysis in health. The medical model informs much of the health care offered throughout the world and understanding the concepts and dynamics underlying it is important to analysing the effectiveness of health care systems in dealing with specific health problems. The social understandings of health offer a gendered way of analysing the influences of socio-economic

relations on health and stimulate thinking about broader socio-political interventions that may be needed to improve the overall health situation.

2.5 What is gender analysis?

Gender analysis developed in the context of international development as issues of women's roles in and benefits from development policies and practices were increasingly raised in the post-colonial era.

2.5.1 Development policies: A focus on women

In the era following independence from colonial rule and up until the early 1970s, development policies concerned with women were designed to relieve poor women's needs entirely in the context of their roles as wives and mothers. It was assumed that the benefits of macro-economic development strategies oriented towards modernisation and industrial growth would 'trickle down' to the poor, and that poor women would enjoy the benefits of these developments as the economic position of their husbands improved.

Common *assumptions about household roles and responsibilities* informed these development interventions:

- the head of the household is a man and his wife is at home doing domestic tasks
- household income is pooled and shared amongst all family members
- the male household head is the chief decision maker, publicly represents all household members, and commands their labour and resources
- knowledge is pooled and shared in the family.

By the early 1970s, feminist academics, development practitioners and activists from both the South and the North(6) were taking an increasing interest in the role of women in development and producing work that challenged these assumptions. For example, Ester Boserup (Boserup, 1970) highlighted the role of women in economic development and looked at the impact of economic development on women's lives. Commenting specifically on agricultural development, Boserup drew attention to the facts that extension services had been directed exclusively at men (equipping men but not women with new knowledge and skills); cash crops had been emphasised at the expense of food crops (equipping men with access to increased cash incomes but not women); and the focus of primary education had been on boys and not girls.

Boserup's work, as well as subsequent research into women and development, revealed that:

- women in all cultures play an important *productive* as well as *reproductive/domestic* role
- there is great variety in the patterns of household organisation from country to country, and from culture to culture. The division of labour and the division of rights and responsibilities between men and women is very varied. However, income, resources, knowledge and responsibilities are rarely pooled or shared out within households in an equitable way
- there are large numbers of female headed households in all cultures and societies.

The consequence of this, Boserup said, was that far from women benefiting from development as their husbands' economic position improved, in fact in agrarian societies of developing countries women had increasingly lost status. They had become marginalised from the processes of development, as victims rather than beneficiaries. Women had become increasingly associated with the traditional, the superstitious and the backward, as men - with the help of development policies - moved into the sphere of the modern, the technical and the progressive.

In the context of a groundswell of research and activism, 1975 was declared the UN International Year for Women. This was followed by the UN Decade for Women from 1976-1985. This high level attention to women attracted significant funding for research into the impact of development on women and led to the institutionalisation of what became known as *Women in Development (WID)* policies. WID policies developed from the concern that women had been left out of development, and were therefore chiefly concerned with 'integrating' women into development. Translated into practical projects this tended to mean:

- projects and programmes *targeting women as a group*, groups run by women for women
- projects and programmes *concerned with women's productive rather than reproductive role* i.e. getting away from the notion that women contribute to development only in their roles as wives and mothers.

This approach was epitomised in income generation projects for women. WID was, effectively, an '*Equal Opportunities*' approach, carrying the implication that women had been left out of development as an oversight. WID policies did not question prevailing models of development: the assumption was that inequality could be addressed by equal opportunities and equality of participation. By the end of the UN Decade in 1985, WID had become an institutionalised aspect of most development agencies and NGOs, and many national governments had official programmes for women's advancement: WID units, policies, officers and publications proliferated.

2.5.2 The shift from Women to Gender

Gender and Development (GAD) developed initially as an academic critique of WID(7). This is an important point to remember because precisely what gender analysis is has tended to change in its translation from theory to practice. Critiques of WID pointed out that

- it tended to *focus on women only*, isolating them from their social context - "the problem - and hence the solution - concerned only women" (Kabeer, 1994).
- it failed to recognise that *not all women are disadvantaged in the same way* or to the same extent; for example, women of different socio-economic classes have very different experiences and interests
- it *did not challenge men's behaviour or roles*, thus seeming to accept that the reproductive role belonged to women alone
- it did not question whether women's increased participation in work recognised as 'productive' was to their benefit.

As a result critiques argued that WID did not sufficiently address the nature of women's subordination. GAD proposed that in order to change women's situation it is necessary to understand how it is maintained. This means examining the social and economic roles of

women and men, and the relationships between men and women of different classes, ages and ethnic groups. These roles and relations are supported by ideologies and the exercise of power. In order to improve the situation of women it is necessary to challenge gender ideologies and enable women to shift the balance of power. It is also necessary to question the frameworks to which we refer in development interventions in terms of whether they support gender ideologies and power structures which maintain inequities.

Gender analysis is not a discipline in its own right, but an approach. It is helpful to distinguish between

- gender analysis as a *descriptive analysis* of a situation, and
- *practical uses* of gender analysis in development interventions

As a *descriptive analysis*, gender analysis “examines the differences and disparities in the roles that men and women play, the power imbalances in their relations, their needs, constraints and opportunities and the impact of these differences on their lives” (Pan American Health Organization, 1997). A number of frameworks are available to conduct this kind of analysis.[\(8\)](#)

A descriptive analysis is, however, only the first step. A gender analysis should lead on to devising *practical strategies* to address the gender inequities identified.

Gender analysis has, in the past, translated with some difficulty into *development practice and health policy*. Academic gender analysts have suggested that GAD is weak on practical application because it is so fundamentally radical in its questioning of current models of development, existing social structures and institutions. It demands a degree of commitment to radical change that is unlikely to be supported by 'the establishment' of national governments and international development agencies.

However, in recent years GAD and gender analysis have increasingly been taken on by the development mainstream. GAD policies have commonly replaced WID policies in development agencies from the World Bank to the smallest NGO. As GAD has filtered through to policy making institutions, the concept has been (inevitably) reinterpreted to suit institutional needs. As it has been taken up in practice, GAD has not always been easy to distinguish from WID. Many GAD practices have continued to focus on women and their roles rather than the relationships between men and women. There has been a recent renewal of interest in addressing the gender identity and behaviour of men[\(9\)](#), but many questions remain around 'including men in GAD' and relatively few policies and programmes have so far aimed to implement this initiative.

It has been suggested that GAD in practice can be seen reflected in two approaches: a *gender 'efficiency' approach* and a *gender 'empowerment' approach*. In reality elements of these two approaches are often combined.

- *gender efficiency approach:*

This approach emphasises that women have been left out of health and development planning because some of their roles are 'invisible' to policy makers due to gender stereotypes. As a result, health/development projects often fail to meet their goals by targeting inputs inappropriately. Therefore all health/development planners need to understand gender roles

and responsibilities as crucial contextual information to plan for the effective and efficient implementation of development programmes. The focus of this approach is on 'efficient' development rather than on women and their needs. It aims to target inputs appropriately, providing appropriate incentives, in order to promote cost effective and sustainable development. In summary, gender analysis makes economic sense. This is a depoliticised version of the original agenda of gender analysis, which implies that there are no potential conflicts between women's interests and efficient development outcomes.

- *empowerment approach:*

This approach is closer to the radical view of gender analysis. Most GAD departments and policies in development agencies suggest that *development agencies should play an active role in improving women's lives*, trying to address the practical and ideological aspects of inequality between men and women. This is a difficult and at times controversial path, dealing not only with what we all do in our gender roles but with what we think and value.

Current approaches to empowerment (in all sectors of development) emphasise *self empowerment*, working with women organising for change in their own lives. Power is defined not in terms of power over others but in terms of self-reliance, inner strength, and the ability to determine choices and exercise control over one's own life. This approach originated in feminist writings and grassroots women's movements in developing countries. It is therefore a *'bottom up' development approach* - that is, it aims to achieve empowerment through the organisation of 'ordinary' women to gain control over their circumstances rather than seeing planners and policy makers as the only people who can improve women's lives. Women are seen as the *agents of change rather than as beneficiaries* of development. The focus is therefore on women's groups, a political mobilisation, popular education and consciousness raising.

Another approach identified is the *gender equity approach*. This approach has been particularly associated with health policy and practice. It is therefore described in detail in the next section, which outlines the history of approaches to women and gender in health.

2.6 A historical perspective on gender and health

2.6.1 Gender and the history of biomedicine

In the development of western medicine (allopathic medicine) (See Chapter 2.4: 'What is health?'), science, and biomedicine in particular, were *characterised as masculine endeavours*, a part of the process of advancing culture, and scientific prowess was viewed as a male gift. The focus of scientific work was to develop a clearer understanding of the workings of the 'natural world' and Nature was regarded as related to the feminine, often identified as woman, "to be unveiled, unclothed and penetrated by masculine science" (Jordanova, 1989).

In the development of scientific practice *male bodies were taken as the norm*, and women were studied only insofar as they represented a deviation from this norm, "a sexual subset of any particular race" (Schiebinger, 1993). Scientists categorised flora, fauna and humans according to contemporary views of the values of their attributes, producing a hierarchical system which divided humans into generic types - 'European', 'American', 'African' - of whom

the 'European' was regarded as the most highly developed. Science which focused on racial differences concentrated on male bodies, while science focusing on sexual difference tended to confine their attention to middle-class Europeans. Scientific views therefore referred to the male, middle-class European as the superior 'species' and the norm.

Thus, science/medicine served to normalise and establish as 'fact', and as 'Science', what were actually contemporary views and values about the 'natural world' and about the human race. Western gendered and racialised notions of nature and culture, male and female became integral to the practice of science and medicine and to norms of health and illness.

One explanatory model employed that expressed this was *biological essentialism* in which women's role and options in society were held to be predetermined by biological attributes such as possession of a womb and the capacity to breast feed. However, these capacities were also seen as rendering women intrinsically pathological, as their organs and hormones were thought to cause not only physical weakness and illness but also mental instability. Women were held to be intrinsically emotional and irrational, always failing to match the normative standard of objectivity and rationality epitomised by white, middle and upper class, European men. Similar biological arguments were used to offer 'scientific' explanations for the supposed inferiority of working class people and of black people.

2.6.2 A Historical Perspective on Women's Health

The rise in scientific thinking in Europe was concurrent with the period of rapid increase in overseas exploration and European mercantilism, slavery and colonisation. Medical missionaries and colonial officers posted to Africa and Asia took with them European middle- and upper-class notions of women's and men's proper and biologically determined roles in society. These ideas bore little relation to local situations. The multiple differences of race, class, age and culture that influenced gender roles, and through these both health experience and health care, were either ignored or held to be responsible for the 'backwardness' and ill-health of colonised societies.

Ideas about women's role as restricted to the domestic sphere informed some of the first initiatives in health care in Africa and Asia, setting the pattern for an approach to women and health that has ignored women's roles in production and that has focused almost exclusively on women as reproducers. In India, for example, in the 1890s the focus was on women as 'victims' of 'primitive societies', suffering ill-health because of 'traditional barbarous practices', and in need of rescue by missionaries.

Later, the colonial focus shifted to women as mothers, who were classed as 'incompetent', in need of training in health and child care. Indigenous health care practices, particularly those associated with childbirth and the role of traditional midwives, were widely dismissed as being based on superstition, and were held primarily responsible (in the absence of convincing evidence even within a western medical framework) for high rates of maternal and infant mortality. Views of women's health thus reinforced the colonialists' justification that their presence was necessary to protect, civilise and educate (Price & Shildrick, 1995).

The history of science and medicine illustrates that science is not completely 'objective' - *it reflects and is involved in perpetuating social norms and perceptions* about gender, race and class. Historical examples can give us an insight into the ways in which science and medicine both formed and were themselves formed by the values of a particular era. However it is

important to recognise that today's science is equally influenced by current values. It is not that the scientists and doctors of the 18th, 19th and early 20th centuries were incompetent and unskilled but rather that their science represented and responded to the 'values and truths of the age'.

Much of the work analysing the history of science and medicine and colonial discourses from a gender perspective has been carried out by feminist writers, but the health field has been slow to take up the challenge of Gender Analysis. Within health disciplines, women's health, in particular maternal and reproductive health, has long been a central concern. In the 1970s and continuing to the present, many health programmes epitomised the welfare approach with a focus on women's domestic role. A predomination of *social welfare oriented maternal and child health and nutrition programmes* reiterated the notion that women's health and women's roles were primarily determined by the biological capacity to reproduce. Assumptions that women were passive recipients of health benefits; that motherhood was women's most important (and often only) role; and that raising and socialising children and caring for members of the family was women's key contribution to health in particular and development in general, underlaid this approach.

In the 1980s there was a growth of feminist writing on health that began to *identify differences* in men's and women's health experiences and access to/use of care facilities and *to offer theoretical explanations for these differences*, covering the biological and the social, which led on to further research projects attempting to prove/disprove hypotheses. In addition, in Africa, Asia and Latin America, women began to initiate and undertake research and develop critiques of the failure of biomedicine to acknowledge and connect with indigenous notions of women's health. They documented and opposed practices of using indigenous populations for testing pharmacological products, in particular in relation to contraceptive methods. A growing number of women's health groups, in both 'the North' and 'the South', have sought to empower women in relation to their health. They have questioned women's role in reproduction, looked at the changing nature of society and of men's and women's roles, and have demystified much health information. They aim to support women to achieve greater autonomy over their health/bodies and their work has not only recognised women's health issues, but a broader range of questions which directly address the links between health experience and gender roles, for example, domestic and sexual violence and occupational health issues.

2.6.3 Current approaches to gender and health:

Health policy makers and practitioners are beginning to recognise the importance and value of gender issues to the health field. Interpretations of gender analysis in the health fields have been varied, but two main approaches have been identified (Standing, 1997):

- a *women's health needs* approach
- and a *gender equity* approach (also known as a gender inequality approach)

A *women's health needs* approach is "concerned with the implications for women of differences in the epidemiological profile between the sexes" (Standing, 1997). This approach stresses that women's particular health needs have been neglected as a result of male-centred models of health and therefore argues for the need to address these needs in a way which views women and their lives holistically - that is, it addresses the full range of women's health problems, rather than just their reproductive health problems, and does this

throughout their life cycle. Within this approach there are a broad range of political perspectives. For example, it has been related to the *gender efficiency approach* because it has been used to argue for “the cost-effectiveness of interventions which target women and girls..., both in comparison to other types of intervention and as a means to improve the health of infants in particular” (Standing, 1997). In contrast there has also been an emphasis on *women’s health rights*, which is particularly influenced by the feminist health movement in the West mentioned above. Critiques of this approach have been similar to critiques of WID (See: Chapter 2.5.2).

A *gender equity approach* is “concerned with the role of gender relations in the production of vulnerability to ill-health or disadvantage within health care systems” (Standing, 1997). So far it has focused particularly on the influence of this on access to and utilisation of formal health services. The concept of ‘equity’ is a ubiquitous one in analyses of the health sector but it has been notoriously difficult to fix its meaning. However, ‘equity’ can be distinguished from ‘equality’ in that *while equality carries some notion of ‘sameness’, equity carries some notion of ‘fairness’*. Therefore while a focus on equality would argue that men and women should be treated exactly the same (that is, not discriminated against in the provision of health care explicitly on the basis of their sex), a focus on equity argues that men and women may have different needs and face different barriers to meeting those needs or having them met. Additionally, different needs and barriers may not lead to equal disadvantage for both sexes. An equity approach therefore stresses that health policy must consider the different and inequitable needs of men and women in *allocating resources for health* promotion, prevention and care (also considering needs according to other aspects of disadvantage, such as class, race, ethnicity, age and disability) and in *designing, implementing and monitoring health systems*. Within this approach there are still different perspectives. For example, ‘equity’ can be interpreted as ensuring that everyone has their basic health needs met by a guaranteed package, or it can be interpreted as redistributing resources to those with the greatest need. These different approaches illustrate that decisions about what is ‘equitable’ or ‘fair’ are inevitably *political*.

A forthcoming paper produced by the Gender and Health Group discusses current approaches to gender analysis in health in more detail with reference to the literature on gender and infectious diseases. This paper reviews the concepts of gender with relation to risk analysis, treatment seeking behaviour, access to services and the impact of disease. These concepts are discussed with reference to the understandings of health and approaches to women/gender and development discussed in this chapter.

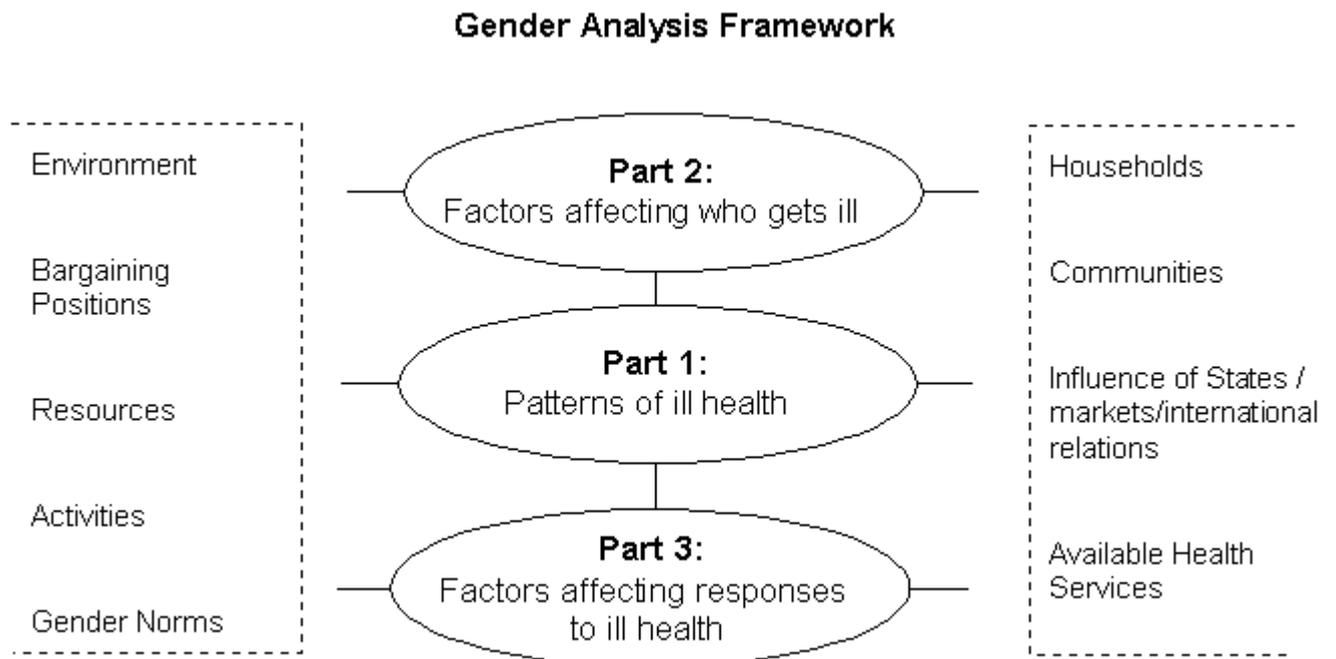
SECTION 2: Guidelines for Gender Analysis and Action

Introduction

What is in the guidelines?

These ‘steps’ or chapters are presented separately and sequentially for clarity. In the ‘real world’, however, planning is carried out in an *iterative process*, moving backwards and forwards between these activities.

Step 1: *Gender analysis framework*

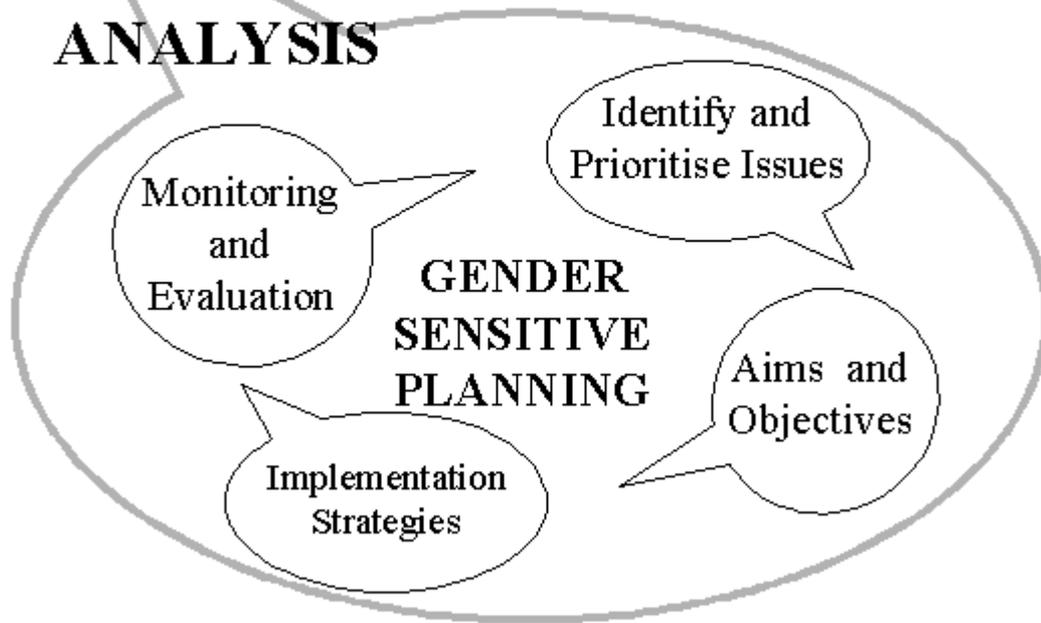


This is the first step in designing, implementing and evaluating health policies, projects and research in a gender sensitive way. The gender analysis helps to identify:

1. who suffers from ill-health (Patterns of ill-health)
2. why particular groups suffer from ill-health (Factors affecting who suffers from ill-health)
3. how men and women’s responses to ill-health are influenced by gender (Factors affecting responses to illness)

Step 2: *Gender sensitive planning*

GENDER ANALYSIS



Chapter 3 - Step 1: Gender Analysis

3.1 Introducing the framework

This chapter provides a practical framework for gender analysis of health problems and services. Gender analysis is the essential first step towards designing and implementing health policy, health projects and health research in a gender sensitive way. Gender analysis aims to identify significant gender differences and inequities in who gets ill, when and why and in how women and men recognise and respond to illness. This chapter is written with the assumption that users understand the concepts outlined in sections 2.1 - 2.3 of [Chapter 2: Background information](#).

The [Gender Analysis Framework](#) consists of three parts:

Part 1: Patterns of ill-health- identifying who gets ill, when and where

This stage involves examining existing sex disaggregated information on morbidity and mortality; what might be called 'health outcomes' data. Look for patterns in:

- *who* gets ill - men and women of different ages, socio-economic and ethnic groups
- *what* types of illness women get and men get
- *when* women and men get sick (for example, the time of year)
- *where* women and men become sick

The aim of this stage is to get a quick snapshot view of gender related differences in patterns of illness.

Further disaggregation by socio-economic class and other relevant social groupings such as ethnicity will provide a fuller picture because it also differentiates amongst women and men.

Remember that the existing data may well not provide a full picture of the situation - there will be gaps in information where appropriate sex disaggregated data is not available, and unintentional biases in data which result in a misrepresentation of the overall situation. Beware of these possibilities as you go through data and consider ways in which some of these gaps and biases might be addressed.

Different epidemiological frameworks will lead to different interpretations of the data. For example, "risk analysis" aims to identify who is at risk of illness, but the epidemiological framework used for conducting research will influence the risk assessment produced:

Risk Analysis

One approach to conducting risk analysis is to screen for characteristics which are associated with particular health problems or conditions. These characteristics can be physical, anatomical, behavioural or demographic (such as sex or age). Screening is therefore conducted for individuals or groups which share these characteristics. Thus, screening to identify high risk pregnancies might target pregnant women over 30 and under 16 as a high risk

group. At the beginning of the AIDS epidemic, commercial sex workers and truck drivers in Sub Saharan Africa were identified as high risk groups for HIV infection. However, there are a number of problems associated with this approach to identifying risk.

There is a danger of implying that only these groups are vulnerable to the particular risks identified. In the case of AIDS, this implication is particularly dangerous as other groups assume they do not need to change their behaviour . The explanations for the high risk identified for these groups focus either on biological difference or the behaviour or “life styles” of individuals. These explanations fail to identify social aspects of risk. For example the identification of high risk groups for HIV centres around their behaviour, but fails to examine the social situations or relationships in which this behaviour is conducted. Sex workers may have few other livelihood options and may therefore find it very difficult to modify their behaviour to minimise risk of infection with HIV (Seidel, 1993).

Parts 2 and 3 involve stepping back from the quantitative "health outcomes" data, and asking why there are gender differences in patterns of morbidity and mortality, what might be called "health processes" information. Part 2 looks at the health effects of what women and men do and where they live and work. Part 3 moves on to looking at the decisions and choices women and men make about their health and health care

Part 2: Factors affecting who gets ill

Why do different groups of men and women suffer from ill-health?

Part 3: Factors affecting responses to ill-health

How are men's and women's responses to ill-health influenced by gender?

Part 1 of the Gender Analysis Framework helped to identify gender differences and patterns in who becomes ill. This is an important first step, but is equally important to go beyond this to ask why certain groups of people are more susceptible to illness than others (this is always more than a question of biological differences), and *why* different groups of people respond to illness in different ways.

Parts 2 and 3 of the Gender Analysis Framework provide guidelines for examining the important social, cultural and economic factors that affect health and responses to ill-health. Susceptibility and response to illness will vary in different contexts. Parts 2 and 3 consist of matrices which can be used flexibly, allowing consideration in any particular context of the wide range of factors that may affect women's and men's health and their response to ill-health.

Completing the matrices

- Each of the factors listed on the left of the matrices - environment, activities, bargaining position, resources and gender norms - is an area

of enquiry to be examined in the context of each of the levels of society - households, communities and states/markets - or contexts - households, communities and available health services - listed across the top of the matrix.

- The categories interrelate and there is some degree of overlap between them. It is not necessary to repeat information or worry about where particular pieces of information should go. There is no right and wrong way to use these matrices. The main aim is to stimulate appropriate questions and to expand understanding of the influence of gender on health and illness.
- The matrices do not necessarily have to be completed fully. These are indicative areas of enquiry. Different users of these gender analysis guidelines will be working in different contexts, and have differing needs for detailed information. Some sections of the matrices will be more relevant to a particular context and should be completed in greater detail, others can be left blank.
- The most important thing is to use the matrices creatively to meet your own information needs.

The matrices are similar, in that the “vertical” categories are the same for each matrix. The questions being asked are different, however, and it is therefore important to consider and complete the matrices separately.

For examples of using the matrices to conduct an analysis, see Section 3: Case Studies.

3.2 Sources of information

Part 1 of the Gender Analysis Framework is an examination of *existing* quantitative data on patterns of morbidity and mortality. For gender analysis, the information must be disaggregated by sex, i.e. it must be possible to identify women and men as separate categories. Throughout this chapter, we will use the terms ‘women’ and ‘men’ as opposed to ‘females’ and ‘males’. These terms are used to personalise the categories, rather than to refer only to adults. Males and females of all ages, including children, should be considered.

Sources of sex disaggregated information might include:

- *routine health information data* - national and local government records, hospital records, disease notifications, health centre records. Note: sex-disaggregated data is often collected at the health service level, but it is commonly aggregated as it is reported to higher levels. If sex-disaggregated data is not available at the district, regional or national levels, try looking at more localised health information records.
- *national and local epidemiological surveys* such as maternal and child health surveys, morbidity/ mortality data for common diseases and for different groups e.g. IMR and MMR, nutritional survey data and district/regional level studies
- *census data* - this can be a source of data on morbidity and mortality; it is also particularly useful in providing data on social and economic indicators such as employment, income, and house ownership disaggregated by sex, which will inform Steps 2 and 3 of the Gender Analysis.

In using existing data and records, it is important to be aware of *gaps* in the information, and also any possible biases.

Although quantitative information appears to be objective, there are quite commonly inherent, if unintentional, biases. The available information may not be presenting a complete or wholly accurate picture. The following are common problems:

- morbidity data gives information only on people who reach the formal health system for preventative or curative services. However, there are many factors which affect people's ability and/or willingness to use formal health services, and which often influence women's and men's behaviour with regard to health care. As a consequence, figures collected at the health service level may fail to represent the complete picture of ill-health in a community. They tell us little about the groups who are not using health services such as why they are not using services and what their health care needs are.
- financial allocations and/or health care system expenditure by geographic area per capita is useful in assessing the extent to which disadvantaged areas have been prioritised. However, this provides little information on who does actually benefit most from the expenditure, because it ignores disadvantaged groups within these areas.
- mortality data can contain reporting errors which are influenced by gender. For example, in some contexts, people may be more likely to report the death of a boy child than a girl child because of the higher value attached to male children, which may mean that they are named and 'regarded as a person' earlier than girl children.
- mortality data is also influenced by priorities given to assessing the cause of death and the difficulties of making multiple causes of death clear.

If there are significant gaps or biases in existing sex disaggregated data, the establishment of sustainable systems to collect sex disaggregated data should be an important part of project, programme or research activities (See Chapter 5.2.4). For gender sensitive planning, health service provision and monitoring, sex disaggregated data is essential.

Parts 2 and 3 of the Gender Analysis Framework may require more contextualised descriptive and analytical information looking at the cultural, social and economic factors that increase certain people's susceptibility to illness and affect why people respond to illness in certain ways. Possible sources of qualitative and quantitative information on some of these issues might include:

- risk analysis studies
- health promotion and prevention studies
- PLA/PRA/RRA appraisals (See 5.2.4)
- anthropological studies
- health systems research reports
- NGO reports

Qualitative and participatory research is likely to be particularly useful and important for gaining an understanding of women's and men's own perceptions of health and ill-health, the factors causing this, attitudes towards treatment and care and how to improve the situation. It may need to be planned as part of a health care planning and monitoring system (See [5.2.4](#)). Qualitative data is valuable for its explanatory power; that is, it can help to explain *why*

people behave in particular ways or make particular choices. However, it is difficult to generalise qualitative data to a wide population. It is therefore necessary to support qualitative findings with quantitative information.

3.3 Matrices

Part 2 : Matrix Factors affecting who gets ill

Why do different groups of men and women suffer from ill-health?	Household	Communities	Influence of States / markets international relations
How does the ENVIRONMENT influence who becomes ill?			e.g. lack of health and safety legislation to protect workers
How do the ACTIVITIES of men and women influence their health?	e.g. washing clothes increases women's exposure to schistosomiasis		
How does the BARGAINING POSITION of men and women influence their health?		e.g. male community members decide to use funds to build a meeting house, not to build a well as favoured by the women members	
How does access to and control over RESOURCES influence the health of men and women?		e.g. women's lack of income earning opportunities may lead them to commercial sex work as a livelihood strategy	
How do GENDER NORMS influence health?	e.g. son preference may mean that daughters are fed last and receive less nutritious food		

note: Do your answers apply across different social groupings /identities (e.g. race, class, age , religion)?

note: Have you thought about information gaps/bias?

Part 3 Matrix: Factors affecting responses to ill-health

How are men and women's responses to ill-health influenced by gender?	Household	Communities	Available health services
How do the ACTIVITIES of men and women influence responses to illness?	e.g. women are responsible for caring for sick family members		e.g. formal care schedules may not fit the schedules of different groups of men and women
How does the relative BARGAINING POSITIONS of men and women influence responses to illness?	e.g. a man with an STD may be able to decide to seek care without his wife's knowledge but she would need to ask him before seeking care		
How does access to and control over RESOURCES influence how men and women respond to ill-health?			e.g. traditional healers may accept payment in kind, while cash is required for user fees at formal services
How do GENDER NORMS affect responses to illness?		e.g. men and women with stigmatised diseases may be treated differently	

note: Do your answers apply across different social groupings /identities (e.g. race, class, age, religion)?

note: Have you thought about information gaps/ bias?

3.4 Understanding the terms used in the matrices

Part 2 : Factors affecting who gets ill - understanding the terms (refer to Matrix above)

There are many factors which influence the health of women and men, and help to explain why there are gender differences in who becomes ill. This matrix focuses on the factors in women's and men's living and working environment, in what women and men do and in the opportunities they have that might affect why they become ill.

Environment

“Environment” refers to women's and men's living and working context.

- poverty has a clear effect on living conditions and women are disproportionately represented amongst the poor. Poverty reduces the likelihood of access to clean water, adequate sanitation, ventilation and hygiene.
- deteriorating environmental conditions may also have a particularly severe impact on women because of the particular roles and responsibilities they hold. Deforestation, for example, can mean women having to travel further to collect firewood, with consequent negative effects on their health (Kettel, 1996).
- there are specific hazards associated with the working conditions of certain jobs, such as mining, heavy engineering, the electronics industry and commercial sex work which will affect gender patterns of ill-health (Birley, 1995; Okojie, 1994; Puentes-Markides, 1992).

For this row of the matrix, consider whether there are significant gender differences in women's and men's:

- living conditions - access to clean water, sanitation, ventilation, hygiene?
- working conditions - consider issues such as use and design of equipment, ventilation, exposure to noise, hygiene arrangements, working hours, terms and conditions, holiday entitlements, exposure to risk
- geographical location and climate
- general social and economic conditions.

Activities

“Activities” refers to what women and men do at home and at work. Different societies assign different roles to women and men. These include:

- “productive” roles i.e. paid work, or production of goods for subsistence or sale
- “reproductive” roles i.e. domestic tasks including cooking, cleaning, caring for children and sick people
- “community” roles i.e. participating in various tasks associated with managing community organisations, and operating and maintaining community services.

Different activities carry different risks of infection, physical and mental stress and illness.

- some working activities often carried out by men, such as certain types of farming, fishing and basket weaving, bring them into greater contact with water, leading to a higher risk of exposure to schistosomiasis. Women's reproductive work also includes multiple water related activities such as drawing water, washing clothes and bathing children (Kaur, 1997).
- the multiple tasks carried out by men and women lead to different profiles of risk throughout their daily lives. A study of malaria in India found that men who sit outside in the early evening ran a greater risk of being bitten by mosquitoes than women who were often inside in the

kitchen protected by the smoke from cooking fires and by their more extensive clothing. Women were found to be more at risk of respiratory disease because of the smoke (Reuben and Panicker in (Vlassoff & Bonilla, 1994)).

- the fact that women often combine “reproductive” work with various kinds of “productive” and “community” work is rarely recognised but this can lead to severe labour burdens which affect their health (Rathgeber & Vlassoff, 1993).

For this row of the matrix, consider:

- what do men and women do?
- are there health risks associated with particular activities?
- are there health risks associated with excessive burdens of work?
- are there health risks associated with lack of work?

Resources

“Resources” refers to gender differences in women’s and men’s access to and control over resources such as money, transport, time, information, political power and influence.

- access refers to the ability to use or access a resource
- control refers to the ability to make decisions about how a resource will be used

- gender norms often prescribe that the male head of household controls the household income even if his wife or daughters are directly involved in earning that income. Women may therefore have less power to use income to purchase preventive measures against disease such as mosquito coils and nets (Agyepong, 1992, Ettlting et al 1989, and Okonofua 1992 in (Tanner & Vlassoff, 1998)).
- legal codes such as property rights and divorce laws may prohibit women from independently controlling resources.

For this row of the matrix, consider:

- are there differences in women’s and men’s access to or control over resources that affect their ability to protect their own health?

Bargaining positions

“Bargaining position” concerns the extent to which women and men are in a position to act in their own best interests when it comes to protecting their own health. This depends on personal perceptions of best interests, but it also depends on an individual’s ability to make decisions, command resources and, at times, influence the behaviour of others. It is quite common for women’s bargaining power, and thus their ability to act in their own best interests, to be limited by cultural norms recognising men as heads of households, limited

access to resources, and perceptions of their own needs being secondary to those of their husband and family.

- a woman may be aware that her husband has other sexual partners but she may not be in a position to protect her own sexual health by insisting that her husband uses a condom. Fear of divorce, violence or accusations of sexual infidelity can seriously weaken a woman's bargaining position (de Bruyn, 1992; Seidel, 1993).
- in some contexts, a woman is required to obtain her husband's legal consent to obtain contraceptives (Ojanuga & Gilbert, 1992).
- norms of male decision making often lead to a predominance of men in public and political decision making positions. Women may therefore have less power than men to make decisions about resource allocations that affect their health. Women may, for example, wish to prioritise spending on a local health centre because it is their role to look after the health of their families, but male decision makers may favour other allocations, leaving women to travel long distances to health facilities

For this row of the matrix, consider:

- are women and men able and willing to protect their own health? Are there significant gender differences in women's and men's ability to protect their own health?
- to what extent can women and men make independent decisions regarding their health and its protection? Are there gender differences in their ability to negotiate with others about their health protection?

Gender norms

“Gender norms” refers to norms and beliefs about women's and men's capacities, characteristics, roles and interests. Norms are prescriptions or guidelines for social behaviour which are usually implicit, or unspoken. A social norm is not necessarily actual behaviour and norms behaviour are not necessarily simply the most frequently occurring pattern, but are influenced by the interests and values of the most powerful groups in society.

- men may be under pressure to provide for their family at the expense of their own health
- in some societies, there is legal and social toleration of domestic violence and of male promiscuity, which can put partners at risk (Okojie, 1994).
- culturally sanctioned practices such as the order in which family members receive food (in some contexts, men eat first, followed by women and children in descending order of seniority), or prohibitions against men or women eating certain types of foods (such as protein rich dairy products) affect the nutritional status of those who are not prioritised (Vlassoff, 1994; Vlassoff & Bonilla, 1994).

For this row of the matrix, consider:

- are there accepted cultural norms or practices that affect women's and men's health, or women's and men's ability to protect their health?

The above five categories can be relevant at a number of different levels of society - and should be considered in each of these contexts:

- **Household** - refers to family groups and what goes on in the home
- **Communities** - refers to groups of people whose association may be based on: geographical locations with some sort of recognised structure, such as a village or local government area; working activities, such as a worker's compound; or cultural links, such as an ethnic sub-group within a geographical community
- **States, markets and international relations** - refers to the wider context: national and international laws, government structures and services, the private sector, NGOs and the services they provide. This focus goes beyond health sector policies and services.

Part 3 : Responses to illness matrix - understanding the terms (refer to Matrix)

This matrix focuses on how men and women recognise and deal with ill-health and how households, communities and states respond differently to the ill-health of men and women. It focuses on the factors that affect women's and men's decisions about ill-health and their choices concerning treatment.

Activities

“Activities” concerns how women's and men's roles and responsibilities affect their perceptions of illness and their choices concerning treatment.

The opportunity costs of seeking care - such as loss of income, or essential household tasks left undone - may not be equal for women and men.

- women's opportunity costs are often higher than those of male members of the same household because of their multiple responsibilities and the difficulty of finding substitute labour especially for child care (Hudelson, 1996). One study found that women in malaria endemic areas of Colombia delayed treatment until sickness interfered with their daily activities because tasks could not easily be deferred (Vlassoff & Bonilla, 1994).
- the illness and loss of activities of one individual will have an effect on others. Providing care for the sick is usually a role carried out by women. Having sick members of the household or community is therefore likely to increase women's overall burden of work (Bonilla et al, 1991 in (Vlassoff & Bonilla, 1994).

For this row of the matrix, consider:

- do women's and men's roles and responsibilities affect their willingness/ability to admit to being ill, and to seek treatment

Bargaining positions

“Bargaining positions” concerns how women's and men's bargaining positions affects their perceptions of illness and their choices concerning treatment.

- a woman might decide she should seek care for herself or for her child, but needs to seek permission from her husband before she can do so. She might therefore wait longer before deciding that the illness is serious enough to do this, or feel unwilling to ask at all.
- a male head of household may be more likely to feel able to make a decision about how to respond to his own ill-health without informing or referring to other members of the household because he is able to decide to use resources and to be absent from home when he chooses.
- a woman may want hospital records as a proof of illness in bargaining with her husband about avoiding sex or reducing household tasks (Chatterji, Chattoo, & Das, 1998).

For this row of the matrix, consider:

- does women's and men's bargaining power affect their willingness/ability to admit to being ill, and to seek treatment

Resources

“Resources” concerns the ways in which women's and men's access to and control over resources affects their perceptions of illness and their choices concerning treatment.

- there are likely to be gender differences in access to and control over resources, such as money, transport, and time, affecting women's and men's ability to seek care and treatment. Costs of accessing health services may include user fees, fees for medicines and transport costs. Cash available within the household may be under the control of its male head with the result that female members of the household may be less able to make independent decisions concerning seeking treatment (Vlassoff, 1994).
- female headed households may have lower incomes than male headed households, with consequences for the ability of the household to seek care for its members. A study in Zambia found female headed households were less able to pay for treatment for AIDS related conditions and consequently received less treatment (Abrahamsen, 1997).
- providing care for a sick person will deplete available resources. Providing home-based care for a sick family members with AIDS means that women have less time and money for other tasks

(Abrahamsen, 1997).

For this row of the matrix, consider:

- do women's and men's access to and control over resources affect their willingness/ability to admit to being ill, and to seek treatment

Gender norms

“Gender norms” includes local perceptions of health and illness as well as norms and values which influence decisions on seeking treatment.

- women and men might have different perceptions of illness resulting from the nature of the illnesses themselves, different levels of formal education and exposure to “western ideas”, or different traditional teachings given to women and men, which affect when and where they seek care.
- there is evidence that women's chances of marriage are reduced and likelihood of divorce increased if they are diagnosed to be suffering from various socially stigmatised diseases such as TB, leprosy, onchocerciasis and HIV. Studies have found women's marriages and marriage prospects to be generally more negatively affected than men's in these circumstances (Awofeso, 1995; Bandyopadhyay, 1996; de Bruyn, 1992; Kaur, 1997; Rathgeber & Vlassoff, 1993).
- social prohibitions against women's mobility in some communities can mean that a woman has to be accompanied to a health facility by a male family member (Vlassoff, 1994; Vlassoff & Bonilla, 1994).
- son preference can lead to higher value being placed on the health of male children. There is evidence that male children receive more health care in some contexts (Okojie, 1994).
- perceptions of acceptable levels of discomfort can lead to gender differences in willingness to accept a “sick” role. There is some evidence that women wait longer than men to seek health care partly due to an unwillingness to disrupt household functioning until they are forced to due to incapacity (Kaur, 1997; Rathgeber & Vlassoff, 1993).
- fulfilling the male role as breadwinner may lead to pressure on men not to admit to being sick because of the economic implications of this.

For this row of the matrix, consider:

- how do local perceptions of illness, and local norms concerning illness and treatment affect women's and men's willingness/ability to admit to being ill, and to seek treatment

The above four categories concern men's and women's choices and behaviour in response to illness. These decisions are largely made in the context of households and family groups, in

the context of community norms. However, it is also important to recognise that the kind of health care available will also affect decision making regarding health and treatment.

Available health services

In most contexts, people are able to seek care from a variety of sources which may include formal public and private health services, traditional health services of various kinds, chemists, drug sellers, healing ministries etc. In each context, it is important to identify the range of services available for health care. *Where* people seek care will depend on their perceptions of the relative accessibility and acceptability of the different services and these perceptions will be affected by the gender related factors in the categories we have listed above.

For this row of the matrix:

- list the health services and facilities, public and private, formal and informal, traditional/ indigenous and allopathic/ biomedical available for treatment
- consider ways in which gender differences in each of the categories listed above might affect women's and men's choices concerning where they go for health care treatment
- gender differences in men's and women's activities will affect choices concerning health care treatment on the basis of location and timing of services
- gender differences in men's and women's bargaining power may affect decisions on the basis of value for money, confidentiality, and perceptions of effectiveness
- gender differences in men's and women's access to and control over resources may affect decisions on the basis of cost and location
- gender differences in perceptions of health and norms concerning health care will affect perceptions of quality and appropriateness. For example, women may be unable or unwilling to go to a male health worker. Confidentiality may be an important factor.

Chapter 4 - Step 2: Gender sensitive planning

([refer to diagram](#))

4.1 Introduction

Gender analysis is the first step in designing, implementing and evaluating health policies, projects and research in a gender sensitive way. The next step is to use this information to analyse and inform the development of health policies, services and research. This chapter poses questions to assist in this process. It focuses first on the formal health care system, and secondly on health research.

The aim of the chapter is to assist in developing equitable health care systems and health research which are sensitive to the ways in which gender has an impact on health. The process of questioning outlined in this chapter will throw up many issues for consideration in the design, implementation and monitoring of health care systems and research. Which issues should be prioritised for action will depend on the opportunities and possibilities for action in the particular working context. The following chapter (5) outlines a range of possible strategies and “entry points” for promoting attention to gender issues in health service development, delivery and research.

4.2 The formal health system

This section moves on from the analysis of gender issues in health outlined in the last chapter, to a consideration of the health system response to these. It questions:

- health system policy
- health system resources - financial and human
- health service provision
- health information systems

4.2.1. Health policy

The policy environment

- What is the current status of gender in policy? Is gender explicitly considered in policy? If so, is this policy followed and is it effective? If not, is there any debate about gender? Where is the impetus to include gender coming from?

Identifying the status of gender in the policy environment may help you consider which areas offer the greatest possibilities for change, the potential allies, and constraints.

See 5.1. (Introduction) and 5.2.1 (Mainstreaming gender awareness in policy), ([Case Study 4](#))

Policy content

- How could the health sector address the factors that make certain groups more vulnerable to ill-health?

See Gender Analysis, Part 2 Matrix and 5.3.1 (Improving the environment)

A focus on curative services can ignore the social and physical conditions which lead to ill-health, such as poor quality housing and sanitation, work conditions and lack of nutrition. Preventive medicine may focus on changing individual behaviour without addressing the socio-economic processes which prevent people from taking steps to address their health. For example, AIDS campaigns have aimed to persuade people to be monogamous and use condoms, without recognising and addressing the barriers to this for certain groups, such as the lack of economic alternatives to commercial sex work or women's weak bargaining positions within marriage.

- Does health care policy assume that women's and men's health needs and priorities are the same or different? Is the possibility of biological and social differences in vulnerability to and impact of specific illnesses considered? Are health policies and planned activities explicit about the particular groups they aim to benefit?

Health policy goals often refer to 'people' or 'all', without consideration of the health effects of factors such as gender, economic situation, ethnicity and disability. Whilst the impression given is one of equality for all, the effect is often inequitable, in that those with greater access to resources may be able to access care more easily

- Are men and women of different groups equally positioned to benefit from services and to make decisions with regard to health? How could policy and planning address the barriers women and men might face in accessing health care?

See Case Study [2](#) and [3](#)

- Does health care policy assume that equal access to health services for women and men will adequately address their different health needs? Is this assumption valid? How could health policy ensure that the specific needs of men and women are met?

Policy may assume that men and women will suffer similar symptoms and respond in the same way to treatment. There is little known about sex differences in biological susceptibility to disease, symptoms, and response to treatment, partly because many clinical trials do not include or compare results for both men and women. However there is some evidence that there are sex differences in the course of various diseases. A poster in Women's College Hospital in Toronto says:

“Treating women the same as men will kill them”[\(10\)](#)

- How could the health sector address factors which restrict the ability of particular groups of men and women to respond effectively to their own ill-health and health care needs?

See Gender Analysis, Part 2 Matrix and 5.3.2. (Personal and Community Development and Empowerment)

- If particular groups are targeted, why is this? Who is not targeted and why? Do these choices refer to gender stereotypes? How could health policy challenge these stereotypes?

Reproductive health programmes have in the past usually targeted women because of their reproductive role, assuming that reproduction is not a male concern. This strategy has ignored the possibility that in many social contexts women are not in a position to make decisions about contraception as this is perceived to be the prerogative of the male head of household. Increased understanding of this situation has led to a recent call for more involvement of men in reproductive health. However, targeting programmes at men may reinforce their decision making power and weaken women's negotiation strategies. The first strategy is problematic because it refers to a stereotype and ignores the effect of gender relations on women's ability to make decisions. However the second approach can also be problematic if it reinforces the balance of power in gender relations.

The AIDS home care programme in Zambia aims to shift the burden of care away from the hospital level by encouraging the care of AIDS patients at home. However, this places an additional care burden of women at the household level. The implications of this are that women's role as carers within the family is reinforced, women's workload is increased and they may be forced to reduce time spent on other activities which sustain the household, such as farming. However, if family members are cared for in hospital, women may need to look after them there. It is important to recognise women's potential labour contribution and its costs in either of these circumstances.

MCH programmes that support women to maintain their children's health provide assistance to women in their role as mothers. However, these programmes often implicitly or explicitly exclude men. This reinforces the norm that child care is solely women's responsibility and excludes men from playing a role in caring for their children.

Health care management and decision making

- Who makes and influences health care policy, planning and management decisions? How could the representation of women in decision making be improved?

See 5.2.1.B (Institutional Change), Case Studies [1](#), [2](#) and [4](#).

- What level of understanding do health care managers have of gender issues in health? How could this be improved?

See 5.2.1 (Mainstreaming gender awareness in policy) and 5.2.2 (Training and Awareness raising)

- Are there mechanisms to encourage primary stakeholder participation, including disadvantaged groups of women and men, in health care policy making, planning, monitoring and evaluation? Are there mechanisms to improve the representation of these groups in decision making bodies at all levels? Are there mechanisms to improve the ability of disadvantaged groups to actively contribute to decision making?

See 5.2.4 (Improving information systems)

4.2.2 Health care resources

Financing health care

What criteria are used to decide on financial allocation to different geographic areas, priority health conditions and specific health activities? Are different groups of men and women equally positioned to benefit from resource allocation?

Working based communities such as areas around mines, are often relatively well served by good quality private and sometimes public health care services, which cater for migrant workers, while rural areas where many of these workers come from have low access to services. In the case of mining, migrant workers are mostly male, so the outcome of prioritising these working communities for services may therefore be that their needs are prioritised for service provision over those of their female relatives.

- How could population based needs assessment and resource allocation take the gender dimensions of health into account?
- Are financing options such as user fees assessed for their impact on different groups of men and women? What strategies to prevent any negative impacts could be devised?
- Are the expected labour and other resource contributions of communities to services and programmes assessed? Do these refer to gender stereotypes? Are these assumptions correct?

Health project planning often assumes that women will be willing and able to commit extra unpaid time to community health projects such as the spraying of houses, the dipping of mosquito nets, or following particular procedures in the care of their children. This assumption is made because care in the household and the maintenance of community resources for health are seen as women's work. However, adding this work to women's already busy schedules may overburden them, with negative consequences for their health and for the

functioning of the project. [\(11\)](#) Planning also sometimes incorrectly assumes that men and women are responsible for certain areas such as water collection or decisions about crops. As a result they target the ‘wrong’ groups in interventions and the work is not carried out.

- Are there any strategies to improve the balance between labour and other resources contributed by men and women? Could labour time be remunerated?

See 5.2.1 (Mainstreaming Gender Awareness in Health Policy)

Staffing health care services

Does the staffing of health services recognise barriers faced by different groups of men and women? Who carries out which services (e.g. case examination for infectious diseases, family planning/sexual health consultation)? Is this acceptable for both male and female clients? How could human resources be allocated to improve equity in access and care for women and men?

See 5.2.3 (Changing service provision to improve access and quality) and [Case Study 1](#)

Health services often exhibit insensitivity to cultural norms, such as prohibitions against women undressing in front of strangers or being examined by a male doctor. There is some evidence that the problems involved in visiting a male doctor or a clinic with mostly male staff restricts women’s access to services and compliance with treatment courses. For example, a study in Guatemala found that women preferred to be examined by local midwives than health personnel because they were allowed to keep their clothes on during the process (Kaur, 1997). A study of non attenders during treatment for leprosy found that all those who dropped out due to shyness were women aged 15-44 (Kaur, 1997).

- Is the awareness of gender issues and the capacity of health staff to address them assessed and relevant training planned?

See 5.2.2 (Training and awareness raising) and [Case Study 1](#)

- Does health sector staffing reinforce gender stereotypes and inequities? What rewards are attached to the type of work carried out by men and by women (for example in terms of pay, privileges, promotion opportunities, career paths, opportunities for private practice)? Is an equal opportunities policy practised in terms of recruitment, promotion, pay, training, maternity leave, posting decisions, transferrals, sexual harassment?

See 5.2.1.B (Institutional Change) and [Case Study 4](#)

Gender relations outside the health sector affect the position and conditions of work within the health sector for different groups of men and women. For

example, if women need to combine housework and child care with a formal sector job, this may restrict the hours they can work, or whether they can be posted away from home. The health sector often fails to address this kind of issue because it may be assumed that women's work in the formal sector is secondary to their domestic work. the organisation of the health sector disadvantages different groups of men and women. Health sectors are generally hierarchical institutions where status and reward often correlate with gender, class and race. For example, even where there is a high proportion of female doctors employed in health care systems, most senior positions are still filled by men.

4.2.3 Service Provision

Accessibility

- Does health care delivery recognise and address barriers different groups of men and women face in accessing services?

See 3.3 Gender Analysis, [Part 3](#)

- Does the way services are provided affect men and women equally?

Location: Do people need to travel long distances to services? Where are they located in relation to the workplaces of different groups of men and women?

Opening times: When are services open? How does this relate to the daily schedules of different groups of men and women?

Costs: What are the costs of accessing services, including user fees, transport costs, costs of medication? Do women and men have different opportunity costs? For example, do women need to find substitute child care?

Information: Where is information about services available? Are these places equally used by men and women? How is information transmitted - for example, is it written in posters or leaflets? Will this affect men and women differently. For example, are there differences in literacy rates?

Confidentiality: can people access services such as STD clinics without being noticed by community members? For example, where are the services situated? Are they separate from other services so that the purpose of visiting is made clear to others? When are they open?

- How could services be provided to address these issues?

See 5.2.3 (Changing service provision to improve access and quality) and 5.2.2 (Training and awareness raising)

Quality of Care

Do health care providers refer to gender stereotypes and norms in their treatment of men and women? Do health providers view the needs of male and female clients differently? Do they have different standards of behaviour for men and women? How could stereotypes and double standards be challenged?

Health providers may be more willing to provide information about and diagnosis of sexually transmitted diseases to men than to women. Women may be seen as peacemakers within the family and providers assume that if a woman has been infected by her husband it will cause trouble in the household if she is made aware of this. Providers may also feel more embarrassed to discuss issues of sexual health with a woman or may be more judgmental about infection with a sexually transmitted disease for a woman than a man. There is also evidence to suggest that some health providers view poor, illiterate women as ignorant and are therefore unwilling to give them information which would enable them to take preventive measures to protect themselves against the recurrence of specific diseases or to treat themselves for minor episodes.

4.2.4 Information systems

- Is the information collected by health information systems at all levels disaggregated by sex, age and other relevant social groupings such as ethnicity or socio-economic class?
- Are health staff trained in analysing this data?
- Are indicators for the needs and access of disadvantaged groups of men and women included in monitoring and evaluation systems?
- Are targets qualitative as well as quantitative?
- Are there mechanisms for enabling facility level data to be used for planning purposes?

Qualitative data may indicate problems with the provision of services which are not illustrated by quantitative rates. For example, if health information systems aim to assess the quality and appropriateness of services provided for men and women as well as utilisation rates or contraceptive uptake rates, this will increase the possibility of using this information to monitor gender issues in the provision of services.

- How could information systems be made more sensitive to gender?

See 5.2.4 (Improving Information Systems) and 3.2 (Sources of information)

4.3 Research in Health

This section moves on from the analysis of gender issues in health outlined in the last chapter, to a consideration of health research in this context. Gender relations influence the design and implementation of clinical research trials both in terms of their ethical sensitivity and scientific rigour.

This section considers:

- research questions
- study groups
- implementation
- analysis

4.3.1 Research questions

What type of questions are being asked in the research and how may they affect the outcome of who benefits from policy changes? i.e. Will the research result in more equitable outcomes for women and men or, at the very least, not worsen inequities?

Ethical issues

- Whose needs/interests do the research questions aim to address? Why is the research addressing these particular needs? Where is the impetus to address these needs coming from?
- How do the research questions fit into broader research and policy agendas? Do they accept or challenge gender stereotypes and power relations both in health research and practice?

Research into contraceptive technologies has sparked controversy and debate about whose needs and interests it aims to meet. There has been a tendency in population policy to conflate women's interests in reproductive choice with policy interests in population control. There is a concern about the pattern of greater promotion and use of provider controlled contraceptives, such as injectable contraceptives and capsule implants, among disadvantaged population groups, and the consequent reduction of reproductive choice amongst those groups. Although arguably there are potential advantages for users (such as not having to be able to read instructions) this provider control raises issues about its use in situations where there is already a power relationship between users and providers. For example, there are concerns about abuses, such providers not giving adequate information about potential side-effects or ignoring those reported by women. Clearly decisions to conduct research involving these kinds of contraceptives need to reflect on whose interests they aim to meet and how.

Research into ischaemic heart disease has often focused solely on men because it has been seen as a 'men's disease'. This perception still persists despite the fact that the numbers of cases in women are rising. There is evidence to suggest that doctors refer to this stereotype in their diagnosis of the disease, being less likely to recognise the symptoms as such in a female patient. There is also evidence that ischaemic heart disease is taken more seriously in men; men are more likely to receive invasive treatment or hospital based treatment more quickly than women (Gijsbers Van Wijk, Van Vilet, & Kolk, 1996). Focusing research on men, perpetuates the assumptions and stereotypes which influence inequities in the provision of care.

Issues for study design

- Does the research question address the potential differential impact of a disease/intervention upon women and men?

See Chapter 3 Gender analysis: Part 2. It outlines the ways in which gender may lead to the differential impact of a disease or an intervention on men and women.

- Does the study assume women and men face the same or different risks of exposure, infection or disease in relation to the disease under study?

See Chapter 3 Gender analysis: Part 1 and Part 2. They outline the differential risks of exposure, infection and disease for men and women

- Does it assume that women and men respond similarly or differently to the treatment/intervention under study?
- What data/previous research supports or challenges these assumptions?
- What are the implications, in terms of both the research process and of the research findings, of assuming gender has or does not have an impact on disease/intervention outcomes? For example: How would these issues affect study design in terms of hypotheses, findings and conclusions, stratification, study sample? (see below)

4.3.2 Hypotheses and study groups

- Do study hypothesis groups include women and men? Why - or why not? Are these reasons tenable?

For example, hypotheses need to be specific about whether the question is being asked in relation to men and women or only one sex - if the trial is carried out only on one sex, it needs to be made clear that the findings may only be applicable to that sex.. Many drug/intervention trials have been carried out using single sex study groups - usually male - on the assumption that women and men will not respond differently to the drugs under trial e.g. trials on drug treatments for heart disease. Although women are often excluded on the basis of factors such as potential pregnancy, the research is almost inevitably extrapolated to women for clinical use. Questioning the exclusion of women does not imply that women must always be excluded in all trials. However it is possible that where there are risks to pregnant women, women could be included in the third stage of the drug or intervention trials and that special attention could be paid to effective informed consent to use reliable contraceptive methods and take regular pregnancy tests during the trial. These possibilities need to be carefully examined by research scientists and ethics committees.

4.3.3. Sampling

- Are study groups stratified and of sufficient size that gender differences in response can be analysed?

If the trial aims to answer the question in relation to both sexes, the study sample will have to be calculated taking differences between men and women's vulnerability to a disease and the impact of that disease into account. For example, if one sex is particularly vulnerable to the disease which the intervention aims to address, this sex will need to be adequately represented in the sample size to ensure enough disease episodes to test the hypothesis. Recruitment design and the factors affecting drop-out for each sex will also have to be considered in order to ensure that enough men or women are recruited and remain with the trial.

See [Case Study 3](#)

4.3.4. Implementation

- Was gender considered in the study design? Is there a difference in the numbers of women and men recruited by the study? Are differences anticipated as a result of the pilot? If so, why? You will need to consider the reasons people join the study:- inducements and barriers
- whether the decision to join the study is made by an individual and whether it is influenced by gender considerations. e.g. a woman's decision making power, issues of how consent is obtained and from whom
- Does gender influence continuation and drop-out rates? Do more women or men drop out? Why? How can research implementation address this?

See [Case Study 2](#), [Case study 3](#) and 5.2.3 (Changing service provision to improve access and equity)

- Are there differences in the potential costs and benefits to men and women of participating in a trial? How does this influence implementation, such as recruitment and consent procedures?

See: [Gender Analysis, Part 3 Matrix](#). It outlines the ways in which gender may lead to differences in the potential costs and benefits of participation for men and women and therefore their willingness and ability to consent to participate in an intervention and to continue participating.

4.3.5 Analysis

- Does analysis ensure that findings can be differentiated by gender?
- How can the findings be presented in a way that the gender differences or similarities are clarified?
- How can the gender implications be made clear to policy makers and planners? For example: the applicability of findings to each sex, gender differences in responses to the intervention possibilities of differential access to the treatment or intervention tested by the research

Chapter 5: Step 3: Strategies to address gender inequities

5.1 Introduction

This section provides an introduction to some of the strategies which have been used in policy and practice to address gender inequities in health. The selection is not intended to be exhaustive, but to illustrate a range of approaches and provide a source of ideas. It draws principally on documented examples and experiences of tackling gender inequities in health projects and programmes, supplemented by information on methodologies and activities drawn from other sectors of development.

The chapter distinguishes between examples of gender equitable health procedures and services, and strategies to promote and sustain gender equitable health services.

5.1.2 Concepts and Issues

Some of the strategies suggested here will be more appropriate to certain institutional settings than others. The experience of Non Governmental Organisations (NGOs), for example, may not easily transfer to public sector institutions. NGOs are usually smaller and have greater flexibility to effect changes in work practice. Their relative independence can enable them to work quite intensively at a “grass roots” level, and to move easily between policy decisions and community work. On the other hand, public sector health departments have the potential for far more wide reaching impact, through their capacity to promote nation wide or region wide changes in policy and practice. In addition, the public sector may increasingly have an important role in regulating the provision of services by the private sector, if the utilisation of the private sector as a care provider is implemented.

Gender equitable health procedures and services

There is no blueprint for addressing gender equity in health. Gender analysis of the context and an analysis of the capacity of the health service to appropriately address gender needs [\(12\)](#) will give an overall understanding of issues to be addressed. The particular activities appropriate to addressing these will depend upon the nature of the implementing agency, the nature and scale of the intervention, the human and financial resources available and the motivation of staff.

Examples of gender equitable procedures and practice include:

- service provision to increase gender equity
- community work with men and women examining gender patterns and norms in health, illness and health care
- planning systems which ensure women’s and men’s views and needs are taken into account
- supporting disadvantaged groups in making and influencing health policy decisions
- mainstreaming gender into health policy
- sex disaggregated health information systems

Strategies to promote and sustain gender equitable practice

It is important not only that gender equitable procedures and practice are piloted, but that they are institutionalised and sustainable. Studies indicate that this requires:

- consistent management support
- widely recognised systems and procedures for routinely ensuring attention to gender concerns
- skilled personnel to spearhead gender-related initiatives
- sufficient allocation of time and resources to gender initiatives

In most circumstances, these conditions for sustainability do not exist. Staff with designated responsibility for gender issues, or staff who assume this responsibility through personal interest, are as often occupied with the task of raising awareness of and commitment to gender issues amongst colleagues - creating conditions for sustainability - as they are with designing and delivering gender equitable health services and policies. Depending on the working context, activities to promote attention to gender issues and create conditions for sustainability, are likely to encounter varying degrees of resistance, ranging in its expression from indifference to hostility.

Strategies to promote attention to gender equity in health systems and services include:

- gender policy development
- gender awareness training
- gender planning training
- forming internal and external professional, support and lobbying networks
- advocacy and lobbying
- accessing and marshalling information

Just as there is no blueprint for gender equitable practice, there is no blueprint for promoting gender equitable practice. Opportunities and constraints will differ in different contexts, and over the course of time. Promoting gender equitable practice is likely, in most settings, to be a long term process requiring persistence, imagination, tact, a willingness to take advantage of unexpected opportunities and to recover from setbacks. A mixture of strategies is necessary, tempered with realistic expectations of the pace of change.

Practical gender needs and strategic gender interests

A distinction has been made between practical gender needs and strategic gender interests (Moser, 1989). This distinction has been used to suggest two main planning approaches (World Health Organization, 1998). In practice it is often difficult to distinguish between practical needs and strategic interests, but the concepts can be useful to refer to in clarifying the aims of strategies with regard to gender needs and gender equity.

A *Practical Gender Approach* (PGA) responds to the health needs of women and men within their socially accepted roles in society, without attempting to modify gender inequities. The practical gender approach improves the health of men or women because it identifies the roles and responsibilities of each sex and attempts to tailor the response to the present situation of men and women in specific contexts. Although PGAs are a key component to efficient responses, they *do not aim to change broader gender inequities*.

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

5.1.3 Organisation of the chapter

This chapter is organised into two parts:

The first part comprises strategies for *working within the health sector*, addressing:

- mainstreaming gender awareness in policy
- training and awareness raising
- changing service provision to improve access and quality
- improving information systems

The second part contains strategies for *working with other sectors*, addressing:

- improving the environment
- personal and community development and empowerment

5.2. Working within the health sector

The following strategies aim to address:

a) barriers to different groups of men and women accessing services such as costs, distance to services, sensitivity of providers to gendered norms, availability of male and female care providers. See issues raised in [Gender Analysis Framework](#) Part 3 .

b) gender stereotypes and inequities in the provision of care such as provider attitudes and understanding of gender issues. See issues raised in [4.2.3](#) (Service Provision)

Addressing these issues will involve working at several levels and in a number of areas, including policy and planning, service provision, training and information collection.

5.2.1 ‘Mainstreaming’ gender awareness in policy

A) Developing a gender policy

The development of gender specific policy within health institutions is an important step in ‘mainstreaming’ a concern with gender inequities in all of their health activities; that is officially recognising the need to influence all methodologies, analyses, policies and planning from a gender perspective and outlining institutional arrangements to ensure that this takes place. The following example outlines some of the necessary or enabling conditions identified for developing a successful gender policy.

Key themes in the process of developing a gender policy

1. ownership of the plan throughout the organisation

2. conceptual clarity about what an agency seeks to achieve
3. a clear analysis of the agency, for example in terms of decision-making structures, incentive systems, planning routines and history with regard to gender equality
4. clear, measurable and achievable objectives for monitoring and accountability
5. clarification of role and responsibility of senior management for implementation
6. strategic choices for effective channelling of efforts and resources
7. policy inputs and 'policy entrepreneurship'
8. the need for professional expertise
9. clarification of nature and level of staff competence required for implementation
10. productive collaboration of host countries in implementation
11. productive relationships with domestic constituencies can provide momentum
12. policy is reflected in internal practice

Source: (Woroniuk, Thomas, & Schalkwyk, 1996). This document also outlines the strengths and weaknesses of different strategies for ensuring the implementation of gender policies.

Examples of developing a gender policy

The following are examples of the process of developing a gender policy and the content of such policies within agencies with a mandate for health:

The Process of Developing a Gender Policy within WHO

Rationale for developing a gender policy:

In response to a growing awareness of the need to address gender issues in 1996 an inter-divisional working group convened to raise awareness and to expand and guide the integration of a gender approach in WHO. A gender policy was seen as a first step to ensure that:

- all research, policies and programmes/projects in WHO are designed from a gender perspective
- this is accomplished in a systematic and sustainable manner.

A gender policy is necessary to ensure a common understanding and coherent approach across WHO, to clarify the responsibility of the various levels of management for ensuring gender issues are adequately considered in WHO and to develop ownership.

Specific objectives of the gender policy are:

- To ensure that WHO programmes promote equality between men and

women and do not create, maintain or reinforce gender roles and relations that may be damaging to health

- To increase the coverage of WHO's projects and programmes, by making interventions more appropriate to the specific needs of men and women.

WHO is also committed to addressing gender equality in its own staffing, hiring of consultants, composition of committees and other technical and advisory groups.

Drawing up the policy:

The policy draws on previous WHO experience and that of other agencies. WHD (Women's Health and Development programme) facilitated a brainstorming session at WHO headquarters in 1998 to share experience from WHO itself and from other institutions, to define key elements needed for mainstreaming gender and to draft an outline gender policy. A drafting group of the GWG (Gender Working Group) was then established to elaborate the recommendations produced by the meeting. This group met two hours a week during a period of two and a half months. The involvement of the WHO Regional Offices and Country representatives was essential to develop a common rationale, language and ownership of the process in which regional differences in emphasis can be accommodated. The draft gender policy has been widely circulated for discussion and input.

The draft gender policy spells out *what activities need to take place* at different levels (senior management, technical programme and gender unit/programme) of the organisation. It identifies essential underpinnings for successful implementation of the policy:

- senior management level commitment
- the allocation of serious financial and human resources
- a clear operational plan
- structural mechanisms for implementation, accountability mechanisms, and indicators to monitor and evaluate the implementation.

Responsibilities:

Technical programmes should ensure all staff acquire the knowledge needed to understand the importance and rationale of mainstreaming gender and the skills to incorporate these concepts, initiate the collection of data disaggregated by sex and age, review their work from a gender perspective, and undertake appropriate activities to address gender disparities.

The gender unit/programme is responsible for the development and implementation of an overall organisational plan for mainstreaming gender, the development and implementation of a capacity building strategy across the organisation, and a common analytical methodology and terminology to ensure a coherent approach in incorporating a gender perspective across programmes.

This unit/programme will play a key role in co-ordination and liaison between senior management and technical programmes and assisting and supporting programmes in the implementation phase of the policy by developing appropriate training strategies, materials and mechanisms for monitoring and evaluation. The unit/programme is also responsible for the collection and dissemination of information, “best practices”, case studies, and data related to gender analysis.

Source: Annemieke Brands, Women’s Health and Development Programme (WHD), WHO.

The integration of gender awareness` into Health Sector Policy in SIDA

In May 1996 SIDA established equality between men and women as an overall goal for Swedish development co-operation. In 1997 this goal was integrated into SIDA’s Policy for Development Co-operation in the Health Sector. For example among the *objectives* for SIDA’s co-operation in the health sector is “to establish supportive partnerships with countries in order for them to achieve...nation-wide coverage for health services of acceptable *quality, emphasising social equity and gender equality*” (italics added, Executive Summary, page 5).

Among *specific strategies* to achieve this are included monitoring of the impact of user fees disaggregated by sex (pg. 16) and the explicit promotion of gender equality in reproductive health programmes (pg. 22).

‘A Handbook for Mainstreaming a Gender Perspective in the Health Sector’, was also produced in 1997, aiming to assist planners, administrators and consultants to identify and understand linkages between gender equality and the goals of the health sector in order to carry out adequate sector analyses and mainstream gender in policy dialogue as well as in planning and development of health sector support.

This document includes questions to form the basis of an analysis of existing national policies in the health sector, explaining the rationale for these and suggesting steps to be taken. The manual gives examples of how SIDA can draw on existing policy documents to raise concerns about gender equity with partners. For example the Beijing Platform for Action, the International Conference on Population and Development ICPD declaration, national policies, gender equality experts and advocates can be drawn upon to underpin its policy dialogue with governments. A national policy on women’s position or gender equality can also serve as an important starting point in policy dialogue and the government ministry or office for women’s affairs can be a useful partner in this process. It is also suggested that SIDA can support linkages with other sectors and ministries working on complementary issues, such as water supply and food security and collaborate with women’s organisations and other advocates on women’s equality, consulting their views on priorities, opportunities and constraints in policy making and practice.

Source: Policy for Development Co-operation: Health Sector, (Sida, 1997b).

Handbook for Mainstreaming A Gender Perspective in the Health Sector, (Sida, 1997a).

(Swedish International Development Co-operation Agency, S-105 25 Stockholm, Sweden).

Mainstreaming a gender perspective in policy

The following example outlines some key elements in ‘mainstreaming’ a gender perspective in institutional policy and practice.

The ‘Web of Institutionalisation’

This identifies 13 key elements which contribute to the institutionalisation of a gender perspective. These represent potential entry points and are linked so that they reinforce each other. The strategies may take place at different levels and with different groups of people predominantly involved in each.

The key elements are:

- Women’s and men’s experience and interpretation of their reality (as the basis for change). Pressure of political constituencies; representative political structures (both in terms of direct representation of population groups and in terms of the representation of their interests)
- Political commitment; policy / planning (integrated across sectors)
- Resources (available to support policy); mainstream location of responsibility for gender issues (as opposed to ‘Women’s or Gender Units or Departments)
- Procedures (routinised daily activities associated with different points in the project cycle - e.g. reference and memorandum formats)
- Staff development (including training in gender awareness and equal opportunities policies)
- Methodology (integrating gender into the skills and practices of practitioners - rationale and tools for operationalisation)
- Delivery of programmes and projects (which meet the needs of men and women)
- Research (for public learning and to monitor change)
- Theory building.

Source: (Levy, 1996).

B) Institutional change

This section aims to address how the organisation of the health sector leads to inequities among providers. ‘Mainstreaming’ gender within health systems should include addressing gender relations within the institutions of the health sector in national ministries of health, health divisions of bilateral and multilateral donors and NGOs. Due to the fact that gender equity has been a relatively new focus in the Health Sector, there are few documented examples of strategies to address inequities among providers. This section refers to the literature on addressing these issues in other sectors and institutional contexts.

The process of developing gender policies needs to include an analysis of the institution in terms of:

- organisational structures: “The formal and informal rules which put boundaries around experience and act as patterns of social constraint” (Goetz, 1995).
- organisational practices: “The everyday behaviours and processes which give substance to and which reproduce structures” (Goetz, 1995).

Gender training which includes a focus on individuals’ experience of these structures and practices can help to raise awareness of the issues. A trainer running a management development course for women civil servants describes how through sharing these experiences and ‘making visible’ “the role of gender in structuring power and opportunity within administration”(Goetz, 1995), women were able to develop appropriate strategies to manage and challenge their situations. Strategies for analysing the informal relations of power, discussions about identifying and working with allies and setting up support networks were also found to be helpful in starting a process of change (Macalpine, 1995).

The development of an equal opportunities policy can contribute towards reducing inequities in recruitment, through adjusting job descriptions and recruitment strategies; contracts, including maternity and paternity leave; and pay. Appropriate strategies will vary from country to country; for example some legal and political environments favour positive discrimination while others do not.

5.2.2 Training and awareness raising

Methods of delivering training

Training and awareness raising has been a key strategy associated with GAD implementation. Although it has been seen as a universal panacea for gender inequities, it is vital that training is linked to mechanisms to promote action on the basis of the new knowledge, such as incentive, supervision and monitoring structures.

Strengths and weaknesses of different methods of delivering training

There are a number of possible ways of delivering training (which need not be mutually exclusive): through specific gender training programmes, through the incorporation of gender issues throughout staff training programmes, or through seminars and publications on gender. Some of the strengths and weaknesses of these different methods are suggested in ‘Gender Equality

Action Plans: A think piece' (Woroniuk et al., 1996):

1) specific gender training programmes: methodologies range from intensive residential courses to shorter courses focusing on practical application in specific circumstances. Standardised core courses tend to promote a shared understanding of the concepts between staff which can be applied to different situations, and provide an opportunity for debate on specific issues. However, formal gender training can be expensive to deliver and needs to be tailored to different levels of any organisation, which can lead to difficulties in accessing or designing enough relevant materials. Courses need to clearly address the practical implications of the training and supportive mechanisms need to be in place to implement these.

2) the integration of a gender perspective into all training activities holds the potential for the presentation of gender issues in a concrete, relevant and practical way and to place them centrally in whatever areas are being addressed. However to ensure that gender aspects are sufficiently understood and not regarded as an 'add on' requires substantial support and follow up from gender specialists. Trainers and materials may also be harder to find.

3) seminars and publications on relevant topics can be effective in conveying information and stimulating debate about current issues; for example linking gender issues to other current 'hot topics'. Newsletters are particularly useful for disseminating lessons from ongoing projects and video showings have been successfully used to present alternative ways of working or the voices of disadvantaged groups. However, information needs to be presented in an accessible manner which usually requires specialist skills and resources. If occasional meetings or publications are not combined with a more systematic approach, gender may be seen as an 'optional extra'.

Source: (Woroniuk et al., 1996).

Training Materials

Different training processes may have to be designed for different levels of staff working in different areas. There is a great variety of gender training resources available.

For example the *Oxfam gender training manual* (Williams, Seed, & Mwanu, 1994) comprises a wide range of exercises which aim to raise awareness and understanding of gender relations and inequities.

One of the problems facing the health sector is that few of these materials deal explicitly with the specific issues which arise in relation to health. An exception is the *WHO/PAHO : Workshop on Gender, Health and Development* (World Health Organization, 1998) which includes exercises introducing the concept of gender, making links between gender and health, exploring the implications for evaluating health needs and developing an understanding of approaches to health and development from a gender perspective.

Developing training programmes

The following examples outline some of the processes which have been followed in designing and implementing training and awareness raising programmes. The first example describes how this process was carried out in a national disease control programme:

Raising gender awareness and tackling gender issues in a the DANLEP leprosy control programme, Orissa, India

Since 1986 the Danish government has been supporting the NLEP in the states of Tamil Nadu, Madhya Pradesh and Orissa through DANLEP, its programme of assistance to the NLEP. Right from the start it was felt that only a program that actively sought the involvement of women would be a success. Research studies have shown gender discrimination towards leprosy patients, with women being the most vulnerable, deprived of family support and livelihood upon contracting the disease.

There was not a single female leprosy field worker in Orissa when DANLEP started its activities in 1986. Several alternative strategies have therefore been developed by DANLEP to educate women about the disease, engage them in leprosy control activities and make services more accessible to them.

The programme recognised the need to initiate awareness raising and include a gender focus in education/training at all levels, from international policy makers to communities. Activities to achieve this included the integration of a gender perspective into nursing colleges' curricula and the production of a manual for health workers. Gender training has also been provided for 'experts' and field staff. The programme has developed a broad range of training materials, such as games, role plays, quizzes, and a gender specific IEC package. The programme has also worked with other sectors and groups such as the adult literacy society, in raising awareness. One objective of awareness raising was to increase the number of women providing leprosy services. Women's groups were identified and involved, live-in women's camps organised, female artists performed for leprosy elimination. Women were trained as volunteers to diagnose leprosy early to prevent advanced stages of the disease.

The programme has also initiated the collection of gender disaggregated data for study and planning purposes.

In several districts of Orissa the target of a prevalence rate less than 1/10,000 population has been reached. Other districts still have some way to go. A recent state-wide door to door search resulted in 62,000 new cases being put on treatment. Many attitudes and approaches towards both gender and leprosy still need to be changed to ensure sustainability for the future.

Source: Shanta Raye, Associate State Co-ordinator, DANLEP, Orissa, India

The following example illustrates the development of a training course to address specific issues identified in a gender analysis of reproductive health and health care.

Training for improving gender sensitivity in the provision of reproductive health services in Mumbai, India

A project aiming to improve the quality of reproductive health care for women in an area of Bombay identified the following gender issues in provider/patient relationships in an analysis of the current situation:

The emphasis in services on the role of women's reproductive and child-care role means that most health providers at primary level are women. However this does not mean that they have a greater sensitivity than male providers towards the issues related to gender roles and how these influence their attitudes and practices. Most health providers refer to gender stereotypes in deciding how to treat men and women. For example, they are often more reluctant to inform women than they are to inform men that they have a STD. In addition they are not well trained in dealing with conflict and in counselling couples who present with sexually transmitted diseases.

The implications drawn were that to successfully improve the ability of services to respond to needs of male and female patients, health providers need to develop greater awareness of gendered issues and skills to address these. A training course was developed for Community Health Workers, Auxiliary Nurse Midwives and Multi-Purpose Workers which introduced them to women's health, including an introduction to gender issues in reproductive health. This involved:

- distinguishing between sex and gender
- the concept of gender roles (using training materials based on Moser's Triple Roles Framework in (Williams et al., 1994))
- reflection on how social and cultural notions of gender influence how we perceive male and female sexuality and feelings of embarrassment and incompetence which surround gynaecological, urological and reproductive health problems.
- identification of power relationships in households and health services and how these influence women's access to services and the way in which services are prioritised and delivered (including health workers attitudes towards STDs, RTIs and infertility in men and women)
- concepts of women's health and where these come from
- reflection on how the above influence the way services are delivered and discussion of how services can be improved (see service provision section)

This training process was also integrated into the training of clinicians in diagnosing and treating RTIs.

Source: Korrie de Koning, Lecturer in Health Promotion, Liverpool School of Tropical Medicine, The project is an action research project to improve women centred health care with a focus on reproductive health care, with Brihan Mumbai Municipal Corporation, Mumbai, India, sponsored by the Ford Foundation

5.2.3 Changing service provision to improve access and quality

Issues of accessibility and quality from a gender perspective are often interdependent. Building an understanding among providers of gender issues and the skills to address them is central to the quality and therefore the social accessibility of services. Changing services is therefore critically linked with training and awareness raising at all levels

See 5.2.2 (Training and awareness raising)

The allocation of sufficient resources, both human and financial, at the appropriate level, is also an essential condition for improving accessibility and quality. For example, adequate allocation of resources to primary care levels is often necessary to ensure that basic services are physically accessible to clients, particularly groups whose possibilities to travel are restricted.

Several examples here are drawn from reproductive health care because it is in this area that much of the practical work to address gender issues has been carried out. However many of the issues addressed and methodologies used are applicable with relation to health care in general and for other specific health needs.

Improving access to services

The following example shows how the organisation of services can be changed to improve physical and social accessibility for women and men, and gives an example of one of the problems encountered in the implementation of these changes.

See the second example in 5.2.2 (Training and awareness raising). This describes how a training process in the same project improved staff understanding and skills to deal with gender issues.

Gender and Access in a Reproductive Health Services Project in Mumbai, India

One issue which arose during the planning of a project aiming to improve the quality of reproductive health services in Mumbai, India was the accessibility of services.

An analysis of the current situation in Mumbai found differences in poor men and women's access to services. Men with few resources are able to use dermatology and urology departments at larger hospitals and their control over resources in the household means that they can decide to seek treatment without necessarily informing their wives. However, reproductive health services for women have so far reinforced the reproductive role of women providing mother and child care, and strongly pushing for use of birth control measures, rather than catering for women with gynaecological problems throughout their life-span. These women therefore need to access gynaecology departments or private services for such problems, but have to request money for travel, doctor fees and drugs from their husbands to visit private practitioners in the area or gynaecology departments which are mostly in

hospitals further away from their homes.

The implications of this analysis are that the treatment of RTIs and minor gynaecological and urological problems provided at primary level would reduce travel and time costs. Most dispensaries and health posts operate from one facility, but are separated in the services they provide. Dispensaries are 50% staffed by male doctors who treat minor ailments and most health-posts are staffed by female doctors providing MCH and FP services. To improve accessibility for women, they also need to ensure that all primary facilities have skilled female doctors. Access to male and female doctors would also improve the chances for stimulating communication between partners, not only about STDs but also about contraceptives.

The project therefore decided to integrate the work of health posts and dispensaries so that the existing pool of male and female doctors can be used to provide care for male and female clients at the primary level.

However opening times are a problem for couples to access services. The intention to provide opening times in the evening affect male and female providers differently. Many auxiliary midwives and female doctors have chosen to work within the municipal health services at primary level because the working conditions fit in with their role as mothers and wives. The implication is that only male providers are willing to work in the evening. Discussions and negotiations have started with all stakeholders to find the best way to overcome this dilemma.

Source: Korrie de Koning, Lecturer in Health Promotion, Liverpool School of Tropical Medicine, The project is an action research project to improve women centred health care with a focus on reproductive health care, with Brihan Mumbai Municipal Corporation, Mumbai, India, sponsored by the Ford Foundation.

The following example illustrates how a research initiative to investigate issues of access to the diagnosis and treatment of an infectious disease includes a gender perspective:

Equity in TB Control, Malawi

Tuberculosis (TB), has long been associated with poor and marginalised groups. A review of sex differences in the epidemiology of TB has drawn attention to gender as focus of inequity. Although men may be biologically more susceptible to TB, it is likely that cases among women are being under-reported in developing countries(13). Women are likely to be disadvantaged in accessing TB care through increased stigma and because of higher opportunity costs in seeking care(14).

In resource-poor settings the diagnosis of TB requires the laboratory testing of three sputum samples usually submitted over two days, with the results available several days later. In Lilongwe, Malawi, a six month study was

carried out to find out how many people submit all their samples, collect their results and, if positive, start treatment. The results of the study suggested that as many as 37% of TB suspects may drop out of the diagnostic process before starting treatment(15). Because of the long process of diagnosis, involving repeat visits to the health facility, it is likely that the most disadvantaged people within the community face the greatest difficulty in accessing care.

A research initiative in Lilongwe seeks to identify who is benefiting and who is losing out in accessing to TB care. Using gender analysis it will explore where people seek care and why when they have symptoms of TB; who delays seeking care and whether there are some people who never access care at all. In participation with different health care providers and groups within the community, ways of reducing barriers to care are being explored. It is hoped that practical strategies will be identified to increase access to TB care for disadvantaged groups which will be applicable to other resource-poor settings.

The Equity in TB Control research initiative is a collaboration between the National TB Control Programme of Malawi, the University of Malawi and the Liverpool School of Tropical Medicine which is funded by the Department for International Development (DFID) Central Africa.

Source: Julia Kemp, Research Fellow, Health Sector Reform Work Programme. Liverpool School of Tropical Medicine

Improving quality of care

The following example illustrates how models of service provision can be arranged to improve their capacity to meet the needs of women with an awareness of how these are shaped by gender relations.

The Coletivo: A Feminist Sexuality and Health Collective in Brazil

The Coletivo was formed 1981 by a group of women who shared the belief that conventional approaches to women's health and family planning were failing to meet women's needs, or to deal with the relationship between sexuality and contraception, and that they were disempowering to clients.

The activities of the Coletivo have developed over time and include the provision of a number of innovative services:

Clinical services:

The Coletivo run a clinic offering an integrated service which aims to recognise the connections between a woman's medical needs and her sexuality, social roles, economic activities and emotional well-being. In addition to clinical care, the clinic therefore provides education about issues such as nutrition and reproductive rights, and psychological counselling. In the area of clinical care, the Coletivo trains 'lay' women to provide complete basic

gynaecological examinations with back up by female clinicians and involves the woman being involved in her own exam, for example encouraging her to examine her cervix in the mirror. This method refers to the principle that information about one's body is the starting point for making effective choices about sexual and reproductive health. A counselling session precedes the annual gynaecological examination and is carried out by the same woman who will be conducting the examination. Referrals are made to other services for syphilis and HIV testing and the full range of contraception is made available. There is an emphasis in the clinical services on prevention and the use of natural remedies.

Other activities:

In addition to clinical services the Coletivo runs educational programs (including workshops on topics such as sexuality, self-esteem, nutrition, Pre-Menstrual Stress, contraception, menopause and contraception/natural childbirth), and training courses for health professionals in women's health care. It also works as an advocate for women's reproductive health and rights, promoting dialogues between feminists, biomedical researchers, church representatives and public health leaders on issues affecting women's health and sexuality. It has carried out research into relevant issues such as a cost-benefit analysis of the outcomes of diaphragm use.

Source: (Diaz & Rogow, 1995).

The following example illustrates how services which target men can meet their specific needs and address gender issues which impact upon both men and women.

Masculinity and men's health needs: some Jamaican initiatives

In Jamaica, the dominant idea of masculinity values virility, strength and control in heterosexual relationships. Men are expected to be the economic providers for the family. Local norms, together with the legacy of slavery and colonial rule, have shaped these ideas of what it is to be a man. However, with increasing male unemployment, the ideal of men supporting families is increasingly hard to meet.

This gap between cultural expectations and men's ability to fulfil them has health implications for both women and men. In Jamaica and elsewhere, domestic violence has increased as men feel the loss of economic and political power and seek to reassert their hold within the home. This can lead to alcohol and drug abuse and, in turn, family breakdown and increasing numbers of woman-headed households.

Men can feel compelled to father children to demonstrate that they are 'real men'. This has significant implications for the reproductive health of both women and men. It is in this arena that ideas of masculinity have directly

influenced health policy and delivery.

The Jamaican National Family Planning Board researched men's sexual behaviour and attitudes, incorporating the findings into a programme to foster male responsibility in reproductive health. Trained counsellors go into the community to encourage men to approach clinics for information, counselling and condoms. On the same basis, a community-based organisation, Fathers, Inc. was founded. It addresses specific men's sexual health issues by training male teenagers to deliver peer-counselling on topics including prostate cancer, relationships, fatherhood and safer sex behaviour.

Whilst these programmes are of value they do not provide space for the needs of gay and bisexual men, or 'men who have sex with men'. With the dominant idea of masculinity being centred on heterosexuality, these alternative models of masculinity are taboo.

In Jamaica, the GLABCOM (Gay, Lesbian and Bisexual Community) programme run by Jamaica AIDS Support provides a forum for the input of this community's health priorities into health service design and delivery.

Source: Steven Lize, Roehampton Institute, London in BRIDGE Bulletin 'development and gender in brief' No.7

(BRIDGE Bulletins are available on <http://www.ids.ac.uk/bridge/>. To support this issue of 'in brief' an on-line guide to gender and health electronic sources has been made available. This has been produced by ELDIS, the electronic development and environment system and can be accessed from <http://nt1.ids.ac.uk/eldis/hot/hgender.htm>.)

5.2.4 Improving information systems

Information collection is vital for improving the understanding of and monitoring gender inequities in health and health care. However, the analysis of information is as important as its collection. Health systems generally collect large amounts of information, but there are a number of problems which limit its usefulness. Firstly, decisions about what kinds of information are collected tend to be made centrally and without the participation of members of specific communities to identify particular problems which need to be addressed. Information collection is therefore rarely based upon need, especially as it is defined at the local level. Secondly, health staff are overburdened with data collection and do not necessarily understand why the data is being collected. Lack of time and skills lead to long delays before data is analysed and much information is not used at all. Thirdly, there is a lack of qualitative approaches to data collection and analysis so that health systems lack information about how and why inequities are occurring.

Possible strategies to address these issues would include:

Integrating a gender equity focus into training at all levels of health system information collection including:

- skills for data collection, including qualitative research techniques such as semi-structured interviews which can be carried out during routine consultation and focus group discussions to identify key issues
- illustration of how available data can be used at a local level to identify inequities and health needs, set priorities and devise strategies to address these with available resources
- the importance of routine disaggregation of data by sex, age and socio-economic group and the analysis of this data
- the development of specific indicators for gender equity and ‘gender sensitive’ indicators

See Developing indicators for Mainstreaming gender in Planning.

- Initiatives which allow women and men in communities to participate in HIS activities from data collection to planning strategies to addressing problems identified (see Using PRA and RRA in community-based research).

Improving the participation of communities in information collection and use

This example outlines some of the possible methods of integrating the needs and priorities expressed by different groups of women and men in communities into health information collection and analysis.

Using PRA and RRA in community-based research

PRA (Participatory Rural Appraisal) and RRA (Rapid Rural Appraisal) can be used both as methods of data collection for gender analysis and as a training tool for health workers to build up an awareness of the diverse health related needs, interests and priorities within communities. These methodologies help to reveal the power structures and relations which influence the prioritisation of needs and interests in health systems and research. Using PRA and RRA tools such as seasonal calendars, wealth ranking, and problem priority matrix ranking(16) with different groups of women and men in the community illustrates the potential diversity of perceptions of situations and problems and therefore the importance of representation of different groups in any planning or priority setting exercise. The use of PRA and RRA can be used to facilitate a dialogue between community members and health systems planners on needs and priorities which is sensitive to power differences between groups, rather than as a method for extracting information (Welbourn, 1992).

There are few documented examples of the repetition of PRA and RRA in the same communities to constitute ‘community-based information systems’, although qualitative group methods of involving community members in planning such as the Delphi panel method are commonly used.(17) However, integrating these methods into routine data collection and priority setting offers the potential for improving the responsiveness of health systems to the specific needs of different groups in the community.

5.2.5 Developing indicators for mainstreaming gender in planning

Using indicators for gender equity in health and health systems is an important part of ‘mainstreaming’ gender in the planning cycle.

The most important aspect of indicators to measure the gender implications and impact of any project or programme is that they must be disaggregated by sex and preferably by age, socio-economic status and ethnicity.

Indicators to measure gender equity will overlap in some cases with indicators of equity in general, such as distance from services or levels of user fees for different population groups.

Indicators in the project cycle:

- *Process indicators* illustrate implementation of activities to improve gender equity. They include services delivered, meetings held, training carried out, etc.
- *Output indicators* measure intermediate results such as products and services delivered during or after a programme. They do not measure long term results.
- *Impact or Outcome* indicators measure the effectiveness, often in the longer term, of a programme or project in achieving its goals. It should be stressed that it might take some length of time before observable outcomes result from interventions aiming to change gendered attitudes and behaviour. It is also difficult to assess whether any changes result directly from project activities due to the number of different factors affecting health outcomes.

The following examples do not represent ‘real’ projects, but they aim to illustrate the kind of indicators which might be used to measure specific objectives in addressing gender issues.

Indicators for gender sensitive planning

Project to improve health service delivery	Gender sensitive indicators	Source / Means of verification
<p>Goal: To improve gender equity in basic health care delivery</p>	<p>Impact indicators:</p> <ul style="list-style-type: none"> • Reduction in morbidity and mortality rates for relevant common diseases disaggregated by sex • Maternal morbidity and mortality rates • IMR disaggregated by sex 	<ul style="list-style-type: none"> • Baseline and follow up surveys • Routine health information at service level
<p>Objectives:</p> <p>1. To improve the capacity of health care providers to deliver quality services that are sensitive to both men and women’s needs</p>	<p>Output indicators:</p> <ul style="list-style-type: none"> • Proportion of men and women of different ages and socio-economic status using key services (such as ante-natal services, care for infectious diseases) 	<ul style="list-style-type: none"> • Utilisation rates • Client perception surveys / focus group discussions / interview with

<p>2. To improve the accessibility of health services for disadvantaged groups</p> <p>3. To improve the participation of disadvantaged groups in health service planning</p> <p>4. To improve conditions of employment for men and women in the health sector</p>	<p>such as TB)</p> <ul style="list-style-type: none"> • Level of client satisfaction with services provided (disaggregated by sex etc.) • Number of men and women diagnosed with key infectious diseases such as malaria and TB and RTIs / STDs • Number of births attended by trained personnel • Proportion of abortions performed through safe medical termination of pregnancy • Feedback from disadvantaged groups on satisfaction with Community Boards of Health • Information on conditions for staff: salary figures disaggregated by sex, age etc.; contracts, benefits • Feedback from staff on employee satisfaction / barriers to promotion 	<p>clients</p> <ul style="list-style-type: none"> • Health system operation plans
<p>Activities:</p> <ul style="list-style-type: none"> • changing opening times • reducing costs for disadvantaged groups • Providing services near to clients e.g. mobile clinics • Training health workers in understanding of gender issues • Restructuring of human resources use to make both male and female staff available • Reallocation of resources to primary level • Development of referral frameworks and structures of 	<p>Process Indicators: (In a logical framework, these would feed into outputs)</p> <ul style="list-style-type: none"> • Services open at times convenient to male and female clients • clients' assessment of health worker sensitivity to their needs • Number / percentage of male and female health workers providing services • Range of activities to address gender issues with service users • Regular availability of drugs for common infectious diseases • Number / percentage of 	<ul style="list-style-type: none"> • Pre-post test results • Health system operating plans • Regular project documentation • Health planning meeting documentation

<p>accountability, incentives and supervision</p> <ul style="list-style-type: none"> • Development of equal opportunities policies and guidelines 	<p>referrals disaggregated by sex, age etc.</p> <ul style="list-style-type: none"> • Improved range of services available at primary level (to reduce indirect costs for users) • Numbers of men and women in decision making bodies such as CBHs • Number of consultations with women and men from different groups in the community 	
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Project to improve health promotion activities	Gender sensitive indicators	Source / Means of verification
<p>Goal: To improve gender equity in the promotion of sexual and reproductive health</p>	<p>Impact indicators:</p> <ul style="list-style-type: none"> • morbidity and mortality rates for common reproductive infections and sexually transmitted diseases disaggregated by sex • Maternal morbidity and mortality rates 	<ul style="list-style-type: none"> • Baseline and follow up surveys • Routine health information at service level
<p>Objectives:</p> <ol style="list-style-type: none"> 1. To improve the capacity of health care providers to promote sexual and reproductive health for men and women 2. To assist men and women in overcoming barriers to maintaining their sexual and reproductive health and responding to ill-health 	<p>Output indicators:</p> <ul style="list-style-type: none"> • Number of men and women diagnosed and treated for STDs and RTIs • Percentage of pregnant women receiving emergency delivery care • Proportion of abortions performed through safe medical termination of pregnancy • Percentage of sexual partners discussing STD/RTI protection measures • Percentage of men and 	<ul style="list-style-type: none"> • Utilisation rates • Health system operation plans • PRA exercises / in-depth interviews / qualitative questionnaires / focus group discussions

	<p>women who recognise the symptoms of RTI and common STDs</p> <ul style="list-style-type: none"> • Percentage of women who feel able to insist on condom use • Percentage of men and women who feel able to access services for RTI/STDs • Number of women reporting incidences of ‘domestic violence’ 	
<p>Activities</p> <ul style="list-style-type: none"> • Training health workers to provide gender sensitive health promotion services • Engaging in community awareness exercises which challenge gender norms • Providing counselling and support services for violence against women and abortion 	<p>Process indicators:</p> <ul style="list-style-type: none"> • Number / percentage of male and female health workers showing improved understanding of gender issues • Number and content of awareness raising meetings addressing gender and equity issues in reproductive health and gendered norms of sexuality / sexual behaviour • Counselling services provided 	<ul style="list-style-type: none"> • Pre-post test results • Health system operating plans • Regular project documentation

5.3 Working with other sectors

5.3.1 Improving the environment:

The following strategies aim to address factors which lead to vulnerability to ill-health for particular groups.

See: [Gender analysis framework](#), part 2

As the Gender Analysis Framework, Part 2 illustrates, physical, socio-economic and political environmental conditions may have a particularly negative impact on specific groups of women and men, particularly among the socially excluded or disadvantaged. In order to fully address a health situation it is necessary to tackle the broader social and economic problems

which produce health problems. This is not necessarily within the capacity of the health sector itself, but multi-sectoral initiatives can be taken.

Strategies to improve the environment for disadvantaged groups will need to be pursued at several levels:

At the policy level, changing socio-economic policy to promote health for the most disadvantaged includes:

- assessing the gender equity impact of plans in each sector which will change the physical environment and providing recommendations for appropriate modification,
- lobbying for improved housing and infrastructure for deprived/ disadvantaged areas
- developing legislation to protect disadvantaged groups of workers.

For example, the recent Green Paper (HMSO, 1998) published in the UK outlines a strategy for 'Healthy Public Policy' in which the Health Sector plays the role of co-ordinating policy in other public sectors which aims to reduce inequities in health.

At the community and household or 'grass roots' level, direct practical action to support women and men who suffer particular risks of ill-health due to poor environmental conditions is necessary. Examples of this kind of support are given in the example below.

NGOs are often in a better position to co-ordinate activities at the policy and 'grassroots' levels, as illustrated by the example below. However, government agencies can also take a role in co-ordinating practical and strategic measures to improve the environment.

The following example shows how an NGO carries out a wide range of activities which aim to address the practical gender needs of a particular group of women workers, by supporting them in their daily roles and working lives and their strategic interests, by lobbying policy makers to recognise and protect their rights as workers:

SEWA - Lobbying for socio-economic policy change - India

SEWA (Self Employed Women's Association) was founded in Ahmedabad, India in 1972 as a trade union of self-employed women with a focus on training and welfare activities.

The self-employed constituted 94% of India's work-force in 1988. The term covers small-scale vendors, home-based producers and labourers selling services or their labour. They are among the poorest workers and women workers among them make very significant contributions to family income. Self-employed workers often face harassment from police or members of the community because of the illegality of their work and have no protection under law against unfair treatment by contractors or 'employers'. They therefore face health hazards due to their lack of security in addition to poor living and working conditions.

The organisation grew out of the belief that the self-employed have rights to fair wages, decent working conditions and protective labour laws and some of

the goals it works towards are nutritional security, full and easily accessible health care, and secure shelter. SEWA works towards these aims in a variety of ways. The central strategy is providing support to self-employed workers organising and lobbying for their rights of at several levels. Firstly, SEWA is involved in *direct action*, mediating between employers and the police. Secondly, *complaints about mistreatment* are made to government and filed in the courts. Thirdly, SEWA *campaigns to bring about national policy change*, for example to make labour laws more responsive to the self-employed. This campaigning has had an international impact, including the recognition of self-employed and home based workers in several international treaties and organisations. The relevant authorities are also lobbied about *specific issues affecting health* such as *the need for low cost sanitation* in the areas where members live and work. SEWA addresses practical needs concurrently with its lobbying work; for example a *community health programme* provides simple, safe, low cost Primary Health Care to SEWA members, disseminates information on health to communities where SEWA members live and work, and trains community health workers. The *maternity benefits scheme* is an example of how addressing a practical need may also be extended to make strategic gains. SEWA's research found that the weeks immediately before and after childbirth pose a serious dilemma for self-employed women; working right up to and after the birth can expose both mother and child to high risk of serious health problems, but deciding not to work can lead to debt. A small self-financed programme for SEWA members was initiated, providing compensation to mothers for the loss of income during this period, along with the care of trained midwives. This has evolved into a state-wide scheme organised by the labour ministry. Another example of simultaneously addressing practical and strategic needs is work around issues of '*domestic violence*' where SEWA mediates between family members, files court petitions against offenders and provides legal aid whilst campaigning for changes in laws which increase women's vulnerability to violence.

Source: SEWA in 1988 (Mahila SEWA Trust, Ahmedabad, India)

SEWA can be reached at: Self Employed Women's Association, Victoria Garden, Bhadra, Ahmedabad - 380 001, India

Many of the decisions which affect the health of populations are taken outside the health sector, in public sector projects and programmes which change the physical environment, such as:

transport and communication, through road construction and bus services; mining; energy, through dam construction; renewable natural resources, such as agriculture, irrigation and livestock; public services such as housing and water supply; and manufacture and trade, including industry and tourism.

The following example illustrates how gender issues can be raised in assessment of the health impacts of such projects and the recommendations which are made for minimising health hazards for particular groups.

Gender issues in Health Impact Assessment

Negative health impacts reduce the social and economic benefits expected from the development programme and transfer hidden costs to the health sector.

Health impact assessment aims to build the management and minimisation of health risks for vulnerable groups into the design and evaluation of (non-health focused) development interventions. That is, incorporating measures to safeguard health into project plans, operations and maintenance schedules. Therefore impact assessment needs to take place at the 'pre-feasibility stage' of the project plans. Actions required may vary from informing the health sector about development projects to specific requests for major planning changes such as resiting a settlement.

The main steps in health impact assessment are: identification of health hazards; interpretation of health risks and the management of health risks. The operational procedures required by a regulating agency to achieve these steps are:

- initial screening of the project for health hazards (for both men and women)
- initial health examination, or rapid appraisal (for both sexes and different socio-economic groups)
- health impact assessment;
- proposals for health risk management, including proposals for the reduction of the factors which influence women's and men's vulnerability and their ability to respond to ill-health

For example:

Livestock commercialisation: In many parts of Africa women care for dairy cattle. The investment of time and other resources has to be increased for supplying commercial dairies often at the expense of other food producing tasks. However, the dairies usually pay cash to the men. Women have increased their labour but lost an income source from occasional sales of milk and milk products. The loss of cash income by women may lead to a reduction in family nutrition as male priorities may be different. Possible mitigation measures would include ensuring that women are paid the cash they earn personally.

Forestry projects which change access to collected food, fuel, fodder and other products: Reduced access to forests can increase the time women need to spend for example collecting firewood, which is likely to have an effect on their nutritional energy balance, or encourage them to buy rather than collect fuel leading to reduced disposable income. Time spent cooking or preparing food may be reduced leading to malnutrition or food poisoning. Possible mitigation measures would include ensuring continued access to traditionally communal land under the terms of purchase of land and the enforcement of

legislation to support these terms.

Mining - men may be forced into migrant labour due to the lack of economic opportunities which would enable them to meet their responsibility to provide for their family. For example, The impact of deep rock mining by migrant labour in South Africa is well documented. Chronic lung disease is common and this often reactivates latent tuberculosis and increases susceptibility to infectious pneumonias that are exported to the labour reserve. Such occupational diseases are often not recorded or recognised in regions where compensation payments would be compulsory. In the South African mines the incidence of TB has risen dramatically over the last decade to a rate of 800-1000 per 100,000. Possible measures to reduce risk would include legislation requiring employers to maintain minimum standards of health and safety in workplaces and workers' accommodation, and upholding workers' rights to compensation. Ensuring the enforcement of such legislation through legal support would also be very important.

Source: (Birley, 1995).

5.3.2 Personal and community development and empowerment

The following strategies aim to address factors which restrict the ability of particular groups of men and women to protect their own health and respond to their ill-health.

A variety of strategies aiming to improve women's bargaining positions have been implemented in social development practice. One set of strategies has been those aiming to increase women's access to income, such as income generation, credit and micro-enterprise schemes. These have proved to have advantages and disadvantages which are well documented in the social development literature(18); for this reason they are not discussed here. Another set of strategies have been those which seek to build self-esteem, skills and confidence at an individual level and to challenge negative community norms.

In the health field, health education for women and self-help groups are often used as personal 'empowerment' tools. Education for empowerment aims to assist marginalised and disadvantaged groups in developing a critical insight into the structures, ideas and practices that keep them in positions of equality (Koning, 1995). Examples of this kind of education in health are found in the work of the SARTHI women's health programme which included the formation of self-help workshops which helped women to challenge negative norms and perceptions about their own bodies and reproductive health through participatory learning processes (Khanna, 1992). Through sharing experiences and increasing their understanding of their own bodies, women are able to begin increasing their capacity to protect their reproductive health and respond positively to illness.

However, building the confidence and skills of individuals does not necessarily allow them to challenge norms in their relationships with others or to take action to address issues which concern them. In order to address the strategic interests of marginalised groups, the process of challenging gendered norms of health and illness and gendered power relations which impact on health needs to be carried out with other groups in the community.

The following example illustrates an ongoing process of community development which aims to empower both women and men in the community to respond positively to the HIV epidemic, by building confidence, knowledge and skills among peer groups, and challenging power relations by encouraging men and women of all ages to recognise the needs and perspectives of others.

STEPPING STONES to the transformation of gender relations?

HIV/AIDS prevention efforts are often predicated on a naive insistence that teaching people the facts will miraculously change behaviour. Top-down education programmes remain locked into the ABC message of 'Abstain! Be faithful! Use Condoms!'. The Stepping Stones training package on gender, HIV, communication and relationship skills was born out of the need to find an alternative strategy, which would empower both women and men to identify their own needs, to share them with their peers, to communicate and discuss them with their partners - and to change the ways in which they relate to one another. Where mainstream HIV/AIDS prevention packages are notoriously weak, the innovative Stepping Stones training programme has facilitated behaviour as well as attitude change.

The Stepping Stones approach was launched in 1995 as part of Action Aid's 'Strategies for Hope' programme, designed to address the vulnerability of women and young people in decision-making about sexual behaviour. The programme is intended for settings where on-going AIDS support programmes are already in place.

It draws on a variety of approaches, including conflict resolution and communication skills work, alcohol and drug addiction work, and uses a participatory adult learning methodology. Peer groups, formed of 10 to 20 members of the same sex and similar age, explore gender roles, money, attitudes to sex and sexuality, and attitudes to death. Participants work towards behaviour change through 18 'stepping stone' sessions over a period of three months. Peer work has been found to be particularly effective in this sensitive area of sexual health. A detailed training manual gives guidance to less experienced facilitators on video usage, role-plays, drawing exercises and other participatory learning methods. Everyone can be involved regardless of literacy.

The package presents a practical but fundamentally radical approach to gender, with reference to sexual health work and HIV prevention in particular. The exercises trigger a discussion about norms and values, female and male identities and the implications of these for the relationships between them. The discussion enables all community members to reflect critically on, articulate and begin to change their circumstances.

Since its introduction, the Stepping Stones training package has been enthusiastically received not only in Africa - the context for which it was originally designed - but also in Asia, the Pacific and Latin America. 'Stepping Stones opens the minds of people ... gives them the opportunity to explore their

needs, to become more critical in finding solutions' (Dominic Dinko, ActionAid, Ghana). In all, it has been distributed to over 1000 organisations in more than 90 countries. A Stepping Stones Training and Adaptation Project has also been developed to support trainers and to help them adapt the package to their local cultural and linguistic circumstances.

The workshop was first used in the village of Buwenda in Uganda. An impact assessment showed that condom usage increased, but also that interpersonal communications in relationships improved and domestic violence and alcohol abuse declined. Young women reported rising levels of self-esteem and assertiveness, along with a determination to be economically independent and more involved in political life. Sexual matters were more easily discussed and there was more care and support given to those suffering from HIV/AIDS.

This positive experience of mobilising the potent resource of community self-support has lessons for policy on HIV/AIDS prevention and sexual health. In particular, there is a need to address the psychological well-being of women and men in relationship to each other, rather than just their physical and material needs. 'I believe this is powerful in any intervention to influence social change, not just HIV/AIDS or gender, but in other development issues as well.' (Helen Amdemichael, ActionAid, Ethiopia). In the words of a participant, Elizabeth Ungam, 'Go for those stones and step on them please.'

Source: Hazel Reeves, BRIDGE

Dr Alice Welbourn

Stepping Stones materials are distributed by: TALC, PO Box 49, St Albans, Herts, AL1 5TX. Contact Kate Newman for more information on the Stepping Stones Training and Adaptation Project: knewman@actionaid.org.uk

The following example shows how structures for the organisation of women can create a space which enables them to voice their concerns and take action to have their needs met.

Identification of priorities and action by a women's group

The Women's Development Programme of the Government of Rajasthan was launched in mid 1984. The principal aim of W.D.P. is "to empower women through communication of information, education and training and to enable them to recognise and improve their social and economic status". Development was seen as 'internalised growth' rather than a matter of the implementation of planned schemes. The programme was therefore based on 'learning organically by doing'. At the village level, work is carried out through a trained village level worker called a Sathin, who is responsible for the formation of women's forums at the village level and works closely with nearby Sathins. The following are examples of the work of the Sathins.

Diminishing latrine space is an increasing problem which women face in rural

areas. This is an experienced suffering which seldom got discussed, analysed and seen as a problem deserving attention on a priority basis. In one village, a Sathin together with a large group of women, initiated a process of problem solving which brought about responsible action arising out of reflection and planning, while simultaneously distilling general principles for future action. The latrine space allotted in this village was on the periphery, along the roadside, which was extremely inconvenient both in terms of distance and lack of privacy. The women took the issue to the village council (the *Panchayat*) but no action was taken. They soon identified that some private gobar decomposition pits were on *Panchayat* land and that the only bottleneck was that this land was on a connecting linkway to the local *Seth's* farm. They looked for an alternative approach to the farm, and, when they had found one, started clearing the space. When the Seth resisted the solution, they argued that the Seth rarely used this route and could use the alternative route. By this time the *Sarpanch* (the village council leader) and the other village men were supporting the women, so the land was finally granted to them. The next step was to construct a wall for which the women and the *Panchayat* shared the costs. The women secured a small *Kheli* (water tank) near the enclosure to ensure the availability of water. Women from other *mohalls* (neighbourhoods) started coming to ask for help.

Source: (Jain, Srivastava, Mathur, Jaitly, & Nair, 1986).

SECTION 3: CASE STUDIES

[Case Study 1: A gender analysis of a District Integrated Population and Development Project, UNFPA, India](#)

[Case Study 2: A gender analysis of a clinical investigation into the causes of 'smear negative' tuberculosis](#)

[Case Study 3: A gender analysis of a double blind placebo controlled trial of pneumococcal vaccine in HIV positive adults in Entebbe, Uganda](#)

[Case Study 4: Getting gender on the agenda in human resource planning and management: a case study from Zambia](#)

[Appendix 1: Glossary](#)

[Appendix 2: References](#)

[Appendix 3: Group members – interests and contact addresses](#)