Gender and Health Equity Network

Gender and Health Equity Resource Guide

Elaine Baume
Mercedes Juarez
Hilary Standing

April 2001

Published by the Institute of Development Studies at the University of Sussex,
Brighton BN1 9RE, UK
Tel: +44 1273 678269; Fax: 1273 621202/691647
Email: publications@ids.ac.uk

Any parts of this book may be copied, reproduced, or adapted to meet local needs, without permission, provided that the parts reproduced are distributed free or at cost – not for profit. For any reproduction with commercial ends, permission must first be obtained from the publisher. The publisher would appreciate being sent a copy of any materials in which text has been used.

© Institute of Development Studies, The Global Forum for Health Research, The World Health Organization, The Harvard Center for Population and Development Studies, 2001
ISBN 1 85864 356 2

Contents

Foreword vii

Abbreviations ix

Introduction 1

1 Institutions mainstreaming gender 3

1.1 Introduction 3

1.2 Resources 10

1.2.1 Organisational change 10

1.2.2 International organisations 11

1.2.3 Donor and development agencies 12

1.2.4 National bureaucracies and ministries of health 12

1.2.5 Legal systems 13

1.2.6 NGOs 14

1.2.7 Human resources development 14

1.2.8 Budgets and finance 15

1.2.9 Governance 16

1.2.10 Sector wide approaches (SWAPS) 16

2 Implementing rights and accountability through networks and advocacy 18

2.1 Introduction 18

2.2 Resources 22

2.2.1 Gender and health advocacy in international politics 22

2.2.2 Right to health including sexual and reproductive health rights 23

2.2.3 Advocacy and networking strategies 25

3 Tools to enhance and implement gender equity 27

3.1 Introduction 27

3.2 Resources 30

3.2.1 Gender analysis frameworks 30

3.2.2 Initiatives incorporating gender into health care practices 31

3.2.3 Participatory methods 32

3.2.4 Monitoring and evaluation 34

3.2.5 Indicators and statistics 35

3.2.6 Checklists and logframes 36

3.3 Examples of tools 37

3.3.1 Gender-sensitivity of health sector institutions: a checklist 37

3.3.2 Project policy orientation and project staffing 38

3.3.3 Monitoring checklist for client exit interviews 45

3.3.4 Indicators of women’s health and nutrition 46

3.3.5 FAO’s SEAGA: minimum requirements for identifying problems, planning programmes and evaluating progress towards meeting health goals 51

3.3.6 CIDA guide to gender-sensitive indicators in the health sector 53

4 Lifespan perspective in gender and health *56*

4.1 Introduction 56

4.2 Resources 62

4.2.1 Gender and health across the life cycle 62

4.2.2 Adolescent girls 62

4.2.3 Mothers 64

4.2.4 Widows 64

4.2.5 Adolescent boys 65

4.2.6 Men 66

4.2.7 Fathers 67

4.2.8 Older men and women 68

5 Issues in gender and health equity 69

5.1 Introduction 69

5.2 Resources 82

5.2.1 Access to and utilisation of services 82

5.2.2 Communicable and non-communicable diseases 83

5.2.3 Environmental health 84

5.2.4 Gender violence 84

5.2.5 Health sector reform 86

5.2.6 HIV and AIDS 87

5.2.7 Mental health 89

5.2.8 Microfinance/microcredit 90

5.2.9 Nutrition 91

5.2.10 Occupational health 92

5.2.11 Sexual and reproductive health 93

Appendix 1 95

Useful websites 95

Case studies

1	Evaluating DfID's gender training programme	4
2	The role of women's groups and local authorities in implementing health care in São Paulo, Brazil	7
3	Accountability and implementation: questions to ask	20
4	Guidelines for reducing maternal mortality	58
5	Fathers Incorporated: men's reproductive health project, Jamaica	60
6	Gender and tuberculosis	71
7	Access and affordability: WHCF, the Philippines	73
8	The development of radio materials on malaria, Kenya	74
9	Microfinance: SEWA, India and YRHA, China	77
10	The Yunnan Reproductive Health Association's (YRHA) micro-finance programme	78
11	SEWA's experience of implementing health insurance for women working in the informal sector	79
12	Measures to improve nutrition in vulnerable groups	81

Foreword

The purpose of this resource guide is to give an overview of gender sensitive interventions and initiatives directly or indirectly related to health that have been tried at macro and micro levels. Through mapping different experiences, the guide provides information on lessons learned, results achieved, and the challenges that have emerged in promoting gender and health equity.

It includes information on gender-sensitive approaches, working methods, practical methodologies and tools which can be incorporated into policies and programmes. In pulling these resources together our aim is to create a practical reference mechanism for those involved in implementing programmes and policies worldwide. We felt that a guide to existing resources that could be periodically updated and reviewed would be more useful than commissioning more exhaustive but perhaps less accessible review papers.

The principal audience for this resource guide is the technical working group, the international advisory group and the country level partners involved in phase 2 of the Gender and Health Equity Network. The focus of phase 2 is on policy implementation through flexible planning and management methodologies, accountability structures and participatory approaches. By making it available in both hard copy and electronic form (http://www.ids.ac.uk/bridge/reports_gend_heal.htm), we hope that it will also become a valuable resource for a broader group of policy makers, programme planners and implementers, local organisations and health service providers outside the project. As the Gender and Health Equity Network progresses we hope the guide will continue to evolve and include the experience of the country level partners as they develop their interventions.

The guide is made up of five different sections:

1. Gender mainstreaming and organisational change
2. Implementing rights and accountability through networks and advocacy
3. Tools to enhance and implement gender equity
4. Lifespan perspective in gender and health
5. Issues in gender and health equity

Each section describes what the topic means, why it is important and how gender equity objectives might be achieved. In stressing the need to develop gender strategies for health equity which are appropriate to specific contexts and resources, the text is illustrated with case studies and examples of good practice from around the world.

The Gender and Health Equity Network is a collaborative project between several national partners and international research centres. These include the Institute of Development Studies, the Harvard Center for Population and Development Studies, the Global Program on Evidence for Health Policy WHO, the Indian Institute of Management, Bangalore and the Karolinska Institute. It is funded by the

Ford Foundation, the Swedish International Development Agency (SIDA), the Global Forum for Health Research and the World Health Organization.

Production of the hard copies of the guide has been funded through a grant from the Health and Population division of the UK Department for International Development (DfID). Thanks also to DfID for allowing us to reproduce material in sections 3 and 4 and Appendix 1 from work originally prepared for the DfID gender website. We would like to thank all our funders for their support.

Feedback on the guide is welcome through email to health@ids.ac.uk. We are particularly keen to hear people's experiences in using the guide.

Special thanks must go to Asha George, of the Harvard Center for Population and Development, for her editing work. Thanks also to the other core members of the Gender and Health Equity Network: Professor Gita Sen of the Indian Institute of Management, Bangalore, Dr Claudia Garcia Moreno of the WHO, and Dr Piroska Ostlin of the Karolinska Institute.

Abbreviations

AIDSCAP	AIDS Control and Prevention Project
AVSC	Now known as Engender Health
BRAC	Bangladesh Rural Advancement Committee
BRIDGE	Briefings on Development and Gender
CEDAW	Convention Elimination of All Forms of Discrimination Against Women
CEDPA	Center for Development and Population Activities
CIDA	Canadian International Development Agency
DANIDA	Danish International Development Agency
DfID	Department for International Development (UK)
FHI	Family Health International
GHE	gender and health equity
HSR	health sector reform
HWCG	Healthy Women Counselling Guide
ICPD	International Conference on Population and Development
ICRW	International Centre for Research on Women
IWHC	International Women's Health Coalition
MFI	microfinance institution
NGO	non-governmental organisation
PAHO	Pan-American Health Organization
PAISM	Women's Comprehensive Health Care Program
PATH	Program for Appropriate Technology in Health
PHN	Population, Health, Nutrition
PRA	Participatory Rural Appraisal
RH	reproductive health
RHO	Reproductive Health Outlook
RTI	reproductive tract infection
SEAGA	The Socio-economic and Gender Analysis Programme
SEWA	Self-Employed Women's Association
SIDA	Swedish International Development Agency
SRH	sexual and reproductive health
STD	sexually transmitted disease
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Family Planning Association
UNIFEM	UN Development Fund for Women
WID	Women in Development
WHCF	Women's Health Care Foundation
WHCO	Women's Health Care Office
WHO	World Health Organization
YRHA	Yunnan Reproductive Health Association

Introduction

Five basic principles form the basis for a comprehensive public health policy: public administration, comprehensiveness, universality, portability and accessibility. *Public administration* avoids the profiteering of companies. *Comprehensiveness* means all necessary services are covered. *Universality* means everyone in a community is covered. *Portability* means that people are free to go where they want because coverage is guaranteed. *Accessibility* means freedom from economic, geographic, bureaucratic and gender barriers to health care.[1]

These principles reflect the political and economic nature of health. In other words, social hierarchies affect who gets ill and the consequences of such illness, including the effects of accessing or not accessing health care. The response of social policies, including those of the health sector, is to attempt to ensure greater human wellbeing by tackling these social inequalities.

Equity

Equity acknowledges social disparity and poverty issues. Those at the lower end are differentiated by gender, social class, age, ethnicity or religion. These social differences are reflected in inequalities in health, education, employment and other indicators.

A human development approach holds all sectors responsible for protecting and promoting individuals' health. In the same way, all public health improvements require substantial changes in the wider macro-environmental, socio-economic, political and cultural context. While this resource guide aims to include a diverse range of issues and concerns within the health sector, it is important to highlight that gender issues should be incorporated and addressed by all public sectors.

Gender analysis

Gender analysis examines the different work, roles and responsibilities of men and women and girls and boys in the household, community, workplace, political process and economy, often held in place by unequal power relations. Gender analysis also helps to identify the consequences of these differences and inequalities over the control of resources, benefits and decision-making on the lives of women and men, their health and general wellbeing.

---

1 Armstrong, P. and H. with Fegan, C., 1998, *Universal Healthcare: what the United States can learn from the Canadian experience*, New York: The New Press

In health, gender analysis generates an understanding of differentials in risk factors and exposures, manifestation, severity and frequency of disease, and in social and cultural responses to disease. It also highlights inequalities in access to resources to promote and protect health, in responses from the health sector and in the ability to exercise the right to health. Applying a gender perspective to health raises questions about both the production and consumption of health services.

The goal is to ensure that policy, programmes and projects promote better health for both men and women and do not create, maintain or reinforce gender roles that may be damaging to health.

Gender disparities also exist in the way that responsibilities and power are distributed within health care. The contribution of women to health and development, both formal and informal, is often not sufficiently considered. Women are an integral part of the health and development process but their contributions tend to be invisible or not valued.

Gender is used to describe those characteristics of men and women that are socially constructed, in contrast to those that are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men.

This learned behaviour is what makes up gender identities and determines gender roles. It is often defined within the context of unequal power relations. As a result, gender contributes to inequities in health, as do other factors such as race and social class.

Gender roles include the expectations held about the characteristics, aptitudes and likely behaviours of both women and men (femininity and masculinity). These roles and expectations are learned, changeable over time, and variable within and between cultures. Factors such as education, technology, economy or war crisis may cause gender roles and the gender division of labour to change.

Under the assumption that individuals can choose to act in the best interest of their own health, most efforts have been geared towards convincing people to change unhealthy attitudes and practices. While this approach may be able to influence some individuals, those segments of the population with less ability to protect themselves do not have the power to opt for more healthy behaviours in order to avoid health risks.

1 Institutions mainstreaming gender

1.1 Introduction

The analysis, information, ideas and examples of best practices included here look at gender inequitable forms of social organisation. Institutional structures, rules, value systems, traditions, management styles and socio-cultural relationships influence how power is used and allocated differently between men and women within organisations.

Involving women as well as men in decision-making is essential for moving towards gender equity in organisations. However, many constraints undermine GHE, since institutional dynamics tend to be heavily biased against women. Women are generally under-represented and their needs, capabilities and interests are often marginalised. Units specifically set up to support participation and gender equity are usually under-resourced in staff and funds, while gender sensitive policy proposals are rarely reflected in budgetary allocations. The transformation of bureaucracies for gender and health equity involves the reform of organisational culture and structures.

Hence the acknowledgement that GHE is a core principle of the health sector must also be translated into commitments at all levels throughout the health sector. To be able to implement GHE policies, gender concerns have to be incorporated into the goals, strategies, tactics, policies, processes, management behaviours, pay systems, job descriptions, budgetary allocations and the cultural practices of organisations promoting health or delivering health services. Very often some of the best moves towards GHE will be the result of incorporating gender concerns into strategic planning.

Case studies:

- Evaluating DfID's gender training programme
- The Women's Comprehensive Health Care Programme in São Paulo, Brazil

Resources:

- Organisational change
- International organisations
- Donor and development agencies
- National bureaucracies and ministries of health
- Legal systems
- Local governments
- Non-governmental organisations (NGOs)
- Human resource development
- Budgets and finance
- Governance
- Sector wide approaches (SWAPs)

Case study 1 Evaluating DfID's gender training programme

The study

The evaluation summarised here was carried out by Stewart in 1998 and aimed to assess the impact of two types of gender training within DfID: gender awareness and gender planning. In her study she interviewed 95 DfID employees: 41 women and 54 men, of whom 50 had attended gender training courses. The non-attendees acted as a control group. In addition course evaluations written immediately following the training were examined.

DfID's gender training programme

DfID's gender training programme was designed 'in recognition that the interests and needs of women (as well as those of men) must be systematically pursued in the formulation of all government policies and programmes'. Its goals were equality between men and women at all levels of government and gender equality in both 'work practice and individual attitudes'. The training courses 'are part of a mix of strategies…which includes management support, the Social Development Division and the Project Information Marker System'.

Trainees

Stewart warns that 'only 18% of the trainees interviewed, and 15% of the overall list of trainees are from senior and therefore influential grades' (p 27). Furthermore within the control group there seemed to be a pocket of resistance to attending the courses as Stewart noted references such as 'having managed to avoid the gender training net'. She suggests that this could be overcome by strengthening the link between gender training and promotion.

Interviews

To measure the effectiveness of the course, knowledge retention was used as an indicator. This was tested by asking trainees and control subjects what the difference was between sex and gender, and the difference between practical and strategic gender needs. Of the trainees 78 per cent were able to answer the sex/gender question and only 30 per cent of the control group while 62 per cent of trainees were able to answer the practical/strategic needs question as opposed to 27 per cent of the control. The conclusion drawn by Stewart is that the course is very effective in raising awareness of gender issues and in particular serves to 'focus and clarify existing knowledge' (p 16). However moving from an understanding into practice is a great step and the gender planning component of the training was more problematic.

Results

- The short time allowed for gender planning did not equip trainees to feel confident about using gender. In the trainee and control group there was an equal number of interviewees who stated that they felt 'very confident' at 20 per cent. Stewart explains this by saying this related to those who have had prior external training probably at university level.
- For the trainees there was a sizeable difference in that 68 per cent felt reasonably confident as opposed to only 5 per cent of the control, suggesting that training did have a significant effect. One trainee reported that now 'I may not always know what to do about it, apart from calling a social development adviser, but I usually know a gender problem when I see one' (p 18). Stewart sees this as a positive result, quoting Schalkwyk and Woroniuk (1997):

> Many training models attempted to turn all staff into 'gender experts' in a short period of time. Yet experience has demonstrated that people do not acquire all the necessary skills in a short workshop and in fact, this type of focus may have contributed to an underestimation of the skills required to work specifically on equality issues (p 18).

This aspect of the course can be judged very good. Trainees felt they had discovered enough about gender to recognise when it was an issue and would need an in depth analysis yet also recognised that they themselves did not have those particular skills and would need to call on others.

Mainstreaming gender within DfID

Most interviewees (84 per cent) felt that both attitudes in DfID and their work had changed in the last five years to incorporate gender more. This was perceived as being due to the following:

- the existence of the Social Development Division, who were seen as easily approachable gender experts who were able to advise on how to implement gender concerns,
- the main players in the Social Development Division team, who were highly regarded and played the roles of champions of gender mainstreaming,
- the gender training course which is mandatory, and thus carries more institutional weight, and acts by clarifying and focusing knowledge that trainees have picked up elsewhere,
- Clare Short's (Minister for International Development) linkage of gender with poverty, ensuring its high profile as part of the new agenda.

Gender interventions as cultural interference

One of the most significant hurdles to gender interventions is the perception held that they involve interfering in another culture. In the interview 26 per cent of respondents gave unqualified agreement to the idea that gender interventions were the imposition of western/feminist agendas (however only 1 per cent of this group were women). A further 42 per cent thought although gender interventions were interference they were valid providing they were carried out sensitively.

Recommendations

- The planning component should be incorporated into the gender awareness training in order to emphasises and illustrate how important gender is and what it means in practice.
- The argument that gender interventions are cultural interference needs to be addressed explicitly in the training as this is the most significant area of resistance. Schalkwyk and Woruniuk have proposed five counter arguments which Stewart suggests bringing into the training.
- The gender planning course proved inadequate in preparing trainees as it was extremely short. Stewart suggests that departmentally focused courses be introduced, e.g. gendered economics for economists. These courses should follow on from the initial gender awareness, be responsive to user needs and compulsory.

Schalkwyk and Woruniuk's counter arguments to gender interventions as cultural interference

1. Almost all development co-operation is about change of one sort or another: changing economic structures, changing farming practices, changing access to the media, changing human rights practices. These all have an important impact on culture and all involve some change to existing culture.
2. Development co-operation focuses on helping governments implement international commitments to gender equality which they have already made, such as the Beijing *Platform for Action* and the *Convention on Elimination of all forms of Discrimination against Women (CEDAW).*
3. There are growing demands for change from women in developing countries. The last decade has seen an explosion of women's organisations and gender equality advocates. These women are articulating clear demands for change. It is no longer possible to argue that calls for equality only come from northern countries. Unfortunately, their voices are not always heard, by representatives of co-operation agencies who do not seek these women out, or by the mainstream media of their own countries or by officials and politicians.
4. There are many influences on culture. With an increasingly global economy and the international flow of products, media images and cultural images almost all cultures are in a state of change. Images shaping changes in gender identities flow not just from development programmes but from other sources as well as imported soap operas, Hollywood movies, pop music and Coca-Cola commercials. Cultural images are also manipulated by religious and political movements. Whose culture are people referring to? Who has defined these elements as the crucial elements to be protected? Culture is not fixed and unchangeable, but dynamic and constantly changing in response to political and economic influences.
5. Finally a basic principle of development co-operation strategies on gender equality is to broaden decision-making processes so that women as well as men, have full input into the definition of what is important and what needs should have priority. All too often 'cultural argument' is mobilised by those in both developed and developing countries who are opposed to that goal.

Taken from Stewart (1998: 30)

References

Schalkwyk, J. and Woroniuk, B., 1997, *Source Book Prepared in Conjunction with the Draft Principles on Equality Between Men and Women*, Stockholm: SIDA

Stewart, S., 1998, *The Contribution of Gender Training to Equality between Men and Women in DfID Development Management*, London: DfID Social Development Division

Case study 2 The role of women's groups and local authorities in implementing health care in São Paulo, Brazil

Location

São Paulo, Brazil

Duration

1989–92

Organisation

Women's Comprehensive Health Care Programme – PAISM. Implemented by the Women's Health Care Office (WHCO) of the São Paulo government

Aim

Mainstreaming the gender perspective into the design, implementation and monitoring of governmental health policies.

Design rationale

The challenge posed to WHCO was to implement a comprehensive health programme with a gender perspective in order to raise health indicators in the city as lobbied for by women's organisations. Feminists challenged the view of women as only mothers in relation to health care and argued for broader reproductive health services, as well as occupational and mental health services for women of all ages. They called for greater access to preventive as well as curative care and to information that would further empower women.

As a result, apart from expanding the scope of services provided, women's groups also argued for reforms in the organisation and quality of care. They demanded changes to the hierarchical structure of health care and new forms of relationship among health professionals and among these and female system users. This meant sharing power with women, as well as new approaches to epidemiological diagnoses and planning, and the application of equality principles in the investment and distribution of resources.

The favourable political and administrative climate of the São Paulo democratic administration (1989–1992) provided the necessary conditions for the effective implementation of the Women's Comprehensive Health Care Programme. Such conditions included:

1. prioritising the health sector and women's health care;
2. creating decentralised decision-making levels – district health authorities (SILOS) – in order to understand realities in the various city regions and encourage community involvement;
3. the presence of feminists in government and pressure from the women's movement for change.

Activities

Several strategies have been used to introduce the gender perspective into the health system:

Training:

- members of central and regional maternal mortality committees, participating in all empowerment courses, in facility managing commissions and in the study for staff career plans at the Municipal Health Secretariat;
- the introduction, in career and public service entrance examinations, of issues such as domestic violence and sexual abuse, laws on women's rights, including criminal code provisions on legal abortion, and federal constitution provisions assuring equality between the sexes.

Participatory planning and advising process:

- creation of women's health advising/co-ordinating offices at municipal health secretariats and district health authorities staffed by women who support the gender perspective;
- epidemiological diagnosis and health planning with a gender perspective. The creation of district health authorities – local health systems. These were fundamental for the introduction of the gender perspective in the implementation of programmes. Operating as a true women's health care advising/co-ordinating office, WHCO supplied permanent technical support to district health authorities;
- funding the empowerment of health professionals is one of the requirements of gender-oriented planning and diagnosis processes. It means improved health services and more satisfaction both for professionals and users.

Networking and advocacy:

- the formation of a critical mass of gender aware health care workers helped to create other forms of institutional relationships with service users and a new look into women's issues, resulting in the progress and advocacy of such policies;
- intersectoral networking as a means to face health problems of the female population and capitalise the actions of other secretariats and institutions operating in women's health care;
- networking with women's organisations, by means of participation in policy planning, implementation and monitoring. In Brazil, the implementation of governmental programmes for women has been more frequent in states and towns with strong and demanding women's organisations.

Outputs and achievements

- Several social actors provided evaluations of the city administration in that period (1989–92). All of them reaffirmed the importance of this experience for the advancement of public policies for women's health care in Brazil.
- Legal abortion care has been implemented in 13 public hospitals in various regions in Brazil, with training and advising services supplied by the São Paulo Jabaquara Hospital professionals.
- Maternal mortality prevention and survey committees, with the participation of the community, the health care movement and women's movements have been established in other cities.
- The creation of health care services for women in situations of sexual abuse and domestic violence and the introduction of emergency contraception at public health centres were also pioneer services lead by the WHCO. Health secretariats in various states and cities/towns are introducing these measures into their health care plans.
- WHCO managed to foster a constant dialogue with women's organisations. These organisations were WHCO partners in many projects, but they also put pressure on other levels of power and decision-making, thus facilitating a part of WHCO's work both directly and indirectly.

Conclusions and lessons learnt

Despite its success, WHCO was not able to solve all women's health problems or achieve all of its feminist goals during the three years of the PAISM project. The best proposals by democratic governments committed to better health standards for poor population sectors and the best feminist proposals for women's health care are sometimes stopped or restricted due to the country's structural conditions, economic policies and social priorities. Brazil, as in most Latin American countries, faces public spending cuts and privatisation of services with deleterious effects on project implementation and effectiveness. Thus there is a need for gender to be taken into consideration not only at the micro level of health services provision, but also at the macro level of public planning.

Source: www.un.org/womenwatch/daw/csw/role.htm

1.2 Resources

1.2.1 Organisational change

In print:

Calas, M. and Smircich, L., 1997, 'The Woman's Point of View: feminist approaches to organisation studies' in S. Clegg and C. Hardy (eds), *Handbook of Organisation Studies*, London: Sage Publications

A review of the contributions of different feminist approaches to organisational studies and change and of how each school of thought has analysed different struggles to mainstream gender and women's participation in decision making.

Rao, A. and Stuart, R., 1997, 'Rethinking organisations: a feminist perspective', in *Gender and Development*, Vol 5 No 1: 10–16

The article uses two metaphors for organisations and their change progress: the iceberg, where the deep structures of organisations are invisible but can explain the actions and practices, and the onion, where changes at one layer do not mean changes at others. The article suggests what the deep structures in organisations can be and also how to change them.

Rao, A., Stuart, R. and Kelleher, D., 1999, *Gender at Work: organisational change for equality*, Bloomfield: Kumarian Press

The book produces an analysis of the institutional barriers to gender equality in the workplace. It examines different strategies and approaches for transforming organisations and how these different approaches have been applied. Cases include Bangladesh Rural Advancement Committee (BRAC) in Bangladesh, CIMMYT (the international wheat and maize research centre) and The Body Shop, a multinational beauty products company.

Stata, R., 1989, 'Organisational learning – the key to management innovation', *Sloan Management Review*, spring: 63–74

Although not specific to either gender or health, this article contains useful information on how to bring about organisational changes. Key findings were: a common understanding of systems thinking helps to improve staff ability to analyse problems and communicate learning to younger staff. Also rewards to staff for complying with new cultural norms of openness and objectivity within the organisation enabled learning and importantly increased the rate of organisational learning. This rate of improvement should be used as a key indicator of change.

1.2.2 International organisations

In print:

UNDAW, 1998, 'Women and health: mainstreaming the gender perspective into the health sector', report of the Expert Group Meeting, Tunis, 28 September–2 October

Section E outlines examples of intersectoral collaboration for gender equity and gives an overview of the area. Examples of good practice are quoted such as the Pan-American Health Organization's (PAHO) co-ordination prevention programme on gender violence through ten countries

Online:

FAO, *Good practice in gender mainstreaming and Implementation of the Beijing Platform for Action: FAO project sheets*, www.fao.org/waicent/faoinfo/sustedev/WPdirect/WPresour.htm

Examples of case studies from Africa and SE Asia.

ILO Gender Website
www.ilo.org/public/english/bureau/gender

Information about the integration of gender issues into the work of the ILO. Includes publications, good practices and international labour standards.

Razavi, S. and Miller, C., 1995, 'Gender mainstreaming: a study of efforts by the UNDP, the World Bank and the ILO to institutionalise gender issues', *Occasional Paper* No 4, UN Fourth World Conference on Women
www.unrisd.org/engindex/publ/list/opb/opb4/toc.htm

Traces the history of gender mainstreaming in the three institutions and analyses what influences it from external pressures, to policy entrepreneurs, to organisational ideologies. Also looks at the influence of gender mainstreaming on policy formulation.

UN and Commonwealth System, 2000, G*ender training resources collection* (accessed date):
www.col.org/GenderResources/

This project, not yet completed, aims to gather gender mainstreaming capacity support materials from all the different UN agencies on this site.

UNICEF, *UNICEF and gender mainstreaming*
www.unicef.org/programme/gpp/

Presents UNICEF policy and contains a short discussion of a gender perspective on the Convention on the Rights of the Child and human rights as a tool in mainstreaming gender.

1.2.3 Donor and development agencies

In print:

Canadian International Development Agency, 1999, *CIDA's Policy on Gender Equality*, Quebec: Canadian International Development Agency

Macdonald, M., Sprenger, E. and Dubel, I., 1997, *Gender and Organisational Change*, Amsterdam: KIT Press with Novib and Hivos

Focusing on development agencies, the book provides a practical approach to change processes with specific chapters on organisational culture, the role of the change agent, and the challenge of monitoring and evaluating change.

Porter, F. and Smyth, I., 1998, *Gender Training for Development Policy Implementers*, Oxford: Oxfam Publications

An Oxfam Working Paper based on research sponsored by DfID that takes a critical look at the gender training programmes of five different international development organisations and suggests that training is only one part of wider strategy needed for organisations to become gender sensitive.

Schalkwyk, J., Woroniuk, B. and Thomas, H., 1997, *Handbook for Mainstreaming. A Gender Perspective in the Health Sector*, Stockholm: Department for Democracy and Social Development, Health Division Sida – Swedish International Development Co-operation Agency

Online:

Canadian International Development Agency (CIDA), *Development of women health professionals programme*, www.acdi-cida.gc.ca/cida_ind.nsf/Oe258f35e6cd1eb28525662d0057b6fe/072d2207577d865c852564a400516d67?OpenDocument

The programme trains women health professionals, especially in the area of nursing and primary care. This co-operative programme is run by Pakistan's Aga Khan University in partnership with McMaster University in Hamilton, and funded by CIDA.

1.2.4 National bureaucracies and ministries of health

In print:

Kabeer, N. and Subrahmanian, R., 1999, *Institutions, Relations and Outcomes: A Framework and Case Studies for Gender-aware Planning*, New Delhi: Kali for Women

The premise of this book is that lack of gender-sensitivity in planning and policy processes causes increase costs in terms of efficiency, welfare and equity. In the Indian context, a series of tools and

analytical frameworks are developed to help to systematically integrate gender in different institutional settings.

Staudt, K., 1990, 'Gender Politics in Bureaucracy: Theoretical Issues in Comparative Perspective', in K. Staudt (ed.), *Women, International Development and Politics: the bureaucratic mire*, Philadelphia: Temple University Press

A review of the literature on bureaucratic movement towards gender redistribution, which examines how the gendered construction of state institutions tends to privilege men and subordinate women.

Taylor, V., 1999, *Gender Mainstreaming in Development Planning: a reference manual for governments and other stakeholders*, London: Commonwealth Secretariat

Development and gender planning converge in respect of the goals of planning. It is logical to assume that, if women constitute the poorest, are the most subordinate and are consistently denied access to the rights, services and benefits of society, then planning needs to be informed by a gender analysis which seeks to address the root causes of these gender based inequalities.

Online:

Rance, S., 1998, *The gender agenda: role of parliamentarians in the establishment of gender-sensitive health policies*, UNDAW discussion paper from the Expert Group Meeting on Women and Health, Tunis, www.un.org/womenwatch/daw/csw/rance.htm

Summarises the findings of an Inter-American Symposium on Legislating for Sexual and Reproductive Health. Suggests how advocates working with parliamentarians can promote gender-equal opportunities for participation in health policies and programmes for women and men as decision-makers, providers and users of services.

1.2.5 Legal systems

In print:

Schuler, M. and Kadirgamar-Rajasingham (eds), 1992, *Legal Literacy: a tool for women's empowerment*, New York: UNIFEM/OEF International

Explores legal literacy as an empowerment tool that can challenge definitions of gender roles, status and rights.

Women, Law and Development International, 1997, *Women's Human Rights Step by Step: a practical guide to using international law and mechanisms to defend women's human rights*, available from Women,Ink: New York

As well as describing the concept of human rights law, this book aims to provide tools which can be adapted to local legal and political contexts. It lists relevant instruments, ratification and links to useful resources.

Online:

The Centre for Reproductive Law and Policy

www.crlp.org/

A non-profit legal and policy advocacy organisation that promotes women's reproductive rights globally. The site provides comprehensive factual information on reproductive issues and the law.

Harvard School of Law and the UNFPA, *Annual review of population law*

www.law.harvard.edu/programs/annual_review/

A database on law and population that contains summaries and excerpts of legislation, constitutions, court decisions and other official government records from every country in the world relating to population policies, reproductive health, women's rights and related topics.

1.2.6 NGOs

In print:

Stuart, R., Roa, A., Kelleher, D. *et al.*, 1997, *BRAC Technical Manual: an action-oriented learning approach to gender and organisational change*, Bangladesh: BRAC

Details tools and methods developed for BRAC as part of its Gender Programme. Includes: needs assessment; strategic planning for senior managers; training of trainers; monitoring and evaluation.

1.2.7 Human resources development

In print:

Raikes, A., 1992, 'Gender and the production of health care services: issues for women's roles in health development', in *IDS Bulletin*, Vol 23 No 1: 19–28

Discusses the role of women in health care in the formal and informal sector and analyses the strategies of women as health care workers.

Standing, H., 2000, 'Gender – a missing dimension in human resource policy and planning for health reforms', *Human Resources for Health Development Journal*, Vol 4 No 1: 27–42

Online:

Dinotshe Tlou, S., 1998, *Health care including management of human and financial resources in nursing*

www.un.org.womenwatch/daw/csw/papers1.htm

A discussion paper produced for the Expert Meeting on Women and Health. Looks at issues surrounding the profession of nursing and the effects of it being a female-dominated profession: also community participation and the western model of health care.

1.2.8 Budgets and finance

In print:

Budlender, D. (ed.), 1999, *Engendering Budgets: the southern African experience*, New York: UNIFEM

Based on a UNIFEM workshop in Harare, the publication considers initiatives taken in engendering budgets in Southern Africa and suggests areas for future research and collaboration.

Sen, G., 1999, *A Quick Guide to Gender Mainstreaming in Finance*, London: Commonwealth Secretariat

Guide aimed at policy-makers, planners and personnel managers, working in/with finance ministries. Issues covered include: mandates for gender equality and equity in the finance sector; ministries of finance and gender; the changing role of ministries of finance; promoting attitudinal change; easing institutional constraints; strategic areas of action.

Online:

Bangser, M., 2000, 'Reframing policies for gender equity: women's agency, participation and public accountability', Harvard Center for Population and Development Studies, *Working Paper Series*
www.hsph.harvard.edu/Organizations/healthnet/HUpapers/gender/bangser.html

Analyses the way in which macro-economic policies imposed by international financial institutions can create greater inequalities and how this can impact on health. Includes user fees and the gender-differentiated impact of such policies, structural adjustment policies and women's health and the challenge in ensuring gender equitable participation and accountability.

Budlender, D., 1998, *The South African women's budget initiative*
www.sdnp.undp.org/gender/links/Gender_in_Development/Selected_Publications/UNDP_Gender_Publications/

UNDP, 1999, *Pro-poor, gender- and environment-sensitive budgets workshop*, 28–30 June
www.undp.org/poverty/events/wkshop/budgets/bud_abstracts.htm

Abstracts of papers mainly in the form of case studies that look at gender budget initiatives worldwide, from the Commonwealth Gender Budget Initiatives to national efforts in Mozambique, India, Bangladesh and developed countries.

1.2.9 Governance

Online:

UNDP Gender in Development Programme (GIDP)
Ashworth, G., 1996, 'Gendered governance: an agenda for change', *GIDP Monograph* No 3
www.undp.org/gender/resources/mono3.html

A gendered analysis of government at both local and national levels.

Jain, D., 1996, 'Panchayat Raj: women changing governance', *GIDP Monograph* No 5,
www.undp.org/gender/resources/mono5.html

Details the development of the Panchayat Raj system in Karnataka, India, where 25 per cent of local government seats were reserved for women. Impacts on health included the prioritising of quality health care and water.

UNDP Gender in Development Monograph Series
Schalkywk, J., 2000, 'Exercises in gender mainstreaming', *GIDP Monograph* No 8
www.undp.org/gender/resources/mono8.pdf

Describes group exercises in mainstreaming gender in poverty, governance, human rights, post-conflict initiatives and water resources. The governance exercise uses the results-logic approach to focus attention on results and impacts when identifying appropriate activities in support of gender equality.

UNDP Management, Development and Governance Division (MDGD)
Women's Political Participation and Good Governance: 21st Century Challenges, 2000
http://magnet.undp.org/new/pdf/gender/wpp/women_book.pdf

1.2.10 Sector wide approaches (SWAPS)

In print:

Cassels, A., 1997, *A Guide to Sector-wide Approaches in Social Development: concepts and working arrangements*, Geneva: WHO

General guide to how SWAPs have been pioneered in the heath sector.

Elson, D. and Evers, B., 1998, *Sector Programme Support: the health sector, a gender aware analysis*, Manchester: Genecon Unit, University of Manchester

This paper employs a macro-meso-micro framework to examine the issues which a national policy framework should address. There is a checklist for a gender-sensitive national sector framework. At macro level, it includes incorporating households and disaggregated gender/age information into planning;

sensitising planning tools e.g. in relation to the role of unpaid reproductive labour; assessing the gender balance of personnel in key strategic and financial roles; and assessing institutional capacity in gender planning. At the meso level, it includes assessment of the gender balance in health sector employment; identification of stakeholders to ensure that women's voices are represented; and assessment of gender differences in access to services.

At the micro level, it involves examining access to resources and decision making within households; and assessing whether households operate in ways which impede access to resources by gender.

Ministry of Foreign Affairs, The Netherlands, 2001, 'Gender equality in sector wide approaches', proceedings of a workshop, The Hague, Netherlands, 22 and 23 February

This workshop was organised by the Women and Development Division of the Social and Institutional Development Department of the Netherlands Ministry of Foreign Affairs. It brought together practitioners, researchers and funding agencies to discuss gender mainstreaming in sector wide approaches in health, education and agriculture. It included participants from Bangladesh, Ghana, Kenya, Tanzania, Uganda and Zambia. Fifteen papers were presented, of which a number explicitly addressed the health sector or drew on experience across the sectors.

Details: Rita Tesselaar, Women and Development Division, Bezuidenhoutseweg 67, 2594 AC. Den Haag, The Netherlands, rita.tesselaar@minbuza.nl

Norton, A., and Bird, B., 1998, 'Social development issues in sector wide approaches', *Social Development Division Working Paper* No.1, London: Department for International Development

This paper summarises some of the issues raised by sector wide approaches from a social development perspective and provides guidance on tools and methods to strengthen the social dimensions of sector-wide programmes. It raises gender issues in relation particularly to enhancing the poverty and gender focus of sector programmes through strengthening accountability mechanisms for excluded groups.

2 Implementing rights and accountability through networks and advocacy

2.1 Introduction

The 1994 Cairo International Conference on Population and Development (ICPD) Programme of Action, Cairo and the 1995 Beijing Platform for Action heralded landmark changes in how women's health was to be conceptualised due to the successful advocacy undertaken by the women's health movement. As a result, family planning and population issues were transformed into broader concepts of sexual and reproductive health and rights (SRHR). Not only were people acknowledged as protagonists in their own reproductive health and lives, but the improvement of women's and men's health and wellbeing was directly related to factors such as equal rights, social discrimination, the division of labour, access to credit, productive assets, land, and job opportunities.

> **Gender equity**
> Due to gender discrimination, women tend to be unable to participate at an equal level in decisions that affect their lives and their health. In most countries women are denied access to health services, educational opportunities, legal rights and other opportunities enjoyed by men.

Through empowerment and participation both men and women from marginalised groups will be able to influence and decide on national and regional health policies, planning and implementation of specific health programmes and activities. The following questions can help to identify critical issues regarding GHE:

- Is there any conflict between international definitions and local traditions regarding gender issues that influence health?
- What is the level of gender issues awareness within the health sector?
- What attempts have been made to address gender concerns within the health sector?
- What agencies are involved in promoting and protecting gender equality and equity (at national, regional and village level: ministries, government departments, parliamentary initiatives, professional associations, NGOs and other civil society organisations)?
- What are the existing mechanisms that facilitate access to appropriate health care by women and men from vulnerable groups?
- Are there measures in place to ensure men's and women's rights to privacy?

Case study:

- Accountability and implementation: questions to ask

Resources:

- Gender and health equity in international conventions
- Right to health including sexual and reproductive health rights
- Advocacy and network strategies

Case study 3 Accountability and implementation: questions to ask

A list of questions set out by the NGO, International Women's Rights Action Watch provides a useful guide to assist researchers and advocates in assessing states' compliance with their Convention Elimination of All Forms of Discrimination Against Women (CEDAW) obligations to ensure rights to equitable health care.

Access

- Do women have the same access as men to health care services?
- What health facilities and personnel are available for women? This could include hospitals, clinics, health posts, and other facilities as well as physicians, nurses, auxiliary health personnel, family planning workers, and community agents. Are there any health facilities and personnel dedicated to the health needs of women?

Gender discrimination

- What measures have been taken to eliminate discrimination against women in the field of health care?
- What legal or cultural obstacles are there to women receiving health care services including family planning?
- Is female genital mutilation or circumcision practised? If yes, under what circumstances? Is it legal?
- Do any groups in the country perpetuate practice (for example, dietary restrictions for pregnant women) that might be harmful to women's health? If so, what measures have been introduced to eradicate such practices?

Health sector analysis

- How many women work in the health sector? In what areas of the health sector do they work? At what level of seniority in these areas do they work?
- Does the country have traditional health workers? If so, what do they do? How many traditional health workers are women?

Maternal and reproductive health

- Is medical care for women during pregnancy and in the post-natal period free of charge?
- Does the state seek to ensure that women receive adequate nutrition during pregnancy and lactation? If so, in what ways?
- What percentage of women receives prenatal care?
- What is the average number of live births per woman?
- Is abortion legal? If so, under what circumstances? Is the cost of abortions covered under national medical insurance or social security? Can poor women receive free or subsidised abortions? If abortion is legal, how available are services in practice?
- Is pre-natal foetal testing available? If so, what is the incidence of abortion following pre-natal testing? If there is incidence of abortion following pre-natal testing, what are the major reasons for such abortions?
- Does the state have any laws or policies requiring abortion? If there are such laws or policies, are the wishes of the mother taken into consideration when determining whether an abortion should take place?
- If abortion is not legal, is it performed anyway? What statistics are available for death and/or illness due to or related to abortion? What provisions are made for care of women with incomplete abortions?
- Is elective sterilisation available? If so, what is the incidence of elective sterilisation for women? For men?
- Does the state have any laws or policies requiring sterilisation? What sanctions exist for failure to comply with these laws or policies?

Contraception

- What is the unmet need for contraception?
- What is the prevalence of contraception, by method?
- Is the husband's authorisation required, either by law or in practice, before a married woman can receive health services including family planning?
- Does the state have any laws or policies that require use of family planning measures? If so, are there any consequences, such as financial penalties, where these laws or policies are not complied with?

Mortality

- What are major causes of female mortality and morbidity?
- What is the maternal mortality rate?
- What are the infant and child mortality rates for boys and for girls? What are the major causes of infant and child mortality and mortality for girls? What are the major causes of infant and child mortality and morbidity for boys?
- What is the average life expectancy for men and women?
- What are the crude birth rates and crude death rates for men and women?

HIV

- What measures have been introduced in the country to increase public awareness of the risk and effects sexually transmitted diseases, particularly, HIV/AIDS? Have any if these measures been aimed specifically at women and girls?
- Have any programmes been introduced to combat sexually transmitted diseases, particularly HIV/AIDS? If so, are any of these programmes dedicated to women and girls? Do any of these programmes pay particular attention to women's reproductive role and female subordination as factors that make women and girls vulnerable to sexually transmitted diseases, particularly HIV/AIDS?
- What measures have been introduced to ensure the participation of women as health care workers in the context?

Source: www.idrc.ca/media/maureen_health.html#appendix

2.2 Resources

2.2.1 Gender and health advocacy in international politics

In print:

Bustelo, C., 1995, 'Reproductive health and CEDAW', *American University Law Review*, Vol 44: 1145–55

The obligations of signatories to the women's convention with respect to reproductive health rights are outlined and a recommendation made to clarify the scope of the concept.

Center for Development and Population Activities (CEDPA), 2000, *Advocacy: building skills for NGO Leaders*, Washington: CEDPA

Manual for use in training NGO leaders to build the necessary skills to advocate for the changes in reproductive health laid down in the Beijing agreements. Designed to be used as a three-day course.

Chapman, A.R., 1995, 'Monitoring women's right to health under the International Covenant on Economic, Social and Cultural Rights', *American University Law Review*, Vol 44: 1157–75

The paper suggests a new approach to monitoring women's right to health based on identification of three types of potential and actual violations of this right: violations resulting from governmental actions, laws and policies; violations based on discrimination; violations related to the failure to fulfil a minimum core of obligations of enumerated rights.

International Women's Tribune Center (ITWC), 2000, *Moving Policy, Taking Action: a community advocacy guide to the Beijing Platform for Action*, New York: IWTC

Addresses how to work on the 12 strategic objectives of the Beijing Platform for Action (one of which is achieving health for women). Includes ways to use the media for advocacy, indicators and different approaches to measuring progress.

Keck, M. and Sikkink, K., 1998, *Activists Beyond Borders: advocacy networks in international politics*, Ithaca: Cornell University Press

An analysis of how activists create and use networks across national borders. The international campaign around violence against women is examined in detail. Chapters include: transnational advocacy networks in international politics; human rights advocacy networks in Latin America and environmental advocacy networks.

Landsberg-Lewis, I. (ed.), 1998, *Bringing Equality Home: implementing the Convention on the Elimination of All Forms of Discrimination Against Women*, New York: UN Development Fund for Women (UNIFEM)

Case studies of how CEDAW has been used to incorporate rights into national constitutions, laws and government policies.

Nowicka, W., 1999, 'Advocating and monitoring the implementation of the ICPD Benefit Programme of Action in Poland: the benefits of NGO reporting to the UN Committee of Economic, Social and Cultural Rights', *Medicine and Law*, Vol 18 Nos 2 and 3:295–303

A description of how a Polish NGO, the Federation of Women and Family Planning, produced an alternative country report to that of the Polish government for the UN Committee on Economic, Social and Cultural Rights, and how this report was used as a basis for questioning Poland's compliance (especially with regard to anti-abortion laws).

Online:

The Beijing Declaration

www.un.org/womenwatch/daw/beijing/platform/declar.htm

Principles 17, 19 and 20 deal most directly with reproductive health and the implementation of health rights.

The Beijing Platform for Action

www.un.org/womenwatch/daw/beijing/platform/health.htm

The strategic objective of achieving health for women is the third of the 12 objectives and is further broken down into five aims: increase women's access throughout their life cycles to appropriate health care; strengthen preventive programmes; undertake gender-sensitive initiatives that address sexual and reproductive health; promote and disseminate research; increase resources.

Petchesky, R., 'Reproductive and sexual rights: charting the course of transnational women's NGOs', www.unrisd.org/engindex/publ/cat/p338.htm

2.2.2 Right to health including sexual and reproductive health rights

In print:

Cook, R., 1993, 'International human rights and women's reproductive health', *Studies in Family Planning*, Vol 24 No 2: 73–86

Discrimination in law with respect to reproductive health care services takes many forms and is evident when laws block access to services, when protective laws are enacted but not enforced, and when laws fail to facilitate women's reproductive health. The article goes on to outline different sources of evidence that can be used to provide insight into the relationship between law and women's reproductive health. It highlights the roles of epidemiological evidence and feminist legal theory and empirical evidence.

Freedman, L., 1998, 'Reflections on emerging frameworks of health and human rights', *Health and Human Rights*, Vol 1 No 4: 315–48

The ways in which the analytical tools of public health can be used in conjunction with emerging theories of human rights to craft effective advocacy strategies, focusing particularly on women's reproductive health and reproductive rights.

Harvard School of Public Health, 2000, 'Sexual and reproductive rights', *Health and Human Rights*, Vol 4 No2

The entire volume is dedicated to the issue and explores the 'double discourse' surrounding sexual and reproductive rights.

Kempadoo, K. and Doezema, J. (eds), 1998, *Global Sex Workers: rights, resistance and redefinition,* London: Routledge

Reports and narratives from male and female sex workers concentrating on their struggle for human and workers' rights.

Mertus, J., Flowers, N., and Dutt, M., 1999, *Local Action, Global Change: learning about the human rights of women and girls*, New York: UNIFEM and the Center for Women's Global Leadership (also available in Spanish and French)

Designed as an educational tool to be used with a wide audience from government officials to youth groups. Provides information on women's human rights alongside exercises and strategies to help implement the instruments.

Moser, C. and Tinker, A., 1995, 'Gender planning: different policies' approaches to reproductive health', *American University Law Review*, Vol 44: 1113–19

How a rights-based framework can be implemented in gender planning. The tools necessary for this are: differentiating between the roles and relations men and women have in the household and the community; defining the practical and strategic gender needs of women; choosing which policy approach to women in development should be applied. Anne Tinker then goes on to outline some of the work being done by the World Bank in the area of women's health.

Tambiah, Y., 1998, 'Realising women's sexual rights: challenges in South Asia', *Nordic Journal of International Law,* Vol 67: 97–105

Sexual rights are a relatively new category of human rights and in South Asia their articulation can be difficult in the light of taboos concerning the public discussion of sexuality and negative attitudes towards women's sexual autonomy. This paper analyses the debates on reforms of the Sri Lankan Penal Code in 1995 in a multi-ethnic context. Addresses the tension between universal human rights and 'ethno-nationalist' group rights.

Online:

Commonwealth Medical Association, 2000, *Monitoring the right to health: calendar on sessions of human rights bodies*

www.commat.org/uncal/uncal.htm

Provides details of sessions for monitoring the six health-related human rights conventions, with details of ratifications. The Commonwealth Medical Association is also in the process of developing a manual on the right to health, details of which should come up on this site.

Correa, S., 1997, *From reproductive health to sexual rights: achievements and future challenges*

www.hsph.harvard.edu/Organizations/healthnet/reprorights/docs/correa.html

Analyses the discussions around the terms 'sexual' and 'reproductive' rights in an international context.

Harvard School of Public Health, *Research library: reproductive rights: information*

www.hsph.harvard.edu/Organizations/healthnet/reprorights/info.html

Links to information on human rights declarations, reproductive rights laws, population policies and sexual rights.

Panos, 1998, 'Using human rights to gain reproductive rights', *Panos Briefing* No 32

www.oneworld.org/panos/briefing/brief32.htm

Outlines the issues of gender, health and human rights and analyses how specific women's health problems relate to specific rights (e.g. 'Safe motherhood: the right to life'). Charts the ways in which partnerships between the health and legal professions are contributing to developing reproductive health and rights, illustrated by case studies.

The People's Decade of Human Rights Education 'Women, Human Rights and Health' Site:

www.pdhre.org/rights/women_and_health.html

Overview of what the human right to health is, which provisions of human rights law guarantee it and the commitments that governments have made to ensuring the realisation of the right to health.

2.2.3 Advocacy and networking strategies

In print:

Cummings, S., Valk, M. and van Dam, H., 1999, *Women's Information Services and Networks: a global source book*, Amsterdam: Kit Press with Oxfam GB

A guide to 162 women's information centres and women's archives around the world and their activities. Information on networks and their relationship to information centres and emerging communications technologies.

SIDA, 2000, *Webs Women Weave*, available through Q Web at qweb@kvinnoforum.se

An assessment of four organisations networking for sexual and reproductive health and rights. Assesses ARROW (Asian Pacific Resource and Research Centre for Women), ESEA (East and Southeast Asian Women and Health Network), IWHC (International Women's Health Coalition), and LACWHN (Latin American and Caribbean Women's Health Network).

Online:

Oneworld's Women's Human Rights Advocacy

www.oneworld.org/whrnet/advocacy/advocacy.htm

Useful short overview of women's human rights advocacy and which strategies have been successfully employed.

3 Tools to enhance and implement gender equity

3.1 Introduction

In this section we have identified the following tools available to enhance and implement gender and health equity:

Resources:

- Gender analysis frameworks
- Initiatives incorporating gender into health care practices
- Participatory methods
- Monitoring and evaluations
- Indicators and statistics
- Checklists and logframes

Examples of tools:

- Gender-sensitivity of health sector institutions: a checklist
- Project policy orientation and project staffing, FHI
- Monitoring checklist for client exit interviews
- Indicators of women's health and nutrition
- FAO's SEAGA (Socio-economic and Gender Analysis Programme) – minimum requirements for identifying problems, planning programmes and evaluating progress towards meeting health goals
- CIDA guide to gender-sensitive indicators in the health sector

Health and gender equity improvements imply changes to immediate risk factors or social determinants that influence individual's behaviour. In order to generate ownership of the change process, the various stakeholders should be involved in formulating necessary social changes. The following questions should be asked:

- Have stakeholders been identified?
- What are the existing mechanisms to involve primary stakeholders in the health sector and in specific health programmes?
- What are the established gender roles and how do they affect gender differences in the incidence, early detection, health seeking behaviour, and use of health services and compliance?
- What policy and programme initiatives exist to meet the needs of specific groups (children, adolescents, men, women, elderly, displaced, disabled, etc.) in the health sector?

Health indicators are particularly relevant to assess changes in life improvement and the status of marginalised groups. Given the present emphasis on poor and marginalised populations, girls and women are a significant target group. In developing countries in particular, they are among the most vulnerable and disadvantaged. Gender-sensitive indicators point out changes in the status and roles of women and men from a given society over time, in order to improve gender equality. Gender and health indicators can help to address gender differentials in health and the underlying factors as well as problems specific to women.

It is essential that gender-sensitive indicators cover both process and output with the central focus on outcome indicators. These indicators need to be complemented by qualitative analysis in order to understand how to achieve more positive outcomes and should be part of all stages of monitoring and evaluation.

According to the source of information and the way the information is interpreted and used, it is possible to generate both quantitative and qualitative gender-sensitive indicators. These provide different perspectives and complement each other. Qualitative analysis enables the comprehension of social processes and understanding of how a situation that quantitative indicators measure can be changed in the future.

Qualitative indicators are particularly relevant to gender since they focus on people's perceptions and views on a specific topic and are usually generated through participatory approaches such as popular consultation, community involvement and participant observation. Other sources of information are participatory rural appraisals, sociological or anthropological field work and behavioural or attitudinal surveys. Because of their participatory nature, qualitative indicators can ensure that the views and needs of marginalised groups are taken into account.

Quantitative indicators usually focus on areas that are easy to measure using statistical information collected in censuses, administrative records or formal surveys. When analysed from a gender perspective, the sources of information to formulate quantitative indicators present some limitations. Censuses, household surveys and registration and administrative data tend to ignore gender-sensitive data. Although sex-disaggregated data is now collected, it is not done in a consistent way.

Interviewers tend to lack training and gender-sensitisation, for example they might fail to identify women who are primarily housewives but who are also engaged in productivity. Failure to include women's work is partly due to the unclear concept of 'active population' which does not take account of seasonal work or productive activities in the informal sector. Another limitation is the use of words such as job, work and employment. These words tend to be associated with a salary or paid wage and therefore exclude all the time-consuming activities in which low-income women are engaged.

A checklist for using gender-sensitive indicators

- **Comparison to a norm:** Use of gender-sensitive indicators should involve comparison to a norm, for example the situation of men in the same country or the situation of women in another country. In this way the indicator can focus on questions of gender equality and equity rather than only on the status of women.
- **Disaggregation:** Data should be disaggregated by sex. Wherever possible, national level indicators should also:
  - be disaggregated by age,
  - be disaggregated by socio-economic grouping,
  - be disaggregated by national and/or regional origin,
  - note the time period,
  - note geographical coverage, and
  - note data sources.
- **Ease of access:** Data should be easy to use and understand. Indicators should be phrased in easily understandable language, and should be developed at a level relevant to the institutional capabilities of the country concerned.
- **Scope of availability:** Indicators should be available for the whole country.
- **Reliability:** Data should be relatively reliable. No data is absolutely reliable but reliability checks should be carried out. For example, findings from censuses should be compared to findings from micro-level studies for accuracy.
- **Measurability:** Indicators must be about something measurable. Concepts such as 'women's empowerment' or 'gender equity' may be difficult to define and measure. In this case proxy indicators, for example relating to greater choice for women in accessing health care or education, may be used instead of the less precise concepts.
- **Time-frames:** Gender-sensitive indicators should be reliable enough to use as a time series. The time span which the indicator covers should be clearly specified.
- **International compatibility:** Gender-sensitive indicators should be collected using internationally accepted definitions. While definitions are sometimes imprecise, they are usually the best terms available and allow for international comparison.
- **Measuring impact:** The indicator should, where possible, measure the outcome or impact of a situation rather than the input. For example, female mortality rates are a better measure of women's health status than access to health facilities.
- **Participation:** Indicators should be used and developed in as participatory a process as possible. This will involve setting up inter-departmental government committees but also holding focus group meetings with the public and eliciting public opinion from women and men wherever possible.

(Commonwealth Secretariat, 1999, *Using Gender-Sensitive Indicators*, Gender Management System Series)

Mechanisms to include information on female labour force activities and time-use in rural and marginal urban areas have yet to be developed. Therefore training interviewers to reduce gender bias and to include women's work is only part of the solution. There is also a need to have more female interviewers. Representatives of different classes, ages and ethnic groups should be employed for household surveys in order to build the confidence of the women being interviewed, who may have problems answering to male interviewers.

Examples of gender-sensitive indicators

- percentage of government expenditure devoted to women's health needs in a) productive and b) non-productive areas
- percentage of budget support allocated for gender priorities
- percentage of female health personnel at the different levels of the health system
- percentage of female health personnel in managerial and professional posts
- percentage of female health personnel with training opportunities (overseas, pre-service and in-service)
- personnel understanding and acceptability that gender inequality and gender relations as factors that influence individual's health and the quality of health services
- salary/wage differentials of women/men by class of workers
- number of/access to primary health care centres by sex
- number of visits to and number of bed-nights spent in hospital by women/men, number of hospital beds as percentage of population
- proportion of girls and boys immunised against specific diseases
- proportion of births attended by a physician, midwife or trained auxiliary
- mortality and length of life, by sex
- maternal mortality rates (per 1,000 live births)
- infant mortality rates and female/male ratio
- number and/or incidence of selected communicable diseases of public health importance, including AIDS, by sex
- percentage of women's/men's incomes spent on food
- access to sanitation and clean water, by sex
- percentage of women's/men's, girls'/boys' injuries by type of incident/accident
- proportion of male involvement in contraceptive use.

3.2 Resources

3.2.1 Gender analysis frameworks

In print:

March, N., Smyth, I. and Mukhopadhyay, M., 1999, *A Guide to Gender-Analysis Frameworks*, Oxford: Oxfam Publications

Aimed at non-specialists wanting to incorporate gender analysis into their work, it communicates how to work with different frameworks and which particular circumstances each one may be appropriate for.

Online:

Liverpool School of Tropical Medicine, 1998, *Guidelines for the analysis of gender and health*
http://www.liv.ac.uk/lstm/GG-1.html

These guidelines, by the Gender and Health Group, are designed to enable health professionals and researchers to address gender issues in their work. They can help to develop gender sensitive planning and evaluation; aid health researchers in including gender dimensions in their research area; and allow policy makers to identify gender issues in the design and implementation of health policy.

Miller, C. and Razavi, S., 1998, 'Gender analysis: alternative paradigms', UNDP *GIDP Monograph* No 6, www.undp.org/gender/resource/mono6.html

Comprehensive review of the body of work on gender analysis including Gender Roles Framework, the DPU Framework, the Social Relations Framework, Feminist Economics and alternative models such as the Women's Empowerment Framework and the SEAGA package.

SEAGA – Socio-economic and Gender Analysis Programme from the FAO
www.fao.org/WAICENT/FAOINFO/SUSTDEV/seaga/SEqt0009.htm

A package of gender analysis tools developed with inputs from many regions. Produced in English, French, Spanish and Portuguese, it includes a framework and users reference, handbooks for the macro (Chapter 6 deals with the health sector), intermediate and field levels, guides, training-of-trainers materials, and an information kit.

3.2.2 Initiatives incorporating gender into health care practices

In print:

Women's Health Project and UNDP/World Bank /WHO Special Programme for Research and Training in Tropical Diseases (TDR), 1995, *Health Workers for Change: a manual to improve quality of care*, Geneva: WHO

Based on research carried out in Uganda, Senegal, Zambia and Mozambique, this manual provides a series of workshops to help workers in the health sector improve quality of care. The methodology takes health workers through a process of identifying their problems and the solutions to these problems. The workshops address structural issues that impact on women's health through examining women's status in society and through analysing their unmet needs. Positive action is emphasised: the manual continually asks 'what can be done' and 'by whom?'

Online:

Commonwealth Medical Association, *A training manual of ethical and human rights standards for health care professionals*
www.commat.org/ethics/toc.htm

The manual addresses the ethical concerns (including gender discrimination) which arise during medical practice in developing countries. It begins by outlining ethical and human rights standards of health care including the principles of medical ethics, human rights, education of professionals and enforcement. Eight training modules follow with annexes on the Helsinki Declaration

Wong, Y., 1998, *Integrating the gender perspective in medical and health education and research*, UN Commission on the Status of Women (CSW) Expert Group Meeting on Women and Health, September www.un.org/womenwatch/daw/csw/integrate.htm

Suggestions to improve on the all-male basis of much medical research and the sexism in service delivery.

3.2.3 Participatory methods

In print:

Brooke, P., 1996, *Traditional Media for Gender Communication*, New York: PACT Publications

Largely focusing on rural areas, this training manual explores how to plan effective communication in a participatory manner. Includes how to use dramas, songs and dances to help a community diagnose and mobilise for action.

Butcher, K. and Kievelitz, U., 1997, 'Planning with Participatory Rural Appraisal (PRA): HIV and STD in a Nepalese mountain community', *Health Policy and Planning*, Vol 12 No 3: 253–61

Using PRA to explore local concerns and perceptions of HIV/AIDS and sexually transmitted diseases (STD) and then to plan collectively to address the emerging issues, the authors found that conducting the research in a gender-sensitive way helped participants to express their opinions confidently. PRA methods were highlighted as a good way to plan around specific health issues although certain problems emerged: the skills needed to analyse the information coming out of the process were more complex and demanding than the process itself – facilitators were not sufficiently trained to develop more complex analyses.

Gujit, I. and Shah, M. (eds), 1998, *The Myth of Community: gender issues in participatory development*, London: Intermediate Technology Publications

Participatory processes are often built on an assumption of 'community' that does not exist. This book tries to understand the gendered aspects of community differences, power relationships and conflicts and how to tackle gender issues more meaningfully. There are three main sections: theoretical reflections on participation and gender; case studies from developing countries; and the efforts of development organisations to incorporate gender in participatory processes.

Johnson, V. *et al.*, 1997, *Stepping Forward: children and young people's participation in the development process*, London: Intermediate Technology Publications

A collection of case studies that look at the key issues and challenges facing those facilitating children's and young people's participation. Includes the ethical dilemmas when working in this field; the process and methods of children's participation; the inter-relationship between culture and children's participation; and the key qualities in programme design. Health-related material includes child-to-child approach and work on well-being indicators.

MacCormack, C., 1992, 'Planning and evaluating women's participation in primary health care' in *Social Science and Medicine*, Vol 35 No 6: 831–7

Provides a methodology for planning and evaluating gender-focused health programmes. Includes: determining women and men's perceptions of health needs; traditional health care roles; gender balance of health care workers; monitoring women's utilisation of services; understanding how the gender division of labour contributes towards risk.

Online:

ActionAid, *Strategies for hope homepage*
www.actionaid.org/stratshope/

Contains online versions of training packages designed for HIV/AIDS care, support and prevention, including 'Stepping Stones', the participatory training programme focusing on changing attitudes.

CARE, *Embracing Participation in Development*
www.care.org/programs/health/reproductive_health.html

A three-part guide: CARE's experience with participatory approaches, conceptual reflections and a field guide to participatory tools and techniques.

Paulson, S., 1996, *Case studies of two women's health projects in Bolivia*, Research Triangle Park, North Carolina: Family Health International
www.fhi.org/en/wsp/wspubs/bolivia.html

A profile of two participative women's health programmes in Bolivia with a strong basis in gender theory. As well as participation in the design and delivery of health care services, the programmes also integrated health care with other social services such as the law and psychological care. (The Family Health International site has details in its publications section of other related research projects in Bolivia.)

3.2.4 Monitoring and evaluation

In print:

Estrella, M. and Gaventa, J., 1998, 'Who counts reality? Participatory monitoring and evaluation: a literature review', *IDS Working Paper* No 70

This paper presents a literature review of experiences in participatory monitoring and evaluation (PMandE) from around the world, used in different contexts and involving all kinds of stakeholders: NGOs, donors, research institutions, government, people's organisations and communities. Contains case studies, tools and an annotated bibliography.

Hardon, A., Mutua, A., Kabir, S. and Engelkes, E., 1997, *Monitoring Family Planning and Reproductive Rights*, London: Zed Books

The book details how to design, carry out and analyse research into quality of care in family planning provision in different cultural settings including indicators.

Hulton, L., Matthews, A. and Stones, R., 2000, *A Framework for the Evaluation of Quality of Care in Maternity Services*, Southampton: University of Southampton

Presents a ten-part quality assessment framework covering: human and physical resources, the referral system, maternity information systems, the use of appropriate technologies, internationally recognised good practice, management of emergencies, human and physical resources, cognition, respect, dignity and equity and emotional support. Tables for each part summarise criteria, standards and indicators.

Online:

Pan-American Health Organization (PAHO), 1997, *Workshop on gender, health and development: facilitator's guide*
http://165.158.1.110/english/hdp/hdpw009.htm

Intended to train health professionals and policy makers, this manual aims to facilitate the understanding that a gender approach is essential for health planning and sustainable development. The modules begin with exploring issues around sex and gender and gender roles and stereotypes. Health needs in terms of access to and control of household resources are analysed, alongside practical and strategic gender approaches. Finally this knowledge is applied to case studies and gender analysis of existing health projects. The texts of handouts for the participants are included, as are model transparencies and flipcharts.

Pathfinder International FOCUS on Young Adults, *Monitoring and evaluation tools*
www.pathfind.org/RPPS-Papers/inventor.htm

Extensive listing of protocols for qualitative and quantitative methods of monitoring and evaluation for use with young adults.

Policy Project, 1996, 'Performance monitoring for family planning and reproductive health: an approach paper', *Working Paper Series* No 1, Futures Group International
www.policyproject.com/pubs/wps1.html

Post Cairo there has been a marked shift from achieving quantitative indicators in programmes and demographic targets to issues of quality of care and client satisfaction. This report looks at several country experiences in changing their performance monitoring methods.

SEAGA, 2000, *Guide to monitoring and evaluation*
www.fao.org/waicent/faoinfo/sustdev/seaga/Setoc001.htm

Part of the SEAGA package (see under 'Gender analysis frameworks' above).

3.2.5 Indicators and statistics

In print:

Beck, T., 1999, *A Quick Guide to Using Gender-Sensitive Indicators*, London: Commonwealth Secretariat

A short user guide that is aimed at policy makers in governments that are establishing gender management systems and/or developing a national database on gender-sensitive indicators, as well as NGOs, women's groups, professional associations and the academic community. Covers how to develop a national level database of indicators, how to gather and use indicators (including health), and an overview of work carried out by the UN and major donors on indicators and gender.

Rowlands, J., 1998, *Questioning Empowerment: working with women in Honduras*, Oxford: Oxfam Publications

An assessment of a health promoter's training programme in Honduras that measures how the rhetoric of empowerment works in practice. Discusses the need to develop 'performance indicators' to track progressive change in power relations, along with pro-empowerment attributes.

Saith, R. and Harriss-White, B., 1998, 'Gender sensitivity of well-being indicators', *UNRISD Discussion Paper* No 95, Geneva: UNRISD

The gender sensitivity of health, nutrition and education indicators, as well as that of some composite indices, is critically examined. The ratio of males to females 0–4 and 5–9 is found to be a more suitable indicator of relative female health than the widely used male and female life expectancy at birth. Nutrition and morbidity data are less reliable because of difficulties in data collection and interpretation added to the tendency of gender inequality not necessarily being linked to income group.

UN, 1997, *Handbook for Producing National Statistical Reports on Women and Men*, New York: UN Publications

The handbook explains how to prepare and use available data, how to develop indicators on critical gender issues and how to publish and disseminate a minimum set of data.

Online:

Standing, H., Tolhurst, R., Ebdon, E. and Duby, F., 1999, *Gender and health resource for DfID intra-net: Health Sector Reform Research Work Programme*, DfID Social Development Department (available online Summer 2001)

Summary from the FAO's SEAGA package of how to develop country-specific indicators to achieve equity and health goals.

UNIFEM, 2000, *Progress of the world's women*
www.unifem.undp.org/progressww/2000/preface.pdf

Concentrating on the economic dimensions of gender equality and women's empowerment in the context of globalisation. Chapter 3 discusses how to link gender equity targets with indicators.

3.2.6 Checklists and logframes

In print:

Kettel, B., 1996, 'Women, Health and the Environment', *Social Science and Medicine*, Vol 42 No 10: 1367–79

Presents a conceptual framework for gender-sensitive research and policy analysis that centres on women's interaction with the biophysical environment and the implications of this for environmental health. This framework is based on Roundy's model of human behaviour and disease hazards in Ethiopia. The model divides a settlement into activity spheres which begin with the individual cell at the centre surrounded by a series of concentric circles representing the compound, settlement, production area and further ranging areas of contact. The model also differentiates different behavioural systems which take place in these activity spheres including: family interaction, socialising, religious activities, water use, animal contact, trade, and primary production. Women and men carry out different activities in different spheres, leading to different risks of ill health.

Online:

AVSC, *What is COPE?*
www.avsc.org/quality/qcope.html

COPE (Client-Oriented, Provider-Efficient services) is a technique to simply assess quality of care. This web site provides information about the COPE tools, which include various questions and frameworks, self assessment for providers and client-interview guides.

Australian Agency for International Development (AusAID), *Guide to gender and development to facilitate gender planning in AusAID development programs*,
www.ausaid.gov.au/publications/pdf/guidetogenderanddevelopment.pdf

It is intended to be a tool to help activity managers and contractors effectively implement AusAID's Gender and Development Policy. Includes series of checklists and guidelines for the health sector

Danish International Development Agency (DANIDA): Health care projects Women in Development (WID) Checklists.
www.um.dk/udenrigspolitik/udviklingspolitik/evaluering/1996-6-3/1996-6-3.annex3.html

This is a very comprehensive checklist covering all stages of the project cycle: WID in project identification and preparation, project implementation, monitoring and evaluation and project analysis. It covers women as mothers, producers, health care practitioners and community members.

3.3 Examples of tools

3.3.1 Gender sensitivity of health sector institutions: a checklist

Are health sector institutions – hospitals, clinics, stakeholder organisations, ministry of health – international health organisations – **gender sensitive?**

– in assessing the needs of service users?
Do they consider how men's and women's health needs differ and at all stages of the life cycle?
Do they consider how those different needs might be addressed directly?

– in assessing the ability of users to gain access to services?
Do they consider gender differences in ability to pay the costs (transport, official and unofficial fees) of using health services?
Do they consider gender differences work schedules?

– in ensuring women's voice in decision making in service delivery?
What is the gender balance of employment at national, district, regional, local levels of the health service?
Do women represent at least 30 per cent of decision-makers at all levels?
Is there gender stereotyping in employment?
Are there support networks for women and men employees?
Does the organisation of work take account of women's reproductive responsibilities (post-natal care, childcare, pregnancy, family food preparation, for example)?
What is the gender balance in community health committees?
Are there links between community health committees and community groups (men's and women's)?

– in enforcing gender aware policies in service delivery?
Is there gender balance among field staff?
Is there gender bias in the orientation of services?
Do field workers speak directly to women and men in households?
Are there links between community health centres and local women's groups?

– in ensuring gender aware policies in employment?
Have health reforms had the same impact on male and female employment levels?

Have health reforms affected male and female occupations differently?

– in determining ways of financing the sector?

Is consideration given to gender-specific implications of different forms of cost recovery such as user charges and insurance?

Elson, D and Evers, B., 1998, *Sector Programme Support: the health sector a gender aware analysis,* University of Manchester: Genecon Unit

3.3.2 Project policy orientation and project staffing

1998, *Through a Gender Lens*, Research Triangle Park, NC: Family Health International
www.fhi.org/en/wsp/wspubs/wspubs.html#anchor95315

Country context

- Does the rationale for the country's Population Health Nutrition (PHN) policies and programmes explicitly include notions of self-determination and benefits for the overall quality of life of women and children, as well as for their health?
- How well are women represented in key policy making roles affecting the national PHN policies and programmes?
- Have organised women's groups supported the family planning programme? Have these constituencies participated in policy development activities? Have the wives of policy makers been reached?
- Are there legal and regulatory barriers that differentially affect women's/men's access to reproductive health services?
- Are PHN policies supported by other policies to improve the status of women and their opportunities for education and employment?
- What level of funding is being spent on gender-sensitive and gender-focused projects?

*Management issues**

- What is the ratio of women to men employed: as health service providers; in other staff positions?
- To what extent are staff trained and informed on gender-sensitive standard operating procedures, research methodologies, service delivery practices? If this is absent, is access possible/available?
- Has the project identified the gender issues facing staff and made institutional arrangements to support change (for example, transport, flexible working hours for parents, adequate and fair wage, childcare provision, and sexual harassment complaint procedures)?
- Are the occupations and roles of female and male staff without gender stereotyping?
- If there is a gender bias? Is this recognised openly (for example, if most of the managers are men and the women are in less influential positions)?

- Are women represented sufficiently in leadership structures, and if not, is there an organisational objective to achieve gender-equitable representation?

* While designed for staff at the field level, it could prove fruitful to explore these questions at the donor and implementing agency offices as well at the project level.

Commitment to gender equity

- Are staff self-aware about the social context within which they work, specifically with regard to:
  - girls' and women's social status, level of choice in partner selection, access to social structures outside the family (such as education and credit)?
  - sexual norms and behaviours, control of resources, partnership patterns, inheritance patterns, level of gender-based violence?
- Do most project personnel believe in gender equity? Is this belief in gender equity expressed as a project objective or guideline?
- Is there a clear policy goal to ensure that this objective is met?
- Have gender relations and gender inequity been understood and accepted as factors influencing women's health and status, as well as development in general? Is this expressed as a project objective or guideline?
- Is there recognition that men need to take more responsibility in childcare, domestic work, family planning and sexual and reproductive health?
- Is this belief expressed as a project objective and implementation guideline?
- Are there project objectives and project activities aimed at increasing women's control over their fertility and sexual health, and men's inclusion in reproductive health issues?
- Do all of the project's promotional and educational resources depict images of women and men in non-stereotyped gender roles?
- Is the project positioned within wider local, national or regional activities aimed at reducing gender inequities and improving women's status?

Project design

Gender roles and power

Division of labour

- How is men's/women's (and boys'/girls') labour distributed by time over the day, week, season, and by type of role (reproductive, productive, community)?
- How much role conflict exists for each sex?
- How does this conflict manifest itself?
- How will the project affect this labour schedule and how can it best use it to advantage?

- Will the project increase women's workload, especially care-giving responsibilities?
- Is alleviation of women's workload a prerequisite for their full participation in the project's activities?

Decision-making

- In which spheres do women/men have direct/indirect decision-making power, both in the household and in the wider community?
- Who has ultimate decision-making authority?
- Who controls household economic resources? Which ones?
- To what extent are women included in local organisations (number of members, numbers in decision-making roles, level of participation)?
- Will the project increase women's/girls' decision-making power within their households, including resource expenditure, sexual relations, marital partner choice and age at first marriage, when and how they will bear and raise children, when and how household health needs are met?
- Will it increase their decision-making power in the wider community?
- Will it challenge their decision-making authority or that of others?

Access

- Which PHN resources do women/men have access to?
- Which are they barred from?
- What different constraints do men and women face in accessing resources (for example, social stigma, provider assumptions, community norms, cost, time)?
- Will the project improve women's and men's access to services and resources?
- Will women's access to services be restricted by lack of access to material resources (for example, fees for services or transportation)?

Control

- Which benefits do women/men get from the use of resources, including their own bodies, health, energy, money?
- Which benefits do women/men control?
- Will the project improve women's control over benefits and resources, including their own bodies, health, energy, money?
- Or is it likely to threaten their control over it?

Definition of key population

- Is the project clear that women are not a homogenous group, but are divided along age, class, caste, religious, ethnic lines?

- Is it clear that the project will benefit poorer, more marginalised women and families?
- Are different sorts of women/men/children included?
- How and to what degree are women and men involved in the PHN sector? If only men or only women play a role, should the other sex be involved?
- Why or why not?
- What is the proportion, position and specific constraints of women-headed households in the community?

Current levels of knowledge about PHN issues and services

- What knowledge do women/men have about PHN issues, including nutrition, sexuality, reproduction, family planning methods, breastfeeding, safe motherhood and/or maternal mortality, the value of girls, sexually transmitted diseases and infertility?
- What knowledge do women/men have about PHN services available in their community?
- What knowledge do women/men have about their reproductive and other health rights?
- Has the project understood the local methods used by women (and men) to safeguard physical and mental well-being?
- What form of traditional healing system exists?
- What different roles do women and men play in the system?
- How will the project tap into and affect these?

Deciding on project priorities

- What are women's/men's gender-specific health needs in the project area, as defined by the women and men themselves?
- What attempts have been made to gain a detailed knowledge of those needs? Are the areas that the project aims to address priorities for women/men?
- To what extent are women/men involved in setting research priorities in population, health and nutrition planning?
- To what extent are women and men from the key population involved in the research planning, implementation and dissemination of results?
- What are the reasons why women/men would be interested in getting involved in the project activities?
- Are any women or men likely to oppose the project? For what reasons?

Project implementation/monitoring

Project decision-making

- Are project participants (women and men) fully involved in deciding the project/programme priorities and how they will be implemented?
- Is there a community advisory committee and is it holding regular meetings?
- Is participation in advisory committees equal by socio-economic group and sex?
- Were rules developed in a participatory manner, involving all community members?
- What are the number of women and men in decision-making positions, by socio-economic group?
- Do people in leadership positions rotate regularly?

Participation/service utilisation rates

- Are data disaggregated by sex, socio-economic status and age?
- Can women/men, in practice, make productive use of health facilities and services, taking into account their workload, daily and seasonal peaks in activities, financial resources, and lack of mobility and decision-making power?
- How does the project address these constraints?
- What percentage of births in the region is attended by trained personnel?
- What are the service utilisation rates by socio-economic groups, sex, age and ethnic background?
- Are these as expected, given local demographics? Are the desired populations being reached?
- How often are clients accompanied by their partners/others and how often do they come alone?
- Are there differences in the payments made (cash or in-kind) by socio-economic grouping of household (for example, is a sliding scale fee system in place)?
- What mechanisms are in place for users of services to provide ongoing feedback?
- What means of redress exist?

Service quality

- Are the benefits from the project/programme attractive: for women; for men?
- What are the success rates of clients achieving their reproductive intentions, by socio-economic group and sex?
- How are the issues/concerns/needs of clients' partners addressed in counselling?
- Is health education planned to include discussion of the following gender issues:
  - the equal value of men and women and the need for joint decision-making and shared responsibilities,
  - women's and men's roles in family planning and reproductive health,

- women's right to good health, quality health services, freedom from violence, joint decisions about household expenditures and so on,
- women's human rights and local legal rights, especially those related to health issues,
- the dynamics of men's and women's decision making in the areas of sexuality, contraception, childbearing, nutrition and other health matters.

- What is done to maintain client confidentiality?

Project evaluation

Process evaluation

- Are data disaggregated by sex, age, social class?
- To what extent were participants' own assessments of the project used to measure its success?
- Were appropriate indicators used (or developed) to describe the situation for women and men, so as to inform project development, implementation and monitoring?
- Were women employed and trained by the project, so that women and men were able to participate on an equal basis in project activities?
- Does the project use the extent to which women's relations with men have improved (for example, cessation of violence, more independent and assertive decision making, greater knowledge of legal rights, and so forth) as an indicator of effectiveness or success?
- Are women and men treated with equivalent respect, both as participants and staff personnel?
- Are staff rewarded for providing better counselling, linkages with other services, addressing sexual and other health needs beyond family planning? Are the issues of violence and non-voluntary sex addressed?
- Have indicators or incentives for steering clients toward certain family planning methods been removed?
- Are staff well trained on all methods? Is a full range of methods available? Are clients provided with sufficient information for informed decision-making and consent?
- Are women and men treated as different audiences for information, education and communication efforts, and are they being reached with gender-appropriate messages that challenge oppressive gender stereotypes?
- What gender-related messages are included?
- Is there sufficient effort devoted to male needs, participation, methods, services and responsibility?
- What mechanisms have been used to educate male and older female family members on: the need for prenatal and postnatal care; the importance of birth spacing; the value of daughters; the benefits of breastfeeding?

Impact on gender equity

- Has the project improved women's access to and control over PHN services and infrastructural facilities? How? What new services exist?
- What impact has the project had on relationships between men and women?
- Has the project increased women's ability to carry out their decisions in a sustained way within their households and the wider community?
- Are men more involved in: family planning; family life? Are they more supportive and safeguarding of women's and children's health, as well as their own?

Impact on health

- Has the project or activity improved women's and men's health? Their level of knowledge?
- How has the project enhanced women's and men's roles as health care providers? What impact has this had on male and female clients' access to health care advice and services and their perception of the quality of these?
- Have objective measures of quality improved?
- What are the continuation rates, by age, socio-economic group and sex? To what extent do male and female clients feel they are meeting their health care needs?

Impact on policy

- Has the project strengthened linkages between research/OR/service evaluation findings on gender issues and the formulation of PHN policies?
- Have policies been revised based on those findings?
- What gender-related process and outcome lessons have been disseminated to key decision makers at: the implementing organisation; local, national and regional organisations and governing bodies; international donor agencies?
- What, if anything, has changed as a result of these efforts?
- Has the project had an impact on the extent to which the implementing agency integrates a gender perspective into their policies and procedures?
- What information has the project given policy makers to show that taking gender issues into account contributed to its success?

3.3.3 Monitoring checklist for client exit interviews

Client-perspective quality of care data will be collected through semi-structured interviews at the point of delivery of service for women clients, and at the community level for male clients (few men receive services from static service delivery points [SDPs]).

Choice

With whom did the client discuss her decision to use family planning?

With whom did she discuss her method choice?

At the time the client accepted the method, was there another method that she would have preferred to use? If so, why was she not able to use the method preferred?

Why did she choose to go to her current service provider?

Acceptability and accessibility of services

How long does it take the client to travel to the service provider?

How long does the client usually have to wait to receive the service she needs?

How does the client feel about the amount of time she needs to wait?

Has the client ever been told to come back again because the provider or choice of method is not available?

Has the client ever had a physical examination? How did she feel about being examined?

Has the client ever used another service before (e.g. private/government provider) and if so why did she change to this one?

Does the client feel she has been given enough privacy?

How could the service be improved?

Cost of services

How much does it cost to travel to the service provider?

Was the client charged a fee for the service? If so, how much?

Does the client feel the charge is reasonable? (Prompt using comparison with cost of basic item of food or cost of preparing a meal.)

How do the costs incurred in using the current service delivery outlet compare to others

Acceptability and quality of provision of contraceptives

What has the client heard about different family planning methods? From whom? (Prompt for effectiveness of counselling.)

Has the client ever used any other method? If so, why did she decide to change method?

With whom did she discuss her decision to change method?

Has the client experienced any problems using her current method? If so what did she do? If not, what would she do if she did experience a problem?

Does the client know when to come back for her next appointment?

Information provided to clients

From where (through which of the media) did the client obtain her information on family planning? What is her preferred medium?

Does the client have any questions regarding the method she is using?

Does the client understand the information that has been given by the provider? (Prompt for communication and client-provider relations and lead into the next set of questions.)

Client–provider interaction

Does the client feel able to ask the provider questions?
Are there questions that the client feels she cannot ask?
Does the client perceive the level of knowledge of service providers to be adequate?
Does the client consider her confidentiality is respected by the provider?
What are the most important qualities in service providers identified by the client (e.g. age, attitude, sex, marital status, educational status)?

Identification of needs

Has the family planning client received information about STD/HIV prevention when she or he received family planning services?
Does a family planning client know where to get STD screening and treatment services?
Are there any perceived difficulties in obtaining those services?
Would the family planning client wish to talk to service providers about any other problems? If so what are these problems?

Source: Taken from Kirstan Hawkins, 1996, 'Participatory design and monitoring of reproductive health projects', *Resources in Social Development Practice*, Vol 1 March, Centre for Development Studies, University of Wales Swansea. Commissioned by Social Development Department, DfID.

Contact: University of Wales Swansea, Swansea SA2 8PP, United Kingdom.
Tel: +44 (0) 1792 295877. Fax:+44 (0) 1792 295682. E-mail: h.lewis@swansea.ac.uk.

3.3.4 Indicators of women's health and nutrition

www.worldbank.org/gender/tools/sectoral.htm

Using the following indicators, policymakers will be able to assess the current status of females' health and see where the need for targeted interventions is highest. They can also monitor both the progress and outcome of national programmes. Please note that these indicators are largely focused on reproductive health.

Indicator	Measure	Interpretation	Source
Infancy and Childhood			
Female infant mortality rate	The number of female infants who die before the age of one per 1,000 female infant births in a given year	High levels reflect problems related to childbirth and/or inadequate care of female infants	Hospital or clinic records, vital registration
Female child morality rate	The number of deaths among girls aged 1 to 4 in a given year per 1,000 female children in that age group at the mid-point of that year	This indicator is of particular significance when compared to the rate for male children since it is an estimate of socio-economic and cultural factors that may overcome the biological advantage of girl children	Community survey, hospital or clinic records, vital registration

Immunisation coverage ratio	Ratio of female infants to male infants covered by immunisation (for all six major childhood diseases as recommended by WHO)	A ratio of less than one (after adjusting for expected numbers in an age group) suggests discrimination against female infants	Community survey, hospital or clinic records
Nutrition status	% of girls with protein-energy malnutrition as measured by:	A high % of girls with protein-energy malnutrition suggests inadequate access to food and/or strenuous physical activity	Community survey, hospital or clinic records
	• weight for height % of girls with protein-energy malnutrition as measured by:	Wasting – indicates acute malnutrition	
	• height for age	Stunting – reflects chronic malnutrition, especially in early childhood	Community survey, hospital or clinic records
	• weight for age	This is the most common indicator for malnutrition. It is a composite of weight for height and height for age	Surveys hospital records, interviews with key informants
Adolescence			
Prevalence of adolescent pregnancies	Proportion of young women who become pregnant before age 19	Relevant for the identification of pregnancy complications because of the mother's physical and psychological immaturity. Such problems are compounded if the woman is unmarried	Hospital or clinic records
Contraceptive usage	% of sexually active adolescents who use family planning	Indicates patterns of sexual behaviour, knowledge and access to contraception	Hospital or clinic records
STD prevalence	% of adolescents who contract an STD	Indicates patterns of sexual behaviour, degree of female negotiation power, use of barrier methods, and access to health services	Focus groups, surveys
Prevalence of traditional practices harmful to adolescent girls	% of female adolescents who have been subjected to genital mutilation	Suggests discrimination against females, and deleterious social and cultural attitudes towards women	Community survey, focus groups
Abortion prevalence	Proportion of adolescents who have had an abortion	Indicates access of adolescents to contraception, appropriate counselling and sex education	Community survey, hospital records, vital registration
Reproductive age group			
Maternal mortality ratio (MMRatio)	The annual number of deaths per 100,000 live births. Maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its mismanagement but	Often erroneously referred to as maternal mortality rate. It represents obstetric risk. Interventions that improve obstetric outcomes will reduce the ration	Community survey, vital registration, hospital records

	not from incidental or accidental causes		
Maternal mortality rate	The number of maternal deaths per 100,000 women of reproductive age (usually taken as 15 to 45 years or 15 to 49 years)	Includes obstetric risk and risks of pregnancy (abortions, ectopic pregnancies). Interventions that affect fertility and obstetric outcomes will alter the rate	Community survey, hospital records
Low birth weight	% of infants born in a particular year who weigh less than 2500 g at the time of birth	Useful as an indirect measure of maternal malnutrition. Low birth weight is caused by either short duration of gestation, retarded intrauterine growth, or both. Among the major factors contributing to poor intrauterine growth are low caloric intake or weight gain during pregnancy and low pre-pregnancy weight	Community survey, hospital records
Total abortion rate	The number of abortions (all types) expressed per 1,000 women of reproductive age	Useful as an indicator of the success of contraceptive services in meeting the needs of women. However, reliable information on abortions (particularly unsafe abortions, which have the most serious impact on women's reproductive health) is difficult to collect	Community survey, hospital records, focus groups
Total fertility rate (TFR)	The number of children a woman would have at the end of her repro life if she survived to that age and experienced a given set of age-specific fertility rates is calculated by adding the age-specific rates for a given year	Indicates average family size; related to the role of women and reproduction, and access to family planning	Census survey, vital registration
Lifetime risk of death (LTR)	The cumulative risk of death from motherhood: LTR =1 - (1 - MMRatio) TFR	Indicates risks associated with each pregnancy and number of times a woman becomes pregnant	Survey, vital registration
Utilisation of health services	Proportion of women with access to maternity care (within one hour walk or travel time). Proportion of women who received any prenatal care from trained medical staff. Proportion of women who received pre-natal care before 20 weeks and/or after 38 weeks. Proportion of pregnant women who received tetanus-toxoid immunisation. Proportion of pregnant women who took iron and folate supplementation. Proportion of pregnant women who were referred and accepted referral. Proportion of women who received postnatal care from	Indicates availability and accessibility of health services, women's perceptions of reproductive risks, cultural and social conditions, socio-economic status	Census, survey

	trained medical staff % of pregnant women who are anaemic (moderate = 7 - 11 g/dl; severe = <7 g/dl)		
Reproductive health status	% of women gaining less than 1kg per month during second and third trimester of pregnancy	Indicates level of maternal nutrition (both before and during pregnancy), risks to mother and baby, and dietary practices	Community survey, hospital records
Quality of care	% of complications diagnosed during prenatal surveillance. % of health facilities able to perform caesareans. Mean waiting time at prenatal clinics % of women who understood treatment received % of women satisfied with treatment % of women who delivered in an institution and who were told about family planning methods. Ratio of midwives to population. Prevalence of postpartum infections acquired in a hospital or medical facility	Indicates regional and national level of health services, health provider training, health worker values, government commitment	Observations, hospital records, interviews with patients and providers
Quality of care	Proportion of health workers able to perform life-saving obstetric functions. Knowledge, attitudes and practices of health workers toward reproductive health Beliefs and attitudes of health workers and traditional birth attendants regarding problems with birthing, pregnancy danger signs and responses	Indicates regional and national level of health services, health provider training, health worker values, government commitment	Observations, hospital records, interviews with patients and providers, maternal mortality committees
Wantedness of pregnancy	Proportion of pregnancies not intended Desired family size	Can indicate the influence of cultural and religious values, role of the woman in the family and the community, and coverage of family planning services	Surveys, interviews with patients and providers
Availability of quality services	% of women with access to family planning and safe abortion services % of women who receive contraceptive counselling after an abortion Proportion of health providers skilled in providing family planning and abortion services Knowledge, attitudes and practices of health workers regarding contraception and abortion	Reflects coverage and quality of family planning and abortion services	Surveys, interviews with patients, providers
Prevalence of STDs	% of women who are diagnosed as having an STD	Suggests patters of sexual and contraceptive behaviour, degree of female negotiation power, access to health services.	Community survey, clinical records

STD treatment	% of women diagnosed with an STD who completed the prescribed treatment % of partners of women who are diagnosed with an STD who report for testing	Indicates women's perceptions about and degree of understanding of treatment, and adequacy of treatment in the community	Hospital or clinic records
STD prevention activities	% of population at high risk (sex workers, migrant labour) who use condoms during sexual contact	Indicates adequacy of education campaigns in reaching target population	Focus groups, interview of key informants, survey
Reproductive tract infection (RTI) proportional morbidity rate	Proportion of total infertility cases attributable to RTIs	Suggests the magnitude of complications and consequences from RTIs	Hospital or clinic records
HIV and AIDS prevalence	% of population sero-positive for HIV infection	Indicates the potential magnitude of the AIDS problem in a community	Anonymous testing of target population
STD and AIDS prevention awareness	% of sexually active adults who know how to avoid acquiring STDs and HIV infection (abstinence, condoms, monogamous relationships)	Indicates the effectiveness of education programmes	Community survey
Cervical cancer screening	% of women over 35 years who have had at least one Pap smear	Indicates degree of coverage of vulnerable group	Hospital, clinic or programme records, surveys
Breast cancer screening	% of women over 50 who have had a breast examin-ation by trained medical staff	Indicates degree of coverage of vulnerable group	Hospital, clinic or programme records, surveys
Violence against women			
Prevalence of gender- related violence in the community	% of women beaten by an intimate male partner	Indicates magnitude of the problem	Community-based surveys
	% of women presenting to health facilities with trauma attributable to domestic violence. % of reported rape cases prosecuted; % of rape prosecutions resulting in conviction	Indicates magnitude of the problem	Hospital or clinic records
	% of reported rape cases prosecuted; % of rape prosecutions resulting in conviction	Indicates level of state effort to address the problem	

Source: Anne Tinker, Patricia Daly, Cynthia Green, Helen Saxenian, Rama Lakshminarayanan, and Kirrin Gill, 1994, 'Women's health and nutrition: making a difference', *World Bank Discussion Paper* No 256, Washington, D.C.: World Bank

3.3.5 FAO's SEAGA: minimum requirements for identifying problems, planning programmes and evaluating progress toward meeting health goals

www.fao.org/sd/seaga/

Within most countries, basic health indicators are usually available. As a policy maker at the national level, one of the most important questions you can ask in reviewing existing data is whether the data are truly representative of all the populations within your country, including women, ethnic minorities, and those residing in rural areas.

In many cases, data are collected on the most accessible populations, which are usually not the most vulnerable populations in need of health and development services. Populations that are geographically remote, lack health services, or are ethnic minorities speaking languages other than the official national language are usually under-represented in national data. Non-representative data distorts the picture of health conditions in the country as a whole.

The following outlines a strategy for developing country-specific indicators to use to diagnosis problems and monitor progress toward achieving health goals. It is important to involve stakeholders at every step of this process.

1. Identify existing health and nutrition data

In many countries, external consulting groups and NGOs have conducted regional and/or national health and nutrition surveys. Results of these surveys can be made available on request. As a first step in reviewing existing data, meetings which bring together the various organisations (stakeholders at the intermediate level) interested in health and development are recommended (e.g. ministries of health and education, WHO, UNICEF, NGOs). These co-ordination meetings can facilitate the review of existing data, identify data limitations, and provide guidance for the design of future health data collection efforts.

2. Develop a regional and national sampling scheme for collecting representative health data

Methods for collecting data that proportionally sample all populations of the country need to be developed. In some countries, national sampling schemes for health already exist. Representatives of WHO, UNICEF, and NGOs can be helpful in identifying what currently exists, and how to access this information. Where national sampling schemes do not exist, representatives from local universities (e.g. demography, sociology and epidemiology faculty) or from international organisations can identify individuals who are trained in and skilled at developing sampling schemes.

3. Develop a list of health indicators

To make the necessary links between health, education, environment and development issues, there is a need for both quantitative and qualitative data. Both health outcome variables (e.g. nutritional status of

children, female mortality rates, population growth rates) and client-based data on access, utilisation, and satisfaction with existing health services are needed.

UNICEF and the Demographic and Health Surveys Programme collect and publish basic health indicators from more than 40 countries around the world. The Demographic and Health Surveys Programme has compiled a list of variables which they routinely collect. These variables relate health variables to other key sectors, such as education, poverty eradication and socio-cultural systems. The following is a list of health variables to consider when designing national data collection systems for the purpose of guiding health policy development.

Basic health indicators

- under 5 mortality rate
- infant mortality rate
- total population
- crude birth rate
- crude death rate
- maternal mortality rate
- total fertility rate (mean number of births per woman 15–49 years)
- GNP per capita
- life expectancy at birth (total, and females as a percent of males)
- percentage of children 12–23 months who are fully vaccinated
- percentage of households without access to piped water
- percentage of households without access to toilet facilities

Women's health

- marital status and prevalence of polygymous marriages among women ages 15–49 years
- age at first marriage
- age at first sexual intercourse
- age at first birth
- duration of childbearing period
- number of years women 15–49 years spend with a child under age 6 years
- percentage of currently married women ages 15–49 years in at least one high-risk birth category (mother too young, too old, has had ≥ 3 births, had a previous birth ≤ 24 months ago)
- percentage of births receiving medical care (prenatal and during delivery)
- contraceptive knowledge, women ages 15–49 years
- contraceptive use, women ages 15–49 years

- violent crimes against women, including domestic violence

Nutrition

- percentage of infants with low birth weight
- percentage of children 0–3 months who are exclusively breastfed
- percentage of children under five suffering from:
  - moderate and severe underweight
  - moderate and severe wasting
  - moderate and severe stunting
- daily per capita calorie supply as a percent of requirements (stratified by sex, rural/urban, and race/ethnicity)

4. Develop method for routinely collecting health data

Once past the point of diagnosing the problem, a system for routine data collection is needed to monitor progress toward reaching a country's stated health goals. Routine data collection can take the form of:

- national surveillance system for key health outcomes,
- periodic (every five years) surveys of randomly selected households throughout the country,
- yearly review and publication of birth and death registry data,
- yearly review and publication of data collected at local health clinics.

In addition to the above quantitative methods for monitoring progress, qualitative information on perceived health needs, access to and utilisation of health services, and satisfaction with existing health services should be collected. These data should be disaggregated by sex and by rural/urban location, and be representative of the different ethnic and linguistic groups in the country. The combination of quantitative and qualitative data is the most informative to policy makers seeking to develop programmes that truly integrate health.

3.3.6 CIDA guide to gender-sensitive indicators in the health sector

Background

Making sure that primary health care is available is a central task in health interventions and especially important for women and girls. As an example of how such an initiative can be evaluated, these CIDA guidelines have been developed in the context of a WID-specific health project whose principal focus is 'safe motherhood', i.e. prenatal care and delivery, postpartum care, and family planning services.

Project objective

To promote women's access to essential health services, so that infant, child, and maternal mortality and morbidity rates are reduced to the national average within five years.

Project components

- To train and upgrade the skills of 300 birth attendants and primary health care providers. These would be drawn mainly from women in the community, and their roles include:

a) providing advice and counselling on basic health care;
b) diagnosing reproductive-related and other health or injury problems, and prescribing limited treatment;
c) providing essential medicines and immunisations;
d) referring serious complications to regional hospitals;
e) hearing and reporting complaints about domestic violence and abuse, and
f) collecting information and data on health in the community.

- Information, education and communication are required to generate a demand for health services and family planning for women and men. Fifty per cent of the stakeholder population, of whom at least 75 per cent will be women, will receive information about local health services. This should ensure sustained access to local services.
- Women will be provided with greater access to more advanced medical technologies and more skilled health personnel. To do this, a mobile health clinic will be set up, which will visit the community according to the schedule convenient to women.

Following is a list of risk/enabling, quantitative and qualitative indicators that would be used through the project cycle.

Risk/enabling indicators

- Women from the community have an interest in the project and are willing to participate.
- Women are interested in being treated by more advanced medical technologies.
- Local men support the project.
- Local elites support poor people's access to the resources provided.

Input indicators

- number of health workers trained
- number of buildings used as clinics, and their condition

- instructional material and its gender make-up
- amount of medical supplies and equipment provided
- provision of mobile clinic

Process indicators

- regular meetings of women and health care workers
- degree of education, counselling, and information provided. Feedback on this information by women
- number of visits to mobile clinic, by sex of mother and child
- views of activities of health workers and clinic parents
- on-going data on health status

Out-put indicators

- number of immunisations and vaccinations
- satisfaction with services by mother, and training health personnel

Outcome indicators

- reduced infant, child and maternal mortality and morbidity rates as compared to the national average within five years

4 Lifespan perspective in gender and health

4.1 Introduction

A lifespan perspective in gender and health helps to understand the differences in health needs between the sexes according to the way men and women age. Addressing the link between health across the life cycle and gender issues enables the identification of the socially constructed roles of women and men and their quality of life during their ageing process.

Young women are especially vulnerable to sexual and reproductive health (SRH) related problems such as abortion, STDs and HIV, and are four times as likely as women older than 20 to die from pregnancy-related causes. Adolescent mothers are more likely to experience premature labour, spontaneous abortion and stillbirths. At the other end of the life cycle, gender analysis is critical to ensure the well-being of the elderly. Not only can they be a vulnerable population, primarily unemployed and often poor, but women due to their longer life expectancy represent more of the elderly. Hence, these elderly women must face both age and gender discrimination. They are less likely to remarry after being widowed and more likely to live alone than are elderly men of their age.

The identification of groups of both men and women that are marginalised, exploited or abused as a result of their gender, class, age or ethnicity is important. Cultural, religious and legal restrictions are different for men and women and may also have direct implications for their health. Women are often prevented from full participation by those restrictions placing them in the weaker position. Equally important is to develop mechanisms to actively involve the marginalised segments in society in decisions that affect their lives and enable them to gain self-confidence and a sense of self-worth.

The type of questions that could be asked:

- Who are the powerless groups that are particularly discriminated against and in what ways does the discrimination and/or lack of power affect their health?
- What kind of disparities can be identified between men and women, boys and girls?
- Do these disparities affect differently the health and well-being of men and women, boys and girls?
- What kinds of health disparities exist between different social groups and between women and men within those groups?
- Do women need permission from husbands, fathers, mother-in-laws, brothers or others to be able to use the health services?
- What type of resistance exists to improve the inclusion of marginalised groups or to change damaging gender stereotypes that result in health disparities between men and women?
- Are women and girls discriminated against in terms of access to health care? If so, what are the reasons for this, and how can this discrimination be overcome?
- What percentage of health personnel are women at the different levels of the health system?

- How are gender disparities among health professionals addressed?
- What are the gender disparities in participation in health care work, including unpaid health care work within the household and the community?
- If mortality and morbidity rates differ between men and women, what is the reason for this?
- What are the major causes of infant and child morbidity and mortality in girls and boys?
- What cultural and other obstacles are there to women and girls receiving health care and family planning services?
- Is abortion legal? What are the services available in practice?
- Have any programmes been introduced to combat AIDS, and have any of these programmes been developed with a focus on women's vulnerability?
- Is intra-household distribution of food biased against women and girls? If so, what are the reasons for this?
- Do women spend more on food than men? If so, what are the implications of this?
- Does access to sanitation and clean water differ by sex? If so, what are the implications of this for women's health?
- What type of violence do women and men experience?
- What cultural definitions influence masculine identity and men's agency in violent and conflict situations?
- What are the effects of public violence on women's and on men's health?
- What are the more recurrent self-destructive tendencies for men and women?

Case studies:

- Guidelines for reducing maternal mortality
- Fathers Incorporated: men's reproductive health project, Jamaica

Resources:

- Gender and health across the life cycle
- Adolescent girls
- Mothers
- Widows
- Adolescent boys
- Men
- Fathers
- Older men and women

Case study 4 Guidelines for reducing maternal mortality

Ensure that all pregnant women have access to appropriate maternal health care, including emergency obstetric care

Every pregnancy is risky. It is essential that *all* women have access to quality emergency obstetric care *wherever* they live and that referral systems and transportation are available, even in the most isolated areas. This is a priority for reducing women's risk of death and disability during complications. The commitment from a government to reallocate resources to achieve this is a demonstration of the value placed on women's lives.

At least 35 per cent of women in developing countries receive no antenatal care during pregnancy, almost 50 per cent give birth without a skilled attendant and 70 per cent receive no postpartum care in the six weeks following delivery.

Overcoming barriers to women's access to health services

Safe motherhood programmes need to tackle a range of different barriers, which include:

- **no physical access** to services in rural areas, particularly during certain seasons, due to poor road conditions and lack of vehicles. In Senegal between July and October rain paralyses transportation on mud roads, which may explain why haemorrhage occurs 1.7 times as frequently and uterine rupture 3.5 times as frequently during these months;
- **high costs** not only of treatment, which may in fact be low or non-existent, but also of transport, drugs, and other expenses such as lodging and food. If a woman has her own independent source of income she is less dependant on others to cover these costs. In most cases, where the cost of services have been increased their use by women has declined;
- **poor information** can mean that women and key decision-makers, such as their husband or mother-in-law and other community members do not know how to recognise, prevent or treat pregnancy complications, or when and where to seek medical help. In Ghana, 64 per cent of women who died of pregnancy complications sought help from a traditional healer before going to a health facility. The main reasons for not seeking hospital care were cost and the belief that the woman was not ill enough;
- **cultural norms** and preferences which may conflict with formal health services, e.g. requirements for privacy, modesty and attendance by females. The Saraguro Indians in Ecuador shun affordable, accessible maternity care because they feel that hospitals violate women's privacy during childbirth and because many health providers are men.

Educating communities about harmful traditional practices

This is particularly important with key members such as husbands and mothers-in-law who have control over the behaviour of young women, regarding such things as:

- food taboos during pregnancy and after birth that may deny the mother and child of essential nutrients;
- food allocation biases that give females less nutritious and smaller amounts of food than men, which can influence the health of pregnant women and lead to low birth weight babies;
- beliefs that colostrum is bad and that breastfeeding should only begin after a delayed period;
- the dangers of traditional birth practices, e.g. the use of cow dung or other substances on the umbilical cord which can cause infection and tetanus; and concepts of pollution which may cause the neglect of the needs of postpartum mothers at a time when they are very vulnerable to health problems.

Empowering women to make decisions regarding their own health

Analyses of causes of maternal mortality need to focus on processes of decision-making related to reproductive health behaviour and access to health care, both at the household and community level. It is important to understand how household and community power structures affect decisions, and how this can lead to delays in seeking treatment, or denial of care. There are many examples of situations where pregnant women in dire need of emergency treatment have not been able to access it due to the absence of their husband, from whom they must seek approval either in accordance with law or social norms. This often leads to tragic outcomes. Political commitment is necessary to change such gender-biased laws and norms. It is essential that women be empowered to make their own choices and decisions regarding their health needs, and to seek services with confidence and without delay.

In Bangladesh, it is usually the mother-in-law and husband who make the decision to seek (or not seek) care, and yet they are least likely to know about pregnancy-related complications and their possible fatal consequences. Cultural norms also restrict women's freedom of movement and do not allow them to be in the company of men outside their immediate family, creating barriers to accessing services.

Useful sources of information on safe motherhood

Much of the information provided here has been taken from two very good websites on safe motherhood:

www.safemotherhood.org

www.familycareintl.org

Case study 5 Fathers Incorporated: men's reproductive health project, Jamaica

Location

Kingston, Jamaica.

Duration/history

Began in spring 1997 with a conference for young fathers where issues were identified and ways forward were suggested.

Aims

The goals are to change the local stereotype of male parental and sexual irresponsibility, and to encourage men's contribution to parenting. The organisation seeks to provide the means for urban and semi-urban working class young men (between ages 16 and 40) to build a positive self-image by addressing real-life problems.

Design rationale

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. However, with increasing 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 domestic violence has increased as men feel a loss of economic and political control and seek to reassert their hold within the home. This can lead to alcohol and drug abuse, and the breakdown of the family, resulting in increasing numbers of women-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. Action is necessary to overcome the false negative stereotypes about young fathers, which are based on real social problems. These must be addressed if the stereotypes are to be successfully overcome. The Fathers Incorporated community organisation was formed to tackle these issues and to address specific male sexual health needs related to relationships, fatherhood, safer sex behaviour and prostate cancer.

Strategies

Target young men through peer counselling, training workshops, and advocacy. Involve young men in decision making and action.

Gender component

Address problems of men's refusal of parental responsibilities, which causes problems for women and children. Address lack of child maintenance and wife beating, which result from unsustainable relationships, casual and unprotected sex, multiple partnerships and refusal to use contraceptives. Facilitate workshops on gender relations, sexuality and post-puberty growth and development.

Innovative approaches

Peer activities; training workshops focusing on male reproductive health and responsibility; community-based interventions; participatory learning approaches. Group learning exercises which take a participatory learning

approach to develop an awareness of the problems that condition men's reproductive health issues as well as a shared understanding of the issues. These result in suggested solutions by participants.

Challenges

High unemployment among men; barriers to young men's access to education and skills training; widespread use of hard drugs; excessive crime and gun violence, influenced by a gun culture which urban young men find appealing; intense peer pressure to show-off masculinity and heightened sexual potency.

Outputs

Co-operation with other local sexual and reproductive health organisations; supporting access to education and skills training; providing parental guidance and a positive masculine image for peers and younger boys; involvement of young men as peers in counselling and leading workshops; providing knowledge of male reproductive health and gender relations; offering advocacy and training for other community-based organisations and skills-development agencies.

Achievements/implementation progress

Raising morale and self-image of young men; providing positive masculine images; influencing change of attitude toward sexual behaviour and fatherhood; raising awareness among young men about gender relations and reproductive rights and responsibilities; involvement in local education with training workshops on sexuality and reproductive health; developing young men as active fathers and community leaders; directing young men to education and skills development; increasing participation of young men in parental activities.

Conclusions/lessons learned

Fathers Incorporated provides a model for successful involvement of men in reproductive health because of the participatory approaches taken in workshops and the use of peer counsellors and educators. Their focus on men's issues and the wider social concerns that affect men's reproductive health is an innovative gender component that impacts on wider male-female relations.

Contacts

Fathers Incorporated, 56 Old Hope Road, Kingston 5, Jamaica, West Indies
Tel: 1 876 927 3590
Dr Barry Chevannes, Dean of Social Sciences Faculty, University of the West Indies, Mona, Kingston 6, Jamaica, West Indies

4.2 Resources

4.2.1 Gender and health across the life cycle

In print:

WHO, 1992, *Women's Health: across age and frontier*, Geneva

A global perspective of the issue of gender and health equity across women's lifespan, from discrimination against the foetus to the health problems of older women. Covers childhood discrimination (nutrition, etc.), adolescence (reproductive health (RH) and gender differences of the effects of alcohol and drugs), occupational health, sex-specific differences in disease and infections, violence and mental health.

Online:

Gender and life cycle approach to reproductive health

www.fao.org/DOCREP/x0257e/x0257e02.htm#P70_11139

Comparison of male and female experiences of social structure and gender systems at different ages produced in detailed table form.

4.2.2 Adolescent girls

In print:

Hulton, L., Cullen, R. and Symons, W., 2000, 'Perceptions of the risks of sexual activity and their consequences among Ugandan adolescents', *Studies in Family Planning*, Vol 31 No 1: 35–46

Single-sex focus group discussions conducted with Ugandan adolescents found that knowledge of safe-sex behaviour and reported behaviour have little in common and that the fundamental barriers to behavioural change lie within the economic and socio-cultural context that moulds the sexual politics of youth. The imperative to explore ways by which young women might achieve status and identity and acquire material resources by means not related to their sexuality is highlighted.

Online:

Adolescent Pregnancy Prevention

www.ncemch.org/RefDes/Kpadolpreg.html

US-focused meta-site that does, however, have a wealth of information, links to other sites and a bibliography.

Captive Daughters
www.captive.org/

Site of NGO working to stop the sex trafficking of girls, with links to other sites, organisations and research.

CEDPA, 1996, *Choose a future! issues and options for adolescent girls*
www.cedpa.org/publications/trainingpub.htm

A training manual of participatory activities to use with young women to encourage them to explore the different option in their life, and strategies to deal with difficult situations. Field-tested in India, Nepal, Nigeria, Egypt, Ghana, Mexico and Uganda, the manual contains 12 modules with stories, games, crafts and other adaptable activities.

FOCUS on Young Adults
www.pathfind.org/publications.htm

Site includes four-page briefs on over 20 selected issues in young adult reproductive health in English, Spanish and French, with extensive references. Plus a selection of best practice case studies including social marketing, IEC, scouting, social action networks, integrated RH and business training, information, education, communication. A series of key elements papers highlight the most relevant research and evaluation in the following areas: school-based programmes, outreach programmes, health facility programmes, social marketing and mass media.

International Centre for Research on Women, 'Adolescent girls' livelihoods'
www.icrw.org

ICRW carried out a range of work on adolescent girls, with a special focus on examining how reproductive health relates to livelihood issues. The site contains information about the programme and details of key resources on adolescent livelihoods.

Prime, 'Client–provider interaction and adolescent RH care in Ghana'
www.intrah.org/prime/ghanasdl/

Prime, in a joint effort with the Ghana Registered Nurse Midwives Association has implemented a self-directed learning programme to improve the client-provider interaction between midwives and adolescents. Preliminary results show improved communication with clients and greater professional interaction amongst midwives.

WAGGS (World Association of Girl Guides and Girl Scouts) Health of Adolescent Refugees Project:
www.wagggsworld.org/projects/harp.html

Details of this innovative project that is being implemented jointly with Family Health International in Uganda, Zambia and Egypt. Adolescent girls in refugee situations are in great need of health

information and services and the WAGGS project starts by teaching the girls about a range of health issues and then challenging each girl to reach 25 of her peers. Boys are now demanding their own version of the project and the number of girls seeking RH care has increased.

4.2.3 Mothers

In print:

Koblinsky, M., Campbell, O. and Heichelheim, J., 1999, 'Quality of care: what does it mean for safe motherhood?', *Bulletin of the World Health Organization*, Vol 77 No 5

Ten years on from the Safe Motherhood Initiative what strategies have been found to reduce maternal mortality rates? The bulletin analyses countries where MMRatios have dropped to under 100 per 100,000 and what common features they have. Strong political support from health ministries, long-term planning, co-ordination between different levels of care, accountability of local officials and free referral to specialist services were all found to be deciding factors.

Oxaal, Z. and Baden, S., 1996, 'Challenges to women's reproductive health: maternal mortality', *Bridge Briefings on Development and Gender* No 38, Brighton: Institute of Development Studies

Extensive review of materials relating to maternal mortality, from statistics, to medical causes, to the socio-economic, cultural and political factors affecting maternal outcomes. Final chapter looks at short-term and long-term strategies, along with the cost effectiveness of safe motherhood strategies.

Online:

UNICEF site

www.unicef.org/programme/health/document/mexeng.pdf

'Women-friendly health services – experiences in maternal care.'

4.2.4 Widows

In print:

Chen, M., 1998, *Widows in India: social neglect and public action,* London: Sage

Analysis of health and well-being of widows including their high morality rates. Details of programmes working to combat the discrimination faced by them, including work by the Self-Employed Women's Association (SEWA).

Owen, M. 1996, *A World of Widows*, London: Zed Books

Excellent coverage of health issues facing widows, including details of programmes working with widows with AIDS, sex and sexuality, child widows, widows and pregnancy, STDs, etc. Situation of widows in relation to international conventions, access and equity.

Online:

Empowering Widows in Development (EWD)

www.oneworld.org/empoweringwidows/

Online resource of UK based NGO, has sections on worldwide development in law and policy concerning widows; widows' organisations; excellent country case studies including Mozambique and India.

Girl widows

www.oneworld.org/patp/pap_7_3/owen.htm

Special issue of the online magazine *People and the Planet* dedicated to the girl child, with an article on girl widows.

4.2.5 Adolescent boys

In print:

Barker, G., 1999, 'Listening to boys: some reflections on adolescent boys and gender equity', paper presented at the AWID Conference panel on Male Involvement in Sexual and Reproductive Health: Hindrance or Help to Gender Equity? 12 November

From research done with boys, the author discovered that promoting gender equity in adolescence may be more effective than in later life, as young men are more willing to consider alternative models. Boys who did hold a gender equity perspective were found to have a family member or friend who modelled and supported non-traditional gender stereotypes.

Online:

Boyd, B. and Moore, C., 1998, *Reaching young men with reproductive health programs*

www.pathfind.org/publications.htm

Recommendations for programme planning, case studies and extensive references.

CEDPA, *Choose a future! Issues and options for adolescent boys*

www.cedpa.org/publications/trainingpub.htm

A manual created with the support of UNFPA as part of its work to implement ICPD Programme of Action. Boys are encouraged to explore gender-equitable approaches to family life, and issues such as conflict resolution are explored with options for how to deal with them.

Family Planning Perspectives, 1998, Vol 24 No 1

www.agi-usa.org/pubs/journals/2403898.html

'Men as partners in RH: from issues to action' contains examples of international programmes addressing adolescent males sexual health from including education about STDs into military training in

Cameroon to encouraging participation of children in building a clinic in Uganda and thus creating a sense of ownership of the project, to counselling by retired teachers in Kenya.

4.2.6 Men

In print:

Greene, M., 2000, 'Changing women and avoiding men: gender stereotypes and reproductive health programmes', *Men, Masculinities and Development: Politics, Policies and Practice, IDS Bulletin*, Vol 31 No 2: 49–59

Looks at the implications of seeing men as problems in reproductive health programmes and concludes that this approach is less useful than one which seeks to transform gender inequities. When programmes reflect assumptions about men's role in child-rearing and their sexual demands, these very relations may be reinforced when dealing with clients, thus service providers must be conscious of their attitudes and roles.

Sweetman, C. (ed.), 1997, *Men and Masculinity,* Oxford: Oxfam Publications

Online:

AVSC's Men as Partners (MAP) programme
www.avsc.org/emerging/map/index.htm

International programme focusing on developing men's partnership with women in family planning, STDs and child-care. Includes 'Programming for male involvement in RH: a practical guide for managers'; services delivery for men's RH; details of worldwide workshops; case studies.

Family Health International, 1998, *Network*, 'Men and reproductive health', Vol 18 No 3
www.fhi.org/en/fp/fppubs/network/v18-3/index.html

Articles on male responsibility, men's reproductive health risks, male participation, influence on contraceptive use.

Harvard School of Public Health:
www.hsph.harvard.edu/Organizations/healthnet/HUpapers/gender/sabo.html
Sabo, D., 1999, *Understanding men's health: a relational and gender sensitive approach*

A gender-sensitive analysis of men's health that examines how constructions of masculinity may influence both men and women's health outcomes. Introduces the idea of positive/negative gendered health synergies where the pattern of gendered relations is associated with favourable/unfavourable health outcomes for one or both sexes. Uses this idea to look at men's involvement in pregnancy and childcare, prison, extramarital sex.

JHUCCP, 'Lessons learned and program implications for how to involve men', *Population Report* No 46, Vol XXVI No 2, Oct. 1998
www.jhuccp.org/pr/

Details of how to reach male audiences with appropriate messages: build on men's approval of family planning; use the mass media; reach out to young and unmarried men. Use communication to promote behaviour change: understand the influence of gender; encourage couple communication; bring information to where men gather. Offer information and services that men would want: inform men about condoms and vasectomy; counsel men with respect and sensitivity; offer men a range of health services.

Men's Health Network
www.menshealthnetwork.org/library/mhn_links.htm

Meta site with extensive links to sites on all aspects of men's health and well-being.

Qweb, 'Male involvement – what can be found on the Internet?'
www.qweb.kvinnoforum.se/sexuality/references.html

Links to organisations dealing with family planning and reproductive health and men's groups joining in a dialogue for non-violence.

UNFPA, 'Male involvement in UNFPA country programmes'
www.fao.org/DOCREP/x0257e/x0257e05.htm

Steps to develop a culturally sensitive approach to decision-making and service and information provision for men that can improve the quality of services without incurring a great deal of additional resources.

4.2.7 Fathers

Online:

Engle, P., 2000, *Men in families: report of a consultation on the role of males and fathers in achieving gender equality*, UNICEF
www.unicef.org/reseval/malesr.htm

A comprehensive report investigating the roles of men within families, especially the role of the father on health and nutrition programming and the relation of fathering to early childhood development that includes examples from case studies. One section explores the role of men in preventing HIV infection in young women and another details action research strategies for working with fathers.

FatherNet

www.cyfc.umn.edu/Fathernet/fatherlink.html

Site hosted by the University of Minnesota's Children, Youth and Family Consortium, which has links to articles about fatherhood and other web sites.

4.2.8 Older men and women

In print:

Bonita, R., 1996, *Women, Aging and Health: achieving health across the life span,* Geneva: WHO

Sets out a conceptual framework and specific courses of action to target the health of ageing women. Assessing the health priorities for this gender and age group the report suggests over 20 strategies, and concludes with an analysis of the social, cultural, political factors which influence their health.

PAHO, 1989, *Midlife and Older Women in Latin America and the Caribbean*

A collection of studies that explores the special needs of this age group, and how their health needs are largely unmet because of the focus on women's reproductive years.

Online:

Federation of Family Planning Associations, Malaysia

www.rho.org/html/gsh_progexamples.htm

FFPAM runs menopause management services for women aged 45–65, in most of its state affiliated clinics. Separate clinics are being designed to run programmes for the over 65s.

Reproductive Health Outlook (RHO) Program for Appropriate Technology in Health (PATH), *Annotated bibliography on gender and sexual health: menopause and ageing*

www.rho.org/html/gsh-b-02.html

Links to online and printed articles on menopause and ageing issues from different countries (focuses on women).

WHO, 2000, 'Women, ageing and health', *Fact Sheet* No 252

www.who.int/inf-fs/en/fact252.html

Introduces the economic, social and political determinants which influence how women age, and asks what a gender-sensitive life course approach to older women's health would be like.

5 Issues in gender and health equity

5.1 Introduction

The aim of a gender sensitive approach is to correct imbalances between the position of men and women in terms of access to resources and benefits, as well as to understand the gender differences in terms of health status and health determinants. To be able to incorporate gender considerations into various aspects of health promotion and disease control programmes, a new operational focus that includes the following will be necessary:

- a special focus on disadvantaged women to improve their health status (single mothers, female-headed households, etc.),
- a special focus on men who are at a disadvantage or at risk,
- the involvement of men as well as women in the process of bringing about change that will benefit everyone's health.

For example, in the case of sexual and reproductive behaviour some problem areas may be due to the socio-economic and cultural contexts influencing people's lives:

- What factors from the economic, social, political, cultural and religious environment have gender implications for SRH?
- What is the current role of the local media in circulating gender stereotypes and its potential to inform and educate on gender issues in connection with SRH?
- What are the current gender relationships at community and household level that have a positive or negative impact in SRH?

In this section the following issues in GHE have been identified:

Case studies:

- Gender and tuberculosis
- Access and affordability: WHCF, the Philippines
- The development of radio materials on malaria, Kenya
- Microfinance: SEWA in India and YRHA in China
- Measures to improve nutrition in vulnerable groups

Resources:

- Access and utilisation of services
- Communicable and non-communicable diseases

- Environmental health
- Gender violence
- Health sector reform
- HIV and AIDS
- Maternal health
- Microfinance/microcredit
- Nutrition
- Occupational health
- Sexual and reproductive health

Case study 6 Gender and tuberculosis

The importance of creating gender-sensitive models of disease control has been acknowledge by tuberculosis (TB) programmes at international level (see *Gender and Tuberculosis*, the Nordic School of Public Health, Stockholm, 1998). Some national TB programmes in the south-east Asian region have already recognised the need to incorporate a gender approach to improve its services.

Poverty has been acknowledged as one of the most important contributing factors for high TB notification rates. The deteriorating social situation of low-income countries, following high population growth and an unfavourable social development, has led to inadequate nutrition and housing of vast segments of the population. It is estimated that women make up 70 per cent of the world's poor. Consequently, some studies show that women face the greatest obstacles in accessing a successful TB treatment.

Cultural beliefs and attitudes concerning TB influence health seeking behaviour, diagnosis, access to health care and compliance to treatment. The existing gap between male and female TB notification rates may partly be due to biological differences between males and females and partly due to gender differences. Socio-cultural aspects such as the household and community roles, social stigma, access to money to pay for health services and transport may produce inequalities between men and women.

Regarding pregnancy and TB, the female immune system allows successful pregnancy but at the same time important immunological changes have been observed and documented in various TB studies. Some of the reported differences among women may be cultural, psychological or environmental rather than hormone-mediated, and therefore different in different cultures (see Graham, R., 1998, 'Steroid Hormones and the immune response: Sex and Gender differences' in *Gender and Tuberculosis,* Stockholm: The Nordic School of Public Health).

A gender-sensitive review of TB programmes should be looking at:

- sex differentials in the epidemiology of tuberculosis; differences in prevalence of infection, rates of progression from infection to clinical disease, incidence of clinical disease, prevalence of HIV co-infection and tuberculosis-related mortality; evidence for social and biological factors influencing differences between males and females,
- gender inequities in case finding, onset of symptoms, access to and use of health services and adherence to treatment,
- gender differences in the social stigma associated with TB,
- effectiveness and cost of existing interventions in TB aimed at addressing these gender inequities,
- gender biases in the design of health systems and policies that may affect access to and impact of TB interventions.

The review findings can help to identify the policy and programme implications and identify priorities for research and programme action from a gender perspective.

Examples of questions to be asked when formulating gender sensitive-indicators in TB:

- Are there gender differences in access to health services?
- What are the vulnerable groups discriminated against in terms of access to health care?
- What percentage of health personnel are women, at the different levels of the TB control programme?
- What mechanisms does the TB programme have in place to address gender disparities among health professionals involved with TB control?
- If incidence/prevalence rates differ between men/women, boys/girls what is the reason for this?
- What cultural and other obstacles are there to women and girls accessing TB services?
- Is there social stigma towards TB? If so, does it differently affect men/women, boys/girls?

- Have any programmes been introduced to combat TB, and have any of these programmes been developed with a focus on the difference in men's and women's vulnerability?
- Is intra-household distribution of money biased against women and girls? If so, how does this cash distribution relate to access to TB services and adherence to treatment?
- Is intra-household distribution of food biased against women and girls? If so, what are the implications of malnutrition as a contributing factor for TB?
- What is the number of men/women, boys/girls diagnosed with TB?

Case study 7 Access and affordability: WHCF, the Philippines

The Women's Health Care Foundation (WHCF) was established in 1980 in order for women to obtain access to health care beyond maternity and family planning. The WHCF operates three fixed-site clinics in the metropolitan Manila area, plus an extensive outreach programme designed to provide information, education and services to women and their families in under-served communities near Manila. Placing the health of women within the context of the wider community, WHCF has a strong community outreach programme. This includes: training of local residents as community health workers to provide health care information to their neighbours; a political advocacy effort that involves lobbying for health care reforms that affect women; networking with NGOs that have similar interests.

The clinic's weekly visits to depressed neighbourhoods are important for the local women who are entitled to free health care in the government-run clinics in the centre of town but find the cost of getting there beyond their reach. With no household help or childcare, leaving home is difficult but the clinic's sessions, held in the home of the community health worker, mean that when the appointment time comes neighbours rush to summon a patient from home.

To ensure *affordability* client fees are extremely low and a fee schedule based on ability to pay has been implemented so that poor women and students can obtain health services. To minimise costs the WHCF leases inexpensive office space and local clinics are held in community health workers' homes. Doctors are hired on a part-time basis whilst nurses and midwives are trained to perform multiple tasks from taking medical histories, to conducting simple laboratory procedures such as gram staining and pregnancy tests.

To increase *accessibility* to services, the WHCF developed several strategies. The clinics open from 8 a.m. to 6 p.m. or beyond, far longer than the government-run clinics. They also opened on Saturdays, allowing access to women who worked full-time during the week. As well as the community health workers, the WHCF recently started to recruit street vendors working in the same areas as sex industry workers, as community-based distributors of condoms. Promotion is done mainly through small street signs and paid notices in telephone directories. Special events are also important: annually on International Women's Day, the WHCF provides free Pap smears and breast exams.

Source*:* http://resevoir.fhi.org/en/wsp/wspubs/philippine.html

Case study 8 The development of radio materials on malaria, Kenya

Location

Kenya (the same process was followed in Nigeria and Sierra Leone). The study and communication intervention were carried out in Tharaka-Nithi District in Eastern Province. Two study sites were chosen: the Tunyai and Chakariga locations. The district has a population of 293, 237 people and an annual growth rate of 3.3 per cent (1989 census). The ration of males to females is 1:1, but in terms of actual residents few males live in the area because they have migrated for work.

Organisation

Gender, health and communication teams, UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR)

Aim

The overall goal of the development of the Healthy Women Counselling Guide (HWCG) is to enable women to value themselves, to make informed decisions about their health and that of their families and, ultimately, to improve the quality of their lives. The aim of developing radio/audio cassettes is to provide information and stimulate awareness of health and gender issues within the context of rural women's daily lives.

Design rationale

In late 1993, a meeting was held in Geneva with representatives of women's groups, health specialists, communication experts and researchers to obtain their suggestions for the HWCG, including the form it should take and how to make it available. The participants agreed that the development of education and information materials for women should be a participatory process which included research into priority problems and gender issues and the development of materials should be carried out with women and health workers so that the emerging materials and messages would be meaningful to women and represent, in fact, their own product. Radio programmes were one choice of material because they have potentially wide dissemination and audio-tapes of the programmes can be used in women's groups, adult literacy classes, public meetings and as resources for health workers. The hypothesis was that radio programmes which dramatise relationships between men and women and how they affect women's health can provoke thought and discussion about gender inequities.

Activities

The process of developing the materials began with qualitative research to identify gender issues. A communication team was then established. This consisted of a medical anthropologist, a communication specialist/radio producer experienced in distance education and establishing radio listening groups, a medical doctor with experience working in rural communities, a graphic designer with experience in text-book illustration and research assistants from the community. Based on the findings, the team developed messages on malaria and gender issues. Three focus group discussions were held with women, men, and women and men together in which the groups prioritised their health problems and decided to focus on malaria. They then reviewed and modified the radio messages and added more information on gender and ways of coping with the disease. Radio was agreed as an acceptable means of communication and the groups identified other channels such as the *barazas* (public meetings), village-to-village meetings, songs on the radio and radio listening groups. The radio materials were developed with the groups in a participatory way.

Strategies addressing gender

The research identified a number of gender issues in women's and men's experience of and responses to malaria. For example, women often tolerate symptoms of malaria until they are critically ill because of the perception that a sick woman is lazy or mean. Men are not always aware of women's health needs. Women lack the resources to seek treatment and the power to demand appropriate services and women need information to help them recognise the signs of malaria in themselves and their families.

Two focus group discussions helped to identify communication structures at family and community levels. The discussions also identified roles played by the family and the community when a woman is ill. Through this process, the story of a woman called Kagendo emerged. The story brought out the social structures that control women, determine how their illness is managed, and the roles played by women friends and family members. The community members then acted out the scenes, and after two days of practice they were recorded and produced as a radio magazine programme.

Outputs

The outputs of the process were the radio story and four radio segments around the topic. These were a dialogue between the character of the story and her friend about anaemia and ways of preventing malaria when pregnant; a role play/discussion in which Tharaka men drinking *marua* are making jokes and discussing malaria; a question and answer format in which a medical doctor is being asked questions about malaria by his age-mates; a talk in which a woman doctor is giving a health talk on malaria in an outpatient clinic. These scripts were pre-tested, translated and recorded with songs and sound effects. The programmes had not been broadcast when the booklet was written.

However, responses to pre-testing gave some indication of women's and men's reactions.

- Women identified with the gender messages in the programme and this generated discussion of these issues, especially the problems of alcoholism among men and general neglect by husbands.
- Men did not seem to enjoy the story and many appeared distracted in men only groups and downcast and ashamed in mixed groups.
- Both women and men agreed that the issues raised such as alcoholism and male irresponsibility were problems in their community. The men agreed that it was important for them to check on the health of their families every day and acknowledged the need for better communication between women and men. Both men and women said that they had learned something about the treatment of malaria, and the need to support women and use family resources responsibly.

Challenges

- Information alone does not translate into behaviour change. Socio-economic and community development and improvements in the quality of primary health care services are issues that need to be addressed in tandem.
- It will be a challenge to ensure that those with the power to make household and community decisions about health and health care receive the gender messages. Important groups will include religious leaders, health workers, opinion leaders in the community and the young people.
- Information is needed about when women listen to the radio and how they get access to radio sets. Women's daily schedules and the time they spend in the house differ greatly in different contexts so a major challenge will be to ensure that women have access to a radio and that programmes are broadcast at a time when they are able to listen. In the Kenyan communities, where radio sets are often controlled by husbands and sons, it has been suggested that organised radio listening groups would provide the greatest access and that the best times would be in the afternoons or on non-market days.

- Community health problems may change seasonally and with changing circumstances. Issues selected by the community as priority topics at the time of preliminary research can change by the time project teams are ready to make programmes.
- The development of radio programmes can be resource consuming in terms of time and funds. To be cost-effective, programmes should be sufficiently generic to be shared widely and used repeatedly with different audiences. However it may be difficult to retain the strengths of a recognisable context for listeners.
- Most radio stations operate on meagre budgets, so without external support in the first instance it may be difficult to institutionalise the participatory methodology of radio programme development.

Lessons learned

- The 'bottom–up' approach demonstrated that working with rural communities greatly improved the product because the designers gained insight into the everyday lives of the women.
- The materials showed that sensitively portrayed scenes can stimulate public discussion about how relationships between women and men may affect women's health.

Next steps

This HWCG is still a project in process and the next steps are to finalise the material developed, share them across the three countries in which they were developed and test their applicability and the degree of adaptation required.

Source: This case study is based on a booklet entitled '*Muccore* (trusted friend), let's share with others! Developing radio and illustration materials for the Healthy Woman Counselling Guide', published by UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR). A demonstration pack on this process is available from TDR at www.who.int/tdr

Case study 9 Micro-finance: SEWA, India and YRHA, China

Membership of micro-finance institutions (MFIs) has resulted in increased income, credit and savings for millions of poor women worldwide. However, little evidence exists showing that membership of these programmes leads to significant health gains for their clients. Two models exist for explaining how membership of MFIs might lead to improved health for women. In the first, as micro-finance activities lead to an increase in household income, savings and greater access to credit, higher expenditures on nutrition and health care are assumed. Secondly, it is thought that the health education messages communicated through the organisational structures of MFIs can lead to an increased demand for services accompanied by an increased ability to pay.

The weakness in these two models lies in their failure to take into account the intra-household allocation of resources: expenditure on health and nutrition may be subject to gender bias and any increase in resources may be focused on males. Furthermore even assuming that the ability to pay exists, this does not always translate into willingness to pay. Households may be more willing to invest in physical assets rather than health care.

As well as investments of additional resources households have to deal with drains away from them. The complex way in which they respond to chronic or acute drains, such as major illnesses or accidents (termed 'shocks' by Rutherford, 1999), needs to be taken into account. According to a study by Cohen and Sebstad (1999) on microfinance and risk management, in order for MFIs to truly meet the need for 'products beyond credit that can help clients mitigate anticipated, but unpredictable, risks' (1999: 7) more energy should be focused on both insurance products and more flexible loans. Although Cohen and Sebstad state that illness, death and loss of an income earner were cited as the most prominent risks by clients in the 2000–2001 World Development Report (1999:3), few MFI products address these major shocks.

In spite of the assertion of health rights for all women of all ages post-Beijing, many MFIs still focus on reproductive health and family planning. The summary below of the Yunnan Reproductive Health Association's (YRHA) experience of integrating microfinance activities with a reproductive health agenda highlights the difficulties of this approach. In contrast the Self-employed Women's Association (SEWA) study illustrates how successful MFIs can be in improving women's health through insurance provision which is tailored to their needs.

References

Cohen, M. and Sebstad, J., 1999, *Synthesis Report on Micro-finance, Risk Management and Poverty*, Washington: AIMS – Management Systems International

Rutherford, S., 1999, *The Poor and their Money. An Essay about Financial Services for Poor People*, Manchester: Institute for Development Policy and Management, University of Manchester

Case study 10 The Yunnan Reproductive Health Association's (YRHA) micro-finance programme

The YRHA, established in 1994, is a Chinese NGO that works closely with local government. YRHA carried out research that found a high correlation between mortality and morbidity associated with poor women's reproductive health and their extremely low utilisation of services. They then decided to implement a micro-finance project with a health fund component.

A five-day participatory planning meeting was held with members of the project team, the local women's federation and representatives of the poor women, resulting in the following project plan:

- The women were to form voluntary groups.
- The groups were to have two types of loan:
  (a) a group development fund of 300 yuan per person for income-generating activities,
  (b) a group health fund of 20 yuan per person to be used on health activities to be decided by the group.
- The group was to create a plan for health activities.

An evaluation of progress six months later revealed mixed results. The impact of the project was evident: improvements were seen in literacy and confidence in expressing their needs. The women reported a high level of satisfaction with the income-generating aspect of the project and asked for further money. However take up of the health funds was extremely low and the reproductive health situation was unchanged. The women asserted that if their financial situation improved then they would suffer from less ill-health, yet the YRHA aim of improving reproductive health status had not been met.

With these two key stakeholders having different perceptions of what health is and how to achieve it, the mixed results were perhaps not surprising. How to create a bridge between these two different knowledge systems needs to be explored so that in the future they can be better integrated in practice.

Source: Jing, F., 2000, 'Participation – a better way to health outcomes?, in *Accountability through Participation: Developing Workable Partnership Models in the Health Sector*, *IDS Bulletin* 31 (1): 37–42, Brighton: IDS

Case study 11 SEWA's experience of implementing health insurance for women working in the informal sector

Gangaben, 35, a vegetable vendor, lives in Gomtipur, a working class area in Ahmedabad City. Rambhai, her husband, was working in a textile mill. He lost his job two years ago as the mill was closed down. They have five children. At 4.00 a.m. Gangaben goes to the wholesale vegetable market, buys vegetables, carries these on her head and sells them in the market the whole day. One day, carrying the vegetables on her head she slipped and fell down. She fractured her back and was admitted to hospital. She had to spend Rs 5,000 (almost half a year's income) on her treatment and could not go to the market for three months. The whole family became indebted by Rs 10,000.

SEWA, based in Gujarat state, West India, is an organisation of more than two million women who work as small vendors, home-based workers, and labourers. These women are typical of the 93 per cent who work in the informal sector. One of SEWA's main aims is to provide women with social security, so that they are better able to cope financially with shocks resulting from ill health, accidents, widowhood and natural disaster. SEWA began a dialogue with insurance companies in the early eighties about insuring women for health and other social security. Initially the women SEWA represented were rejected by the companies as being too high risk. It was not until a woman manager in the United India Insurance Coverage took up the cause that SEWA were able to launch an insurance scheme in 1992. By that time SEWA had 40, 000 members and was a financially viable institution.

Coverage of the scheme

The insurance covers sickness, accidental death of a member and that of her husband, loss during riots, flood, fire and theft of equipment and household goods, natural death and maternity. The annual premium is Rs 60. Maternity is covered by SEWA itself as no company was willing to insure women for this. Chronic or long-term illnesses are excluded by the insurance company, including gynaecological problems, as the insurance companies insist that it is impossible to determine whether these conditions may pre-exist policies. Only in-patient treatment is reimbursed. Older non-working women are also excluded from the scheme as are children and spouses.

Health benefits of the scheme

One of the main benefits was that women who would ordinarily place their own health at a lower priority than that of their husbands and children were themselves receiving hospital care. As links with local doctors and hospitals are strengthened, SEWA is developing a referral service to doctors that it trusts: some of them have even offered their services at a discounted rate. Some SEWA co-operatives are running counters in the compounds of municipal hospitals to offer rationed drugs at discounted rates to members.

The maternity cover ensures that poor rural women have some form of support at the most vulnerable point in their lives. SEWA's maternity benefit schemes include post-natal health education, pre-natal tetanus toxoid immunisation and a small cash component for emergency expenses and extra nutrition.

Social benefits of the scheme

Not only does the scheme ensure that women have economic benefits during a period of shock but it was also found to act as a booster for other SEWA activities. Women happy with the scheme encouraged other women to join SEWA so that they too would be able to benefit. Increased faith in the scheme was also found to lead to women making increased savings including some depositing a sum of Rs 500 and paying their annual premium from the interest. Through learning the process of making a claim women are also gaining confidence in dealing with bureaucracy. The experience of SEWA is also feeding in to government policy: the Malhotra Committee,

which was appointed by the Indian government to review the insurance industry, consulted SEWA on how to create affordable and appropriate systems.

Problems encountered in administering the scheme

The documentation process is sometimes problematic: women can find it difficult to produce the correct papers. They may be unable to explain to doctors what is necessary, the women may be cheated by unqualified doctors without proper registration, or they may be prescribed inappropriate treatment. In these cases the insurance companies will not pay out and women may become extremely dissatisfied and drop out of the scheme. Papers may also be lost, or the process and cost of obtaining certificates and photocopies may be too difficult for some women. However SEWA is acting to counter these challenges. Training in the concept of insurance is teaching women to carefully preserve all the documentation that they may need.

The kind of medical treatment admitted by the insurance companies has also caused difficulties. Only hospitalised treatment is covered and a hospital needs to have a certain number of beds to be recognised, preventing rural women from using some of the most convenient hospitals local to them. There has been a great demand from women to have outpatient treatment included but the insurance companies insist that it would be too costly and difficult to administer.

Source: Chatterjee, M. and Viyas, J., 1999, 'Organising insurance for women workers – the SEWA experience', paper presented at the conference Linking Women's Health and Credit in India: Program Experience and Future Action, 20–22January, New Delhi: PATH.

Case study 12 Measures to improve nutrition in vulnerable groups

In the short to medium term, measures to improve the nutrition of vulnerable groups include:

- **Food supplementation** In the short term, food and micro-nutrient supplementation programmes such as targeted free school meals and the provision of iron and folate tablets may improve the nutritional status of disadvantaged groups.
- **Identify appropriate local food sources** Encouraging the cultivation of micronutrient-rich crops in home gardens is one way of helping to ensure an adequate supply of suitable foods, especially for women

A project in West Sumatra, Indonesia promoted dark-green leafy vegetables (which are rich in iron and vitamin A) through the radio and other media. After the 1987–89 campaign, the proportion of pregnant women who consumed these vegetables daily rose from 19 to 32 per cent (World Bank).

- **Pricing mechanisms** Governments can promote better nutrition by ensuring that low-income families have the means to purchase nutritious foods. Measures to ensure adequate food supplies include consumer price supports for staple foods, income transfers for vulnerable households, and food fortification.
- **Reducing workloads** Strategies to reduce women's workloads are also likely to have a positive effect on their nutritional status. These might include improving environmental conditions such as sanitation or making labour saving technologies available.
- **Education, awareness raising and counselling** Public awareness and educational campaigns can help to promote an understanding of the special nutritional needs of adolescent girls and pregnant women and challenge gender biased norms, for example regarding nutritional needs of young girls relative to young boys.

Young people and their caregivers are often unaware of the increased need for energy-producing foods and micronutrients during adolescence to support physical development and prepare young women for childbearing. Nutrition education, provided through multiservice and vocational training centres, has been effective in improving adolescents' nutritional status (World Bank).

Useful sources of information:

Gomez Gomez, E., 1993, 'Sex Discrimination and Excess Female Mortality in Childhood', in E. Gomez Gomez (ed.), *Gender, Women and Health in the Americas,* Washington, D.C.: PAHO

UNICEF, 1998 *The State of the World's Children – Focus on Nutrition*

World Bank, *Agenda for Women's Health and Nutrition* available at:
www.worldbank.org/html/extdr/hnp/health/newagenda/whn.htm

An overview of Women's Health and Nutrition available at: www.worldbank.org/html/prmge/know/esw256.htm

WHO, *Gender and Health a Technical Paper*, available at:
www.who.org/frh-whd/GandH/GHreport/gendertech.htm#Introduction

5.2 Resources

5.2.1 Access to and utilisation of services

In print:

Bandyopadhyay, L., 1996, 'Lymphatic filariasis and the women of India', *Social Science and Medicine,* Vol 42 No 10: 1401–10

Increasing the numbers of health workers and instigating gender training programmes throughout the health care system improves the quality and appropriateness of services for women.

Ojanuga, D.N. and Gilbert, C., 1992, 'Women's access to health care in developing countries', *Social Science and Medicine,* Vol 35 No 4: 613–17

Suggests practical strategies to improve women's access such as changing opening times to cover a wider range of women's schedules.

Puentes-Markides, C., 1992, 'Women and access to health care', *Social Science and Medicine,* Vol 35 No 4: 619–26

Reviews available literature on access to health care for women with specific reference to Latin America and the Caribbean. Various approaches to defining variables affecting access to health care appear in the literature reviewed, including ability to pay, behavioural issues, socio-cultural issues, values, education, religion, or demographic variables.

Online:

Hatcher Roberts, J., Vlassof, C. and Jones Aresenault, L. (eds), 1995, The female client and the health-care provider
www.idrc.ca.acb/showprod.cfm?&DID=6&CATID=15%ObjectGroup_ID=39

A selection of case studies, some of which are in Spanish (also available in print from the International Development Research Centre), exploring the gendered relationship between client and provider. Topics emphasised are maternal health services and tropical diseases.

Kutzin, J., *Obstacles to women's access: issues and options for more effective interventions to improve women's heallth*
www.worldbank.org/html/extdr/hnp/hddflash/hcwp/hrwp008.html

The paper explores the gender-specific barriers to health service use. Barriers to access reduce the effectiveness of services or increase their cost. Typical obstacles to access are explored here, followed by suggestions for overcoming them. These include: reducing the economic costs of service use, outreach, maternal waiting homes, multipurpose facilities, strengthening of first contact care, restructuring of pricing and exemption policies, addressing cultural barriers, integrating NGO providers into the health system, increasing the supply of women health care providers.

5.2.2 Communicable and non-communicable diseases

In print:

Council on Ethical and Judicial Affairs, 1991, 'Gender disparities in clinical decision-making', *Journal of the American Medical Association*, Vol 266 No 4: 559–82

Examines evidence of gender disparities in health care, including disparities in providing major diagnositc and therapeutic interventions.

Hartigan, P., 1999, 'Communicable diseases, gender and health equity', *Harvard Center for Population and Development Studies, Working Paper Series*, Vol 9 No 8
www.hsph.harvard.edu/Organization/healthnet/Hupapers/gender/hartigan.html

This paper addresses the problem of outmoded gender stereotypes in communicable disease taxonomy, research and control. It analyses the impact of gender on the likelihood of contracting these diseases and how the process of the disease is gendered.

Rathgeber, E. and Vlassof, C., 1993, 'Gender and tropical diseases: a new research focus', *Social Science and Medicine,* Vol 7 No 4: 513–20

Presents a framework for gender-sensitive research on the differential consequences of tropical disease for women, men and children. The framework distinguishes between economic/productive variables, such as the sexual division of labour and economic policies affecting access to services; social/reproductive activities, such as the health care roles of women in the household; and social stigma and personal factors, such as knowledge and beliefs about disease.

Tanner, M. and Vlassof, C., 1998, 'Treatment seeking behaviour for Malaria: a typology based on endemnicity and gender', *Social Science and Medicine,* Vol 46 No 4–5: 523–32

Provides a typology that combines the key factors of gender variables with epidemiological features. Gender variables are divided into personal factors, social and reproductive activities and economic/productive activities. These are then assessed for their importance for different levels of intervention for malaria control: the individual, the household, the community and services. The potentially different patterns of vulnerability by sex and age are also presented according to levels of endemnicity and transmission in a geographic area.

Online:

Amazigo, U., *Women's health and tropical diseases: a focus on Africa*
www.un.org/womenwatch/daw/csw/tropical.htm

5.2.3 Environmental health

In print:

Kettel, B., 1996, 'Women, health and environment', *Social Science and Medicine*, Vol 42 No 10: 1367–79

Puts forward a methodology for carrying out gender-sensitive policy analysis and research on women's interaction with the biophysical environment.

Online:

Sims, J., Butter, M., 2000, 'Gender equity and environmental health', *Harvard Center for Population and Development Studies, Working Paper Series*, Vol 10, No 6

www.hsph.harvard.edu/Organ…t/Hupapers/gender/simbutter.html

Looks at the need for a broader approach to environmental health that addresses gender as both a social and biological construct. Analyses how gendered social roles mediate environmental hazards and exposures. Also available in print.

5.2.4 Gender violence

In print:

Armstrong, A., 1998, *Culture and Choice: lessons from survivors of gender violence in Zimbabwe*, New York: Women, Ink

Lessons drawn from three years of experience with survivors of gender violence in Southern Africa are used to explore new ways to design programmes to address the problem.

Cook, P., 1998, *Abused Men: the hidden side of domestic violence*, Oregon: Arrowdot Productions

Online:

Coalition against Trafficking in Women:

www.uri.edu/artsci/wms/hughes/catw/public.htm

The site is described as an 'online resource centre' and has extensive links to organisations and online articles on the trafficking and the sexual exploitation of women and girls. Some material in French and Spanish.

Garcia-Moreno, C., 1999, 'Violence against women, gender and health equity', *Harvard Center for Population and Development Studies, Working Paper Series*, Vol 9 No 15

www.hsph.harvard.edu/Organ…thnet/Hupapers/gender/garcia.html

An overview of domestic and sexual violence and its health consequences which analyses social and cultural norms that perpetuate or exacerbate violence.

ICRW 1999, *Domestic violence in India: a summary report of three studies,* Washington: ICRW
www.icrw.org

This report pulls together information from three studies funded by USAID on violence against women in Gujarat, best practice among responses to domestic violence in Maharashtra and Madhya Pradesh, and responses to domestic violence in Karnataka and Gujarat.

Panos, 1998, 'The intimate enemy: gender violence and reproductive health', *Panos Briefing* No 27, www.oneworld.org/panos/briefing/genviol.htm

The document starts with looking at the health consequences for women of gender violence and moves into different ways to address the problem from an international human rights angle, to changing national legal frameworks, to improving services for victims through sensitising health workers and providing counselling. Examples are cited of a wide variety of initiatives with their contact details.

RHO, *Program example: South Africa: training in gender awareness and gender violence for primary health care nurses in rural areas*
www.rho.org/html/gsh_progexamples.htm

The Health Systems Development Unit at the University of Witwatersrand and ADAPT, an NGO focusing on gender violence, collaborated to develop a gender violence training module following on from research that discovered that not only were nurses as likely, but statistically more likely to themselves to be subjects of gender violence, and that male nurses and other male health care workers share the same concept of gender relations as larger society.

RHO, *Annotated bibliography – violence against women*
www.rho.org/html/gsh-b-01.html

Links to around 30 online and published articles on violence against women, many of which are aimed at health care workers.

UNIFEM, *Women @ work to end violence: voices in cyberspace*
www.undp.org/unifem/w@work/index.htm

Excerpts from an online working group on ending violence against women that includes legal strategies, advocacy, training of officials and civil society, service provision, research, the media and changing male behaviour.

WHO, Women's Health and Development Unit, 2000, *Violence against women information pack*, www.who.int/frh-whd/VAW/infopack/English/VAW_infopack.htm

As well as defining and examining the scope of the problem, this pack explores the health consequences for different groups of women and what health workers can do.

WHO/FIGO 1977, 'Elimination of violence against women', report of a workshop held on 30 and 31 July www.who.int/violence_injury_prevention/vaw/endvaw.htm

Health, gender and human rights aspects of violence against women. Case studies on health systems responses to gender violence.

5.2.5 Health sector reform

In print:

BRIDGE, 1997, *Gender-aware Health Sector Reforms and Healthcare Provision: a select biography*, Brighton: BRIDGE Publications

Online:

Hardee, K. and Smith, J., 2000, 'Implementing reproductive health sector services in an era of health sector reform', *Policy Occasional Paper* No 4, Washington: Futures Group International www.policyproject.com/pubs/op4.html

Reproductive health initiatives and health sector reform (HSR) share the goals of equity and quality. The question of interest to those working in reproductive health is whether the reform measures aimed at increasing efficiency will be sufficient to ensure universal access to high-quality reproductive health services by 2015, as outlined in the ICPD Programme of Action. This paper reviews evidence that addresses the question of the complementarity of reproductive health initiatives and HSR.

PAHO, 1999, *Towards gender equity in health sector reform policies*
http://165.158.1.110/english/ags/downloads/msd18_4.pdf

Report from the 18th Session of the Subcommittee on Women, Health and Development. After discussing the implications for gender equity of HSR the report offers strategies for incorporating gender perspectives. Some case studies are also available at this site: 'Violence against women in health sector reform policies in Central America' and 'Women's needs and the response of health sector reform: experience in Chile/Ecuador'.

Standing, H., 1999, 'Frameworks for understanding gender inequalities and health sector reform: an analysis and review of policy issues', *Harvard Center for Population and Development Studies, Working Paper Series*, Vol 9 No 6
www.hsph.harvard.edu/Organ…net/Hupapers/gender/standing.html

Traces the development of debates around HSR and gender from the early 1980s, covering the different approaches to HSR and its links to the macro-economic and political environment and gender analysis. Formulates a conceptual framework for gender and HSR.

5.2.6 HIV and AIDS

In print:

BRIDGE (prepared for DANIDA), 1999, *HIV/AIDS and Gender Sources*, Brighton: Institute of Development Studies

Bibliography covering reproductive health, human rights, sex workers, men and masculinity and institutional resources relating to gender and HIV/AIDS.

Farmer, P., Connors, M. and Simmons, J. (eds), 1996, *Women, Poverty and AIDS: sex, drugs and structural violence*, Amsterdam: Royal Tropical Institute (KIT)

Analyses of gender and HIV/AIDS at the macro level with case studies, charts, a glossary and bibliography.

Foreman, M., 1998, *AIDS and Men: taking risks or taking responsibility?* London: Panos/Zed Books

The book explores the impact of men's actions and attitudes on women, children and other men and examines initiatives working with men. The second half of the book looks at men with HIV/AIDS and how it affects them.

ICRW, 2000, *Bridging the Gap: addressing gender and sexuality in HIV prevention*, Washington: ICRW

Findings from a decade of the ICRW 'Women and AIDS Research Program'. The focus is on evaluating group-based interventions with discussion of the implications for scaling-up in a way to reflect a gender and sexuality approach.

Online:

AIDSCAP, 1996, *A dialogue between the sexes: men, women and AIDS prevention*
www.fhi.org/en/aids/aidscap/aidspubs/women/sexdialog.html

The background and methodology to using dialogue between men and women to exchange ideas and to promote understanding resulting in the increased involvement in men of HIV/AIDS prevention.

AIDSCAP, 1996, *Behaviour change – a summary of four major theories*
www/fhi.org/en/aids/aidscap/aidspubs/behres/bcr4theo.html

Brief explanation of the four major theories of behaviour change in relation to HIV prevention produced to encourage people working with HIV/AIDS to examine what underlies their prevention efforts.

AIDSCAP, *Model interventions: the AIDSCAP women's initiative*
www.fhi.org/en/aids/aidscap/aidspubs/women/wimodel.html

Description of advocacy work, networking and work with people with aids, carried out by the AIDSCAP Women's Initiative to encourage more equitable relationships between men and women.

Baden, S. with Wach, H., 1998, 'Gender, HIV/AIDS transmission and impacts: a review of issues and evidence', *BRIDGE Report* No 47, Brighton: Institute of Development Studies
www.ids.ac.uk/bridge

The review looks broadly at the topic from socio-economic correlates and determinants of transmission, to an in-depth analysis of the limitation of existing data in terms of gender bias. Country case studies for Brazil, Bangladesh and Uganda.

Gordon, G. and Crehan, K., *Dying of sadness: gender, sexual violence and the HIV epidemic*
www.undp.org/gender/beijing5/gen_pub.htm

Looks at the specifically gendered and sexualised nature of violence and its relation to the transmission of HIV. Special attention is paid to rape (both the under-reporting of male rape and the mass rape of women) and sexual mutilation in conflict situations.

McSweeney, B., 1999, presentation by Dr McSweeney, UN Resident Co-ordinator in India, to the ECOSOC Panel on UNAIDS, Geneva, 22 July
www.unaids.org/about/governance/files/panelindia.doc

Details inter-governmental and inter-agency co-ordination on HIV/AIDS in India, with special reference to gender.

Panos, 2000, *Rape survivors slam 'executioner' government over AIDS drugs*
www.panos.org.uk/news/00-03-10/safricarape7.html

Discussion of South African government's decision not to finance AIDS drugs as a preventative measure to raped women.

Royal Tropical Institute (KIT), 1996, *Facing the challenges of HIV/AIDS/STDs: a gender-based response: a resource pack on policy and intervention implementation*
www.kit.nl/ibd/assets/images/RPBook1.pdf

Resource pack both analysing the intersections between gender and HIV/AIDS, and a series of activity cards for training purposes.

Solomon, S., 1998, *Women and HIV/AIDS concerns – a focus on Thailand, Philippines, India and Nepal*, discussion paper produced for the Expert Group Meeting on Woman and Health, Tunis, 2 October www.un.org/womenwatch/daw/csw/papers1.htm

Includes health financing and national HIV policies as they particularly impact on women.

UNAIDS Best Practice Site
www.unaids.org/bestpractice.collection/subject/human/keygender.html

Bibliography and links to examples of best practice in gender and HIV/AIDS.

UNAIDS, 1999, *Gender and HIV/AIDS: taking stock of research and programmes*
www.unaids.org/publications/documents/human/gender/una99e16.pdf

Gendered analysis of individual risk and societal vulnerability along with programmatic responses to address gender inequity.

UNIFEM, 2000, *Gender, HIV and human rights: a training manual*
www.undp.org/unifem/public/hivtraining/

This manual takes the stance that HIV transmission and lack of care for the HIV+ is worsened by gender inequalities. Building on empirical evidence that shows AIDS projects that enhance the economic and decision-making capacity of women at community level work well to prevent transmission, and evidence that macro economic and political factors that create gender inequalities exacerbate the epidemic, the manual aims to educate a critical mass of change makers in the gender dimensions of HIV/AIDS.

WHO, 2000, *Pregnancy and HIV/AIDS*
www.who.int/inf-fs/en/fact250.html

Brief fact sheet with key points.

5.2.7 Mental health

In print:

Gomel, M., 1997, *Nations for Mental Health: a focus on women*, Geneva: WHO

The first part of the book reviews research on the special mental health needs of women and then moves onto show how they can be addressed at the macro level through policy and the legal system. Projects working to improve women's mental health are then described.

Online:

Astbury, J., 1999, 'Mental health', *Harvard Center for Population and Development Studies, Working Paper Series,* Vol 9 No 18
www.hsph.harvard.edu/Organizations/healthnet/HUpapers/gender/astbury.pdf

RHO (PATH), *Annotated bibliography on gender and mental health*
www.rho.org/html/gsh-b-02.html

Vecchio Good, M., 1998, 'Women and mental health', paper for the Expert Group Meeting on Women and Health, Tunis, September
www.un.org/womenwatch/daw/csw/papers1.htm

5.2.8 Microfinance/microcredit

In print:

Dror, D.M., and Jacquier, C., 'Micro-insurance: extending health insurance to the excluded', *International Social Security Review*, Vol 52 No 1

The article asks how microcredit and improvements to healthcare delivery can be combined.

Sculer, S., Hashemi, S. and Badal, S., 1998, 'Men's violence against women in rural Bangladesh: undermined or exacerbated by microcredit programmes?', *Development in Practice*, Vol 8 No 2: 148–57

WHO–IBRD, 1994, final report of the Joint WHO–IBRD Workshop on 'Banking For Health': Improving the Health Status of Vulnerable Groups through Increasing Availability of Credit, Particularly to Women, Geneva, 15–17 June

Discusses key issues in linking health to credit for vulnerable groups, lists recommended actions and details cases in Nigeria, Egypt, Burkina Faso and Zambia.

Online:

ELDIS, *The Micro-finance Gateway*
www.ids.ac.uk

New site with searchable database of over 12,000 documents on microfinance, 2,000 available online, plus details of conferences and discussion groups.

Freedom from Hunger, *Credit with education*
www.freefromhunger

Programmes in Ghana and Bolivia to provide credit with education proved successful in improving health seeking behaviour and women's nutrition. Freedom from Hunger is also the co-ordinator of the

Learning Exchange, an international group of NGOs that are linking microfinance and health interventions.

Microenterprise Innovation Project (USAID), 2000, *Health insurance schemes for microentrpreneurs*
www.mip.org/grants/mbp/reseau.htm

Details of a pilot project of a hospitalisation insurance scheme with 4,000 women in Dakar.

OUTREACH, *Recommendations on microfinance programmes*
www.igc.org/csdngo/outreach/23_02_00.htm

A critical analysis of the benefits of microfinance.

5.2.9 Nutrition

In print:

UN Administrative Commission on Co-ordination, Sub-Committee on Nutrition (ACC-SCN), 199–, *Challenges for the 21st Century: a gender perspective on nutrition through the life cycle*, Geneva: ACC-SCN Secretariat at the WHO

An overview of nutrition and gender that includes sections on how women's land rights affect nutrition, conflicts in women's time allocation, Disease-Adjusted Life Years (DALYs) and the global burden of disease, and breastfeeding policies. Most data is not gender disaggregated and the evidence from case studies is limited.

Online:

Johnson-Welch, C. 'Focusing on women works: research on improving micronutrient status through food-based interventions', *Omni Research Report Series*
ICRW, www.icrw.org

Synthesis of five reports on programmes addressing micronutrient deficiencies through providing women with opportunities for active participation in problem solving and resources.

World Bank, 1995, *An overview of women's health and nutrition*
www.worldbank.org/html/extdr/hnp/health/newagenda/whn.htm

This World Bank publication gives and overview of women's health and nutrition globally and focuses on actions that can be taken by the health sector. It suggests essential clinical and public health interventions, discusses factors to be considered in programme planning and implementation, and describes ways that assistance agencies can facilitate programmes.

5.2.10 Occupational health

In print:

Date-Bah, E. (ed.), 199, *Turning Vision into Reality*, Geneva: ILO

The impact of recession, globalisation, structural adjustment on women in the workplace.

Online:

All India Institute of Hygiene and Public Health Programmes in Sonagachi, Calcutta

www.rho.org/html/gsh_progexamples.htm

www.walnet.org/csis/groups/nswp/dmsc/index.html

The two original interventions of this local government initiative, a health clinic and outreach by peer educators, were transformed into a broader self-empowerment movement by the sex workers themselves. The health impacts include condom use rising from 3 per cent in 1992 to 90 per cent in 1998, HIV rates remaining steady whilst STDs dropped, the proportion of prostitutes under 19 falling from one in five in 1995 to one in thirty in 1998. Social impacts include the organisation of the sex workers into a union with 30,000 members, which fights for their official recognition and respect by negotiating with local power powerbrokers and holding national conferences.

Dewan, A., 1998, *Occupational and environmental health of women*, Expert Group Meeting on Women and Health, Tunis, September

www.un.org/womenwatch/daw/csw/papers1.htm

ILO, *Gender issues in occupational safety and health*

www.ilo.org/public/english/bureau/gender/osh

Looks at the key issues and protective legislation with recommendations of how to integrate the gender perspective into occupational safety.

Ostlin, P., 2000, 'Occupational health', *Harvard Center for Population and Development, Working Paper Series*, Vol 10 No 9

www.hsph.harvard.edu/Organizations/healthnet/HUpapers/gender/ostlin.html

RHO (PATH), *Annotated bibliography on sex workers*

www.rho.org/html/gsh-b-01.html

Links to articles about issues for sex workers including: occupational safety approaches, HIV, health-seeking strategies, violence and designing appropriate health care strategies for this group.

5.2.11 Sexual and reproductive health

In print:

Andina, M. and Pillsbury, B., 1998, *Trust: an Approach to Women's Empowerment – Lessons Learned from an Evaluation on Empowerment and Family Planning with Women's Organizations*, Los Angeles: Pacific Institute for Women's Health

A multi-country study of how women's NGOs and their empowerment activities impact on family planning, and how to better understand the relationship between empowerment and reproductive health. Contains over 20 short case studies that detail different family planning projects and their effect on both men and women. Recommends actions for organisational participation and empowerment.

Hardon, A. and Hayes, E. (eds), 1997, *Reproductive Rights in Practice: a feminist report on the quality of care*, London: Zed Books

An appraisal of the quality of care and adherence to reproductive rights in different family planning settings in eight countries. Recommendations for change are included in the final section.

Mamdani, M. (ed.), 1998, *Community-based Programmes Addressing Women's Reproductive Health Needs in India: a documentation*, New Delhi: Ishtm

Catalogues 72 organisations working in the area and case studies dealing with issues such as safe motherhood, RTIs and adolescent RH.

Plata, M.I. and Calderon, M.C., 1995, 'Legal services: putting rights into action – Profamilia – Colombia', *American University Law Review*, 44:1105–11

How Profamilia, the largest Colombian family planning association, provided legal aid, information and counselling services concentrating on reproductive health, domestic violence and family matters to encourage women to utilise both the international and national laws in place for their protection.

Sciortino, R., 1998, 'The challenge of addressing gender in reproductive health programmes: examples from Indonesia', *Reproductive Health Matters*, Vol 6 No 11: 33–44

The author assesses how reproductive health programmes can best address gender equity. Early programmes that focused exclusively on women suffered a fatal flaw: women could not act on their new understanding of reproductive health and gender relations as long as the society around them, especially the attitudes and expectations of their husbands, remained unchanged. More recent programmes focusing on male involvement have proven to be counter-productive: involvement reinforces male authority and leaves women in a passive and powerless role. The author concludes that the most effective approach is to focus on relationships by first empowering women with knowledge and only then involving men.

Online:

AVSC

www.avsc.org

Site of this non-profit international reproductive health organisation that provides working papers, programme studies and links to other sites.

Family Health International (FHI): *Network*

1998, 'Improving service quality', Vol 19 No 1, www.fhi.org/en/fp/fppubs/network/v19-1/index.html

Issue focusing on improving the quality of delivery of family planning services.

1998, 'Family planning and women's lives', Vol 18 No 4, www.fhi.org.en/fp/fppubs/network/v18-4/index.html

Issue focusing on how family planning use affects various aspects of women's lives, from how contraception influences quality of life, to family planning as a family decision to the special needs of abused women.

1999, 'Community-based distribution', Vol 19 No 3, www.fhi.org.en/fp/fppubs/network/v19-3/index.html

Includes an article on how gender norms affect community distribution and case studies.

Family Health International, *The impact of family planning on women's lives: toward a conceptual framework and research agenda*

www.fhi.org/en/wsp/wspubs/hongselz.html

The paper proposes a conceptual framework for examining the impact of family planning on six areas of women's lives: personal autonomy and self esteem; physical and psychological health; educational attainment; employment and economic resources; family relationships; public standing.

UNDP/UNFPA/WHO/World Bank Special Programme of Research Development and Research Training in Human Reproduction (HRP), 1999, 'Training in gender and reproductive health', *Progress in Human Reproduction Research*, No 50: 7

www.who.int/hrp/progress/50/05.htm

A training course on gender and reproductive health that aims to build institutional capacity regionally, and to increase the numbers of programme managers, policy makers and trainers with a gender perspective on health. The curriculum will be published after a pilot testing has been completed in five different centres.

Appendix 1 Useful websites

Key: Usefulness of site	
***	Excellent
**	Good
*	Specialist

Organisation/programme and website address	Information
General sites on women's health/gender and health	
* Canadian International Development Agency (CIDA) www.acdi-cida.gc.ca/health.htm	Outlines their strategy and contributions to global health, with a small section on empowering women through better health. A search on CIDA's website offers information on some relevant projects including:
* www.acdi-cida.gc.ca/cida_ind.nsf/ 0e258f35e6cd1eb28525662d0057b6fe/072d2207577 d865c852564a400516d67?OpenDocument	Development of Women's Health Professionals programme CIDA The programme trains women health professionals, especially in the area of nursing and primary care. This co-operative programme is run by Pakistan's Aga Khan University in partnership with McMaster University in Hamilton, and funded by CIDA.
** Canadian Society for International Health www.csih.org	Clicking on *Abstracts* brings up a list of summaries of research on health issues for the 5th Canadian Conference on International Health 1998. Not all are gender related but there are some interesting summaries of studies on women and occupational health, addressing HIV, and reproductive health. There is also one that looks at the importance of the cultural context of gender and literacy as a guide and basis for sustainable solutions to health problems and approaches for health promotion and illness prevention.
* Development Assistance Committee (DAC) Source Book on concepts and approaches linked to gender equality www.oecd.org/dac/htm/sourcebk.htm	Scroll down to near the end of the *Source Book* to find a list of about 30 references on gender and health. Most are journal articles, books or development organisation's publications and cannot be accessed on-line.
*** ELDIS http://nt1.ids.ac.uk/eldis/hot/hgender.htm	ELDIS is a gateway to on-line information on development. This particular page of the website provides access to extensive on-line gender and health resources and scrolling down to the bottom of the page offers a link. Plus more offered in ELDIS, enabling a search for *more* resources on-line.

*** Family Health International http://resevoir.fhi.org/en/wsp/wspubs/bibthgen.html #anchor613489	This page of FHI''s site has an outstanding on-line bibliography: *Through a Gender Lens: Resources for Population, Health and Nutrition Projects*. Contains ordering information.
** ID21 www.id21.org/search.htm	A search such as gender and health produces highlights of recent research on gender and health, though some are only tenuously related to the search topic.
* International Centre for Research on Women www.icrw.org/	ICRM's publication link has information about books that can be ordered on-line. Most of the health related ones focus on the girl child and adolescents. Promoting Women in Development (PROWID) link gives an outline of a few reproductive health projects, for example, a Bangladeshi project; Integrating Sexual and Reproductive Health into Service Delivery Systems.
** International Development Research Centre www.idrc.ca/gender/	The site offers easy access to an assortment of relevant research and reports, speeches, books, magazine articles and links. The entire text of *The Female Client and the Health-Care Provider* edited by Janet Hatcher Roberts and Carol Vlassoff is online.
* Latin American and Caribbean Women's Health Network www.infoera.cl/	Offers health information in Spanish.
* The People's Decade of Human Rights Education www.pdhre.org/rights/women_and_health.html #commitments	Offers a comprehensive list of *Governments' Obligations* and *Governments' Commitments*, under international law, concerning women and health.
** Program on Women, Health and Development www.paho.org/english/hdp/hdwmuje.htm www.paho.org/english/ags/agsmsd18.htm.	The Program on Women, Health and Development (HDW) of PAHO, regional office of the WHO provides information about HDW activities in the Americas, information about 3 publications, calendar of events and a database. Reports on gender and HSR: see HSR section
** Q Web Sweden Society and Women's Health www.qweb.kvinnoforum.se/qwhealth.htm	This section of Q web's site displays selected links, addresses, references and papers and presentations related to women's health in different social and cultural contexts.
** The Socio-economic and Gender Analysis Programme (SEAGA) www.fao.org/sd/seaga/	The SEAGA programme was conceived to offer practical means to implement the concepts behind socio-economic and gender analysis. The SEAGA package can be downloaded and chapter 6 includes an extensive set of guidelines on the health sector.

* UNICEF The Progress of Nations 1996 report www.unicef.org/pon96/contents.htm Men in Families www.unicef.org/reseval/malesr.htm	Includes a section on women that is largely health related. Report of a consultation on the role of males and fathers in achieving gender equality. Covers issues such as the effect of the traditional role of the father on health and nutrition programming for children, but also covers issues other than health.
*** Women's Health and Development Programme www.who.int/frh-whd/	Women's Health and Development Programme of WHO, providing information on women's health, violence against women, and female genital mutilation. There is also a link to one of the key texts in the area of women and health under publications: *Gender and Health: Technical Paper*
** Women and International Development Programme at Michigan State University www.isp.msu.edu/WID/	Over 30 abstracts of working papers on health and mortality with details of how to order and pay for them can be accessed by clicking on *resources* and then on *working papers*.
Womenwatch www.un.org/womenwatch/ *** Expert Group Meeting on Women and Health 1998 www.un.org/womenwatch/daw/csw/healthaide/htm www.un.org/womenwatch/daw/csw/healthr/htm	The UN internet gateway on the Advancement and Empowerment of Women. This website provides background information about the meeting. Clicking on discussion papers provides access to a collection of useful papers on mainstreaming the gender perspective into the health sector. The website also has links to the experts present at the meeting and details of an on-line dialogue on gender and health that was held last year. For an excellent general report from the meeting that covers a range of health issues.
** World Bank GenderNet, www.worldbank.org/gender www.worldbank.org/gender/know/health.htm www.worldbank.org/gender/tools/sectoral.htm www.worldbank.org/gender/opera/lolinks.htm#H	This site describes how the bank promotes gender equality Clear checklists of essential and expanded services for women's health. Comprehensive list of gender and health indicators for monitoring gender-related aspects of policies/projects. Provides an outline of bank-financed projects, including a section on health related ones, which contain gender analyses and actions/components.

Health sector reform, health systems and management	
** Commonwealth Secretariat www.health-at-commonwealth.org	provides access to: - information on *Gender Management Systems*, featuring short guidelines; - *Community Participation and Women's Health*, which offers access to summaries of best practice from a variety of countries; - information on a training course in gender and health to be delivered by distance education.
* ELDIS http://nt1.ids.ac.uk/eldis/hot/hreform.htm	This page of ELDIS provides resources on all the major issues related to HSR. However, there is little specifically related to gender.
* Instituto Nacional de Salud Publica www.insp.mx/cgi-bin/all	A search on gender and health produces a few abstracts of papers related to gender and health, and primarily HSR.
** Partnership for Health Reform www.phrproject.com/globali/mrh.htm	This site offers details of a maternal and reproductive health special initiative. A couple of related publications dealing with health reform initiatives are listed on the same page.
*** The Program on Women, Health and Development www.paho.org/english/ags/agsmsd18.htm.	Reports on gender and HSR in the Americas, from the 18th Session of the Subcommittee on Women, Health, and Development of the Executive Committee. Includes guidelines and three case studies.
** Women, Environment and Development Organisation (WEDO) www.wedo.org.	Excerpts from the WEDO study, *Risks, Rights and Reforms*, a critique of health reforms under structural adjustment. Currently available on-line by clicking on *what's new*. WEDO's site also includes short country profiles under the title, *One Year after Cairo Report: Assessing Government Action to Implement their ICPD Commitments*

Specific health conditions/diseases	
*** Centres for Disease Control www.cdc.gov/health/womensmenu.htm	Offers information on specific health conditions and diseases of particular concern to women.
* Global Network on Gender and AIDS www.hivnet.ch:8000/gender-aids/tdm www.hivnet.ch:8000/join/	Forum for discussion on gender and AIDS For information about how to join.
** UNAIDS www.unaids.org/unaids/document/ women/index.html	Women and AIDS page, featuring best practice documents: *Gender and HIV/AIDs* and *Microbicides for HIV Prevention*.

www.unaids.org/unaids/bpc/techupd/index.html	Technical up-dates, including *Gender and HIV, Mother to Child Transmission*, and *Men Who have Sex with Men*.

Sexual and reproductive health	
*** AVSC www.avsc.org	A non-profit, international, reproductive health care organisation. Their site provides access to working papers (on-line) and other publications (with ordering information). Information about AVSC activities and useful information concerning reproductive and sexual health also available on-line
*** The Centre for Reproductive Law and Policy www.crlp.org/	A non-profit legal and policy advocacy organisation that promotes women's reproductive rights around the world. This comprehensive site is a resource for obtaining factual information on a wide range of women's reproductive issues worldwide.
** Face to Face www.facecampaign.org	A campaign for women's right to family planning and reproductive health care, sponsored by UNFPA, the International Planned Parenthood Federation and national NGOs in Europe
** Family Care International www.familycareintl.org	A non-profit organisation dedicated to improving women's sexual and reproductive health and rights in developing countries. Offers fact sheets, regional information, and other useful materials that can be downloaded or ordered online.
*** Family Health International www.fhi.org Women's Studies Project www.fhi.org/en/wsp/women.html	FHI provides loads of high quality research, education and services in family planning, STDs/HIV and family health aimed at improving the health and well-being of populations worldwide. Provides a range of resources including fascinating country reports examining the immediate and long-term consequences of family planning on women's lives.
*** The Global Reproductive Health Forum (GRHF) www.hsph.harvard.edu/grhf www.hsph.harvard.edu/rt21 www.hsph.harvard.edu/grhf-asia	A valuable internet source for information on reproductive technologies, gender, and health, GRHF aims to encourage the proliferation of critical, democratic discussions about reproductive health, rights, and gender on the net. Information about reproductive technologies. Provides information on GRHF's South Asian Project, including in-depth research.

* HERA www.iwhc.org/hera/hera.htm	Their site offers action sheets which define the central concepts of the agreements reached at the International Conference on Population and Development (1994) and the Fourth World Conference on Women (1995)
* ICPD+5 NGO Forum www.ngoforum.org/	Information and follow up information on the International Conference on Population and Development in Cairo (1994)
** International Planned Parenthood Federation http://ippfwhr.org/ippfwebsite/index.html	Provides resources on reproductive health, gender-based violence, STIs/HIV and AIDS, male involvement, youth issues and management and information systems.
** International Women's Health Coalition www.iwhc.org	The site has outlines of IWHC activities in Africa, Asia, and Latin America to promote women's reproductive and sexual health and rights. Also included are abstracts and ordering information for several IWHC publications and reports.
*** The John Hopkins Center for communication Programs www.jhuccp.org NET LINKS www.jhuccp.org/netlinks.stm POPLINE: www.jhuccp.org/popline/index.stm	Part of the Johns Hopkins School of Hygiene and Public Health, the Center works with many international organisations in the USA and overseas to promote healthy behaviour. A search on this site produces many research papers on reproductive health issues. Among the extensive on-line services provided by the Center are the following: • an online searchable database of over 400 reproductive health, population and development organisations with internet resources, • biographic database on population, family planning, and related health issues.
** The Population Council www.popcouncil.org www.popcouncil.org/gfd/gfd.html www.popcouncil.org/rhpdev/rhpdev.html www.popcouncil.org/ebert/ebert.html	Research and information about programmes supported by the Population Council including the following: • Gender, Family, and Development Program • Reproductive Health Products Development Program • Robert H. Ebert Program on Critical Issues in Reproductive Health
** Q Web Sweden www.qweb.kvinnoforum.se/qwsexrep.htm www.qweb.kvinnoforum.se/papers/maleinvolv.htm	Provides many links to organisations dealing with family planning and reproductive health. Plus links to organisations interested in men's involvement in reproductive and sexual health. Also links to men's groups joining in a dialogue for non-violence.

** Reproductive Health Outlook www.rho.org	Provides summaries of up-to-date information, links to the best in-depth reproductive health information on the web, and the chance to communicate with international experts and peers through their community forum message boards.
* Research for sex work network www.walnet.org/csis/groups/nswp/index.html www.walnet.org/csis/mainmenu.html#health	This network encourages research on and the development of appropriate interventions for sex workers and their clients to reduce transmission of STDs, including HIV/AIDS. Commercial Sex Information Service: Health
* Rising Daughters Aware (formerly the Female Genital Mutilation Network and Message Board) www.fgm.org	An excellent well presented resource for information on female genital mutilation.
*** Safe Motherhood Initiative www.safemotherhood.org/init_welcome.htm	Safe Motherhood is a global effort to increase maternal safety and reduce the number of deaths and illnesses associated with pregnancy and childbirth. The site features an exhaustive range of resources on this topic.
** UNICEF: Safe Motherhood www.unicef.org/safe/	Offers some guidelines and information about country initiatives.