WHO/RHR/01.29
Distr.: General

A Training Curriculum for
Health Programme Managers

World Health Organization

Transforming Health Systems: Gender and Rights in Reproductive Health

Page number

Contents

A training curriculum for
health programme managers

Transforming Health Systems: Gender and Rights in Reproductive Health

Jane Cottingham
Sharon Fonn
Claudia Garcia-Moreno
Sofia Gruskin
Barbara Klugman
Adelina Ndeto Mwau
TK Sundari Ravindran
Rachel Snow
Makhosazana Xaba

Edited by TK Sundari Ravindran

World Health Organization

Department of Reproductive Health and Research
Family and Community Health

2001

Citation
Transforming health systems: gender and rights in reproductive health. A training curriculum for health programme managers.
Geneva, World Health Organization, 2001
WHO/RHR/01.29

Designed by Grundy and Northedge Designers
Printed by Schüler SA, Switzerland

Acknowledgements

The development of the course on gender and rights in reproductive health and this training curriculum has been a collaborative project of three organizations:

- François Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, Boston, MA, United States of America
- Women's Health Project, School of Public Health, University of the Witwatersrand, Johannesburg, South Africa
- World Health Organization, Geneva, Switzerland.

The entire project was conceived and developed by a team of international experts working in research, policy development, health service provision, training and advocacy in sexual and reproductive health and gender equality. They are: Jane Cottingham, Claudia Garcia-Moreno (World Health Organization, Switzerland); Sharon Fonn, Barbara Klugman, and Makhosazana Xaba (Women's Health Project, School of Public Health, University of the Witwatersrand, South Africa); Sofia Gruskin, (François Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, USA); Adelina Ndeto Mwau, (Coalition on Violence Against Women, Kenya); TK Sundari Ravindran, (Rural Women's Social Education Centre, India); Rachel Snow, (Institute for Tropical Health, University of Heidelberg, Germany).

Each module was developed by one or two team members with substantial input from other members of the team.

The final development of all modules and sessions was also shaped by the following people from the organizations involved in the regional adaptation of the curriculum: Monica Gogna, Mariana Romero and Silvina Ramos, Centre for the Study of State and Society (CEDES), Argentina; Fang Jing, Li Xiaoliang, Li Jianhua, Liu Wei, Zhao Jie and Zhang Kaining, Yunnan Reproductive Health Research Association, China; Jill Astbury and Martha Morrow, Key Centre for Women's Health, Australia; Esther Sempebwa Nagawa and Mary T Mujomba, Centre for African Family Studies, Kenya.

Independent reviews were carried out by: Lesley Doyal, University of Bristol, United Kingdom; Alice Miller, Columbia University, USA; Ranjani K Murthy, independent development consultant, Chennai, India.

Administrative support was provided by Manuela Colombini, Erin Gibson, Karie Pellicer, Jenny Perrin, Sinead Ryan, Tracey Slanger and Elizabeth Torpey-Sirven.

We would like to thank all of these individuals and their organizations for the extensive time, thought and energy that they have given this project. Additional thanks are due to Paul Van Look, Director of the Department of Reproductive Health and Research, World Health Organization, for his ongoing encouragement and support, and to many of the other staff of that Department for their reviews and contributions.

A wide range of donors have provided funds to support the training initiative, through overall support to the World Health Organization, institutional development grants for

the regional courses, and scholarships for course participants. We gratefully acknowledge support from: the Government of the Netherlands; the Ford Foundation; the John D and Catherine T MacArthur Foundation; the Rockefeller Foundation; United Nations Population Fund (UNFPA); United Nations Children's Fund (UNICEF); the World Bank; anonymous donations to Harvard University.

In particular, we should like to thank the Rockefeller Foundation for providing support through its Bellagio Centre in Italy for the two study group periods it accorded the coordinating committee, in November 1999 and in May 2000.

We acknowledge the following donors who made financial contributions to the preparation of the courses and/or scholarships for the regional courses: Centre for African Family Studies, Kenya: the Rockefeller Foundation, the Ford Foundation, UNFPA Nigeria and Uganda, WHO Ghana; Centre for the Study of State and Society (CEDES), Argentina: the Ford Foundation, UNFPA, Pan American Health Organization (PAHO), WHO, UNICEF Argentina, PROMIN (Maternal and Child Program, Ministry of Health, Argentina), Maternal and Child Program of the Ministry of Health of the Province of Buenos Aires (Argentina), Universidad Peruana Cayetano Heredia, Latin American Consortium of Reproductive Health Programs; Key Centre for Women's Health in Society, Australia: the Ford Foundation (through the Center for Educational Exchange with Viet Nam), Mr Kare Lotsberg (Norway), National Family Planning Coordinating Board (Indonesia), Pakistan Voluntary Health and Nutrition Association, University of Krida Wacana (UKRIDA) (Indonesia), UNFPA Philippines, World Population Foundation (the Netherlands); Women's Health Project, South Africa: European Commission, ICCO Netherlands, Oxfam Canada, Rockefeller Foundation, Terre des Hommes, UNFPA, World Bank, WHO; Yunnan Reproductive Research Association, China: the Ford Foundation, China.

PART ONE

Introduction

Principle 4 of the ICPD **Programme of Action**

Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes.

The human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights.

The full and equal participation of women in civil, cultural, economic, political and social life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex, are priority objectives of the international community.

Introduction

Operationalizing Cairo and Beijing

The title of this manual – *Transforming health systems: gender and rights in reproductive health* – reflects the aspirations of the initiative. The aspiration is to reform health systems to enable reproductive (and all other) health services to be gender sensitive and to uphold rights. The curriculum evolved over a five year process that brought together people with diverse skills from different regions of the world, and included conducting the course in different parts of the world and learning from participants.

The manual is a training resource for health trainers to use with health managers, planners, policy-makers and others with responsibilities in reproductive health. It provides a unique training curriculum designed to equip participants with the analytical tools and skills to operationalize reproductive health policies and programmes as envisioned in the *Programme of Action* of the International Conference on Population and Development (ICPD) held in Cairo in 1994 and the *Platform for Action* of the Fourth World Conference on Women (FWCW) held in Beijing in 1995.

The ICPD changed the focus of population policies, which until then had been directed at demographic goals and regulating women's fertility. The *ICPD Programme of Action* emphasized that population policies should focus on the well-being and quality of life of individuals and on the right of women to make decisions about their bodies and on matters affecting their reproductive health. Further, it advocated the need for health and population programmes to have an integrated focus centred on sustainable development and the eradication of poverty, and based on human rights norms and standards. The empowerment of women – their autonomy and

self determination in all spheres of life, particularly with regard to sexuality and reproduction – was seen as the cornerstone of all health and population programmes.

Although the new agenda outlined in the ICPD and FWCW recommendations has been widely endorsed by national governments, NGOs and multilateral agencies, implementation has lagged. One of the key factors hindering implementation is a generalized lack of capacity to identify effective means of integrating a gender and rights perspective into planning and priority setting activities.

As a result, policies and programme changes since the ICPD have tended to focus on how to bring together what are often seen as the three "legs" of reproductive health: maternal health, family planning, and prevention and treatment of sexually transmitted infections (STIs). However, the reproductive health agenda outlined in the recommendations involves much more than adding a few components to existing maternal and child health and family planning programmes. It calls for concrete approaches to integrating human rights concerns, and for addressing gender inequalities within an overall framework of equity and social justice.

A brief history of the initiative

The initiative, of which this manual is a product, began in 1996 with the working title "Operationalizing Cairo and Beijing". It is a collaboration between:

- François Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, Boston, MA, United States of America
- Women's Health Project, School of Public Health, University of the Witwatersrand, Johannesburg, South Africa
- World Health Organization, Geneva, Switzerland.

The initiative has been managed by a nine member international co-ordinating committee of gender and reproductive health specialists from both developing and industrialized countries.

The main goal of the initiative has been to increase the number of health programme managers, planners, policy makers and trainers who understand a gender and rights perspective on health, and who have the analytical tools to help implement gender and rights-sensitive reproductive health policies and programmes. To achieve this goal we focus on strengthening training capacity within countries. Gender and human rights are new analytic orientations for many people working in the area of reproductive health, and the manifestation of gender inequalities and violations of human rights is different in diverse societies. Therefore, from the outset the initiative worked through a multi-country collaborative process. A core curriculum was developed and piloted in Johannesburg, South Africa in August-September 1997. It was then disseminated to training centres in different regions of the world and four institutions were selected to conduct the course in their region. These were: Centre for African Family Studies (CAFS), Nairobi, Kenya; Centre for the Study of State and Society (CEDES), Buenos Aires, Argentina; Key Centre for Women's Health in Society, University of Melbourne, Victoria, Australia; and Yunnan Reproductive Health Research Association, Kunming Medical College, Yunnan, China.

In November 1998, participants from each of these regional collaborating training centres joined members of the co-ordinating committee in Geneva for an 11-day Regional Adaptation Workshop where the pilot course was reviewed. Between 1999 and 2000, six regional courses were held: two each in Victoria and Kunming, and one each in Nairobi and Buenos Aires, using a version of the curriculum adapted by the collaborating centre for their region. In the meantime, three further courses were held in South Africa.

In March 2000, the international team met again at a Regional Evaluation Workshop, to consolidate the lessons learned through regional testing and adaptation of the curriculum. The curriculum was revised based on this evaluation and field-tested once again in South Africa in August-September 2000.

The curriculum presented in this manual is the end product of this multi-stage, international collaborative process.

What does this training curriculum offer?

This manual offers a session-based and case-based curriculum on how to promote gender equity and reproductive rights through the use of evidence, policy development and service delivery. The curriculum is founded on the premise that the development of workable reproductive health programmes calls for training that not only includes new technical skills, but faces head-on the challenge of changing approaches and perspectives. It aspires to transform health workers, managers and policy makers into active change agents committed to transformation of health systems.

Transformation

The entire curriculum is focused on transformation. It provides tools and skills for conceptual analysis and for effecting positive changes within a health care system.

Foundation Modules are followed by Application Modules

Rather than being organized by reproductive health issues (e.g. adolescent health, abortion, STIs, male participation), the curriculum starts with Foundation Modules on gender, the social determinants of health, and rights. These Foundation Modules provide participants with a gender and rights framework and perspective to enable them to take a critical look at their particular health programmes and policies.

This is followed by three Application Modules: the Evidence Module, which enhances participants' ability to view available evidence through a gender and rights lens, and generate new evidence for transforming health systems; the Policy Module, which provides analytical and practical skills to make change happen in small and big ways; and the Health Systems Module, which imparts the information and skills to implement, manage and sustain the transformation of health systems.

Weaving gender and rights into every module

In this curriculum, gender and rights are incorporated into every module of the course, rather than being handled as add-

on topics to reproductive health, as is so common in other courses. Here, each Foundation Module reinforces the analysis of and approach to reproductive health issues from a gender and rights perspective. Each Application Module helps apply these tools into the different elements of health system reform: research, policy and programme planning, and monitoring and evaluation of health services.

Sexual and reproductive health

Sexual and reproductive health issues such as reproductive tract infections and cancers, contraception, pregnancy and child-birth, adolescent health, abortion, sexual violence, form the content of the case studies, exercises, groups and data sets used throughout the various modules.

Communications skills

The curriculum also aims to build participants' confidence and skills in communicating about reproductive and sexual rights and health so that they can present coherent arguments on the issues, and plan interventions for their own workplace(s).

Integrity of content and methodology

The shift in paradigm that the ICPD represents puts people at the centre of programmes. This can best be communicated through training methodologies that do the same. An educational methodology that depends only on lectures by experts is making a statement about where one expects to find solutions to problems. Participatory methods affirm the value of the wisdom and knowledge that everyone brings to a problem situation.

How the manual is organized

The manual is in three parts. This opening part includes the brief background to the course provided above, practical details about who the course is for, what it contains, how it is run, and who can run it. The second part contains the six teaching modules with an opening and a closing module, and the third part contains annexes with tools and resources for participatory training methods, for facilitating participatory

sessions, some examples of participatory exercises, evaluation forms, and a sample course time-table.

Who is the course for?

This course aims to build a critical mass of senior health personnel who are able to implement the commitments made at Cairo and Beijing by using a gender and rights framework in their work. It is therefore aimed principally at managers, trainers and policy makers within the health sector. Those involved in advocacy, policy and programme changes to implement reproductive health programmes, such as health activists, NGOs, staff of bilateral and multilateral agencies and donors, will also find the course useful. The curriculum is specifically designed to be used by academic and activist trainers who are likely to be offering courses in research and programming in health, as well as in gender.

How long does it take?

If run in its entirety the course takes three weeks.

Integrating the course with other training

The course was originally designed to be run as a stand-alone short course, but it may be useful as a module in graduate programmes, professional programmes, or university curricula on health systems, rights or gender.

The participatory approach

Our approach to training is problem posing and participatory. Each session presents situations and poses problems. Participants work with each other and with inputs from the trainer to find solutions.

Problem posing education bases itself on creativity and stimulates true reflection and action upon reality (Freire P. *Pedagogy of the oppressed.* London, Penguin, 1972:56). It is different from the transfer or transmission of knowledge or facts to the passive learner, where the trainer is seen as possessing all essential information, and trainees as "empty

vessels" needing to be filled with knowledge.

The choice of participatory methods is deliberate: there is a coherence between the values we promote and the way we go about sharing them. From the beginning, all participants are recognized as thinking, creative people with the capacity for action. Each person is a contributor, bringing different perceptions based on her or his own experiences.

A conscious effort has to be made to use participatory methods to genuinely enable people to grow in awareness, maturity and self-reliance, and not to control them. Any tool is only as good as the person using it and the use to which it is put. (See Annex 3 for more discussion on facilitating participatory sessions.)

Planning your course

The curriculum

The curriculum consists of six teaching modules, and one opening and one closing module, to be covered in a three-week training course. (See Annex 4 for model timetables.)

The Foundation Modules are:

- Gender
- Social determinants
- Rights.

The Application Modules are:

- Evidence
- Policy
- Health systems.

No module deals specifically with a particular reproductive health topic. But across the modules, specific aspects of reproductive health have been addressed, rather than population groups such as adolescents, older women, refugees and migrant women. However, since adolescence is a crucial time for developing a sexual identity, learning about one's body, sexuality and pregnancy, and because of the special

The Foundation Modules

The Application Modules

sexual and reproductive health needs in this period of one's life, this population group is specifically addressed in a number of sessions.

The reproductive health topics addressed are:

- maternal mortality and morbidity
- contraceptive technologies
- abortion
- HIV/AIDS
- STIs and RTIs
- cervical cancer
- sexuality
- violence against women
- infertility.

Each of these topics is addressed in at least one module. For example, violence against women is primarily covered in the Social Determinants Module, abortion in the Policy and Rights Modules, HIV/AIDS in the Rights Module, maternal health and contraceptive technologies in the Evidence Module, cervical cancer in the Health Systems Module, and so on. When planning your training course, course organizers will probably need to modify the list of topics according to local priorities, and alter the sessions accordingly.

It is not always possible to include all the priority reproductive health topics in the six modules. We therefore suggest including in the course schedule special sessions and guest lectures on current debates in reproductive health of relevance to the country or region where the course is held. Some of the current debates that have been addressed in courses to date are: medical methods of abortion, disability adjusted life years (DALYs) and their use in policy decisions, male involvement in reproductive health, and injectable contraceptives.

The facilitating team

Each of the modules requires its facilitators to have considerable expertise in the subject area, an understanding of gender and rights, and a willingness to use participatory methods. For best results, the course requires a team of facilitators of at least

three or four people, both women and men, from a mix of disciplines such as economics, gender studies, law, medicine and public health, and who have an understanding of gender and rights and participatory methods of training.

Teamwork is called for, with all facilitators meeting at least once before the course and discussing how their respective modules and sessions are linked.

While resource persons have a role to play in running specific sessions, as do guest lecturers for the current debates sessions, this course cannot be run solely by experts who drop in and out and are only familiar with the few sessions they run.

There needs to be an overall course co-ordinator who will ensure that links between modules and between sessions are clarified and that there is continuity and harmony in the concepts presented and view points expressed by facilitators.

Assessment

In South Africa, where this course was first piloted, it was (and continues to be) run as a formally assessed course, at the end of which qualifying participants receive a certificate of competence from the University of the Witwatersrand. However, not all courses run in the regional sites were formally assessed and graded for certification.

In this curriculum, each of the Application Modules includes an application exercise to be completed by participants, on which facilitators provide detailed feedback. These application exercises may be marked or graded in case of formal certification requirements. Detailed criteria for assessing these exercises are provided in the relevant session descriptions (see Session 7, Evidence Module; Session 5, Policy Module and Session 6, Health Systems Module).

Each of the application exercises may be allocated equal weightage, say 30 per cent each. Ten per cent marks may be awarded for class participation (alternately, five per cent each may be awarded for regularity in attendance and for class participation). In the South Africa course, each participant is allotted one session in which she or he has to present the "Main points for closing the session" and is graded by the facilitator. The course also required that in order to be awarded

the certificate of competence, a participant has to score a minimum mark of 50 per cent in each of the six modules, in accordance with the requirements of the University which awarded the certificate of competence. Clearly, this requirement will vary depending on which institution or university is running the course.

It would be useful to have the course assessed by the participants. A course evaluation form to be filled on the last day of the course is provided in Annex 5.

How to use the manual

The module brief

Each module starts with a module brief, which describes the objectives of the module as a whole ("What participants will get out of the module"), presents the conceptual framework for the module and the content of the sessions ("The thinking behind the module"), illustrates how the sessions are linked to each other ("Structure of the module"), and presents in tabular form the objectives, format and duration of all the sessions ("Module outline"). Use these parts of the module brief in the introduction session for each module, and in the summary and consolidation at the end.

The descriptions of the sessions

After the module brief are the descriptions of the sessions, with activities presented in the sequence in which they are expected to happen. The session descriptions contain:

- what participants should get out of the session
- time
- materials (handouts and other accessories)
- a list of readings for the facilitator
- a list of readings for participants
- how to run the session
- activities and steps
- main points for closing the session
- lecture notes for the facilitator
- handouts.

There are step-by-step guidelines on the kind of questions to ask participants and the usual responses (based on past experience), and on how to direct the process towards achieving the session's objectives. Some sessions provide a choice of activities. Some require that you prepare something in advance. This is clearly indicated under "Prior preparation" at the beginning of the session.

Overheads

Where it is appropriate to use overheads this is indicated with the symbol indicated here in the margin. The text, tables or diagrams to be presented as overheads are usually included in the session description, but overheads may sometimes have to be prepared from the lecture notes for the facilitator or the handouts. In addition, the facilitator may find it useful to present as overheads the sections "What to cover in the discussion" and "Main points for closing the session".

Handouts

The handouts are provided as illustrations. The case studies or exercises in them may or may not be suitable for your target group, and you are expected to modify them. Moreover, data and information provided will have to be updated.

Lecture notes

Lecture notes for the facilitator are provided for sessions which involve longer inputs. These contain outlines of lectures and illustrative case studies that may be adapted to suit your target audience.

Readings and the course files

The list of readings for facilitators for each session contains a range of publications and articles which formed the basis for the content of the session. They are meant to help the facilitator prepare for the session. Readings for participants are meant to be included in the course files distributed to participants at the beginning of the course (see Opening Module, Session 2, Step 3). **Course organizers must make**

sure that the requisite copyright permissions are sought for photocopying published articles.

The course files are to be prepared by the course organizers in advance and are to be distributed to participants when they fill out their registration forms on the opening day of the course. The course files will contain:

- Readings for participants
- Course time-table
- Logistical and administrative details concerning the course (see Session 2, Opening Module, p.22)
- Module briefs of the three Foundation and the three Application Modules.

Evaluation of this manual

This manual has evolved over five years, being tested and tried in different places. Our hope is that it will continue to evolve through use and adaptation by groups and institutions in different settings. As you use this manual, you will undoubtedly find elements you think can be improved, and others that work well. We encourage you to take a few minutes to fill out the evaluation form at the very end of the book, and return it to us. You may also send comments through the WHO Department of Reproductive Health and Research email: rhrpublications@who.int.

PART TWO

Teaching modules

Opening module

Module outline

		Objectives Participants will:	Format of activities	Time: 5 hours and 30 minutes
SESSION 1	Welcome and introduction	• begin to feel relaxed with each other • be introduced to each other and to the facilitators	Participatory exercises	1 hr 30 mins
SESSION 2	Administrative and logistical matters	• know something about the history and background of the course • be informed about administrative and logistical matters	Input session	30 mins
SESSION 3	A group contract	• discuss expectations and anxieties • discuss their contributions to the course • reach consensus on ground rules that will govern the entire course and commit to these ground rules • set up working groups to facilitate group processes during the course	Group work followed by consolidation in the whole group	1 hr 45 mins
SESSION 4	Overall framework of the course	• be clear about the objectives, content and framework of the course • understand how the course addresses barriers to the achievement of reproductive and sexual rights and health as defined by the *Programme of Action* of the International Conference on Population and Development (ICPD) in Cairo, and the *Platform for Action* of the Fourth World Conference on Women (FWCW) in Beijing	Group work Discussion and input	1 hr 5 mins 40 mins

Module brief

What participants should get out of the Opening Module

Participants will:

- be introduced to other participants and to key facilitators
- be oriented to administrative and logistical issues
- have an opportunity to express their expectations of and anxieties about the course
- reach consensus on the ground rules that participants and facilitators will observe
- be introduced to the background, history, objectives, content and overall framework of the course
- understand how the course addresses barriers to the achievement of reproductive and sexual rights and health as defined by the *Programme of Action* of the International Conference on Population and Development (ICPD) in Cairo, and the *Platform for Action* of the Fourth World Conference on Women (FWCW) in Beijing.

The thinking behind the module

Getting to know each other and the course

This module is scheduled for the first part of the opening day, and is to be followed by the first session of the Gender Module. Its purpose is to help participants get to know and feel at ease with each other, and to orient them to the course content and methodology.

Ground rules for an enabling learning environment

There are four sessions. The first aims to welcome and introduce participants and facilitators and to break the ice. This second is a brief orientation to the background and history of the course, and to administrative and logistical details. The third session offers participants an opportunity to discuss their expectations and any anxieties they may have. Based on these, participants and facilitators develop a group contract which sets out the ground rules that will facilitate an enabling learning environment. The fourth session introduces participants to the objectives, content and overall framework of the course.

SESSION 1

Welcome and introductions

What participants should get out of the session

Participants will:

- begin to feel relaxed with each other
- be introduced to each other and to the key facilitators.

1 hr 30 mins

1 hour and 30 minutes

Materials

- cards and pens, one for each participant
- pins and bulletin board for putting up cards
- cardboard name stands, one for each participant
- flip chart or overheads

How to run the session

How introductions are done tends to vary in different cultures and in different places; you should choose a process which is suitable for your group. Steps 2 and 3 are an example of a way to do introductions which is participatory and engaging. The activity for this session also serves as an ice-breaker, helping participants to relax and to get to know one another beyond their names and formal job titles. In addition, it sets the tone for the participatory learning methodologies used throughout the course. (There are more examples of ice-breakers in Annex 3.)

1 hr 30 mins

Activity: Getting to know each other

5 mins

Step 1: Facilitator's welcome

Welcome participants and introduce yourself. Explain the introduction activity you have chosen.

5 mins

Step 2: Which animal am I?

Give each participant crayons and a card on which they should draw the animal that best represents who they are. Ask them to think about why this animal represents them.

Also ask participants to write the name they wish to be addressed by during the course on the cardboard name stand in front of them.

1 hr - 1 hr 20 mins

Step 3: Who am I and where do I come from?

Ask participants to take turns to:

- introduce themselves by their name, their country, the job they do, and the organization they work for
- show the animal they drew and explain why it represents who they are
- say what tasks, responsibilities or concerns they have left behind when coming to this course
- say what they expect from the course.

Step 4: Expectations

As participants speak, write down on a flip chart or on overheads the expectations that participants have voiced and explain that expectations will be discussed at length in Session 3.

Put the pictures of animals up on the walls.

Step 5: Types of expectations

Between this session and Session 3, go back to the expectations that you put on the flip chart or overheads and categorize them. Code (with different colours or symbols, for example) the categories. Some of the categories of expectation that usually emerge are:

- new information and skills
- group dynamics and learning processes
- applying the information and skills gained on the course when back in the workplace.

Keep these flip charts or overheads. You will use them again when you revisit expectations in the Closing Module on the last day of the course.

Session developed by Makhosazana Xaba

SESSION 2

Administrative and logistical matters

What participants should get out of the session

Participants will:

- know something about the history and background of the course
- be informed about administration and logistics.

30 mins

30 minutes

Materials

The following handouts are not included in the training manual. The facilitator must prepare them.

- map of the city marked with the place/s where participants are staying and other places such as banks, places to eat, a pharmacy, and so on
- information on administrative and logistical details such as per diems, using the fax, phone, e-mail and photocopying facilities, relevant phone numbers and contact details, and so on
- information on recreational activities and sight-seeing
- details of assessment and grading (as relevant to your course)

How to run the session

This is an input session explaining the details of the course.

Activity: Orienting ourselves

7 mins

Step 1: What is this course all about?

Give a brief input on the history and background of the course, who it is aimed at, and what the overall aims of the course are, drawing on Part 1: "Introduction". You will deal with the specific objectives of the course in Session 4.

10 mins

Step 2: Let's make sure the course runs smoothly

Give information on logistics and administrative matters. You may include issues such as:

- who to talk to for which need: ideally, introduce the people responsible for logistics

- the resource room: what is available there (computers, printers, photocopier, telephone, fax, e-mail, paper, additional readings), where it is and how it should be used
- per diem and sponsorship where applicable
- the physical location of the course venue in relation to other amenities like banks, travel agencies, restaurants, entertainment, and so on
- any special health or diet requirements of participants.

The first day is often disrupted if participants need to change money and banks have limited opening hours. It is best to schedule time on the opening day for banking and attending to other administrative matters. You may prepare and include in the course file handouts and maps with essential details. This will help save time.

Step 3
The course files

Go over the content of the course files with participants. They will contain the readings, module briefs of the foundation and application modules, the course timetable, information on assessment and grading (see below) and logistical and administrative information as required. Remember to point out on the timetable events that are not content-related, like time scheduled for a photo session, and social events such as dinners and sightseeing trips.

Step 4:
How will participants be assessed?

Explain the various methods that will be used to assess participants. Some guidelines are presented in "Assessment of the course" on p.12 of Part 1. These have to be adapted to suit your course. On the timetable, point out the days when you will give an assignment for grading. Prepare a handout if possible, summarising the methods of assessment and marking schemes, and include this in the course file.

Session developed by Barbara Klugman

SESSION 3

A group contract

What participants should get out of the session

Participants will:

- discuss their expectations of and anxieties about the course
- discuss their contributions to the course
- reach consensus on the ground rules that will govern the whole course and commit themselves to these ground rules
- set up working groups to facilitate group processes during the course.

1 hour and 45 minutes

Materials

- flip charts
- 5 or 6 sets of 3 cards in 2 different colours
- pens.

How to run the session

This session provides an opportunity for participants to discuss their expectations of and anxieties about the course (which they stated in Session 1) and to evolve a group contract. There is just one activity, divided into five steps.

What is a group contract?

The group contract is an agreement that a group reaches on how to behave, what to expect, and how to respond to one another during the course. It is important for adult learners to define their own rules and to do this through discussion and consensus building. Three weeks is a long time for a group of people to live and work closely together, and interpersonal relationships and group dynamics play an important role in making the learning environment positive or obstructive. This session's activity attempts to help participants anticipate and plan how to deal with issues of group dynamics and interpersonal relationships.

1 hr 45 mins

Activity: Ensuring good group dynamics

5 mins

Step 1: Divide into small groups

Divide the group into four or five small groups with an equal number of participants in each. Give two sets of colour-coded cards to each group.

30-40 mins

Step 2: Prioritize anxieties and contributions to good group dynamics

Ask the groups to discuss and prioritize the following:

- three major anxieties about the course
- how participants can contribute to facilitating a good group process.

Point out that individuals should offer contributions to making the group work well that they themselves can commit to, rather than suggesting what might be nice for someone else to contribute.

Each group writes their major three anxieties on three separate cards. They then do the same for the three most important contributions to good group dynamics which they feel everyone ought to observe.

40 mins

Step 3: Discussion

When all the small groups have completed Step 2, ask each group to present to the whole group the three anxieties and three contributions they have prioritized. They stick their cards to the wall or white board in front of the whole group. When everyone has made their presentations, engage the whole group in a discussion on each of these, beginning with the anxieties.

What to cover in the discussion

Anxieties

Some anxieties are healthy and easy to live with, for example about whether participants will be good enough and get their certificates of competence. Identify anxieties that fall into this category and tell participants that these are natural to have.

Begin to develop a list of rules through the discussion of some of the anxieties, such as "I will be attacked for my ideas". Clarify that it is important to challenge the idea but not the person, and write this down as part of the list to be considered for the group contract.

When dealing with anxieties such as "I will not be heard," ask participants "How will the group know you are not being heard?". This will help participants see that they have an individual responsibility for making the group aware of their specific needs.

Another anxiety that many participants express is whether what they say will remain confidential. The group then has to agree to respect confidentiality.

Some of the men may be anxious that the programme may entail a fair amount of "male bashing". The group would then have to agree that it will not encourage an anti-male attitude in participants and facilitators.

Move suggestions for dealing with this and similar anxieties to a list of contributions. Some examples of contributions emerging from the discussion of anxieties are: taking personal responsibility for active participation, and being sensitive to the difficulties that those who do not have English as their first language may experience.

Contributions

Some of the contributions that the participants bring up, such as taking responsibility to speak up in the group, will be related to the anxieties they expressed. During the presentations of contributions it is important to get a personal commitment from the group for ensuring that certain things happen. For example, while everyone may agree that time-keeping is important, not everyone will be willing to be the time-keeper. On the other hand, some contributions, like "Do not interrupt while others are talking", need everyone's commitment.

Expectations

This part of the discussion is based on the expectations that participants expressed in Session 1 and which you have subsequently categorized.

Go over the list of expectations with participants and explain where and how in the programme each of these will be met. The facilitator of this session must be familiar with the course content and methodologies as well as the timetable.

As with the anxieties, fulfilling some expectations depends more on the participants than on the facilitators. For example, "Learning from each others' experiences".

Think through in advance the kinds of questions that are likely to emerge in this discussion.

Some expectations are not likely to be met. These may be about the content of the course, or extra-curricula activities. It is your responsibility to clarify which expectations the course cannot meet and to explain that it is not usually possible to meet all the expectations of a diverse group. But it may well be possible to accommodate some expectations – for example, a visit to a local non-governmental organization – even if these were not originally planned.

Step 4: The group contract

Use the solutions to anxieties and contributions to a good group process that the participants have proposed to evolve ground rules for the course. List these on a flip chart as they emerge and are agreed upon.

Once all the ground rules have been agreed upon, put the flip charts up on one of the walls. They must stay up until the end of the course.

Example of a group contract

We agree during this course to:

- keep time
- respect one another's contributions to the group and in particular not to interrupt other participants
- support one another when the need arises
- interrogate the idea and not the person
- share our experiences
- turn off our cell phones during sessions
- speak out when we do not understand, feel unheard, disagree with or are hurt by what someone said
- observe rules of confidentiality in the sessions and in small groups.

Step 5: Taking responsibility

Working groups or committees often need to be set up to make sure that the group contract is observed. Ask the group to set up two or more committees to:

- ensure that the group contract is observed
- provide weekly feedback to the course organizers about the progress of the course
- take responsibility for participants' welfare, organize recreational activities and so on.

Session developed by Makhosazana Xaba

SESSION 4

Overall framework of the course

What participants should get out of the session

Participants will:

- be clear about the objectives, content and framework of the course
- understand how the course addresses barriers to achieving reproductive and sexual rights and health as defined by the *Programme of Action* of the International Conference on Population and Development (ICPD) in Cairo in 1994, and the *Platform for Action* of the Fourth World Conference on Women (FWCW) in Beijing in 1995.

1 hour and 45 minutes

Materials

- Handout: "Definitions"

- 6 flip charts mounted on the wall facing the participants
- marker pens
- overhead: based on "What does this training curriculum offer ?" on p.6 of the Introduction

Readings for facilitators

1. United Nations Population Fund. *Programme of Action of the International Conference on Population and Development,* Cairo, 5–13 September 1994. New York, United Nations, 1996 (UN Doc. A/CONF.171/13).

2. United Nations. *Platform for Action of the Fourth World Conference on Women,* Beijing, 4–15 September 1995. New York, United Nations, 1996 (UN Doc. A/CONF.177/20).

3. The introduction to this manual (Part 1) which gives details of the background to the course and its structure and content.

How to run the session

The facilitator of this session has to be familiar with the structure and content of all the modules of the course, and the links between them.

There are two activities. In the first, you introduce participants to the definitions of reproductive and sexual rights and health as outlined in the *Programme of Action* of the ICPD, and the *Platform for Action* of the FWCW. Participants read the definitions and list barriers to the achievement of these in their own countries. They then work in groups to make a list of major shared barriers. In the second activity, you show how this course addresses these barriers and enables participants to acquire the conceptual tools to deal with them. This activity ends with a presentation using overheads of the structure of the course and its specific objectives.

Activity 1: Barriers to achieving reproductive and sexual rights and health

Step 1: International declarations and programmes of action

Ask if participants are aware of, have participated in, or know their own country's involvement in the International Conference on Population and Development (ICPD) held in Cairo in 1994, and the *Programme of Action* that came out of it.

Talk about how the ICPD shaped the international community's understanding of the interlinkages between population and development, and promoted the concepts of sexual and reproductive rights and health. Note that most countries of the world supported the ICPD's *Programme of Action.* Find out before you start this session if any of the participants' countries did not support any part of it and the reasons why. Share what you have found out.

Then ask if they all know about the Fourth World Conference on Women (FWCW) held in Beijing in 1995. Talk about how that conference, in addition to restating the ICPD position on reproductive rights and sexual and reproductive health, asserted women's human right to control their sexuality.

Discuss how international conference declarations and programmes of action are agreed on by consensus and therefore become the lowest common denominator of agreement between countries. Implementing these agreements should be the minimum we expect of our countries. However, very often these commitments are very far from where our countries actually are in terms of both policy and services. Stress that their usefulness, as laid out later in the Policy Module (Module 5), comes from global participation in them, and that we can maximize the promises without being trapped by the processes.

10 mins

Step 2: Definitions

Hand out the definitions of reproductive health, sexual health, reproductive rights and sexual rights reproduced in the handout: "Definitions". You may note that the language of sexual rights is not used in the FWCW (Beijing) document, but that people in the field talk about this paragraph as "the sexual rights paragraph" because it is about applying human rights to the area of sexuality (paragraphs 7.2 and 7.3 of the ICPD document and paragraph 96 of the FWCW document).

Read the paragraphs aloud or ask a different participant to volunteer to read each paragraph.

10 mins

Step 3: Barriers in different countries

Ask each person to read the paragraphs individually and to list barriers and factors that make it difficult for their country to achieve reproductive and sexual rights and health.

25 mins

Step 4: Common barriers

Divide participants into groups. Ask them to share their lists with each other to collectively come to an agreement on the major barriers and to write these down.

40 mins

Activity 2: The course structure

15 mins

Step 1: Grouping the barriers

Get each group to report back on the list of major barriers to sexual and reproductive rights and health they have come up with. Explain that this should be quick and not involve too much discussion; this is the first day of the course and a general orientation to the issues rather than an in-depth discussion. As each group presents its list, write each issue on one of the six flip charts put up on the wall, depending on which of the six modules of the course will be addressing the issue. You may put it on more than one flip chart if the issue is addressed in several modules. By the end of the group reports, the issues raised will have been organized by module topic. (But you have not at this stage actually named the modules on the flip charts.)

10 mins

Step 2: The modules

Tell participants that the course aims to help them to work out how they might contribute towards promoting sexual and reproductive rights and/or improving sexual and reproductive health services by addressing the very barriers that they have identified.

Go to the first flip chart. This list will be of barriers to the implementation of sexual and reproductive health and rights which are related to gender relations. Some examples include: women's low status and how this affects women's ability to make choices about motherhood, and family planning being targeted mainly at women. Explain that these issues will be looked at in the first module, which is on gender. The Gender Module establishes the links between gender inequalities and sexual and reproductive rights and health, and provides the tools for analysing the extent to which health policies and programmes are gendered.

Then go to the next list, which will be of issues related to the social determinants of health and illness, such as poverty, structural adjustment programmes, the lack of basic infrastructure like transport to get to health services, and so on. Explain that these are all issues related to social determinants (or ask the group to characterize this list) and go on to explain what the Social Determinants Module aims to do.

Go through each list of issues in the same way until you have covered all the modules.

Point out how much information this activity generated and that participants actually had most of the information they needed.

Step 3: Content and methodologies

Put up the objectives and the main features of the course as an **overhead** transparency. (See Introduction: "What does this training curriculum offer ?" for details.)

After your input on the content of the course, discuss the methodologies. (See Annex 3: "Ideas for facilitating participatory sessions" for details.)

Main points for closing this session

The issues are interrelated

Many issues that participants have identified could have been placed in a number of different modules. This is because the barriers to the achievement of sexual and reproductive rights and health are interrelated.

The modules are interconnected

The six modules into which the course is organized are interconnected, and each module attempts to build on the earlier ones.

Conceptual tools and how to use them

The course is not organized into reproductive health topics (like maternal health, and reproductive tract infections) but into Foundation and Application Modules. The Foundation Modules provide the conceptual tools. The Application Modules provide the skills for applying these tools to transforming policy making and the planning and implementation of health services, to achieve sexual and reproductive health and rights. Almost all of the cases and examples used in the modules are reproductive and sexual health issues.

Applying the course in different work situations

The course is intended to support participants in their own work situations. This may mean, in the case of health service managers, enabling them to take action to promote sexual or reproductive rights, or to improve the quality of the health services they manage. For participants from the donor community, the course will help ensure that their programme funding promotes sexual and reproductive rights and

the development of high quality reproductive health services within primary health care services. Participants engaged in advocacy will acquire the tools to identify the barriers to policy change and the best possible strategies for advocating for policies.

Communication and planning skills

The course also aims to build participants' confidence and skills to communicate about reproductive and sexual rights and health to present coherent arguments on the issues, and to plan interventions which they will be able to implement in their workplaces.

Session developed by Barbara Klugman

Handout

1 Definitions

Reproductive rights

"...reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government - and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed."

Paragraph 7.3 of: United Nations Population Fund. *Programme of Action of the International Conference on Population and Development,* Cairo, 5–13 September 1994. New York, United Nations, 1996 (UN Doc. A/CONF.171/13) and repeated in paragraph 95 of: United Nations. *Platform for Action of the Fourth World Conference on Women,* Beijing, 4–15 September 1995. New York, United Nations, 1996 (UN Doc. A/CONF.177/20).

Sexual rights

"The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."

Paragraph 96 of: United Nations. *Platform for Action of the Fourth World Conference on Women,* Beijing, 4–15 September 1995. New York, United Nations, 1996 (UN Doc. A/CONF.177/20).

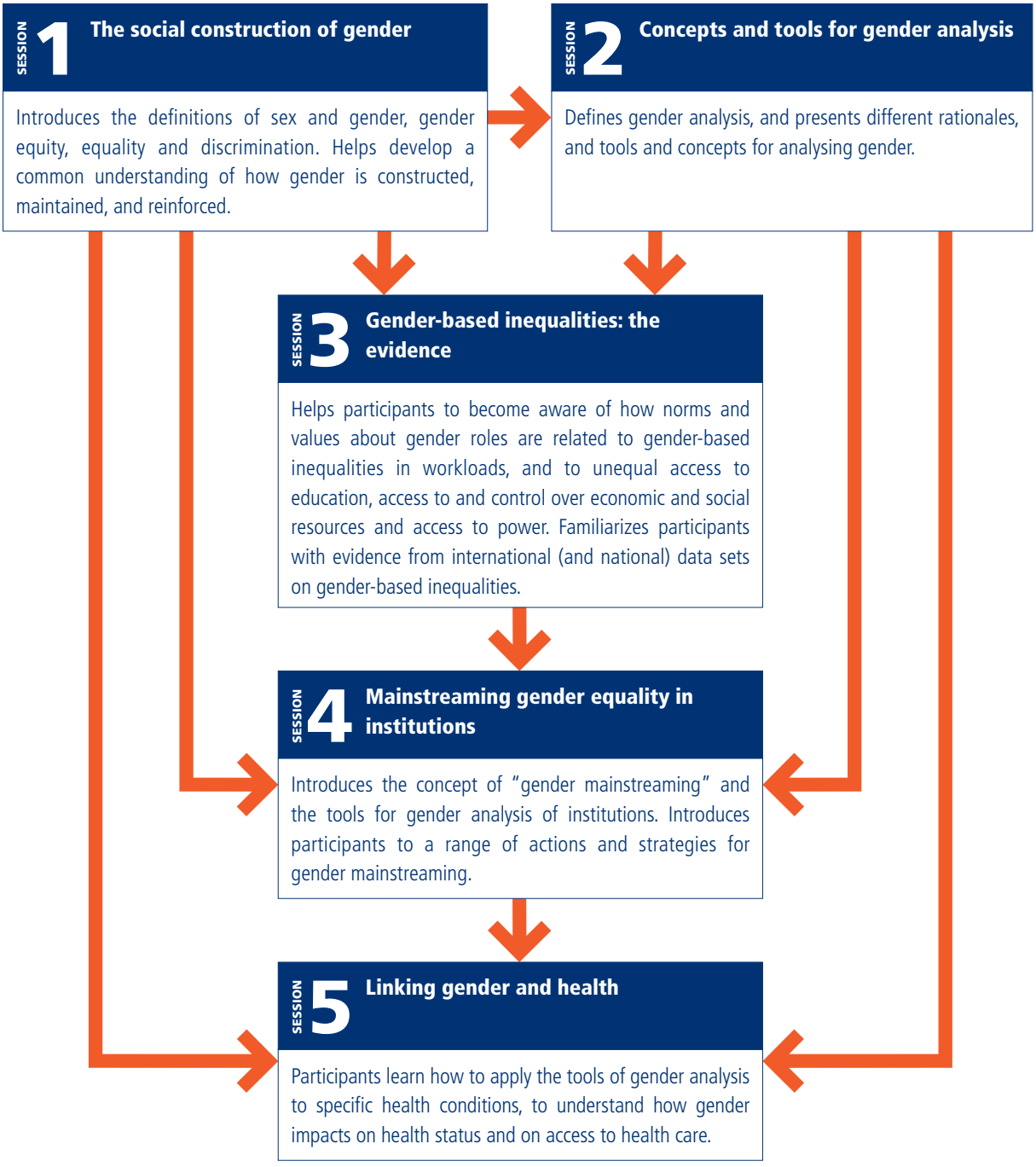
Reproductive health

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."

Paragraph 7.2 of: United Nations Population Fund. *Programme of Action of the International Conference on Population and Development,* Cairo, 5–13 September 1994. New York, United Nations, 1996 (UN Doc. A/CONF.171/13) and repeated in paragraph 94 of: the *Platform for Action of the Fourth World Conference on Women* (United Nations 1995). United Nations. *Platform for Action of the Fourth World Conference on Women,* Beijing, 4–15 September 1995. New York, United Nations, 1996 (UN Doc. A/CONF.177/20).

Module 1: **Gender**

Structure of the Gender Module



MODULE 1

Module brief

What participants should get out of the Gender Module

Participants will:

- be familiar with the conceptual differences between sex and gender, and develop a common understanding about how gender is constructed, maintained, and reinforced
- become aware of the common areas and the variations in the construction of gender in different social and cultural contexts
- understand and apply concepts and tools for gender analysis, including tools for gender mainstreaming
- become aware of how norms and values about gender roles are related to gender-based inequalities in workloads and to unequal access to education, access to and control over economic and social resources, and access to power
- examine and interpret evidence from international (and national) data sets on gender-based inequalities in education, and in economic, social, and political status
- learn how to apply the tools of gender analysis to specific health conditions and understand how gender impacts on health.

The thinking behind the module

Gender as a social construct

Starting with participants' own life experiences, this module introduces them to the concept of gender as a social construct. The module looks at how gender as a social construct attributes different roles and responsibilities to females and males, and gives them unequal access to resources and power. You introduce tools to help participants understand the mechanisms that underlie and contribute to gender-based differences, and apply these tools to health issues to see how gender impacts on health. The Gender Module lays the basis for understanding the themes of the three application modules: how gender issues permeate health information; evidence used for making decisions in the health sector; health policies; and planning and implementing health programmes.

Session 1 helps participants develop an understanding about how gender is constructed, maintained and reinforced. It also clarifies terms like gender equality, gender equity and gender-based discrimination. The session starts from participants' life experiences of how they have been socialized into playing gender roles. You then lead

them to discover that the gendered roles they play as adults are a result of messages they have learned and internalized since childhood. Further, they begin to see the roles that the family, school, religious institutions, work organizations, media and other social institutions play in constructing what men and women do in society. By reflecting on their own experiences, they begin to understand that the social construction of gender can also be determined by race, class, caste, age, marital status and so on.

(We suggest that you schedule the first session of the Gender Module for the opening day of the course, following on from the Opening Module. The other gender sessions will take another full day.)

In Session 2, participants revisit the concepts of gender and sex and do an exercise to clarify the differences between the two concepts. Gender differences are sometimes confused with biology: for example when we assume that women are better suited for the caring professions such as nursing and child-minding, because they are naturally made that way. This session also introduces some basic concepts and tools for analysing gender: the gender-based division of labour; gender roles and norms; access to and control over resources; and access to decision making and power.

Session 3 illustrates how the gender-based division of labour is far from a simple sharing of responsibilities, and is at the root of women being under-valued and their low status in society. You introduce participants to international (and/or national) data sets that show how gender differences are transformed into gender-based inequalities in the way resources and power are distributed. Participants then apply the gender concepts they have learnt in the previous sessions to interpret these data sets.

Session 4 introduces the concept of gender mainstreaming. Gender inequality is imbedded in many institutions in society, including health institutions. If society does not value women's input, social institutions are unlikely to do so either. If society does not give women access to decision-making, social institutions will not either. Likewise, if society does not value women's health, health institutions probably won't either. It is also important to analyse whether and how health institutions reinforce gender inequalities actively and explicitly, or more passively, by omission.

This session aims to help participants become sensitive to how the skills, information and tools that you have introduced them to during the course can help them in gender mainstreaming their own health institutions, as well as the health programmes they run, fund or use.

Session 5 helps make the links between gender and health. Using the case study of a health condition affecting both women and men, participants unravel the differentials between males and females in health status, health seeking behaviour and health outcomes arising from biological and gender differences.

Module outline

		Objectives Participants will:	Format of activities	Time: 9.5 hours
Introductory session	Introduction to the Gender Module	• be acquainted with module structure, objectives and content	Input	15 mins
SESSION **1**	The social construction of gender	• be introduced to the definitions of sex and gender • develop a common understanding of how gender is constructed, maintained, and reinforced; and of the meanings of gender equity, gender equality and gender discrimination • become aware of the common areas and differences in the construction of gender in different social and cultural contexts	Individual work Work in pairs Whole group discussion	15 mins 15 mins 1 hr 30 mins
SESSION **2**	Concepts and tools for gender analysis	• internalize the conceptual differences between sex and gender • learn tools and concepts for gender analysis	Individual work Whole group discussion and summary Input and discussion	10 mins 1 hr 30 mins
SESSION **3**	Gender-based inequalities: the evidence	• become aware of the ways in which norms and values about gender roles are related to gender-based inequalities in workloads and to inequalities in access to education, access to and control over economic and social resources and access to power • learn to examine and interpret evidence from international (and national) data sets on gender-based inequalities in education, economic and political status	Group activity Whole group discussion	1 hr 1 hr 15 mins
SESSION **4**	Mainstreaming gender equality in institutions	• be introduced to the concept of gender mainstreaming • become aware of the steps and changes required for achieving gender equality within their organizations	Input	1 hr 30 mins
SESSION **5**	Linking gender and health	• learn to apply the tools of gender analysis to specific health conditions, and to understand how gender impacts on health status	Input Group work Whole group discussion and summary	20 mins 30 mins 50 mins
Concluding session	Module summary	• have a consolidated overview of tools and concepts introduced in the module, and the links between them	Input	10 mins

Introduction to the Gender Module

What participants should get out of the session

You will introduce participants to the module's structure, contents and objectives.

15 minutes

How to run the session

This is an input session.

Introduce the module using **overheads** of:

- "What participants should get out of the Gender Module"
- "Structure of the Gender Module"
- "Module outline".

SESSION 1

The social construction of gender

What participants should get out of the session

Participants will:

- understand the definitions of sex and gender
- develop a common understanding of how gender is constructed, maintained and reinforced, and understand the meanings of gender equity, gender equality and gender discrimination
- become aware of the common areas and differences in the construction of gender in different social and cultural contexts.

2 hrs

about 2 hours

Materials

- marker pens
- at least 3 flip charts divided into 5 columns labelled like this:

Age	People involved	Place	What the incident was about	Feelings associated with the incident

- overhead or flip chart: "Sex and gender", on p.43
- overhead or flip chart: "Gender equality, gender equity and gender discrimination", on p.43

Readings for the facilitator

1. Oakley A. *Sex, gender and society,* reprint. Bath, Pitman Press, 1982.

2. United Nations Division for the Advancement of Women/ Office of the High Commissioner for Human Rights/United Nations Development Fund for Women. Background paper prepared for the DAW/ OHCHR/UNIFEM Expert Group Meeting on Gender and Racial Discrimination (Zagreb, 21- 24 November 2000). New York, United Nations, 2000.

3. United Nations Division for the Advancement of Women/ Office of the High Commissioner for Human Rights/United Nations Development Fund for Women. Report of the Expert Group Meeting on Gender and Racial Discrimination, Zagreb, Croatia. Available online at: www.un.org/womenwatch/daw/csw/genrac/report.htm (Date accessed: February 2001).

How to run the session

This session consists of two activities. In the first, each participant writes down her or his first experience of realizing that he or she was different from members of the opposite sex. Participants then share these experiences in pairs. The second activity is a discussion with the whole group and an input from the facilitator.

30 mins

Activity 1: Going back to childhood

15 mins

Step 1: Individual work

Ask participants to think as far back as possible in their lives and to write down their first experience of realizing that they were different from members of the opposite sex and/or expected to behave differently and treated differently from members of the opposite sex.

In one or two paragraphs they should try to record:

- how old they were
- who was involved
- where the incident took place
- what the incident was about
- how they felt about it
- how other aspects of their identity (race, religious identity, nationality, ethnicity, caste) came into play in this incident.

15 mins

Step 2: Sharing in pairs

Participants then share their stories in pairs.

1 hr 30 mins

Activity 2: Exploring sex, gender and socialization

20 mins

Step 1: Report-backs to the group

Put up the flip charts you have made. Ask one of the pairs to volunteer to report on each others' stories to the whole group. Write the essential details under the specific columns.

There may not be enough time for all pairs to report back. Ask for examples that involve different actors and different places. For example, if the first pair reported about something that happened at home and involved family members, ask for volunteers who have a school-based incident to describe, and so on.

When participants have stories about physical/biological differences, for example when they mention the differences in genitalia and menstruation, encourage them to also give other examples that are not about physical features but about expected behaviour.

5-10 mins

Step 2: Your input: introducing sex and gender

This is an appropriate moment to introduce the definitions of sex and gender. Draw participants' attention to the fact that differences between boys and girls are not just those related to their anatomy and physiology. Boys and girls are taught to dress differently, behave differently, carry out different tasks, and so on.

Put up an already prepared flip chart or **overhead** transparency with these definitions of sex and gender.

Sex and gender

Sex is the biological difference between males and females.

Gender refers to the economic, social and cultural attributes and opportunities associated with being male or female in a particular social setting at a particular point in time.

Following this, introduce the terms gender equality, gender equity and gender discrimination on more flip charts or **overheads.** This is to help participants develop a common vocabulary for describing the various elements of gender-based differences.

Gender equality, gender equity and gender discrimination

- **Gender equality** means equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities and society at large.
- **Gender equity** means fairness and justice in the distribution of benefits and responsibilities between women and men. It often requires women-specific programmes and policies to end existing inequalities.
- **Gender discrimination** refers to any distinction, exclusion or restriction made on the basis of socially constructed gender roles and norms which prevents a person from enjoying full human rights.

30 mins

Step 3: Group discussion: personal experiences

Go through each column in the flip chart you have filled in, and start a discussion.

What to cover in the discussion

Age

The youngest age is usually interesting to note as it highlights how early socialization begins. The usual range is 5 to 10 years.

The people involved

Family members, peers, teachers and people in educational and religious institutions are usually the first to introduce a child to appropriate codes of gendered behaviour.

Place

This often corresponds with the kinds of people involved. The home or family for example, at play, in school or in church for peers and teachers and adults in general.

What the incident was about

Usually this includes:

- **Division of labour:** the kind of household chores that girls are expected to do compared to boys; girls work inside the home and boys outside; girls work for others in the home, for example cooking, washing dishes, cleaning the house and washing clothes; boys are sent out on errands; girls do things for boys like serving food, cleaning up after them and doing their washing; boys in some cultures are asked to escort girls in public.
- **Dress codes:** across cultures, girls and boys are expected to be dressed differently right from the moment they are born. These differences may vary across cultures and societies.
- **Physical segregation of boys and girls:** in many cultures, especially in Asia, physical segregation starts at an early age. Common experiences often include being told not to play with members of the opposite sex, or not to get involved in any activity that will bring one into physical contact with people of the opposite sex.
- **The kinds of games girls and boys play:** girls are not encouraged to play games like football, which involve vigorous physical activity and physical contact with each other; boys are often not allowed to play with dolls or play as homemakers. Boys who do not engage in rough physical games are thought to be "sissies".
- **Emotional responses:** girls and boys are expected to respond differently to the same stimulus; while it is acceptable for girls to cry, it is seen as a weakness in boys.
- **Intellectual responses:** there is an expectation that girls are not to talk back or express their opinions. This is often mentioned in relation to school and how teachers pay more attention to boys because they expect more of boys. In one training programme, a participant from Japan told the story of how, when she obtained the highest marks in class, her teacher called her and asked her to agree that instead he would give the highest marks to the boy who was really second. He explained that it would not be good for the boy to come second and the boys would not treat the girl well if she did better than them.

Class, caste, ethnic and other differences

Explore how differences across class, caste, ethnicity and nationality affect how girls and boys are expected to behave. For example, the physical segregation of boys and girls may not be as strict in other parts

of the world as it is in some countries of South and West Asia. There may be differences in the division of tasks by sex across different classes: girls from poorer social backgrounds are usually expected to shoulder many household responsibilities, and boys are expected to earn money; while girls and boys from richer households may have a very protected upbringing without responsibilities.

Women and men's different responses to the activity

This activity may cause stress and tears among some women in the group who are reminded of very painful experiences. They may feel angry that they did not have their eyes open about what was really happening to them. Some women have taken this opportunity to give examples of how they themselves have been perpetuating the oppression and abuse of women, and they get upset when they discover how trapped they have been.

In some groups, women express negative feelings about the specific incident: feelings of resentment, anger, disappointment, frustration, confusion, rejection, isolation, and loneliness and inferiority.

Men, on the other hand, have often expressed positive feelings: feeling superior, feeling like a man, feeling powerful and respected. Some men however may express that they feel burdened by the fact that they are expected to be the breadwinners in their households, or by the expectation that they should be strong and never break down in adverse circumstances.

Men can also feel insecure or defensive especially if they are a minority in the group. A lot depends also on the tone of the facilitator. Stereotyping all males as a problem, or blaming men for the problems faced by women is unfair and counter-productive.

Wrapping up

Ask participants how they felt doing the exercise, and deal sensitively with the emotions that may come out.

A common question that arises during this discussion is: why do women oppress other women? Or: isn't it women who are mainly responsible for oppressing other women?

Do not avoid the question, but make comparisons with other forms of oppression like racism, and caste and class discrimination. Explain that it is common for some individuals within the oppressed groups to deal with their frustrations of being oppressed and discriminated against by reinforcing the views of the oppressor group.

Women often do not themselves have resources and power. They derive their power through their relationship with men, which places women who are dependent on the same men (for example, mother-in-law and daughter-in-law) in competition with each other.

Note that caste, class, race, ethnicity and gender-based discrimination can often work together to oppress women of various groups.

Explain that what is under discussion is a world view, an ideology that views men as inherently superior to women. This ideology, called "patriarchy", can be upheld and perpetuated by both women and men. Give examples of workers oppressing other workers and ask the group to come up with other examples.

30 mins

Step 4: Group discussion: institutions of gender socialization

Move the discussion beyond personal childhood experiences and individual incidents to institutional norms, practices, structures and resource allocation patterns.

Encourage a discussion by asking the following questions:

- To which institutions did the people who introduced you to or reinforced gender norms belong? What are the norms and practices of these institutions? Who do these norms and practices privilege?
- Were you given reasons about why you were supposed to behave in a particular manner?
- Did you challenge that? Do you know others who challenged it? If yes, what happened? If not, why not?

What to cover in the discussion

The social institutions which introduce and reinforce gender norms

Behind the people who introduce and reinforce gender norms are a range of social institutions: the family, religious institutions, communities, schools, the media, and the state. Of these, the family, the media and religion play a major role from very early on in a person's life.

The rules and practices of these institutions are perceived to be unchangeable. In many instances girls and boys receive no explanations about why they ought to behave in a particular way. If reasons are given at all, they generally include cultural and religious motivations.

Some participants may say that the reason they did not challenge certain ideas was because they accepted that culture and religion could not to be questioned. If this happens in your group it is important to point out that culture changes all the time, that it is defined by people and redefined constantly. Give relevant examples or ask the group to give examples.

When children have challenged certain ideas they have been discouraged, scolded and sometimes punished. Later in life those who dare to do things differently often get labelled, isolated and constantly reminded of how different they are.

The circular reasoning behind gender role stereotyping

Point out also the circular reasoning involved in gender role stereotyping. Boys and girls are systematically taught to do or not do certain things, or not behave in certain ways, and then we assert that "Men are not good at managing the household or taking care of babies," or that "Women cannot handle crises." It seems unreasonable that after prescribing that girls/women and boys/men perform different roles, society perceives females as less valuable than males.

The difficulty in challenging society's gender norms and practices

The threat of socially condoned aggression and even violence hangs over those who dare to challenge accepted norms and codes of behaviour – for example, women who go out alone at nights; or gay people. In some cultures, women do not have the support of the families they were born into to help them get away from the violence they may face in their marital homes. Point out how this violence or aggression may also be amplified or affected by race, ethnicity, national

status, etc., so even if in general women are oppressed by gender roles, particular women will have different abilities to seek remedies.

It is easier for women and men to conform to socially prescribed gender roles than deal with the consequences of non-conformity. The repercussions are either too difficult to deal with or do not seem to be worth the social costs involved.

A country's laws and policies may formalize gender norms

Gender norms have often been formalized in law and policy. For example, laws of inheritance often favour males, and marriage and divorce laws in many countries treat women as subordinate to men. Most countries do not have or do not enforce existing laws that could address domestic violence, and rape within marriage is rarely identified as a crime. Encourage participants to share examples from their own countries. Note the important difference between policies that could be used to undo gender-based inequality but are not used, and the actual lack of laws to provide remedies, or laws that serve to perpetuate gender inequality.

Main points for closing this session

Gender roles are learnt

Gender roles are not natural roles: boys and girls are systematically taught to be different from each other. Socialization into gender roles begins early in life. This includes learning to be different in terms of, for example:

- appearance and dress
- activities and pastimes
- behaviour
- emotions that we show
- responsibilities
- intellectual pursuits.

Gender roles are learnt and therefore can be unlearnt. They are not unchangeable.

The role of the family, other social institutions and women themselves

Gender roles are taught and reinforced by various social institutions: the family, the school, religious institutions, the workplace, society as represented by peers and neighbours, to mention a few. Women play as significant a role as men in socializing girls and boys into their gender roles.

Society generally values women less than men

Society prescribes specific roles for girls and boys, women and men, but values them differently. In almost all societies girls and women are valued less than boys and men. This unequal value is the source of discrimination and oppression for women and accounts for the inferior status given to women in society.

It is difficult to put pressure on the family to change

The family is one of the most important social institutions which upholds and reinforces gender-based inequalities. And yet, the fact that the family belongs to the private sphere (compared to public sphere institutions like the workplace, schools and state institutions) has helped to keep what happens inside the family isolated from the forces of change and policy pressure towards gender equality.

Sticking to gender roles is ensured through a spectrum of controlling behaviour. This may range from simple approval/disapproval to social ostracism and socially condoned aggression and even violence (like the honour killing of women who marry against the family's wishes in some societies). Others' non-interference in what happens within a household, giving absolute power to a household's male head, is one of the most powerful tools for maintaining gender inequalities.

Gender-based inequality is often written in laws and policies

Gender-based inequality is systematically legitimized and institutionalized through laws and policies. This makes the task of challenging and breaking out of gender roles extremely difficult.

Men are also constrained by the construction of masculinity

While gender-based differences disadvantage women much more than men, men are also constrained by the construction of masculinity. There may thus be men, too, who are concerned with redefining gender roles and relations.

Fighting gender inequality is about challenging an ideology

The issue of gender inequality is far more complex than men being against women or women having to fight men. It is about challenging the ideology which rates men as superior to women (an ideology which women as well as men may help perpetuate) and vests in them greater power. And it is about challenging the institutions which uphold these values.

Session developed by Makhosazana Xaba.

SESSION 2

Concepts and tools for gender analysis

What participants should get out of the session

Participants will:

- internalize the conceptual differences between sex and gender
- learn tools and concepts for gender analysis.

1 hour and 40 minutes

Materials

- Handout 1: "Statements on sex and gender"
- Handout 2: "Concepts and tools for gender analysis"

- overhead: "The social construction of sexuality", on p.51
- overhead: "Summary of sex and gender", on p.52
- overhead of Handout 2
- overhead: "Access to and control over resources" on p.53

Readings for the facilitator

1. Canadian International Development Agency. *A handbook for social/gender analysis.* Ottawa, Coady International Institute, and CIDA, 1989.

2. Moffat L, Geadah Y and Stuart R. *Two halves make a whole: balancing gender relations in development.* Ottawa, Canadian Council for International Co-operation, MATCH International and Association Québécoise des Organismes de Coopération Internationale, 1991.

How to run the session

This session consists of two activities. In the first, each participant is given statements which they have to label as sex or gender. Then the whole group discusses participants' responses, and you provide a summary of the differences between sex and gender. By looking closely at some of the statements, you can also use this discussion to lead into concepts like the gender-based division of labour, and gender roles and norms. The second activity is an input on commonly used concepts and tools for gender analysis.

1 hr 10 mins

Activity 1: Sex or gender?

10 mins

Step 1: Individual work

Each participant is given Handout 1 containing statements that refer to the differences between men and women, some the result of sex and others the result of gender. Ask participants to write the letter G next to those they think refer to gender and the letter S to those they think refer to sex.

45 mins

Step 2: Whole group discussion

Call out each statement from Handout 1 and ask participants to say whether the statement refers to a biological difference: sex, or a socially constructed difference: gender.

The statements that refer to gender differences offer a lot of possibilities for discussion that could lead on to the concepts for gender analysis. Call out statements in sub-groups, starting with all those that refer to sex. These are statements number 1, 4 and 7. Then go over the gender statements as follows:

Statements 2, 6 and 8 introduce the concept of the gender-based division of labour

- The gender-based division of labour is socially constructed; it varies across societies and cultures; it has also varied over time.
- Today, women's household and reproductive work is not being counted in the calculation of their contribution to the economy (Statement 2).

Statement 3 is about gender roles and norms

This statement is about a child brought up as girl and then doing better at school when he learns he is a boy. It leads to discussions on gender roles and norms, and social expectations about what girls are supposed to do compared to boys. Refer to the previous session, and reiterate the powerful influence expectations have on the roles that women and men adhere to.

Statement 5 is about sexuality and sexual behaviour

Statement 5 introduces for the first time socially constructed norms about sexuality and sexual behaviour. This statement should be used to start a discussion about the accepted norms of sexual behaviour. You may note that the relationship between gender and sexuality is strong, but much current work is finding that they are not identical systems of control. Some of the examples that follow combine gender and sexuality. One way to begin to disentangle this is to note the many different ways that people in sexual relationships do not conform to dominant identities associated with gender and sexuality, such as "feminine lesbians".

You may ask participants to identify other such beliefs about women's and men's sexuality --for example, that men's sexual drive is strong, and that when they are aroused they cannot control their behaviour. (You may want to challenge participants to think about how this functions in relation to gay men, or men who have sex with men, who may act in ways that otherwise wholly conform to masculine

stereotypes.) Let them explore the idea that women have to be restrained, therefore, and not act in ways that could sexually provoke men, like being alone with a man or dressing in a certain way.

Put up an **overhead** of the box below to introduce the idea that sexuality is composed of many elements, not just physiological ones.

The social construction of sexuality

Source: Extracted from Dixon-Mueller R. The sexuality connection in reproductive health. In: Zeidestein S, Moore K, eds. *Learning about sexuality: a practical beginning.* New York, The Population Council and International Women's Health Coalition, 1995.

The social construction of sexuality refers to the process by which sexual thoughts, behaviours, and conditions (for instance, virginity) are interpreted and given cultural meaning. *[1, 2]*

It incorporates collective and individual beliefs about the nature of the body, about what is considered erotic or offensive, and about what and with whom it is appropriate or inappropriate for men and women (according to their age and other characteristics) to do or to say about sexuality.

In some cultures, ideologies of sexuality stress female resistance, male aggression, and mutual antagonism in the sex act; in others, they stress reciprocity and mutual pleasure. *[3]*

The social construction of sexuality recognizes that women's and men's bodies play a key role in their sexuality, but also looks carefully at the specific historical and cultural contexts to gain an understanding of how specific meanings and beliefs about sexuality are generated, adopted, and adapted.

References

1. Ortner SB, Whitehead H, ed. *Sexual meanings: the cultural construction of gender and sexuality.* Cambridge, Cambridge University Press, 1981.
2. Vance C S. Anthropology rediscovers sexuality: a theoretical comment. *Social Science and Medicine,* 1991: **33(8):**875-884.
3. Standing H, Kisekka MN. *Sexual behaviour in sub-Saharan Africa: a review and annotated bibliography.* London, Overseas Development Administration, 1989.

Statements 9 and 10: Elements of both sex and gender

Participants may have divided responses to Statement 9 about violence as natural male behaviour. Some may mark it as sex and others as gender. Some may argue that males are biologically prone to aggressive behaviour, while others could maintain that aggressive and violent behaviour is learnt. While biology may have some role to play in male aggression and risk-taking, the socialization of boys and the condoning of male violence plays a major role.

Encourage male participants to share experiences of how they may have been taught to be aggressive. Female participants may also want to share incidents where they saw boys being encouraged to be aggressive.

Statement 10 has both sex and gender as underlying causes. Women are more vulnerable to sexually transmitted diseases because of their biology but also because the social construction of male sexuality condones irresponsible sexual behaviour on the part of males, a gender factor. (For further help with this discussion, refer to Handout 1 "But why?" in Session 3 of the Health Systems Module.)

Step 3: Summary

Summarize the following points about sex and gender on an **overhead.**

Summary of sex and gender

- Gender identifies the socially constructed characteristics that have come to define male and female ways of being and behaviour within specific historical and cultural contexts. Gender also refers to the web of cultural symbols, norms, institutional structures and internalized self-images, which through a process of social construction defines what is meant by "masculine" and "feminine".
- Gender role socialization also prescribes what are appropriate masculine and feminine sexual roles and behaviours. In many cultures, female resistance, male aggression, and mutual antagonism in the sex act is viewed as the norm.
- Gender is a context-specific concept: gender relations vary according to ethnic group, class, culture and so on. This underlines the need to incorporate diversity when we analyse gender.
- Gender relations have changed over time, because they are nurtured by factors that change over time. This means that current gender relations are not necessarily fixed, and can be modified through interventions.
- Gender relationships are personal as well as political. Personal, because the gender roles that we have taken on define who we are, what we do and how we think of ourselves. Political, because gender roles and norms are maintained and promoted by social institutions. Challenging these means challenging the way society is currently organized.
- People's understanding of sexuality is culturally conditioned and changes over time. The relationships between the constructs of gender and sexuality are strong, but many theorists believe that they are connected but not identical systems of meaning.

30 mins

Activity 2: Tools and concepts for analysing gender

10 mins

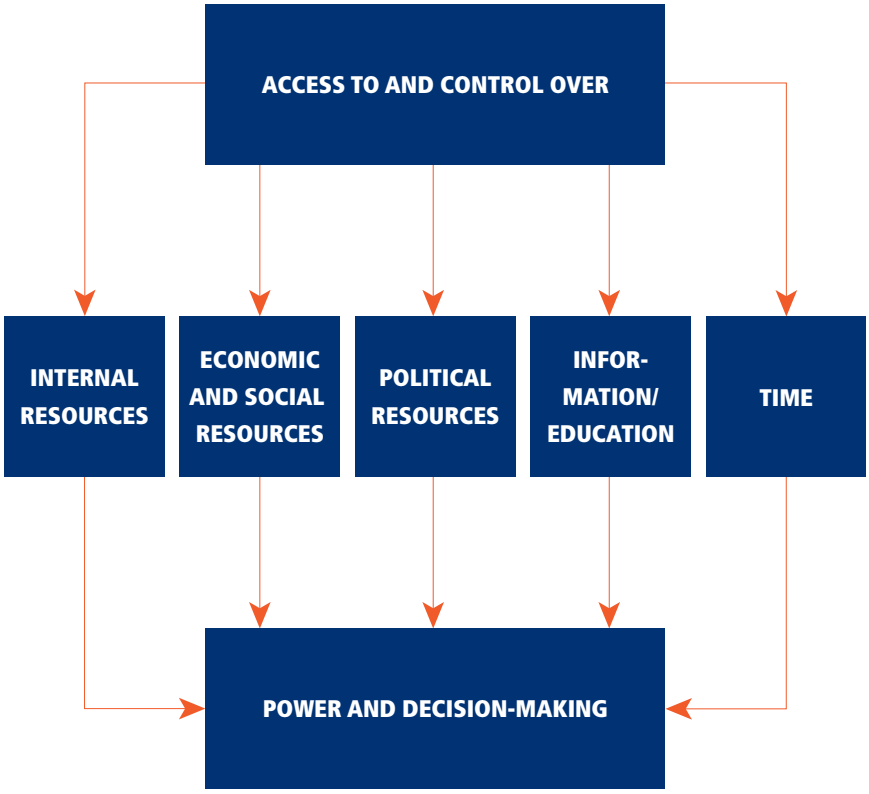
Step 1: Definitions

Distribute Handout 2 to participants and allow them about 10 minutes to read it individually. It contains definitions of commonly used gender concepts: the gender-based division of labour, gender roles and norms, access to and control over resources, and power.

20 mins

Step 2: Clarifying some concepts

Put up **overhead** transparencies of Handout 2 a few at a time, and see if participants have any questions. For example, you may have to clarify the difference between access and control by using more than one illustrative example. You may also put up an overhead of the diagram below.



Many of these concepts have already been introduced earlier in this session and in Session 1. The purpose of this activity is to highlight major gender concepts, which will be used throughout the course, and to ensure that participants have a common understanding of these.

Session developed by Makhosazana Xaba and Adelina Mwau

Handout

1 Statements on sex and gender

Source: adapted from William S, Seed J, Mwau A. *Oxfam gender training manual.* Oxford, Oxfam UK and Ireland, 1994.

Read the following statements. Write the letter S next to statements that refer to sex differences and the letter G next to statements that refer to gender differences.

1. **Women give birth to babies, men do not.**
2. **According to United Nations statistics, women do 67 per cent of the world's work, yet their earnings for it amount to only 10 per cent of the world's income.**
3. **In one case, when a child brought up as a girl learned that he was actually a boy, his school marks improved dramatically.**
4. **Women suffer from pre-menstrual tension, men do not.**
5. **Sex is not as important for women as it is for men.**
6. **In ancient Egypt, men stayed at home and did weaving. Women handled family business. Women inherited property and men did not.**
7. **Men's voices break at puberty, women's don't.**
8. **In a study of 224 cultures, there were 5 in which men did all the cooking and 36 in which women did all the house building.**
9. **Men are naturally prone to violent behaviour.**
10. **Women are more vulnerable to STDs than men.**

Handout

2 Concepts and tools for gender analysis

1. The gender-based division of labour

In almost all societies, women and men perform different activities, although the nature and range of these activities vary across classes and across communities. They have also changed over time. Women are typically responsible for childcare and household work, but they also engage in producing goods for household consumption or for the market. Men are typically responsible for meeting the household's needs for food and resources.

2. Gender roles and norms

In all societies, males and females are expected to behave in ways that are very different. They are socialized from early childhood to conform to masculine and feminine roles and norms. They have to dress differently, play different kinds of games, be interested in different issues and subjects and have different emotional responses to situations. There is a tacit perception that what males do is better and more valuable than what females do.

The impact of socially constructed gender roles is felt significantly in the area of sexuality and sexual behaviour. Women are expected to make themselves attractive to men, but be more passive, guarding their virginity, never initiating sexual activity, and taking care to protect themselves from the uncontrolled sexual desires of men. In some societies this is because women are held to have lesser sexual drive than men. In other societies the ways women are controlled are based on the idea that women have uncontrollable sexual desires. Men are often expected to be virile and have sexual desires that are uncontrollable once aroused, to take the initiative in sexual activity, and to be, by nature, incapable of being monogamous.

3. Access to and control over resources

Women and men have unequal access to and control over resources. This inequality disadvantages women. Gender-based inequalities in relation to access to and control over resources exist within social classes, races or castes. However, women and men of different races, classes and castes may be differently unequal. For example, women from one social class could have more power than men from a lower social class.

- Access is the ability to use a resource.
- Control is the ability to define and make decisions about the use of a resource.

For example, women may have access to health services, but no control over what services are available and when. Another common example is women having access to an income or owning property, but having no control over how the income is spent or how the property is used.

There are many different types of resources which women have less access to, and less control over. These include:

Economic resources
- work
- food
- credit
- money
- social security, health
- insurance
- child care facilities
- housing
- facilities to carry out domestic tasks
- transport
- equipment
- health services
- technology and scientific developments.

Political resources
- positions of leadership and access to decision-makers
- opportunities for communication, negotiation and consensus building
- resources that help vindicate rights, such as legal resources.

Social resources
- community resources
- social networks
- membership in social organizations.

Information/education
- inputs to be able to make decisions to modify or change a situation
- formal education
- non-formal education
- opportunities to exchange information and opinions.

Time
- hours of the day available to use as they choose
- flexible paid work hours.

Internal resources
- self esteem
- self confidence
- ability to express one's own interests.

4. Power and decision-making

Having greater access to and control over resources usually makes men more powerful than women in any social group. This may be the power of physical force, of knowledge and skills, of wealth and income, or the power to make decisions because they are in a position of authority. Men often have greater decision-making power over reproduction and sexuality.

Male power and control over resources and decisions is institutionalized through the laws and policies of the state, and through the rules and regulations of formal social institutions. Laws in many countries of the world give men greater control over wealth and greater rights in marriage and over children. For centuries religious institutions have denied women the right to priesthood, and schools often insist that it is the father of the child who is her or his legal guardian, not the mother.

SESSION 3

Gender-based inequalities – the evidence

What participants should get out of the session

Participants will:

- become aware of the ways in which norms and values about gender roles are related to gender-based inequalities in workloads and to inequalities in access to education, access to and control over economic and social resources, and access to power
- learn to examine and interpret evidence from international (and national) data sets on gender-based inequalities in education, economic and political status.

2 hours and 15 minutes

Materials

- Handout 1: "Data about women, education and politics"
- Handout 2: "Data about the economic value of activities and time"

- overhead: "Women and girls are Kenya's breadwinners", on p.60
- overhead: "Women do 56 per cent of the work in Venezuela", on p.60
- overhead: "More paid work doesn't reduce unpaid work", on p.61

Readings for the facilitator

1. Mosse JC. *Half the world, half a chance: an introduction to gender and development.* Oxford, Oxfam, 1993.

2. United Nations Development Programme. *Human development report 1995.* New York, Oxford University Press, 1996:29–115. Available online at: www.undp.org/hdro/highlights/past.htm

3. World Bank. *Engendering development through gender equality in rights, resources, and voice.* New York, Oxford University Press, 2001.

Readings for the participants

Reading 2.

How to run the session

There are two activities in this session. The first is a small group activity. You give participants a set of interrelated data tables on women's status in relation to the status of men. There are some questions which they have to answer in order to interpret these tables. Each group prepares a group report. The second activity is a session with the whole group, where each group presents its report. This is followed by a discussion and input from you about how gender differences become structurally entrenched and then transformed into gender-based inequalities.

Activity 1: Looking at the evidence

Step 1: Handouts 1 and 2

Divide participants into four groups. Give two groups Handout 1, which contains a set of tables with gender-specific data from selected developing and industrialized countries. The tables show women's and men's participation in economic activities and contribution to the gross domestic product (GDP). Give the remaining two groups Handout 2, containing a set of tables which present gender-specific data on school enrolment and political participation for different regions of the world.

You may choose to replace these data sets with national data sets on the same subjects: economic participation and contribution to the GDP and/or relative incomes of women and men, educational attainment and political participation. If you do use the data sets from these handouts, we advise you to update them.

Step 2: Looking at the tables

Go over the tables in each of the handouts and explain what the columns and rows represent. You will find explanations at the bottom of each table.

Step 3: Group work with the tables

Participants work in their small groups in this session. One person from the group will report back to the big group.

Activity 2: Analysing structural gender gaps

Step 1: Group presentations

Each of the four groups gives a seven minute presentation of their responses to the questions on the data sets they were given. The two groups presenting on educational enrolment and political participation should go first so that we begin with relatively simpler concepts, examining the progress made in closing the gender gap in education and contrasting this with the lack of progress in women's political participation.

The groups presenting on work and economic contribution should go next. This will allow us to look at how, despite educational

40 mins

Step 2: Whole group discussion

attainment, the gender-based division of labour has led to women being excluded from economic and political decision-making. After all the presentations are finished, you can raise some issues for discussion.

What to cover in the discussion

Draw on the participants' presentations to highlight the following points.

The gender gap in education

In developing countries, in relation to educational enrolment, the gender gap in school enrolment has been halved between 1970 and 1990. In developing countries as a whole, female enrolment in primary and secondary schools has been growing faster than male enrolment. The latest figures from UNDP's *Human development report 1999* show female primary enrolment to be 94 per cent of male rates, and secondary enrolment to be 83 per cent of male rates.

Gaps in enrolment are smaller than those in adult literacy rates. This indicates a changing trend: among the older generation, far fewer women than men were educated, while among the younger generation, the proportion of girls enrolled in schools is relatively higher.

At the same time, it needs to be acknowledged that women are still at a disadvantage in the area of education.

The gender gap in politics

Women are almost totally absent from the world's political arena. Women, who constitute almost half the electorate, hold only 12 per cent of the world's parliamentary seats and less than 6 per cent of the seats in ministerial cabinets.

Women's involvement in market and non-market activities

In many societies women contribute much more to the total labour output of a household than men.

Even in the few places where they contribute equally, women's contribution to non-market activities is far greater than their contribution to market activities, while the converse is true for men.

Many of the activities that consume women's time, like cooking, child care and cleaning, are not considered to be work because they do not involve earning an income. Women's time is therefore considered less valuable than men's because men usually earn cash.

When women are involved in earning income for the family, they generally continue to have all the additional responsibilities within the home.

At this point you can bring in examples from different settings, using **overheads** of the boxes below. You need to make the point that irrespective of the nature of the economy – rural or urban, traditional or modern, agrarian or industrial – women end up working a double shift, and spend a significant proportion of their work time in non-market activities.

Women and girls are Kenya's breadwinners

Source: United Nations Development Programme. *Human development report 1995.* New York, Oxford University Press, 1996:92, Box 4.1.

Women in rural Kenya work on average about 56 hours a week, and men only about 42 hours. Children between the ages of 8 and 16 also work many hours. If time spent for education is counted, girls spend about 41 hours a week in economic activity, and boys 35 hours.

Women shoulder the heaviest burden in household work, including firewood and water collection: 10 times the hours of men. This carries over to girls, whose household work takes about 3.7 times the hours of boys.

Women in households that farm such cash crops as tea and coffee work the most of any rural women – 62 total hours a week. As Kenya's farming becomes more cash-oriented, women tend to shoulder more work, not less.

Women do 56 per cent of the work in Venezuela

Source: United Nations Development Programme. *Human development report 1995.* New York, Oxford University Press, 1996:93, Box 4.2.

In Venezuela, women are a minority in the labour force, but they work more total hours than men, according to a study of urban time use by the central bank. Time is divided into five categories: income-earning activities, household activities, personal care, studying, and social activities and leisure.

Men have a distinct advantage over women in income earning activities: 6 hours a day compared with only 2.25 for women. But women's time in household work is a striking 11.5 multiple of men's time. Men's overall advantage shows up in the 10 per cent more time they enjoy in social activities and leisure.

In 1988, women and men spent 12.3 billion hours in work that is counted to be of economic value: men 8.9 billion hours and women, 3.4 billion. But if all working hours are counted, women contribute 12.9 billion hours and men, 9.7 billion. So women do 56 per cent of Venezuela's work.

More paid work doesn't reduce unpaid work

Source: United Nations Development Programme. *Human development report 1999.* New York, Oxford University Press, 1999:81, Box 3.3.

In OECD (Organization for Economic Cooperation and Development) countries men's contribution to unpaid work has been increasing. But a woman who works full time still does a lot of unpaid work. Once she has a child, she can expect to devote 3.3 more hours a day in unpaid household work. Married women who are employed and have children under 15 carry the heaviest work burden – almost 11 hours a day.

Bangladesh had one of the largest increases in the share of women's participation in the labour force – from 5 per cent in 1965 to 42 per cent in 1995. This has been important for export growth, with women as the main workers in the garment industry. But women still spend many hours in unpaid work. A survey of men and women in formal urban manufacturing activities shows that women put in on an average 31 hours a week in unpaid work – cooking, looking after children, collecting fuel, food and water. They spend 56 hours in paid employment. Men spend an average of 14 hours a week on unpaid activities such as house repair, and 53 hours on paid employment. Thus women in formal sector employment work an average of 87 hours a week, compared to men's 67 hours a week.

Women do a disproportionate amount of non-market activities

This is the most significant point to grasp about the gender-based division of labour – that it is unfair that women are engaged disproportionately more in non-market activities. Why does this make a difference?

- Women who are engaged in non-market activities do not have a cash income, which becomes a serious limitation especially in a market economy where goods and services have to be bought for cash. As a result, women become dependent on men for economic resources and all other resources that have to be paid for.
- There is a gender-based division of labour also in the workplace, with some kinds of jobs thought to be more suitable for men, and others for women. For example, nurses and pre-school teachers are usually women, and miners are all men.
- Among women who work, not many women make it to senior decision-making positions. This may be attributable to a combination of factors: fewer women may have access to higher education and training; even those who do may be constrained by their reproductive role and responsibilities for household work; there may be gender biases in the selection of persons to top positions, where women are seen as not suitable for positions that require extensive travelling or long hours of work.

- Because only work with exchange value is recognised in economic terms, women's work becomes invisible. This is evident in the fact that the per capita GDP for women is much lower than the per capita GDP for men.

Main points for closing this session

Much of women's work is invisible

The invisibility of women's work leads to the designing of development policies and programmes based on the stereotype of the male breadwinner and the woman homemaker. For example, income-generation activities for women supplement the family income rather than increasing women's employment opportunities, which would help them earn a livelihood.

Women have less access to money and productive assets

Women's access to credit is limited when they do not have a cash income, and this, in turn, limits their ability to invest in productive assets that will produce more income. Women are not usually the owners of property such as a house or farmland bought by a household through the combined contribution of women's and men's labour, women working within, and men, outside the home.

- The gender-based division of labour is more than that – it is an important factor underlying women's unequal access to and control over resources.

Women lack political power and are not sufficiently represented in parliaments

Women's lack of political power contributes further to the persistence of policies that do not take into account gender-based inequalities, or further consolidate them. (This is discussed in greater detail in the Policy Module.)

Comparing gender differences in educational attainment with gender differences in access to economic and political power, the gaps in economic and political participation appear to be far more resistant to change. It is clear, however, that "the limited numbers of educated and capable women" can no longer be cited as a major barrier to women's representation in economic and political decision-making.

Values and norms are at the core of persisting gender inequalities

Values and norms about male and female roles, the fact that women look after children or that there are inadequate childcare facilities, and the lack of recognition of women's economic role may lie at the core of persisting gender inequalities in access to economic and political power.

Session developed by TK Sundari Ravindran and Jane Cottingham

Handout

1 Data about women, education and politics

You have been given two tables. The first presents female literacy, primary enrolment ratio and secondary enrolment ratio as a percentage of male rates for three time points – 1970, 1990 and 1997 – for different regions of the world. The second table presents gender-specific data on the number of seats in parliament held by women as a proportion of the total for the years 1994 and 1999, and women's share at the ministerial level, for 1994.

Step 1: Trends in literacy and education

- Summarize the trends observable across the different regions in the bridging of the gender gap in literacy, and in primary and secondary enrolment. (For example: in which region has the gap narrowed most, and in which region least? How does the progress in literacy rates compare with that in primary and secondary education?)
- What, in your opinion, are the factors underlying gender gaps in primary and secondary school enrolment? Why are the gaps wider for secondary enrolment compared to primary enrolment? And for literacy rates compared to primary and secondary enrolment?
- What do you think are the consequences for women's status? And men's status?

Step 2: Trends in political participation

- Summarize the trends observable across the different regions over the two time points.
- What are the factors underlying women's low level of political participation? What are the consequences for women and men?

Step 3: The differences between the two

What are the major differences you can see between the progress made in closing the gender gap in education compared to political participation? Why are the trends in these two sectors so different?

Table 1: Trends in gender gaps in educational status

	Female adult literacy as percentage of male rate			Female primary net enrolment as percentage of male ratio			Female secondary net enrolment as percentage of male ratio		
	1970	1992	1997	1970	1992	1997	1970	1990	1997
All developing countries	n.a.*	73	79	79	88	94	68	78	83
Least developed countries	n.a.	57	65	61	84	83	43	67	66
Sub-Saharan Africa	n.a.	66	75	72	85	85	60	72	76
Arab states	38	61	66	63	92	91	47	77	85
East Asia (including China)	n.a.	80	83	87	96	100	76	79	88

chart continues

	Female adult literacy as percentage of male rate			Female primary net enrolment as percentage of male ratio			Female secondary net enrolment as percentage of male ratio		
	1970	1992	1997	1970	1992	1997	1970	1990	1997
South-East Asia and the Pacific	72	90	91	90	97	99	74	95	95
South Asia (including India)	40	55	59	60	75	86	43	60	70
Latin America and the Caribbean	91	97	98	101	98	98	91	98	101
Industrialized countries	n.a.	n.a.	100	n.a.	n.a.	100	n.a.	n.a.	100
World	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

* n.a. = not available

Sources: Data for 1970, 1990 and 1992: United Nations Development Programme. *Human development report 1995.* New York, Oxford University Press, 1996:68, Table A2.6. Data for 1997: United Nations Development Programme. *Human development report 1999.* New York, Oxford University Press, 1999:232, Table 25.

Some definitions

Female adult literacy as percentage of the male rate: The number of females who are literate for every 100 males who are literate.

Female primary/secondary net enrolment as percentage of the male ratio: The number of girl children of primary/secondary schooling age (usually 6–10 years for primary and 11–14 years for secondary schooling) who are enrolled in primary/secondary schools for every 100 boys of primary/secondary schooling age enrolled in school.

Table 2: Trends in women's political participation

	Seats in parliament held by women (as percentage of total)		Ministerial seats held by women (as percentage of total)
	1994	1999	1994
All developing countries	10	10	5
Least developed countries	6	9	5
Sub-Saharan Africa	8	11	6
Arab states	4	4	1
East Asia (including China)	19	5	6
South-East Asia and the Pacific	9	12	3
South Asia (including India)	5	6	3
Latin America and the Caribbean	10	15	8
Industrialized countries	12	19	8
World	10	12	6

Sources: Data for 1994: United Nations Development Programme. *Human development report 1995.* New York, Oxford University Press, 1996:62, Table A 2.4,. Data for 1999: United Nations Development Programme. *Human development report 1999.* New York, Oxford University Press, 1999:145, Table 3.

Some definitions

Seats held in parliament as percentage of total: Of every 100 parliamentarians, the number who are women.

Ministerial seats held by women as percentage of total: Of every 100 ministers, the number who are women.

Handout

2 Data about the economic value of activities and time

You have been given three tables. The first presents gender-specific data on the number of minutes of work per day. The second is about time allocated for activities which have an economic value, for the purpose of calculating GDP. The third table shows male and female representation in administrative and managerial positions and GDP per capita.

Step 1: The gender differences

Summarize the gender differences observable across countries and across rural and urban areas (where applicable) in:

- number of hours of work
- time allocation
- representation in senior decision-making jobs.

What, in your opinion, are the factors underlying each of these differences?

Step 2: The consequences for women

What are some of the consequences of these differences for women's and men's lives?

Step 3: The consequences of women's lower GDP per capita

What are some of the reasons why women's GDP per capita is lower than that of men's in all countries? What do you think are the consequences for women's and men's status in society?

Table 1: Work time in minutes per day

	Year	Females	Males	Females as percentage of males
SELECTED DEVELOPING COUNTRIES				
Urban				
Colombia	1983	399	356	112
Indonesia	1992	398	366	109
Kenya	1986	590	572	103
Nepal	1978	579	554	105
Venezuela	1983	440	416	106
Rural				
Bangladesh	1990	545	496	110
Guatemala	1977	678	579	117

chart continues

	Year	Females	Males	Females as percentage of males
Kenya	1988	676	500	135
Nepal:	1978	641	547	117
Highlands	1978	692	586	118
Mountains	1978	649	534	122
Rural hills	1978	583	520	112
Philippines	1975–77	546	452	121
National				
Korea, Republic of	1990	488	480	102
SELECTED INDUSTRIALIZED COUNTRIES				
National				
Australia	1992	443	443	100
Austria	1992	438	393	111
Canada	1992	429	430	100
Denmark	1987	449	458	98
Finland	1987/88	430	410	105
France	1985/86	429	388	111
Germany	1991/92	440	441	100
Israel	1991/92	375	377	99
Italy	1988/89	470	367	128
Netherlands	1987	377	345	109
Norway	1990/91	445	412	108
United Kingdom	1985	413	411	100
USA	1985	453	428	106

Source: United Nations Development Programme. *Human development report 1999.* New York, Oxford University Press, 1999:237, Table 27.

Some definitions (Table 1)

Work time: Time spent in carrying out all types of work within and outside the house, remunerated or unremunerated.

Female work time as percentage of male: For every 100 minutes of work time spent by men, the number of minutes of work time spent by women.

Table 2: Percentage of total work time spent in market and non-market activities

	Year	Percentage of total work time spent in market activities		Percentage of total work time spent in non-market activities	
		Females	Males	Females	Males
SELECTED DEVELOPING COUNTRIES					
Urban					
Colombia	1983	24	77	76	23
Indonesia	1992	35	86	65	14
Kenya	1986	41	79	59	21
Nepal	1978	25	67	75	33
Venezuela	1983	30	87	70	13
Rural					
Bangladesh	1990	35	70	65	30
Guatemala	1977	37	84	63	16
Kenya	1988	42	76	58	24
Nepal:	1978	46	67	54	33
Highlands	1978	52	66	48	34
Mountains	1978	48	65	52	35
Rural hills	1978	37	70	63	30
Philippines	1975–77	29	84	71	16
National					
Korea, Republic of	1990	34	56	66	44
SELECTED INDUSTRIALIZED COUNTRIES					
National					
Australia	1992	28	61	72	39
Austria	1992	31	71	69	29
Canada	1992	39	65	61	35
Denmark	1987	58	79	42	21
Finland	1987/88	39	64	61	36
France	1985/86	30	62	70	38
Germany	1991/92	30	61	70	39
Israel	1991/92	29	74	71	26
Italy	1988/89	22	77	78	23
Netherlands	1987	19	52	81	48
Norway	1990/91	38	64	62	36
United Kingdom	1985	37	68	63	32
USA	1985	37	63	63	37

Source: United Nations Development Programme. *Human development report 1999.* New York, Oxford University Press, 1999:237, Table 27.

Some definitions (Table 2)

Market activities: Market activities are defined as activities leading to the production of goods and services for the market, as well as in household production of goods for the household's own consumption. However, the production of services for household consumption – cooking, fetching water and fuel, child care, care of the sick and elderly – are considered to be non-market activities for the purposes of measuring economic output.

The percentage of total work time spent in market/non-market activities: Of 100 minutes of total work time spent by a person, the number of minutes spent in market activities/non-market activities.

Table 3: Women's participation in economic decision-making and women's real GDP per capita in PPP$, 1997, selected countries

	Female administrators and managers as percentage of total	Female GDP as a percentage of male GDP per capita in PPP$
SELECTED DEVELOPING COUNTRIES		
Bangladesh	4.9	58.11
Colombia	38.8	52.82
Guatemala	32.4	29.54
Indonesia	6.6	50.99
Kenya	n.a.*	74.16
Korea, Republic of	4.2	44.84
Nepal	n.a.	54.15
Philippines	34.8	55.62
Venezuela	22.9	39.54
SELECTED INDUSTRIALIZED COUNTRIES		
Australia	43.3	69.02
Austria	21.8	46.47
Canada	42.2	62.05
Denmark	20.0	71.13
Finland	26.6	58.95
France	9.4	63.30
Germany	26.6	64.63
Israel	19.2	51.60
Italy	53.8	44.47
Netherlands	16.8	51.95
Norway	30.6	74.29
United Kingdom	33.0	60.72
USA	44.3	67.96

* n.a. = not available

Sources: Female administrators as a percentage of total: United Nations Development Programme. *Human development report 1999.* New York, Oxford University Press, 1999:142, Table 3.
Female GDP as a percentage of male GDP per capita in PPP $: United Nations Development Programme. *Human development report 1999.* New York, Oxford University Press, 1999:139, Table 2.

Some definitions (Table 3)

GDP or gross domestic product: The total output of goods and services for final use that are produced by an economy by both residents and non-residents, regardless of the allocation to domestic and foreign claims. It does not include deductions for depreciation of physical capital or depreciation and degradation of natural resources. Non-market activities – which include cooking, processing food for own consumption, fetching water and fuel, child care, care of the sick and elderly – are not included as services in the calculation of GDP.

PPP$ or Purchasing Power Parity dollar: The number of units of a country's currency required to purchase the same representative basket of goods and services (or a similar basket of goods and services) that a United States dollar would buy in the United States. When we use the PPP$ to measure a country's GDP, we do not apply the dollar exchange rate applicable in the market, but an exchange rate that measures how much of a country's currency is required to buy the same goods and services as one US$ in the US. This makes GDPs across countries comparable to each other.

Female administrators and managers as percentage of total: Of 100 administrators and managers, the number who are women.

Female GDP as percentage of male GDP in PPP$: The number of dollars contributed to the GDP by the female population of a country for every 100 PPP$ contributed by its male population.

SESSION 4

Mainstreaming gender equality in institutions

What participants should get out of the session

Participants will:

- understand the concept of gender mainstreaming
- become aware of the steps and changes required for achieving gender equality within their organizations.

1 hour and 30 minutes

Materials

- Lecture notes for the facilitator: "Mainstreaming gender equality in organizations"
- Handout 1: "Questions that will help you do a gender analysis of your organization"
- Handout 2: "Ideas for actions for mainstreaming gender equality in your organization".

- overhead: main points of Part 1 of the lectures notes
- overhead: "Two important aspects of gender mainstreaming", on p.71
- overhead: "How gender sensitive are an organization's programmes?", on p.72
- overhead: Handout 2
- blank overhead transparencies

Readings for the facilitator

1. Hadjipateras A. Putting gender policy into practice: lessons from ACORD. *Bridge, Issue 5: approaches to institutionalising gender.* Available online at: www.ids.ac.uk/bridge/dgb5.htm. (Date accessed: 2000).

2. Swedish International Development Cooperation Agency. *Handbook for mainstreaming a gender perspective in the health sector.* Stockholm, Department for Democracy and Social Development, Health Division, Swedish International Development Cooperation Agency, 1997.

Readings for the participants

Reading 2.

How to run the session

From: AIDOS and the Women's Health Project. *Reproductive health for all: taking account of the power dynamics between men and women.* Johannesburg, University of the Witwatersrand, 2000.

This is an input session on the concept of gender mainstreaming, and on the actions that an organization may take in order to mainstream gender equality into its structures and programmes.

Activity 1: Exploring gender mainstreaming

Step 1: Your input and a group discussion

Start with an introduction saying that the previous sessions showed how gender inequality is embedded in society's norms and values, rules and systems. For this reason, it is also likely to be embedded within our organizations and institutions.

Then ask participants where and in what contexts they have heard the term "gender mainstreaming", and what they understand it to mean.

After listening to the various responses, put up **overheads** containing the main points outlined in Part 1 of the "Lecture notes for the facilitator". These include:

- defining the concept of gender mainstreaming
- two aspects of the mainstreaming strategy
- gender mainstreaming in relation to women-specific programmes: does one preclude the other?

Clarify that mainstreaming gender is not a once-off task, but an ongoing process. After talking about the two aspects of the gender mainstreaming strategy, put up an **overhead** of the text below, or hand it out on a piece of paper, and give participants a few minutes to read through it.

Two important aspects of mainstreaming gender equality

Gender mainstreaming is a strategy for gender equality. It requires:

- equitable distribution by sex of the resources, opportunities and benefits of the mainstream development process,
- including the interests, needs, experiences and visions of women as well as men in defining development approaches, policies and programmes and in determining the overall development agenda.

A gender mainstreaming initiative does not preclude initiatives specifically directed towards women. Such positive initiatives are necessary and complementary to a gender mainstreaming strategy.

After you have presented the rest of the overheads of Part 1 of the lecture notes, ask participants to discuss how much they think gender issues have been taken into account in their organizations' programmes and activities. Get them to talk about the extent to which their organizational structures pay attention to addressing gender inequalities. Let them reflect on the realities of their workplaces in relation to the two aspects of gender mainstreaming.

Step 2: Examining the gender sensitivity of organizations' programmes

Overhead. How can an organization ensure gender mainstreaming in the content of its programmes and interventions? This list of questions offers a tool for examining programme content to evaluate its gender sensitivity.

How gender-sensitive are an organization's programmes?

- Does the programme design and planning take into account the different roles and responsibilities of women and men, and their differential access to and control over resources? The differentials in their access to power and decision-making?
- Does the design and implementation strategy of the programme try to challenge existing gender and social relations?
- Have the potentially different impacts of this programme on women and men (and on different groups of women and men) been considered?
- Has it been ensured that any part of the intervention will not contribute to worsening the position of women (or of poorer women in relation to wealthier women?)
- Have gender specific indicators been identified and included into the monitoring system for programme performance?

Get participants to give examples of programmes that have and have not taken account of these issues. Some examples of not taking gender roles into consideration or reinforcing traditional roles when designing health programmes include: not scheduling services at times that are convenient to women; treating women as having the sole responsibility for childcare and thus targeting all child health related messages exclusively at them; assuming women's time is expendable and requiring them to volunteer their time.

Participants may wonder how health programmes could help to challenge gender norms, which are socially and culturally constructed. Some ways health providers could try to do this include: not requiring women to have their spouse's agreement before providing contraceptive services; and involving men accompanying their wives in discussions about child health, maternal health and contraception.

Help participants think through programme designs that may worsen the positions of women in relation to men, or of poorer women in relation to women who are better off. Get them to think of ways of preventing this from happening.

Step 3: Mainstreaming gender equality in an organization's structure and functions

Move on to the second aspect of gender mainstreaming: mainstreaming gender in the structure and functioning of an organization. Explain that very often, in trying to mainstream gender equality in its programmes, an organization may come up against obstacles and barriers within its own structure. An organization's decision-making structures and processes and the distribution of power and authority within organizations need to change in ways that make it possible for gender sensitive programmes to be supported and adequately resourced.

Distribute Handout 1 and put up an **overhead** you have made from it.

Ask participants to volunteer to respond to these questions as an illustration of how to use them. Some may want to carry out a gender analysis of their organization when they get back to work, using the questions in Handout 1. It can be useful to have a discussion about how best to do this: individually, or through specially constituted teams, or through organizing a special workshop with interested colleagues and/or decision-makers.

Step 4: Action and barriers

Distribute Handout 2 to participants and give them about five minutes to read through it and think through what needs to be done to mainstream gender equality in their organizations.

Then brainstorm action-ideas on how participants can go about mainstreaming gender equality in their organization's structure as well as its programmes. Write these up on **overheads** or a flip chart and display them. You may want to add the points made in Part 2 of the lecture notes.

Discuss issues like the potential barriers to mainstreaming gender equality in organizations, and give examples of some successful interventions.

Main points for closing this session

Gender inequality is embedded in social institutions

Gender inequality is embedded in many institutions in society. This is the result of two factors. First, most institutions are controlled by men, usually by particular groups of men (wealthy, educated, those who inherit leadership, and so on). Over time, the institutional goals, management styles, interpersonal relationships and so on become consolidated. Whether women are in leadership positions or not, the way of doing business has already been set.

Social institutions are a mirror of society

Second, institutions are microcosmic representations of the society in which they are located, and reflect gender (and other) norms

inherent therein. If society does not value women's input, social institutions are unlikely to do so. If society does not give women access to decision-making, social institutions will not do so either. Likewise, if society does not value women's health, health institutions are unlikely to.

The role of health institutions in reinforcing gender inequalities

It is important to analyse whether and how health institutions reinforce gender inequalities by acts of commission or omission. Once a gender analysis of any health institution has been carried out, it will be possible to plan for action to mainstream gender equality in that institution. Analyses should include the barriers to mainstreaming, and a commitment to working with allies. (When we talk about health institutions we mean all institutions concerned with planning, implementing and evaluating health services, training health staff and so on.)

Session developed by Barbara Klugman

Lecture notes for the facilitator:

Mainstreaming gender equality in organizations

Part 1: Concepts and definitions

What gender mainstreaming is short for

The term "gender mainstreaming" is a short-hand way of referring to the strategies and processes that can change the way that institutions operate in relation to the power and privilege that is associated with things done by and for men and women. We use the word "mainstream" to indicate that issues of gender inequality should be dealt with in every aspect of organizational structure and programming, rather than as a separate, add-on activity. In other words, gender inequality should be addressed in the mainstream of organization and programming. The full phrase should be: "mainstreaming attention to gender equalities in institutional structures and their programming".

Gender activities are often an afterthought

The need to mainstream gender is a reaction to what often happens in organizations. In general, organizations have tended to carry on with business as usual, and then address gender by adding on a few additional activities that target women. In the gender mainstreaming approach, the organization has to consider how the following aspects of an organization may impact negatively on women, fail to address women, or may not promote gender equality at all:

- overall goals
- rules for running the organization
- the entire range of programmes and policies
- allocation of resources
- organizational structures, job description and staffing
- monitoring and evaluation systems.

Two important aspects of mainstreaming gender equality

Two aspects of a mainstreaming strategy were emphasised in the *Platform for Action* of the United Nations Fourth World Conference on Women in Beijing. These are captured in Handout 1.

- First, for the content of development programmes, mainstreaming gender requires that the resources, opportunities and benefits of the development process be distributed equitably (to men and women). This requires the integration of equality concerns into the analysis and formulation of policies, programmes and projects, to ensure that these have a positive impact on women and reduce gender inequalities. (This aspect of gender mainstreaming will be dealt with in some detail in the context of health policies and programmes in the fifth and sixth modules.)

- Second, for how an institution or organization works, the process needs to ensure that women's interests, needs, experiences and visions contribute to defining the approaches, policies and programmes and to determining the overall development agenda. This means that institutional strategies and mechanisms need to be devised which will enable women to formulate and express their views and participate in decision-making at all levels.

Does gender mainstreaming imply that there should not be separate programmes that target only women?

No. Given the depth of inequality facing women, it is sometimes necessary to target women specifically to ensure a level playing field for women and men over a period of time. For example, special educational, training or health programmes may be necessary for women to overcome the negative impact of gender inequality. Initiatives which specifically target women are complementary to mainstreaming initiatives.

Part 2: Action ideas for mainstreaming gender equality in an organization

How can an organization go about mainstreaming gender equality in its structure as well as its programmes and activities? This may require diverse actions, including:

- A formal gender analysis: in order to identify all the processes which need to be addressed.
- Developing a policy on mainstreaming gender equality in the organization: to specify the goals of the policy, which activities will be undertaken in particular to address strategic gender interests of staff and constituencies, by when, who is responsible, what resources will be allocated, and how the implementation of the policy will be monitored.
- Staff education processes: to build staff's understanding that gender inequality can result in violations of women's human rights, and has a negative impact not only on women staff members, but on the organization and its work overall.
- Ensuring that female staff do not bear all the institutional responsibility for mainstreaming gender equality: or only junior staff, but staff at all levels and men and women equally.
- Changing specific policies: hiring procedures which may discriminate against married or unmarried women; policies which do not allow for maternity leave for women or paternity leave for men; promotion policies which assume that women may not be able to deal with certain types of jobs or challenges (for example, those that require extensive travelling).
- Mainstreaming gender equality and equity in job allocation, job descriptions and performance evaluation systems: so that there is no gender stereotyping.
- Evolving gender specific indicators: for monitoring all programmes and organizational functioning.
- Enforcing existing policies: such as policies on sexual harassment in the workplace.

- **Changing procedures/practices where appropriate:** such as the times at which meetings are held; the expectation that staff members put in hours of work after the working day is over. These not only make it difficult for women to participate effectively, but may also label women as not committed to the same extent as men. Such practices also make it impossible for men to share in domestic responsibilities when they wish to. Conscious inclusion of women in interview committees and appraisal committees even if they are not in leadership positions would be examples of this kind of affirmative action.
- **Establishing a committee to manage the entire process:** comprising of all department heads and the chief functionary of the organization.
- **Allocating resources to support the entire process.**

Handout

1 Questions that will help you do a gender analysis of your organization

- **Identify all the different positions in your organization's organogram. Which of these positions do men fill? Which do women fill?**
- **What is the proportional representation of women in decision-making positions?**
- **What are the rules and systems for decision-making processes? Are these top-down or participatory?**
- **Are there opportunities for non-management staff to take the initiative and to contribute to key decisions?**
- **Who has access to the organization's resources: for example, transport? computers? telephones? contacts with political leaders and key social figures? contacts with the media?**
- **Who makes decisions about which people have access to resources?**
- **Does the organization have mechanisms to actively encourage women's participation at all levels?**
- **Are there strategies to increase women's participation at decision-making levels?**
- **Does the organization have mechanisms to build staff capacity across the organization for women and men to do a gender analysis at the policy, programme and institutional levels? Is this capacity rewarded formally?**
- **Does the organization have staff who will be able to design and carry out programming that supports gender equality?**
- **Are gender related responsibilities mainstreamed into job descriptions for all staff? Is the performance evaluation system of staff gender sensitive?**

Handout

2 Ideas for actions for mainstreaming gender equality in your organization

You may find the following key points from the "Beijing +5" [1] document and the ICPD Programme of Action [2] useful in deciding on possible actions for mainstreaming gender equality in your organization.

"Political will and commitment at all levels are crucial to ensure mainstreaming of a gender perspective in the adoption and implementation of comprehensive and action-oriented policies in all areas. Policy commitments are essential for further developing the necessary framework, which ensures women's equal access to, and control over economic and financial resources, training, services and institutions as well as their participation in decision-making and management. Policy making processes require the partnership of women and men at all levels. Men and boys should also be actively involved and encouraged in all efforts to achieve the goals of the Platform for Action and its implementation." ***[1:49]***

"Programme support to enhance women's opportunities, potential and activities need to have a dual focus: on the one hand, programmes aimed at meeting the basic as well as the specific needs of women for capacity building, organizational development and empowerment; and on the other, gender mainstreaming in all programme formulation and implementation activities. It is particularly important to expand into new areas of programming to advance gender equality in response to current challenges." ***[1:53]***

"Develop and use frameworks, guidelines and other practical tools and indicators to accelerate gender mainstreaming, including gender-based research, analytical tools and methodologies, training, case studies, statistics and information." ***[1: 116a]***

"Promote and protect the rights of women workers and take action to remove structural and legal barriers as well as stereotypical attitudes to gender equality at work, addressing inter alia: gender bias in recruitment; working conditions; occupational segregation and harassment; discrimination in social protection benefits; women's occupational health and safety; unequal career opportunities and inadequate sharing, by men, of family responsibilities." ***[1:118b]***

"Governments and employers are urged to eliminate gender discrimination in hiring, wages, benefits, training and job security with a view to eliminating gender-based disparities in income." ***[2:4.7]***

"Government, international organizations and non-governmental organizations should ensure that their personnel policies and practices comply with the principle of equitable representation of both sexes, especially at the managerial and policy-making levels ..." ***[2:4.8]***

References

[1] United Nations. Further actions and initiatives to implement the Beijing Declaration and the Platform for Action. Unedited final outcome document as adopted by the plenary of the twenty-third special session of the General Assembly on 10 June 2000. New York, UN, 2000.
Available online at: http://wcd.nic.in/bej5plus.htm

[2] United Nations Population Fund. Programme of Action of the International Conference on Population and Development. Cairo, 5–13 September 1994. New York, United Nations, 1996.

SESSION 5

Linking gender and health

What participants should get out of the session

Participants will learn to apply the tools of gender analysis to specific health conditions, and understand how gender impacts on health status.

1 hour and 40 minutes

The materials you will need

- Handout: "Sex, gender and tuberculosis"
- overhead: "The links between gender and health", on p. 82

Readings for the facilitator

1. United Nations Population Fund. *The state of world population 2000.* New York, UNFPA, 2000.

2. World Health Organization. *Gender and health.* Technical Paper. Geneva, WHO, 1998.

Readings for the participants

Reading 2.

How to run the session

There are three activities. The first is your input on the links between gender and health. In the second activity, participants work in small groups to examine how gender impacts on health, using the case of a specific health condition common to women and men. This is followed by report-backs to the big group and a general discussion.

20 mins

Activity 1: The links between gender and health

Introduce the session with a brief input, using an **overhead** of the box below.

The links between gender and health

- Women and men differ in relation to the physical spaces they occupy, the tasks and activities they perform and the people they interact with.
- In almost all cultures and settings around the world, and across social groups, women have less access to and control over resources than most men, and are denied equal access to facilities like education and training. However, what it is to be a man or a woman varies across cultures, races and classes. It is important to unpack the concepts "women" and "men" and be clear about which groups of women and men we are referring to.
- Gender-based differences in access to and control over resources, in power and decision-making, and in roles and responsibilities, have implications for women's and men's health status. They result in: differential risks and vulnerabilities to infections and health conditions; different perceptions of health needs and appropriate forms of treatment; differential access to health services; different consequences or outcomes from disease; and differing social consequences as a result of ill health.
- Gender may influence health status in the following ways:
  - exposure, risk or vulnerability
  - nature, severity and frequency of health problems
  - ways in which symptoms are perceived
  - health seeking behaviour
  - access to health services
  - ability to follow advised treatment
  - long term social and health consequences.

Ask participants to think of some examples of how gender influences each of the aspects listed on the overhead.

30 mins

Activity 2: Sex, gender and tuberculosis

10 mins

Step 1: Reading individually

Divide the group into four or five small groups. Give each participant a copy of the handout. Each member of the group reads individually. The handout included here looks at gender issues in tuberculosis. You may choose to use another example of a health condition which is common to both sexes but which affects them differently.

20 mins

Step 2: Group discussions

Each small group then discusses its responses to the questions, and one person records these for reporting back to the big group.

50 mins

Activity 3: Report-backs and discussion

30 mins

Step 1: Report-backs

Each group reports back to the big group (six or seven minutes per group). Allow questions when all the presentations have been made, not after each one. Note down any substantive issue or question raised, and bring this up in the big group discussion in Step 2.

20 mins

Step 2: Discussion

Facilitate a discussion with the whole group and end the activity by drawing out the main points.

What to cover in the discussion

Keep the focus on gender

It is likely that a number of questions will be related to the specific health condition referred to in the handout. It would be best to avoid going into details about these, and keep the focus on gender.

Interrogate the evidence

Go through each of the discussion questions and summarize the ways in which sex and gender play a role in it. For example: what does the evidence tell us about women's and men's vulnerability to tuberculosis? That tuberculosis is found to be more prevalent among men, especially in the adult age groups. However, this may not mean that women are less vulnerable. The diagnostic tests used, the nature of the data on prevalence – all these may result in under-reporting of women. The evidence is inconclusive.

Health seeking behaviour

Do we expect differences in health seeking behaviour between men and women? Why? How does gender play a role in this? And so on.

Referring back to Session 2: How do the concepts impact differently on male and female health?

It may be useful now to refer back to the gender concepts introduced in Session 2: the gender-based division of labour, gender roles and norms, access to and control over resources, and power. Go over each of these and elicit responses about how they may impact differentially on the health of males and females. You may start with tuberculosis for

discussion, but this is the time to broaden the discussion to a more general level and consider how the differences in women and men's health are not merely the result of their biological differences but also because of socially constructed gender differences.

Poor women working with firewood stoves are, for example, at a higher risk of respiratory problems because of the gender-based division of labour which makes cooking women's responsibility. It is men rather than women whose jobs involve driving, including long-distance hauling with sleep deprivation and so on, making men more vulnerable to traffic accidents. Women's limited access to information may mean that they are not able to recognize symptoms which indicate an infection or health problem. Women may not have the time, because of their double work day, to seek timely care for health problems. On the other hand, men's full time jobs outside the home may make it difficult for them to take leave for a clinical consultation.

Main points for closing this session

Gender factors and biological differences impact on women's and men's health status

Gender factors interact with biological differences between women and men to impact on their health status.

Women and men may be exposed to differential risks of contracting a health problem because of gender-based division of labour, or because of gender roles and norms.

Women and men may also have varying perceptions of what represents ill health, and what needs to be done about it.

Access to resources

Women often have more limited access to resources than men, which are necessary for good health.

Even when they have adequate access, women may have no authority to make decisions. This contributes to further ill health or their inability to adequately treat their conditions.

The health sector upholds society's gender rules and norms

The health sector mirrors society in its views and expectations of women and men. For instance, health education messages are mostly addressed to women, because they are seen as responsible for the health of family members. Women are supposed to be accepting of authority and not question the health provider's views and decisions. In many settings, the health sector assumes that all men and women are heterosexual, married and monogamous, and anyone who does not conform to this pattern is viewed with disapproval. The health sector, in other words, is another social institution which upholds gender roles and norms.

A gender analysis of health institutions is necessary

A gender analysis of health institutions is not only necessary to identify actions for mainstreaming gender equality within an institution, but is also a pre-condition for eliminating gender-based inequalities resulting from health programmes.

Session developed by Makhosazana Xaba and TK Sundari Ravindran

Handout

1 Sex, gender and tuberculosis

Read the following extract carefully and then discuss with members of your group responses to the questions given below.

From: World Health Organization. *Gender and tuberculosis. An information sheet.* Geneva, WHO, 2001.

Gender and tuberculosis

Globally, 8.4 million people are estimated to develop tuberculosis (TB) each year, and nearly 2 million deaths result from the disease. Overall, one-third of the world's population is currently infected with the tuberculosis bacillus, over 90 per cent of them in developing countries.

It is the poorest people from the poorest countries who are most affected by tuberculosis. Not only are they more vulnerable to the disease because of their living and working conditions, they are also plunged deeper into poverty as a consequence of tuberculosis. A person with TB loses, on average, 20-30 per cent of annual household income due to illness.

The situation warrants urgent action to curb the epidemic. Examining the gender dimensions of TB is important for overcoming barriers to effective prevention, coverage and treatment of tuberculosis.

Tuberculosis incidence and prevalence is higher in adult males than in adult females. In most settings, tuberculosis incidence rates are higher for males at all ages except in childhood, when they are higher in females. Studies have reported that sex differentials in prevalence rates begin to appear between 10 and 16 years of age, and remain higher for males than females thereafter. The reasons for the higher male prevalence and incidence are poorly understood, and need further research to identify associated risk factors.

Reported incidence rates for tuberculosis may under-represent females

Standard screening norms may cause more women than men with tuberculosis to be missed. Women appear to be less likely than men to present with symptoms of cough or sputum production, or test positive for tubercle bacilli on sputum microscopy.

Lower rates of notification may also be a consequence of a smaller proportion of women than men with tuberculosis visiting a health facility and/or submitting sputum specimens for testing.

There are sex differences in the development and outcome of tuberculosis

Once infected with TB, women of reproductive age are more susceptible to fall sick than men of the same age, and also to die from it. Evidence on the contribution of pregnancy to these differences is inconclusive.

HIV is contributing to sex differentials in risk of tuberculosis in young people

HIV weakens the immune system, and a person who is HIV positive and infected with TB is much more likely to develop active disease than a person similarly infected but HIV negative. Since young women are at a greater risk of HIV infection than men in the same age group, in parts of Africa where incidence of HIV is high, there are more young women notified with TB than young men.

Tuberculosis in pregnancy enhances the risk of a poor pregnancy outcome

Case-control studies from Mexico and India report that pulmonary tuberculosis in the mother increases risk of prematurity and low birth weight in neonates two-fold, and the risk of perinatal deaths between three and six-fold.

In pregnant women with a late diagnosis of pulmonary tuberculosis, obstetric morbidity is increased four-fold, according to a recent review on tuberculosis and pregnancy. The review also reported enhanced risk of miscarriage, toxaemia and intrapartum complications.

Genital tuberculosis frequently leads to infertility in women

Tuberculosis of the genitourinary tract is often difficult to diagnose in both women and men. It is however, a rare condition in men. On the other hand, one in eight women with pulmonary tuberculosis may also have genital tuberculosis, as suggested by studies from India and Turkey. Genital tuberculosis is an important cause of infertility in many developing countries, with far-reaching consequences to their lives and their wellbeing. In India, genital TB was the cause of tubal damage in nearly 40% of women experiencing tubal infertility.

Social and economic consequences of tuberculosis varies by gender

Because of gender differences in the division of labour and in roles and responsibilities, tuberculosis affects women and men differently. In one study, women patients reported inability to spend time on childcare, and difficulty in carrying out household chores because of the deterioration in their physical condition. Male patients reported distress because of loss of income and inability to contribute adequately to household expenditure.

Social isolation because of stigma associated with tuberculosis affects both sexes. But the consequences may be harsher for women and girls. Women patients from Pakistan were at risk of divorce or marital breakdown, while in India, women with tuberculosis were concerned about rejection by husbands and harassment by in-laws and reduced chances of marriage, if single, while male patients were concerned principally with loss of income and economic hardship.

Despite early care-seeking, women have a longer period of delay before diagnosis

Studies to-date report either no gender differences, or a greater delay for men in the time lapse between onset of symptoms and the patient's first contact with a health care provider. However, women had a longer delay before tuberculosis was diagnosed because

- They often sought care from a private practitioner or a less qualified professional, and waited for the treatment to take effect before going to the hospital

- They did not go to the hospitals where TB treatment was available, because of the distances to be covered and restrictions on their physical mobility
- Fewer women presenting with chest symptoms were referred for sputum examination by doctors
- It took the doctors longer to diagnose women with tuberculosis than men, perhaps because they did not present with what is considered 'typical' symptoms: prolonged cough with expectoration.

Men are more likely not to complete treatment

Studies report that while men are better able to access TB treatment from a DOTS facility, the need to earn a livelihood also acts as a barrier to completing treatment. Women, on the other hand, have greater difficulty reaching an appropriate facility, but those that do, usually complete treatment.

Questions for discussion in small groups

Your response may be based on the reading above, but need not be restricted to it. Feel free to draw on your experiences and previous knowledge of these issues when answering the following questions.

- Are there different risk factors for women and men?
- Do the roles that society prescribes for women and men account for differences in the risk factors?
- What are the barriers/obstacles to obtaining treatment for the condition? Are the barriers different for women and men?
- Are there differences for women and men in the severity of consequences? What do you think accounts for these differences?
- Are there different responses from the health sector?
- Are there different responses from society at large?

SESSION 6

Module summary

What participants should get out of the session

Participants will have a consolidated overview of the tools and concepts introduced in the Gender Module, and of the links between them.

10 minutes

How to run the session

This is a one activity input session.

What your input should cover

Review the main points made in the Module brief and put up your **overhead:** "Structure of the module".

Highlight the tools and concepts

- the distinction between sex and gender
- the gender-based division of labour, tasks and activities
- roles and norms concerning masculinity and femininity
- access to and control over resources
- power and decision-making
- gender mainstreaming.

Applying the tools and concepts

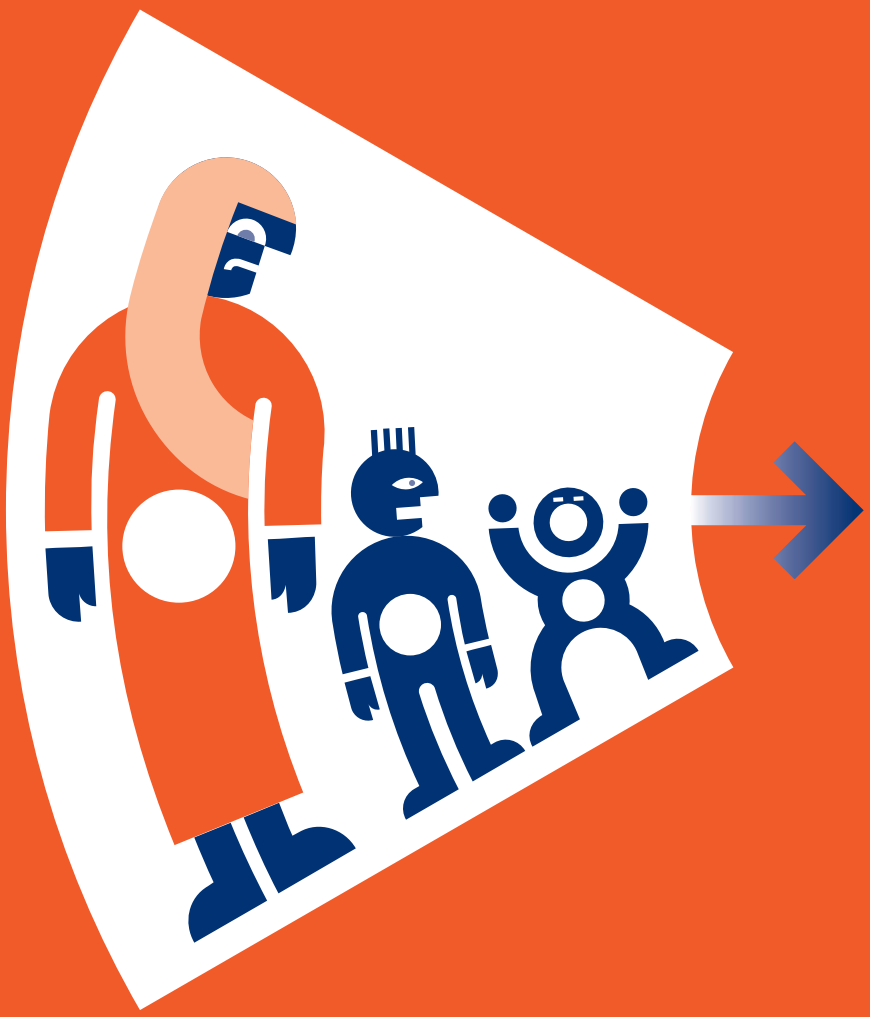
Remind participants that they used these concepts to carry out a gender analysis of their organizations and to identify actions needed for promoting gender equality at the organizational level. Remind them that this is an exercise that needs to be done in all health institutions – those directly delivering health services, those training health personnel, institutions responsible for planning, policy making and resource allocation, institutions involved in producing drugs and equipment, and so on. The tools and concepts for gender analysis were then applied to a specific health issue to analyse how gender impacts on various dimensions of health.

Introduce the next two modules

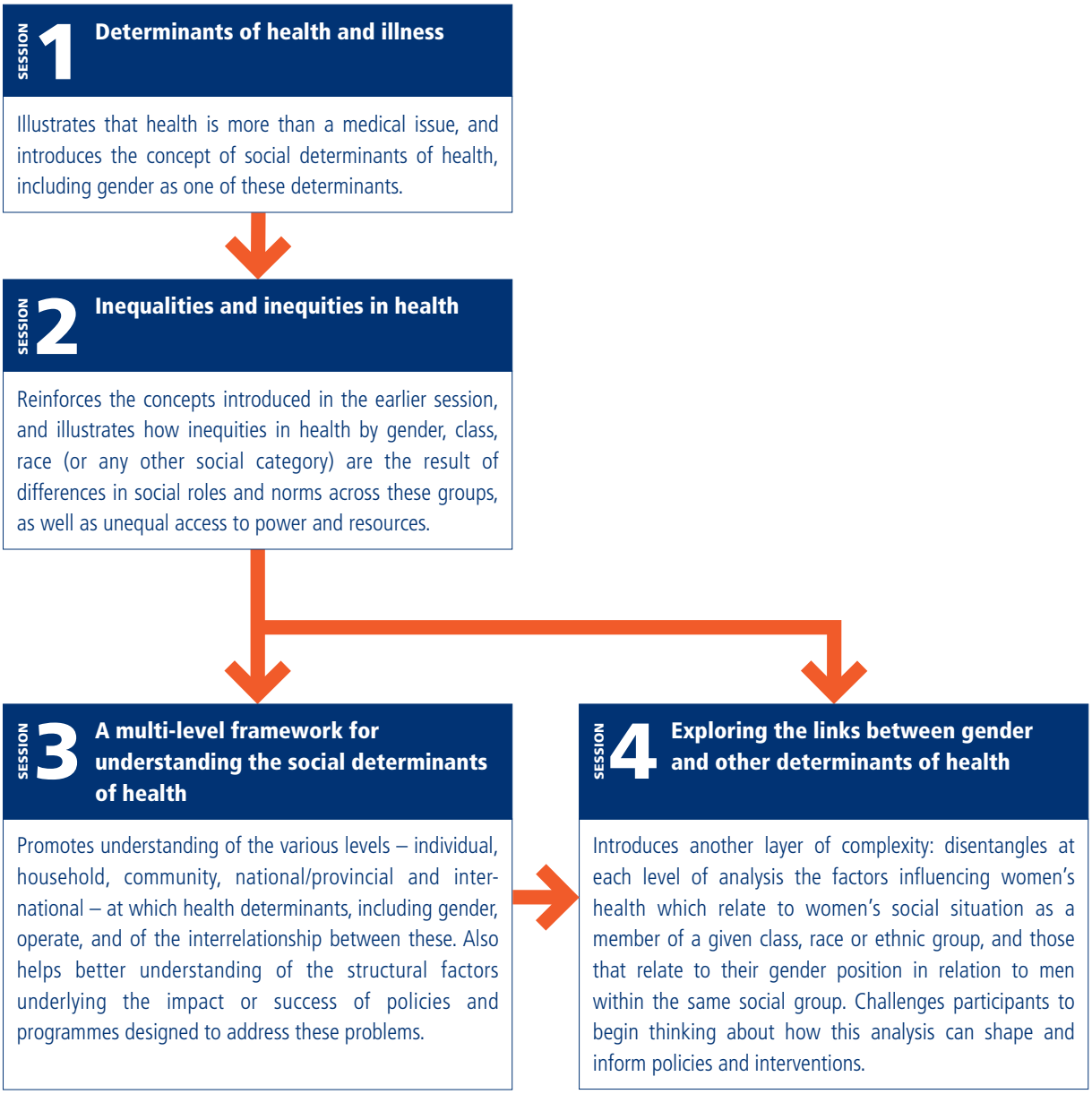
The next two modules will provide further analytical concepts and tools, related to determinants of health, and rights. The concepts introduced in these three foundation modules will be revisited throughout the course to examine how to address gender issues in health information,

health policies and programmes. For example, while the concept of gender mainstreaming was introduced in the first module, the information and skills necessary to initiate action for gender mainstreaming will be provided in the application modules on evidence, policy and health systems.

Module 2: **Social determinants**



Structure of the Social Determinants Module



MODULE 2

Module brief

What participants should get out of the Social Determinants Module

Participants will:

- be aware that health is more than a medical issue, and be familiar with the concept of social determinants of health
- be able to identify gender as one of these determinants, and be aware that it is affected by and interacts with other determinants
- have an understanding of the various levels at which health determinants operate, and the interrelationship between these
- distinguish between the factors affecting women's health:
  - that are common to women and men of a specific social group (for example, rural/urban, poor/rich)
  - that arise from women's biological differences from men
  - that are related to gender-based differentials
- and understand how these may all be interrelated
- acquire the skills to apply the social determinants and gender framework to understand the structural factors underlying the impact of health policies and interventions
- understand that this knowledge can be applied to shape and inform health policies and interventions.

The thinking behind the module

Health is a social issue

The approach to gender issues in health that has been adopted in the course as a whole, and in this module, is guided by the view that health is not simply a medical issue based on natural and biological factors and medical interventions. Health is a social issue. Where and how we live, what we do, whom we interact with, and the nature of these interactions and relationships – all these affect our health. Thus, health is a product of the interaction between our biology and the physical, socio-cultural and political environment in which we live and act.

The Social Determinants Module places gender in the context of other social determinants of health, and shows the links between gender and other health determinants.

The Gender Module showed that women and men have different roles and responsibilities and different social realities, and that this is not only because of biological differences but also because of socially determined gender norms. Women and men have different responsibilities, and differential access to and control over resources.

Consequently, women's health needs, their health seeking behaviour and their access to health services are likely to differ substantially from those of men, thus contributing to gender differentials in health status.

Session 1 introduces the concept of social determinants of health through two group exercises. It argues that a social determinants framework, when based on a gendered understanding of the world, requires that we take gender into account as an important determinant of health.

Session 2, based on readings on inequities in health, builds on these concepts to show that inequities in health across social groups are largely a consequence of unequal access to power and resources. This session discusses the concepts of health equity and health equality. Equity is not the same as equality: it is a commitment to increase the equality of opportunity in health and human development for the groups in society which have suffered discrimination. Unequal access to power and resources creates conditions that put some people at a higher risk of ill health and limit their access to health care within and outside the home, creating inequities in health status. The session locates gender inequities in health in the context of inequities related to other social determinants of health. It shows how gender is affected by other social determinants and how it interacts with them.

Session 3 is a participatory exercise which aims to help participants understand the various levels at which health determinants (including gender) operate, and of the interrelationship between these. Factors affecting health are also influenced by the local, national and global environments. A community's access to resources is related to the wealth of a country as well as to the community's relative power in the national context. Similarly, international forces – like a slump in the export prices of agricultural commodities – may cause widespread unemployment in a local community. This in turn would affect the resources available to a household and to its women, thus having an impact on their health. Health sector reforms that some countries have initiated – in particular introducing user charges and privatizing health services – also have a bearing on the health of women and men.

Session 4 introduces another layer of complexity for analysing the factors which influence health.

It helps participants see the need to understand

- factors that relate to women's and men's social situation: their class, race, ethnicity or position in the social hierarchy as member of a community, which may be common to women and men
- factors that relate to the biological differences between women and men

Module outline

		Objectives Participants will:	Format of activities	Time: About 9 hours and 30 minutes
Introductory session	Introduction to the Social Determinants Module	• be acquainted with module objectives and contents	Input	10 mins
SESSION **1**	Determinants of health and illness	• be aware that health is more than a medical issue, and familiar with the concept of social determinants of health	Individual/small group work Big group discussion Small group work Big group discussion	20 mins 40 mins 45 mins 15 mins
SESSION **2**	Inequalities and inequities in health	• understand the factors underlying inequities in health status by gender and other social determinants of health (such as race, class, ethnicity and place of residence) • locate inequities in health by gender within the context of inequities related to other social determinants of health, and discern how gender interacts with and is affected by other social determinants of health	Individual work reading essential literature Work in groups Big group discussion and summing up	Outside course hours 40 mins 1 hr 50 mins
SESSION **3**	A multi-level framework for understanding the social determinants of health	• have an understanding of the various levels at which determinants of health operate (international, national, community, household, individual) • gain insights into the structural factors underlying the impact of policies and programmes	Small group work Participatory big group exercise	40 mins 1 hr 50 mins
SESSION **4**	Exploring the links between gender and other determinants of health	• distinguish between factors affecting women's health that are common to women and men of a specific social group (e.g. rural/urban, poor/rich); that arise from women's biological differences from men; and that are related to gender-based differentials in roles and norms; access to and control over resources and in power between women and men within the same social group • distinguish amongst the above three categories the different levels of at which the determinants operate • acquire the skills to apply a gender and social determinants framework to shape and inform policies and interventions	Big group participatory exercise Plenary discussion	1 hr 15 mins 45 mins
Concluding session	Module summary	• have a consolidated overview of tools and concepts introduced in the module, and their linkages	Input	15 mins

- factors that relate to women's status in relation to men because of gender, particularly in relation to power and control over resources.

Sessions 3 and 4 both contribute to a more nuanced understanding of the determinants of health, and provide essential tools for the design of interventions and policies. For example, the interventions needed to address women's health problems which arise from their poverty (social situation), may be very different from those needed to address the problems arising from their relative lack of power in relation to men in their own households. Similarly, appreciating the complex interaction of international and national, and community, household and individual factors in determining gender differentials in health status, helps us understand why a policy or programme might succeed or fail to make an impact.

Introduction to the Social Determinants Module

What participants should get out of the session

You will introduce participants to the module's structure, content and objectives.

10 minutes

How to run the session

This is an input session.

Introduce the module using **overheads** from the Module brief:

- "What participants should get out of the Social Determinants Module"
- "Structure of the Social Determinants Module"
- "Module outline".

SESSION 1

Determinants of health and illness

What participants should get out of the session

Participants will:

- be aware of health as more than a medical issue
- be familiar with the concept of the social determinants of health and illness.

2 hours

Materials

- Handout 1: "A modern parable"
- Handout 2: "Poem"

- handout or flip chart: "Questions for discussion: what makes a person healthy?", on p.99
- flip charts and pens

Readings for the facilitator and the participants

1. Blaxter M. *Health and lifestyles.* London, Tavistock-Routledge, 1990: chapter 3 "What is health?".

2. McKeown T. *The modern rise of population.* London, Edward Arnold, 1976: chapter 5 "The medical contribution".

How to run the session

This session consists of three activities. The first is a small group discussion or individual work on determinants of health and illness, followed by a discussion in the big group. In the second activity, participants read a story in small groups and write down their responses to questions. These responses are then discussed in the whole group. The third activity is the reading of a poem which looks at the connection between poverty and illhealth.

1 hr

Activity 1: Discussing the determinants of health and illness

5 mins

Step 1: Looking at the questions for discussion

Present participants with the questions in the box, either as a handout or on a flip chart. Make it clear that there are no right or wrong answers.

Questions for discussion: what makes a person healthy?

1. What is a healthy person like?
2. What are some of the factors which contribute to good health?
3. What are some of the factors which contribute to ill health?
4. Of the factors listed in questions 2 and 3, which are social and which are biological?
5. Are there differences in health status across different social groups? If yes, what are they, and what are some of the reasons for these differences?
6. What are the differences, if any, between the social and biological causes of ill health?

15 mins

Step 2: Write down responses

Participants may work individually or in groups (depending on the size of your group). They must write down their responses on a piece of paper if they are working individually or on a flip chart if they are working in a group.

40 mins

Step 3: Whole group discussion

After participants have written down their responses facilitate a discussion in the whole group. This is not a report-back session; participants respond to the questions as you raise them. The first two questions could be taken together for discussion, the third and fourth together, and the fifth and sixth one at a time.

What to cover in the discussion

Questions 1 and 2: Defining health

Responses to the first question usually start off with the obvious – a healthy person has no infections - and usually include: a healthy person does not feel tired all the time and has no lingering aches and pains; a healthy person is relaxed, positive, happy; and so on.

Answers to the next question, on what makes for good health, usually overlap with those to the first, and range from having one's basic needs for food, clothing and shelter met, having access to basic amenities such as water supply and sanitation, and living in a pollution-free and clean environment, to living in pleasant surroundings, being productive, creative and useful, relaxed and happy, and feeling positive and supported.

Use the responses to both these questions to help participants arrive at an agreement on what is meant by health. More often than not, the definition they arrive at is similar to the WHO definition of health as "not merely the absence of disease but a state of complete physical, mental and social well-being".

Questions 3 and 4: Exploring the social causes

Questions 3 and 4 are intended to elicit responses that look beyond the obvious physical and biological causes of ill health. The responses usually range from: living in an unhealthy environment, crowded and poor quality housing, malnutrition, congenital problems, poverty and lack of education, to diseases related to lifestyles – stress, smoking and substance abuse, lack of exercise, eating junk food and so on. Armed conflicts and wars, forced migration and natural calamities are also sometimes mentioned.

Question 5: Different social groups have different health status

The discussion on this question should elicit and examine the factors underlying observed differentials in health status by: place of residence (rural/urban); socio-economic status group; race/caste/ethnicity/religion; and sex. This includes differentials in risks and vulnerability, in perceptions about health, health seeking behaviour, access to health services, responses of the health provider, and long term social and health consequences. For example: Why are rural infant mortality rates higher than urban rates in most countries? Is it poverty, lack of education, poorer environment, or lack of access to health services? And why do we take for granted that poor people would suffer higher mortality rates? In what ways does poverty make it difficult for a person to be healthy? Remind participants of the various dimensions of health they looked at in Session 5 of the Gender Module.

Question 6: The social causes of illness are different from the biological causes

While the biological causes of ill health may not always be preventable, the social causes can be confronted and modified by policy and programme interventions. However, these two sets of causes cannot easily be separated. A child with a low birth rate may be born in a rich or a poor household. But this is more likely to happen in a poor household because of the poor nutritional status of the mother, or infections, lack of antenatal care, and so on. Further, the survival chances of a baby with a low birth weight would differ significantly depending on the household's resource base. Policy interventions could be designed both to prevent low birth weight from avoidable causes and to improve the survival chances of babies born in under-resourced environments.

Important points to highlight

- Health is a socially constructed reality: a product of the physical and social environment in which we live and act.
- Differences in people's health status, including gender differences, arise not only from biological differences but also from differentials in social and economic status.
- Social determinants of illness can be confronted and modified by policy interventions.

This activity was modified by the Key Centre for Women's Health, Melbourne, Australia, to focus on gender differentials in determinants of health. Participants were divided into three groups and given a slightly different set of questions based on those in the box: "Questions for discussion: What makes a person healthy?" on p.00. The first group was asked to answer questions about the healthy adult/person, the second about the healthy man and the third about the healthy woman.

While many characteristics of a healthy man and a healthy woman (as described by participants) were similar, there were also some striking differences. For example, a healthy man was considered to be someone who could shoulder responsibilities and had energy to do his job, while a healthy woman was described as someone who was able to do household work and take good care of her skin.

The discussion highlighted the underlying values behind these descriptions: assumptions about women's and men's roles and activities, and expectations that a woman should be beautiful and have a nice skin while a man should be strong. These were related back to the discussions on gender roles and norms in the Gender Module.

The main points that this activity highlighted were:

- gender roles and norms are important social determinants of health and illness
- gender norms lead to different assumptions about what good health means for men and women.

45 mins

Activity 2: "A modern parable"

This activity aims to consolidate what participants learnt in the previous activity and explore social determinants of health in greater depth.

20 mins

Step 1: Reading and discussion in groups

If you did the earlier activity in groups, this one could continue in the same groups. If not, divide participants into groups of no more than eight members each. Each group reads Handout 1: "A modern parable" and then discusses the questions and writes their responses on a flip chart.

5 mins

Step 2: Reading each others' responses

Ask each group to put up its flip chart on the wall. Participants have five minutes to walk around and read them.

20 mins

Step 3: Whole group discussion

Start the discussion with these two questions:

- What do you think is the "machinery" that causes ill health in present-day society?
- What is needed, then, to prevent ill health?

What to cover in the discussion

Exploring the machinery of ill health

It is important to go beyond the narrow picture in the story. Very often, the responses to the two questions in the handout are about the need for better training for the workers and greater safety. But start questioning whether the machinery itself is a given, something that cannot be changed. This will bring to the surface the values that underlie the decisions in the story: Is it okay to trade worker safety off against increased production? Is it okay to settle for a lower level of production if this would ensure worker safety? Does it make sense to increase production when it also increases the level and scale of investment required to deal with the injuries that result? Why not slower machinery and a first aid centre, rather than high productivity machines which create the need for a high tech hospital and at the same time seriously compromise workers' well being?

Putting profits before people

The parallel with present-day society may be much more difficult to elicit from participants. The machinery that causes ill health is a way of life that puts profits before people. What is seen and promoted as development often causes a great deal of damage to people's health. Ask participants to give examples of this from their settings: environmental pollution, the use of chemical fertilizers and pesticides to increase food production, a way of life that contributes to the breakdown of social support networks, and so on. These factors have differential impacts on different social groups, and within these, women and men are affected differentially.

Preventing ill health

Preventing ill health involves questioning many things that we have taken as given: the accumulation of wealth as development; the widening gaps between the rich and the poor; the provision of medication and drugs to treat health problems that are caused by social inequalities.

What the health care system now does is the same as providing first aid to the seriously injured workers of the factory in the modern parable without questioning why such hazardous machinery was being used in the first place, who benefited from it, why it was that the workers were expected to take responsibility to learn to use the machines more safely, and whether the machinery could be replaced.

Important points to highlight

- Social causes of illness, such as poverty and lack of access to health services, are not given; they are the result of a way of life that puts profits before people and vests power in some while denying it to others.

- Social causes of ill health are related to issues of social justice and equity. They are, therefore, not inevitable but can be changed if there is political will.

Activity 3: A poem to consolidate

This activity is meant to reinforce the message about the social causes of illness. Ask one of the participants to volunteer to read Handout 2, the poem by Berthold Brecht. It is not necessary to discuss or debate the poem.

Session developed by TK Sundari Ravindran

Handout

1 A modern parable

Read the story and discuss the questions in your group. Write your group's responses on a flip chart.

- **What, in your opinion, is the message the story is trying to convey?**
- **What parallels can you draw between this modern parable and present-day society's approach to the health problems of the population?**

From: Wilkinson A. *It's not fair*. London, Christian Aid, 1985:72.

There was once a factory which employed thousands of people. Its production line was a miracle of modern engineering, turning out thousands of machines every day. The factory had a high accident rate. The complicated machinery of the production line took little account of human error, forgetfulness, or ignorance. Day after day men and women came out of it with squashed fingers, cuts, and bruises. Sometimes a man would lose an arm or leg. Occasionally someone was electrocuted or crushed to death.

Enlightened people began to see that something needed to be done. First on the scene were the churches. An enterprising minister organized a small first aid tent outside the factory gate. Soon, with the backing of the Council of Churches, it grew into a properly built clinic, able to give first aid to quite serious cases, and to treat minor injuries. The town council became interested together with local bodies like the Chamber of Trade and the Rotary Club. The clinic grew into a small hospital, with modern equipment, an operating theatre, and a full time staff of doctors and nurses. Several lives were saved. Finally the factory management, seeing the good that was being done, and wishing to prove itself enlightened, gave the hospital its official backing, with unrestricted access to the factory, a small annual grant, and an ambulance to transport serious cases from workshop to hospital ward.

But year-by-year, as production increased, the accident rate continued to rise. More and more men and women were hurt or maimed. And, in spite of everything the hospital could do, more and more people died from the injuries they received.

Only then did some people begin to ask if it was enough to treat people's injuries, while leaving untouched the machinery that caused them.

Handout

2 Poem

A Worker's Speech To A Doctor

We know what makes us ill
When we are ill, we are told
That it's you who will heal us.

For ten years, we are told
You learned healing in fine schools
Built at the people's expense
And to get your knowledge
Spent a fortune.
So you must be able to heal

Are you able to heal?

When we come to you
Our rags are torn off us
And you listen all over our naked body
As to the cause of our illness
One glance at our rags would
Tell you more. It is the same cause that wears
Our bodies and our clothes.

The pain in our shoulder comes
You say, from the damp; and this is also the reason
So tell us; where does the damp come from?

Too much work and too little food
Makes us feeble and thin
Your prescription says;
Put on more weight
You might as well tell a bulrush
Not to get wet.

How much time can you give us?
We see: one carpet in your flat costs
The fees you earn from
Five thousand consultations.

You'll no doubt say
You are innocent. The damp patch
On the wall of our flats
Tells the same story.

Berthold Brecht

SESSION 2

Inequalities and inequities in health

What participants should get out of the session

Participants will:

- understand the factors underlying gender inequalities and inequities in health status as well as other social determinants of health (like race, class, ethnicity and place of residence)
- locate gender inequities in health in the context of inequities related to other social determinants of health, and see how gender interacts with other social determinants of health and is affected by them.

2 hours and 30 minutes

Prior preparation

- Readings are to be distributed to participants on the afternoon before this session is run. See instructions under Activity 1 on p.107.

Materials

- Handout: "How to report back on the readings"

Readings for the facilitator

General

1. Kreiger N. Embodying inequality: a review of concepts, measures, and methods for studying health consequences of discrimination. *International Journal of Health Services,* 1999, **29(2):**295–352.

Gender

2. Arber S. Comparing inequalities in women's and men's health: Britain in the 1990s. *Social Science and Medicine,* 1997; **44(6):**773–87.

3. Doyal L. *What makes women sick: gender and the political economy of health.* London, Macmillan, 1995:chapters 1 and 2.

4. Macran S, Clarke L, Joshi H. Women's health: dimensions and differentials. *Social Science and Medicine,* 1996, **42(9):**1203–1216.

5. Young R. The household context for women's health care decisions: impacts of UK policy changes. *Social Science and Medicine,* 1996, **42(6):**949–963.

Social class/income level

6. Davey-Smith G, Bartley M and Blane David. The Black report on socio-economic inequalities in health 10 years on. *British Medical Journal,* 1990, **301:**373–377.

7. Kaplan GA et al. Inequality in income and mortality in the United States: analysis of mortality and potential pathways. *British Medical Journal,* 1996, **312:**999–1003.

8. Marmot MG, Kogevinas M, Elston MA. Social/economic status and disease. *Annual Review of Public Health,* 1987, **8:**111–135.

9. Rahkonen O, Lahelma E, and Huuhka M. Past or present? Childhood living conditions and current socio-economic status as determinants of adult health. *Social Science and Medicine,* 1997, **44(3):**327–336.

Other social determinants of health

10. Kaplan GA. People and places: contrasting perspectives on the association between social class and health. *International Journal of Health Services,* 1996, **26(3):**507–519.

11. Lillie-Blanton M, Laveist T. Race/ethnicity, the social environment and health. *Social Science and Medicine,* 1996, **43(1):**83–91.

12. Verheij RA. Explaining urban-rural variations in health: a review of interaction between individual and the environment. *Social Science and Medicine,* 1996, **42(6):**923–935.

Readings for participants

Readings 3, 4, 6, 8, 11 and12.

How to run the session

There are three activities in this session. In the first, participants read an article on social inequities in health individually over an evening, out of class hours. The second is a group activity in which participants discuss the main findings of their articles in groups, and prepare a group report. The third is a whole group discussion based on the group reports.

Activity 1: Preparation for reading

This activity has to be introduced to participants the day before this session takes place, usually on the day on which the Gender Module is being run.

Divide participants into six groups and give each group a key basic reading on inequalities and inequities in health. You may choose from the list of readings above or draw on other readings. At least two groups have to read articles on gender-based inequities, two on inequities by

social class/income group, and two on inequities arising from other social determinants such as race/ethnicity, or place of residence.

Ask participants to read their articles individually during the evening, outside class hours.

2 hrs 30 mins

Activity 2: Reporting on the readings

40 mins

Step 1: Preparing a group report

This activity is for the day after participants have read the articles.

Those who read the same article work together to prepare a written group report. The handout explains how.

1 hr

Step 2: Presenting group reports

Each of the six groups presents a summary report of their readings to the whole group. They are each allowed seven minutes, with between three and five minutes after the presentation for clarification. Note down any issue that needs substantive discussion and bring it up in the whole group discussion which follows.

50 mins

Step 3: Whole group discussion

What to cover in the discussion

Social factors affect many aspects of health

Summarize the main points made in the presentations, drawing attention to the ways in which social class, race/ethnicity or gender may influence many dimensions of health, ranging from risk and vulnerability, to health seeking behaviour, access to health services, and long term health and social consequences.

For example, living in a low income settlement with poor housing conditions and sanitation may expose people to a higher risk of tuberculosis. The absence of any accessible health facilities may make it difficult for an infected person to initiate treatment. Further, because she or he is from a low income group, the person may be unable to afford treatment.

Make links with points made in the gender and health session [Session 5] of the Gender Module, and elicit responses from participants to extend the discussion to include other social determinants.

Inequity and inequality

The discussion then moves on to the distinctions between differences and inequality on the one hand, and inequity on the other. In public health, the concept of health inequity is often used to describe inequalities in health that are perceived to be unfair. This concept arises from the recognition that there are bound to be differences in the health status of individuals, and for a number of reasons, many of these random or biological and hence unavoidable. But when the health indicators for one group are observed to be consistently lower than those for another group, and this group does not have the same access to many of the social and material conditions and other resources necessary for healthy living, then we may call this health inequity.

Equity – the absence of particularly unfair differences, is different from equality – the absence of differences in general. The use of the

concept of health equity may appear to be in conflict with health equality, as viewed from a human rights perspective. Pursuing equity in health means trying to reduce social disadvantages or their health effects among disadvantaged groups; it thus requires selectively focusing on disadvantaged groups, which may be seen as giving them preferential – and therefore unequal – treatment.

From a human rights perspective, equality – and equal protection for groups and individuals in law – is a crucial concept. However, equality and non-discrimination do not mean identical treatment in every instance. International human rights law recognizes positive discrimination in favour of socially disadvantaged groups in order to ensure genuine equality in practice.

Thus, while equity is not the same as equality, it is a commitment to increase the equality of opportunity for health and human development for groups within a society who have suffered discrimination, and in this sense it corresponds very closely with important elements of the human rights framework, introduced in the Rights Module.

Is there a difference between gender and other social determinants of health?

Yes. One difference is that gender-based inequities interact with inequities by social class, race, caste or ethnicity, so that women may face additional disadvantages compared to men from the same social stratum or group. Further, the construction of gender varies across race, class, caste, ethnicity and so on. We cannot look at gender relations in isolation. A second, more important difference is that there is often a tendency to confuse gender-based inequities in health status with those arising from biological differences.

Main points for closing this session

Inequities in health arise largely from differentials in social and economic status, and differential access to power and resources. This is also true of gender-based inequities in health.

Gender-based inequities in health co-exist and interact with inequities related to other social determinants, placing women at an additional disadvantage.

Session developed by TK Sundari Ravindran

Handout

1 How to report back on the readings

Your group has been given an article on inequalities in health. Read the article yourself, and then as a group discuss the main findings and prepare a brief written presentation of no more than seven minutes. Nominate one of the group members to report back to the big group.

The presentation should:

- **start with a brief introduction to the paper: title, author(s), whether it is a research study, a review article, or chapters from a book**
- **outline the main thesis or argument in no more than five or six lines: What is the paper about? What is it telling us about how social class, race/ethnicity or gender influences health status?**
- **describe how the article builds the arguments towards the main thesis.**

It is not necessary to cover every point made in the paper, or paraphrase it page by page. Just pull out the main threads. Present a few (no more than three) tables or graphs if these will contribute substantially to illustrating the arguments.

Conclude with your own reactions to the paper. Did you find the paper useful? In what ways? Are there some points you do not quite agree with? Why?

SESSION 3

A multi-level framework for understanding the social determinants of health

What participants should get out of the session

Participants will:

- have an understanding of the various levels at which determinants of health operate (international, national, community, household, individual, and so on)
- gain insights into the structural factors underlying the impact of health policies and programmes.

2 hrs 30 mins

2 hours and 30 minutes

Materials

- overhead: "The various levels of determinants", on p.112
- several sets of cards in five different colours, at least A5 size
- twine, cellophane tape and a large display board or wall where the display can stay up for the whole course

Readings for the facilitator

1. Arber S. Class, paid employment and family roles: making sense of structural disadvantage, gender and health status. *Social Science and Medicine,* 1991, **32:**425–436.

2. Cooper DE, et al. *The impact of development policies on health: a review of the literature.* Geneva, World Health Organization, 1990: chapters 2 and 7.

3. Dyches H, Rushing B. International stratification and the health of women: an empirical comparison of alternative models of world-system position. *Social Science and Medicine,* 1996, **43:**1063–1072.

Readings for participants

Readings 2 and 3.

How to run the session

This session begins with a small group activity to identify the social determinants of health operating at various levels, followed by a whole group activity in which the multi-level framework is constructed with inputs from the various groups and yourself.

40 mins

Activity 1: Building a framework for analysis

10 mins

Step 1: Looking at the various levels: from the international to the individual

Start the session with a brief introduction to the activity.

Overhead Put up the following table to illustrate what you mean by determinants operating at various levels.

The various levels of determinants

Individual	Household	Community	National	International
biological or genetic; age; parity; birth order; education; employment; decision-making power; marital status	the social and economic status of the household within the community; the household's access to resources	level of development; rural or urban; stratified or homogenous; having health resources or not; inheritance norms, norms for place of residence after marriage	size of the country; population; level of development; type of governance; structure of the health system; extent to which dependent on the global market; nature of health policies and contours of health sector reform packages	global economic scenario and dominant economic ideologies; balance of power between various geo-political forces; health sector reform; international human rights regime

Ask participants for other examples of social determinants of health operating at each of the levels.

30 mins

Step 2: Exploring the levels in groups

Divide participants into about five groups. Ask each group to identify factors that influence a person's health status that they consider important, at each of the five levels. Each group is given cards of five different colours, each colour corresponding to one of the levels.

They write each factor on a separate card of the appropriate colour for the corresponding level. The cards and the writing should be large enough for people to read when displayed on a board.

1 hrs 50 mins

Activity 2: Constructing the multi-level framework

20 mins

Step 1: Putting up the cards

You need a large display board or a blank wall where you can leave the display undisturbed until the end of the course. Put up five column headings marked "individual", "household", "community", "national" and "international".

Each group takes turns to display below the column headings their five cards. One member of each group puts up the group's cards.

Each group adds on new factors and does not repeat factors if they have already been mentioned.

Examples of factors from course participants

Individual	Household	Community	National	International
Age	Number of members	Rural/urban	Size	Global economic situation
Sex	Number of adults/children	Level of development	Population	Terms of trade
Marital status	Employed person	Stratified/ homogenous	GNP	Nature of dominant ideologies
Birth order	Assets owned	Status of women in the community	Type of government	Dominant paradigms in the health sector
Education	Caste/ race status	Health resources in the community	Unemployment levels	Influence of Human Rights in the regime
Occupation	Number of members with schooling	Economic resources	How affected by globalisation	
Decision-making power		Job opportunities	HDI and GDI ranking	
		Social cohesion	Structure of the health system	
			Coverage by health services	
			Whether implementing health sector reforms	

45 mins

Step 2: The links between the factors

After all the groups have put up their cards, each group takes turns to illustrate the links between factors at various levels.

Each group may be asked to work through just one factor, starting from one of the levels and linking to others.

Example: Poor nutrition in a child

Consider the example of poor nutrition in a child. The child may be a girl, or have a high birth order. This is a factor at the individual level. The child may be born in a household with limited resources, located in a community where the income from farming has fallen dramatically because of a fall in prices of primary products internationally and the government's lack of bargaining power in the international setting.

Example: National programmes

Starting at the national level, a national programme for improving irrigation facilities through the construction of large dams would benefit some communities and lead to the displacement of others. If the community is poor and has little bargaining power, then it is not likely to demand the implementation of a reasonable rehabilitation and resettlement programme; to be a poor household in such a community could mean loss of livelihood and living space and being reduced to destitution. The women in the household would be the worst affected.

Recognizing diversity in the group

If the participants come from diverse backgrounds and work with diverse groups (which would be the case in an international course) it may be useful to discuss how the individual, household, community and national/provincial factors vary in different country settings.

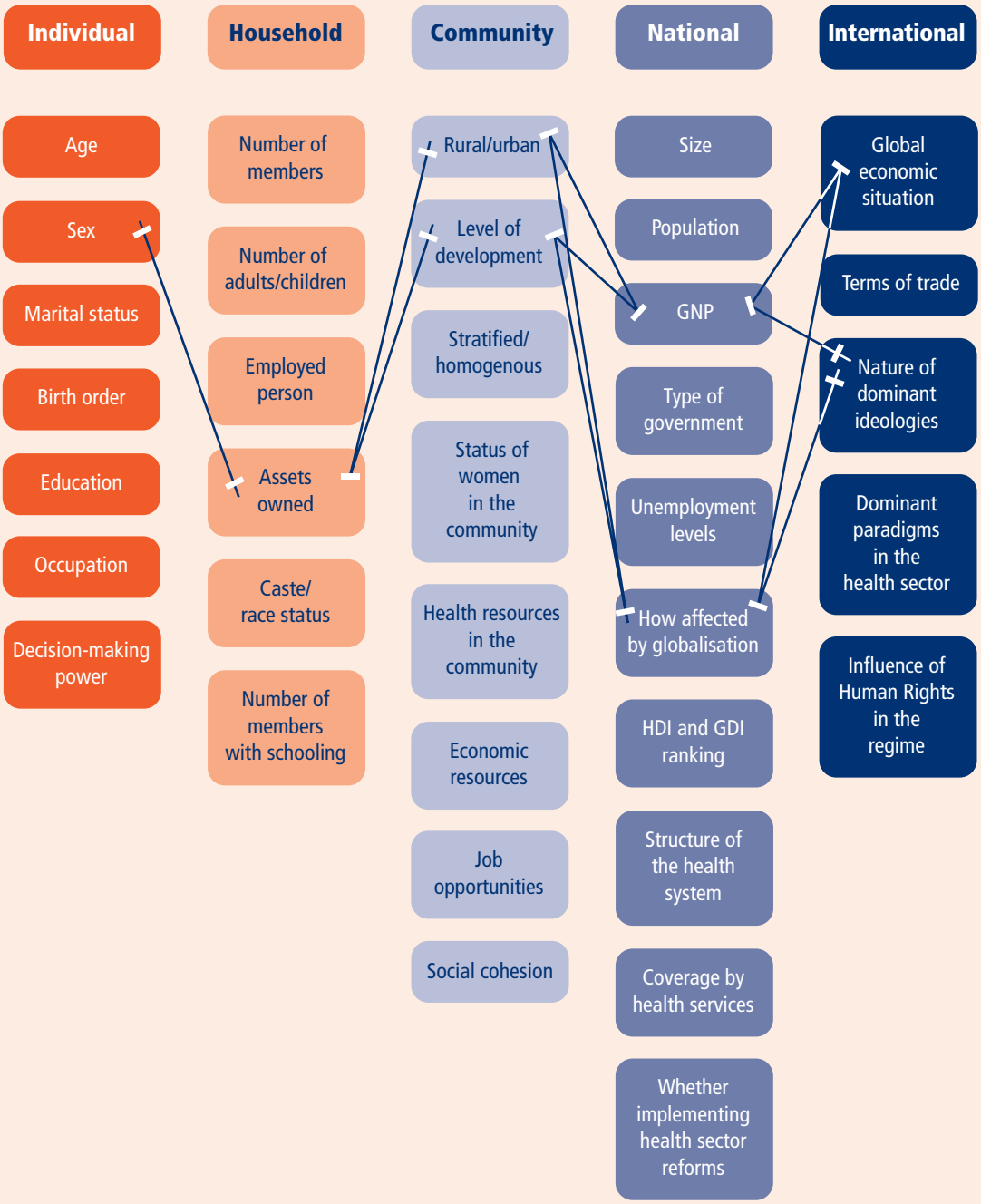
In order to make the links across factors at different levels graphically, use string or twine and cellophane tape to connect cards representing different level *(see diagram opposite).*

Often, each factor is connected to several others. Other members of the group making the presentation are encouraged to identify as many links as possible.

In the course conducted by the Women's Health Project, South Africa, health managers attending the course were often quick to give ignorance as an important factor leading to a health problem. For example, saying women were poorly nourished because they were ignorant about balanced diets. This exercise gave the facilitator an opportunity to challenge this notion, and to draw attention to the neglect of the rights of these women – the right to livelihood – as well as other factors that may also be involved, such as the high cost of nutritious food, and women's lack of land rights.

This part of the activity can become time consuming. Maintain a brisk level of questioning and discussion, and ensure that making the links across the different levels is completed within about 40–45 minutes so that participants stay interested.

Multilevel factors influencing low nutrition in a girl child in a developing country



Important points to highlight

Social determinants of health operate at various levels, from the individual to the international.

Some of the determinants at the different levels are common across countries and regions, while others vary.

There is a need to go beyond determinants at the individual and household levels – beyond attributing poor health to being a woman or being poor – to lack of education, living in a low income settlement without access to basic amenities, poor access to health facilities and so on.

Underlying many of the factors at the individual and household levels are larger political and economic forces. If we do not see the links between these factors, which are easily discernible, and the structural factors operating at the macro-level, we may end up blaming the victim, or unable to effect any improvements in the health of certain population groups. At the same time, the impact of international and national forces – for example, structural adjustment programmes and health sector reform – is governed by norms and practices at the community and household level.

The five levels operate collectively, sometimes in the same direction, at other times in contradictory directions – but often to the disadvantage of marginalized groups.

Step 3: Whole group discussion

At this point participants may feel daunted or defeated by the larger forces at play. It is important to discuss how understanding the larger forces can and should significantly help us design better and more appropriate interventions.

What to cover in the discussion

Using an example: a high level of reproductive morbidity among women in a given community

Consider the issue of a high level of reproductive morbidity among women in a given community. A situation analysis may point to the absence of reproductive health services. However, the reason for this absence may in fact not be a lack of resources. The country's health services may be influenced by donor funding policy (a factor at the international level) which sees population control as the priority. If this is the factor underlying the lack of reproductive health services, the intervention needed may not be to mobilize more funds, but advocacy and lobbying efforts at various levels, such as mobilizing international opinion against the donor's policy.

Looking at other scenarios

You could elicit and discuss similar examples from participants. For example, a large proportion of pregnant women with a complication in delivery not going to a health facility could be a question of empowerment. If so, working with women in the community would help. If, in addition, there are poor roads and no transport, the local government would have to be involved in improving the road, the local health centre may have to be lobbied for making a vehicle available, or resources mobilized from elsewhere – for example, from a special scheme of the federal government – for buying a vehicle. If, on the other

hand, the main reason is the introduction of user fees for delivery services following the World Bank's recommendations on health sector financing, action may have to be undertaken at many levels: from a community health fund for mothers-to-be, to national-level lobbying and advocacy to focus public opinion on the adverse consequences of the introduction of user fees.

The importance of understanding structural factors

There is another reason why it is important to understand the structural factors influencing access to the conditions necessary for good health and to health services. Say we are designing a nutrition education programme in a province or at the national level, because of a research finding that poor diet is an important contributor to malnutrition in children. At about the same time, the government cuts its food subsidies and staple foods are no longer available at subsidized prices for the poor. The programme would immediately have to take into account that nutrition education alone would not help, because food is now more expensive. To be effective, the programme may have to be redesigned, for example to include access to food at subsidized prices to those most in need.

A quick look at rights

The next module, on rights, provides a framework and conceptual tools for looking at the rights involved when a person suffers ill health, and for designing interventions and proposing policy measures that aim not only to prevent the neglect or violation of rights necessary for the prevention of ill health, but also to enable the enjoyment of rights essential for good health.

Main points for closing this session

Understanding the national and international factors that underpin the individual and household factors influencing health is necessary for designing appropriate and effective interventions.

Session developed by TK Sundari Ravindran.

SESSION 4

Exploring the links between gender and other determinants of health

What participants should get out of the session

Participants will:

- be able to distinguish between the factors affecting women's health:
  - that are common to women and men of a specific social group
  - that arise from women's biological differences from men
  - that are related to gender-based differences in roles and norms and access to and control over resources, and the power relations between women and men within the same social group
- acquire the skills to apply the social determinants and gender framework to shape and inform health policies and interventions.

2 hours

Materials

- overhead: "Miriam's story"
- a ball of twine or wool, a pair of scissors

How to run the session

This session consists of two activities. The first is a participatory exercise known as "the spider's web". It involves reading out a case study of a woman suffering from ill health and unravelling the factors that contributed to it. The activity illustrates how so many factors are intertwined, using the analogy of the spider's web. The second activity is a whole group discussion to help participants understand both the links and the differences between sex, gender and other social determinants of health.

1 hr

Activity 1: The spider's web

Step 1: Divide the room up

The floor of the room is divided into five big squares or rectangles. One half of the room is assigned to three factors that women have in common with men of the same social group: economic, socio-cultural and political factors. These are marked on the three squares or rectangles on the floor. The other half of the room is divided into two squares or rectangles, marked "sex" and "gender", as shown in the diagram on p.121.

5 mins

Step 2: Your input

Explain that this session builds on the earlier session which looked at the various social determinants of health and the different levels at which they operate. It aims to show us how to distinguish between the determinants that affect both women and men and those that predominantly affect women's health because of their biological and gender-based differences from men. It also aims to examine the links between these two kinds of determinants.

55 mins

Step 3: "Miriam's story"

Put up an **overhead** of "Miriam's story" or use another case study which has the potential for similar discussion.

When the course was run in Argentina, the case study used for the spider's web exercise was "How did Mrs X die?", about a woman who dies in childbirth. (World Health Organization. *Education material for teachers of midwifery. Foundation module: the midwife in the community.* Geneva, WHO, 1996:11-30.)

Miriam's story

Miriam is 36 years old and the mother of six children. She grew up in a village 400 kilometres away from the capital city of her country. She stopped schooling after her second grade. Her parents were poor, and the school was three kilometres. Away from the village. Her father believed that educating a girl was like 'watering the neighbour's garden'.

When she was 12, Miriam was circumcised, as was the custom in her tribe. At 16, she was married to a man three times her age. Her father received a substantial *lobola.* The very next year, she gave birth at home, to a baby boy. The baby was stillborn. The health centre was 10 kilometres away, and anyway, did not attend deliveries. Miriam believed that the baby was born dead because of the repeated beatings and kicks she had received all through her pregnancy. Instead, she was blamed for not being able to bear a healthy baby.

Miriam's husband considered it his right to have sex with her, and regularly forced himself on her. Miriam did not want to get pregnant again and again, but had little choice in the matter. She had no time to go to the health clinic, and when she went sometimes because her children were sick, she was hesitant to broach the subject of contraception with the nurses.

Her life with her husband was a long saga of violence. Miriam struggled to keep body and soul together through her several pregnancies and raising her children. She had to farm her small plot of land to feed the children, because her husband never gave her enough money. She approached the parish priest several times for help. He always advised her to have faith in God and keep her sacraments.

One day her husband accused Miriam of 'carrying on' with a man in the village. He had seen Miriam laughing and chatting with the man, he claimed. When she answered back, he hit her with firewood repeatedly on her knees saying 'you whore! I will break your legs'. Miriam was badly injured; she thought she had a fracture. For weeks she could not move out of the house. But she did not have any money to hire transport to go to the health centre. Unable to go to the market to trade, she had no income and literally starved.

Miriam was terrified of further violence. She had had enough. As soon as she could walk, she took her two youngest and left the village. She now lives in a strange village, a refugee in her own country, living in fear of being found by her husband and brought back home.

Demonstrate how the spider's web exercise works with one or two examples.

Stand at the centre of the room with a ball of wool or twine. The participants take turns to read the case study in parts, and after each sentence or each couple of sentences, you call out, "But why?"

For example:

Facilitator: Miriam stopped schooling after her second grade. But why?
Participant 1: Her school was three kilometres away from the village.
Facilitator: But why?
Participant 2: The village was a poor one, far away from the capital city.

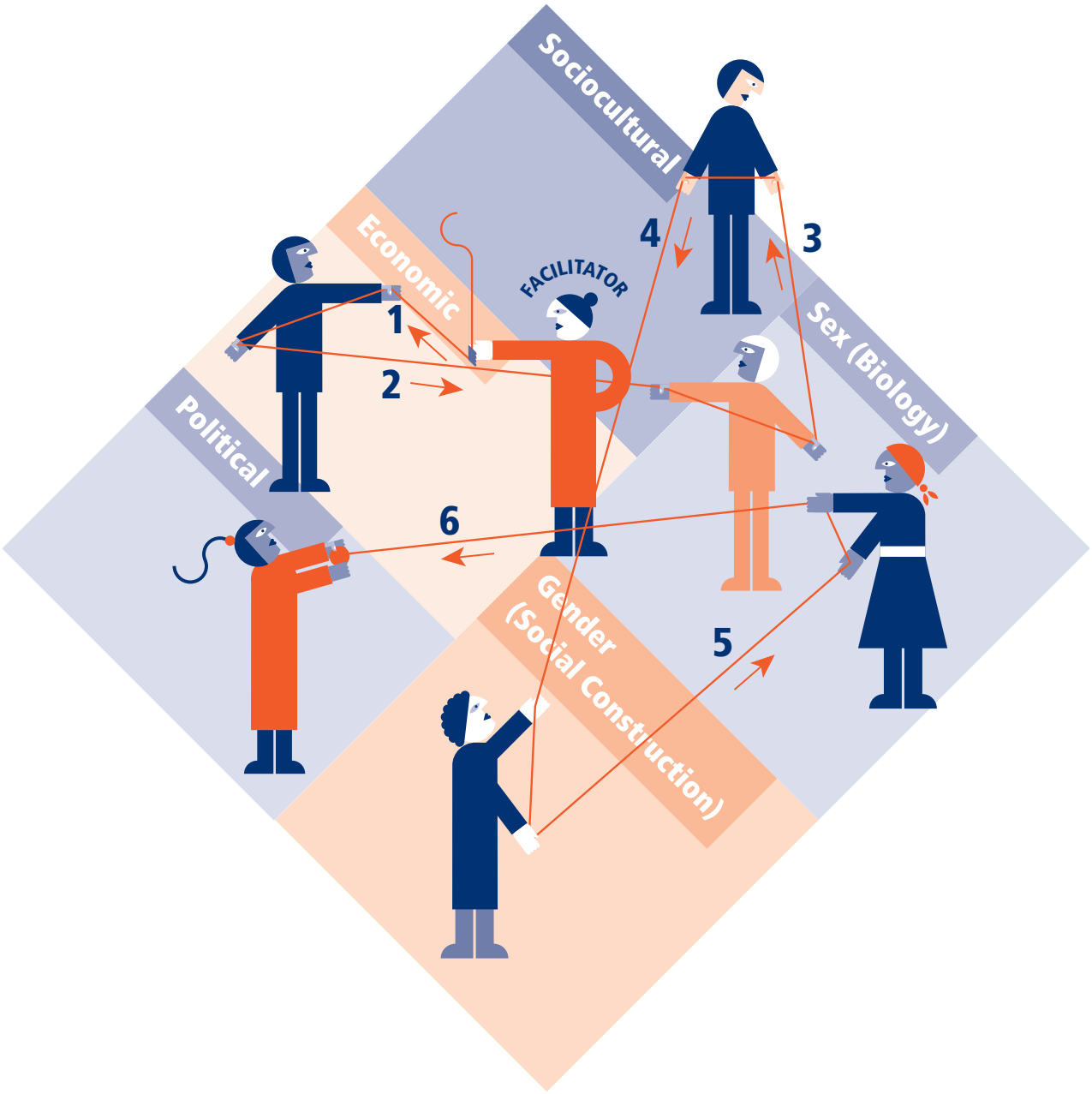
The person who gave this last answer has identified a reason that would affect both boys and girls in Miriam's village. This factor could be classified as economic – the backwardness of the village, or as political – the village's lack of bargaining power to secure resources.

As soon as the participant identifies that the reason is that the village is powerless, the facilitator asks "So how would you classify this factor?" The participant may say "Economic". As soon as he or she says this, the person goes and stands in the square marked "economic". The facilitator, standing at the centre with the ball of twine, holds one end of the twine, and throws the ball to the participant standing in the "economic" square. You may probe further, and ask "Can you classify it as any other factor?" And another

participant may say "Political". She or he would go and stand in the "political" square, and the person standing in the "economic" square would throw the ball to her or him, while holding on to the twine. Now all three are linked by the twine.

There is another reason why Miriam stopped schooling – her father did not think education was necessary for girls. This would get classified as "gender", and the ball would pass on from the person in the "political" square to the person identifying this factor and occupying the "gender" square.

And so on until by the end we are left with a complex spider's web of factors underlying the woman's ill health.



Keep up a brisk pace

The activity should be conducted at a brisk pace, with each "But why?" following in quick succession, the factors classified and a new participant coming into the web.

You should decide before the activity at which points you will be stopping to probe "But why?" Restrict this to no more than 10 or 12 questions.

15 mins

Step 4: Cutting the web

When the spider's web is complete, challenge participants to find points at which they can cut the web. What intervention could they make which would make a difference to Miriam's situation? This could happen while the participants are still standing entangled in the web.

You could ask participants to respond from a specific vantage point

Facilitator: If you were a local activist, where would you cut the web?
Participant: I would intervene to help Miriam stand up to her husband's violence; I would give her shelter in my house, and help her farm her land.

Facilitator: If you were the nurse at the local clinic, where would you cut the web?
Participant: I would be sensitive to signs and symptoms of battering in women who come to my clinic. I would help them find shelter and social support through a suitable agency.

Facilitator: If you were from the department of health of the national government, where would you cut the web?
Participant: I would advocate for the setting up of one-stop centres within major hospitals to help women affected by domestic violence.

And so on.

As each participant answers, cut her or him free. After three or four such examples, participants return to their seats for debriefing and discussion.

45 mins

Activity 2: Whole group discussion about how factors are linked

15 mins

Step 1: Participants give feedback

Encourage participants to start by sharing their feelings about the exercise. How did they feel when they were entangled? How did it feel to cut the web at specific points? What lessons do they draw from the exercise? What do they think the entanglement signified?

Participants usually share their feeling of being hopelessly trapped as the spider's web was being constructed, and feeling that they would never be able to unravel the problems. Cutting through some parts of the web gives insights into possible actions that individuals or groups can take – no matter how complicated a situation appears or at which level a person is able to intervene: individual, community or national.

What to cover in the discussion

Where to start

Point out that the key to cutting the complex web may lie in starting with the woman herself. This would create greater space for her to reflect on her situation, interact with others and facilitate her empowerment, helping her see that change is possible.

Draw attention to the fact that in the spider web exercise, many gender factors were also classified also as socio-cultural, for example the reason for Miriam's circumcision, or her early marriage. This point should be brought up for discussion – that culture and tradition are not gender neutral and may become tools for discrimination against women. They are likely to be the parts of the spider's web that are the most difficult to cut through.

Where is it appropriate to cut the web?

Economic, socio-cultural and political factors that affect women's health are so intertwined with factors related to gender and sex that they seem to mesh into one. While it is important to see these links, it is equally important to separate them out analytically so that we can identify where it is most feasible and appropriate to cut the web.

Step 2: A more general discussion

Move the discussion to a more general level.

Which factors affect women exclusively?

Explain that the spider web exercise identified some factors which affected women predominantly or exclusively – for example female circumcision, early marriage and battering. Other factors were common to men and women in Miriam's community – for example the distance from the school and the health centre.

It is important to analyse health issues in this way. Say women in a community are suffering from iron-deficiency anaemia. This may be because of something common to women and men – hookworm infestation; or it may be caused by women's biological difference from men – malaria infection during pregnancy; or it may arise from gender differences – discrimination in food allocation leading to malnutrition. Each of these causes calls for a completely different intervention.

Unravelling sex, gender and other factors

Elicit other examples from participants of sex and gender factors – as opposed to economic, socio-cultural and political factors – operating at various levels, which may be responsible for a health condition or problem.

Unless one carries out an analysis to unravel gender and sex from other factors underlying a problem, interventions may not address the causes, and may in fact further undermine women's position. There are many examples of such interventions: targeting women for health education assuming that ignorance is the cause of their malnutrition; not dealing with men and safe sex, but testing and treating women for sexually transmitted infections; and so on.

The social determinants perspective and the rights framework

Draw participants' attention to the links between a social determinants perspective and a rights framework (which is introduced in the next module) in relation to health. Understanding the social causes underlying ill health also helps us identify the economic, socio-cultural, civil or political rights involved. Violating or neglecting these may underlie the health problem. Addressing these violations or neglect would create conditions that enable good health.

Step 3: Connecting the multi-level framework and the present one

What is the connection between the multi-level framework introduced in Session 3, and this one?

The division of the factors affecting health which are common to both sexes and those that are specific to women, can be done for each of the five levels of factors: individual, household, community, national and international. For example, Miriam's father's attitude to the education of girls is a gender factor operating at the household level. The absence of a school in the community is an economic or political factor operating at the community level, and so on.

One way of visualizing the connections between the two frameworks is to see the five squares on the floor as the unpacking of each of the five levels participants put up on the wall or board in the previous session.

Main points for closing the session

Distinguish between determinants affecting women and men, and sex and gender factors

It is useful to distinguish between health determinants common to women and men and those that are sex and gender related, because each of these sets of factors require a different type of intervention.

The analysis of a health situation or a specific health problem should explicitly consider the gender dimension and its links to other determinants of the problem.

The designing of interventions should be based on such an analysis and take into account the potential impact of these interventions on gender power relations.

Health problems caused by multiple factors need a multi-pronged strategy

Often there are multiple factors causing a problem, and a multi-pronged strategy is required to address these simultaneously.

A social determinants perspective forces us to look at the issue of rights

The analysis of a health situation from a social determinants perspective also helps identify the rights which are being neglected or violated which may be contributing to the health problem. Addressing these rights violations or neglect also creates the necessary conditions for addressing the health situation.

Session developed by TK Sundari Ravindran and Adelina Mwau

SESSION 5

Module summary

What participants should get out of the session

Participants will:

By the end of this session, participants will have an overview of the tools and concepts introduced in the Social Determinants Module, the links between them, and the links between the tools introduced in the Gender Module and the Social Determinants Module.

15 minutes

How to run the session

This is an input session.

What your input should cover

Overhead Go over the main points in the Module brief and review the "Structure of the Social Determinants Module".

Highlight the tools and concepts introduced in this module

- gender as one of the social determinants of health, cross-cutting and interacting with others such as race, class and ethnicity
- the many levels at which social determinants of health, including gender, operate
- at each of the many levels, the distinction between factors which are common to women and men, and those that are different for women and men because of biological or gender factors.

Gender factors seldom operate alone

This module locates the distinction between sex and gender, and gender concepts such as access to and control over resources and power and decision-making, within the context of other social determinants of health. This provides us with a more nuanced understanding of gender as a determinant of health. Gender factors seldom operate alone or at one level. There is a need to go beyond a simplistic analysis of health problems using gender tools alone if we are to design policies and interventions, or to unravel why a policy or programme succeeds or fails to make an impact.

Link up with the Rights Module

Throughout the module on social determinants, you have drawn participants' attention to the fact that the violation or neglect of rights may underlie adverse health situations in many instances. The next module, on rights, provides a framework and tools for moving towards equity in health, paying specific attention to non-discrimination. It spells out the norms and obligations of state and non-state actors. It also helps plan and design interventions which go beyond simply meeting perceived needs, but which include the active promotion and protection of rights, which are essential for the sustained enjoyment of good health by all members of society.

Module 3: **Rights**

Structure of the Rights Module

SESSION 1 — Human rights from a personal perspective

Illustrates that the promotion or violation of human rights is relevant to everyone's life. And that the realization of rights is necessary for achieving reproductive and sexual health.

SESSION 2 — Introduction to international human rights in relation to reproductive health

Introduces the relationship of reproductive health to human rights. Familiarizes participants with concepts and institutions related to the promotion, monitoring, implementation and enforcement of the human rights norms and standards relevant to reproductive and sexual health.

SESSION 3 — Balancing the burdens and benefits of human rights in relation to reproductive health policies and programmes

Enables participants to recognize the implications of the violation of rights or the promotion of rights in the design and implementation of health policies and programmes. Provides an approach for using this analysis to arrive at more effective action.

SESSION 4 — Population policies and reproductive rights

Introduces participants to the paradigm shift from controlling population growth rates to recognizing reproductive rights internationally since the International Conference on Population Development (ICPD) in Cairo in 1994 and the Fourth World Conference on Women (FWCW) in Beijing in 1995. Applies a rights framework to case studies of recent population policies from specific countries.

SESSION 5 — Working with sexual rights

Promotes understanding of the conceptual and methodological approaches which help to shape and define sexual rights, and their links with reproductive rights. Provides participants with the opportunity to consider approaches to implementing sexual rights at various levels of intervention.

SESSION 6 — Applying a rights framework to reproductive and sexual health issues

Reinforces the concepts introduced in earlier sessions through case study examples. Highlights various ways in which the violation or promotion of rights interacts with reproductive and sexual health, and how awareness of this can help to shape and inform policies and interventions.

SESSION 7 — Using international human rights to translate government commitments into action

Concretely applies the international human rights framework to reproductive and sexual health by giving participants approaches to creating positive change through incremental steps. Focuses on actions at local, national and international levels.

MODULE 3

Module brief

What participants should get out of the Rights Module

Participants will:

- be familiar with the basic concepts of rights, including reproductive and sexual rights
- understand how rights are defined in international human rights documents, and how they are used by various actors (such as non-governmental organizations, governments, the United Nations system) at the international and national levels
- learn about institutions which are promoting, monitoring, implementing and enforcing human rights norms relevant to reproductive and sexual health
- be able to apply human rights concepts and a human rights methodology to analyse reproductive health programmes, policies and research
- acquire the skills to conceptualize and apply a reproductive and sexual rights framework to sexual and reproductive health issues.

The thinking behind the module

The need for a reproductive and sexual rights approach

This module is intended to provide participants with the knowledge and skills they need to apply a human rights framework to analysing and implementing policies and programmes related to reproductive and sexual health. This includes an understanding of the content and nature of reproductive and sexual rights, and the work of relevant institutions. The module also provides concrete examples of the application of a reproductive and sexual rights approach.

Drawing on the Gender and Social Determinants Modules, we look at how human rights and a human rights framework can be used to address the factors which impact on health status and the delivery of health services. Implementing this approach should help to strengthen local, national, regional and international partnerships concerned with reproductive and sexual health.

The first session introduces the concept of rights. Through a group exercise we examine the impact that participants believe the promotion or violation of rights has had on their lives to demonstrate that the realization of rights is necessary for reproductive and sexual health. This exercise draws on participants' personal experiences and then relates these to internationally recognized human rights. Drawing out the

gendered aspects of the experiences that participants share allows discussion of the compounding effects of neglect or violation of rights, such as the rights to non-discrimination, privacy and education. It also highlights the fact that the violation or neglect of rights rarely occurs in isolation and that the harmful effects often compound one another. We look at the health consequences of the violation or neglect of rights, as well as at the impact of the way reproductive health policies and programmes are designed and implemented on the realization of rights. This session aims to help participants understand that the discourse of rights may be used very differently: for example when rights are used in advocacy as opposed to when they are used to make policy. However, it is possible to arrive at a shared understanding of the basic concepts.

Once this conceptual groundwork has been laid, the second session introduces the principles and practice of promoting and protecting human rights. The discussion is intended to highlight the basics of human rights law, including core documents and key institutions. We look at the obligations of governments under the human rights documents as they are relevant to reproductive and sexual health. This framework then sets the stage for a structured discussion of reproductive rights. These are to be understood as those rights from the international human rights documents which relate to an individual woman's ability to make and effect decisions about her life, and which impact on her reproductive and sexual health. Both the International Conference on Population and Development (ICPD) in Cairo and the Fourth World Conference on Women (FWCW) in Beijing recognized reproductive rights as being integral to, and the foundation for, the realization of sexual and reproductive health. This session is therefore crucial in enabling participants to work with reproductive rights as they are understood by governments and institutions of power. It will also help to provide them with a critical tool in their efforts to make the changes necessary for improving reproductive health.

The third session provides an opportunity to use human rights concepts and methodology in relation to analysing and improving a public health policy or programme. The exercise is intended to familiarize participants with applying human rights to their daily work. The session provides participants with the tools to work towards integrating health and human rights concepts into policies and programmes. The underlying premise is that those which respect human rights are better and more effective. The example we use concerns the mandatory HIV testing of sex workers, but the methodology provided is intended to be useful in an analysis of any reproductive health policy or programme.

The fourth session focuses on the national and international ideological, political and methodological shifts that have taken place in population policies since the Cairo and Beijing conference processes. The session outlines the history of these processes at the international level and provides national examples of related changes. It

also discusses the changes that are still needed to operationalize the commitments made by governments in Cairo and Beijing.

The fifth session introduces the concept of sexual rights. Participants consider international and national efforts to define and implement sexual rights, and compare and contrast sexual rights with reproductive rights. A final exercise gives participants the opportunity to discuss how sexual rights may be useful to their daily work. The fourth and fifth sessions give participants the necessary analytical and methodological background for implementing reproductive and sexual rights.

In the sixth and seventh sessions participants apply the concepts and methods using concrete examples. Participants are challenged to apply the analytical and methodological tools from earlier sessions to begin to develop strategies for integrating human rights concerns into their daily work. There are three options in the sixth session. Each is intended to highlight how the promotion or violation of human rights can interact with reproductive and sexual health, and how awareness of this can help to shape interventions and actions. The seventh session looks at efforts – at the international and national levels – to implement reproductive and sexual rights in the years since the Cairo and Beijing conference processes. It focuses on the range of actors, including NGOs (non-governmental organizations), governments and the UN (United Nations) system. It ends with approaches for determining useful actions for the future. This session is geared to providing participants with an approach to linking their work with other actions taking place in their communities and around the world.

Module outline

		Objectives Participants will:	Format of activities	Time: about 14 hours
	Introduction to the Rights Module	• be acquainted with module objectives and contents	Input	15 mins
SESSION 1	Human rights from a personal perspective	• become aware that the promotion or violation of rights is easily identifiable and relevant to everyone's life • understand that the realization of rights is necessary for reproductive and sexual health	Small group work Big group discussion	25 mins. 50 mins
SESSION 2	Introduction to international human rights in relation to reproductive health	• understand the relationship of reproductive rights to human rights • become familiar with concepts and institutions relevant to the promotion, monitoring, implementation and enforcement of human rights norms and standards related to reproductive and sexual health	Participants' reading and discussion in the big group, supplemented by input from facilitator	2 hrs
SESSION 3	Balancing the burdens and benefits of human rights in relation to reproductive and sexual health policies and programmes	• understand the impact that the promotion of rights or violation of rights can have on reproductive and sexual health • be able to use a public health and rights based approach for identifying and solving problems	Input Individual work and discussion in pairs interspersed with plenary discussion	1 hr 1 hr 45 mins
SESSION 4	Population policies and reproductive rights	• be familiar with the Cairo and Beijing conferences, and how they are a product of women's struggle and have reoriented the population and development discourse • recognize that policies are a site of struggle and that the concepts of reproductive rights and health which this course looks at are based on a human rights approach concerned with empowering women, gender equality, and equity in resource distribution • be able to apply a reproductive and sexual rights framework to analyse population control policies • understand how population control policies impact on sexual and reproductive rights and services	Individual reading Input Discussion in big group	Outside class hours 1 hr 1 hr
SESSION 5	Working with sexual rights	• learn about the evolving content of sexual rights and the issues raised by the recognition of them • recognize that sexual rights are a requirement for the achievement of both sexual health and gender equality • understand the difference between reproductive rights and sexual rights • be able to conceptualize practical interventions to realize sexual rights at different levels (legislative, health system, community)	Big group input and discussion Small group work	1 hr 45 minutes
SESSION 6	Applying a rights framework to reproductive and sexual health issues	• apply the concepts introduced in earlier sessions to examples which highlight various ways in which the violation or promotion of rights interact with sexual and reproductive health • become aware of how the understanding of these interactions can help to shape policies and interventions	Small group work Big group discussion	1 hr 15 mins 1 hr

Module outline *(continued)*

		Objectives Participants will:	Format of activities	Time:
SESSION 7	Using international human rights to translate government commitments into action	● be familiar with a range of approaches to applying reproductive and sexual rights to the work they are engaged in ● contextualize their work in relation to the range of actors engaged in similar endeavours	Small group work Big group discussion Individual work Sharing in big group	20 mins 40 mins 10 mins 50 mins
Concluding session	Using international human rights to translate government commitments into action	● have a consolidated overview of tools and concepts introduced in the module, and their links	Input	15 mins

Introduction to the Rights Module

What participants should get out of the session

You will introduce participants to the module's structure, contents and objectives.

15 minutes

How to run the session

This is an input session.

Introduce the module using **overheads** from the Module brief:

- "What participants should get out of the Rights Module"
- "Structure of the Rights Module"
- "Module outline".

SESSION 1

Human rights from a personal perspective

What participants should get out of the session

Participants will:

- become aware that the promotion or violation of rights is easily identifiable and relevant to everyone's life
- understand that the realization of rights is necessary for reproductive and sexual health.

1 hr 15 mins

1 hour and 15 minutes

Materials

- Handout: "Personal accounts of rights being violated"
- Handout of the *Universal Declaration of Human Rights*. This can be downloaded from www.unhchr.ch/html/intlinst.htm
- flip chart or board for writing on

How to run the session

This session consists of two activities. The first is in small groups. The second is a report-back and discussion in the whole group, where participants should reach conclusions.

1 hr 15 mins

Activity: Personal accounts of rights being violated

25 mins

Step 1: Working in small groups

This first activity is to take place with no reference or access to any human rights document. Participants work in groups to identify situations in which they feel a right was violated.

Divide participants into groups of five. Give each person the handout "Personal accounts of rights being violated", which describes what they should do. Tell the groups that they have 20 minutes for their discussion, and to make notes on the rights which they feel were relevant to the stories they shared to report back to the whole group.

15 mins

Step 2: Whole group report-back

Ask the first group to report on the rights that they considered relevant to their group. Why did they see these as important? Note the rights that are mentioned on the board or flip chart. When listing the rights, put these in two separate columns: one for civil/political rights and another for economic/social and cultural rights. Each group then adds to the list rights that have not been mentioned yet. Put rights which are not internationally recognised under the column category to which it is most closely related. At this point, do not go into the stories behind the rights.

Some of the rights that previous participants have raised include:

- right to health
- right to security
- right to be treated equally
- right to respect
- right to emotional fulfilment
- right to information
- right to choice
- right to dignity
- right to earn an income and support a family
- right to make decisions concerning one's life
- right to education.

10 mins

Step 3: Discussion: How the violation of rights has impacted on reproductive and sexual health

Ask participants to volunteer to share stories about what they consider to be violations of rights which impacted on sexual and reproductive health, or about the violation of reproductive and sexual rights.

Some examples that have come up include:

- female genital mutilation
- the right to be informed when one's partner tests positive for HIV
- the right of health workers to be protected from HIV infection
- the right to choose one's marriage partner, and not be forced into an arranged marriage
- the right to use a contraceptive method of one's own choice without overt or covert coercion from the health system
- the right not to be discriminated against in the labour market because of having children

25 mins

Step 4: *The Universal Declaration of Human Rights*

Hand out copies of the *Universal Declaration of Human Rights* (UDHR). Participants take five to seven minutes to read it individually. Tell them to skip the preamble and to begin reading at Article 1.

Go over each of the rights listed on the board or flip chart and ask participants to identify which article in the UDHR most closely addresses it. If time is limited, choose only those rights which participants thought impacted on reproductive and sexual health.

One point which is often raised, is whether something can be considered a violation of rights even when it is legal within a country's framework. Make it clear that the answer can be yes.

Clarify that human rights standards are relevant to laws, policies and practices. Governments have the primary obligation to promote and protect rights, and they also draft the international standards. Governments have an obligation to amend their national laws to be in line with international human rights standards and to ensure that their laws are not in violation of their international human rights obligations. Those advocating for a change in legislation or procedures can use international human rights norms to call attention to the gap between the national law and the international standard, and thus hold governments responsible for appropriately amending their laws.

In the South African course, some of the violations impacting on reproductive and sexual health that participants identified included female genital mutilation, being forced into an arranged marriage, a woman being denied a job because she had small children, and the difficulty poor women experienced in accessing health services. They then reported female genital mutilation to be covered under Article 3 of the UDHR, which is about the right to security of person. The right to make decisions about one's marriage partner was found to be covered in Article 16, which affirms that marriage shall be entered into only with the free and full consent of intending spouses. Discrimination in the labour market because of having a child was interpreted as violation of the right to equality, and related to articles 1 and 2 as well as Article 23. Article 21, which affirms right of equal access to public services in one's country, was seen as affirming poor women's equal access to public health services.

Main points for closing the session

There are identifiable violations of rights and obstacles to enjoying rights. Most of the rights protections for the issues we are concerned with are covered in international human rights documents, but existing standards need to evolve and be applied to new situations.

There are different interpretations of rights. But the provisions in the UDHR are written in such a way that all of the concerns can be covered. It is necessary to be clear about how rights language is being used: for advocacy, to make policy, to hold governments accountable, and so on.

Session developed by Sofia Gruskin

Handout

1 Personal accounts of rights being violated

You have 20 minutes to finish these tasks. Appoint one member of the group to report back to the whole group.

1. **Thinking back on your own life**
   Spend two minutes alone recalling one incident when you felt a right was violated.

2. **Sharing**
   Share your story with the rest of the group if you feel comfortable to.

3. **Name the rights**
   At the end of each story, the person sharing should try to name which rights she or he thinks were relevant to the story and in what ways. Write these down. Group members are then free to suggest other rights which they feel were relevant.

4. **Develop a list**
   Start a list of rights from these contributions. Each person shares a story until everyone who wants to speak has had a turn. As the list of rights grows, each time a right is relevant to more than one person's story put an X next to it.
   If the group is large, try to restrict the stories to avoid repetition.

5. **Look for systematic differences**
   Are there systematic differences in the violation of rights that different members of your group have reported on? For example, by race, class and sex? In other words, are women more at risk of experiencing a rights violation and more likely to report violation of the right to non-discrimination, compared to the others?

6. **Generalizing to uncover further relevant rights**
   As a final step before returning to the big group, revisit the stories that related to reproductive and sexual health. Go beyond the specific story to consider additional rights you could add to the list if the group considered the issue in general terms. For example, an incident relating to disrespectful treatment in a health facility when a person came for treatment for a sexually transmitted infection (STI) may have been identified as a violation of the right to respect. However, if one considers the wider issue of prevention and treatment of reproductive health problems, a number of rights may immediately appear relevant. In human rights terms, these are some of the issues likely to be relevant:

- the right not to be discriminated against
- the right of access to health services
- the right to information.

SESSION 2

Introduction to international human rights in relation to reproductive health

What participants should get out of the session

Participants will:

- understand the relationship between reproductive rights and human rights
- be familiar with concepts and institutions relevant to promoting, monitoring, implementing and enforcing the human rights norms and standards related to reproductive and sexual health.

2 hrs

About 2 hours

Materials

Handout provided in the manual

- Handout 1: "International human rights in relation to reproductive health." This is meant to serve as an outline of key points and not as a definitive summary. You may either reproduce it as it is, stressing this point and elaborating on each of the points during the whole group discussion. Or you could rework it, elaborating a bit more on each section, or focus specifically on points you consider important for the particular group.

Handouts to be prepared by the facilitator

- Handout 2: The list of ratifications and reservations for all of the human rights treaties by the countries represented in the participant list. You can download this from: www.unhchr.ch/. Click on "treaties", choose the human rights treaty you are interested in presenting and click on "status of ratifications".
- Handout 3: The box "United Nations conferences and women's human rights", on p.144
- Handout 4: The box "Selected examples of reproductive rights", on p.145
- copies of the various human rights documents mentioned in Handout 1, which can be downloaded from: www.unhchr.ch/html/intlinst.htm. These include the *Covenant on Civil and Political Rights, the Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, and Convention on the Elimination of All form of Discrimination against Women* (CEDAW).

Overheads

- overhead of box: "Government obligations to protect, respect and fulfil human rights", on p.142
- overhead of box: "United Nations conferences and women's human rights", on p.144
- overhead of box: "Selected examples of reproductive rights", on p.145

Other materials

flip chart or board for writing on

Readings for the facilitator

1. Bilder R. An overview of international human rights law. In: Hannum H, ed. *Guide to international human rights practice,* 2nd ed. Philadelphia, University of Pennsylvania Press, 1992:3–18.

2. Bunch C. Women's rights as human rights: toward a revision of human rights. *Human Rights Quarterly,* 1990, **12:**486.

3. Eide A. Economic, social and cultural rights as human rights. In: Eide A, Krause C, Rosas A, eds. *Economic, social and cultural rights: a textbook.* Dordrecht, Martinus Nijhoff, 1995:1–40.

4. Hannum H. Implementing human rights: an overview of strategies and procedures. In Hannum H, ed. *Guide to international human rights practice,* 2nd ed. Philadelphia, University of Pennsylvania Press, 1992:19–38.

5. Sullivan D. The public/private distinction in international human rights law. In: Peters J, Wolper A, eds. *Women's rights—human rights: international feminist perspectives.* New York, Routledge, 1995:126–134.

6. United Nations Population Fund. *Programme of action of the International Conference on Population Development,* Cairo, 5–13 September 1994. New York, United Nations, 1996.

Readings for participants

Reading 2.

How to run the session

This session consists of reading and discussing Handout 1 together in the whole group.

2 hrs

Activity 1: International human rights and reproductive health

10 mins

Step 1: Reading Part 1: The basics

Start with a brief introduction to this session.

In order for participants to be able to use reproductive rights in their daily work and to advance the protections they offer, they must understand both the intrinsic opportunities and limits of the definitions that have been internationally agreed upon. This session is intended to provide the basic framework and structure of international human rights law as the basis for applying reproductive rights to the rest of the work in this course.

Tell participants to read Handout 1 individually, and to stop for a whole group discussion after they have read Part 1. Give them five to seven minutes to read.

15 mins

Step 2: Summary and discussion

Ask one or more participants to summarize the main points in Part 1. Once participants have worked with the basic concepts of human rights, engage them in a discussion concerning the human rights of women specifically.

What to cover in the discussion

The public and private spheres

Ask participants whether they think women's human rights are different. Why do they think a separate human rights convention focused on discrimination against women was needed? Point out that the fact that the modern human rights movement was created in the aftermath of World War II partly explains its public orientation and its limited ability to monitor what goes on in the private sphere. Clarify the meaning of the public and the private sphere and the implications for women's human rights. Also note that women can and should claim rights under all the treaties, and that the Convention on the Elimination of All form of Discrimination against Women (CEDAW) is not their only or primary source of rights. It spells out the meaning of discrimination which can then also be used in other parts of the rights system to understand how men and women face different obstacles to enjoying their rights.

Men and women and human rights

Take one right from the UDHR and ask participants if they think the violation of that right would be the same for women and for men. You may take, for example, the right to information (Article 19), the right to security of person (Article 3), the right to take part in the government of one's country (Article 21) or the right to work (Article 23). Make the links to the Gender Module, and specifically to evidence in Session 3 on women's access to and control over resources and their political participation.

Take care not to make women's rights appear as a separate claim, so make sure that this section builds from a gender analysis to bring appropriate attention to women's realities. Highlight the fact that while legally all human rights apply to women, in reality they often do not because of gender based discrimination.

A systemic problem

Mention domestic violence and how the violation of human rights includes the state's action or inaction in an abusive situation. The systemic

problem is the human rights issue, more than the individual act. Systemic issues could include everything from whether there are education and public awareness campaigns, investigations when domestic violence occurs, a system that supports women who report a violation, shelters, effective remedies, public knowledge of effective remedies, and so on.

Institutions also violate reproductive and sexual rights

Link this to the discussion on institutions and levels in the Social Determinants Module, and highlight how reproductive rights and sexual rights are violated by a variety of institutions: the household, organized religion, the state, markets and international organizations. The government is obliged not only to respect and fulfil the rights through its policies, laws, and programmes, but also to prevent violations of rights by non-state actors.

Step 3: Part 2: Governments' obligations

Participants read Part 2 of Handout 1 for the next five to seven minutes. Ask a few participants to summarize the main points related to international human rights law and to government obligations.

Put up the **overhead** on government obligations in relation to the right to health, and discuss it.

Government obligations to respect, protect and fulfil human rights

Example: the right to health

- **Respecting the right** means the state cannot violate the right directly. A government violates its responsibility to respect the right to health when it is immediately responsible for providing medical care to certain populations, such as prisoners or the military, and it arbitrarily decides to withhold that care.
- **Protecting the right** means the state has to prevent violations of rights by non-state actors, and offer some sort of redress, that people know about and can access, if a violation does occur. This means the state would be responsible for making it illegal for anyone (private or public practitioner, insurance company) to automatically deny insurance or health care to people on the basis of a health condition. It would be responsible for making sure some system of redress exists and that people know about it and can access it.
- **Fulfilling the right** means the state has to take all appropriate measures – including but not limited to legislative, administrative, budgetary and judicial measures – towards the fulfilment of the right, including promoting the right in question. A state could be found to be in violation of the right to health if it failed to incrementally allocate sufficient resources to meet the public health needs of all of the communities within its borders.

How have governments successfully respected, protected and fulfilled rights?
Get participants to give you examples of a government successfully meeting its obligation to respect, protect or fulfil the right to reproductive or sexual health, and examples of failures to do so. Some positive examples include the provision of sex education to adolescents, the implementation of a safe motherhood programme, or a family planning programme that provides free and ready access to contraceptive methods. State legislation against sexual harassment in the workplace and against domestic violence against women are positive examples of state action to prevent violation of sexual and reproductive rights by non-state actors. Negative examples include policies and laws that restrict the availability of abortions, the absence of a policy on cervical cancer screening, and family planning programmes that are only integrated with maternal and child health services (thereby possibly excluding men).

Step 4: Drawing a circle of rights

Here is a quick, whole group exercise that demonstrates how rights are interrelated:

- both negative and positive steps are needed for all rights
- the enjoyment of one right rests on the enjoyment of others.

The example below is of a woman's right to choose the number and spacing of her children and how she wants to do this (Article 16 of CEDAW). You may choose any right related to reproductive or sexual health.

- Draw a circle in the centre of a flip chart or board and write "A woman's right to choose the number and spacing of her children and how she wants to do this" in the circle.
- Draw other circles around it and ask participants to suggest what rights are useful or necessary to make this right real.
- Then draw lines between these rights as they relate to each other. You end up with a molecule-like figure.
- Place factors that are not rights but necessary conditions on the outer rim of the diagram.
- Note the different actors that are required to make each of these rights actionable.

Suggestions for related rights usually include: freedom of information, laws protecting bodily integrity and freedom from forced sexual activity, access to the benefits of scientific progress, and changes in cultural attitudes that allow women to have fewer children.

Step 5: Part 3: Monitoring rights and building political commitment

Participants read Part 3 of Handout 1 for the next five to seven minutes. Ask a few participants to summarize the main points related to standard setting and monitoring mechanisms.

Find out from participants what they know about reproductive rights, and about the paradigm shift following the Cairo conference. Tell them that this will be dealt with in greater detail in Session 4.

Then put up the following **overhead,** which you can also give out as Handout 3. Go over the main points.

United Nations conferences and women's human rights

- Prior to the 1990s, there had been several UN conferences on population but they did not have a focus on rights.
- There had also been several UN conferences on women, but they had not focused on human rights, or on issues concerning reproduction and sexuality.
- The first world Conference on Human Rights, which took place in Tehran in the 1960s, made a mention of the right to determine the number and spacing of one's children.
- In 1993, the second world Conference on Human Rights, which took place in Vienna, set the stage for what happened first in Cairo and then in Beijing. It affirmed that women's rights are human rights; that the eradication of all forms of discrimination on the basis of sex should be a priority for governments; and, finally, that women have a right to the enjoyment of the highest standard of physical and mental health throughout the life cycle, and that this includes a right to accessible, adequate health care and to a wide range of family planning services.
- The first time a comprehensive framework for realizing reproductive rights was set out at the international governmental level was in Cairo in 1994. It emphasized the link between population and development, and meeting the needs of individuals. This was a departure from the focus on abstract demographic targets, and it affirmed the focus on reproductive rights.

Step 6: Part 4: Reproductive rights

Participants take about five to seven minutes to read through the fourth and final part of Handout 1.

Participants summarize the main points

Once again, ask participants to summarize the main points. Ask them to give some examples of what they consider to be reproductive and sexual rights: the right to choose one's sexual partner, the right to freedom from non-consensual sex, the right to choose whether one has children, when and how many, the right to a safe maternity and safe abortion, and so on.

Governments and a gender perspective

How would a gender perspective impact on governmental obligations under the human rights treaties it has ratified? For example, governments reporting under the Convention on the Rights of the Child may be required to provide sex-specific data on children's health, and to put in place policies and programmes that would enable girl children to enjoy the same rights to health, education and social services under the convention as boys do.

Governments and a reproductive and sexual rights perspective

What would a reproductive and sexual rights perspective bring to government obligations under the human rights treaties it has ratified? The box below gives many examples, which you can put up as overheads and give out as Handout 4.

Go over the **overhead.**

Selected examples of reproductive rights

These rights can be used to protect and promote gender equality in reproductive and sexual health.

The right to life: Traditionally understood to relate to freedom from arbitrary deprivation of life. Now also includes the positive obligation of the state in relation to, for example, maternal mortality. Think of more than 515 000 women who die each year in pregnancy and childbirth from avoidable complications.

Rights to bodily integrity and security of the person: Traditionally understood to relate to actions concerning individuals in the custody of the state. Now also includes understanding this right as including security from sexual violence and assault at the hands of a partner or others. As well as, for example, in relation to population programmes that compel sterilization or abortion, or those that physically prohibit women from receiving family planning services.

The right to privacy: Traditionally understood to refer to privacy in relation to a person's home and correspondence. Now also includes some protections in relation to sexuality. In this regard, the Human Rights Committee, the treaty body which monitors governmental compliance with the *International Covenant on Civil and Political Rights,* has stated, directly related to sexuality, that "it is undisputed that sexuality is covered by the concept of privacy" and that "moral issues are not exclusively a matter of national concern in that they are subject to review for consistency with international human rights instruments".

The right to the benefits of scientific progress: Traditionally understood to relate to technology transfers between countries of the North and the South. Now, could also include, for example, recognition that a woman's right to control her own reproduction would obviously be enhanced by: access to microbicides, female controlled methods of contraception, research into a greater range of male contraceptives and access to safe abortion.

The right to seek, receive and impart information: Traditionally understood only in relation to the media and a free press. Now also in relation to how realization of this right is critical to reproductive

health, for example with respect to reproductive decision making, a woman's ability to make fully informed choices, as well as her ability to protect herself against sexual exploitation, abuse or infection.

The right to education: Traditionally understood only in relation to literacy. Literacy is obviously critical to reproductive health, but also, since sexuality is recognized as an element of the human personality, education is essential to developing this aspect of oneself.

The right to health: Traditionally understood to refer to the right of individuals to the highest attainable standard of physical and mental health. Increasingly understood to mean that governments must create conditions which assure for all the enjoyment of the highest attainable standard of health, including facilities for the treatment of illness and the rehabilitation of health. Occupational and environmental health issues are also seen as being covered under this right. This right also brings increased attention to women's health issues. For example, this interpretation would draw attention to the almost complete lack of attention and resources devoted to the early detection of cervical cancer by a number of governments, or state controlled reproductive health programmes that exist for some population groups but exclude certain marginalized communities from their consideration and outreach.

The right to equality in marriage and divorce: Traditionally understood to refer to the equal ability of women and men to voluntarily enter into marriage and divorce. This right has been often neglected and violated. This neglect or violation may be because it is tolerated, acknowledged or even condoned by governments, or because it remains insidiously hidden or deliberately ignored. As this right is relevant to women's ability to control and make decisions about their lives, its importance is beginning to be recognized by people engaged in reproductive health work.

Non-discrimination: Traditionally understood to mean that all people should be treated equally and given equal opportunity, including assurance of equal protection under the law. The last 20 years have seen the development of the idea of substantive equality, which notes that some distinctions are necessary to promote rights for people who are differently situated – but that all differences in treatment must be based on objective and reasonable criteria and a goal which promotes rights. Therefore, applying different approaches to girls and boys in reproductive and sexual health policy and programme development must be based on a valid recognition of gender related differentials. The influence of prescribed gender roles and cultural norms when determining the differentials should be minimized.

Main points for closing this session

It is clear what governments have to do

Government obligations for promoting and protecting human rights have been clearly spelled out. They must take certain steps and effect particular results, even though the processes to do this may vary greatly.

Institutions and procedures are in place

Institutions and procedures which help to ensure monitoring and accountability do exist.

Expanded accountability in the traditional framework

Reproductive rights are not new rights but have helped to push for additional accountability under the traditional human rights framework for issues that are relevant to reproductive and sexual health.

Be clear about how you are applying a right

Key provisions have been written in such a way that many sexual and reproductive concerns can be covered. It is necessary to make it clear whether you are applying a principle to a new set of facts and advocating for that principle, or stating what is already formally accepted in the system. Variations exist depending whether the rights language is being used for: advocacy, to make policy, to hold governments accountable, and so on.

Session developed by Sofia Gruskin

Handout

1 International human rights in relation to reproductive health

This is an outline of key points and not a definitive summary.

Part 1: The basics of international human rights law, including core documents, key institutions and how the human rights of women fit in

International human rights law defines what governments can do to us, cannot do to us, and should do for us. The implementation of international human rights law relies in the first instance on the actions of governments themselves, although monitoring systems exist.

The legal obligation for implementing human rights is focused on governments, but all kinds of other actors have responsibilities for promoting rights, such as corporations, individual health care providers, and so on.

Human rights law is meant to be equally applicable to everyone, everywhere in the world, across all borders and across all cultures and religions.

Human rights are primarily about the relationship between the individual and the state. International human rights law consists of the obligations that governments have agreed on in order to be effective in promoting and protecting the rights of individuals.

When governments fail in their obligations to, or when they deliberately restrict rights without valid justification, they can be seen under international law as being responsible for violating rights.

The modern human rights movement was created in the aftermath of World War II and focused on key abuses identified at the root of that conflict. This partly explains its public orientation and the limits of its ability to protect what takes place in the private sphere.

The key human rights document is the *Universal Declaration of Human Rights* (UDHR). It is not a legally binding document; it represents the shared aspirations of governments about what rights are, and why they should exist for all people everywhere.

The two covenants, the *International Covenant on Economic, Social and the Cultural Rights and the International Covenant on Civil and Political Rights,* further clarify the rights set out in the UDHR. Unlike the UDHR, they are legally binding documents on those countries which ratify them.

These three documents together are often called the *International Bill of Human Rights.* Other human rights documents that have been developed elaborate and in some cases move beyond these three. This means that the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW) or the *Convention on the Rights of the Child,* which might seem particularly useful for work in reproductive and sexual health, should not be read in isolation. The understanding of

governmental obligations under the human rights treaties continues to develop, so the interpretation of the rights contained in the *International Covenant on Civil and Political Rights* is now much more sensitive to gender equality than it was even a few years ago. Governments are legally responsible for simultaneously complying with all their obligations under all of the treaties they have ratified.

Rights considered to be more civil and political include rights such as the right to life, to be free from torture, to vote, to information or to association. Rights considered to be more economic, social and cultural include such rights as the right to education, to work and to the highest attainable standard of physical and mental health.

Human rights are used in a number of different ways by different actors: as grounds for making policy and programme decisions; to analyse what a government is or isn't doing and to point out that the gaps may be legally recognizable violations; and perhaps both informally and formally as an advocacy tool. Some may primarily use the formal system of rights (international treaties and their reflection in national law) and some may primarily use the principles behind them (informal). Given these differences it is always important to be clear how the rights language is being used and for what purpose.

Part 2: Governmental obligations under international human rights law, including permissible limitations on rights

For every right, governments have three levels of obligation: they have to respect the right, protect the right, and fulfil the right. To respect a right means not to directly violate it. To protect the right means enacting laws setting up mechanisms to prevent violation of the right by non-state actors. To fulfil the right means to take active steps to put in place institutions and procedures, including resource allocation, that will enable people to enjoy the right.

Human rights machinery recognizes that resources and other constraints can make it impossible for a government to fulfil all rights immediately and completely. In practical terms, a commitment to the right to health is going to require more than just passing a law. It will require financial resources, trained personnel, facilities and, more than anything else, a sustainable infrastructure. Therefore the realization of rights is generally understood to be a matter of progressive realization, of making steady progress towards a goal.

Enforcing the rights of individuals is supposed to take place in the first instance at the national level, by governments.

If governments fail to or are unwilling to enforce the rights of individuals, then the international system can be used to dialogue and sometimes to critique the situation. It is important to recognize that much rights work in health is about incorporating rights standards to strengthen state practice, and is not only based on denouncing states for failures.

To determine whether a government is doing all it can to ensure that rights are being realized, look first at the scope of the government's

obligations (respect, protect, fulfil), then at permissible limitations on those rights. From there it is possible to begin to determine whether a violation has occurred.

Governments can legitimately restrict most rights. This means most rights are not absolute. Rights that can never be restricted, even if justified as necessary for the public good, include the right to be free from torture, slavery or servitude, the right to a fair trial, and the right to freedom of thought.

Public health is a valid justification for restricting most rights, for example state interference with freedom of movement when necessary to impose quarantine or isolation at a particular time for a serious communicable disease, such as Ebola fever. This is a restriction that may be necessary for the public good and therefore could be considered legitimate under international human rights law. The basic principles to consider before rights can be legitimately restricted, like in the case above, are spelt out in the Siracusa Principles. These principles are discussed in detail in Session 3.

Part 3: Monitoring rights at the international level through human rights treaty bodies. Building political commitments through the international conference processes, such as Cairo and Beijing

Treaty bodies

Every UN human rights treaty has a treaty monitoring body called a committee, which monitors the compliance of the states that have bound themselves to the treaty legally (ratification). Ratification by a state of a UN human rights treaty implies that they are willing to take part in the monitoring process.

Whether and to what extent a government is in compliance with its obligations under a particular treaty is monitored through a system of regular reporting by the government to the Committee concerned.

These periodic reports by a government to these committees include information on the steps it has taken to implement its obligations, any difficulties it has had in doing so, and exactly how it has incorporated its obligations into domestic law.

It is supposed to report on both law and practice.

The reports are potentially self-serving, but they are becoming more and more effective. This is because treaty monitoring bodies are less and less likely to accept them at face value. Treaty bodies also get information from NGOs (non-governmental organizations), often in the form of "shadow reports", which they can use in questioning the official government report. The work of NGOs is critical to this process.

Treaty bodies also issue "General Comments" and "General Recommendations", which can help to further elaborate their interpretation of rights contained in the treaty. For example the treaty body that monitors the Women's Convention has elaborated recommendations on health, violence against women and HIV/AIDS.

International conferences – political commitments

The declarations and programmes of action of international conferences such as those in Cairo and Beijing are key to moving the human rights agenda forward because they help clarify and give content to certain rights and clusters of rights, for example by getting international consensus at government level on the notion of reproductive rights across a series of international conferences beginning in Cairo.

While international conferences do not make new law, they are important as they reflect the political commitments of governments at a very high level. They are also important for bringing visibility to new issues.

These conference commitments are about government action and about what should or should not be done at the national and international level. They are about setting out not just a declaration of principles, but also a programme of action, designed to be relevant to all policy and programme work in reproductive health.

In addition, the treaty bodies have begun to use the commitments in Cairo and Beijing around reproductive rights in their dialogues with governments. This has helped to make governments more accountable for the provisions in the documents.

Part 4: How to think about reproductive health in the context of human rights, and therefore about reproductive rights

Reproductive rights are not new rights. They relate to an individual woman's or man's ability to control and make decisions about her or his life which will impact on her or his reproductive and sexual health. According to international consensus no new rights have been created. Rather, the constellations of rights that together make up what we call reproductive rights have been identified from within the existing human rights documents.

Reproductive rights are understood to be entitled to protection for their own sake, but also because they are essential as a precondition for the ability to exercise other rights without discrimination.

Reproductive rights means considering governmental obligations under the human rights documents in a whole new light. For example, consider the rights to education, health and social services in relation all of the well-known causes of maternal mortality. A government which fails to provide education, health and social services to young women of reproductive age, could well be found to be in violation of these rights now recognized as part of reproductive rights. This is likely not to have been the case before the Cairo conference.

Consider the additional elements of information that a gender perspective and recognition of the existence of reproductive and sexual rights would bring to governmental accountability under the human rights treaties it has ratified. Think through the added dimensions that considering a right from this perspective brings. For example, the right to bodily integrity and security of the person was traditionally understood to relate to actions concerning individuals in the custody of the state. But now it can also be interpreted as security from sexual violence and assault at the hands of one's intimate partner or others.

SESSION 3 Balancing the burdens and benefits of human rights in relation to reproductive and sexual health policies and programmes

What participants should get out of the session

Participants will:

- understand the impact that the promotion of rights or the violation of rights can have on reproductive and sexual health
- be able to use a public health and rights based approach for identifying and solving problems.

2 hours 45 minutes

Materials

- Handout: "A case study for analysing a reproductive health intervention"

- overhead: "The Siracusa principles", on p.153
- overhead: "Population policy of country X", on p.154
- overhead: "Four quadrants: The quality of human rights and public health in a programme", on p.155
- flip chart

Readings for the facilitator

1. Alexander P. Sex workers fight against AIDS: an international perspective. In: McClintock A, ed. *Sex workers and sex work.* Durham, Duke University Press, 1994.

2. ECOSOC. *Siracusa principles on the limitation and derogation provisions in the International Covenant on Civil and Political Rights.* New York, United Nations, 1984:1–6 (UN Doc. E/CN.4/1984/4).

3. Gostin L, Mann J. Toward the development of a human rights impact assessment for the formulation and evaluation of public health policies. In: Mann JM, Gruskin S, Grodin MA, Annas GJ, eds. *Health and human rights: a reader.* New York, Routledge, 1999:54–71.

4. International Federation of Red Cross and Red Crescent Societies and the François-Xavier Bagnoud Centre for Health and Human Rights. The public health–human rights dialogue. In: Mann JL, Gruskin S, Grodin MA, Annas GJ, eds. *Health and human rights: a reader.* New York, Routledge, 1999:46–53.1994. New York, United Nations, 1996.

Readings for participants

Reading 4.

How to run the session

This session consists of two activities. It starts with a presentation by the facilitator to the full group. In the second activity, participants work individually and then in pairs, with intermittent discussions in the whole group and input from you.

Activity 1: Rights in the context of health policies or programmes

Step 1: Introducing the theme

Begin with an introduction of the purpose of this session – to enable participants to recognize the implications of the violation of rights or the promotion of rights in the context of health policies or programmes, so that they will be able to design and implement more effective policies and programmes.

What your input should cover

Overhead Start the input with an explanation of the Siracusa principles, which were briefly referred to in Session 2.

The Siracusa principles

In order for governments to validly restrict the rights they see a need to restrict, for example to movement or information, certain criteria have to be met. The restriction must be:

- in accordance with a law or policy
- in the interest of a legitimate objective
- strictly necessary to achieve that objective
- carried out by the least restrictive alternative
- not drafted or imposed in an unreasonable or discriminating way.

The idea is that the restriction is the last resort after the government has done all it can do.

Illustrate with an example.

Population policy of country X

Faced with a severe economic crisis, which included growing unemployment, rising prices and pervasive poverty, the government of country X has decided that stringent population reduction measures need to be introduced. The government believes that population growth in their country has cancelled out development efforts and that the most effective policy option would be to intensify state sponsored population reduction measures. In an effort to drastically reduce birth rates, contraceptive technologies whose safety or efficacy has not been adequately tested are being introduced. A programme of severe incentives and disincentives is also being considered. Under this policy, the number of children a woman already has determines the family planning method she may use. Those with no children can have the oral pill, those with one child may have an IUD inserted, and those with two or more children are sterilized. Before the introduction of this policy, poor access to resources compounded by repeated pregnancies and inadequate health care resulted in very high reproductive morbidity rates in women. The new policy does not address these issues and is introducing family planning services in a context of high reproductive morbidity without the back up of comprehensive reproductive health care.

Evaluate this example against the Siracusa principles. Here are some useful points for discussion.

Principle: In accordance with the law. In the example, a policy has been put in place, which means that this principle has been adhered to. The policy framework ensures the possibility for accountability, redress and challenge. This is different from situations where actions are taken by representatives of the government without a policy.

Principle: In the interest of a legitimate objective. The objective in the example is unclear. Coping with the economic crisis is a legitimate objective, but it is unclear from the facts presented if the objective is to cope with the economic crisis or to reduce population growth for its own sake. Either objective could be legitimate, but the question must be considered.

Principle: Strictly necessary to achieve that objective. Whatever the objective, it would be difficult to justify this policy as strictly necessary to achieve it.

Principle: The least restrictive alternative Again, an evaluation would include asking whether, at least, the range of methods could be made available to all women and men seeking family planning services.

15 mins

Step 2: A methodology for maximizing the public health and human rights elements of policies and programmes

This methodology is adapted from: International Federation of Red Cross and Red Crescent Societies and the François-Xavier Bagnoud Centre for Health and Human Rights. The public health–human rights dialogue. In Mann JM, Gruskin S, Grodin MA, Annas GJ, eds. *Health and human rights: a reader.* New York, Routledge, 1999:46-53.

Introduce participants to the following methodology. It attempts to maximize both the public health and human rights quality of policies and programmes.

There are four steps:

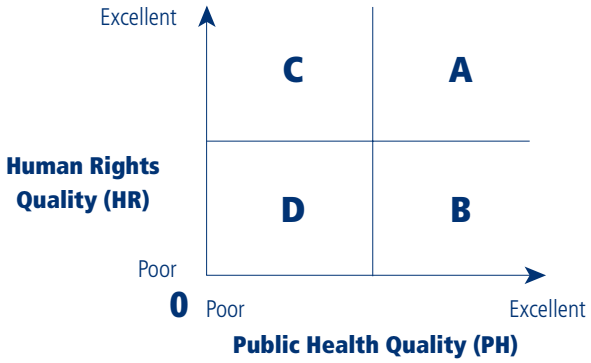
1. Considering the extent to which a policy or programme represents good public health.
2. Considering the extent to which it is respectful of and promotes rights.
3. Considering how to get the best balance between health and rights.
4. Considering whether this is the best approach for dealing with the public health goal the policy or programme seeks to address.

30 mins

Step 3: Working through the steps

This chart helps you go through the steps.

Four quadrants: The quality of human rights and public health in a programme



SECTOR EXPLANATIONS:	
A: best case	**C:** need to improve PH quality
B: need to improve HR quality	**D:** worst case; need to improve both PH and HR quality

About the chart:

- vertical axis: human rights quality
- horizontal axis: public health quality
- quadrant A: optimal human rights and optimal public health
- quadrant B: excellent public health but human rights aspect needs to be improved
- quadrant C: human rights aspect is fine but public health suffers
- quadrant D: bad public health and bad human rights

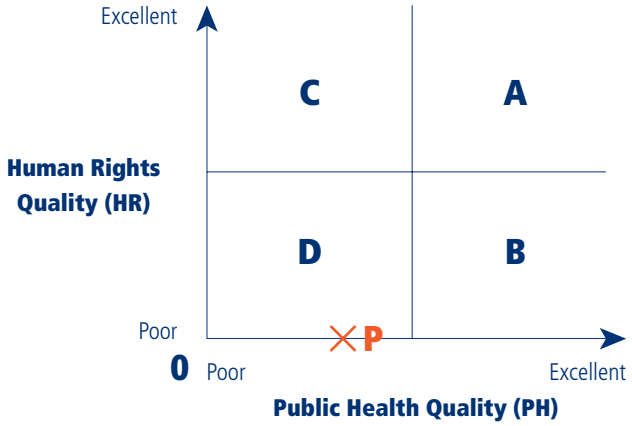
The assumption is, generally, that in designing and implementing a health policy or programme quadrant A is where one would prefer to be. A programme or policy which is respectful of rights, while still achieving its public health goal, is going to be better than one that limits or restricts rights.

How do we use the chart to work through a policy or programme in order to maximize both the public health and human rights aspects?

The first step: What makes a good public health intervention

Mark the extent to which the policy promotes and is good for public health as a point P along the horizontal axis. (See Figure 1 below) If the point lies within quadrant B, this indicates good public health quality, and the farther right the point, the better it is. If the point lies within quadrant D, this indicates poor public health quality, and the farther left the point, the poorer the quality.

Figure 1

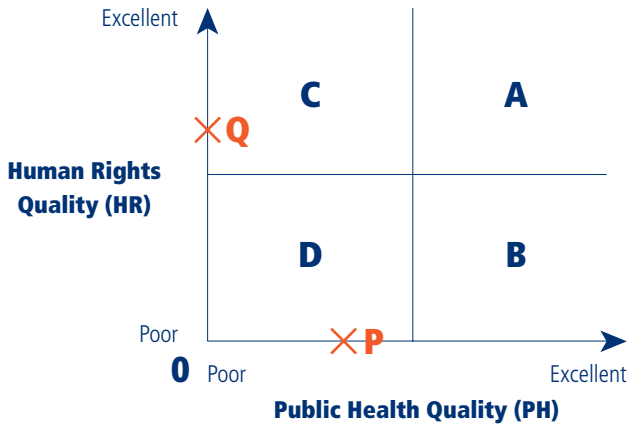


At this point, brainstorm about elements participants would consider in deciding if something is a good public health intervention. Note these down on a flip chart. The list should include: effectiveness, coverage, feasibility, cost, community involvement, and so on.

The second step: Consider the rights aspect of the policy

Consider the rights aspect of the policy and mark this as a point Q along the vertical axis. (See Figure 2 below) If the point lies within quadrant C, this indicates good human rights quality, and the farther north the point, the better the human rights quality is. If the point lies within quadrant D, this indicates poor human rights quality, and the farther south the point, the poorer it is.

Figure 2

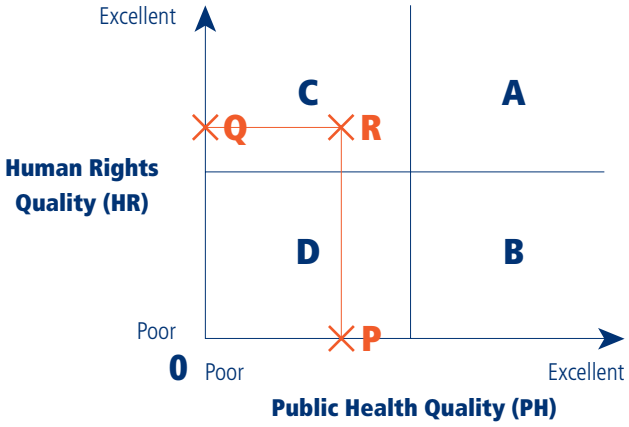


Suggest that determining the human rights value of a policy or programme can be done by considering each of the rights in the UDHR and determining for each right if it is positively or negatively impacted upon, or irrelevant. Ask participants to remember government obligations as well as the Siracusa principles. Make it clear that sex based discrimination in the UDHR should be integrated across the various relevant rights in the UDHR.

The third step: Where public health and human rights intersect

Draw a vertical line from P on the horizontal axis, and a horizontal line from Q on the vertical axis. The point of intersection of these two lines, R, gives the quadrant in which the policy lies for its public health and human rights quality. (See Figure 3 below)

Figure 3



The goal is to be in quadrant A or move toward it by working through the various aspects of the policy.

1 hr 45 mins

Activity 2: A case study for analysing a reproductive health intervention

10 mins

Step 1: Assessing the quality of public health

Give each participant a copy of a case study of a health intervention with instructions for analysing its public health and human rights quality. The handout given here is an example. While the steps for analysis stay the same, you may wish to substitute this case study with another.

Participants complete the public health analysis of the intervention. They may discuss this with their neighbours before reaching a decision.

20 mins

Step 2: Whole group discussion on the public health quality

After participants have analysed the public health quality of the intervention, they move into a whole group discussion.

What to cover in the discussion

Questions to guide the discussion

Ask participants these questions which are linked to the public health quality of the intervention:

- What are the reasons for focusing on this population?
  - presumption that they are at a higher risk of being infected
  - large number of sex partners from whom and to whom they could presumably receive or transmit infection
  - real or perceived lack of power to negotiate condom use with clients
  - increased likelihood of having other STIs: assumption is that they are more likely than other people to contract HIV and spread it to others (their clients)
  - politically expedient: looks like something is being done.
- Why not focus on testing clients?
- Is there likely to be pre- and post-test counselling?
- What test is likely to be used? How accurate is the test given at six month intervals likely to be?
- Will all sex workers be tested? Which sex workers are likely to be identified?
- What happens to sex workers once they are found to be infected?
  - If the card is removed are these women likely to immediately find other sources of financial support? Why do women generally engage in sex work? Will this need go away if they are found to be infected? Will revoking their cards impact on sex workers' ability to use health and other services?
- Does this approach in any way control the clients' rate of transmission to these women?
- Given the health commissioner's concerns, is this approach likely to be effective in preventing heterosexual transmission?

Put up your **overhead** transparency of "Four quadrants: The quality of human rights and public health in a programme". What is the level of consensus among participants for the public health quality of the intervention? Call out at each point beginning with 0 along the horizontal axis of the chart, running your pen along the axis. Ask participants to raise their hands when they think you have reached the quality of the intervention. Mark this point on the horizontal axis. Let this point be P.

Step 3: A rights analysis using the UDHR

Ask participants to now carry out a rights analysis of the intervention using the UDHR. Are any of the rights being restricted? If yes, are these restrictions valid under the Siracusa principles? Participants work individually, consulting with their neighbours if they want to. Make it clear that sex based discrimination, which a gender analysis would reveal, is included in this analysis.

Step 4: Whole group discussion on the human rights quality

Facilitate a discussion in the big group on the human rights quality of the intervention.

What to cover in the discussion

Rights to be considered and discussed include Article 1, Article 2, Article 3, Article 5, Article 6, Article 7, Article 8, Article 9, Article 12, Article 13, Article 20, Article 21, Article 22, Article 23, Article 25, Article 27 and Article 29. While many of these rights may not be immediately relevant to the example provided, a discussion will allow the consideration of the proposed intervention from a rights framework.

You have the option of using the International Covenant on Civil and Political Rights or the International Covenant on Economic, Social and Cultural Rights, or the Convention on the Elimination of All forms of Discrimination Against Women, if you are familiar with their interpretation.

Step 5: Where do the quality of public health and human rights intersect for this intervention?

Put up your **overhead** transparency of "Four quadrants: The quality of human rights and public health in a programme" again, with point P now marked on it. Find consensus for the human rights quality of the intervention. Call out at each point beginning with O along the vertical axis of the chart, running your pen along the axis. Ask participants to raise their hands when they think you have reached the quality of the intervention. Mark this point on the vertical axis Q.

Draw a vertical line through point P and a horizontal line through point Q. Mark the point of intersection R. In the case provided in the handout, this point R is likely to lie in quadrant D. In other words, the intervention is of poor public health as well as poor human rights quality.

Step 6: Discussion: How to move towards quadrant A

Focus the discussion on what specific changes would be needed for this intervention to move towards quadrant A.

What to cover in the discussion

Questions to raise

- How can we make the public health objective respond to the problem in as targeted, precise and gender sensitive a manner as possible?
- How can we make the response to the problem more effective?
- Is the policy/programme overly restrictive or intrusive (for example, does it reach too many or too few people?
- What changes do participants propose to reduce the severity, scope and duration of the burdens arising from the policy?
- What does improving human rights do to the public health quality of the intervention?

Participants may propose a number of different options. You can discuss each of these in relation to whether they are of a better public health and human rights quality than the example. Anonymous voluntary testing and counselling sites available to the general population, including sex workers, and the promotion of condom use are usually seen as having better human rights and public health quality. However, there may be debates about feasibility and coverage.

Main points for closing this session

Respect for rights makes for more effective interventions

Policies and programmes which respect rights are actually better and more effective. Human rights and public health concerns are not incompatible.

Considering human rights is a useful way of assessing current programmes

Considering human rights in the design, implementation or evaluation of health policies and programmes is a useful way to determine if existing health policies and programmes promote or violate rights, especially gender equality, and to judge their effectiveness.

Public health decisions are often politically expedient

Public health decisions are often made for political expediency, without consideration of their effects on human rights, and even to some degree their effect on public health.

People working in public health have an important human rights responsibility

- People working in public health have a responsibility to look at whether human rights are promoted, neglected or violated by actions taken in the name of public health.
- The links to the government that exist for anyone working in public health, whether as an agent of the state or because they receive government funding, impose a dual obligation to promote and protect health, as well as to promote and protect human rights.
- People working in public health have the power to decide to restrict rights, so this responsibility has to be taken seriously.

Health policies that violate rights have negative consequences

Health policies or programmes that violate rights have long term negative consequences in that they make it harder for people and communities to trust any policies or programmes.

Session developed by Sofia Gruskin

Handout

1 A case study for analysing a reproductive health intervention

Read the following case study and then evaluate its public health quality using the questions to guide your thinking.

Case study

In this particular country, the health commissioner is concerned with preventing heterosexual transmission of HIV/AIDS. She decides to add an HIV test to the routine testing for sexually transmitted infections (STIs) given to sex workers every three months. Sex workers are given a card to carry which says they are disease free. If they are found to be infected with an STI, their card is temporarily revoked for a three month period. The HIV test will be added to the STI tests at the six month interval. If a woman is found to be HIV infected, the card will be permanently revoked.

Analysing the public health components

Take 10 minutes to complete the public health analysis of this intervention. You may discuss it with your neighbours if you wish to. Ignore the rights aspects for the moment. Go through the following steps:

- **state the public health problem being addressed**
- **state the goal of the proposed action**
- **determine the public health quality of this intervention. Is this good public health? Will it achieve the stated goals?**

Bear in mind the various elements of a good public health intervention listed earlier in the session: effectiveness, coverage, feasibility, cost, community involvement. You should consider all these when determining the quality of any public health policy or programme. Once you have considered them for this analysis, identify the place on the horizontal axis of the chart "Four quadrants: The quality of human rights and public health in a programme" below which you think represents the public health value of the programme. Mark this point P.

Analysing the human rights components

After the whole group discussion and voting on the public health quality of the intervention, take 20 minutes to complete the human rights analysis of this same intervention. You may discuss this with your neighbours if you wish to. Ignore the public health aspects of this intervention for the moment. Go through the following steps:

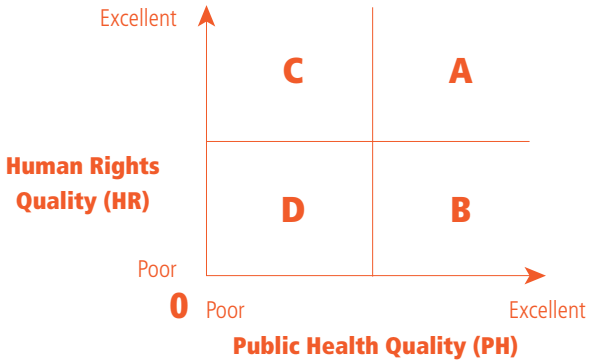
- look at the UDHR (starting with Article 1) and consider every right that is being violated or promoted by this intervention
- think through how exactly the right is being impacted upon in the short term as well as in the long term
- remember to consider for each right, government obligations to respect, protect and fulfil it
- recall the rights which can never be restricted (as discussed in Session 2)
- pay attention to the severity, scope, frequency and duration of whatever violation you see.

Once you have completed the analysis, identify the place on the vertical axis of the chart which you think represents the human rights value of the programme. Mark this point Q.

Assessing the overall quality of public health and human rights

Draw a vertical line through P and a horizontal line through Q. R, the point of intersection of these lines, represents the overall public health and human rights quality of the intervention.

Four quadrants:
The quality of human rights and public health in a programme



SECTOR EXPLANATIONS:	
A: best case	**C:** need to improve PH quality
B: need to improve HR quality	**D:** worst case; need to improve both PH and HR quality

Discussion in the whole group

After this, there will be a whole group discussion and you will vote to arrive at the point on the vertical axis which represents the group's consensus on the human rights quality of the intervention. In this way you will identify the quadrant the intervention fits into, which will indicate the combined quality of its health and human rights components.

SESSION 4

Population policies and reproductive rights

This session has been adapted from Klugman B, Fonn S, Tint KS. *Reproductive health for all: taking account of the power dynamics between men and women.* Johannesburg, AIDOS and Women's Health Project, University of the Witwatersrand, 2000: Module 2, Activity 3: "Comparing politics: population control versus human rights and health".

What participants should get out of the session

Participants will:

- be able to apply a reproductive and sexual rights framework to analyse population control policies
- understand how population control policies impact on sexual and reproductive rights and services
- be familiar with the content of the International Conference on Population Development (ICPD, Cairo) and Fourth World Conference Women (FWCW, Beijing)
- understand how these conferences are a product of women's struggle and how they have reoriented discourse on population and development
- recognize that policies are a site of struggle and that the concepts of reproductive rights and health which this course looks at are based on a human rights approach concerned with the empowerment of women, gender equality, and equity in resource distribution.

2 hours (excluding time spent on reading outside class hours)

Prior preparation

- Handout 2 is to be distributed to participants on the afternoon before this session is run. See instructions under Activity 1 on p.165.

Materials

- Lecture notes for the facilitator: "The international women's movement and the reproductive and sexual health and rights agenda"
- Handout 1: "Differences in health services: population control versus a human rights approach"
- Handout 2: "Population policy of the Ayn province of Jull, 1997"

- overhead: table from Handout 1

Readings for the facilitator

Analyses of country population policies

1. Dasgupta J et al . From contraceptive targets to reproductive health: India's family planning programme after Cairo. In: *Confounding the critics: Cairo five years on. Conference report. Cocoyoc, Mexico 15-18 November 1998.* New York, HERA, 1999:68–74.

2. Klugman B. Population policy in South Africa: a critical perspective. *Development Southern Africa,* 1991, **8(1):**19–33.

3. Population and family planning policies: women-centred perspectives, *Reproductive Health Matters,* 1993, **1(1).** This edition of *Reproductive Health Matters* carries analyses of the population related policies of Japan, India, Malaysia, Mexico and South Africa. In particular, see TK Sundari Ravindran's "The politics of women, population and development in India" (pp.26–38).

Analyses of population control and women's and human rights discourse

4. Hartmann B. Population control has not gone away. In: Boston Women's Health Book Collective. *The new our bodies ourselves.* New York, Simon and Schuster, 1999:723–724.

5. Petchesky R. From population control to reproductive rights: feminist fault lines. *Reproductive Health Matters,* 1995, **6:**152–161.

6. 5. Sen G, Germain A, Chen L, eds. *Population policies reconsidered: health, empowerment and rights.* Boston, Harvard School of Public Health and International Women's Health Coalition, 1994. Of particular relevance to this session is the article by C Garcia-Moreno and A Claro "Challenges from the women's health movement: women's rights versus population control" (pp.47–61).

Analyses of the role of women's movements in relation to the international agenda

7. Chen MA. Engendering world conferences: the international women's movement and the United Nations. *Third World Quarterly,* 1995, **16(3):**477–493.

8. Freedman LP, Censorship and manipulation of reproductive health information: an issue of human rights and women's health. In: Coliver S, eds. *The right to know: human rights and access to reproductive health information. Philadelphia, University of Pensylvania Press,* 1995.

9. Sen G, Corrêa, S. Gender justice and economic justice: reflections on the five year reviews of the UN conferences of the 1990s. *Dawn Informs,* 2000, **1:**5–7.

Readings for participants

At least one reading from each of the categories above.

How to run the session

This session consists of three activities. The first is an individual reading assignment for the evening before this session. The second activity is an input by the facilitator. The third activity is a discussion of the readings in the whole group.

Activity 1: Reading

This is to be done the day before the session. Divide participants into groups. Give them Handout 2. Tell them to read the handout and write down their responses to the questions.

Activity 2: The role of the women's movement in promoting a reproductive and sexual health and rights agenda

Step 1: Your input

Begin with the rationale for this session. In order to analyse and improve current reproductive health services, it is important to understand how and why they began, what their intentions were, and how these influence the possibilities for developing and maintaining gender sensitive sexual and reproductive health programmes which have a human rights orientation.

In many countries, the organization of reproductive health services is shaped by national population policies concerned with lowering or increasing population growth. While in some countries population policies have been revisited and changed following the ICPD (Cairo), the process of reorienting health systems and services is slower. In some cases women's health advocates have identified and worked with sympathetic policy makers to bring about such shifts.

This input session provides information on the role of the women's movement in bringing a gender and human rights perspective to reproductive health issues, shifting the focus away from reducing birth rates.

Prepare a talk on the role of the women's movement in promoting a reproductive and sexual health and rights agenda, and the nature of the paradigm shift after Cairo. Your talk should be accompanied by visuals in the form of overheads or a power point presentation to engage participants' attention.

Start with participants' experiences

Ask participants about their own experience before giving them more information. For example, ask them what they know of the involvement of the women's movement or women's groups in their country in promoting a reproductive health/rights agenda. Why did governments come to an agreement in Cairo that reproductive services should be

integrated into primary health care? What are the implications of this for women? Men? Adolescents? And so on.

The talk should cover the points in the lecture notes for the facilitator. Ground your input by drawing on the literature, and the experiences of specific countries.

20 mins

Step 2: Comparing the population control approach with a human rights and reproductive rights approach

After your talk, present a comparison between the population control approach and a human rights and reproductive rights approach to reproductive health.

Put up as **overheads** the tables from Handout 1. Also give the handout to participants.

What to cover in the discussion

Why does the table distinguish between a needs based and a rights based approach?

Meeting needs is one dimension of human rights. However, programmes often stop short of addressing human rights when they go beyond meeting immediate needs. Many health policies are needs oriented – that is they aim to help address health problems. Few policies actually manage to challenge women's position in society – to promote women's equality to men and their access to and control over resources. Yet it is these steps which are necessary to improve women's overall well-being. A human rights approach not only meets immediate health needs but empowers women. It also publicly promotes equality between women and men, for example in relation to sexual and reproductive decision-making. (The reference to meeting women's needs as opposed to changing women's position in society is often described in the literature as meeting women's practical needs on the one hand, and promoting their strategic needs or interests on the other. Given the targets of this course, spending time on complex concepts like practical and strategic gender interests does not seem appropriate.)

In the next module you will explore this issue further, by looking at the difference between gender specific policies and gender redistributive policies. Both promote human rights.

1 hr

Activity 3: Implementation of the reproductive rights agenda - challenges posed by the legacy of population control

10 mins

Step 1: Introduce the activity

This activity aims to help us understand the legacy of population control programmes in health services. It illustrates that population control has not gone away despite the acceptance of the ICPD agenda by governments, and emphasizes the need for continued efforts.

50 mins

Step 2: Discussing the reading

Start a discussion on the case study of a population policy in Handout 2.

What to cover in the discussion

The post-ICPD population policy of the Ayn province of Jull

No reproductive or sexual health goals

Ayn's post-ICPD policy contains a peculiar combination of reproductive health language and demographic goals. While many of the goals relate to the reduction of birth rates and fertility, there are also goals related to infant and maternal mortality. Interestingly, no reproductive or sexual health goals are included.

The policy violates rights and does not consider non-state actors

Ayn's population policy also violates rights in many of the ways that the pre-ICPD policy of Jull did. The wide range of incentives and the suggestion of disincentives to government servants is cause for grave concern. The consistent references to couples in Ayn's population policy indicate that it is married women and men who are the focus of services, and unmarried women may not have access to them. Similarly, the discussion throughout is about the number of children couples may have before accepting contraception, thereby indicating that those beyond the reproductive age group are not included.

Further, the policy does not really focus on preventing violations of reproductive rights by non-state actors, for example within the household, the community and religious institutions.

The same assumption as before 1994

Even though it was formulated after the Cairo conference, the assumption of this policy is still that population size causes poverty. The policy does not recognize the role of the development models adopted by a country in causing or accentuating poverty.

Beyond maternal health

The policy defines women's health needs beyond maternal health, to include a few additional reproductive health services. The range of services offered has been slightly expanded to include reproductive tract infections (RTIs) and sexually transmitted diseases (STDs), and there is a move to promote male methods of contraception. Issues such as access to safe infertility treatment are not the focus in the new policy.

The new policy does not adopt a rights based perspective

It is interesting to note that while quality of care is mentioned, it is discussed purely in terms of improving infrastructure and training. There is no mention of better information and counselling, of client-provider interaction, of expanding choice, and so on. Community participation is mentioned as important, but for implementing the policy and not in shaping it or directing it in any way. Thus, the new policy falls way short of upholding a rights based perspective.

Main points for closing the session

Demographic trends are indicators not goals

Demographic trends (fertility, mortality and migration) are useful indicators of development efforts, rather than goals in their own right. Population control policies of the past, although originally motivated by a concern that high rates of population growth could negatively impact on population well-being, often degenerated into policies pursuing fertility reduction as an end in itself. They were driven by demographic targets in many parts of the developing world. In countries with large populations, a system of incentives and disincentives was often adopted to recruit more and more "acceptors" of family planning.

From population control to human rights

The ICPD in Cairo in 1994 brought about a paradigm shift in reproductive health services – from population control to human rights: meeting women and men's needs and promoting women's equality with men in sexual and reproductive decision-making in policy and programme formulation. The women's movement, and gender sensitive politicians and bureaucrats, had a key role to play in bringing about this shift.

Women's bodies are often the objects of policy

Despite this change, women's bodies are frequently the objects of policy, whether these are national government population policy or the "policy" of men's control within the household. Interventions, whether in legislation, government policy, health services or advocacy, should put women's right to control their bodies and to decision-making in relation to sexuality and reproduction at the centre of their goals.

What about pro-natal polices?

The ICPD is yet to lead to changes in the pro-natal policies of some of the countries facing below maintenance birth rates. In some such countries, the government provides incentives for particular ethnic groups and particular income groups to produce more children, and not others.

Words can have different meanings

Although many countries with population control policies have started to rethink or have even changed their population policies since the ICPD, it is important to remember that the same words can have different meanings. Different interest groups are interpreting the Cairo and Beijing documents differently. Many international and national agencies and individuals have started to use this language to refer to family planning services, rather than to the integrated services and holistic approach intended in the definitions in the ICPD *Programme of Action.*

Continue the struggle for human rights, health and health care

It is essential therefore that all of us interested in upholding a rights based perspective – whether as managers of health services or as NGOs or within donor organizations – continue our struggle for human rights, health and health care.

Session developed by Barbara Klugman and TK Sundari Ravindran

Lecture notes for the facilitator:

The international women's movement and the reproductive and sexual health and rights agenda

The following is meant to serve as an outline of key points, and not as a definitive summary of the issues. You may want to adapt it to focus on points you consider particularly pertinent to the group you are working with

The input is in two parts

The first part is about the involvement of women's movements in reproductive health. The second part discusses the impact of women's participation on the population control agenda, culminating in the International Conference on Population and Development in Cairo in 1994 and reaffirmed at the Fourth World Conference on Women at Beijing in 1995 and in the subsequent five year reviews of each.

1. The involvement of women's movements in reproductive health

Women in all parts of the world, throughout history, have been responsible for women's health – childbirth, contraception, and abortion. Over the past few centuries, the professionalization of health care has displaced women's control over these processes. Doctors and scientists are seen as the embodiment of knowledge on the human body and on health. Natural processes such as childbirth became medicalized, and women's control over these has been eroded. Midwives, who for centuries have cared for women through pregnancy and childbirth, have been marginalized.

Abortion, practised by women in most parts of the world since time immemorial, has been criminalized in the past century. Though it is legal in most countries, this is usually on limited grounds such as in the case of danger to the woman's life or where pregnancy is the result of rape. There are still some countries where abortion is illegal. It is not women who can choose whether or not they want to continue a pregnancy, but law enforcers and medical practitioners.

While many lives, including those of women, have been saved by modern medicine, the beneficiaries of medical knowledge and technology have very little control over decisions about how and when these are used, and to what effect. For example, decision-making about how women should give birth, whether abortions should be legal, or on the kinds of contraceptives that should be developed are made at the top, by scientists and medical professionals.

During the three decades from the mid-1960s, when the international community was promoting a population control agenda, women's organizations in many parts of the world were involved in efforts to change the medicalization of reproduction and the denial of the right to control and regulate one's own fertility and sexuality.

Women have taken up struggles against these issues as individuals and as organizations, in their own countries and internationally. These struggles have taken many forms:

- Welfare services – for example providing shelters for women who have been abused
- Local self-reliance – for example alternative services provided by women for women, or initiatives to help women understand how their bodies work and enable them to make informed decisions about contraception
- Oppositional politics – women mobilize around specific campaigns such as violence against women or against the testing of technologies on women without their full involvement and agreement
- Engagement politics – women establish mechanisms to participate with government and other players in policy and programme debates and implementation.

The particular form of engagement has depended both on the specific interests of the women concerned, and on the national or community context.

Where the prevailing context is completely antagonistic towards women's rights, women's groups have found the provision of alternative services to be the most feasible response. Where government creates some space for engagement and may be persuaded by good evidence and the knowledge that their constituencies' needs are not being met, there may be opportunities to engage with government to help make change happen.

Strategies for change are discussed in greater detail in the Policy Module. The key issue here is that women's groups have mobilized around health rights and services for years, and with the onset of population policies, women's groups became the major force articulating how and why such policies abused people's human rights and did not meet their health needs. In some contexts they have managed to identify and work with allies within the government to prevent or change policies.

2. The impact of women's participation on the international reproductive health agenda

During the late 1970s, and more so during the 1980s and 1990s, women organizing nationally started to make links across the globe. The International Women's Health meetings, held once in four years since 1981, provided one such forum, which brought together activists working on women's health and rights. Opposition to population control policies began to be articulated in terms of women's rights.

In the 1990s, women's groups engaged with multilateral institutions, especially the United Nations, to promote an understanding of reproductive health as a broad and inclusive area which needs to be addressed from the perspective of the individual, and through a human rights lens.

In doing so, a new discourse has emerged, which instead of seeing control of population numbers as the solution to world poverty, recognizes that poverty results from diverse factors, of which unequal economic power

relations are the most significant. This is coupled with consumption patterns in countries of the North and corruption amongst national elites, so that what resources there are, are not equitably shared within countries.

In this discourse, control over reproduction is the right not only of couples but also of individual women and men. Gender equity and women's empowerment is seen as critical for women to be able to exercise their reproductive rights. Contraceptive technology is meant to help women and men realize their reproductive choices, rather than help governments keep down the birth rate.

This approach, known as the reproductive health approach:

- gives high priority to quality of care in its many dimensions
- pays attention to the needs not only of married women but also unmarried women, men, adolescents, and people beyond their reproductive years
- aims at the provision of integrated reproductive health services within the context of primary health care, rather than vertical reproductive health services, or, within that, only contraceptive services
- promotes the right to choice and aims to create conditions that would enable choice (for example providing information in an accessible form)
- encourages male responsibility in family planning and in women's reproductive health
- focuses on issues of infertility as well as fertility control, so that women and men have greater choices about reproduction.

These values were consolidated through the consensus reached at the ICPD in Cairo in 1994, and re-affirmed at the FWCW in Beijing the following year, and in the five year reviews of both in 1999 and 2000. These conferences applied existing human rights frameworks to the area of reproduction.

The specific approach to sexual and reproductive rights and health can be grasped in brief through the definitions of these given out in the handout "Definitions" of the Opening Module, and in the detail of the Cairo and Beijing texts. (Ask participants to refer back to this handout in their course files at this point.)

The diversity of the chapters of the ICPD Programme of Action illustrates the extent to which population matters are now being considered in broad terms – how population trends interact with the environment and the economy and should be used in the planning and monitoring of development interventions; and how consumption patterns need to be addressed in the quest for equality and quality of life for all.

The international women's health movement has targeted UN conferences as key moments for building an international consensus on applying human rights frameworks to the fields of reproduction and sexuality, since they set a clear international and national agenda for governments, the private sector, NGOs and international agencies. They also influence the direction of donor funding, which is of critical importance to the poorest countries of the world and their people, who are dependent on such funds for the provision of basic services.

Handout 1

Differences in health services: population control versus a needs based and a human rights approach

Source: Klugman B, Fonn, S, Tint KS. *Reproductive health for all: taking account of the power dynamics between men and women.* Johannesburg, AIDOS and Women's Health Project, 2001:82. Reprinted with kind permission of AIDOS (The Italian Association for Women in Development) and Women's Health Project.

	Population control/ family planning	Meeting women's needs	Promoting women's rights
Defining women's health	A narrow bio-medical meaning as maternal health, or the health of women of reproductive age, focusing on birth and child bearing without death or disease, and on contraception.	Provision of services of a high standard which are women-centred – based on women's experiences and needs. Recognition that women's health needs go beyond reproduction.	A broad understanding centred on the right of women to make autonomous choices about reproduction and sexuality.
Goals	Demographic reduction or increase of fertility and population (main goal). Improve women's and children's health and family welfare (secondary goal).	Improve women's health. Provide women with a range of services ensuring choice, for example in methods of contraception.	Women's control over their bodies; sexual and reproductive decisions. Right to information, privacy, bodily integrity. Gender equality generally as it impacts on health, for example food security, education, control over income, and so on.
Assumptions	Population size/growth is the main determinant of poverty, under-development and environmental sustainability. Population control will reduce fertility.	Poverty is due to the economic growth model of development. Focus is on meeting basic needs and not on population control. Improving women's status and providing quality reproductive health programmes will help to reduce fertility.	The interaction of inequalities – based on class, on other social divides such as caste or ethnic group, and on gender – lead some to be poor and others to be wealthy, some to be empowered and others to be disempowered. These inequalities can and should be challenged in order to achieve social justice. A more equitable distribution of resources, such as education and health services, are part of this challenge.
Service range	Contraception; infertility (if in support of increasing population growth rates); maternal health; abortion (if culturally acceptable and seen as part of a population-control agenda).	Within sexual and reproductive health: contraception; maternal health; abortion; STDs, RTIs; HIV/AIDS; sexuality; violence against women; cancer screening. Part of broader primary health care so that reproductive health needs can be met alongside other service needs (e.g. chronic diseases, mental health, occupational health).	Information and counselling services to build women's confidence to challenge their subordinate position to their sexual partners and in society. Community based activities to organize women to challenge social inequalities. Organization of men to understand and take on their role in promoting women's equality in sexual and reproductive decision-making and in society generally. Focuses beyond services to laws and policies, for example maternity leave, against rape.

chart continues

	Population control/ family planning	Meeting women's needs	Promoting women's rights
Age and marital status	Married women; reproductive age (15–44 years).	Women of all ages throughout their life cycle, married and unmarried.	
Service delivery standards	Quality of care is usually not emphasized as focus is on quantity of women seen.	High quality of care is promoted as a part of professional health standards at the core of service delivery.	High quality of care is promoted both as a health related right and also as a woman's rights issue – with a focus on respect, dignity, confidentiality and choice.
Information and education	Communication is top-down, focusing on directions for contraceptive use. Persuasion and motivation are the information processes. Provider gives advice on what is best.	Full information provided on risks and benefits of contraceptive technologies so women can exercise choice.	Focus on understanding the body and sexuality in order to make decisions and be in control of one's life. Promotion of women's sexual and reproductive rights. Attention to men's responsibility in relation to sexual and reproductive rights and health.
Participation	Policies usually top-down with providers driven by targets or other policy considerations.	Health workers understood to have more knowledge than users, but an effort to ensure women's needs are met.	Mobilization of women for better health policy. Use of peer education to build and empower women for action. Efforts to draw on community input regarding priorities for health service provision and evaluation of services.

Handout

2 Population policy of the Ayn province of Jull, 1997

Read the following policy, and note down your responses to the questions given below. You will discuss these with the whole group tomorrow.

1. Introduction

… The 1994 International Conference on Population and Development articulated a call for a broader and more holistic population policy approach, linking demographic concerns, including fertility reduction, to a range of reproductive health concerns, particularly those affecting women. It also called for increased male responsibility for sexual and reproductive behaviour. Jull is signatory to this call. The reproductive health approach must necessarily be integrated into the province's population policy initiative.

… Rapid growth of population has serious implications for socio-economic development and the preservation of the environment. This has resulted in the following:

- **Production of food may not keep pace with population growth. Already, 51% of female children and 47% of male children in this province are malnourished.**
- **Pressure on land and other facilities will result in social tension and violence.**
- **Housing in rural and urban areas will become a serious problem. There is already a backlog over the last 20 years of 4.7 million new urban housing units.**
- **44.3 million people in rural areas and 7.3 million people in urban areas will not have access to sanitation facilities, and 13 million in the province, will not have safe drinking water by the year 2001.**
- **There will be 25 million people below poverty line in this province by the year 2001, and there will be an increase in the number of illiterates and number of unemployed.**
- **The environmental degradation resulting from increasing population growth will be untenable. …**

2. Population stabilization goals

... The demographic goals of the province are set as under [*sic*]

	Current rate	5 yrs hence	10 yrs hence	20 yrs hence
Natural growth rate	1.44	1.15	0.80	0.70
Crude birth rate	22.7	19.0	15.0	13.0
Crude death rate	8.3	7.5	7.0	6.0
Infant mortality rate	66.0	45.0	30.0	15.0
Maternal mortality ratio	380	200	120	50
Couple protection rate (%)	48.8	60.0	70.0	75.0
Total fertility rate	2.7	2.1	1.5	1.5

3. Structures and processes for implementation

... Population stabilization committees will be set up at the district and sub-district level. The sub-district population stabilization committees will encourage each village government and town corporation to prepare a Population Stabilization Action Plan, which will specify the demographic goals and expected levels of achievement annually and a charter of social actions for population stabilization, arrived after consensus within the community. The Action Plan will also specify actions be taken to achieve the goals within a specified time frame. ...The Sub-district Action Plan will be formed based on all these local Action Plans. It will include specific interventions for improving the quality of services. The financial and technical support required for the implementation of these Action Plans will be made available through the District Population Stabilization Committees.

... Improving quality of services will be an important process for implementation. The essential ingredients for quality in service delivery are:

- **availability of medical and paramedical personnel in the required places at the required times**
- **adequate technical and managerial skills and a degree of commitment and motivation amongst personnel delivering family planning services**
- **an enabling environment for quality services in terms of adequate infrastructure, essential equipment and sufficient supplies of drugs, dressings and other materials**
- **community participation in the programmes. (in helping implement the programme).**

4. Specific operational strategies

a) ... Promotion of terminal methods of contraception, through:

- increased focus on couples with parity 2
- ensure reduction of births occurring in women of parity 3 and above
- promote vasectomies to account for at least 30% of all sterilizations ...
- target those couples who are likely to have more children in an attempt to have sons with the introduction of the girl child scheme: the only daughter or one of two daughters of a couple adopting sterilization will get a series of monetary benefits until she is 20 years old, and a lump sum when she is 20 years old, provided she remains unmarried until she is 18 years. ...

b) Promotion of spacing methods of contraception, through:

- information campaign on spacing methods
- ensure proper screening procedures before IUD insertion and monitor retention levels
- increase access to condoms and oral pills through community based distribution programmes and social marketing. ...

c) Shift target setting for both terminal and spacing methods from the provincial level, which is top-down, to the village government level.

d) Ensure safe delivery through equipping first referral units, providing a fund at the village government level for transporting emergency delivery cases.

e) Ensuring safe abortion through training of personnel, and equipping more health centres to provide the services. ...

f) RTI/STD prevention and management mainly through making the services of a gynaecologist available at specified timings (on a contract or consultancy basis where recruitment is not possible) in 450 Primary Health centres designated as Primary cum Women's Health Centres. ...

g) Incentives:

i) Incentives will be provided at the community level, to those villages, which exceed a couple protection rate of 60%. Such incentives will include additional works, school buildings and development schemes including Low-Cost Sanitation Scheme and Weaker-Section Housing Scheme. ...

ii) Incentives will also be provided to individuals. This will be in the form of a cash award of (the equivalent of) US$2500 to three couples per district selected by lucky dip in each of the following categories:

- those with two girl children adopting a permanent method of contraception
- those with one child adopting a permanent method of contraception
- those with two or less children accepting vasectomy.

In the sanction of development schemes (housing loans, credit for investment in small scale enterprises, micro-credit programmes for women) to individuals, other things being equal, preference will be given in the following order of priority:

- **acceptor of a permanent method with two girl children**
- **acceptor of vasectomy with one child**
- **acceptor of permanent method with one child**
- **acceptor of vasectomy with two children**
- **acceptor of any permanent method with two girl children.**

iii) Incentives will be provided to service providers in the form of a gold medal and/or cash awards, including to teams of service providers who have achieved performance levels above the prescribed minimum standards under the sub-district Action Plans. …

iv) Government expects that its employees should serve as role models and that they must take the lead in adopting the two-child norm. Government will accordingly examine the desirability of limiting perquisites routinely provided to government employees such as leave travel grants (usually provided for the employee, his/her spouse and children) and educational grants for the first two children only. …Government will also explore the possibility of modifying service rules and promotion policies such that the adoption of the two-child norm is encouraged.

Note: Ayn and Jull are fictitious names for a real case.

Questions

1. **What are the implications of this population policy for the right of couples and individuals to choose if they want to have children, when and how many? Why?**
2. **List aspects of this policy which you believe violate any of the rights guaranteed by international human rights documents?**
3. **What are the implications of this population policy for health services? Why?**
4. **How different would reproductive health services in Ayn be if they were oriented towards individual choice?**

SESSION 5

Working with sexual rights

What participants should get out of the session

Participants will:

- learn about the evolving content of sexual rights and the issues raised by their increasing recognition
- recognize that sexual rights are a requirement for the achievement of both sexual health and gender equality
- understand the difference between reproductive rights and sexual rights
- be able to conceptualize practical interventions to realize sexual rights at different levels (legislative, health system, community).

1 hr and 45 minutes

Materials

- Handout: "Determinants of HIV transmission in Botswana"

- overhead: "ICPD definition of sexual health", on p.180
- overhead: extract from the South African Constitution, on p.180
- flip chart

Readings for the facilitator

1. *Health and Human Rights,* 2000, **4(2)** (special focus on reproductive and sexual rights).

2. Health, Empowerment, Rights and Accountability. "Gender equality and equity", "Reproductive rights and reproductive health", "Sexual rights". *Women's sexual and reproductive rights action sheets.* New York, HERA, 1998.

3. Gupta GR. Strengthening alliances for sexual health and rights. *Health and Human Rights,* 1997, **2(3):**55–63.

4. Miller AM. Sexual but not reproductive: exploring the junction and disjunction of sexual and reproductive rights. *Health and Human Rights,* 2000, **4(2):**68–109.

Essential readings for the participants

Readings 2 and 4.

How to run the session

This session consists of two main activities. The first is an interactive input session, with contributions from participants along the way. The second is a small group activity.

1 hr

Activity 1: The right to non-discrimination and sexual health

30 mins

Step 1: Sexual health

Put up on an **overhead** the following definition of sexual health:

ICPD definition of sexual health

Sexual health has been defined in the ICPD Programme of Action as "the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases" (ICPD 7.2). [United Nations Population Fund. Programme of Action of the International Conference on Population Development, Cairo, 5–13 September 1994. New York, United Nations, 1996:7.2]

Write up the following statement on a flip chart:

Constitution of the Republic of South Africa, Act No. 108 of 1996

"(2) No person shall be unfairly discriminated against, directly or indirectly, and, without derogating from the generality of this provision, on one or more of the following grounds in particular: race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture or language."

Read the constitutional clause to the participants and then ask them the following question:

- How does the right to non-discrimination in this clause relate to sexual health for all people?

Refer participants to the definition of sexual health on the overhead. Take responses. If the room is very quiet, give participants an opportunity to "buzz" with their neighbour for about two minutes. Then ask the question again and take responses.

What to cover in the discussion

This activity aims to help participants recognize that various types of discrimination can and do impact on people's sexual health.

Discrimination can impact on people's sexual health

Discrimination and inequality impact on many and diverse aspects of people's lives, including that most intimate of issues, sexuality and sexual experience. Coerced sex, in the form of rape, having no choice in whom one marries, or peer pressure to engage in sexual relations at a young age, can all have negative psychological effects on a person. In addition, in the context of sexually transmitted diseases and particularly HIV/AIDS, it can be life threatening. Traditionally those in the health field have focused on the reproductive health dimension of sex, leaving aside the emotional and mental health dimensions, as well as the physical health dimensions beyond reproduction.

In some instances, discussion of discrimination in relation to sexual health is conflated with discussion on gay rights. The discussion in this course should illustrate that many people suffer abuses which undermine their sexual health, irrespective of their sexual orientation.

All people, whether women or men, disabled, homosexual or heterosexual must:

- have access to information, education and counselling on human sexuality and sexual health in a language and form that they can understand
- be able to protect themselves from sexually transmitted disease
- be able to choose if, when and with whom they have sexual relations
- be free from fear of, or actual perpetration of, sexual violence or any form of pressure to have unwanted sexual relations
- be free from violence which might result from their voluntary sexual relationships
- expect and demand equality, full consent, mutual respect and shared responsibility in sexual relationships.

Step 2: Sexual rights

Before participants begin this exercise, present the following information to the group:

- Although paragraph 96 from the *Platform for Action* of the FWCW (Beijing) does not use the word sexual rights, it is commonly referred to as the sexual rights paragraph and is commonly understood to form the framework for sexual rights. (Note that this paragraph is limited to the sexual rights of women. You might want to challenge participants to rework it for an adolescent heterosexual boy, for example.)
- In a process similar to formulating reproductive rights, no new rights were created at Cairo and Beijing. But there were attempts to ensure that matters beyond the traditional boundaries of human rights would get adequate attention and protection.
- If the group is interested in knowing why the actual language of sexual rights is not used in the *Platform for Action*, refer them to the facilitator's readings, which will provide the necessary background.

Ask participants to refer to the handout from the Opening Module, Session 4: "Definitions", which contains the ICPD definition of reproductive rights and the FWCW definition of sexual rights, and given them about 10 minutes to individually read these two definitions. They should then consider the following questions and write down key points.

- What is each paragraph on reproductive rights and on sexual rights trying to address?
- Why was there a perceived need for a specific sexual rights paragraph?
- Why does the paragraph 96 of the FWCW focus on women's sexual rights?

Step 3: Whole group discussion

Once participants have written out their points, go over each of the questions in the whole group and use this as an opportunity for participants to share their thoughts and clarify their ideas. If participants do not raise key issues like those listed below, bring them up yourself. At the end of the discussion, put up the overhead on the ICPD definition of Sexual Rights to reinforce the points made.

What to cover in the discussion

The differences between sexual rights and reproductive rights

Many people consider sexual rights to be a subset of reproductive rights. These two sets of rights are, however, conceptually different in significant ways, and hence require different remedies.

Reproductive rights are limited to certain groups

Sometimes one hears practitioners saying "We just put it all under reproductive rights". The problem with this is that it can mean that the needs of people who fall outside the arena of reproduction are ignored – older women; women and men who do not have children.

Disconnecting sexual activity and reproduction

Sexual rights create the conditions which enable individuals to determine whether to connect sexual activity with desired reproductive ends. They reinforce people's right to engage in a range of non-reproductive sexual practices (some of which are illegal in many countries, for example anal sex).

People have sexual relations from adolescence into old age. As long as they are having sexual relations, they have sexual health needs – related to information, education, services, and protection from sexually transmitted diseases, and to problems of sexual function. The term "sexual rights" includes the right to sexual health irrespective of one's reproductive status. Sexual rights include the full range of protections across rights, over and above health concerns alone.

Why focus on women's sexual rights?

Unfortunately coercion in sexual relations is commonplace in many cultures. At its most extreme is the problem of rape, whether as part of war, or in peace time. There are also forms of violation of sexual rights that are specific to certain cultures and religions, like female genital mutilation and forced temple prostitution. It is therefore essential that governments recognize the right of each individual to

decide if, when and with whom they want to have a sexual interaction, and to ensure that these rights are protected and promoted by state and non-state actors.

The paragraph focuses on women because it is predominantly women whose sexual rights are abused. However, sexual rights should apply to everyone. If a culture of sexual rights were promoted amongst adolescent boys, for example, it would help build their ideas of masculinity in ways which promote their own self-esteem, while building a culture of respect for women.

Sexual rights within a traditional human rights framework

Within a traditional human rights framework, sexual rights can be understood to include such rights as freedom from torture, arbitrary killing and execution, and arbitrary detention, protection of bodily integrity, rights to information, expression, and development of the personality, freedom to participate in political and cultural life, and a move towards state accountability for non-state actor violence. The language of autonomy, dignity and civic participation for women has also been noted in some writings (see Miller 2000, Reading for the facilitator 4).

Activity 2: Exploring sexual rights using an example

Divide participants into four groups.

Introduce the group exercise to participants. Propose that rather than discuss sexual rights in abstract, you will look at ways of realizing sexual rights at various levels using a specific example.

Give each of the four groups a different identity:

- Group 1: health service management
- Group 2: policy makers
- Group 3: a peer education NGO
- Group 4: a rights based advocacy group

Give all groups a copy of the handout: "Determinants of HIV transmission in Botswana". Ask them to look at the figure illustrating the determinants, which is supported by some of the text from the Botswanan policy.

Using the information in the handout, ask participants to identify at least three interventions that their group could make in order to promote sexual rights. They must write these up on a flip chart under the heading of their group identity. Give them 40 minutes.

For the last 5 minutes of the session, ask each group to put its chart of activities on the wall and let the participants walk around the room reading the charts. Put a blank piece of paper next to each chart with "Additions" written on it. Encourage participants to spend some time between and after future sessions adding any ideas they have for actions that each group could take. You may do the same.

The sorts of ideas that might come out of each group

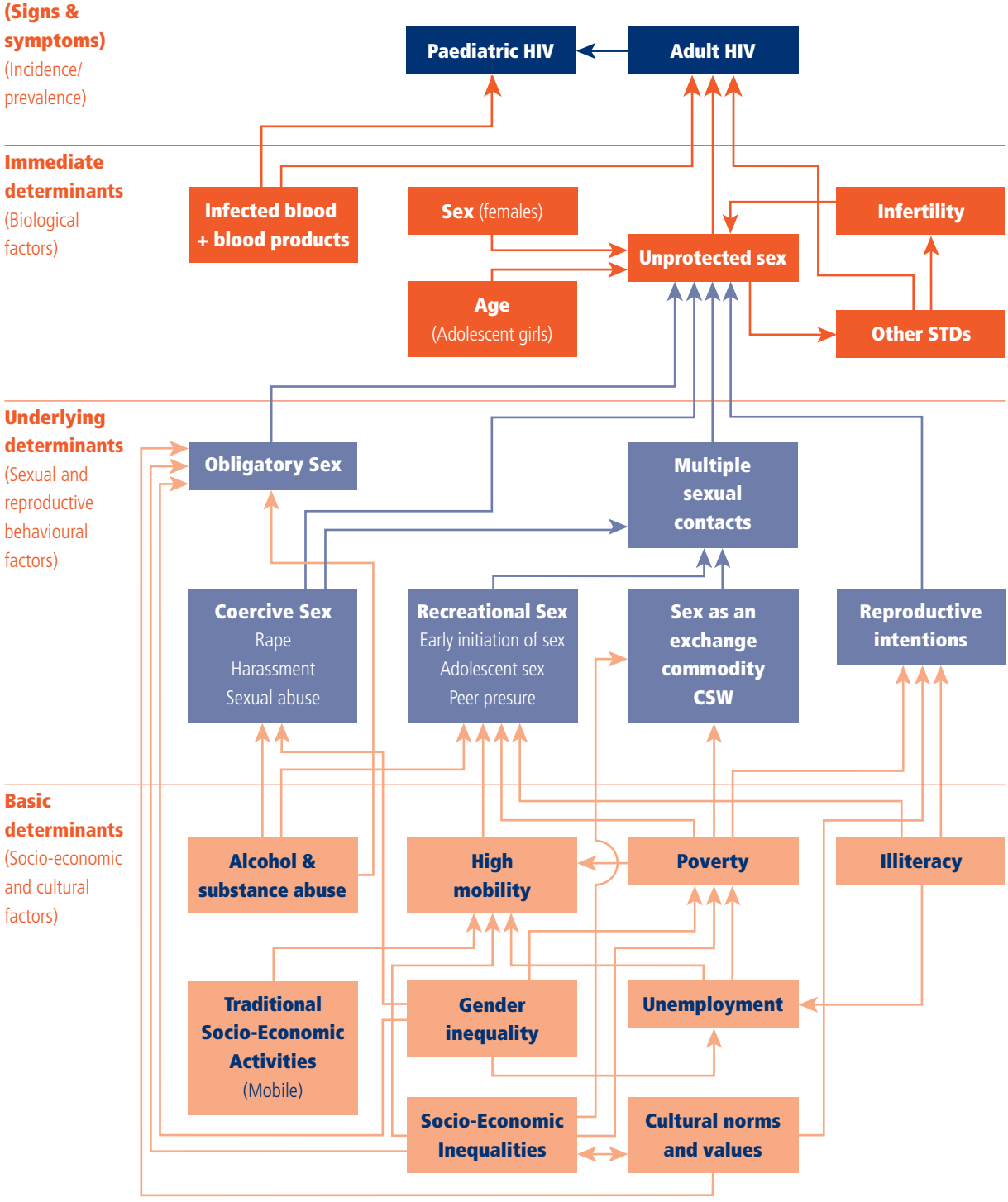
Health service management	Policy makers	Peer education NGO	Rights based advocacy group
• Train health workers to be able to cope emotionally with seeing women who have suffered violence; provide them with the skills to offer the necessary counselling and information and to seek redress for violations. • Train health workers to identify and treat sexually transmitted diseases correctly and sympathetically. • Develop a health promotion strategy targeting traditional leaders to gain their support for an end to obligatory sex that denies women the ability to protect themselves from disease or to choose if, when and with whom to have sexual relations.	• Understand the wide range of laws (e.g. criminal, family, health, labour) that affect sexual rights. • Modify laws, policies and programmes in order to ensure full support for sexual rights. • Give urgent attention to promoting women's access to employment in order to limit their recourse to sex as an exchange commodity. • Develop and implement a youth development strategy that creates opportunities for young people in career development, accessing sports facilities and recreation activities • Run a campaign against unprotected sex. • Provide more resources for implementation.	• Identify peer education materials which provide accurate information on sexuality. • Raise awareness that both women and men have the right to control and make decisions about their sexuality and sexual relationships. • Raise awareness about the health risks that women and girls face, including violence. • Train facilitators to use such materials.	• Mobilize all health oriented and rights based NGOs to develop a campaign for an end to discrimination on the basis of sexual orientation. • Lobby the departments of health in each province to provide sexual health services to adolescents, not only to women of reproductive age. • Inform women of their legal rights and encourage them to recognize and report violations. • Monitor legislation on violence against women, sexual harassment, etc. and use findings to advocate for changes.

Session developed by Barbara Klugman and Sofia Gruskin

Handout

1 Determinants of HIV transmission in Botswana

Figure 1: Determinants of HIV Transmission in Botswana



Source: Government of the Republic of Botswana. *Botswana HIV and AIDS: second medium term plan: MTPII 1997 – 2002.* Gaborone, AIDS/STD Unit, National AIDS Control Programme, Ministry of Health, Republic of Botswana:15–18.

Gender

As is the case elsewhere in sub-Saharan Africa, the patterns of the HIV epidemic in Botswana, particularly in the sexually active age group, has a clear gender bias … The gender gap widens in the youth group 15–29 years, where 68% of infections were women. Certainly biological difference in part explains this gender bias. However, these variables do not sufficiently account for this gender disparity in the distribution of HIV infection.

… Lack of women's empowerment against prejudicial cultural and traditional practices in sexual and reproductive matters and relationships have been identified as factors that make women vulnerable to HIV infection. On the other hand, an exclusive focus on women is necessary but not sufficient in promoting gender equality in sexual and reproductive matters. Promoting the role and responsibilities of men in sexual and reproductive issues is in its own right critical in protecting both men and women against HIV infection. Such an approach may reduce various forms of sexual abuse and exploitation and promote positive sexual and reproductive behaviours.

Sexual and reproductive health factors

… As yet there have been no systematic studies done on the prevalence and incidence of sexual health problems such as rape, sexual harassment, violation and exploitation especially among young people in Botswana. However, judging from media reports and public concern, the prevalence of rape and sexual violation is high in Botswana. Such social ills present serious risk for HIV infection, especially for women. There is anecdotal evidence that teenage girls have sexual relations with older men. This sexual relationship formation pattern may in part explain the disproportionate rate of HIV infection between teenage boys and girls. However, since most girls who have sexual relationships with older men are likely to have peer boyfriends, most boys may be infected through this route. There is also concern about the possibility of sodomy among incarcerated prison populations. A study conducted in the Botswana prisons report that the practice of "thigh sex" is common among male inmates. This practice may be a risk factor in cases of cuts and open sores among those practising this behaviour.

SESSION 6

Applying a rights framework to reproductive and sexual health issues

What participants should get out of the session

Participants will:

- apply the concepts introduced in earlier sessions to case study examples which highlight how the violation or promotion of rights interacts with sexual and reproductive health
- recognize how the understanding of these interactions can help to shape policies and interventions.

2 hours 15 minutes

Materials

- Handout 1: "Minna's story"
- Handout 2: "I wanted choice"
- Handout 3: "A golden flower withering prematurely"

- *Universal Declaration of Human Rights* (You have the option of using human rights treaties, such as the Convention on the Elimination of All Forms of Discrimination Against Women for this exercise if you are used to working with their interpretation.)

Readings for the facilitator

1. Cook R. Abortion laws and policies: challenges and opportunities. *International Journal of Gynaecology and Obstetrics,* 1989, supplement to **3:**61–87.

2. García-Moreno C. *Violence against women, gender and health equity.* Harvard Center for Population and Development Studies Working Paper series No. 99.15. Boston, Harvard School of Public Health, 1999:1–8.

3. Hord CE, Gerhardt AJ eds. *When contraception fails. Initiatives for reproductive health policy.* Chapel Hill, IPAS, 1996.

4. Tarantola D, Gruskin S. Children confronting HIV/AIDS: charting the confluence of rights and health, *Health and Human Rights,* **3(1):**61–86.

5. United Nations. *Declaration on the elimination of violence against women.* New York, United Nations (United Nations General Assembly Resolution 48/104, 20 December 1993).

6. United Nations Population Fund. *The state of world population 1997. The right to choose: reproductive rights and reproductive health.* New York, UNFPA, 1997: 53–62 and 66.

How to run the session

This session consists of two activities. The first is an exercise in small groups using a case study. The second is a group report-back followed by a discussion and inputs from the facilitator.

This exercise focuses primarily on using a rights based approach for developing strategies and action steps. This session is complementary to the application exercise in Session 5 of the Policy Module, which is intended to build on this one.

Activity 1: Reading and preparing responses

Divide participants into groups of seven to ten. Give each group a case study and ask them to prepare to present their responses to the big group. Handouts 1 to 3 provide three stories on HIV/AIDS, abortion and maternal mortality. Each highlights different aspects of how the promotion or violation of human rights can interact with reproductive and sexual health and how awareness of this can help to shape both policies and interventions. Each case study poses the same set of questions. You can use all three cases or only the one that seems most relevant to the group you are working with.

It is useful for more than one group to work on a particular case study so that in the discussion in the big group it becomes clear that there is a need for various strategies to be used simultaneously to address particular issues.

Activity 2: Whole group discussion

The groups come back to the whole group. Each group has to present a summary of their responses to the questions in the handouts. This should take about 10 minutes per group. After each group presentation give a maximum of 10 minutes for questions for discussion.

What to cover in the discussion

The example given here uses the story in Handout 1: "Minna's story" to highlight the possible points of discussion and the range of possible responses that groups may present.

1. **Identify how this situation (HIV/AIDS in the family) may impact on Minna's health.**
   - How does it affect her sources of support, including financial, family, education, economic opportunity?
   - How does it increase her vulnerability to HIV/AIDS, violence, rape, STIs, psychological trauma, and so on.

2. **Identify the various causes of poverty, causes of lack of income, causes of gender based discrimination and the root causes of HIV.**

3. List each of the relevant actors and consider each of their responses to the situation.

- Relatives, school system, NGOs, mother, government (including the Ministry of Health and the Ministry of Education), self.

4. Identify the gaps or inadequacies of the responses that a rights approach highlights.

- Minna – not heard
- Family – discrimination: favours males, won't pay her fees
- Mother – requests she stay home
- School – did not waive fees, discrimination, not in support of Minna
- NGO – didn't prioritize situation, won't/can't help
- AIDS service organization – didn't provide for affected people. Was there adequate service for the mother?
- Government – not providing education, not providing adequate care, allowing economic exploitation of family, of Minna.

5. Use the Universal Declaration of Human Rights to identify each of the rights implicated in the situation. For each right discuss how and in what ways it is relevant. Be sure to consider the three levels of government obligation (to respect, protect and fulfil) as discussed in Session 3.

- Articles 1, 2, 3, 6, 7, 8, 9, 16, 22, 23, 24, 25, 26 of UDHR

6. Using this analysis, determine essential actions that should be taken to ensure this situation does not happen again. Consider both short and long term approaches and pay particular attention to the concepts respect, protect and fulfil.

- Short term approaches
  - Method for determining what Minna wants
  - AIDS service organization to stop withholding services
  - Equal education for girls and boys
  - Get school authority to waive fees now; get them to waive fees in extreme circumstances
  - Rally donations
  - Listen to Minna (allow her to participate in the decisions that affect her) both about how her mother should be cared for and about going to school
  - Work to make her choices equal to those of her brothers
  - Mother should receive drugs and not have to sell sewing machine
  - Support for other children in similar circumstances.

- Long term approaches
  - Increase funding for education and health care
  - Gender equality through legislative change, and so on (pay attention to Women's Convention [CEDAW])
  - Provision of free education
  - Provisions against child labour
  - General economic equity
  - International funding assistance, and not exploiting labour force

- Incorporation of human rights provisions into domestic legislation
- Improved health care, welfare, social services, and so on.

7. **Discuss the three types of actions identified: those that will impact on the underlying causes (conditions), those that are specific to the occurrence of the violation and the harm done, and those that are focused on the rights related consequences of the violation (the kinds of legal remedies that can be accessed, and so on).**

Start a discussion after each presentation

At the beginning of the first of these discussions, mention that the Policy Module will be addressing how to make these actions happen through a policy analysis and developing a strategy for policy change.

There is a need for different and complementary strategies

Even when faced with the same issue, groups may choose different approaches to address them. No single solution is sufficient.

Draw out the economic, social, cultural, civil and political dimensions of the issue under discussion in greater detail. Encourage other participants to add new factors. Similarly, encourage other participants to identify relevant rights that the reporting group has not mentioned.

Then discuss how using rights can facilitate choices in problem solving. It can introduce some order when we approach problems that may seem insurmountable. This can lead into a discussion about short and long term strategies. Emphasize the need to locate whatever strategy one chooses in the wider context.

Main points for closing the session

Human rights documents are useful

Using the rights as they are spelled out in the human rights documents can provide a convenient methodology for categorizing issues and allow for a shared framework, even amongst diverse actors, in determining strategies for action.

Range of short term, long term and concurrent strategies

No single action or short term approach will be sufficient to solve these issues. Attention must be given to employing a range of strategies at the same time, both short and long term strategies, if health issues are to be adequately addressed.

Forming partnerships outside the sector

Strategies to address reproductive and sexual health issues require partnerships with allies outside the health sector.

Session developed by Sofia Gruskin

Handout

1 Minna's story

Adapted from Gruskin S, Tarantola D. *Children confronting AIDS: a health and rights perspective.* Abidjan, UNICEF, UNAIDS, 1997.

Today Minna has told her teacher she has to stop going to school. Minna is 12 years old. She lives in a small town. Her father was a bus driver and her mother a seamstress. Her father died of AIDS six months ago after an illness that exhausted the family's resources. Her mother is very sick and has had to stop working. Two months ago, she had to sell her sewing machine to buy the drugs she needed. Her mother has told Minna that she must stop going to school and help to take care of her. There is no more money for school fees. Minna has been a very good student and is eager to continue. Minna has two brothers, aged 14 and 16. They will be able to continue going to school because relatives will pay their school fees.

Minna's relatives have approached the local education authority asking them to waive her school fees but were told this was not possible. They turned to a local AIDS service organization for help but were told that while Minna's situation was unfortunate, their mandate was still limited to providing care and support for people living with HIV. They turned to a local NGO Education For All. This NGO had a long waiting list for children seeking their support.

Minna's family met and decided they had done all they could do and that Minna should be sent to the capital city where young girls can easily find employment as domestic helpers.

Questions for discussion

1. **Identify how this situation (HIV/AIDS in the family) may impact on Minna's health.**
2. **Identify the root causes of the situation.**
3. **List each of the relevant actors and consider each of their responses to the situation.**
4. **Identify the gaps or inadequacies of the responses that a rights approach highlights.**
5. **Use the *Universal Declaration of Human Rights* to identify each of the rights implicated in the situation. For each right discuss how and in what ways it is relevant. Be sure to consider the three levels of government obligation (to respect, protect and fulfil) as discussed in Session 3.**

6. **Using this analysis, determine the essential actions that should be taken to ensure this situation does not happen again. Consider both short and long term approaches and pay particular attention to the respect, protect, fulfil concepts). Consider three types of action:**

- **those that will impact on the underlying causes (conditions)**
- **those that are specific to the occurrence of the violation and the harm done**
- **those that are focused on the rights related consequences of the violation (the kinds of legal remedies that can be accessed, and so on).**

Handout

2 I wanted choice

From: Budlender D, ed. *Health in our hands: proceedings and policies of the 1994 Women's Health Conference.* Johannesburg, Women's Health Project, University of the Witwatersrand, 1995. Reprinted with kind permission of AIDOS (The Italian Association for Women in Development) and Women's Health Project.

I am the eldest daughter of seven children. I had a Catholic upbringing. We went to church virtually every day. Secretively since my first year at university I had become sexually active with one partner. I always had to hide my contraceptive pills so that no one should know, especially my mother and father. There was no notion of privacy in the family with six other siblings. Some kid brother is always running through your drawer and there were no lockers at university, so it always was: what if I miss?

Then finally, I fell pregnant. I was 21 and had just graduated. I was a product of 1976. I was a young black kid and the world was at my feet. But I was pregnant. Who could I go to? I confided in an older friend, as telling my boy friend was not an option. She said "Why are you so stupid?"

We started knocking on the doors of doctors. The doctors said they couldn't help. No amount of tears or shouting helped. Then my best friend said her other best friend knew someone who had helped many others. She said I should tell my parents that I will stay out for a few days for civic action. Luckily in those days we could always use the excuse that you were picked up by the police!

My friend said they must get me to bleed and then it would be okay. They were pumping water and vinegar in me. My friend was also very Catholic. She said that if her husband came home I must get out. We started at ten in the morning. But they could not induce bleeding.

By the third day I was quite ill. My pelvis and uterus were badly battered. All my friends were trying to help me. Then we found a doctor who was struck off the roll because he had done this to people in the neighbourhood. He said he must first induce bleeding. I was very delirious at this stage. I don't know what the doctor did to me, but he got me to bleed. We went to the clinic, I had a short D&C, I went home. My parents could not understand why I was so sick. I told them that three years of varsity and political action had taken its toll.

Without my best friends I would have died. I wanted choice. I wanted to be different. When my friends fell pregnant their life was predetermined. I wanted choice, and the choice was for life and it was my choice and I made that choice.

Questions for discussion

1. Identify how this situation may impact on this woman's health.
2. Identify the root causes of this situation.
3. List each of the relevant actors and consider each of their responses to the situation.
4. Identify the gaps or inadequacies of the responses that a rights approach highlights.
5. Use the *Universal Declaration of Human Rights* to identify each of the rights implicated in the situation. For each right discuss how and in what ways it is relevant. Be sure to consider the three levels of government obligation (to respect, protect and fulfil) as discussed in Session 3.
6. Using this analysis, determine the essential actions that should be taken to ensure this situation does not happen again. Consider both short and long term approaches and pay particular attention to the respect, protect, fulfil concepts). Consider three types of action:

- those that will impact on the underlying causes (conditions)
- those that are specific to the occurrence of the violation and the harm done
- those that are focused on the rights related consequences of the violation (the kinds of legal remedies that can be accessed, and so on).

Handout

3 A golden flower withering prematurely

This case study was used in the course run in Kunming, China by the Yunnan Reproductive Health Research Association (YRHRA), Kumming Medical College, in 1999.

Jinwan village is a rural village inhabited by the Lahu minority community. It is located more than 60km away from the nearest town. The nearest bus terminus is at the seat of the township government, 30km from Jinwan. On sunny days, tractors can make the travel from the township government to Jinwan, but in the rainy season this mountainous stretch can be traversed only on foot. There is only one rural doctor in Jinwan. In case of serious illness, the villagers have to travel more than 30km to the township hospital or to a further away county hospital or prefecture hospital for treatment.

Generation after generation of women in Jinwan have given birth at home. Local tradition considers that women's menstrual blood is unclean and will bring bad luck to men if they touch it. It is also believed that tractors or ox-carts cannot be used to carry pregnant women because their blood and even their breath will bring ill luck to the drivers. For this reason, pregnant women experiencing difficult labour have to be carried by their relatives the entire distance of 30km to the township hospital. There is a private clinic in Nanxi village, which is 15km from Jinwan. Hearing from word of mouth that the midwifery services provided in this clinic are both excellent and cheap, some women in difficult labour are now being taken there for delivery.

Jinhua (in Chinese, "Golden Flower"), is one of the most beautiful young women in Jinwan. She was married during the last spring festival. During this spring festival, on the anniversary of her marriage, she was already 9 months pregnant. People congratulated her and wished her a safe delivery and healthy baby. Jinhua has had no prenatal examination, nor any information or counselling since she became pregnant. The township hospital had sent her some materials publicizing new methods of delivery. But Jinhua has not received much education and could not understand what was in these materials.

One night, Jinhua felt that she was about to give birth. But the baby did not come out even eight hours after the membranes had ruptured. Her relatives were greatly alarmed and quickly brought her to the private clinic. Doctors in the clinic worked hard for 3 hours and eventually she delivered a baby boy who had already suffocated to death. Then Jinhua began to haemorrhage. Her relatives again carried her to the township hospital, and then to the county hospital. Unfortunately, Jinhua did not survive the ordeal. She passed away on arrival at the county hospital.

Questions for discussion

1. Identify the various causes of this situation.
2. List each of the relevant actors and consider each of their responses to the situation.
3. Identify the gaps or inadequacies of the responses that a rights approach highlights.
4. Use the *Universal Declaration of Human Rights* to identify each of the rights implicated in the situation. For each right discuss how and in what ways it is relevant. Be sure to consider the three levels of government obligation (to respect, protect and fulfil) as discussed in Session 3.
5. Using this analysis, determine the essential actions that should be taken to ensure this situation does not happen again. Consider both short and long term approaches and pay particular attention to the respect, protect, fulfil concepts). Consider three types of action:

- those that will impact on the underlying causes (conditions)
- those that are specific to the occurrence of the violation and the harm done
- those that are focused on the rights related consequences of the violation (the kinds of legal remedies that can be accessed, and so on).

SESSION 7

Using international human rights to translate government commitments into action

What participants should get out of the session

Participants will:

- learn approaches to applying reproductive and sexual rights to the work they are engaged in
- contextualize their work in relation to the range of actors involved in similar efforts.

2 hours

Materials

- Handout 1: "Cairo and Beijing in your country"
- Handout 2: "Actions that some multilateral agencies have taken to implement the Cairo and Beijing agreements"

- overhead: Handout 2
- overhead: "How does your work fit into the larger framework", on p.199
- flip chart on board for writing on

Readings for the facilitator

1. Earth Summit Watch. *One year after Cairo: overview of country reports.* An overview of the country-by-country survey of ICPD implementation. Available online at: www.earthsummit.watch.org/cairo1/ (Date accessed: 2000).

2. United Nations Division for the Advancement of Women, United Nations Population Fund, United Nations High Commissioner for Human Rights. *Roundtable of human rights treaty bodies and specialized agencies on human rights approaches to women's health, with a focus on sexual and reproductive health and rights.* New York, UNFPA, 1998.

3. United Nations Population Fund. *The state of world population 1997. The right to choose: reproductive rights and reproductive health.* New York, UNFPA, 1997:53–62 and 66.

Essential readings for participants

Reading 2.

How to run the session

There are two activities in this session. The first is work in small groups followed by a whole group report-back and discussion. The second is an individual activity to determine participants' personal priorities in implementing reproductive and sexual rights, followed by sharing in the whole group.

Activity 1: Looking at Cairo and Beijing

Step 1: Cairo and Beijing in participants' own countries

Begin by telling participants that efforts to implement reproductive and sexual rights, and Cairo and Beijing more generally, are happening all at once at a variety of different levels around the world. Ensuring that reproductive and sexual rights can become a reality for women everywhere requires action from NGOs, governments, and the international system. In order to keep this work moving forward, it can be useful to see how our work fits into the larger picture of what various institutions, international and national, are doing.

Divide participants into four or five groups. Give them the following questions for discussion (Handout 1). Ask them to come back to the big group after 15 minutes.

- Has information about Cairo and Beijing and, more generally, about reproductive and sexual rights, been disseminated in your country? Who are the actors involved in this process? What kinds of information are being disseminated by each of them, to whom and how?

- Has the government or any other actor put into place an institution, mechanism or process to review if and how the provisions of Cairo and Beijing are being implemented?

- Have there been any changes in laws, policies, or resource allocation concerning reproductive and sexual health since Cairo and Beijing? Who has been involved in making this happen?

Step 2: Sharing information with the whole group

Participants come back to the whole group and each group takes three to five minutes to report back. Using a flip chart, group the answers they give according to the following categories. Bear in mind that there should be information on each of the categories of actors at each level.

Actors	Levels
• The United Nations	• International
• Other intergovernmental organizations	• Regional
• Governments	• National
• Non-governmental organizations	• Local
	• Community

Summarize the major points.

Participants are likely to have enough information about what these actors are doing within their countries, but they may be less aware of the details of the global activities which these actors are involved in. Distribute Handout 2.

Present Handout 2 as **overheads.**

1 hr

Activity 2: Participants' personal priorities

10 mins

Step 1: Participants reflect on their own work

Ask participants to take five to ten minutes to consider how the work they are doing fits into this larger framework by thinking through the following questions and noting down their answers.

Put up the questions below as an **overhead.**

How does your work fit into the larger framework?

- Which reproductive and sexual rights issue do you consider to be a priority in your own work?
- What is the current status of this issue in your country?
- What steps or actions do you think are needed to improve the status of this issue? This includes considering actors that need to be engaged, the materials and resources that will be needed, and the strategies that would need to be adopted.
- What problems do you anticipate will arise when you try to do this work?

Step 2: Committing to action

Start a discussion in the whole group. Make the point that exactly what you do is not as important as the fact that you take concrete action. Reproductive and sexual rights, and Cairo and Beijing, are only as strong as people's willingness to use them. It is our own responsibility, no matter if we sit in a government or an NGO, to make these commitments real.

Go around the room and ask each person to commit aloud to one action they will take in the next year, no matter how small, to make reproductive and sexual rights a reality in the populations they work with. Make sure that each participant gets the chance to speak.

Write down each participants' commitments on a flip chart.

Push participants to be specific, and to make the connection between the action they propose and the promotion of reproductive and/or sexual rights. For example, if a participant says that she or he will work more on Safe Motherhood, ask for details about the specific action or actions. Would it be new interventions? Advocacy? Research? Also ask participants what aspects of reproductive and sexual rights their action would promote.

Tell participants that, if they would like to, they can work with this same intervention in the application exercise at the end of the Policy Module.

Aim at no more than two to three minutes per participant, or a maximum of 50 minutes for all participants.

Pass on the flip charts containing participants' commitments to the facilitator of the Policy Module for follow-up work.

Main points for closing this session

There are many actors/institutions around the world which are trying to promote reproductive and sexual health and rights.

Systematically considering how one's work fits into a bigger picture can be a useful tool for determining priorities and setting action steps for the future.

Session developed by Sofia Gruskin

Handout

1 Cairo and Beijing in your country

You have 20 minutes to discuss, as a group, the following questions. Appoint one person to note down key points emerging from the discussion and report back.

- **Has information about Cairo and Beijing and, more generally, about reproductive and sexual rights, been disseminated in your country? Who are the actors involved in this process? What kinds of information are being disseminated by each of them, to whom and in what ways?**
- **Has the government or any other actor put into place an institution, mechanism or process to review if and how the provisions of Cairo and Beijing are being implemented?**
- **Have there been any changes in laws, policies, or resource allocation concerning reproductive and sexual health since Cairo and Beijing? Who has been involved in making this happen?**

Handout 2

Actions that some multilateral agencies have taken to implement the Cairo and Beijing agreements

To update and add to this information, refer to the websites of the various United Nations agencies including the World Health Organization, and the United Nations Population Fund.

The United Nations

The majority of current efforts within the United Nations to implement and to monitor what has happened since the Cairo and Beijing conferences involve supporting national implementation efforts and ensuring accountability for what is being done at the national governmental level.

The Commission on the Status of Women has been responsible for reviewing the implementation of Beijing.

The Commission on Population and Sustainable Development has been responsible for reviewing the implementation of Cairo.

The treaty monitoring bodies responsible for overseeing the government obligations under the human rights treaties have begun to think about issues related to reproductive and sexual health, such as maternal mortality or HIV/AIDS, in the way they interpret government obligations under their treaties.

World Health Organization (WHO)

WHO is committed to implementing the agreements from Cairo and Beijing and those from their five-year reviews.

It addresses these key actions in many of its activities, including:

- collaborating with United Nations human rights treaty bodies to ensure attention to sexual and reproductive health issues in their monitoring of countries
- collaborating and assisting countries to respect, protect and fulfil reproductive rights, and to adopt a human rights framework in implementing their reproductive health programmes
- developing a practical tool for assessing gender considerations in reproductive health research
- developing a strategic approach to contraceptive introduction, involving participation of all key stakeholders
- supporting research on women-centred barrier contraceptive methods and on microbicides
- developing guidelines and norms for reproductive health interventions, including maternal and newborn health, preventing and managing sexually transmitted infections, eligibility criteria for contraceptive use, and the provision of safe abortion
- developing indicators for monitoring reproductive health programmes at country and district levels
- developing guidance for adolescent health programming and interventions.

United Nations Population Fund (UNFPA)

Post-Cairo, UNFPA policy guidelines for gender, population and development were revised in 1998. The new policy, "Support for Mainstreaming Gender Issues in Population and Development Programmes", has led to the following strategic and programmatic changes:

- redefining strategies and priorities to adopt two different but complementary approaches: mainstreaming the perspective of gender equity in the main programme areas on the one hand, and on the other supporting strategic projects for women
- work with human rights treaty bodies to incorporate reproductive rights issues in the reporting mechanisms of CEDAW (the Convention of the Elimination of All Forms of Discrimination against Women)
- attempts to implement gender equality and equity and the promotion of human rights in all its programme support to countries. Examples include support for formulating new family and marriage codes guaranteeing reproductive rights and gender equality in countries of Francophone Africa; and support for efforts in Latin America to incorporate sexual and reproductive rights as well as gender equity into the new Constitution in Ecuador and Venezuela.

SESSION 8

Module summary

What participants should get out of the session

Participants will:

By the end of this session, participants will have an overview of the tools and concepts introduced in the Rights Module. They will understand the links with the tools introduced in the Gender Module and in the Social Determinants Module.

15 minutes

How to run the session

This is an input session that pulls together all the tools and concepts introduced in the Rights Module. It also makes the links with tools and concepts introduced in the Gender and Social Determinant Modules.

What to cover in your input

Overhead Include the main points from the Module brief and also the graphic representation of the module "Structure of the Rights Module".

Weaving in a gender perspective

Highlight how this module weaves a gender perspective into the application of human rights concepts. It builds on the social determinants analysis of health status and health service delivery, and focuses on how human rights and a human rights framework can be used to address these factors. This is most evident, for example, in Sessions 5 and 6.

The last of the Foundation Modules

This marks the end of the Foundation Modules of this course, which are intended to develop a gender and rights perspective and provide the tools for analysing issues and problems using gender, social determinants and rights concepts. This means, for example, that for any intervention or policy we examine or plan, we would ask:

- Does this consider underlying causes/social determinants at all levels of the problem being addressed? Does it identify the rights implicated in each of these factors?
- Does it address gender issues? Does it attempt to transform gender power relations?
- Does it address the rights implicated? In what ways?

Module 4: **Evidence**

Structure of the Evidence Module

SESSION 1 — Collection and interpretation of data

Provides a refresher on the use of health statistics. Illustrates challenges in generating good information on sensitive sexual and reproductive health topics. Discusses the concept "generalizability" of data and sources of bias.

SESSION 2 — The research process step by step

Provides an overview of basic concepts in health research: research question(s), sample population and study design. Introduces the concept of a gender perspective in health research.

SESSION 3 — Ethical issues in reproductive health research

Provides insights into key ethical dilemmas in reproductive health research, from a gender perspective. Acquaints participants with principles of ethics in research, focusing on reproductive health. Presents international ethical guidelines for the conduct of research.

SESSION 4 — Evidence for planning: reconciling evidence from different sources (Case: maternal health)

Provides skills at reconciling data from different sources for health planning. Provides experience in identifying gender bias in collecting, analysing, interpreting and presenting information.

SESSION 5 — Evidence for policy and programming: selecting appropriate technologies for fertility regulation

Develops skills for identifying information needed to select technologies for fertility regulation appropriate to a given setting, integrating gender and rights concerns.

SESSION 6 — Evidence for monitoring: reproductive health indicators

Builds skills for identifying most relevant reproductive health indicators in a given setting. Provides examples of indicators which incorporate gender and rights concerns.

SESSION 7 — Evidence for service evaluation: applied exercises

Acquaints participants with a range of techniques for data/information collection for service evaluation. Provides hands-on skills in constructing tools for data/information collection, and helps participants learn how to integrate gender and rights dimensions in data/information collection for monitoring, surveillance and evaluation of services.

MODULE 4

Module brief

What participants should get out of the Evidence Module

Participants will:

- be familiar with basic concepts in health research and be able to identify types of evidence that are useful to reproductive health service planning and policy
- be familiar with common examples of research bias, including gender bias, in the collection, interpretation and presentation of health information
- be aware of current international guidelines for ethical practice in health research and how they apply to current controversies in reproductive health research
- be able to identify relevant reproductive health indicators in a given setting that incorporate gender and rights.
- have acquired skills in health systems appraisal, technology assessment and service evaluation that incorporate a gender and rights perspective.

The thinking behind the module

What research can be used for

Health research, and the evidence it generates, makes it possible to identify:

- health problems
- the determinants of those problems
- the interventions needed
- the impact of interventions.

Among health systems planners, useful evidence will identify health seeking and service utilization rates, and the improvements that health delivery systems need. Monitoring and evaluation allow short term or ongoing reassessments of whether specific interventions, technologies or services are having the desired impact. Long term monitoring and surveillance systems allow the health system to be adapted to changing health needs.

How research can fail women

Evidence which we use to evaluate whether a health system is effective or whether given technologies or interventions are optimal, should include attention to the needs and concerns of potential clients. Unfortunately, the evidence on which reproductive health services and family planning technologies have been evaluated has often paid scant attention to the rights or the broader health and social needs of clients, who are mostly women. The evidence has frequently failed to include information on whether rights relevant to women's reproductive health are protected, whether the available services match prevailing health needs, or even whether the minimum standards of good practice are being met. This neglect reflects both the long-standing low status of women and the specific interest of states in controlling women's fertility rather than promoting their well-being.

Evidence needs to be reoriented

Strengthening reproductive health systems to promote gender equality and reproductive rights requires, therefore, a reorientation of the types of evidence used for assessing needs, measuring the quality of services, evaluating interventions, and monitoring impact over the longer term. This is the purpose of this module.

Session 1 provides participants with a refresher on health statistics and basic research terminology, while highlighting the challenge of collecting data on sensitive topics in sexual and reproductive health research. By using participants' own data on the timing of their first sexual and reproductive experience, the session provides a review of sampling, bias, and generalizability. Courses directed at more senior researchers may choose to skip the emphasis on research fundamentals in Session 1 and focus on the discussion on gender differentials in sexual norms, conjugal age differences, and recent trends in the timing of sexual and reproductive events.

Session 2 provides a step by step review of the research process, describing a range of study designs and their applications. Participants are presented with short research problems and given the chance to walk through the steps, from framing the research question(s), to defining the sample population and sample selection, to identifying a suitable mix of methods for pursuing the research question(s). The examples range from simple to complex problems. This session refers back to the gender and health session of the Gender Module (Module 1, Session 5) and concepts learnt in the Rights Module (Module 3) to illustrate the effect of applying a gender and rights perspective to all steps in the research process.

Session 3 provides participants with international guidelines for ethical health research, because gathering information may conflict with patient privacy or the immediate provision of care. Ethical research dilemmas within reproductive health are accentuated by gender inequalities – women are often the objects of reproductive

health research in settings where they lack the social status to ensure the protection of their health and rights. The legacy of population control in many settings further compromises women's choices (and sometimes men's) in relation to participation in family planning research when overzealous concern for population control is allowed to override ethical concerns in contraceptive trials or accepted standards in clinical care. The session is designed as a formal debate to provide participants with a chance to enhance their skills in articulating and advocating for ethical principles.

Session 4 provides participants with an opportunity to apply a gender analysis to research reports and articles, and to identify sources of gender bias in the way data is collected, analysed, interpreted or presented. The session then looks at how potential planning mistakes may emerge if decisions are based on only one type of evidence. It builds on the preceding session by providing concrete examples of how different research methods highlight different aspects of a given problem, and how recommendations for action reflect the type of evidence that has been used. The exercise emphasizes the value of reconciling data from different sources to identify plans that will be effective and long lasting. The case material provided is on maternal health, but other examples can be used as the method is generalizable to other health problems.

Session 5 offers a concrete example of how to identify information needs that will accommodate gender and rights concerns in the selection of fertility regulation technologies. There is strong emphasis on the need to:

- address both fertility regulation and disease prevention in a given setting
- promote and protect reproductive rights
- promote shared responsibility among men and women while ensuring attention to women's urgent practical needs.

The overall framework for selecting effective fertility regulation technologies can be applied to other technologies (for example, technologies for diagnosing sexually transmitted infections (STIs)). But the example provided shows how existing family planning programmes can be systematically re-evaluated in a way that is consistent with the Cairo and Beijing agendas.

Session 6 introduces the concept of indicators and how they can be used in monitoring health status, the utilization of services and service quality. There is an emphasis on demystifying indicators as something only necessary for external monitors, and on their usefulness as a self-generated tool for the ongoing monitoring of quality control, performance and impact. Participants will acquire skills to identify the reproductive health indicators that will be most useful in a given setting, and you will show them a range of existing and new indicators that can

be used to monitor gender equity and reproductive rights in sexual and reproductive health.

Session 7 provides hands-on exercises in the development of tools for the evaluation of services. These group exercises give participants first hand exposure to the difficulties in constructing tools for gathering information, and thus increase their understanding of what concepts like bias, validity or generalizability mean in practice. The discussion questions for each exercise highlight how gender and rights dimensions can be addressed in data/information collection.

Module outline

		Objectives Participants will:	Format of activities	Time: about 18 hours
Introductory session	Introduction to the Evidence Module	• be acquainted with module objectives and contents	Input session	15 mins
SESSION **1**	Collection and interpretation of data	• be re-acquainted with the use and value of simple statistical measures: mean, median, range and variance	Data collection exercise conducted prior to the session	1 hr 40 mins (outside class time)
		• be introduced to the notion of confidentiality, sensitivity in sexual and reproductive data, and ways of protecting the privacy of research subjects	Input	1 hr 15 mins
		• discuss the interpretation and generalizability of data, and concepts of bias	Facilitated discussion	30 mins
SESSION **2**	The research process step by step	• be acquainted with basic steps in the designing of a research study	Input	50 mins
		• be introduced to the concept of a gender and rights perspective in health research	Participatory exercises in whole group	40 mins
SESSION **3**	Ethical issues in reproductive health research	• be acquainted with principles of ethics in research, focusing on reproductive health	Introductory lecture	1 hr
		• have an overview of international ethical guidelines for the conduct of research	Group work to prepare for debate	30 mins
		• debate key ethical dilemmas in reproductive health research from a gender perspective	Debate and discussion	1 hr
SESSION **4**	Evidence for planning: reconciling evidence from different sources (Case: maternal health)	• recognize that research results reflect what question was asked, how the evidence was gathered, and from whom it was solicited	Individual reading	outside class hours
		• understand the need to reconcile evidence from different sources for sound decision making	Small group work	40 mins
		• be able to identify gender bias in the collection, analysis, interpretation and presentation of health information	Report-backs and whole group discussion	1 hr 40 mins
SESSION **5**	Evidence for policy and programming: selecting appropriate technologies for fertility regulation	• develop skills for identifying information needs for selecting fertility regulation technologies appropriate to a given setting	Input by facilitator	45 mins
			Small group work	1 hr
		• be able to integrate gender and rights concerns when making this selection	Report-backs and discussion in whole group	1 hr
SESSION **6**	Evidence for monitoring and evaluation: reproductive health indicators	• be familiar with different types of health indicators and their uses	Input by facilitator	30 mins
		• come up with indicators most relevant to specific settings	Quiz	15 mins
		• have the skills to use and/or develop indicators that capture the gender and rights dimensions of a health issue or problem	Small group exercise(s) followed by plenary	1 hr 30 mins
SESSION **7**	Evidence for service evaluation: applied exercises	• be acquainted with a range of techniques for data/information collection for service evaluation	Input by facilitator	30 mins
		• have hands-on practice in constructing tools for data/information collection	Hands-on group exercise	3 hrs
		• learn how to integrate gender and rights dimensions in the monitoring and/or evaluation of services	Group presentations and whole group discussion	2 hrs

Introduction to the Evidence Module

What participants should get out of the Evidence Module

Participants will:

Participants will be familiar with the structure, contents and objectives of Module 4.

15 minutes

How to run the session

This is an input session.

Introduce the module using **overheads** from the Module brief:

- "What participants should get out of the Evidence Module"
- "Structure of the Evidence Module"
- "Module outline".

SESSION 1

Collection and interpretation of data

What participants should get out of the session

Participants will:

- be re-acquainted with the use and value of simple statistical measures: mean, median, range and variance
- discuss the interpretation and generalizability of data, and concepts of bias
- be introduced to the notion of confidentiality and sensitivity in sexual and reproductive health data, and ways of protecting the privacy of research subjects.

1 hour and 40 minutes

Prior preparation

- The data gathering exercise has to be done the previous day. See description under Activity 1 below.

Materials

- 3 large pieces of newsprint for data sheets, as on p.214
- overhead: Summary statistics from data generated by participants on their first sexual and reproductive experience, example on p.215
- overhead: "Variables", on p.216
- overhead: "An overview of summary statistics", on p.217

How to run the session

This session combines three complementary activities. The first is to collect and analyse data on the timing of sexual and reproductive events. Note that participants must complete this first activity in their own time on the day before you start this session. The second activity is a whole group discussion, based on the data generated, which explores gender differentials in sexual norms, and gender role expectations in relation to age, power and responsibility for reproduction. The third activity is a discussion about gendered sexual norms and reproductive experiences, based on the data that participants have generated.

Activity 1: Gathering data

Allow 10–15 minutes on the day before the session to introduce this activity. When participants have completed the data sheets, you analyse the data in your own time and prepare an input for the next day.

Step 1: The data collection sheet

Prepare two or three large pieces of newsprint with the following table, with enough lines to allow one per participant, plus an extra five lines.

Data sheet – First sexual and reproductive experience

M or F	Age at first menses (F) or when voice changed (M)		Age at first sex		Age at first pregnancy (F) or age at first pregnancy of partner (M)		Age at first birth		Age at first marriage	
	You	Your partner (indicate M or F)	You	Your partner (indicate M or F)	You	Your partner (indicate M or F)	You	Your partner (indicate M or F)	You	Your partner (indicate M or F)
1										
2										
3										
4										
etc.										

Step 2: Put the data collection sheet somewhere private

Put the data sheet somewhere that will ensure privacy for those filling it in. You and another course facilitator should fill in your own data on any vacant lines, so that two data lines are already completed. But not lines 1 and 2 – in this way, no one will know which data corresponds to which participant.

Step 3: Explain how to fill it in

Participants can fill in the data sheet in any of their breaks. Ask each member of the group to go alone to the data sheet and fill in their personal information. Explain that they can use any free line, not necessarily the very next open one. Also explain that:

- "Your partner" refers to the partner with whom you first had sex, or the partner you first married, not your current partner.
- If a question does not apply to you, for example if you have never been married, put a dash.
- If you don't have the information, for example, you do not know the age of the person who was the "father" of your first pregnancy, then put a question mark. This differentiates questions that do not apply from missing data, a point you may want to explore later.

Step 4: Analyse the data

Once the data sheet has been completed, do an analysis of the data in your own time. Calculate the following summary statistics from the data:

- range
- mean
- median
- mode
- standard deviation.

Prepare an overhead of the results of your analysis. The box below "Example of summary statistics from data generated by participants on their first sexual and reproductive experience" gives an example from one of the courses.

Example of summary statistics from data generated by participants on their first sexual and reproductive experience

Sample size = 37; Females = 34; Males = 3

1. Age at first menses
Range: 11–17
Mean: 13.4
Median: 13
Mode: 13
Standard deviation: 1.8

2. Age at first sex
Range: 9–28
Mean: 19.1
Median: 19
Mode: 18
Standard deviation: 3.8

58% of the women had their first sexual experience under age 20

3. Age of first sexual partner
Range: 14–45
Mean: 22.3
Median: 21
Mode: 19
Standard deviation: 5.5

66% of first sexual partners were over age 20

4. Age at first pregnancy
Range: 16–36
Mean: 24.1
Median: 23.5
Mode: 21
Standard deviation: 5.3

20% of the women in the sample had their first pregnancy under age 20

5. Age at first marriage
Range: 20–30
Mean: 25.3
Median 25
Mode: 25
Standard deviation: 2.9

6. Age of partner at first marriage
Range: 22–36
Mean: 27.8
Median: 27
Mode: 23
Standard deviation: 4.2

1 hr 15 mins

Activity 2: Discussing the data

10 mins

Step 1: Whole group discussion: sensitive issues

Start the session by asking participants how they felt putting personal information down on the data collection sheet. Find out if they thought that the process had respected confidentiality. Take about 10 minutes for this discussion. Mention that this is a key element in the *International ethical guidelines for biomedical research involving human subjects*, prepared by the Council for International Organizations of Medical Sciences (CIOMS) in collaboration with the World Health Organization in 1993. (See Session 3 in this module.)

Ask whether there are other sexual and reproductive health data that are highly sensitive, and discuss the limitations of conducting research on such topics. Probe to find out if participants can think of other important reasons for ensuring confidentiality when collecting sensitive data, other than for ethical reasons. Some examples would be social stigma, or concern for the safety of the respondent (in the case of women experiencing domestic violence, for instance). Go through one or two examples, such as induced abortion, substance abuse, or HIV/AIDS.

What to cover in the discussion

Take the utmost care with this sensitive data

Information/data related to reproductive and sexual health is highly sensitive. We need to take the utmost care in maintaining confidentiality, in both the data gathering as well as the reporting processes.

Reporting bias compromises the data

When respondents are not comfortable with answering certain questions, they may not respond at all or respond inaccurately. In the case of early sexual experience or abortion, for example, there may be a common tendency to under-report. This is called systematic under-reporting or reporting bias, and compromises the quality of the data.

15 mins

Step 2: Variables

Put up an **overhead** containing the list of variables.

Variables

Age at first menses (females)
Age at which voice changed (males)
Age at first sex (females/males)
Age of first sexual partner (females/males)
Age at first pregnancy (females)
Age of partner at first pregnancy (females/males)
Age at first marriage (wives/husbands)
Age at first birth (mothers/fathers)

Ask participants what analysis can be done using these variables. Some usual responses are: average age at first menses; average ages at first sex, pregnancy, marriage and birth; differences in these by sex; proportion of those sexually active in adolescence; percentage of teenage pregnancies.

Step 3: Review the summary statistics

Put up your **overhead** containing summary statistics from the data generated by participants. Review the summary statistics.

When presenting the data, ask participants to define the different summary statistics: range, mean, median, mode and standard deviation. Explain each of these and the differences between them.

An overview of summary statistics

Range = the smallest and largest values.

Mean = the sum of the observed values/number of values. The mean is sensitive to extreme values. In other words, two observations as different as 1 and 9 would give a mean value of 5. (1+9)/2 =5.

Median = the middle number of a set of numbers arranged in numerical order. If there is an even number of values, the median is the result of adding the two middle values and dividing by 2. A median value of 13 for age at first menses means that 50 per cent of those in the sample had their first menses at age 13 or below. The median is not sensitive to extreme values, and hence is a better summary measure when the data are known to have outliers.

Mode = the value with the maximum number of observations. A mode value of 18 for age at first sex means that the number of respondents who had their first sexual experience at age 18 is greater than the number who had their first sexual experience at other ages in the range (9–28 years).

Standard deviation (SD) = an estimate of the variance, or the spread of the values about the mean. The standard deviation is a summary measure of the difference between each value and the mean. A high standard deviation means that the data values are widely dispersed around the mean, while a low standard deviation means that all values lie within a narrow range. For example, for the narrow range 11–17 years (of age at first menses), the SD is 1.8; for the broad range 14–45 years (of age of first sexual partner), the SD is 5.5.

30 mins

Step 4: Generalizability, sampling and sources of bias

Use this opportunity to discuss issues around the generalizability of data, sampling and sources of bias.

What to cover in the discussion

Generalizability

Ask the group if the data generated from this exercise would be true of their society in general, and, if not, in what way does the data differ? Define the concept of generalizability.

The sample

Ask participants to describe how they would define themselves as a sample of society as a whole. Get the group to list the demographic characteristics that would describe them.

Select a different age or social group (for example, a meeting of 65 years and older retirees). How might their data differ from that generated by the course participants? Make it explicit how these demographic characteristics are another way of talking about the social determinants of health or reproduction.

Sampling affects generalizability

The discussion moves on to the impact of sampling on the generalizability of data. Sampling is the process of selecting a number of study units from a defined study population. A representative sample has all the important characteristics of the population from which it is drawn. Therefore, information on a representative sample is generalizable to the population from which the sample is drawn.

It is not necessary to always choose samples to be representative. Purposive samples can also be used, depending on the research question. For example, to know the average age at menopause of women in a population we need a representative sample. But to understand women's perceptions of menopause we may actually want to include women with atypical responses in our sample in order to understand the entire range of perceptions.

Bias

What happens when there are errors in sampling procedures? This leads to a distortion in the results, or biases.

Some examples of sources of bias

- **The selection may not be random:** Willingness to take part in a study may attract persons who are anxious to get clinical care or treatment. For example, women willing to undergo a community screening study for reproductive morbidity may be those who perceive that they have a problem.

- **Certain members of the population may be omitted:** For example, surveys conducted during the day may exclude a majority of men and women working outside the home.

- **Non-response:** Substantial non-response is always worrisome. Those unwilling to answer questions may have no relevant experience, or they may have the greatest relevant experience, especially if the health problems being addressed are socially or morally sensitive (for example, domestic violence, abortion, or STIs).

- **Gender bias:** Females may be under-represented in the sample or vice-versa. For example, when STI incidence studies are based on clinic records there is a tendency to gender bias in the sample because users of STI services are predominantly males. For other health problems, the reverse may be true.

What are the sources of bias in the data generated from this group? The sample was self-selected, and we have agreed that the group cannot represent the population in this area.

How to review research fundamentals when some participants have previous exposure to research

Most courses on health systems draw participants with a wide range of prior research experience. You may find yourself trying to pitch a review of research fundamentals simultaneously to epidemiologists and to people with no training in research. How to handle this?

Prepare for the input on the previous day, forewarning the class that this is a refresher on fundamentals, and then hold to your commitment and pitch to the least experienced. Remember – in such a short session your goal is not to teach technical research skills, but concepts and judgement. And because conceptual training does well with multiple teachers, try to enlist the more experienced researchers to help you teach. Tell them ahead of time that you will be grateful for their assistance, and create time during the input for them to offer their own examples or to rephrase your definitions. In all likelihood the repetition and rephrasing will improve their understanding. And finally, remember that even busy researchers sometimes forget fundamentals and they may appreciate this more than you expect!

Activity 3: Discussing gendered norms and experiences

Start a discussion on gendered sexual norms and reproductive experiences, based on the data that participants have generated and presented in the previous activity.

What to cover in the discussion

Young people

Why does the age at first sexual experience often differ for females and males? What is the common explanation for these differences? Explore gendered ideas about normal sexual behaviour among young males and females, including the social values of modesty and virginity. What are the positive and negative consequences of these different social expectations?

Age differences in couples

When first sex, marriage, or first births occur, how do the ages of the females and males within the couple differ? Is there any pattern? Why is this? How are typical age differences within couples linked to different expectations about power and responsibility? How do these coincide with differences in economic power? Or with life expectancy?

First sex, first marriage, first birth

In many parts of the world, recent trends show first sex occurring at earlier ages, while the age at marriage and first birth is getting later. What are the causes of these changes, and how do they coincide with changing social roles for males and females? What are the implications of these changes for reproductive health services?

Pregnancy before marriage

If the data suggest that some pregnancies occurred before marriage, explore the social expectations placed on each partner (mother, father) for pregnancies outside marriages. How do these impact on the reproductive health of males and females, and the need for services?

What is normal?

You can use this session to open discussions on current controversies about gender and sexual norms. For example:

- sexual roles and behaviours among adolescent girls and boys, and the positive and negative social effects of these differences
- recent trends in age at first sex, marriage and first birth, and the impact of these changes on girls and boys
- the social expectations placed on each partner (mother, father) when unplanned pregnancies occur
- typical age differences between husbands and wives, and the consequences.

Session developed by Rachel Snow and Sharon Fonn

SESSION 2

The research process step by step

What participants should get out of the session

Participants will:

- be acquainted with the step by step process of designing a research study
- be introduced to the concept of a gender perspective in health research.

1 hour and 30 minutes

Materials

- Handout 1: "Study designs"
- Handout 2: "Examples of problems addressed by health research"

- overhead: "Steps for research", on p.222
- overhead: "Overview of study designs", on p.225
- overhead: "Research questions, the study population and the study unit", on p.226
- overhead: "Some main points from the Gender Module, Session 5: Linking gender and health", on p.228
- overhead: Handout 2
- flip chart: "Questions for undertaking research", on p.229

How to run the session

This session consists of two activities: an interactive input by the facilitator, followed by an exercise in the whole group.

50 mins

Activity 1: Discussing research

5 mins

Step 1: What is research?

Start by asking participants what the word "research" means to them. Make the point that research is simply the act of finding out more about an issue or problem, with a specific purpose in mind.

Go over the objective of the session, that it aims at introducing the essential components of health research. Put up the **overhead** "Steps for research" from the box below.

Of the several steps outlined here, this session will look specifically at three: problem identification, specifying research objectives, and research methodology. Mention that participants will have an opportunity to design data collection tools in the last session of the module. Make it clear that this session does not attempt to teach them how to carry out research; it aims to acquaint participants with the research process in their capacity as health professionals who often use research information or who may commission research.

Steps for research

Problem identification

Literature review

Specifying the research question(s) and objective(s)

Research study design and methodology

Review of existing evidence/data

Data collection

Data processing

Data analysis

Report writing

Using research findings:
- Dissemination/feedback to respondents
- Application to policy and/or intervention

Source: Varkevisser CM et al. *Designing and conducting health systems research projects.* International Development Research Centre Canada. Health Systems Research Training Series, volume 2, part 1. Ottawa, IDRC, 1991.

5 mins

Step 2: Do you know where you're going?

As a way of starting the input on steps in health research, the following fable is used in the course in South Africa.

From: Botha JL, Yach D. Manual of epidemiological research methods. A supplement of an abridged version of the IB-ESSA workshop manual, Tygerberg, South Africa Medical Research Council, 1987.

Once upon a time a sea horse gathered up his seven pieces of eight and cantered to find his fortune. Before he had travelled very far, he met an eel, who said:

"Psst. Hey bud. Where ya going?"

"I'm going to find my fortune," replied the sea horse proudly.

"You're in luck," said the eel. "For four pieces of eight you can have this speedy flipper, and then you'll be able to get there a lot faster."

"Gee, that's swell," said the sea horse, and paid the money and put on the flipper, and slithered off at twice the speed.

Soon he came upon a sponge, who said:

"Psst. Hey bud. Where ya going?"

"I'm going to find my fortune," replied the sea horse.

"You're in luck" said the sponge. "For a small fee I will let you have this jet-propelled scooter so that you will be able to travel a lot faster."

So the sea horse bought the scooter with his remaining money and went zooming through the sea five times as fast.

Soon he came upon a shark, who said:

"Psst. Hey bud. Where ya going?"

"I'm going to find my fortune," replied the sea horse.

"You're in luck. If you take this short cut," said the shark, pointing to his open mouth, "you'll save yourself a lot of time."

"Gee, thanks," said the sea horse, and zoomed off into the interior of the shark, and was never found again.

The moral of the fable is: if you're not sure where you're going, you're liable to end up somewhere else.

10 mins

Step 3: Asking the right questions

Start a closer examination of the different research steps by providing a realistic example of the type of observation that prompts research questions among planners and providers. One example on reproductive tract infections (RTIs) is given below, but you may select an example that is more relevant to your setting.

What to cover in your input

Example: in a rural health centre, medical officers notice that the number of women presenting with RTIs has increased. They would like to know why.

In the example, the health professionals suspect that there is a problem and want to know more. Specific research objectives can now be identified. Answering these questions will help us identify a suitable study design.

What is (are) the research question(s)?
For the example above, some of the research questions may be:

1. What is the magnitude of the increase in the number of women presenting with symptoms of RTIs?
2. What accounts for this increase? Is it because more women are now coming to this health centre (as opposed to not seeking medical care or seeking traditional health care) or is it that the incidence and prevalence of RTIs have increased?
3. Are there differences in the above for different groups of women, for example by demographic characteristics such as age, marital status and parity; and by social class, race, ethnicity and place of residence?

What kind of evidence would answer these questions?
The kind of evidence that will answer these questions includes:

- the number of women presenting with symptoms of RTIs at this health centre each month, starting with the present and going back several months (if possible, one or two years)
- the health seeking behaviour of women with RTIs – looking at current as well as past episodes of RTIs
- the reasons for changes in health seeking behaviour (if relevant)
- it may be important to look for data on different groups of women: for example by demographic characteristics such as age, marital status and parity; and by social class, race, ethnicity and place of residence.

What existing evidence will answer these questions?
The first question may be answered with existing evidence – data from the health records of the health centre.

What type of new evidence is needed?
To answer the second question, new evidence is needed.

Step 4: Study design

Proceed to a brief input on study design.

The study design is determined by:

- the state of knowledge of the problem
- the type of research questions.

Put up the **overhead** of this table and explain the different types of study designs. (Refer to Handout 1 for more information on study designs.)

Overview of study designs

State of knowledge	Type of research question	Type of study design
Knowing that a problem exists, but knowing little about its characteristics	What is the nature of the problem? What is the magnitude? Who is affected? How do affected people behave? How do affected people perceive the problem?	Descriptive, quantitative and/or qualitative
Suspecting that certain factors contribute to the problem	Are certain factors associated with the problem? What are the processes through which these factors contribute to the problem?	Analytical, quantitative Qualitative
We know that certain factors are associated with the problem. We want to establish the extent to which a particular factor causes or contributes to the problem	What is the cause of the problem? Will the removal/addition of a particular factor reduce the problem? (e.g. stopping smoking/introducing iron supplementation)	Experimental or quasi-experimental Experimental or quasi-experimental: quantitative and/or qualitative
We have sufficient knowledge about cause to develop an intervention that would prevent, control, or solve the problem	What is the effect of the particular intervention? (e.g. a training programme, treatment with a new drug)	

Source: Varkevisser CM et al. *Designing and conducting health systems research projects.* International Development Research Centre Canada. Health Systems Research Training Series, volume 2, part 1. Ottawa, IDRC, 1991:118.

Different types of studies

A descriptive study involves the systematic collection and/or presentation of data to give a clear picture of a particular situation.

An analytical study attempts to establish cause or risk factors for certain problems. This is done by comparing two or more groups, some of which have or develop the problem and some of which do not.

In an experimental study women and men are randomly allocated to at least two groups. One group is subjected to an intervention while the other group(s) is not. The effect of the intervention on the problem is determined by comparing the two groups. For example, women with iron deficiency anaemia are assigned to two groups, one given iron supplementation and the other not. The group which has experienced the intervention is called the experimental group, and the second group is called the control group. After a certain time period, the anaemia status of both groups of women is checked again, and the effect of iron supplementation is ascertained. In the example above, when the assignment to the two groups is not random but one group has experienced an intervention and the other group has not, the study design is called quasi-experimental.

A pre-experimental study: If instead of comparing two groups, the same group is studied before and after the intervention, this is called a before-and-after (or pre-experimental) study. It is important to note that in large scale studies there are many factors besides the intervention itself that can impact on the outcome, and therefore data should be interpreted with caution. It is always advisable to use a control group wherever feasible.

Qualitative: When questions such as perceptions of the problem, ways in which it is experienced by those affected, and the processes through which various factors impact upon a problem are being addressed, the study design used is qualitative.

In the example of the RTI study we have been considering, to answer questions regarding the health seeking behaviour of women and reasons for changes, if any, the study design we would choose is descriptive and could involve both a quantitative and a qualitative component. This is because the research question aims to understand more about the nature of the problem.

Note: These are only examples of possible study designs for various kinds of research problems. There are no hard and fast rules. It is most important to ensure that the study design will address the research objectives.

Step 5: The study population

The next step after the study design is to select the study population. The study population is the group of people or units from which we draw our sample. It must be defined precisely in terms of age, sex, time, and so on. The study unit is each unit of the sample selected from the study population.

Overhead Illustrate with a few examples:

Research questions, the study population and the study unit

Research question	Study population	Study unit
Is malnutrition related to weaning in district X?	All children aged 6–24 months in district X	One child aged 6–24 months in district X
What happened to women who had abnormal pap smears in hospital Y in 1999?	Patient files of all women who had an abnormal pap smear in hospital Y in 1999	One file of a patient with an abnormal pap smear in hospital Y in 1999
What is the sexual experience among 9th graders at school Z?	All grade 9 students at school Z	One grade 9 student at school Z

Going back to the RTI study example, the study population would consist of all women presenting at the rural health centre with symptoms of RTIs during a specified time period. Symptoms of RTIs would have to be defined, and the study population specified in terms of "women presenting in health centre A, during month B, with symptoms a, b or c".

The sample must be representative of the study population, and the sample size must be determined scientifically to make sure that the evidence is valid and generalizable. (Note that this session will not go into details of sampling.)

The best way of making sure that the sample represents the population is when each person in the wider population has a known and equal chance of being selected into the study. This is called random sampling, and it means that people were selected on the basis of chance.

Deciding whether a study population was big enough to generate meaningful evidence is not easy, but look to see whether the investigators based their design on a "sample size" calculation. When attempting to plan new studies, get advice on determining the correct sample size, as many studies are too small to generate reliable or useful results.

How generalizable is the evidence?

When reviewing evidence, always ask whether the sampling scheme that was chosen for the study allows you to generalize the results to the group you are concerned with.

If the evidence was gathered in another country, in a different type of health service or social setting, is there any reason to think the evidence may not apply to the group you are concerned with?

In the past, many United States clinical trials were conducted on men, because women's monthly cycles were thought to make drug studies more difficult. Data on new drug effects were generalized to women, despite the fact that no women had been sampled.

United States federal legislation passed in the late eighties made it mandatory that both women and men be included in the study of any drugs that both sexes might use.

Step 6: Integrating a gender and rights perspective into health research

Integrating a gender and rights perspective means incorporating the following concerns, even at the stage of setting the research agenda:

- In what ways are rights being promoted and how are women or men likely to benefit from this research?
- Are there gender barriers that will introduce bias, or otherwise interfere with the objective outcome(s) of this research?
- Are there any rights that are likely to be violated when conducting this research?

In the RTI example, gender and rights awareness is reflected in the recognition, when framing the research question, that women may not always access medical care even when they have problems. Hence, an unbiased study of women's health seeking for RTIs will have to account for gender/power differences in women's lives. Research methods (specifically data collection) would ensure that women in the study population feel comfortable and are able to articulate their responses – for example, by engaging female interviewers, ensuring privacy and confidentiality, allowing for open-ended responses, using local terminology for symptoms, and so on. The analysis and interpretation of results will also bear in mind how gender and rights impact on RTIs. For example, is a recurrence of infection related to non-use of condoms? Would this be related to women's employment or educational status (used as an indicator of women's status)?

Refer participants back to Session 3 of the Rights Module, which examined the rights implications of public health policies and programmes.

Remind participants also of Session 5 of the Gender Module, where we did a gender analysis of health problems. Gendered health research would, wherever relevant, ask questions about whether and how gender impacts on the health problem in question.

Put up the following **overhead.**

Some main points from the Gender Module, Session 5: Linking gender and health

Questions to ask about the role of gender in a specific health problem

For health problems affecting women and men:

- Are there different risk factors for women and men?
- Do the roles society prescribes for women and men account for differences in the risk factors?
- What are the barriers/obstacles to obtaining treatment for the condition? Are the barriers different for women and men?
- Are there differences for women and men in the severity of consequences? What accounts for these differences?
- Are there different responses from the health sector?
- Are there different responses from society at large?

For health problems which are sex-specific:

- Are the risk factors related to gender roles and or norms?
- Are barriers to obtaining treatment, health seeking behaviour, severity of consequences, responses from the health sector and from the society influenced by the role society prescribes for men and women?

Questions to ask about rights:

- Consider every right that may be violated or promoted by this intervention
- Think through how exactly the right is being impacted upon in the short term as well as in the long term.

40 mins

Activity 2: Discussion about research problems

Distribute Handout 2 and put it up as an **overhead.**

Read each problem aloud, and ask for responses to the following questions:

- What is/are the research questions?
- What existing evidence would answer these?
- What type of new evidence do you need?
- What kind of research methodology is needed?
- Who/what would the study population be?
- How will gender/rights issues be addressed in this study?

Questions for undertaking research

Write out responses to each of these questions on a flip chart(s) in table form:

What is/are the research questions?	What existing evidence would answer these?	What type of new evidence do you need?	What kind of research methodology is needed?	Who/what would be the study population?	How will gender and rights be addressed in the study?

What to cover in the discussion on Problem 1 in Handout 2

The research questions

- Has the number of newborns of very low birth weight increased?
- If yes, is this increase in the proportion of deliveries which result in the birth of infants of very low birth weight? Or is the increase in numbers the reflection of an increase in the number of deliveries (the proportion is the same)?
- Is there a difference in the social and economic status of women delivering low birth weight babies, and women delivering babies of normal birth weight?

Definitions

We would have to define what we mean by "very low birth weight", specifying this as below xxx grams at birth (usually 1500 grams), and the "socio-economic status" in terms of number of years of education, income levels, and so on.

What kind of evidence is needed?

- the number of live births in this hospital, starting from the present and going back a few years
- the number of live births with a birth weight below 1500 grams during the same period
- the socio-economic status of the mothers.

Most of the information above may be available from hospital records. In that case, no new data collection is needed.

Study design

The study design to be used here is descriptive and quantitative.

Sample

The sample population consists of hospital records of deliveries in that hospital for the past x years. The sample unit is one record of a delivery.

Our gender and rights perspective

How would we bring a gender and rights perspective to this study? One way would be to reframe the question on the characteristics of women giving birth to infants of low birth weight to include not the income level of the household but an indicator of the woman's access to resources, as well as her education and other factors associated with gender based discrimination. Also, because of the known relationship between maternal health and nutritional status and low birth weight of infants, and because there are gendered differences in women's health and nutritional status, these could also be included as factors to examine. There is also evidence of an association between domestic violence and low birth weight which could be explored. Other confounding variables such as smoking and substance abuse will also need to be examined.

Main points for closing this session

Precision

Identifying sound research objectives needs you to clearly specify the research question you want to address. You must generate a precise list of the types of evidence needed to answer that question. There is a temptation to ask questions that are vague, or to have many objectives for one study. The correct research design is more likely to be chosen if the objectives are clear, and expressed in measurable terms.

Don't overlook potential evidence

Evidence is often at hand, and overlooked (Problems 1 and 4). For example, examining the duty rota for students for the past month or two to see if there are systematic patterns by gender may provide the hard evidence needed to establish whether or not women students are indeed being given extra menial duties, and being made to do the most demanding work.

A range of techniques

Operations research (Problem 2) includes a wide array of techniques for determining what is actually going on in a service. Mystery clients, observations, and exit interviews with clients can all provide insights into client-provider interactions. Focus group discussions can quickly draw

out public fears and perceptions about services and products (see Session 7, Handout 4). Provider biases, if they are widespread, require gathering evidence on their sources of information (training, information-education and communication) and commodity suppliers.

Good baseline data

Collecting impact data (Problem 3) requires generating good, representative baseline data before the intervention. If the overall case load in the service is high, baseline cases over one to two months may be adequate, but a low case load in the baseline period will make it harder to detect a positive change after the intervention (even if it is real!).

The impact of outside factors

When measuring the impact of interventions (Problem 3), it is necessary to anticipate other factors that could change your outcome measure (in this case, STI rates) during the intervention period (for example, an increase in truck stop sex trade, a seasonal return of urban workers, and so on). These should be monitored during the study to ensure that outside events don't interfere with your ability to measure changes. (Refer to the note on before-and-after studies in Handout 1.)

Session developed by Nana Kgosidintsi, Rachel Snow and Khin San Tint

Handout

1 Study designs

Study designs from Varkevisser C. M. et al. *Designing and conducting health systems research projects.* International Development Research Centre Canada. Health Systems Research Training Series, volume 2, Part 1. Ottawa, IDRC, 1991:118-129.

1. Introduction

Depending on the existing state of knowledge about a problem that is being studied, different types of questions may be asked that require different study designs. Some examples are given in Table 9.1.

Table 9.1. Research questions and study designs

State of knowledge of the problem	Type of research questions	Type of study design
Knowing that a problem exists, but knowing little about its characteristics or possible causes	What is the nature/magnitude of the problem? Who is affected? How do the affected people behave? What do they know, believe, think about the problem?	Exploratory studies or descriptive studies: Descriptive case studies Cross-sectional surveys
Suspecting that certain factors contribute to the problem	Are certain factors indeed associated with the problem? (e.g., is lack of preschool education related to low school performance? Is low fibre diet related to carcinoma of the large intestine?)	Analytical (comparative) studies: Cross-sectional comparative studies Case-control studies Cohort studies
Having established that certain factors are associated with the problem; desiring to establish the extent to which a particular factor causes or contributes to the problem	What is the cause of the problem? Experimental or will the removal of a particular factor prevent or reduce the problem? (e.g., stopping smoking, providing safe water)	Cohort studies Quasiexperimental study designs
Having sufficient knowledge about cause to develop and assess an intervention that would prevent, control, or solve the problem	What is the effect of a particular intervention/strategy? (e.g., treating with a particular drug, being exposed to a certain type of health education) Which of two alternative strategies gives better results? Are the results in proportion to time/money spent?	Experimental or quasiexperimental study designs

The type of study design chosen depends on:

- **The type of problem,**
- **The knowledge already available about the problem, and**
- **The resources available for the study.**

When investigating health-management problems, such as overcrowding in a hospital out-patient department or shortage of drugs at PHC level, a good description of the problem and identification of major contributing factors often provides enough information to take action.

When exploring more complicated management problems and many health problems, we usually want to go further and determine the extent to which one or several independent variables contributes to the problem (for example, the contribution of low-fibre diet to cancer of the large intestine). For these types of problems, more rigorous analytical or quasi-experimental studies will have to be conducted before we decide on appropriate interventions.

2. Overview of study types

Several classifications of study types are possible, depending on what research strategies are used. Usually a combination of research strategies is used, including:

- **Nonintervention studies** in which the researcher just describes and analyzes researchable objects or situations but does not intervene; and
- **Intervention studies** in which the researcher manipulates objects or situations and measures the outcome of his manipulations (e.g. by implementing intensive health education and measuring the improvement in immunization rates).

Nonintervention studies

We will first concentrate on nonintervention studies and their use in Health Systems Research. We will discuss:

- Exploratory studies,
- Descriptive studies, and
- Comparative (analytical) studies.

1. Exploratory studies

An EXPLORATORY STUDY is a small-scale study of relatively short duration, which is carried out when little is known about a situation or a problem.

For example A national Acquired Immunodeficiency Syndrome (AIDS) control program wishes to establish counseling services for Human Immunodeficiency Virus (HIV) positive and AIDS patients, but lacks information on specific needs patients have for support. To explore these needs, a number of in-depth interviews are held with various categories of patients (males, females, married, single) and with some counsellors working on a program that is already under way.

When doing exploratory studies we **describe** the needs of various categories of patients and the possibilities for action. We may want to go further and try to explain the differences we observe (e.g., in the needs of male and female AIDS patients) or to identify causes of problems. Then we will need to **compare** groups.

Note Comparison is a fundamental research strategy to identify variables that help explain why one group of persons or objects differs from another.

In Health Systems Research, **small-scale studies that compare extreme groups** are very useful for detecting management problems. We could, for example, compare:

- Two health centres that are functioning well and two that do not function satisfactorily to detect the possible reasons for bottlenecks in the functioning of the peripheral services;
- One community with high and another with low participation in health activities to identify factors that contribute to community participation;
- 40 mothers who delivered in a maternity ward and 40 who delivered at home to find reasons for the low percentage of supervised deliveries.

Exploratory studies gain in explanatory value if we **approach the problem from different angles at the same time.** In the study that is looking for causes of the low percentage of supervised deliveries, it may be very useful to include observations and interviews with health staff in the maternity centres that should serve the mothers in question and interviews with their supervisors, as well as with the mothers themselves. In this manner, **information from different independent sources can be cross-checked.**

For some management problems, such a "rapid appraisal" may provide sufficient information to take action. Otherwise, a larger, more rigorous comparative study will have to be developed to test differences between groups with respect to various independent variables.

Note If the problem and its contributing factors are not well defined (see Module 8 group work) it is **always advisable** to do an **exploratory study** before embarking on a large-scale descriptive or comparative study.

2. Descriptive studies

A DESCRIPTIVE STUDY involves the systematic collection and presentation of data to give a clear picture of a particular situation.

Descriptive studies can be carried out on a small or large scale.

Descriptive case studies describe in-depth the characteristics of one or a limited number of "cases." A case may be, for example, a patient, a health centre, or a village. Such a study can provide useful insight into a problem. Case studies are common in social sciences, management sciences, and clinical medicine. For example, in clinical medicine the characteristics of a hitherto unrecognized illness may be documented as a case study. This is often the first step toward building up a clinical picture of that illness. Descriptive case studies that lead to the construction of theories may be very time consuming. If they are of short duration, you may as well call them explanatory studies.

However, if one wishes to test whether the findings pertain to a larger population, a more extensive, cross-sectional survey has to be designed.

Cross-sectional surveys aim at quantifying the distribution of certain variables in a study population at one point of time. They may cover, for example:

- **Physical characteristics** of people, materials, or the environment, as in
  - prevalence surveys (of bilharzia, leprosy), or
  - evaluation of coverage (of immunization, latrines, etc,),
- **Socioeconomic characteristics** of people, such as their age, education, marital status, number of children, and income,
- The **behaviour** of people and the **knowledge, attitudes, beliefs, and opinions** that may help to explain that behaviour (KAP studies), or
- **Events** that occurred in the population.

Cross-sectional surveys cover a sample of the population. If a cross-sectional study covers the total population it is called a **census.**

A cross-sectional survey may be repeated to measure changes over time in the characteristics that were studied.

The surveys may be very **large,** with hundreds or even thousands of study units. In these cases only a **limited number of variables** will usually be included, to avoid problems with analysis and report writing. If cross-sectional surveys are **smaller** they can be **more complex.** They may include all the elements just mentioned. Small surveys can reveal interesting associations between certain variables, e.g., between having leprosy and socioeconomic status, sex, and education.

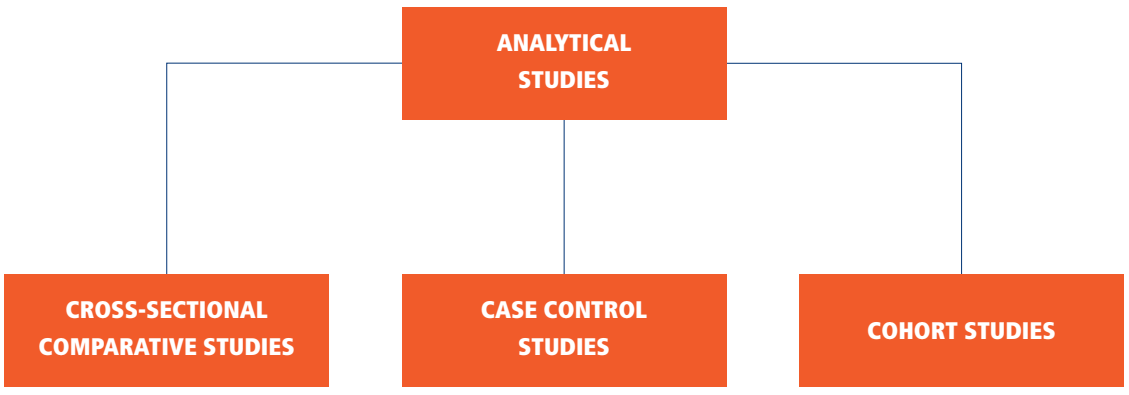
Researchers often go further and will combine a DESCRIPTION of the study population with a COMPARISON of a number of groups within that population (see below). Such combinations are very common and thus the distinctions between descriptive and comparative studies are sometimes quite fuzzy.

3. Comparative or analytical studies

*An ANALYTICAL STUDY attempts to establish **causes or risk factors** for certain problems. This is done by comparing two or more groups some of which have or develop the problem and some of which have not.*

Three commonly used types of analytical studies are discussed here.

Figure 9.1. Types of analytical studies



Cross-sectional comparative studies

Many cross-sectional surveys focus on comparing as well as describing groups.

For example A survey on malnutrition may wish to establish:

- The percentage of malnourished children in a certain population;
- Socioeconomic, physical, political variables that influence the availability of food;
- Feeding practices; and
- The knowledge, beliefs, and opinions that influence these practices.

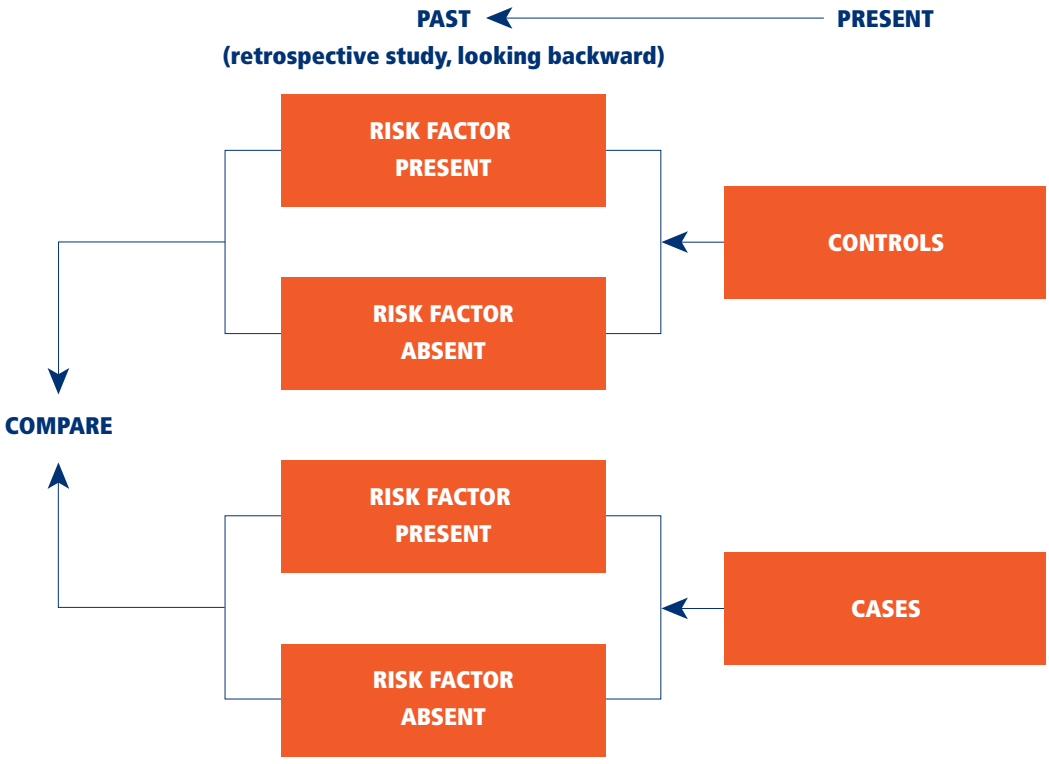
1. The researcher will not only describe these variables but, by comparing malnourished and well nourished children, he or she will try to determine which socioeconomic, behavioural, and other independent variables have contributed to malnutrition.

In any comparative study, one has to watch out for confounding or intervening variables. (Please refer to Module 8 for examples and discussion.)

Case-control studies

In a CASE-CONTROL STUDY, the investigator compares one group among whom a problem is present (e.g. malnutrition) with another group, called a control or comparison group, where the problem is absent to find out what factors have contributed to the problem.

Figure 9.2. Diagram of a case control study



Adapted from Holland, W.W. et al. 1985. *Oxford textbook of public health, volume 3: invesetigative methods in public health.* Oxford University Press, Oxford, England.

For example In a study of the causes of neonatal death the investigator first selects his "cases" (children who died within the first month of life) and "controls" (children who survived their first month of life). He then interviews their mothers to compare the history of these two groups of children, to determine whether certain risk factors are more prevalent among the children who died than among those who survived.

As with a cross-sectional comparative study, the researcher has to control for **confounding variables.** In case-control studies, this may be done to some extent beforehand, by **matching** the groups for expected confounding variables. Matching means taking care that the cases and controls are similar with respect to the distribution of one or more potentially confounding variables.

For example In the study on possible causes of neonatal death we would like to match the mothers for age (as this factor could influence death), as well as for other socioeconomic variables (education, marital status, and economic status). We might select, for each mother of a baby that died within a month after birth, a mother of exactly the same age whose baby did not die. We might also match the groups on environment and select "controls" from the same village as "cases".

Note Although ideally a researcher would like to match the cases and **controls for all variables** except the ones he is testing as risk factors or "causes" for the problem under study, this is in practice impossible, even inadvisable. (You might "match away" variables you are interested in.) Case-control studies, therefore, use stratification as well as matching to control for confounding variables.

Cohort studies

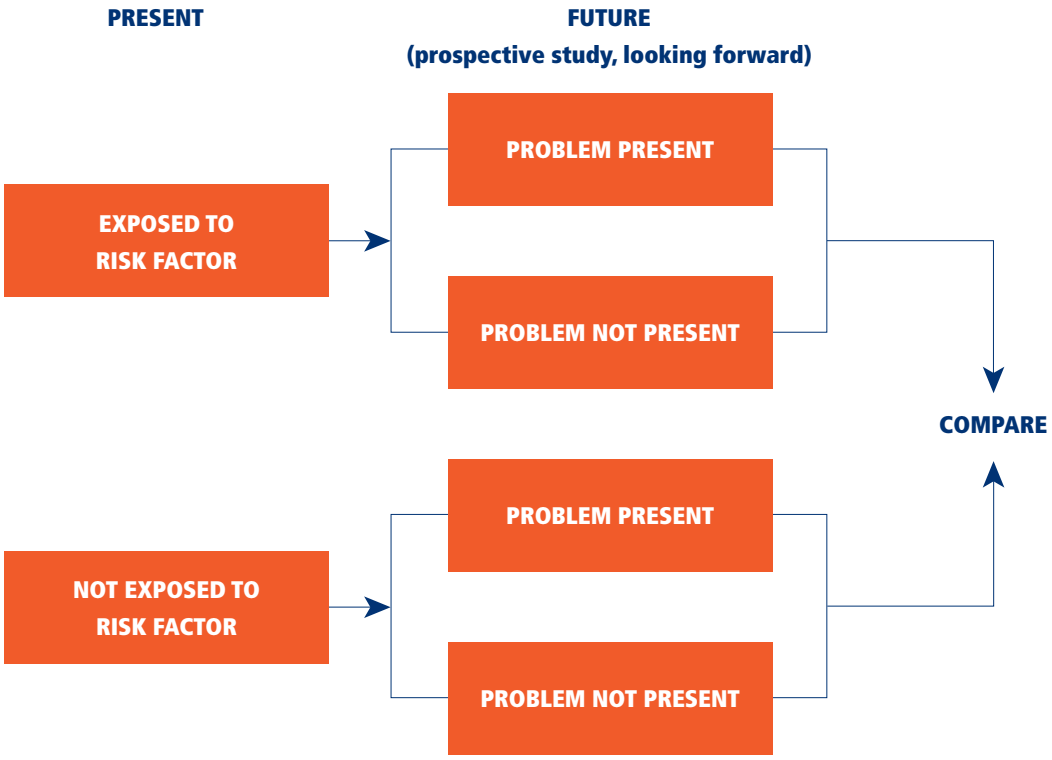
In a COHORT STUDY, a group of individuals that is exposed to a risk factor (study group) is compared with a group of individuals not exposed to the risk factor (control group). The researcher follows both groups over time and compares the occurrence of the problem that he or she expects to be related to the risk factor in the two groups to determine whether a greater proportion of those with the risk factor are indeed affected.

A well known example of a cohort study is the Framingham study of smokers and nonsmokers that was conducted to determine the importance of smoking as a risk factor for developing lung cancer.

A study may start with one large cohort. After the cohort is selected, the researchers may then determine who is exposed to the risk factor (e.g. smoking) and who is not, and follow the two groups over time to determine whether the study group develops a higher prevalence of lung cancer than the control group. If it is not possible to select a cohort and divide it into a study group and a control group, two cohorts may be chosen, one in which the risk factor is present (study group) and one in which it is absent (control group). In all other respects the two groups should be as alike as possible.

The control group should be selected at the same time as the study group, and both should be followed with the same intensity.

Figure 9.3. Diagram of a cohort study



Adapted from Holland et al. 1985.

Uses and limitations of different types of analytical studies

You may use any of the three types of analytical studies (cross-sectional comparison, case-control, or cohort) to investigate possible causes of a problem.

For example If you assume there is a causal relationship between the use of a certain water source and the incidence of diarrhea among children under 5 years of age in a village with different water sources:

- You can select a group of children under 5 years and check at regular intervals (e.g. every 2 weeks) whether the children have had diarrhea and how serious it was. Children using the suspected source and those using other sources of water supply will be compared with regard to the incidence of diarrhea (cohort study).
- You can also conduct a case-control study. For example, you may compare children who present themselves at a health centre with diarrhea (cases) during a particular period of time with children presenting themselves with other complaints of roughly the same severity, for example acute respiratory infections (controls) during the same time, and determine which source of drinking water they had used.
- In a cross-sectional comparative study, you could interview mothers to determine how often their children have had diarrhea during, for example, the past month, obtain information on their source of drinking water, and compare the source of drinking water of children who did and did not have diarrhea.

Cross-sectional comparative studies or case-control studies are usually preferred to cohort studies for financial and practical reasons.

Cross-sectional comparative studies and case-control studies are relatively quick and inexpensive to undertake. With cross-sectional comparative studies, however, the number of stratifications one can make is limited by the size of the study. The major problem with case-control studies is the selection of appropriate control groups. The matching of cases and controls has to be done with care. Cohort studies are the only sure way to establish causal relationships. However, they take longer than case-control studies and are labour intensive and, therefore, expensive. The major problems are usually related to the identification of all cases in a study population especially if the problem has a low incidence, and to the inability to follow up all persons included in the study over a number of years because of population movement.

Intervention studies

In intervention studies, the researcher manipulates a situation and measures the effects of this manipulation. Usually (but not always) two groups are compared, one in which the intervention takes place (e.g. treatment with a certain drug) and another group that remains "untouched" (e.g. treatment with a placebo).

The two categories of intervention studies are:

- experimental studies and
- quasi experimental studies.

1. Experimental studies

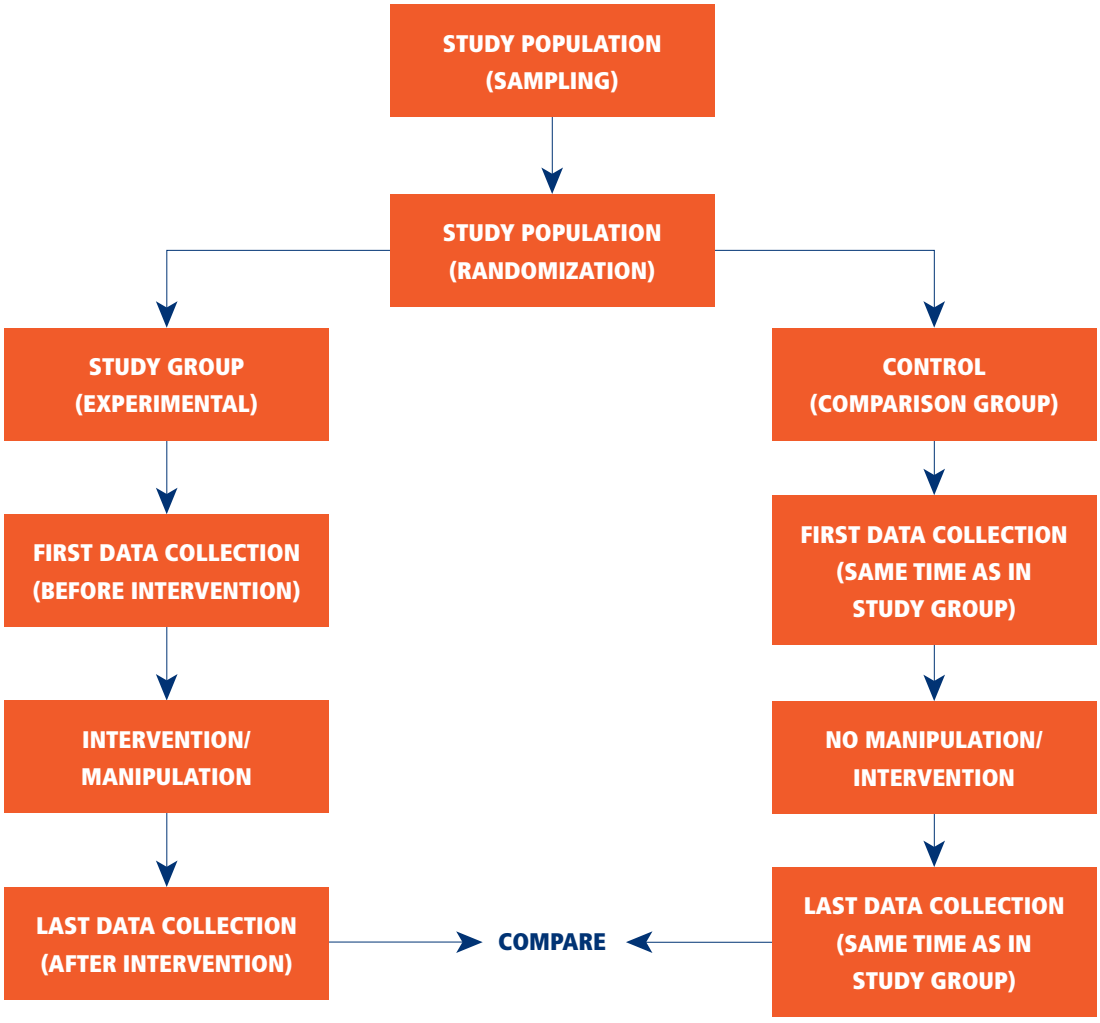
An experimental design is the only type of study design that can actually prove causation.

In an EXPERIMENTAL STUDY, individuals are randomly allocated to at least two groups. One group is subject to an intervention, or experiment, while the other group(s) is not. The outcome of the intervention (effect of the intervention on the dependent variable/problem) is obtained by comparing the two groups.

The classical experimental study design has three characteristics:

- **Manipulation** - the researcher does something to one group of subjects in the study.
- **Control** - the researcher introduces one or more control group(s) to compare with the experimental group.
- **Randomization** - the researcher takes care to randomly assign subjects to the control and experimental groups. (Each subject is given an equal chance of being assigned to either group, e.g., by assigning them numbers and "blindly" selecting the numbers for each group.)

Figure 9.4. Diagram of an experimental study



Note The strength of experimental studies is that by randomization the researcher eliminates the effect of confounding variables.

A number of experimental study designs have been developed. These are widely used in laboratory settings and also in clinical settings. For ethical reasons, the opportunities for experiments involving human subjects are restricted. However, randomized control trials of new drugs are common and this design is often considered for the testing of the efficacy of other interventions. Feasibility as well as ethics must be seriously considered in choosing this design.

For example A researcher plans to study the effect of a new drug. (The drug has already been tested extensively on animals and has been approved for trial use.) He plans to include 300 patients in the study who are currently receiving a standard treatment for the condition that the new drug has been designed to alleviate. He explains the study to the patients asking their consent to be divided into two groups on a random basis. One group will receive the experimental drug while the other group will continue to receive the standard treatment. He makes sure that the medications are disguised and labelled in such a manner that neither the research assistant administering

them nor the patient knows which drug is used. (This is called a "double blind" experiment.)

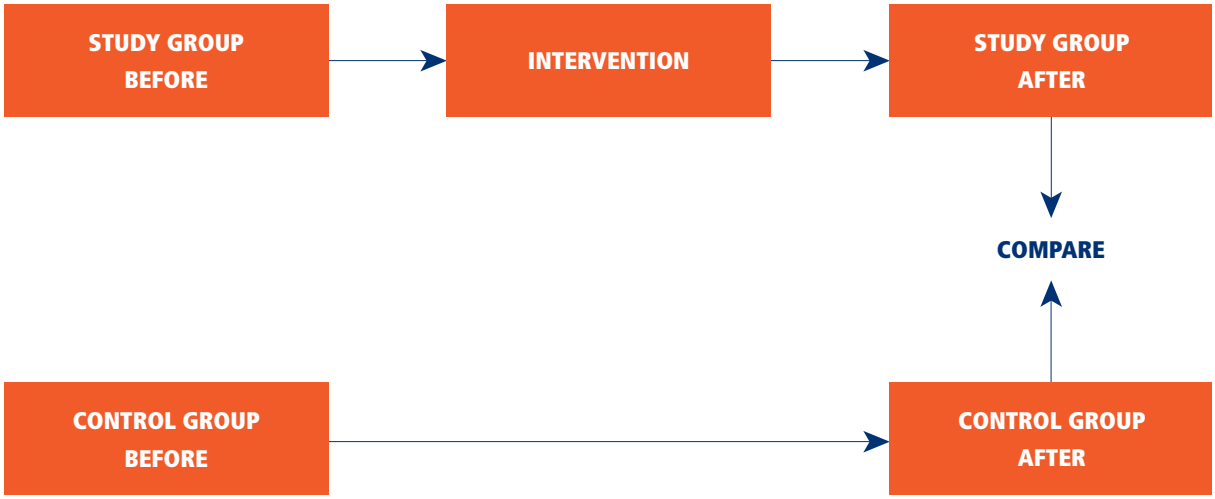
At community level, where Health Systems Research is frequently undertaken, we experience not only ethical but also practical problems in carrying out experimental studies. In real life settings, it is often impossible to assign persons at random to two groups, or to maintain a control group. Therefore, experimental research designs may have to be replaced by quasi experimental designs.

2. Quasi experimental studies

In a QUASI EXPERIMENTAL STUDY, at least one characteristic of a true experiment is missing, either randomization or the use of a separate control group. A quasiexperimental study, however, always includes manipulation of an independent variable that serves as the intervention.

One of the most common quasiexperimental designs uses two (or more) groups, one of which serves as a control group in which no intervention takes place. Both groups are observed before as well as after the intervention, to test if the intervention has made any difference. The subjects in the two groups (study and control groups) have not been randomly assigned.

Figure 9.5. Diagram of a quasi experimental design with two groups

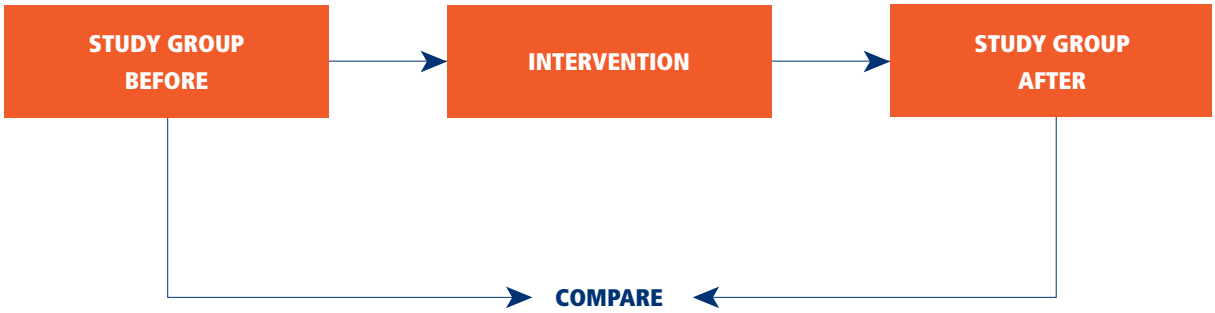


Example of a quasi experimental study

A researcher plans to study the effects of health education on the level of participation of a village population in an immunization campaign. She decides to select one village in which health education sessions on immunization will be given and another village that will not receive health education to serve as a control. The immunization campaign will be carried out in the same manner in both villages. A survey will then be undertaken to determine if immunization coverage in the village where health education was introduced before the campaign is significantly different from coverage in the "control" village which did not receive health education. (Note: The study is quasi experimental because the subjects were not assigned to the control or experimental groups on a random basis.)

Another type of design that is often chosen because it is quite easy to set up uses only one group in which an intervention is carried out. The situation is analyzed before and after the intervention to test if there is any difference in the observed problem. This is called a "before-after" study. This design is considered a "pre-experimental" design rather than quasi experimental, because it involves neither randomization nor the use of a control group.

Figure 9.6. Diagram of a before-after study



Example of a before-after study

The outpatient clinic of hospital X is extremely crowded. Waiting times of over 5 hours for patients before they are attended to are not uncommon. The hospital management has a study carried out to analyze the bottlenecks and implements most of the recommendations made. Three months later, another study is done to check to what extent the bottlenecks have been solved and where further action is necessary.

This design is often used for management problems that pertain to one single unit (hospital, school, village). However, if the problems occur at a larger scale or if they might be influenced by other factors apart from the intervention during the trial, it is highly recommended that the design include both a study and a control group.

In the trial with health education on immunization, for example, K would have been quite risky to work without a control group. Outside events (such as a health education campaign on immunization by radio or other mass media) might have led to improved knowledge on immunization in both the study group and the control group. (Note: The immunization campaign by radio provides a so-called "rival explanation" for your results.) If you had had just a study group and no control, you might have concluded erroneously that all of the increase was due to your own intervention.

Handout

2 Examples of problems addressed by health research

Problem 1

In a large tertiary obstetric service the health professionals suspect that the number of newborns of very low birth weight is increasing. The service wants to know if this is true, and if so to have a better understanding of the social and economic situation of the women who are delivering low birth weight babies. How can you answer these questions?

Problem 2

The state family planning service supplies free oral pills, IUDs, injections, condoms and both male and female sterilization. However, even though overall contraceptive use is at 40 per cent, almost 90 per cent of new users in the last 24 months have taken IUDs. You suspect there may be extensive provider bias, incentives or rumours that are leading so many clients to take one method. How can you determine what is going on?

Problem 3

You are about to introduce a new counselling service for men in your STD clinics, which focuses on preventive behaviours, especially the use of condoms. This is a pilot project. The new service has cost a lot, and in order to justify its expense you will need evidence demonstrating whether the new service has any positive health impact. How can you generate the evidence to evaluate the new service?

Problem 4

You are appointed dean of the medical faculty. After a year you notice that the female medical students seem to do well in the classroom, but quickly fall to the bottom of the class once clinical work begins. In a given month, three women students complain to you that the hospital staff creates obstacles for women students by giving them extra menial duties, appointing them to do the most demanding work, and even humiliating them during open rounds. After two days observing in the hospital, you agree this seems to be the case. What kind of evidence may help you address this problem?

SESSION 3

Ethical issues in reproductive health research

What participants should get out of the session

Participants will:

- be acquainted with the principles of ethics in research, focusing on reproductive health
- have an overview of international ethical guidelines for conducting research
- have debated key ethical dilemmas in reproductive health research from a gender perspective.

2 hours and 30 minutes

Materials

- Lecture notes for the facilitator: "Ethical issues in reproductive health research"
- Handout: "Ethical and appropriate research"

- overheads or Powerpoint presentation based on Lecture notes for the facilitator
- overhead: "Ethics and human rights", on p.246
- 8 pieces of paper for the debate: 4 marked "For quinacrine research" and 4 marked "Against quinacrine research"; some blank pieces of paper, following instructions on p.246

Readings for the facilitator

1. Council for International Organizations of Medical Sciences (CIOMS). *International ethical guidelines for biomedical research involving human subjects.* Geneva, CIOMS, 1993. Available online at: www.who.int/dsa/cat98/ethic8.htm#International Ethical Guidelines for Biomedical Research Involving Human Subjects

Readings for the participants

1. Berer M. The quinacrine controversy continues. *Reproductive Health Matters,* 1995, **6:**142–146.

2. Pollack AE, Carigan CS. The use of quinacrine pellets for non-surgical female sterilization. *Reproductive Health Matters,* 1993, **2:**119–120.

How to run the session

This session consists of a presentation on ethical principles in research and the current international guidelines that govern research, particularly in reproductive health. It also includes gender guidelines for conducting research. This is followed by a debate on the ethics of a controversial reproductive health research issue, where you ask participants to take positions and defend them. In this manual, the case of testing quinacrine is used, but another topic may be used, as long as there are clear arguments both for and against the issue, with adequate information to support both positions, but where the ethics of the intervention can be questioned. The debate is followed by a discussion which should link the issues raised in the debate with the ethical and gender guidelines.

Give the handout to participants the day before and instruct them to go through the readings for this session which are in their Course Files. This will allow them some time for becoming familiar with the issues.

Activity 1: Introducing ethical principles

This is an interactive input session. Ensure that the concepts – which can seem quite theoretical – are clear to everyone. Encourage discussion on key points by asking participants for concrete examples.

Step 1: Your lecture

Prepare and present a lecture (aided by Powerpoint or **overheads**) containing the key points in the lecture notes, including:

- background to the development of universal ethical principles and standards
- key ethical principles elaborated in the Declaration of Helsinki: respect for persons, beneficence and justice
- informed consent as a key issue in medical research
- gender considerations in research.

Step 2: Some questions

Ask participants for examples of research where:

- some of the ethical principles may not be adhered to
- gender equality would not be promoted in health and health care
- it would make a difference whether the researchers are women or men.

10 mins

Step 3: The link between ethics and rights

Put up the following **overhead** and go over its contents.

Ethics and human rights

Source: Mann JM, Medicine and public health, ethics and human rights. In: Mann JM, Gruskin S, Grodin MA, Annas GJ, eds. *Health and human rights: a reader.* New York, Routeledge, 1999:446.

"Ultimately, ethics and human rights derive from a set of quite similar, if not identical, core values … rather than seeing human rights and ethics as conflicting domains, it seems more appropriate to consider a continuum on which human rights is a language most useful for guiding societal-level analysis and work, while ethics is a language most useful for guiding individual behaviour … Thus, public health work requires both ethics applicable to the individual public health practitioner and a human rights framework to guide public health in its societal analysis and response."

The presentation and discussion are used as a basis for the debate that will follow, where participants can put this theory into practice.

1 hr 15 mins

Activity 2: The debate

10 mins

Step 1: Choosing the teams

Choose a way to appoint eight participants as speakers in the debate, four on each side. This could be done by having each participant choose a piece of folded paper from a hat. Four pieces of paper will be marked "For quinacrine research" and four will be marked "Against quinacrine research". The rest will be blank. The people who draw blank pieces will be the judges. One person (preferably an outsider) should be appointed as the debating arbiter. Give each team copies of the handout.

30 mins

Step 2: The rules of a debate

Ask if anyone can explain the rules of debating. If not, explain that one group of four people will defend the project concerning quinacrine research, and the other group will oppose it, on the basis of the information in the handout. Each group chooses the order of their speakers, each of whom will develop arguments to support the group's position. The first two speakers in each group have five minutes each to lay out their argument, and the second two speakers three minutes each. Speakers from each group alternate, so the groups should anticipate the main arguments that the other group will make in order for subsequent speakers to refute them. They are given a maximum of 30 minutes to prepare. During this time the judges are also given the handout and have an opportunity to discuss it before the debate.

35 mins

Step 3: Start the debate

You should keep strict time. The arbiter starts the process, inviting the first speaker from group 1 (in favour of the project) to begin. Next is the first speaker from group 2. Remember: the first two speakers in each group have five minutes each to lay out their arguments, and the second two speakers three minutes each.

When all eight speakers have presented their arguments, the arbiter then asks the judges to vote in favour of one group or the other. Whichever has the greater number of votes wins the debate.

25 mins

Activity 3: Discussion

Bring the group together again, and ask for a discussion of how the quinacrine research case relates to the ethical principles discussed earlier.

What to cover in the discussion

Respect for persons

Were the subjects going to be given full information about the research (refer to the box "Informed consent" in your lecture notes), such as the purpose, and the procedures? Is any inducement being made? Is there provision for keeping information confidential? Is the study population particularly vulnerable?

Beneficence

Is the scientific data adequate to demonstrate the safety of quinacrine for humans? What are the risks associated with quinacrine? What are the potential benefits? Do the benefits outweigh the risks? Have the previous research results been based on scientifically sound designs? Are there alternatives which are available as good as the proposed procedure?

Justice

What population group is the focus of the research? All categories of women, or only poor women? Is this ethical? Will the potential benefits and risks be distributed equitably at national and international levels?

Gender equity

Does the research address a demonstrated public health need expressed by women and/or men? This may be difficult to answer, but there may be some evidence of women's and men's desires concerning the kinds of contraceptive methods they need. Will the research promote equality between women and men? One way of tackling this question is to ask: would the discussion be the same if this were a method of male sterilization?

Why the proposed quinacrine research is unethical

Demonstrate, through the discussion of these questions, that the proposed quinacrine research is unethical from many points of view:

- The information given to subjects will be inadequate because it is based on flawed research.
- The benefits do not outweigh the risks because the product is suspected to be carcinogenic (cancer-causing).
- There is an (acceptable) alternative – mini-laparotomy, and also vasectomy, which is cheap and easy.
- The population being targeted is poor women, which calls into question the issues of both respect for persons and distributive justice.
- In a situation of high (or growing) HIV prevalence, promotion of female sterilization may take efforts away from promotion of protection against STIs and HIV and be detrimental to women in particular, thus reinforcing gender inequalities.

Session developed by Jane Cottingham

Lecture notes for the facilitator:

Ethical issues in reproductive health research

These notes provide you with the major content of the input in Activity 1 of this session. You may either use it as it is, elaborating on each of the points during discussion, or rework it to focus on the points you consider particularly pertinent to the group you are working with.

Universal ethical principles and standards

The development of universal ethical principles and standards for research began after the atrocities committed by the Nazis during World War II. In 1947, the *Nuremberg Code* was elaborated, to protect subjects of medical research. In 1966 the *International Covenant on Civil and Political Rights* included specific protection in Article 7: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation." The fundamental document in the field of ethics and biomedical research – the *Declaration of Helsinki* – was established in 1964, and all of our current principles guiding medical research are based on that. For instance, the *International ethical guidelines for biomedical research involving human subjects*, prepared by the Council for International Organizations of Medical Sciences (CIOMS) in collaboration with the World Health Organization in 1993 are the main guidelines that WHO uses in conducting reproductive health research.

The key ethical principles elaborated in the *Declaration of Helsinki*

- **Respect for persons**

  This includes two fundamental ethical considerations:

  - respect for autonomy, which requires that those who are capable of deliberation about their personal choices should be treated with respect for their capacity for self-determination

  - protection of persons with impaired or diminished autonomy, which requires that those who are dependent or vulnerable be afforded security against harm or abuse.

- **Beneficence**

  This refers to the ethical obligation to maximize benefits and minimize harms and wrongs. This principle gives rise to norms requiring that the risks of research are reasonable in the light of the expected benefits, that the research design is sound, and that the investigators are competent both to conduct the research and to safeguard the welfare of the research subjects. Beneficence further forbids the deliberate infliction of harm on persons – sometimes called "non-maleficence" (do no harm).

- **Justice**

  This refers to the ethical obligation to treat each person in accordance with what is morally right and proper, to give each person what is due to her or him. In the ethics of research involving human subjects, the principle refers primarily to distributive justice, which requires the equitable distribution of both the burdens and the benefits of participation in research. Differences in distribution of burdens and benefits are justifiable only if they are based on morally relevant distinctions between persons. One such distinction is "vulnerability". This refers to a substantial incapacity to protect one's own interests because of impediments like the inability to give informed consent, lack of alternative means of obtaining medical care or other expensive necessities, or being a junior or subordinate member of a hierarchical group. Accordingly, special provisions must be made for the protection of the rights and welfare of vulnerable persons.

Any of the above principles can be elaborated on in further detail (refer to the CIOMS guidelines). To make the connection with other parts of the course, especially the Health Systems Module (sessions dealing with client-provider interaction and the importance of information), select the issue of informed consent for further elaboration.

Informed consent

Informed consent is an important issue in medical research, particularly in the area of human reproduction. Historically, contraceptive research has raised many questions because of the concern that methods on trial might in fact cause infertility or affect in other ways people's abilities to reproduce, or may have been done without women's awareness or full information.

Informed consent

The key pieces of information needed to ensure that a potential research participant can make an informed decision (informed consent or dissent) are:

- the purpose of the research
- the procedures to be undertaken
- the foreseeable risks or discomforts
- the expected benefits to subjects or others
- appropriate alternatives if any
- how confidentiality will be maintained
- a statement that participation is voluntary and subjects have an option to withdraw at any time
- the availability of medical treatment or compensation in case of injury from participation.

If a research protocol does not demonstrate how this information will be given to research subjects, or if it is subsequently found that subjects did not receive this information, the research (and the research results) can be considered unethical.

Gender considerations

In addition to the ethical questions, a number of gender specific questions need to be considered, especially in relation to reproductive health research. Because women suffer the far greater burden of reproductive ill health, and because women, not men, get pregnant (willingly or not), they are usually the subject of research in reproductive health. This is not the case in other areas of medical research, where women have been notably absent from trials of drugs, for instance, mainly to avoid possible effects on the fetus of women who are pregnant. This has meant, however, that little is known about the possible differences in the effects of drugs (and different dosages) on women as opposed to men. However, because of their greater illiteracy and lack of decision making power (refer to the Gender Module, Session 3), women are frequently in a more vulnerable position than men, particularly in matters related to sexuality and reproduction.

Gender considerations in reproductive health research

These are questions on gender that have been developed by WHO, specifically for use in reproductive health research.

The topic of the research (1): Does the research address a demonstrated public health need and a need expressed by women or men?

Women and men have different reproductive health needs, which are both biologically determined and affected by gender roles. Reproductive ill-health affects women more than men, yet women are less likely to be in a position to have their voices heard concerning their own priorities in health needs. The research proposal should provide evidence that the proposed research responds to women's (or, as appropriate, men's) expressed or felt needs in reproductive health.

The topic of the research (2): Is the research likely to contribute to reducing gender inequities in health and health care?

The principle of gender equity means that the proposed technology or intervention should reduce disparities in health between men and women, and not make them worse. The principle of equity means that those with the greatest need have the greatest claim on resources. The proposal should describe how the proposed research will affect gender equity, and at least demonstrate that it will not increase inequities or inequalities between women and men. It should also discuss the potential constraints on adopting the technology, intervention or behaviour.

The process of research (1): Disseminating results and sharing knowledge

In reproductive health research, where the subjects may often be women, particular plans may need to be developed for ensuring that

the results of the research reach those subjects and the wide community of women. The proposal should present plans for sharing the information produced.

The process of research (2): Sex composition of the research team
Does the nature or topic of the research make it important that the researchers are women rather than men, or vice versa?

Handout

1 Ethical and appropriate research

Note: This case is fictitious, but is based on information from a variety of published sources.

A request for your comments

Your Ministry of Health has been approached by outside researchers to carry out a field trial of quinacrine, a new method of non-surgical female sterilization. The purpose of the study is to assess the acceptability and effectiveness of quinacrine as a non-surgical method of sterilization, among healthy women desiring no more children, in some population groups in your country. The Ministry asks you to give your comments on whether you think the research is appropriate and ethical, and provides you with the following information which has been given to them by the researchers.

The information the ministry gives you

Quinacrine

Quinacrine was developed in the 1920s and used as an anti-malarial drug during the Second World War. Subsequent infection-related uses were for tapeworm infestation, amoebiasis, and giardiasis. It is an effective sclerosing agent that causes inflammation that eventually leads to scar formation. As a method of non-surgical sterilization, it is introduced in pellet form (7 pellets of 26mg each, totalling 252mg) into the fundus of the uterus during the proliferative phase of the menstrual cycle, where it causes local inflammation resulting in tubal occlusion after 6–8 weeks. Introduction is done with an IUD inserter.

Quinacrine is safer than surgical sterilization: no case fatalities for 100 000 quinacrine sterilizations in comparison with the range for surgical sterilization of 2 per 100 000 in industrialized countries to 20 per 100 000 in some developing countries. Major complications are also lower for quinacrine sterilization, reported at a rate of 0.03 per cent compared to 1.7 per cent for laparoscopic sterilization.

In terms of long term complications, being a relatively new method these are not definitely known. Cancer is one concern, but it may take 10–20 years to appear. Oral administration of quinacrine at higher doses and over longer periods than those needed for quinacrine sterilization has not been associated with reports of increased cancer risk.

Background and rationale for the study

Current methods of female sterilization – tubal ligation or laparotomy – are quite invasive and costly in terms of both the training of medical personnel and the equipment needed for carrying out the procedure. The procedure is not 100

per cent effective, and can cause side effects. There is, therefore, a need for a safer method that would require less expertise and less of a technological investment than surgical sterilization. Quinacrine is one such method. Because it has been available on the market for many years for other medical uses, it is extremely cheap (less than $1 per dose of pellets needed for sterilization).

Quinacrine has already been used in over 100 000 women in different parts of the world. No serious complications have occurred and side effects have been moderate and transient. These results might suggest that the product could be introduced into any country without study, but since quinacrine has not up to now been studied in the African context, the investigators feel that it is necessary to study the effectiveness and acceptability of quinacrine specifically in African women. This would also provide an opportunity to accumulate additional data on the effectiveness and side effects of the product, and as a result to design appropriate training materials for health personnel and potential users.

The maternal mortality ratio in South Africa as a whole is 170 per 100 000 live births, but in some parts of the country it is much higher than this. The benefits of a new contraceptive that can raise contraceptive prevalence, and thereby lower maternal mortality, will be especially great in an area of high maternal mortality and low contraceptive prevalence.

The proposed study would recruit subjects from two rural areas and two poor urban areas in the country. The researchers feel that, because of the cheap price and the urgent need for preventing unwanted pregnancies, quinacrine would be a particularly useful method for low income women.

Additional notes given to you by your research assistant

2. It seems that there was a very big study (about 30 000 women) carried out in Vietnam, the results of which were published in *The Lancet* in 1996. However, there was subsequently a public debate about this because of criticism of the study from various quarters, including WHO. First, it seems that only a small sample of the women were followed up, so that there was concern about what had happened to the other women. Second, a WHO Toxicology Panel looked at the data on quinacrine and concluded that, since some animal studies showed that quinacrine might be carcinogenic (cancer-causing), additional toxicological studies were needed before clinical trials of the method in humans should proceed. It recommended formal toxicological studies on the possible carcinogenicity of quinacrine administered into the uterus.

3. Quinacrine has been approved for various medical purposes by the United States Federal Drug Administration, but not as a method of female sterilization through tubal occlusion. In fact approval has not been sought for such use in the United States. As far as we know, no national or international drug authority has given its approval.

4. Some international journals have published articles indicating a lack of good scientific evidence that quinacrine is safe for use as a female sterilizing agent. Attached are two such articles. (See the readings for this session.)

SESSION 4

Evidence for planning: reconciling evidence from different sources (Case: maternal health)

What participants should get out of the session

Participants will:

- recognize that research results reflect what question was asked, how the evidence was gathered, and from whom it was solicited
- understand the need to reconcile evidence from different sources for sound decision making
- be able to identify gender bias in the collection, analysis, interpretation and presentation of health information.

2 hrs 20 mins

2 hours and 20 minutes

Prior preparation

- Participants have to be assigned readings on the day before this session is run, as explained in Activity 1, p.256. They will read their articles individually in the evening, in preparation for the session.

Materials

- Handout: "Instructions for group work on maternal health"
- flip chart: "Conclusions from readings on maternal health", based on table on p.257
- blank overheads

Readings for the participants

1. Jejeebhoy SJ. Safe motherhood: empower women, ensure choices. Paper presented to the 10th Anniversary of Safe Motherhood in Sri Lanka 1997. Concluding section (unpublished document). Available online at: www.who.int/archives/ whday/en/pages1998/whd98_03.html

2. Rooney C. *Antenatal care and maternal health: how effective is it?*. Geneva, World Health Organization, 1992.

3. Spies CA et al. Maternal deaths in Bloemfontein, South Africa 1986–1992. *South African Medical Journal* 1995, **85:**753–755.

4. Women's Health Project. *Provision of maternal and neonatal services for the PWV province.* Johannesburg, Women's Health Project, 1994, Introduction and Chapter 4.

How to run the session

There are three activities. The first is an individual activity in which participants read a research report on maternal health in an evening, out of class hours. The second is a group activity where participants discuss the main findings of the article and prepare a group report identifying recommendations for an intervention based on the evidence they have. The third activity is a report-back from the groups followed by a discussion in the whole group.

Activity 1: A specific health problem

This activity has to be introduced to participants on the day before you do Session 4. Schedule about 10 minutes for this. Divide the class into four groups. Give each group one of the four readings listed above, which all look at how to improve on a particular health problem: maternal health. The different readings refer to different types of studies on maternal health, different data sources used, and how this leads to different recommendations. You may select readings addressing any other reproductive health problem from different angles.

40 mins

Activity 2: Recommendations

Explain the objectives of this session. Then ask participants to gather into their four groups. Each group has two tasks.

The first is to examine the report or article they have read and identify how gender has been addressed in the collection, analysis, interpretation and presentation of information.

The second task is for each group to consolidate their responses on the main findings of the article or report and come up with recommendations for action by health service planners to improve maternal health.

Distribute the handout "Instructions for group work on maternal health".

Groups will have about 30 minutes to complete their tasks and come back to the big group. Emphasize that the groups have to come up with recommendations for interventions. They should base their recommendations on what they have read, but not just reproduce the authors' recommendations.

1 hr 40 mins

Activity 3: Reporting back and reaching conclusions

1 hr

Step 1: Report-backs Call the groups into the big group and allow each group 10 minutes to present their reports. Encourage the listeners to question the justification for the recommendations. Allow five minutes per group for questions and answers.

Step 2: Writing up conclusions As groups make their presentations, write the main conclusions emerging from the reports in a table on a flip chart. The following table is an illustration.

Example of conclusions from readings on maternal health

Article or report	Discipline	Data source	Findings	Gender addressed?	Recommendations
Antenatal care and maternal health	Epidemiology	Published and unpublished studies	Effectiveness of antenatal care in preventing maternal mortality is questionable, especially in developing countries	No	Need more research, both epidemiological and operational, which identifies interventions that are known to be effective in developing country settings
Maternal deaths in Bloemfontein	Medicine	Case reports of 91 maternal deaths in a tertiary hospital	Maternal mortality ratio (MMR) for the institution was 171 per 100 000 live births. 71 per cent of the deaths were from direct obstetric causes. 35 per cent of deaths could have been prevented	No	Improve obstetric care in, and institute early referrals from, hospitals which refer complications
Safe motherhood	Social sciences	Published and unpublished reports and studies	Empowerment of women is an important factor in realizing safe motherhood	Yes, in the analysis, interpretation and presentation of information reviewed	Empowerment of women and expansion of women's choices should form a core element of safe motherhood interventions
Provision of maternal and neonatal services	Social sciences	Discussions with women who had used delivery services	Women reported negative experiences of maternal/neonatal health services	Yes, in framing research questions and in the interpretation of results	Develop interventions and make changes to meet women's needs

20 mins

Step 3: Discussing a gender perspective in research

Point out that the inclusion of women as study subjects (for a health concern that affects only females) does not in itself make for a gender perspective in research. A gender perspective calls for the systematic consideration of relevant gender issues in framing research questions, in data collection and in the analysis and interpretation of information.

Are there ways in which the studies on antenatal care and the hospital-based maternal mortality study could have addressed important gender issues? Sometimes, the study design and the sample population make this difficult. For example, if the maternal mortality study depended on hospital records, then unless these records are reworked to include gendered information, a gender analysis cannot be carried out.

20 mins

Step 4: Eliciting appropriate interventions

Challenge the group to come up with a package of interventions that would reconcile evidence from these various sources. Ask participants to summarize the main learning points from this session. Add to these as necessary.

Main points for closing this session

The research methods influence the recommendations

Different research methods allow us to reach different conclusions about what is needed to address a particular problem. This leads to different recommendations for interventions.

Different disciplines ask different questions

Health research includes a wide array of disciplines including demography, social sciences and epidemiology. The nature of questions asked is determined by the discipline of the researcher.

Use qualitative and quantitative information

It is often useful to include both qualitative and quantitative information when addressing a health problem.

A package of interventions

Data from different sources and disciplines often needs to be reconciled to come up with a package of interventions that will address the complex range of issues contributing to a health problem.

Be careful about generalizing

Not all published data can be generalized to other situations.

How to address the lack of a gender perspective

There is often very limited evidence on the gender dimensions of a health problem. This usually leads to the omission of gender issues from interventions. It would be useful to adopt a two-pronged approach: advocating for more research on gender issues on the one hand, and ensuring that interventions consider explicitly their impact on females and males separately, on the other.

Health interventions are informed by more than just evidence

Available evidence is not the only factor to consider when making decisions about health interventions. Practical and political interests and questions of feasibility play an important role. (The Policy Module and the Health Systems Module will be addressing some of these factors.) Being familiar with the relevant evidence will help us assess the appropriateness of interventions that are being implemented and offers us scope for advocating for change.

Session developed by Sharon Fonn

Handout

1 Instructions for group work on maternal health

You have all read an article or a published report on maternal health. You and your group have two tasks:

The first is to identify how gender issues have been addressed in the collection, analysis, interpretation, and presentation of information. Ask yourself questions like: does the information on women's characteristics include data on women's status so that an analysis of status and delivery outcomes could be carried out? Is the information collected, analysed, interpreted and presented in a manner that provides hypotheses on the impact of the gender based division of labour, gender roles and norms, access to and control over resources, or power, on the health problem under consideration?

The second task is to consolidate the main findings of the article or report and come up with recommendations for action that should be taken by health service planners to improve maternal health. See the information in the report as the primary data on which you should base your planning decisions.

Prepare a 10 minute presentation based on your interpretation of the article or report, focusing on the following questions:

- **What discipline(s) do the questions raised in the article/report represent?**
- **What data source(s) does the article/report use?**
- **What are the main findings?**
- **Is gender addressed? If yes, in what ways?**
- **Based on the above, what recommendations would you, as a group, make on interventions to improve maternal health?**

Make an overhead presenting your findings in table form, like this:

Article or report	Discipline	Data source	Findings	Gender addressed?	Recommendations

SESSION 5

Evidence for policy and programmes: selecting appropriate technologies for fertility regulation

What participants should get out of the session

Participants will:

- develop skills for identifying the information needed for selecting technologies for fertility regulation that are appropriate to a given setting
- be able to integrate gender and rights concerns when making this selection.

2 hours and 45 minutes

Materials

- Handout 1: "Instructions for group work on making policy recommendations"
- Handout 2: "South Africa"
- Handout 3: "Nepal"
- Handout 4: Specifications of existing methods of fertility regulation (to be prepared by the facilitator). One possible source for this is www.rho.org

- overhead: "The user/technology/service interface", on p.263
- overhead: "Some examples of demand factors", on p.264
- overhead: "Some examples of supply factors", on p.264
- overhead: "Summary of what we know about users' perspectives on fertility regulation technologies", on p.265

Readings for the facilitator

1. Cottingham J. Beyond acceptability: users' perspectives on contraception. In: Ravindran TKS, Berer M, Cottingham J, eds. *Beyond acceptability: users' perspectives on contraception.* London, Reproductive Health Matters, 1997: 1-4.

2. Snow RC. Each to her own. In: Sen G, Snow RC, eds. *Power and decision: social control of reproduction.* Boston, Harvard School of Public Health, 1994.

3. World Health Organization. *Contraceptive introduction reconsidered: a review and framework.* Geneva, WHO, 1994.

Reading for the participants

Reading 3.

How to run the session

There are three activities. The first is your opening lecture which provides a framework for selecting appropriate fertility regulation technologies. Participants then break into small groups to do a document review of national data from two countries and prepare recommendations for the technologies to be selected for these settings. The groups report back and the session closes with a discussion.

45 mins

Activity 1: Your input

10 mins

Step 1: Sharing personal experiences

Ask volunteers to share their personal experiences of fertility regulation. What were the factors that influenced their choice of contraceptive method?

The responses usually include factors such as:

- postponing child-bearing or not wanting to have more children
- the effectiveness of the method
- the side effects of the method
- whether the method interferes with sexual activity
- whether the method is easy to use
- the need for secrecy
- access to health services
- whether the method is provider-dependent
- the range of methods readily available in the public health system
- the availability of abortion, in case of method failure.

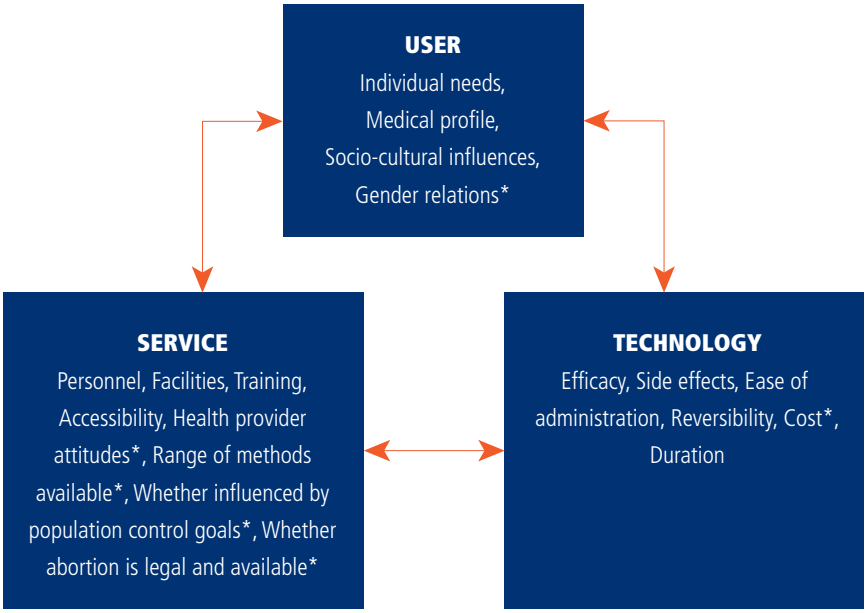
Group the factors into three main categories: those that are related to the characteristics of the user, those that are related to the characteristics of the technology, and those that are related to health services.

10 mins

Step 2: Framework for selecting appropriate fertility regulation technologies

Put up as an **overhead** this framework for selecting appropriate fertility regulation technologies. Go over factors relating to each dimension of the interface which need to be considered when selecting fertility regulation technologies that are appropriate for a given setting.

The sorts of ideas that might come out of each group



* Not part of the original framework
Source: Spicehandler J. *Contraceptive introduction reconsidered: a review and framework.* Geneva, World Health Organization, 1994.

Highlight the factors related to service delivery in particular, because these do not often come up in the earlier discussion on factors determining individuals' choices of technologies. Apart from considerations related to the health system's capability in relation to infrastructure and there being trained personnel to administer the technologies without compromising on quality, there are a number of other factors that need to be considered.

For example, countries which have had population control programmes driven by demographic targets have geared services to provide methods which are most effective in fertility reduction, but there is often no scope for individuals to select a method of their choice and which is appropriate for their reproductive goals. (Refer back to Session 4 in the Rights Module which discusses the violation of rights this represents.) Health provider attitudes in many such settings have been shaped by policy directives to maximize the number of acceptors of contraception, and not by quality considerations.

The availability or otherwise of legal abortions in the public health services is another factor that would influence whether or not barrier methods – which are not the most effective in preventing pregnancy – are a good option. The disadvantages of these have to be balanced against their advantages for preventing STIs/HIV.

The extent of STIs including HIV must, nonetheless, be seriously considered when selecting optimal contraceptive technologies for a given setting. Barrier methods such as the condom are the only means of prevention at this stage, and condoms warrant inclusion in any setting where such infections are a serious threat.

In countries where family planning has been integrated with the maternal and child health (MCH) programme, men have been excluded

from service delivery, as have adolescent girls, and, in many instances, women who are not currently married.

Draw attention to the ways in which women's rights and degree of autonomy impact on their contraceptive options, and the need to take these into account in any planning process for fertility regulation programmes. Some examples, such as the need for secrecy, have been highlighted in Step 1.

Step 3: Demand and supply factors influencing contraceptive behaviour

Factors influencing contraceptive behaviour in different settings are also classified according to demand factors and supply factors. Put up **overheads** of these two boxes.

Some examples of demand factors

- age profile of the population and prevailing norms for age at marriage, age at first birth, and the birth interval
- demand for delaying, spacing or terminating methods among different age groups
- abortion rates (if available) and the distribution of abortions by age
- regional health conditions, including anaemia and hypertension, and particularly the age specific incidence (prevalence) of STIs and HIV, and the need to reconcile fertility regulation with disease prevention
- gender relations, for example: do fertility decision-making roles within the home require women to use contraceptives secretly? Do sexual roles preclude use of barrier methods within marriage? Is male sterilization socially feasible?
- preferences of local users (and potential users) for different contraceptive attributes: extent and length of effectiveness, non-reversibility, resistance to chemical or mechanical methods, and whether use is associated with each act of intercourse (as in the case of barrier methods)
- tolerance for bleeding disturbances
- social acceptance of abortion.

Some examples of supply factors

- prevailing distribution options
- nature and quality of the distribution options
- provider capabilities
- opportunity for follow-up
- initial and recurrent costs
- availability and quality of abortion services.

10 mins

Step 4: Users' perspectives

Overhead What do we know about users' perspectives on fertility regulation technologies?

Summary of what we know about users' perspectives on fertility regulation technologies

Contraceptive users lack complete information about methods and services.

Women's and men's needs and preferences change over time and vary with the person's stage of life.

Users like safe and effective methods; side effects and method failure are the major reasons why women discontinue and do not use contraception.

Individual perspectives and preferences vary widely and defy generalization.

There is a limited range of methods available in many developing countries.

There is a lack of information about: the perspectives of men, adolescents, women having an abortion, women having repeated abortions, women in the post-partum period.

Source: Cottingham J. Beyond acceptability: users' perspectives on contraception. In: Ravindran TKS, Berer M, Cottingham J, eds. *Beyond acceptability: users' perspectives on contraception.* London, Reproductive Health Matters, 1997:1-5.

It is clear that a mix of methods is needed, catering to the varied needs of different sections of the population and also for the same individual at different stages of her or his reproductive span.

1 hr

Activity 2: Choosing appropriate fertility regulation technologies

Divide participants into four groups. Two groups will review evidence from one particular country to make an assessment of the fertility regulation technologies most appropriate for that setting. They will have to present the evidence for making their choices, and identify other evidence they would need to ensure that these choices:

- are feasible and realistic
- take into account users' perspectives and their rights
- contribute to gender equality or, at least, do not run counter to it.

The examples provided are from South Africa and Nepal (Handouts 2 and 3). Handout 1 sets out the instructions for group work and reporting. You will have prepared Handout 4, listing the characteristics of different methods of fertility regulation, to help participants make their decisions about the most appropriate methods for the country settings.

Participants have about one hour to read the handouts, decide on the fertility regulation methods they would recommend, identify additional evidence needed, and prepare a five minute presentation.

1 hr

Activity 3: Reporting back on chosen technologies

40 mins

Step 1: Report-backs

Each group has 10 minutes for a report-back and discussion. As each group reports, note down the justifications they give for their choice of technologies and the evidence they mention.

Challenge and probe

For example, groups often mention male condoms as a method of choice. They justify this by saying it is the most appropriate method for prevention of STIs/HIV and a male method. Challenge them to think about the kind of evidence they would need for deciding that condom promotion is feasible. Have they looked at current levels of condom use? What other information would they need (costs, existence of community-based distribution or other social marketing programmes, male attitudes to condom use, women's perspectives on condom use, and so on).

There may be population groups whose needs may not have been addressed, for example adolescent girls. Would they suggest introducing a new method? If yes, which one? What further information will they look for to ascertain that this would be appropriate?

20 mins

Step 2: Group discussion

After all four groups have reported back, move on to a general discussion on the kinds of evidence needed on users, services and technology to be able to choose appropriate methods of fertility regulation. Refer back to the framework on the interface, and start a list of indicators/information under each dimension.

Examples of the kind of information needed on user profile and user preferences:

- contraceptive prevalence by methods available
- proportion of women with an unmet need for contraception
- proportion of users of male condoms and male sterilization among users
- distribution of women with an unmet need by reasons for not using contraception
- age specific fertility rate in the 15–19 age group
- rates of HIV incidence (male and female)
- STI prevalence rates

- user perspective studies indicating method preferences, perceptions about quality of services, barriers to use
- indicators of gender differentials in access to education, employment and power.

Examples of information about services

- population policy of the country
- whether family planning services are state sponsored; whether they are provided alone, integrated with maternal and child health services, or integrated with primary health care
- range of methods available and cost of these
- legal status of abortion
- information on health services, such as per capita public expenditure on health, percentage of population with access to primary health care services, doctor-population ratio
- indicators of women's access to health care, such as proportion of deliveries that take place in health facilities, proportion of pregnant women using antenatal services
- studies on quality of care in family planning services and in health services in general.

Examples of information about the technologies

- side effects and contra-indications
- availability
- cost
- ease of administration
- potential for abuse
- common concerns and complaints that users have about the method.

Main points for closing this session

Matching technologies to local needs and service capabilities

Matching technologies to local users' needs and service capabilities should be a logical step in the delivery of all technologies. In many aspects of health care, this is the case. But the selection of the "optimal" mix of technologies for fertility regulation has unfortunately not included such considerations in many settings.

Getting the mix right

Personal needs for fertility regulation technology vary considerably, and existing technologies offer a range of different features. Hence, we emphasize an appropriate balance or mix of fertility regulation methods.

Upholding gender equality and rights

Selecting appropriate fertility regulation technologies can be done in a way which upholds gender equality and rights, and features quality of care (as one of these rights). This requires attention to the nature of the

service setting, the profile and preferences of users, and the characteristics of the technologies under consideration.

Delivery of family planning

The selection of an appropriate mix of fertility regulation technologies is a necessary but not sufficient condition to ensure that these are available to users in a way that upholds gender equality and rights. The latter requires fundamental changes in the delivery of family planning services – from a population control to a rights perspective (as detailed in Session 4 of the Rights Module).

The evidence we need is there

Much of the evidence needed for making an appropriate selection of fertility regulation technologies already exists, and has to be identified and applied suitably.

Session developed by Rachel Snow, TK Sundari Ravindran and Khin San Tint

Handout

1 Instructions for group work on making policy recommendations

The information you will be given

You will be given a case example with health and population data for an existing country (Handout 2 or 3). You will also be given Handout 4 with current data on the characteristics of different methods of fertility regulation.

Make a policy recommendation about fertility regulation technologies

Referring to the framework presented earlier in the session (users, services, technologies), and making use of the information provided in the handouts, you have one hour within which to review the evidence and make a recommendation to the ministry about which three fertility regulation technologies would be most appropriate for the national programme. A wider range of methods would certainly be desirable for most programmes. However, priorities for selected methods are commonly made within national and other (such as NGO) programmes, and we ask you to do the same. Prioritize the three technologies that you feel would provide the safest, most acceptable, and most beneficial options for this national programme.

Justify your choices

Explicitly address the following points in your summary presentation.

How do you explain or justify your selection, with regard to the available information on:

- users' perspectives and their rights?
- underlying health needs and risks?
- the quality of existing services – can the method be delivered with assurance of quality?
- the rights and empowerment of women – will the method contribute to gender justice, or at least not run counter to it?

Prepare a six to eight minute presentation. Present your findings in a table like this:

	Fertility regulation technology assessed as appropriate (top 3 choices)	Key evidence on which selection has been based	Additional evidence (indicators, types of information) that would have been most helpful to our decision-making
1.			
2.			
3.			

Handout

2 South Africa

South Africa's population was approximately 40 million in 1999. The population growth rate was 1.8 per cent. Life expectancy at birth in South Africa is now 47.3 years for males and 49.7 years for females. *[1]* This low life expectancy is a direct consequence of the HIV/AIDS epidemic, with more than 1.3 million believed to be infected with the human immuno deficiency virus (HIV) in the late 1990s. Surveys show that HIV infection is more common among women than men, and that young women between the ages of 15 and 24 years are disproportionately affected. *[2]*

The total fertility rate (TFR) in South Africa, according to the Demographic and Health Survey (DHS) of 1998, was 2.9 for the period 1995–1998. Differentials in fertility rates are wide, with a TFR among non-urban women (3.9) almost double that among urban women (2.3). Further, the total fertility rate is 3.1 among Africans, 2.5 among coloureds and 1.9 among whites. Fertility rates are also higher in the Northern Cape, Eastern Cape and KwaZulu-Natal provinces, and lowest in the Free State, Gauteng and the Western Cape provinces. *[3]*

Information on fertility rates by age group is not available from the DHS. However, a recent study states that adolescent childbearing levels are high, with more than 30 per cent of 19-year-old girls reported to have given birth at least once. *[4]*

Three quarters of all women covered by the DHS of 1998 had never used a method of contraception, and 50 per cent were currently using contraception. Of women who were currently married or living with a man, 56.3 per cent were current users of contraception. Among women who were sexually active during the four weeks preceding the survey, 62.4 per cent were current users of contraception. *[3]*

Current use of contraception by methods, South Africa *[3]*

Percentage of all women, currently married women and sexually active women currently using contraceptive methods, South Africa 1998 (age 15-49 yrs)

Contraceptive method	Percent currently using, among		
	All women (15-49 yrs)	Women currently married or living with a man (15-49 yrs)	Sexually active women (15-49 yrs)
Any method	50.1	56.3	62.1
Any modern method	49.3	55.1	61.2
Pill	9.3	10.6	13.2
IUD	1.2	1.8	1.9

chart continues

Contraceptive method	Percent currently using, among		
	All women (15-49 yrs)	Women currently married or living with a man (15-49 yrs)	Sexually active women (15-49 yrs)
Injection	27.3	23.2	30.1
Diaphragm/foam/ jelly	0.0	0.0	0.0
Condom	1.9	1.7	2.3
Female sterilization	8.7	15.8	12.0
Male sterilization	0.9	2.1	1.7
Any traditional method	0.6	0.9	0.7
Number of women	11 735	5 077	6 062

A recent study (1992–97) in the Agincourt sub-district of Bushbuckridge, a rural region of the Northern Province adjacent to South Africa's border with Mozambique, found that the proportion of women who used contraceptives before giving birth was relatively low among adolescents and young women (4 per cent at ages 12–16 and 10 per cent at ages 17–21), and was somewhat higher among older women (20 per cent at ages 22–29 and 18 per cent at ages 30–49). This pattern is reversed after childbearing in the youngest age groups, however, with 39 per cent of both the 12–16-year-olds and the 17–21-year-olds using contraceptives. *[5]*

The authors argue that South Africa's family planning policy, which targets married women and women who have been pregnant at least once, fails to address the contraceptive needs of young women, especially adolescents, before their first pregnancy. Better access to contraception will require, first, a recognition of the special needs of adolescent girls, including the skills necessary to negotiate with male partners. Second, it will require providing them with appropriate information on reproductive health, including contraception. It will also require an appropriate range of contraceptive supplies and services, and training of clinic staff. *[5]*

Contraceptive services in South Africa are available through the primary health care network. Abortion is legal, although services are still not readily available in rural areas because of infrastructural constraints and limited numbers of trained personnel. There are no recent studies on the quality of care in family planning services. However, according to a study conducted in 1992–93, women receiving services in the public as well as the private sector experienced long waiting periods, limited information and choice of methods, sometimes inadequate technical competence, and they were not asked what they needed or how they felt. In addition to improvements in these respects, the women suggested better education about health, contraception and sexuality in schools and communities, and specific changes in the training of health care workers. *[6]*

Total health expenditure as a percentage of the country's gross domestic product (GDP) is 7.1 per cent, and public expenditure constitutes 46.5 per cent of health expenditure. Public expenditure per capita on health was 184 international dollars (internationally comparable, not dependent on local exchange rates) in 1999. *[1]*

The government of South Africa has pledged its commitment to the improvement of health services by including the right to health in the new Constitution, and identifies reproductive health as a priority. However, it has to contend with the public health legacy of apartheid, including wide variations in the distribution, coverage and quality of health services across provinces and between urban and non-urban areas.

References

1. World Health Organization. *World health report 2000.* Geneva, WHO, 2000.
2. http://www.pathfind.org/worldwide/safrica_2htm (Date accessed: October 2000).
3. South Africa Department of Health. *South Africa demographic and health survey 1998.* Preliminary report. Pretoria and Calverton, Medical Research Council and Department of Health, and Macro International Inc., 1999.
4. Kaufman CE, de Wet T, Stadler J. *Adolescent pregnancy and parenthood in South Africa.* Policy Research Division Working Paper No. 136. New York, The Population Council, 2000.
5. Garenne M, Tollman S, Kahn K. Premarital fertility in rural South Africa: a challenge to existing population policy. *Studies in Family Planning,* 2000, 31(1):47–54.
6. Gready M et al. South African women's experiences of contraception and contraceptive services. In: Ravindran TKS, Berer M and Cottingham J, eds. *Beyond acceptability: users' perspectives on contraception,* London, Reproductive Health Matters, 1997.

Handout

3 Nepal

Nepal had a population of about 23.4 million in 1999, with an annual population growth rate of 2.5 per cent. Life expectancy at birth was 57.3 years for males and 57.8 years for females. *[1]* The under five mortality rate for the country is high, at 139.2 per 1000 live births in 1996. The maternal mortality ratio per 100 000 live births was estimated to be 539 (1996). The female literacy rate in 1996 was 37.8 per cent compared to 67.9 per cent for males. While the female work participation rate was 40.4 per cent (1991), women constituted only 15.4 per cent of all workers in the organized sector. Less than 5 per cent of parliamentary seats were held by women in 1997, and only 2 per cent of ministerial seats. *[2]*

Nepal's total fertility rate (TFR) was 4.6, according to the Nepal Family Health Survey (NFHS) of 1996. *[3]* Adolescent fertility rates are high. NFHS figures show that more than half the women aged 19 years have had at least one birth or were currently pregnant. However, most of these are not premarital pregnancies, as 43 per cent of women in the 15–19 age group are married.

The available data on HIV suggest that the epidemic is still in an early phase, but the cumulative number of self-reported cases of HIV and AIDS has increased from 467 in 1996 to 1778 cases in November 2000. *[4]* While HIV infection rates remain low in the general population, recent studies among commercial sex workers (CSWs) and intra-venous drug users (IVDUs) suggest that Nepal has reached the stage of a concentrated epidemic, in which the HIV/AIDs prevalence exceeds 5 per cent in one or more sub-groups. Infection rates in female CSWs underscore their vulnerability, with evidence that the epidemic is more advanced in Kathmandu than elsewhere. Recent rates among CSWs in Pokhara were 1 per cent, *[4]* but prevalence has reached 17 per cent among CSWs in Kathmandu. *[4]* Risk appears particularly high among CSWs returning from sex work outside Nepal, especially from India.

While HIV surveillance data from intravenous drug users (IVDUs) showed persistently low rates of infection (1.6 per cent) through the early 1990s (1991–93), data from 1999 indicate that the prevalence has reached 40.4 per cent among male IVDUs. *[4]*

On the subject of STIs in Nepal, data from family planning attendees in 1999 found trichomonas vaginalis was 6 per cent, chlamydia 1.7 per cent, gonorrhoea 1.7 per cent and active syphilis 1 per cent. As expected, rates are higher among clients reporting symptoms to STI care facilities: Among male patients attending dermato-venerealogy (DV) services in 1997, the prevalence of chlamydia was 5.5 per cent, gonorrhoea 13.6 per cent, and active syphilis 9.5 per cent. Among female symptomatic patients, the prevalence of trichomonas vaginalis was 9.3 per cent, chlamydia 5.2 per cent, gonorrhoea 1.9 per cent and active syphilis 7.9 per cent. *[4]*

Current use of contraception by methods, Nepal 1996 ***[3]***

Contraceptive method	Method mix among users of modern methods
Any modern method	100.0
Pill	5.4
IUD	1.2
Injection	17.3
Condom	7.3
Implants	1.5
Female sterilization	46.5
Male sterilization	20.8

Contraceptive services are available through public health facilities as part of the government's family planning programme. The government pursues a population policy committed to fertility reduction. Abortion is illegal and a criminal offence.

The country has a poor network of modern medical facilities, including public health facilities. Total health expenditure forms only 3.7 per cent of the gross domestic product (GDP), and public expenditure as part of total health expenditure is a mere 26 per cent, indicating that health services are paid for out-of-pocket by the population. Public health expenditure per capita in international dollars is 11 dollars. ***[1]*** **Just over a quarter (27.6 per cent) of pregnant women are covered by antenatal services and only 7.6 per cent of the deliveries take place in institutions.** ***[3]***

References

1. World Health Organization. *World health report 2000*. Geneva, WHO, 2000.
2. World Health Organization. *Women of South-East Asia. A health profile.* New Delhi, WHO South-East Asia Regional Office, 2000.
3. Pradhan A et al. *Nepal family health survey 1996.* Kathmandu and Calverton, Ministry of Health, New ERA and Macro International Inc., 1997.
4. University of Heidelberg/National Centre for AIDS and STD-HIV Control Project. *Briefing report 2000.* Kathmandu, Nepal. UoH/NCASC STD-HIV Control Project, 2000.

SESSION 6

Evidence for monitoring: reproductive health indicators

What participants should get out of the session

Participants will:

- be familiar with the concept of different types of health indicators and their uses
- be able to come up with the indicators most relevant to specific settings
- have the skills to use and/or develop indicators that capture the gender and rights dimensions of a health issue or problem.

2 hrs 15 mins

2 hours and 15 minutes

Materials

- Handout 1: "Adolescent reproductive health project"
- Handout 2: "Safe motherhood project"
- Handout 3: "Improving the quality of family planning services"
- Handout 4: "Prevention and control of RTIs/STDs"
- Handout 5: "The gender/rights dimension"

- overhead: "Areas for impact assessment", on p.277
- 15 strips of paper each with an indicator from the box: "Global/national reproductive health indicators", on p.278
- flip chart marked as indicated on p.279
- overhead: "Critiquing and developing gender and rights sensitive indicators", on p.283

Readings for the facilitator

1. World Health Organization. *Indicators to monitor maternal health goals: report of a technical working group, Geneva, 8–12 November 1993.* Geneva, WHO, 1997.

2. World Health Organization. *Monitoring reproductive health: selecting a short list of national and global indicators.* Geneva, WHO, 1997.

3. World Health Organization. *Selecting reproductive health indicators: a guide for district managers.* Geneva, WHO, 1997.

Readings for the participants

Reading 3.

How to run the session

There are three activities. The first starts with a brief input introducing the concept of indicators. The second is a quiz on definitions of some commonly used reproductive health indicators included in WHO's global indicators list. The third activity consists of two options for small group work, followed by a group discussion. The first option will help participants construct and apply gendered reproductive health indicators for specific well defined local projects. The second option is for participants who are familiar with indicators and their use and who would benefit from a more challenging exercise on critiquing and developing gender and rights sensitive indicators.

30 mins

Activity 1: Indicators and how to use them

5 mins

Step 1: What are indicators?

Start with a series of questions to participants, along the following lines:

- Can you tell me the name of a good movie that you saw recently? Why did you think it was good?
- Would you describe neighbourhood X (the name of a part of the city or town where this course is taking place) as high income or middle income?
- What are some indications that would prompt you to say, on seeing a person, that she or he is not looking very well?

What participants do in each of the above instances is come up with indicators of a good movie, a middle income neighbourhood or poor health. Thus, indicators may be defined as evidence used to make an assessment about a complex situation or event.

5 mins

Step 2: What is a health indicator?

Begin with defining what a health indicator is, and give some examples.

A health indicator is usually a numerical measure which provides information about a complex situation or event. When you want to know about a situation or event and cannot study each of the many factors that contribute to it, you use an indicator that best summarizes the situation. For example, to understand the general health status of infants in a country, the key indicators are infant mortality rates and the proportion of infants of low birth weight.

10 mins

Step 3: Rates and ratios

Get participants to tell you the difference between rates and ratios, and explain these concepts if necessary.

Rates

An indicator is a rate or proportion when the numerator is included in the population defined by the denominator (Last JM et al. *A dictionary of epidemiology.* New York, Oxford University Press, 1995). For example, the literacy rate in a population has literate persons in the numerator and total population in the denominator.

Ratios

An indicator is a ratio when it is an expression of a relationship between a numerator and a denominator where the two are usually two separate and distinct quantities (Last JM et al, *A dictionary of epidemiology*. New York, Oxford University Press, 1995). For example, the population sex ratio has as numerator the number of males in the population, and in the denominator the number of females in the population.

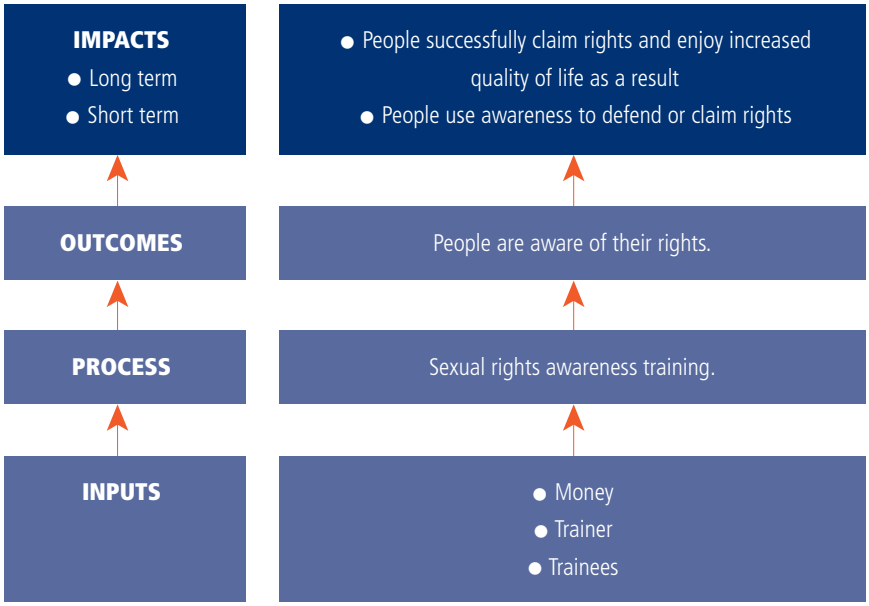
10 mins

Step 4: Multiple uses of indicators

Introduce participants to the multiple uses for reproductive (and other) health indicators. Put up the figure below as an **overhead.**

Indicators are used to measure inputs, process, and outcomes as well as the long term impact of a project. If the project is a sexual rights awareness training programme, the input indicators would be the amount of money, the numbers and quality of trainers, preparation time and so on. The indicators of process would be the number of training programmes conducted, the numbers of trainees covered. The outcome indicator would be the number of trainees who are aware of sexual rights. Impact indicators would be the proportion of trainees who use awareness to defend or claim rights, the proportion of trainees who have influenced the awareness levels of other members of society, and so on.

Areas for impact assessment



Source: Roche C. *Impact assessment for development agencies.* Oxford, Oxfam, 2000:2.

15 mins

Activity 2: Quiz: definitions of reproductive health indicators

Divide participants into two teams, team A and team B. Write each indicator from the WHO global/national reproductive health indicators (in the next box) on a strip of paper, fold it up and put all the folded strips into an open box. Have a quiz on the definitions of these indicators.

Global/national reproductive health indicators

a. Total fertility rate
b. Contraceptive prevalence rate
c. Maternal mortality ratio
d. Percentage of women attended at least once during pregnancy for reasons related to pregnancy
e. Percentage of births attended by trained health personnel (excluding trained and untrained traditional birth attendants)
f. Number of health centres per 500 000 population with functioning basic essential obstetric care (basic EOC)
g. Number of hospitals per 500 000 population with functioning comprehensive essential obstetric care (comprehensive EOC)
h. Peri-natal mortality rate
i. Percentage of live births of low birth weight
j. Positive syphilis serology prevalence in pregnant women attending for prenatal care
k. Percentage of women of reproductive age screened for haemoglobin levels who are anaemic
l. Percentage of obstetric and gynaecology admissions owing to abortions
m. Reported prevalence of women with genital mutilation
n. Percentage of sexually-active, non-contracepting women aged 15–49 years who report trying for a pregnancy for two years or more
o. Reported prevalence of urethral discharge in men aged 15-49 years.

Source: World Health Organization. *Monitoring reproductive health: selecting a short list of national and global indicators.* Geneva, WHO, 1997.

Put up a flip chart marked like this:

Indicator chosen	Definition	Rate/ratio	Marks: Team A	Marks: Team B
e.g. contraceptive prevalence rate	Number of women in the 15-49 age group using any modern method of contraception is the *numerator,* and the number of all women in the 15-49 age group is the *denominator*	rate		

Ask each team to take turns to choose a folded strip of paper and read out the indicator written on it. One member of the team comes to the flip chart and writes out the definition, stating what the numerator is, and what the denominator is.

For example, contraceptive prevalence rate will have to be written as:

$$\frac{\text{Number of women aged 15–49 currently using a method of contraception}}{\text{Total number of women aged 15–49}}$$

Push for precision in definitions – what would they define as a method of contraception? Modern methods? Traditional and modern? Which traditional methods? Are all women in the 15–49 age group included? Or is it only currently married women? And so on.
(A list of WHO definitions is available online at: www.who.int/reproductive-health/pages_resources/listing_global_monitoring.htm.

A complete and accurate response gets five marks. If both teams share in giving the complete definition, the marks are shared. The team with the highest marks is the winner.

1 hr 30 mins

Activity 3: Option 1: Gendered reproductive health indicators

30 mins

Step 1: Group work

Divide participants into four groups. Each group is given a hypothetical reproductive health project for which they have to develop indicators (Handouts 1, 2, 3 and 4).

1 hr

Step 2: Report-backs

One person from each group reports back to the whole group on:

- the reproductive health project under consideration
- indicators to be used and their definitions
- the attempt made to bring gender and rights dimensions into one or more of the indicators
- mode of collection of information on these indicators
- how often will the information be collected (for example, census information is collected once in a decade).

Each presentation should be five minutes and may be followed by a ten minute discussion.

Some of the indicators that may emerge from each of the groups are outlined below.

Adolescent reproductive health project

- proportion of female adolescents reporting condom use (this may be further refined, for example to specify regularity of condom use, access to condoms, or whether a condom was used in their most recent sexual encounter)
- 15–19-year-olds as a proportion of all abortion related obstetric and gynaecology admissions
- proportion of women in the 15–19 age group who have had one or more children or are currently pregnant.

Safe motherhood project

- percentage distribution of maternal deaths by place of death
- proportion of women who died at home or on their way to the hospital because the hospital was too far away
- percentage distribution of maternal deaths in hospital, by time between admission and death
- proportion of women reporting a delivery complication who delivered in a health facility.

Improving the quality of family planning services

- percentage distribution of all women using contraceptives, by method used
- proportion of women and men reporting that they were given adequate information on various contraceptive options available
- proportion of contraceptive users who are men
- proportion of contraceptive users reporting at least one follow-up contact with the health facility or health worker
- proportion of satisfied users at the end of x months following acceptance.

Prevention and control of RTIs/STDs

- proportion of clinic users who are aware of the symptoms of one or more RTIs/STDs
- number (and/or proportion) of clients seeking treatment for RTIs/STDs
- proportion of clients (by sex) whose partners have also sought treatment
- proportion of those diagnosed with an RTI/STD who completed treatment (reasons for not completing treatment: cost? access? quality?)
- proportion of those who completed treatment who are cured of the problem.

What to cover in the discussion following each presentation

Accuracy

Verify that the indicators are accurately defined, and that the numerator and the denominator of the indicator are specified wherever relevant.

Validity

Examine the indicators for validity, making sure that they measure what is supposed to be measured. For example, the proportion of women covered by antenatal care may be a measure of utilization, but not a measure of the success of a safe motherhood programme – unless it could be established that the kind of antenatal care provided helped to reduce the probability of maternal death or of serious morbidity.

Reliability

Examine the indicators for reliability, making sure they are not dependent on the subjective perceptions of the person collecting the data or the person reporting. For example, indicators such as "malnourished" are completely dependent on the perception of the data collector, unless the term is clearly defined as weight-for-age below xx, or body-mass-index (BMI) below yy, and so on.

Gender and rights

Which of the indicators addressed above had the potential to address the gender/rights dimensions of the issue? For example in the adolescent project, information on condom use should be collected from both girls and boys. In addition to finding out the proportion of girls aged 15–19 who are currently pregnant or have had a child, the proportion of boys aged 15–19 who have either fathered a child or are responsible for a current pregnancy could also be an indicator. This information may be collected by asking girls who are mothers or are currently pregnant about the age of the father. Antenatal records in health centres could routinely collect data on the age of the father.

In the safe motherhood project, a gender/rights dimension may be added to the indicator on the distribution of maternal deaths in hospital by time duration between admission and death, by asking for reasons for delay. Similarly, reasons for non-use of a health facility by women reporting a delivery complication would give insights into whether gender based discrimination, through the lack of access to resources and power, or through roles and norms, played a role in this delay.

To add a gender dimension to indicators for the family planning programme and the RTI/STD programme, indicators should be analysed by the sex of the respondent. In addition, finding out reasons for the non-use of any contraceptive method, or non-use of health services for RTIs/STDs from both women and men, could help bring out the role of gender in this.

Mode of data collection

Data on the indicators may be collected as part of routine data collected by health facilities, or routine records maintained by health workers. Alternatively, there may be a need for special surveys or studies. One criterion for choosing an indicator should be how easy it is to collect data on it. Thus, while in the adolescents' programme we could have come up with the indicator "proportion of adolescents having an unsafe abortion", data on this would be so difficult to collect that it is not helpful.

Timing of data collection

Draw participants' attention to the need for baseline information in order to be able to monitor or evaluate any situation. For a three year project, data may be collected at two or three time points; and in routine data collection such as hospital records, data analysis may be carried out at two or three time points.

1 hr 30 mins

Activity 3: Option 2: Critiquing and developing the indicators

30 mins

Step 1: Groups review and discuss gender and rights sensitive indicators

Divide participants into four groups. Assign each group one element of quality of care (for example, accessibility) and give them a set of indicators to evaluate STD/HIV prevention services. (Make separate handouts for each group, based on the details outlined in the table "The elements of quality of care and their indicators" in Handout 5. Choose four elements of quality of care from this table for the groups to work on, making four different versions of Handout 5.)

Ask each group to review and discuss their indicators in relation to their gender/rights sensitivity: do they evaluate the responsiveness of services to gender/rights issues? If the group concludes that these perspectives are not adequately included in the indicators, then it has to rework the indicator. The group may also propose additional gender/rights sensitive indicators of the quality of care element under review.

30 mins

Step 2: Report-backs

Give each group seven minutes to make their presentation.

30 mins

Step 3: Group discussion

For the main points you need to draw out in this discussion, see Activity 3, Step 2 (accuracy, validity, reliability etc.).

Prepare an **overhead** indicating:

Critiquing and developing gender and rights sensitive indicators

- the quality of care element which you worked on
- the list of proposed indicators for evaluating this element
- indicators among these that are (or have been) gendered
- indicators that incorporate a rights dimension.

Session developed by TK Sundari Ravindran, Khin San Tint and Centro de Estudios de Estado y Sociedad (CEDES), Argentina

Handout

1 Adolescent reproductive health project

Instructions for group work

Your group has 30 minutes to work on the following problem. Nominate a reporter who will report back to the whole group. Your small group discussion should come to a close five to ten minutes before the half-hour is up to allow time for the reporters to write up their presentations.

The project

A new project for the improvement of the reproductive health of adolescents is being initiated in your district. The project is planned for a three-year period.

The objectives are:

- **to promote condom use**
- **to prevent unsafe abortions**
- **to promote postponement of childbearing.**

What are the indicators you will use for evaluating this project? How will you make one or more of these address the gender/rights dimension?

How will you collect the information on these indicators? How often will you collect it?

Handout

2 Safe motherhood project

Instructions for group work

Your group has 30 minutes to work on the following problem. Nominate a reporter who will report back to the whole group. Your small group discussion should come to a close five to ten minutes before the half-hour is up to allow time for the reporters to write up their presentations.

The project

Concern has been raised about the number of maternal deaths reported in your area. A safe motherhood project aimed at reducing maternal deaths over the next three years is to be implemented very soon.

The specific objectives are:

- **to prevent delay between the development of a serious complication in pregnancy and reaching a health facility providing emergency obstetric care**
- **to prevent delay within health facilities in initiating appropriate treatment.**

What are the indicators you will use for monitoring this project? How will you make one or more of these address the gender/rights dimension?

How will you collect the information on this indicator? How often will you collect it?

Handout

3 Improving the quality of family planning services

Instructions for group work

Your group has 30 minutes to work on the following problem. Nominate a reporter who will report back to the whole group. Your small group discussion should come to a close five to ten minutes before the half-hour is up to allow time for the reporters to write up their presentations.

The project

In your province, more than 80 per cent of contraceptive users have adopted female sterilization. Your brief is to improve the quality of family planning services offered in the five primary health centres under your supervision over the next three years.

You design a project, which aims to:

- **widen contraceptive choice for women**
- **promote male methods of contraception**
- **improve follow-up services**
- **improve client satisfaction.**

What are the indicators you will use for monitoring this project? How will you make one or more of these address the gender/rights dimension?

How will you collect the information on these indicators? How often will you collect it?

Handout

4 Prevention and control of RTIs/STDs

Instructions for group work

Your group has 30 minutes to work on the following problem. Nominate a reporter who will report back to the whole group. Your small group discussion should come to a close five to ten minutes before the half-hour is up to allow time for the reporters to write up their presentations.

The project

A new RTI/STD prevention and control project is being implemented in your health facility.

The objectives of the project are to:

- **improve awareness of the signs and symptoms of RTIs/STDs**
- **promote treatment seeking among those with symptoms of RTIs/STDs**
- **encourage partner notification and treatment.**

What are the indicators you will use for monitoring this project? How will you make one or more of these address the gender/rights dimension?

How will you collect the information on these indicators? How often will you collect it?

Handout

5 Gender and rights sensitivity of quality of care indicators

Instructions for group work

Your group has 30 minutes to work on the following problem. Nominate a reporter who will report back to the whole group. Your small group discussion should come to a close five to ten minutes before the half-hour is up to allow time for the reporters to write up their presentations.

The problem

You have been given the details of one element of quality of care for clinic based RTI/STI services, and indicators corresponding to this element. Review and discuss these indicators in terms of their gender/rights sensitivity: do they evaluate the services' responsiveness to gender/rights issues? If you conclude that the indicator lacks adequate gender/rights sensitivity, then rework that indicator. You may also propose additional gender/rights sensitive indicators of the quality of care element under review.

The elements of quality of care and their indicators

Element	Definition of element	Indicators
Accessibility and availability	• All have access to sexuality education • Clinic hours available are convenient for client • Distance/means/cost of travel convenient and affordable • Preventive and simple curative services affordable according to client's ability to pay • Cost of condom not a deterrent to use • High risk groups, such as commercial sex workers (CSWs), receive access to services through peer group outreach or other methods	• Percentage of the population under age 15 who have had sexuality education • Percentage of clients (percentage potential/former clients) report hours are convenient • Percentage of clients (percentage potential/former clients) report service location convenient/affordable • Percentage of clients (percentage potential/former clients) report services affordable
Acceptability	• Prevention and STD services delivered at socially acceptable venue • Acceptable length of waiting time for initial and follow-up visits • Sex, ethnic group, age status of clinic provider appropriate for client/potential client • Confidentiality maintained • Condoms acceptable	• Percentage of target community who go to clinic for health problems • Percentage of clients (percentage potential/former clients) reporting level of privacy as acceptable • Percentage of clients (percentage potential/former clients) who report waiting time as acceptable • Percentage of clients (percentage potential/former clients) reporting comfort with clinic provider • Percentage of clients (percentage potential/former clients) reporting confidentiality as adequate
Technical competence	Clinic provider: • Can identify facts of HIV/STD transmission and prevention • Can assess the relationship of contraceptive methods with STD risks for each client • Can diagnose and treat common STDs	• Percentage of symptomatic patients adequately assessed, diagnosed and treated • Percentage of clinic providers maintain adequate records of services provided and store them in a secure location

chart continues

Element	Definition of element	Indicators
Technical competence *(continued)*	● Refers patients with STD symptoms that clinic provider is unable to diagnose or treat ● Uses aseptic technique ● Uses protective clothing and gloves ● Can conduct risk assessment without moral judgements using green, yellow, red light approach; green = encourage low risk to continue their current behaviour; yellow =caution; red =stop risky behaviour ● Can recognize all people at risk of exposure to HIV ● Can recognize different presenting symptoms of AIDS plus symptoms of recurring yeast infections in women ● Has record keeping systems established and maintained	
Client–provider Interaction	● Confidentiality ● Can counsel client/commercial sex worker (CSW) with respect ● Can conduct risk assessment without moral judgements ● Freedom from coercion	● Percentage of clients satisfied with provider confidentiality and provider attitude ● Percentage of providers satisfied with amount of time per client
Information/ Counselling for client	● Information materials available ● Counselling of HIV/STD transmission and prevention to all adolescents prior to becoming sexually active, nd all currently sexually active adults ● Topics covered include information that: - STDs/HIV can be asymptomatic - STDs/HIV can present with symptoms such as pelvic pain, genital lesions and vaginal discharge - most STDs can be treated - without treatment, STDs can cause infertility or other serious health consequences - risk can be reduced through abstinence, postponed sexual activity, mutual monogamy, condom use and negotiation ● Instructions for condom use ● Sufficient time for provider to counsel client ● High risk groups, such as CSWs, should receive intensive counselling and access to services through peer group outreach or other methods ● Information, education and communication campaign associate condoms with prevention of transmission of HIV/STDs to children	● Percentage of women with pelvic pain, genital lesions and vaginal discharge counselled on STDs/HIV ● Percentage of clients counselled on STDs/HIV; risk reduction; condom use and negotiation ● Percentage of partners notified ● Percentage instructed on condom use ● There is a checklist of information that the provider should cover, and corresponding education material ● Percentage of clients feel sufficient time spent with providers
Essential supplies, equipment and medication needed, plus norms and standards	● Table, speculum, gloves ● Electricity ● First line of drugs for STDs ● Sterilizer or autoclave ● Refrigerator at clinic (kerosene if no electricity) ● Condoms, spermicides, provision and/or referral for other contraceptives	● Storage guidelines posted

chart continues

Element	Definition of element	Indicators
Essential supplies, equipment and medication needed, plus norms and standards *(continued)*	• Consistent supply of drugs, supplies, and necessary equipment maintained • Medications and condoms stored properly • Proper disposal of bio-hazardous waste	• Percentage of STD services and HIV prevention counselling offered with family planning, maternal health services • Percentage of clients obtained contraceptives
Comprehensiveness of care, and links to other reproductive health services	• Integrate all STD/HIV prevention with family planning/maternal health or other services where feasible and efficient • Referral for other contraceptives or services • Communication/referral system developed and operational	• Percentage of partners contacted • Percentage of referrals documented • Percentage of partners notified • Functioning follow up system
Continuity of care and follow up	• Partner notification (only after assessment of risk of violence if women) • Direct referral of partners by infected individuals seen by provider • Regular clinic hours • If possible, regular provider schedule • System to follow up client who has not returned • Follow up lab treatments (e.g. syphilis) • Follow up lab tests	

Source: Pan American Health Organization. *Quality of care in women's reproductive health: a framework for Latin America and The Caribbean.* Washington, PAHO, 1994.

SESSION 7

Evidence for service evaluation: applied exercises

What participants should get out of the session

Participants will:

- be acquainted with a range of techniques for data/information collection for service evaluation
- have hands-on exposure to constructing tools for data/information collection
- learn how to integrate gender and rights dimensions in data/information collection for monitoring and/or evaluating services.

5 hrs

about 5 hours of class time, and an evening's work after class

Materials

- Handout 1: "Instructions for group assignments on tools for collecting data"
- Handout 2: "How to design a questionnaire"
- Handout 3: to be prepared by the facilitator using: Britten N. Qualitative interviews in medical research. *British Medical Journal,* 1995, 311:251–253
- Handout 4: to be prepared by the facilitator using: Kitzinger J. Introducing focus groups. *British Medical Journal,* 1995, 311:299–302

- overhead: "Various data collection techniques", on p.292

How to run the session

The session starts with your input, in which you review qualitative and quantitative techniques for data collection. This is followed by a small group exercise where participants work in the same groups as they did in Session 6. Participants develop and pilot data collection tools for assessing the outcomes of the same projects as in Session 6. In the third activity the groups report back, and this is followed by a detailed discussion and feedback from you.

30 mins

Activity 1: Input on data collecting techniques

Various data collection techniques

Qualitative

1. Observation
- Provides detailed descriptions of programme activities, processes and participants
- Highly dependent on the skill, training, and competence of the observer
- Needs concentration, patience, alertness, sensitivity and physical stamina.

2. In-depth interviews
- Involves asking open-ended questions, listening and recording the answers, following up with additional relevant questions
- Informal conversational interview, interview using a general guideline, and standardized open-ended interview
- Purpose: allows us to enter into and document another person's perspectives.

3. Focus groups
- Interview with a small group of people (6–8) on a specific topic
- Aimed at obtaining high quality data in a social context where people can consider their own views in the context of the views of others
- Fairly easy to asses the extent to which there is a consistent shared view of the programme among participants.

Quantitative

4. Review of records
- Relatively inexpensive
- Some constraints due to type of records, classification, missing data
- Overall picture on programme's performance: who are the clients, coverage, morbidity.

5. Check-lists
- Provide a comparison matrix of different facilities
- Quick reference on what was done and what was not done.

6. Questionnaires
- Follows a well defined structure to prevent own interpretation
- All questions are asked in the same way
- Could use a combination of open and close-ended questions
- Respondents must fit their experiences and feelings into the researcher's categories unless the questionnaire is open-ended
- May serve to obtain comparable information across settings.

3 hrs

Activity 2: Developing and piloting tools for data collection

Tell participants to get back into the same groups as for the activity to develop indicators in Session 6 to work on developing data collection tools for assessing the outcome of the same projects.

Sub-divide each of the four groups into two: one to develop a tool for collecting qualitative information, and another for collecting quantitative data.

Those developing tools for quantitative data should make sure that their tools provide information related to the indicators they developed in the earlier session.

Those developing tools for qualitative information should specify what aspects they will collect information on, using their tool. For example, in the adolescent reproductive health project one aspect could be male adolescents in the community with a positive attitude to condom use. Each group will develop their tools and test them with another group. Handout 1 gives details of the process. Handouts 2 and 3 are about questionnaire design and interview and design and Handout 4 explains how to design guidelines for focus group discussion.

Inform the participants that they have to make a 10 minute presentation on the data collection tool they have developed. They also have to submit it in written form, for grading.

The presentation and the written report should address the following questions:

1. What were the changes made to this tool after the piloting? Why?
2. How have you addressed gender, rights and ethical issues in this tool?

When this session was run in Yunnan, China, an operations research (OR) exercise was used as the application exercise. Earlier, the OR approach had been introduced as part of Session 2, the introduction to health research. For the application exercise (Session 7) results from an OR study carried out in Kunming, China were used. The study was an assessment of the Maternal and Child Health Poverty Alleviation Fund, a health financing project to help low income mothers.

Participants were divided into two groups. One group was given the qualitative information from the OR study, and the other was given the quantitative data. Each group had to examine the data/information given and answer the following questions:

From the data, can you suggest why it was generated? What are the study hypotheses? How could we utilize the data? What are some possible biases? How could one reduce the biases?

The groups exchanged their responses in a big group discussion. Facilitators then gave their input on the actual OR study, its objectives, hypotheses, the analysis and interpretation of results, and how the data/information was used. Participants then had an opportunity to critique the study as it had been done, based on what they had learnt in the various sessions of this module.

2 hrs

Activity 3: Presentations and feedback

The questionnaire designing assignment may be used for grading, to contribute to certification where appropriate. Whether or not the assignment is graded, this activity would consist of detailed feedback from the facilitator to participants on how their questionnaires and information collection tools may be improved.

Each group has 15 minutes for the presentation and any discussion following it. The tools should be presented as an overhead and presentations should cover the changes made, as well as the gender, rights and ethical issues that have been addressed.

As the groups make their presentations, evaluate the tool and note down points for your feedback.

Ask for the following details:

- Who are the respondents? (sample units)
- How will they be chosen? (sampling from the sample population)
- What are the reasons for the above?
- Where will the data collection take place? Why?

Take the following points into account when you evaluate the tools.

The data collection tool is constructed so that the questions:

- will elicit unique responses
- are relevant to the issues being addressed
- are not repetitive
- are in logical order
- are sensitive to and respectful of the respondent.

Other points to look out for in the evaluation are how gender, rights and ethical issues will be addressed both in the tool and in the way information will be collected using the tool: for example, ensuring that both women and men are included in the sample, that questions pertinent to both sexes are included where relevant, that privacy is respected, that there is informed consent, and so on.

Give the participants detailed feedback immediately after each presentation. If you have time, you can give groups an opportunity to revise their data collection tools and resubmit them for evaluation.

Session developed by Mariana Romero and Khin San Tint

Handout

1 Instructions for group application exercise on tools for collecting data

Preparation

You were given handouts in Session 6 for developing indicators to evaluate reproductive health programmes. You have also been given handouts on questionnaire design (Handout 2) and interview design (Handout 3). And we have reviewed qualitative and quantitative techniques to collect data. Handout 4 is for your general information, and does not relate specifically to this assignment.

The assignment

1. **Review what you have learnt about data collection techniques**
   Individually, you have one hour to review the new handouts on data collection techniques.

2. **Develop your tool**
   Then, spend one hour as a group to develop and write your tool for collecting information for assessing the outcome of the programmes in Session 6. If you are developing a tool for quantitative data, make sure that your tool provides information about the indicators you developed previously. If developing a tool for qualitative information, specify which aspects you will be collecting information on.

   When developing the tool, bear in mind that the questions should:

   - elicit unique responses
   - be relevant to the issues being addressed
   - not be repetitive
   - be in logical order
   - be sensitive to and respectful of the respondent.

   Be clear about:

   - who your respondents are
   - how they will be chosen and why
   - where the data collection will take place and why.

3. **Pilot your tool**
   Once you have written the tool it has to be piloted with a few members of another group. All participants should make themselves available for an hour to be interviewed as part of the piloting process.

4. Revise and finalize

After this, your group has 1 hour and 30 minutes to revise and finalize the tools, discuss their strengths and weaknesses, and rights, ethical and gender issues that have arisen in the process.

Prepare a 10 minute presentation, and a written report which includes:

- **the final tool**
- **changes that were made after piloting, and why**
- **ethical issues that you have considered**
- **rights issues that you have considered**
- **gender issues that have been addressed by your tool.**

This assignment will be graded. All the members of one group get the same mark.

Handout

2 How to design a questionnaire

Source: Extracted and adapted from: Botha JL, Yach D. *Manual of epidemiological research methods: a supplement to perspectives in community health.* Abridged version of the IB-ESSA workshop manual. Tygerberg, South African Medical Research Council, 1987:17–18.

Step 1: Only ask the necessary questions

Questions should be based on your study objectives – keep them within the scope of the study. Short-list the variables that you need. Use existing questionnaires as a guide only. Design your questions to suit your particular study.

A short, well conceived questionnaire elicits much better information than a long, rambling, one.

Step 2: Word the questions carefully

Questions can be open-ended and the respondent replies in whatever way she or he chooses. The alternative is to have closed-ended questions where predetermined possible answer categories are marked off and coded. This ensures quicker, more standardized data collection.

How should questions be asked?

- **Find out from potential respondents what questions are meaningful to them and how to phrase the questions to make sure that they are understandable and acceptable.**
- **Questions should be simple, concise and specific. Make sure that there are no ambiguities.**
- **Decide whether and where open-ended or closed-ended questions are most appropriate.**
- **Ask one question at a time. Break up complex questions into simple ones. For example "Do you use a method of contraception? If not, why not?" should be broken up as follows: "Do you use a method of contraception? Yes/No. If no, what are your reasons? If yes, which of the following methods are you currently using?" and so on.**
- **Avoid questions which suggest to the respondent the answer that is expected (this is called a leading question). For example "Do you believe that IUDs have adverse health effects?"**
- **Take special care with wording questions and locating them within the sequence of questions when seeking personal or sensitive information.**
- **Closed question categories should be mutually exclusive and exhaustive: there should be no overlap of categories, and all possibilities should be covered. Always allow for an "other" category where the respondent can specify the answer.**

Step 3: The lay-out of the questionnaire

- Order the questions meaningfully to ensure a smooth, logical flow. Non- threatening items should be put first so that the respondent feels at ease.
- Provide visual markers to make the form easy to complete – for the interviewer in interviews and the respondent in self-administered questionnaires. Examples of visual aids include putting related questions in boxes and using arrows, flow diagrams, geometric symbols, and so on.
- Ensure good spacing and printing for easy reading, and enough space for filling in the responses.

Step 4: Pilot the questionnaire

- Select respondents who are similar to the target population.
- Do trial runs of the questioning, leaving space for noting required changes.
- Assess logistical issues such as time taken, wording, common responses which suggest categories for closed questions, and common misinterpretations of the question.
- Make the necessary changes.

Module 5: **Policy**

Structure of the Policy Module

MODULE 5

Module brief

What participants should get out of the Policy Module

Participants will:

- articulate a shared understanding of the meaning of "policy"
- conceptualize the policy-making process. This includes the range of factors which influence policy decisions and policy implementation at the levels of government, the workplace or the home
- identify the necessary components of strategy design/planning for policy change/service delivery changes
- identify gender inequality in policies and programmes and address it in the process of policy analysis, strategy design and implementation
- use specific tools to analyse policy-making processes and design intervention strategies/plans (or advocacy strategies) to impact on actual policies or programmes, whether at a macro or micro (workplace) level.

The thinking behind the module

Hostility to change

In most countries, changes in policy, including the law, and/or changes in practice are required to enable people to achieve their sexual and reproductive rights and health. The political and social context is often hostile to such changes, despite evidence that these would demonstrably improve the population's health. This tends to be particularly so with changes necessary for the promotion of gender equality.

Analysis

In this context, health advocates and decision-makers in health services need to do policy analyses which help them understand the contextual and institutional barriers to change. They also need to be able to identify those opposed to or uninterested in making these changes, and understand their reasons and the kind of influence they exercise over policy making. Drawing on these insights, they need to plan advocacy campaigns or other interventions to ensure that the necessary changes can occur.

Strategic planning

Lack of experience amongst health service leadership in strategic decision-making for change is an important barrier to improved sexual and reproductive health services. These people also need to acquire the skills to develop a strategic plan to gain support for changes. Strategic

planning is also needed to ensure that the practical conditions for implementation are in place – for example, resources mobilized, alliances and networks formed, and methods and messages for advocacy developed. Strategic planning should be based on an awareness of how change strategies can promote social and gender equity so that new policies and programmes jointly address practical, efficiency questions, and issues of equity and equality.

Because the word "policy" has different meanings in different political contexts, the first session builds a shared understanding of how it will be used in the module. It aims to consider policy in its broadest sense, so that the module can be of use when analysing and attempting to make changes at very diverse levels. These range from legislative change to change in health system policies such as the mechanisms for ensuring effective drug distribution. Or, from the processes through which decisions are made within a specific health setting, to the priorities governing a specific NGO's activities. This session also acquaints participants with concepts of gender blind, gender neutral, gender specific and gender redistributive policies, which helps classify policies according to the different ways in which they identify and address gender inequalities.

The second session builds an understanding of the diverse factors which influence:

- whether a problem is identified as something of concern to decision-makers
- which solutions or policy options are chosen
- the processes through which such solutions become formal or informal policy
- the processes through which they are implemented to a lesser or greater extent.

The session uses a model to show the interaction of different factors, which include the overall context, the specific policy or implementation processes and the diverse actors, at different but interlinked moments of the policy process. The session also looks into the role of policy activists in ensuring that these factors are identified and addressed in order to achieve a particular policy or implementation goal.

Session 3 provides participants with a tool for strategic planning, on the basis of the policy analysis from the previous session. This tool helps participants prepare for an ongoing evaluation of an initiative to achieve changes in their own workplaces, at whatever level is appropriate to them. This may be as policy makers in legislatures or national government, as donors, as managers of health facilities or of NGOs.

Session 4 gives a number of case studies to show how the model for policy analysis and the tools for strategic planning from earlier sessions can be applied. It helps participants see how these

Module outline

		Objectives Participants will:	Format of activities	Time: about 14 - 15 hours
Introductory session	Introduction to the Policy Module	• be acquainted with the module objectives and content	Input	15 mins
SESSION **1**	What is policy?	• articulate a shared understanding of the meaning of "policy" • understand ways in which different policies identify and address gender inequalities	Whole group discussion Group activity followed by whole group discussion	45 mins 1 hr 15 mins
SESSION **2**	A framework for analysing the policy and implementation processes	• understand the complex processes through which policies are developed and implemented • become familiar with a model to identify factors which influence policy decisions and policy implementation at different levels • be introduced to guidelines for taking into account the impact of policy on women and on gender inequality	Input with participant engagement Small group work Group report-back and big group discussion	2 hrs 30 mins 1 hr 1 hr
SESSION **3**	Tools for influencing the policy and implementation processes	• understand the need for different strategies to target different individuals on the basis of their position and attitudes relative to a policy goal • become aware that strategic planning requires knowing the policy terrain, and a step-by-step approach • be introduced to a model of "steps" to support strategic planning • know about the processes necessary for mainstreaming gender in strategic planning and implementation	Role plays Input with participant engagement throughout	45 minutes 1 hr 15 mins
SESSION **4**	Case studies of processes of policy change and implementation	• identify the factors facilitating and constraining efforts to achieve a specific new policy goal or implementation goal • incorporate a gender analysis in the above process • gain insights into the usefulness of the framework and tools presented in sessions 2 and 3 • recognize the effectiveness of a policy analysis and strategic planning process and the impact of addressing gender issues throughout this process, by being exposed to one currently taking place	Option 1: Input from a guest speaker Option 2: Small group work Option 3: Small group work	1 hr 2 hrs 2 hrs
SESSION **5**	Application exercise: development of a strategy to influence or implement a policy	• have an opportunity to practice using specific tools to undertake a policy analysis and design a strategy to change a policy or programme • undertake this process in relation to a policy or programme the participant plans to change once returning home, whether at a national or workplace level • internalize the intentions of the tools and the process of applying them to diverse situations • internalize how the process of mainstreaming gender equality in health is embedded within everyday decision-making about change processes	Individual work	3 hrs 30 mins
SESSION **6**	Consolidation on strategies to influence or implement a policy	• consolidate the main lessons learnt in this module • see the links between the previous modules, this module and the next one	Input and big group discussion	1 hr

tools can help to explain the success or failure of specific policy initiatives or implementation strategies. Different case studies could be used in different countries or with different participants.

Session 5 offers participants an opportunity to consolidate their own skills by using the model and strategic planning tool to plan a detailed intervention strategy that they wish to undertake once they go back to work after the course. Participants may choose to develop further the intervention that they identified as a priority in Session 7 of the Rights Module. This time for application ensures that on leaving the course the participants can actively apply learning in their own situations. The activity will be assessed for certificate purposes.

Session 6 allows participants to share the difficulties they experienced and the ideas they developed in their individual exercises. This is to consolidate their understanding of the purpose and methods of policy analysis and strategic planning.

Introduction to the Policy Module

What participants should get out of the session

Participants will be familiar with the structure, content and objectives of the Policy Module.

15 minutes

How to run the session

This is an input session.

Introduce the module using **overheads** from the Module brief:

- "What participants should get out of the Policy Module"
- "Structure of the Policy Module"
- "Module outline"

You need to make these key points:

- The purpose of this course is to build people's confidence and ability to make change happen, at whatever level they are working.
- This module helps people to analyse how change happens so that they will be able to support change processes in their own work.

SESSION 1

What is policy?

What participants should get out of the session

- articulate a shared understanding of the meaning of "policy"
- understand ways in which different policies identify and address gender inequalities.

2 hrs

2 hours

How long this session takes will depend on the extent to which participants are used to engaging with policy processes; and the extent to which they believe they can impact on policy. For a group of people actively working with policy making or advocacy, this entire session could simply be part of the introduction to the next session, as a discussion in the whole group.

Materials

- Handout: "How different policies identify and address gender inequalities"

- blank overheads or a flip chart
- overhead: "Defining policy", on p.307
- overhead: table "Different policy approaches to gender", in the handout

How to run the session

This session consists of two activities. The first is a brainstorming session followed by a discussion to draw out participants' understanding of policy and develop a definition from this. The second activity is a group exercise.

45 mins

Activity: In the big group: what does "policy" mean?

5-7 mins

Step 1: Brainstorm

Ask the group what the word "policy" means to them, and write their ideas up on an overhead or flip chart.

What to cover in the discussion

The meaning of the word "policy" differs in different countries. In general people think of it narrowly, to cover government legislation and/or government regulations. For the purposes of this course, since it

aims to encourage changes in practice wherever the participants are situated, a broader definition of policy would be helpful.

The discussion should generate a very broad list of what policy can mean, including:

- the goals/aims/visions of a government, group or organization
- the plan of action adopted in relation to those goals
- a decision
- a group of decisions
- an orientation
- that policy evolves in the process of implementation so that frequently the intention of formal policy, such as legislation, is not what is actually delivered in practice
- that policy is manifested in practice (i.e. as an approach) or in writing (e.g. a white paper, law, or mission statement).

Step 2: Exploring broad definitions

Encourage broad definitions of policy, at various levels. If participants don't come up with this kind of definition, ask questions like: "What about households? Do households have policies?" Participants may come up with ideas such as where the male head of a household allocates a set amount of money to his wife to cover domestic costs for the month; or where there is a rule that children have to come home in the evenings by a set time; or where a woman does all the cooking or men are served food first. In this way they can see that ongoing practices are a form of policy.

Ask also about policies in the workplace, such as how many days' leave a person can take, or grievance procedures.

While most of the examples presented in this curriculum are about government policy – whether in legislation or in public health services – a broader perspective on policy is necessary in order to empower not only participants who work for government, but also those in NGOs or donor organizations or other structures, to develop the skills and the recognition that they can initiate or influence policy change.

Summarize on an **overhead.**

Defining policy

- Policies exist beyond government legislation and regulations.
- Policies exist at all levels of society – international, national, provincial, community, household.
- Policy exists within different sectors of society – government, private sector, civil society (religious institutions, trade unions, NGOs), households.
- Policy evolves during implementation so policy intentions may not be the same as the policy that is actually delivered in practice.

Policy may therefore be broadly defined like this:

Policies are set principles, guidelines and objectives to guide activities whether at organizational, sectoral, national or international levels.[1]

[1] Drawn from "Policy formulation, analysis and influence", input in the course run in Kenya in 1999 by the Centre for African Family Studies.

In China, the word for policy incorporates the word for government. Thus "policy" means "government strategy".

When the course was run in China, some of the definitions participants gave were:

- behaviour rules and resource distribution principles
- models
- governmental schemes of resource distribution
- manoeuvre
- policies can not be made by anybody
- certain kinds of governmental management rules on specific subjects
- regulations
- a series of laws and regulations made by the ruling class to maintain their own rule
- a means of management stipulated by the government
- policy is lower than laws and higher than regulations
- policy means to act to the rules
- restrictions on individuals
- guiding rules stipulated by the state
- authoritative and mandatory
- includes politics and strategy
- the rules of bureaucratic consciousness

Because of this limited view, there needed to be some discussion about how to describe policy more broadly, such as workplace policy. More importantly, since policy is considered to be the business of government only, it was important to identify how participants themselves engage with policy processes. This was necessary to explain why the course has a module on policy and how engaging with policy at different levels is possible and important to achieve sexual and reproductive rights and health for the population.

In this context, participants needed enough time to explore the meaning of policy. The facilitators asked each individual to write their own idea of policy and then these were all discussed in the big group.

If your group is not familiar with the concept of policy, it might be worthwhile to divide the session into several steps, rather than have a big group discussion.

15 mins

Step 3: There are formal, written policies and less formal, unspoken ones

Distinguish between formal policies and informal or unspoken policies. For example in many countries urban health services have better facilities, more equipment and more staff than rural health services. There may be no formal policy that a department of health will give priority to urban health services over rural ones. However, in effect, the failure to insist that equal attention is given to rural health services means that whatever the written policy, the actual policy is to discriminate against rural health services and therefore the people who rely on them. If the health system only employs men at management level because that's the socially normative thing to do, then arguably their practice suggests an unwritten policy to exclude women.

In this way absence of a decision, or failure to address a problem is also a type of "policy-in-practice". For example, if there is no legislation or regulation or even health system practice to ensure that the poorest people in society can afford health services, then this can be called a de facto policy. In this way, "non-decisions" are also policy.

In this curriculum, the word "policy" is used to cover all the varieties of meanings discussed above. However, when teaching, you may need to be more specific. You will have to make it clear to participants when you are talking about legislation, formal policy such as a government white paper, policy made through legal court cases, regulations such as government decisions about acceptability of a specific drug, and so on. You may be referring to more practical policies such as a protocol for treating sexually transmitted diseases, or an institutional system such as how supervision is done or people are promoted. It can be confusing to participants to use one word – policy – for all of these things. However, the purpose of this module is to identify any systems of decision-making, and any institutionalized decisions that participants may want to change, at whatever level of "policy" these are.

1 hr 15 mins

Activity 2: How do policies identify and address gender inequalities?

In addition to having a shared understanding of the term "policy", participants need to be able to work out if and how different policies identify and address gender inequalities.

Step 1: Examples of different policies

Prepare a list of examples of different policies. The handout provides some examples to give you ideas. You may use these, or include other examples to make a new handout.

25 mins

Step 2: Group work with the examples

Divide participants into groups of four. Give each group a copy of the handout. Ask them to allocate each policy to one of the boxes in the table in the handout. Participants have 20 minutes for this group exercise.

40 mins

Step 3: Go through each policy in the whole group

In the big group, go through each policy.

Put up an **overhead** with the table from the handout. Ask one group which column (or policy approach) they allocated to policy 1. Listen to the other groups to reach consensus. Write this down in the relevant column on the overhead.

Then ask another group where it allocated policy 2, and so on until all eight policies have been covered.

Tell participants that these columns help you to get a general idea of whether a policy recognizes gender norms, and if and how it tries to change these. Ideally, we should be trying to develop policies which promote gender equity and equality or, at a minimum, make women's lives easier.

Tell participants that gender specialists have given names to each of these approaches. Write down the name of each of the policy approaches on the overhead. Go through each of the names. Then summarize each policy approach.

In the examples given in the handout, your completed table would probably look as follows, although depending on additional content they may have given to each policy, participants could justify placing them in different columns.

Different policy approaches to gender

This policy ignores gender norms.	This policy recognizes differences in gender roles, responsibilities and access to resources. It takes account of these, but does not try to change them.	This policy recognizes differences in gender roles, responsibilities and access to resources. It hopes to make women's lives easier, but will not actually change existing inequalities.	This policy recognizes differences in gender roles, responsibilities and access to resources. It hopes to support changes in these, so as to promote gender equality.
Gender blind	**Gender neutral**	**Gender specific**	**Gender redistributive**
	1		
		2	
		3	
			4
	5		
6			
7			
			8

What to cover in the discussion

Gender unequal

Many policies do not recognize differences between women and men. Some policies, which we might call "gender unequal", actually privilege men's well-being over women's. These are policies which directly deny women's rights or give men rights and opportunities that women do not have. For example, a policy which denies a married woman the right to medical insurance in her own name makes her dependent on her husband for access to medical insurance. In a context where her husband is unemployed, then she (and her husband) are denied access to medical insurance. A policy which requires a man's consent before a

woman can be sterilized is also gender unequal in that it deliberately gives men power over women. This approach is not given in the table on the handout, but if there are such health policies in your country, you could include this approach.

Gender blind

Gender blind policy is blind to gender differences in the allocation of roles and resources. Thus what may appear to be a good policy – for example one which brings clinics close to people's homes – may not impact equally on men and women since women may not control transport to reach the clinic or may not have funds to pay for services. A recruitment policy which gives both educational levels and years of experience as its criteria may seem to be a fair policy. However, it does not recognize that while certain women may have good work experience and competence, they may not have had the same opportunities as men for formal education, and the policy will discriminate against women. For this reason we can call it gender blind – not intentionally discriminatory, but reinforcing gender discrimination nevertheless.

Gender neutral

Gender neutral policy is aware of gender differences, but does not seek to change this. Instead it uses gender differences in an instrumental sense, for example by targeting all nutritional education at mothers because under the present division of labour they look after children.

Gender specific

Gender specific policy is aware of the practical gender needs of women and men and tries to address them. For example, creating a separate outpatients area run by women doctors for women patients so that they can discuss their reproductive health problems freely; or designing educational interventions to help adolescent boys deal with peer pressure for smoking or consuming alcohol.

Gender redistributive

Gender redistributive policy tries to change the allocation of roles, resources, and power between men and women in society. For example: raising awareness amongst men on the reproductive health consequences of women's work burden and problems of repeated pregnancy; promoting male methods of contraception including investment in research on male methods of contraception.

Explain the concept of policy analysis like this:

Step 4: Your input: explaining policy analysis

Policy analysis guides us for future policy development

The purpose of analysing policy is to identify the factors facilitating and constraining (government) action/inaction. By examining the process through which a policy was developed and how this process impacted on both policy content and implementation, we may learn lessons for future policy development.

It also allows us to identify if and how a policy or practice could promote gender equity and equality. This module provides participants with frameworks and tools to help them analyse policy processes – retrospectively or as part of ongoing strategic planning.

Now that participants have a shared understanding of the term policy, and recognize that policies can ignore or address gender inequities in a variety of ways, they are ready to move on to the body of the Policy Module. The intention is for them to be able to analyse policies to understand why they were developed at a particular time, and what shaped the policy content. This will also help them understand if and why the policy takes account of or tries to change gender norms. Once they have gained confidence in retrospectively analysing policies, they will be able to think about how to influence and shape policy content themselves.

Main point for closing this session

The reason for doing policy analysis is to be able to impact most effectively on policy development and implementation.

Session developed by Barbara Klugman

Handout

1 How different policies identify and address gender inequalities

In this table each column represents a different policy approach to gender. Under the table, you have a list of different policies. Decide where each policy fits in the table and fill in its number under the appropriate column. You have 20 minutes to do this exercise.

Different policy approaches to gender

This policy ignores gender norms.	This policy recognizes differences in gender roles, responsibilities and access to resources. It takes account of these but does not try to change them.	This policy recognizes differences in gender roles, responsibilities and access to resources. It hopes to make women's lives easier, but will not actually change existing inequities or inequalities.	This policy recognizes differences in gender roles, responsibilities and access to resources. It hopes to support changes in these, to promote gender equity or equality.

List of policies

1. **Maternal health policy: trains midwives to improve their clinical skills to prevent maternal morbidity and mortality**
2. **Water supply policy: establishes a mechanism to provide taps close to villages so that women will not have to walk as far to fetch water**
3. **Human resource policy: includes provision for child care facility at the workplace**
4. **Land policy: removes restrictions on women's right to inherit land**
5. **Occupational health policy: protects women and men from working in places which are hazardous to their reproductive health**
6. **Senior management recruitment policy in a department of health: requires all managers to have a PhD**
7. **Community-based AIDS care programme: says that health care system cannot take responsibility for caring for people with AIDS so that home-based care must be instituted**
8. **Information, Education and Communication policy: establishes messages and methods to advocate to women and men about mutual respect and equal rights in sexual decision-making as a means of promoting safer sex practices.**

SESSION 2

A framework for analysing the policy and implementation processes

What participants should get out of the session

- understand the complex processes through which policies are developed and implemented
- become familiar with a model to identify factors which influence policy decisions and policy implementation at different levels
- be introduced to guidelines for taking into account the impact of policy on women and on gender inequality. This means that any policy analysis must necessarily also be a gender analysis.

4 hrs 30 mins

4 hours and 30 minutes

Materials

- Lecture notes for the facilitator: "Framework for analysing factors influencing policy development, content and implementation"
- Handout 1: "Framework for analysing factors influencing policy development, content and implementation"
- Handout 2–4: Group exercises 1-3
- Handout 5: "House vote opposes IMF and World Bank on 'user fees'" (optional reading material to be enclosed in participants' course files)
- Handout: summary of major points in the input, prepared by the facilitator

- overhead: "Sex education in schools", on p.317
- overhead: Handout 1: "Framework for analysing factors influencing policy development, content and implementation"
- overhead: "Contextual factors influencing policy", Box 1 in the lecture notes for the facilitator
- overhead "Problem identification: whose problems?", Box 2 in the lecture notes for the facilitator
- overhead: "Policy development through consultant/policy elite nexus", Figure 2 in the lecture notes for the facilitator
- overhead "Stakeholder analysis chart of actors in the policy process", Table 1 in the lecture notes for the facilitator.

Readings for the facilitator

Policy analysis

1. Foltz A. The policy process. In: Janovsky K, ed. *Health policy and systems development: an agenda for research.* Geneva, World Health Organization, 1996:207–223.

2. Grindle M, Thomas J. Policy makers, policy choices, and policy outcomes: the political economy of reform in developing countries. *Policy Sciences,* 1989, **22:**213–248.

3. Kabeer N. Gender-aware policy and planning: a social relations perspective. In: MacDonald M, ed. *Gender planning in development agencies.* Oxford, Oxfam, 1994:80–97.

4. Reich M. Applied political analysis for health policy. *Current Issues in Public Health,* 1996, **12(4):**186-191.

5. Stover J, Johnston A. *The art of policy formulation: experiences from Africa in developing national HIV/AIDS policies.* Washington: Policy Project, Futures Group, 1999.

6. Walt G, Gilson L. Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning,* 1994, **9(4):**353–370.

Case studies: South African case

7. Klugman B. Empowering women through the policy process: the making of health policy in South Africa. In: Presser H, Sen G, eds. *Women's empowerment and demographic processes: moving beyond Cairo.* London: Oxford University Press, 2000:95–118.

8. Klugman B, Varkey SJ. From policy development to policy implementation: the South African Choice on Termination of Pregnancy Act. In: Klugman B, Budlender D, eds. *Advocacy for abortion access: ten country studies.* Johannesburg, Women's Health Project, School of Public Health, University of the Witwatersrand, 2001:249-277.

Other case studies of activism for policy change

9. Ellsberg M, Winkvist A, Liljestrand J. The Nicaraguan Network of Women against Violence: using research and action for change. *Reproductive Health Matters,* 1997, **10:**82–92.

10. Nunes F, Delph Y. Making abortion law reform work: steps and slips in Guyana. *Reproductive Health Matters,* 1997, **9:**66–76.

Information on the impact of fees-for-services

11. Gilson L. The lessons of user fee experiences in Africa. *Health Policy and Planning,* 1997, **12(4):** 273-285.

12. Schneider H, Gilson, L. The impact of free maternal health care in South Africa. In: Berer M, Ravindran S, eds. *Safe Motherhood Initiatives: critical issues.* Oxford, Blackwell Science Limited for Reproductive Health Matters, 1999:93–101.

How to run the session

This session is an introduction to policy analysis. It provides some time for participants to work with the framework they are given, and this work is strengthened in later sessions.

The session is divided into three main activities. The first is your input explaining the framework for analysing the policy process. The second is group work in which participants draw on examples of specific policy processes to apply the framework. The third requires reports from the groups and is followed by a discussion on these in the whole group. It draws out lessons on the usefulness of the policy analysis framework.

If the course you are running intends to focus on policy analysis, strategic planning or advocacy, or to pay greater attention to these aspects relative to other modules, then this session could be reworked to run entirely in a participatory way. Rather than presenting the framework to them, you could draw out the framework from the participants, on the basis of their own analysis of factors influencing the development and content of a specific policy.

You may, if you wish, choose to include only the first activity in this session, and have the group exercise as part of Session 4, which aims to apply the framework and tools introduced in this session and the next.

Activity 1: Input on the policy framework and its dimensions

Step 1: Introductory discussion

It is helpful to begin by discussing with participants their understanding of how policies are made. Ask them whether policies are always rational, based on a sound understanding of underlying issues. Ask for a specific example related to reproductive and sexual health or rights from the group. Some of the examples may be:

- many countries forbid sex education in schools despite the evidence of high levels of pregnancy amongst school goers
- many countries spend most of their health budgets on urban specialist hospitals despite the fact that a large proportion of their population is rural and does not have access to basic health care.

Ask why such policy decisions are made.

From the discussion of these examples draw out more general points about how policy content results from considerations which have very little to do with actual needs of the poor or poor women. Thus equity – including gender equity – is frequently not the basis for policy decision-making.

What to cover in the discussion

The rationalist approach

People often think of policy as something based on logic. They imagine that rational individuals, with all possible information at hand, and no conflicts of interest, use this information to decide upon policy and then

implement it. This is often referred to as the rationalist approach to policy analysis.

What happens in real life

However, in real life, policy is usually the result of a very complex interaction of factors. Policy makers often have conflicting information. They are frequently engaged in struggles for power, whether through elections or within a bureaucracy. This may determine what decision they make about a specific issue more than any considerations of the needs of people on the ground, the costs, or human rights.

Overhead Give the example from the box below, of factors underlying a country's sex education policy.

Sex education in schools

There is no sex education in schools. What could the influencing factors be?

- political leadership fearing that the public will not elect them if they support something which is seen to be breaking with convention, like cultural or religious norms
- government giving priority to spending funds on something other than the education system
- educational officials reacting to the idea of sex education because it has been suggested by a donor and is therefore considered to be "external" pressure
- decision-makers' reluctance to challenge gender norms of their society by strengthening girls' understanding of their bodies and rights.

The interactive approach

The understanding that policies are the result of a complex interaction of factors, is often referred to as an interactive approach to policy analysis. Policies are often sites of contestation, reflecting the dominance of particular groups and ideologies. In addition, policies often change over time rather than through one major change in legislation or practice. This has led many policy analysts to talk about policy as incremental.

If you want to influence policy

Policy content as well as its implementation is not always rational. Both result from a complex negotiation of many factors which may have little to do with the actual problem that the policy is intended to address. It is therefore important for people who want to influence policy to be able to understand what the various factors are which impact on both policy content and its implementation.

20 mins

Step 2: The different dimensions of the framework

Start now with your input on policy framework and its dimensions. The major content of this input is outlined in the lecture notes for the facilitator. You may want to adapt your input based on these notes, using whichever example of a policy process that you wish to include. It may be useful to make a handout with all the major points from this input (not included in this manual), to be given to participants at the end of Step 1.

Because of the complexity of this input session, the process has been broken down into several steps.

Put up an **overhead** of Handout 1: "Framework for analysing factors influencing policy development, content and implementation". You may give participants Handout 1 for reference at this point.

Explain each dimension: context, actors and process (problem identification, solution development, political and bureaucratic processes) and the factors within each of these, starting with context, drawing on the lecture notes. This is only meant to be a quick overview, before you go into each dimension in detail.

20 mins

Step 3: Explaining the contextual factors

Make and put up an **overhead** with the main categories from Box 1: "Contextual factors influencing policy" from the lecture notes for the facilitator. These include social, political, economic, cultural and the immediate national and international factors. While explaining each of these factors, use the example of a particular country or policy process. The South African case study on the process of changing the abortion law is given as an example of how this may be done. In the lecture notes, this example comes after the table. But use it alongside the explanation of the table so that you keep going back to the overhead of the policy framework.

Points to highlight

Policy is a product of context

Changes in policy require acting on diverse aspects of context in order to create an enabling environment for policy change and for implementation. For example, a change in government may provide a good opportunity for intervention. Likewise, a collapse in the economy might hamper efforts to change policy which require additional funds for implementation.

The context will influence both policy development and the extent to which policy can be implemented.

Gender norms are part of this context

Analysis of context must include analysing how gender norms, social values about women, the division of labour and other dimensions considered in Module 1 are relevant. They need to be included in the policy analysis, so that the policy analysis includes a gender analysis.

10 mins

Step 4: Who are the actors in policy?

Go back to the framework. Put up the **overhead** of the framework again. Tell participants that you are now moving on to the next dimension: the actors who have a stake in the formulation as well as in the implementation of the policy. Go over the major actors in the policy

process: politicians, government officials, research institutions, NGOs, and specific constituencies such as professional or religious associations. Explain their roles in the policy process that you are using for this input, and give illustrative examples.

Frequently women are not mobilized into organizations which make their voices heard. It is important to identify whether or not there were any organizations of poor or marginalized women who participated in the example of a policy process that you used. Spend some time discussing how to support the participation of poor or marginalized groups of women in a change process.

15 mins

Step 5: What is the process?

Still referring to the overhead, indicate that you are now moving on from context and actors to process. This framework considers three aspects of process:

- the problem identification process
- the solution development process
- the political and bureaucratic process.

Go over the main points under the problem identification process from the lecture notes and explain as required.

Then put up an **overhead** from Box 2: "Problem identification: whose problems?" from the lecture notes. Discuss how to ensure that the problem identification process does not exclude poor and marginalized groups to become an exercise carried out by academics and bureaucrats.

15 mins

Step 6: The problem identification process

After this input, ask participants to share their experiences of inappropriate problem definition or effective problem definition in the big group.

Points to highlight

A problem only becomes recognized as a problem when people concerned about that issue intervene in some way.

How a problem is defined will depend on who is involved in defining that problem.

It is essential that the way a problem is defined is based on the interests of those who are marginalized or discriminated against, so that equity concerns are at the centre of defining the problem. Policies should aim to be at least gender specific, and ideally gender redistributive.

Mainstreaming gender in health means that in the process of problem definition, we make sure that women's perspectives, experience and priorities shape problem definitions.

Move on now to solution development, covering the main points from the lecture notes. Highlight the fact that frequently neither problem

10 mins

Step 7: Solution development

identification nor solution development is carried out in a way that involves those experiencing the problem. Rather, they very often address the interests of particular interest groups, such as:

- consultants wanting to do more research
- politicians wanting to maintain their political support
- donors wanting to support a programme that fits their country's policies or their institution's values: for example a vertical programme providing only contraception services, or only sexually transmitted disease services, irrespective of the impact on ordinary people.

Put up an **overhead** with Figure 2: "Policy development through consultant/policy elite nexus" from the lecture notes. The illustration shows how solutions can represent the interests of a small grouping of people. Note that in this illustration, activists have been removed from the policy process. Their key role in creating an interface between problems, solutions and the political process has gone. The term "activists" here is being used specifically for those actors who have gender and other equity concerns at the centre of their agenda.

Points to highlight

Solutions need to reflect the experience and needs of those who are most disadvantaged in society in order to promote a human rights approach to health, and specifically to promote gender equality.

Solutions need to be realistic, not offering policies or plans that cannot be implemented. They should identify what steps can be taken to overcome obstacles to implementation.

There may be some concern amongst participants as to what part of a solution goes into legislation, what into policy, what into regulations, and so on. This differs from country to country and you will need to let participants know that they should find out how things work in their own countries. Sometimes "policies" are simply instructions sent down through a bureaucracy.

10 mins

Step 8: The political and bureaucratic process

Overhead Go back to the framework. You have now considered how the overall context influences policy content, and also how the processes of problem definition and solution development can influence policy content.

You can move on to the role of the political and bureaucratic process using the questions and content from the lecture notes.

15 mins

Step 9: Bringing together the context, actors and process

Overhead Go back to the framework. You have now considered how the overall context influences policy content, who the actors influencing policy are, and likewise, how the processes of problem definition and solution development can influence policy formulation. The political and bureaucratic process also deals with the issue of policy implementation.

Put up an **overhead** of Table 1: "Stakeholder analysis chart of actors in the policy process" in the lecture notes. This gives participants an idea about how they can bring together all three dimensions (context, actors

and process) in a way that gives a sense of the overall terrain. All they do is put ticks in different boxes or write short notes in each.

Points to highlight

Many different actors influence problem identification, solution development and political decision-making processes

It is essential to identify actors and understand their motivations, their power and influence in order to develop strategies to address them. It is particularly important to develop coherent and effective strategies to respond to the positions of any opposing groupings in terms and language which make sense to decision-makers.

Step 10: The role of policy activists

The last step before concluding the input is to go over the role of policy activists in bringing problems and solutions to the political agenda. Use the lecture notes for this.

Step 11: Rounding off the activity

Now that you have finished presenting the overall framework, the following points should come out as the main factors influencing policy and implementation.

Points to highlight

Sexual and reproductive rights legislation, policies and implementation reflect the social, political and economic context

Each context requires its own analysis, the development of strategic options, and action to implement these.

What remains the same is the need to ensure that the solutions meet the needs of ordinary women, men and adolescents and also contribute to the more equal allocation of responsibilities and resources between the sexes.

Implementation

The above input was related to policy formulation. A similar analysis may be carried out for policy implementation. For example, what is the context in which the policy is being implemented? What are the processes and mechanisms (especially the political and bureaucratic processes) for policy implementation? Who are the actors with a stake in the implementation of this policy? Which of them support it, and who is likely to be against the policy?

1 hr

Activity 2: Applying the framework for policy analysis

Divide participants into three groups.

Explain the activity. It involves applying the framework for policy analysis to identify the factors influencing a specific example of a policy process. Handouts 2–4 have three exercises for analysing policy processes. You may choose one of these to use with all three groups, or use a different exercise with each group. You may prefer to use recent examples from participants' countries. Session 4 on case studies provides some more examples of policy processes, which may also be used.

In the South African course, there are usually some participants from South Africa, where the new government has instituted free health care at clinic level. There are also usually participants from Zambia and other African countries that have recently implemented fees for services or other systems of "cost recovery". Most participants have experience of these changes. They are generally asked to do the exercise in Handout 2, looking at the issue of "fee for services" using their own knowledge of it.

If you have participants from countries with and without user fees, you may do the activity with participants from countries with free health care in one group and participants from countries with "fee for services" in another. Or when there are many participants, there may be more than one group on each topic.

The purpose of using two opposing policy situations is to allow participants to compare the different contexts and policy processes, systems of decision-making and actors that have given rise to such different policies.

An alternative approach was used in China. Amongst their course participants, some had substantial experience in policy making, while others had none. The facilitator divided the participants into two groups, one with experience of policy and one without.

The experienced group was asked to identify an example of an existing policy which they knew something about. This group had to describe the policy process that led to the making of that policy. The facilitator knew that this exercise would challenge the policy makers, since they were unable to give a simple description of how they made policy. The second group was asked to think through a hypothetical policy process on a specific issue.

Each group was given an opportunity to report back. The facilitator then ran a discussion on the ideal policy process compared to the real policy process.

Participants have one hour to do this activity and write up their analysis on a flip chart.

1 hr

Activity 3: Group report-backs and discussion

45 mins

Step 1: Group report-backs

Give each group an opportunity to report its conclusions in no more than 10 minutes and then open the floor to general discussion.

Here are some issues which frequently come up over the user fee issue in Case study 1:

- Where a country is dependent on international donors (context) there is likely to be pressure to implement fees for services.
- The economic crisis has had a significant impact on access to health care as have pressures from international monetary institutions (context).
- The extent to which senior politicians are committed to equity (actors/political climate) will influence whether or not they introduce fees.
- A change in the system can cause major disruptions to health workers (actors/bureaucracy) who are frequently not consulted before policy change, and therefore they may not make an effort to implement the new system.
- The absence of mechanisms for public input into policy, and of pressure groups and NGOs who can represent the interests of the poor, creates a situation in which those in power are not under substantial pressure to allocate more resources for health care.
- Fees for services impact more on women's access to services than men's because of women's lesser control over household financial resources. This is an example of a gender blind policy, which did not intend to specifically discriminate against women.

1-2 hrs

Step 2: Lessons learnt

While the group discussion is likely to focus on the particular exercises given to the groups, the concluding part of this session should reflect on lessons learnt. It should look at how different factors influence the content of and the implementation of policy, including the extent to which they address gender equity and equality.

Identify any aspects of the framework which groups found difficult to use, and clarify these. Ask participants in what way they found this exercise helped them to unravel why policies are not always logical.

In concluding, point out that while this activity, as well as the earlier presentation, were retrospective analyses – looking at how a policy or an implementation process came about – the methodology is equally useful for forward planning. This will be the topic of Session 3, so the concluding comments from this session lead into it.

To close the session, give participants Handout 5.

Session developed by Barbara Klugman

Lecture notes for the facilitator:

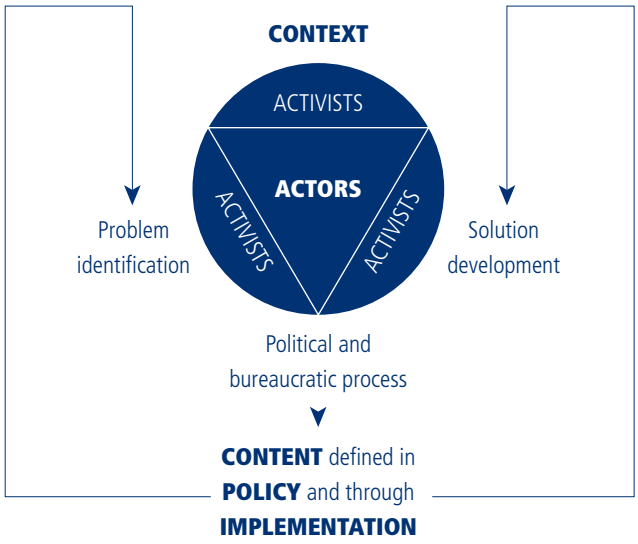
Framework for analysing factors influencing policy development, content and implementation

A slightly simpler version of this framework was originally published in Klugman B. Mainstreaming gender equality in health policy. *Agenda,* 1999:48–70.

The following is an outline of key points and not a definitive summary of the issues. You may want to rework it to make it suitable to the group you are working with.

This framework draws on some of the key conceptual developments in policy analysis over the last decade. In particular, it draws on Walt and Gilson's *[1]* recognition of the role of context, actors and political process in influencing policy content and on Kingdon's *[2]* conceptualization of the existence of "multiple streams" of problems, solutions, and politics and the need for "policy entrepreneurs" to create links between these streams. In relation to stakeholders, it draws on Reich's *[3]* work on political mapping.

Figure 1: The framework



1. The role of context in influencing policy change

Sexual and reproductive rights legislation and implementation reflect the prevailing social, political and economic context, including the national/international nexus.

Context can be divided into the socio-economic and political context; immediate contextual factors; international factors; and cultural factors (see Box 1).

Box 1: Contextual factors influencing policy

Adapted from Leichter HM. *A comparative approach to policy analysis: health care in four nations.* Cambridge, Cambridge University Press, 1979.

The social context

- Position of women:
  - in the economy, educational system, legal status
  - in kinship and inheritance structures
  - in civil society organizations and in community life
- Legal and social/cultural approach to individual rights relative to group/family rights
- Gendered content of this, e.g. does a child belong to parents, her father, her mother or their families?
- National human resource base:
  - management capacity
  - research capacity
- Existence of infrastructure for delivery of social goods including education, health care, water supply, electricity, transport systems, telecommunications and broadcasting

The political context

- Constitution or legal framework:
  - a human rights perspective?
  - incorporating gender equality?
  - a religious perspective – who controls the interpretation of religion?
- Historical nature of political regime, e.g. communist/left wing, right wing; democratic or dictatorship
- Role of civil society:
  - the right to vote?
  - the right to choose parties?
  - practice of political accountability to constituencies?
- Framework for relationship between civil society and government, e.g. a lobbying system; institutions for negotiations
- Recognition of the role of advocacy?
- Degree of space for criticism? Space for media freedom of expression?
- Extent of civil society political organization, i.e. trade unions, women's movement, student movement, etc.
- Involvement of and representation of women

The economic context

- Nature of economy: command economy, market led economy or mixed economy
- Existence of resources
- Priorities in allocation of resources: is equity a factor?
- Role of international interests in influencing allocation of resources including
  - relative power of donors
  - extent of government control over donor money
- Centralized or decentralized allocation of and accounting for resources

The cultural context

- Predominant social values and norms on gender, reproduction and sexuality whether arising from religious or ethnic bases or other historically institutionalized processes
- Traditional practices which may undermine sexual or reproductive rights or health
- The extent to which gender or other inequalities are institutionalized, i.e. the extent to which patriarchal values are built into institutional norms and systems of decision-making

The immediate context

- Impact of a change in government and related shifts in ideology
- Impact of war
- Impact of shifts in national identity as a result of either of the above
- Impact of an international agreement e.g. CEDAW or consensus e.g. ICPD
- Impact of collapse in the market

The international context

- Proportion of donor funds in national budget; sector-wide or donor specific approach
- Nature of international alliances and commitments
- Whether the government has ratified key international human rights treaties

The impact of context on the efforts to liberalize abortion legislation in South Africa

- **In 1996, the Choice on Termination of Pregnancy Act was passed. This Act provides for abortion on request up to 12 weeks; and under a broad set of circumstances, in consultation with a health worker, up to 20 weeks; adolescents do not require parental consent; trained midwives can do abortions.**

Many people have asked how it was possible to win this law, and to what extent the process can be followed in other countries. It is important to recognize that the same activities will not lead to the same results in different contexts.

These are some of the key factors in relation to the socio-economic and political context, which facilitated winning of this law in South Africa:

- **The South African Constitution provides for equality on the basis of gender. It also provides for security in and control over the body; and the right to make decisions concerning reproduction. In relation to health care, it includes the right to have access to health care services, including reproductive health care. There is a profound commitment to human rights in the Constitution, law and policy; there is a commitment to religious rights but not at the expense of individual rights to equality. Thus the context was favourable to gender redistributive policy – to redistributing reproductive rights so that women too would be able to exercise these rights.**

- There is a poor quality and inequitable but functioning health system so that provision of abortion is possible. This in turn depends on the government's ability to implement its general commitment to improving health services.

Key cultural factors which influenced the winning of the law in South Africa included:

- South Africa's population is religious, with diverse but predominantly Christian religions. There is a strong discourse of African patriarchal "tradition". However, at the time of the legislative process, the predominant discourse of civil society organizations was of human rights, including women's rights, and particularly the right to equality. Thus, in the legislative process, it was possible to mobilize around women's right – particularly the right of black women who had previously been disenfranchised and discriminated against – to abortions. Previously, only white people and rich people had access to abortions. However, given the significant role of religion and the concept of African traditional values, it was necessary to ensure that religious leaders and people who represented "African" values spoke in favour of the new laws.

A significant immediate contextual factor was the change of government in 1994 after years of apartheid discrimination:

- The new democratically elected government had committed itself to immediate social and legal change on all fronts. It wanted to be seen to be acting. In addition, its platform of human rights included a moral imperative to end population control (whether control of fertility or movement). This was therefore a very enabling contextual environment in which to argue for women's right to control their fertility through access to abortion, as part of a broader reproductive rights and health strategy.

The role of the international context was not very significant:

- Since South Africa had been isolated from international trends because of sanctions, the ICPD and other international agreements did not play a significant role in influencing this decision. However, the global trend towards macro-economic approaches that promote fiscal restraint has meant that there are not substantial funds available to implement the commitment to increased access to health care, including the provision of new services such as abortion services. Links between NGOs in different parts of the world did impact on the development of the new law, since South African NGOs accessed experience from different countries in how to word legislation. Lessons learnt from different countries were taken into account and shared with legislators.

2. The role of actors in influencing policy content

In order to develop a coherent strategy, it is essential to identify which actors, or stakeholders, share your goals for policy change, and which are against them. Which of these have power or influence and which do not? Which are mobilized and which are not? Could certain groups be mobilized in support of your goal? Once the actors are identified, specific strategies need to be identified: to work with those who share your aims and to

neutralize those who do not. The analysis of the political decision-making process will also help to understand the motivations of decision-makers. However, you need to address the motivations, interests, resource-base and influence of all stakeholders.

Frequently women are not mobilized into organizations which make their voices heard. It is important to identify whether or not there are any organizations of poor or marginalized women and how to support their participation in a change process.

Some examples of actors in the policy development or implementation process:

- politicians and political parties
- government officials
- NGOs
- community groupings/"people's organizations"
- specific constituencies (e.g. professional organizations, religious organizations)
- the media
- research institutions.

Some of these actors will support a policy or implementation goal while others will oppose it. Some will have more resources and power than others and will therefore have more influence. Some will be mobilized and others will not. An analysis of actors is necessary in order to identify existing potential allies and opponents, who could be mobilized in support of a specific change process and what resources they do or do not have.

3. The role of the process of problem identification in influencing policy content

The framework identifies the process of problem identification as very significant in ensuring that the final policy and its implementation are aiming to promote social and gender equity. When people who do not have the interests of the majority at heart define a problem, the problem definition may not recognize the specific interests of the majority. Mainstreaming gender in health means making sure that women's perspectives, experience and priorities shape problem definitions; it means focusing on equity – putting the needs of those who are most disadvantaged first whether these are children, women, men or specific groups of people.

The following box highlights issues related to the process of problem identification and definition. These need to be taken into consideration when looking at how a policy came about, or when attempting to plan a policy or implementation intervention. Again it uses the South African experience in order to show how the issue of abortion was first identified as a problem, in order to get it onto the political agenda.

Box 2: Problem identification: whose problems?

Who defines the problem?

- Need to ensure that ordinary people's perspectives – women's, men's, adolescents' (and within this, marginalized groupings of men, women and adolescents) – are heard and that legislation and programmes are designed to meet their needs, as they perceive them
- Need to ensure that inequality does not silence the experience or the voices of certain groupings, for example poor women who are either not recognized as having the right to input, or who do not have the confidence to express their views
- Need to ensure that the way the problem is defined identifies and addresses how the issue impacts specifically on poor women's position in society as well as their daily life experience: focal issues, as raised in the Gender Module, are their power, their roles, their access to and control over resources.

The problem definition process in South Africa

- Civil society: consultative process of *Women's Health Conference* in 1994 mobilized mass-based organizations, policy activists and future government bureaucrats from rural and urban areas. The conference emphasized the participation of black women because of historical discrimination on the basis of "race". This process developed a consensus on priority problems facing health system transformation and in relation to sexual and reproductive rights and health. It developed policy proposals including on maternal health, contraception, access to abortion, cancer, STDs, HIV/AIDS, etc. It also developed proposals to address discrimination including on ageing, lesbian health, access to water, and so on
- Political party (African National Congress) drew on members of branches, interacting with party policy analysts, to identify priorities and actions: free health care; equity across provinces; equality across "race" lines; addressing violence; promotion of sexual and reproductive rights
- Constitution development: participatory process of public advertising; civil society responses; women's organizations lobbying on the right to reproductive health.

4. The role of the process of solution development in influencing policy content

There are many institutions in society, such as universities, private sector bodies, and government technical staff, whose task is to develop solutions to society's problems. There are often many different ways of solving a problem. It is important to look at what the solutions tabled were, who tabled these, why, and whose interests they represent, in trying to understand how a policy was developed.

Solutions need to address equality – to ensure that barriers to the sexual and reproductive rights of those with the least power and resources, notably women, are addressed. Solutions need to address equity –to ensure that the policy or programme applies to all people, and will be implemented in such a way that the inequalities in the allocation of resources and power between men and women and between different social groups are reversed.

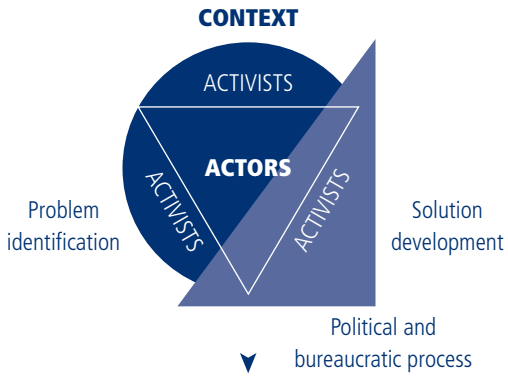
It is essential to establish mechanisms during the process of advocacy to gather information about how those who are poorest or suffer discrimination experience the issue, and what sorts of solutions would improve their overall situation.

Frequently neither problem identification nor solution-development is carried out in a way that involves those experiencing the problem. Rather, it often addresses the interests of particular interest groups, such as:

- consultants wanting to do more research
- politicians wanting to maintain their political support
- donors wanting to support a programme that fits their country's policies or their institution's values. For example, a vertical programme providing only contraception services, or only sexually transmitted disease services, irrespective of the impact on ordinary people.

The illustration in the figure "Policy development through consultant/policy elite nexus" shows how the solutions can represent the interests of a small grouping of people. Note that in this illustration, activists have been removed from the policy process. Their key role in creating an interface between problems, solutions and the political process has gone.

Figure 2: Policy development through consultant/policy elite nexus



CONTENT of policy is skewed by failure to take account of problems as definedby the poor or marginalized, including women, i.e. failure to redistribute power, and access to and control over resources.

It is also essential to consider whether or not a solution can be implemented – are there the resources (staff, funds, facilities) to implement this solution? Other less tangible things like the management capacity or the institutional willingness for change also need to be considered, so that policies or programmes are realistic. Alternatively, solutions need to take into account the potential barriers to implementation, and try to address these.

The process of solution development in South Africa

In South Africa, following the problem identification process in relation to abortion, specific solutions were put forward. In addition, an abortion reform NGO developed draft legislation as the basis for lobbying. There was some contestation between different interest groups about the best possible solution. For example, doctors and NGOs with lawyers argued that nurses should not be allowed to do abortions. This can be interpreted as doctors trying to hold onto their medical preserve and being supported by other professionals such as lawyers.

In contrast, women's rights and health groups argued that nurses should be allowed to do abortions in the first trimester, in order to ensure access to abortion for rural women since there are few doctors in rural areas. Ultimately the law agreed that midwives should be able to do abortions, in keeping with the new government's commitment to equity of access.

The process of solution development in South Africa paid little attention to issues related to implementation. Those involved in developing the new policy had never been in government, and had little experience of health systems. The law does not address how it will take account of limited health system capacity for referral, drug supply and so on.

What's more, little consideration was given to whether or not health workers would support the liberalized abortion law. While there was some information indicating that nurses would not support the change in law, the new law did not indicate how it would address nurses' concerns. The process of developing the new law did not include processes of consultation with nurses' organizations in order to gain their input and build their sense of ownership over the new law. Once the law was implemented, many nurses became gatekeepers, not referring women who needed abortions. No institutionalized system to both promote health worker support and to require health workers to implement the law were established.

Another factor that was not considered in solution development was how to ensure that women would be told about the law and their new rights and how to access these.

5. The role of the political and bureaucratic process in influencing policy content

How does one work towards putting a problem identified through the processes that have been described above on the policy agenda? This requires an analysis of the political and implementation process and opportunities for intervention. This analysis should include asking:

Who is responsible for making and implementing legislation or policy in a specific country, area or workplace?

In the context of a country, this would include:

- politicians
- government at different levels and all bodies responsible for implementing the legislation or policy
- others in a "policy elite" like powerful business people or religious leaders.

It is important to assess what proportion of decision-makers are women or people from historically disadvantaged positions in society who might be more sympathetic to a policy which promotes gender equality and sexual and reproductive rights and health.

Are there formal or informal opportunities for public input?

Some political processes include formal mechanisms such as lobbying systems or public hearings in which different actors can present their perspectives. In some political systems, decisions are made behind the scenes, and any influencing has to be done at a personal level.

Thus one has to consider if there are moments within the formal political system (such as public hearings on a white paper or parliamentary hearings) where the public can intervene. If the only members of the public who have access to policy makers/implementers are those who build personal relationships with those in power, then this poses different challenges for influencing policy. Many systems include both – formal and informal mechanisms of decision-making. When people talk about political systems being gendered, one thing they are often referring to is the informal moments in which political decisions are made, such as when men go out for a drink in the evening – an activity which often excludes women decision-makers because of their domestic responsibilities.

What are decision-makers concerned about?

Grindle and Thomas *[4]* have identified four different concerns that seem to be the major factors that influence decisions made by politicians and senior government officials. These are:

- the meaning of change for political stability and political support
- the technical advice they receive
- their relationships with international actors
- the impact of their choices on bureaucratic interactions, i.e. how policy or implementation decisions affect their power at work, their levels of responsibility, and so on.

It is important to work out what factors influence those who are in power, so that advocacy activities address their concerns, in a language that they understand.

Political and bureaucratic processes in the South African case

Political processes and mechanisms

- In the South African case, the change of government in 1994 resulted from a highly organized civil society. This meant that the new government was

committed to a participatory process for policy development. A range of mechanisms for this have been established, including the holding of public hearings by parliament. There are also opportunities for people to provide written input at specific moments of the legislative process. Once implementation begins, there are fewer mechanisms for public input. Also, significantly, few mechanisms for participatory decision-making within the bureaucracy have yet been established. In addition to publicly owned radio and television services, there is a free and privately owned media which, while representing the values of the owners of the media, does offer opportunities for getting information and specific perspectives out to the public.

- Thirty per cent of parliamentarians of the ruling party are women and they have a high representation on the health select committee in parliament.

What were decision-makers concerned about?

- ### The consequences of change for political support

The interests of politicians became apparent in the South African political process when the parliamentary process was postponed. When a women's health activist asked a parliamentarian why this had happened, he said that the political party wanted to wait until local elections were over, for fear that this legislation would make them lose votes.

In order to persuade politicians that a liberalized law was in the interests of their constituency, activists brought poor black women who had been criminalized for having abortions to speak at parliamentary hearings rather than speaking on behalf of them. They mobilized religious figures to speak in favour of the legislation on the basis of addressing women's suffering and meeting their health needs. And they mobilized people from diverse ethnic backgrounds to show that there was a groundswell of support from different constituencies.

- ### Technical advice

Key pieces of technical information influenced the politicians deciding on South Africa's abortion law. There was historical research that showed that all South African cultures and "races" had been performing abortions for centuries. Medical research showed the costs carried by the public health sector of treatment for incomplete (illegal and unsafe) abortions, thus providing a monetary motivation for liberalized law.

- ### Relationship with international actors

Information on how liberal abortion law looks in other parts of the world served to support parliamentarians in shaping a new law. Information on the links of South African anti-abortion groupings to right wing terrorist groups in the United States of America served to undercut their legitimacy.

Impact on bureaucratic interactions

The South African strategic planning process was weak in relation to addressing the concerns and needs of the bureaucracy. Neither politicians nor NGO activists took adequate account of likely barriers to implementation. Their focus was on the political process, ignoring that once the Act was won it would have to be implemented by a bureaucracy. The

legislation, or subsequent regulations, should have addressed such issues as:

- time-frames, financial allocations, and human resources
- how to implement a new service in the context of health system restructuring, with major changes under way through decentralization and changes in financing systems
- training of doctors and midwives in the procedures
- building management support for the new legislation to ensure that it would be implemented in the context of health system restructuring
- winning the support of health care providers so that they would not see this Act as yet another burden, or as running against their values
- building the knowledge base of communities so that they could put pressure on the bureaucracy to deliver services
- winning the support of health care providers in an ongoing and systematic way
- training of doctors and nurses in the procedures.

As a result, after the law was won in 1996, implementation was very slow. Service providers complained of lack of management support; nurses at clinic level often operated as gatekeepers instead of referring women appropriately; and communities did not know the rights provided by the law, and did not always support them.

6. Stakeholder analysis using the framework

The following stakeholder analysis chart is a tool for bringing together all the dimensions of policy making discussed above. It helps us analyse the overall terrain through simply ticking in different boxes or writing short notes in each. The chart gives an idea of some categories of actors one could include in this analysis. Each of these may have to be elaborated on in some detail. For example, politicians might need to be divided to include the relevant minister, the parliamentary committee, a number of different political parties, etc. Government may have to be divided into the national level, and then different provinces and local levels.

Table 1: Stakeholder analysis chart of actors in the policy process

	Politicians	Government officials	NGOs	Community groupings/ "people's organizations"	Specific constitu -encies (e.g. professional organizations)	Media	Research institutions
Moment of involvement:							
Problem identification							
Solution development							
Political process							

chart continues

	Politicians	Government officials	NGOs	Community groupings/ "people's organizations"	Specific constitu -encies (e.g. professional organizations)	Media	Research institutions
Implementation process							
Position in relation to goal:							
Support							
Not mobilized							
Against							
Capacity for mobilization							
Primary activities undertaken:							
Advocacy campaigns							
Coalition building							
Media liaison							
Working within the system							
Working from the outside							

This list would be different in the case of an implementation process, e.g. training of health workers, operational health systems research, technical advice to officials.

7. The role of "policy activists" in bringing problems and solutions to the political agenda

Kingdon *[2]* points out that many problems are never taken up by people who could develop solutions. Likewise many solutions are never taken on board by politicians or government implementers. This raises the question of who gets a specific problem onto the policy agenda, who decides on a specific solution and gets it into policy and into implementation. The South African case illustrates how organizations which were committed to new abortion legislation took advantage of all opportunities to develop a specific problem definition and solutions which promoted equity of access. They then used opportunities to get these onto the agenda of politicians. This is the role that Kingdon describes as that of "policy entrepreneurs". *[2:122]* In the model for this session, they are described as "activists" or "policy activists".

Policy activists have an important role to play in bringing problems and solutions to the political agenda. This could be any of us who have a commitment to policy changes for reproductive and sexual health and rights. Policy activists should aim to:

- identify and address the full range of actors
- neutralize the opposition
- strengthen the capacity of those in support of their policy goal
- identify strategies to aim to address politicians' and bureaucrats' concerns.

The South African abortion legislation process: the role of policy activists

While opportunities for input exist in the political process, there have to be organizations of civil society to take advantage of these. In South Africa at the time of the abortion legislative process, organizations of women and women's advocacy NGOs formed alliances to mobilize for reproductive rights in the Constitution. Health, human rights and medically oriented groups mobilized for liberalized abortion legislation.

Policy activists who had helped define the problem from women's perspective and develop policy proposals (solutions), then engaged with the formal political process by working from the outside (giving information to the media, mobilizing mass-based organizations) and from the inside (giving information directly to parliamentarians, giving evidence at hearings).

The following were the strengths and weaknesses of interventions that different policy activists designed to address different stakeholders.

Strengths

- Identification of and support to key parliamentarians and health department officials
- Strategies to educate and ensure the media were well informed and had pro-choice people to interview
- Development of a network of pro-choice religious leaders
- Building the participation of mass-based organizations such as trade unions and women's organizations
- Identifying the international links and political motivations of anti-choice groups to show that they were working against the new South African dispensation
- Building an alliance of NGOs (the Reproductive Rights Alliance) working in the medical, legal, human rights and women's health advocacy fields to get maximum benefit out of organizational interventions.

Weakness

- Inadequate identification of health system leadership below national level. Did not identify health service providers as a constituency to mobilize before the new legislation to ensure their support for and capacity to implement new legislation.

References

1 Walt G, Gilson L. Reforming the health sector in developing countries: The central role of policy analysis. *Health Policy and Planning,* 1994, 9(4):353–370.

2 Kingdon J. *Agendas, alternatives and public policies.* New York, HarperCollins, 1995.

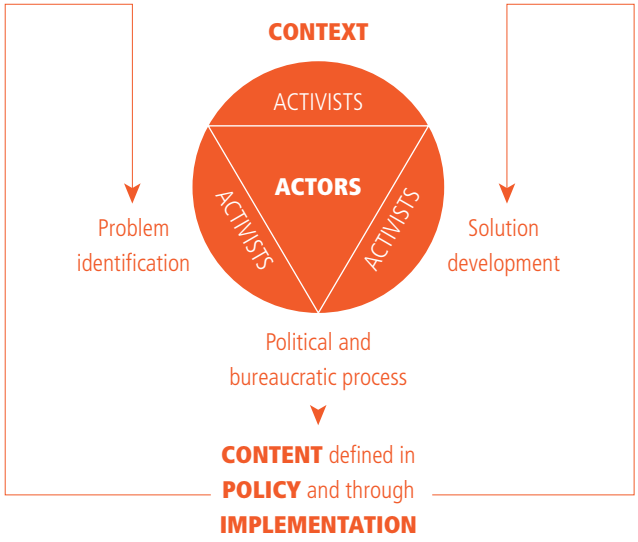
3 Reich M. Applied political analysis for health policy. *Current Issues in Public Health,* 1996, 12(4):186–191.

4 Grindle M, Thomas J. Policy makers, policy choices, and policy outcomes: the political economy of reform in developing countries. *Policy Sciences,* 1989, 22:213–248.

Handout 1

Framework for analysing factors influencing policy development, content and implementation

A slightly simpler version of this framework was originally published in Klugman B. Mainstreaming gender equality in health policy. *Agenda,* 1999:48–70.



Handout

2 Group exercise 1

This case example is used with participants from countries in which user-fees for health services have been introduced as part of Health Sector Reforms. Groups members draw on their own experiences with the implementation of user fees for health services to carry out this exercise.

What you have to do

1. **Identify the factors facilitating and constraining the implementation of the "fee-for health services" policy: the factors that made it easy, or put pressure on the government to decide on this policy, and the factors which made it difficult for them, or which are making implementation difficult.**

   In order to do this systematically but quickly, please follow these steps:

   - **Identify three contextual factors which influenced this policy.**
   - **Identify how the political and implementation process affected both policy content and implementation.**
   - **Identify at least two actors who were influential in winning this policy, two whose voices were not heard and two who were against this policy. You can make a chart showing their power, influence and position in relation to the policy goal ("for" or "against" or "not mobilized"). Indicate which of these could be considered to be "policy activists".**

2. **Identify the impact of this policy on women and men by considering:**

   - **Whose needs does it meet? Which women? Which men? Which adolescents? Which children?**
   - **What, if anything, does it do to challenge women's roles in society, unequal power relations between men and women, or women's access to and control over resources?**
   - **Is the reduction of gender inequity a goal of the policy?**

Handout

3 Group exercise 2

The "Pre-paid scheme"

This case example is adapted from a case used in the *Operationalizing Cairo and Beijing* course run by the Yunnan Reproductive Health Research Association, Kunming, China, in 1999.

The H____ County and Y____ County of S___ Province have experimented with "the Pre-paid Scheme of Maternal and Children's Care" in several townships within their administrative jurisdiction. The scheme is as follows. Couples of reproductive age shall submit a small amount of money as a pre-paid "medical scheme" fund, which will be run by the local health department. Pregnant women participating in this scheme will be provided with five prenatal examinations and three postpartum care services to ensure the safety of both the child and the mother. The scheme is implemented through engaged couples being enrolled for the scheme fund on registering for a marriage certificate. An alternative is that local medical workers will sign a contract with the families needing to participate in this scheme.

This scheme is the result of the need to find local financing mechanisms for health services, because of cuts in public spending. However, being a voluntary scheme, its success depends on the number of couples registering for it. Local health workers who have to canvass for the scheme find this an additional burden. For medical officers in charge of health centres, the paper work and responsibility this scheme have introduced is problematic. On the other hand, they would also like to have the possibility of raising local finances through this scheme, which gives them relative autonomy in terms of spending. People in urban areas with a steady income are more willing to participate in such schemes than those in rural areas. The latter do not see the rationale in paying for services before the need arises.

What you have to do

1. **Identify the factors facilitating and constraining the implementation of this policy: the factors that made it easy, or put pressure on the government to decide on this policy, and the factors which made it difficult for them, or which are making implementation difficult.**

In order to do this systematically but quickly, please follow these steps:

- **Identify three contextual factors which influenced this policy.**
- **Identify how the political and implementation process affected both policy content and implementation.**
- **Identify at least two actors who were influential in winning this policy,**

two whose voices were not heard and two who were against this policy. You can make a chart showing their power, influence and position in relation to the policy goal ("for" or "against" or "not mobilized"). Indicate which of these could be considered to be "policy activists".

2. Identify the impact of this policy on women and men by considering:

- **Whose needs does it meet? Which women? Which men? Which adolescents? Which children?**
- **What, if anything, does it do to challenge women's roles in society, unequal power relations between men and women, or women's access to and control over resources?**
- **Is the reduction of gender inequity a goal of the policy?**

Handout

4 Group exercise 3

Fee-for-service reforms in Malvania's health system

This case example was used in the *Operationalizing Cairo and Beijing* course run by the Key Centre for Women's Health, University of Melbourne, Australia, in 1999.

Malvania is a developing country with a large rural population but a growing urban industrial sector. Since independence some 40 years ago, the government has provided access to government hospitals and clinics, as well as medicines for a token payment (equivalent to the cost of two cups of tea at a roadside stall) and free to those unable to afford even this amount.

Malvania has enjoyed a high level of economic growth accompanied by considerable foreign investment, although the currency crisis of the last two years has led to an economic recession and pressure from the International Monetary Fund to restrict public expenditure. The level of public expenditure on public health care (3.5 per cent) is below that recommended by the World Health Organization; however, the government maintains that it is no longer able to afford a welfare model of public health care and wishes to contain or actually reduce public health care expenditure.

Prime Minister Escudo has denounced the previous model of public health care as creating a "welfare mentality" and as an unwanted inheritance from colonial times. He has announced that a number of health care services will be privatized and has launched a new funding policy with the slogan "Health care costs – Every individual's responsibility!" The nation's medical association has strongly endorsed this policy. Although some government subsidies will continue to be paid for the very poor, Malvanians will now be expected to contribute to the real cost of their health care, in government or private facilities, from the following potential sources:

- **from a reserved part of their compulsory retirement savings or those of their spouses or children**
- **from a workplace-based insurance scheme (all enterprises with more than 50 employees must be part of a scheme)**
- **from their own private health care insurance.**

Those unable to pay must appear before a committee which will investigate their financial circumstances and issue an "indigent's certificate" to deserving cases who will then be entitled to basic hospital accommodation.

Prime Minister Escudo's ruling party has had an overwhelming majority in parliament since independence, and exercises close control over interest groups and the mass media. Although some consumer representatives have been consulted during the policy formulation stage, it has not been the government's practice to allow interest groups to influence policy

to any great extent. However, the government is concerned that its opponents might gain increased support at the next election from rural voters angered by the removal of the health care benefits that they had previously received.

What you have to do:

1. Identify the factors facilitating and constraining the implementation of this policy: the factors that made it easy, or put pressure on the government to decide on this policy, and the factors which made it difficult for them, or which are making implementation difficult.

   In order to do this systematically but quickly, please follow these steps:

   - Identify three contextual factors which influenced this policy
   - Identify how the political and implementation process affected both policy content and implementation
   - Identify at least two actors who were influential in winning this policy, two whose voices were not heard and two who were against this policy. You can make a chart showing their power, influence and position in relation to the policy goal ("for" or "against" or "not mobilized"). Indicate which of these could be considered "policy activists".

2. Identify the impact of this policy on women and men by considering:

   - Whose needs does it meet? Which women? Which men? Which adolescents? Which children?
   - What, if anything, does it do to challenge women's roles in society, unequal power relations between men and women, or women's access to and control over resources?
   - Is the reduction of gender inequity a goal of the policy?

Handout 5

House vote opposes IMF and World Bank on "user fees" for education and health in poorest countries.

Press-release from The House of Representatives, August 3, 2000

In a landmark move, the US House of Representatives on Thursday approved a measure to pressure the International Monetary Fund (IMF) and World Bank to stop requiring that impoverished countries charge "user fees" for access to primary health services and primary education. The anti-user fees measure is included in the Foreign Operations appropriations bill approved Thursday by the full House. It was originally introduced as an amendment in committee by Rep. Jesse Jackson, Jr. (D-IL), a staunch advocate for debt cancellation and economic justice for impoverished people around the world. This House action represents the first time that Congress has required the IMF and Word Bank to change the specific conditions they impose in borrowing countries.

User fees, charges imposed for using a health clinic or attending school, have led to increased illness, suffering and death when people cannot pay for health services, and decreased school enrolments when poor families can no longer afford to send their children to school. In a tragic example in Zambia quoted by UNICEF, a researcher observed a 14 year boy with acute malaria turned away from a health clinic for want of a 33 cent registration fee. According to the report, "within 2 hours, the boy was brought back dead". The requirement that the world's most impoverished countries charge fees for primary health and education has long been one of the most controversial features of the austerity programs mandated by the IMF and World Bank. Advocates for the abolition of the fees point to scores of studies which demonstrate that their imposition forces a society's most impoverished families to deny their children basic education and their sick and dying health care.

Although James Wolfensohn, President of the World Bank, has contended in addressing members of Congress that the Bank has abandoned user fee requirements, current documents, such as the program for Tanzania linked to the granting of limited debt relief, contradict his stance.

Under the provision adopted by the House, beginning in 2002, US funding would be provided only when the heads of the World Bank and IMF certify their institutions "will not include user fees or service charges through 'community financing,' 'cost sharing, ' 'cost recovery,' or any other mechanism for primary education or primary healthcare, including prevention and treatment efforts for AIDS, malaria, tuberculosis, and infant, child, and maternal well-being" in any of their programs.

Actress Valerie Harper, a RESULTS Board member and one of the leading advocates of abolishing user fees, argued to members of Congress that

charging the world's most impoverished people for the basic health and education was a "terrible tragedy." She pointed out, "I live in one of wealthiest areas of the wealthiest country in the world, and my daughter can attend Beverly Hills High School for free. Meanwhile, women in the poorest countries of sub-Saharan Africa are told they have to come up with hard cash to send their kids to first grade or see a doctor at a clinic. We must not accept this."

Njoki Njoroge Njehu, a Kenyan who directs the 50 Years Is Enough Network, a coalition of US groups opposing IMF and World Bank policies, said, "This significant step by the House brings closer the day when people throughout the Global South will be able to decide on their own priorities. We do not want to raise another generation on promises from the IMF and World Bank that the sacrifice of their education and health will be 'short-term pain for long-term gain'".

Recent studies have revealed some of the damage done by user fees imposed by IMF/World Bank structural adjustment programs:

- In Kenya, introduction of a 33 cent fee for visit to outpatient health centers led to a 52 percent reduction in outpatient visits. After the fee was suspended, visits rose 41 percent.
- Introduction of user fees at rural clinics in Papua New Guinea led to a decline of about 30 percent in attendance, and although it subsequently increased it never returned to pre-fee levels. Health workers also reported a reduction in completion rates for courses of treatment.
- In Dar es Salaam, Tanzania, the three public district hospitals saw attendance drop by 53.4 percent between the second and third quarters of 1994, when user fees were introduced.
- In Nicaragua, about a quarter of primary schoolchildren have not enrolled in primary school since charges for registration and a monthly stipend were introduced.
- In Niger, cost recovery measures implemented as part of a structural adjustment program between 1986 and 1988 had the following results: 1) a sharp decline in already very low primary school enrolment rates: these went from 17 percent in 1978 to 28 percent in 1983 to 20 percent in 1988; 2) a drop in utilization of preventative care services; 3) increased exclusion of the most impoverished from care at Niamey Hospital, where outpatients who did not pay for care would wait an average of 24 days before seeking care while an outpatient who did have to pay for care would wait an average of 51 days; and 4) exemption systems that were applied to the benefit of urban, military, and civil service families and not for the intended beneficiaries (the most impoverished).
- UNICEF reports that in Malawi, the elimination of modest school fees and uniform requirements in 1994 caused primary enrolment to increase by about 50 percent virtually overnight – from 1.9 million to 2.9 million. The main beneficiaries were girls. Malawi has been able to maintain near full enrolment since that time.

SESSION 3

Tools for influencing the policy and implementation processes

What participants should get out of the session

Participants will:

- understand the need for different strategies to target different individuals on the basis of their position and attitudes relative to a policy goal
- become aware that strategic planning requires knowing the policy terrain, and a step-by-step approach
- be introduced to a model of "seven-steps" to support strategic planning
- know about the processes necessary for mainstreaming gender in strategic planning and implementation.

2 hours

Materials

- Handouts 1–4: "Group exercise"
- Handout 5: "Seven-step strategy for influencing policy", from box on p.353

- overhead: "The resistance to change continuum", on p.347
- overhead: "Seven step strategy for influencing policy", on p.353
- flip charts

Readings for the facilitator

1. Centre for Development and Population Activities. *Cairo and beyond: a handbook on advocacy for women leaders.* Washington, CEDPA, 1995.

2. Sharma R. *An introduction to advocacy: training guide.* Washington, Support for Analysis and Research in Africa (SARA), USAID Africa Bureau, Office of Sustainable Development, undated.

3. Readings for Session 4.

How to run the session

Activity 1 starts with an input from you, followed by a role play and group discussion designed to help participants recognize how different actors have different styles and motivations for decision-making. Activity 2 is a small group exercise followed by an input, using local examples for illustration and participant engagement throughout.

45 mins

Activity 1: Introducing tools for strategic planning

5 mins

Step 1: Introductory input

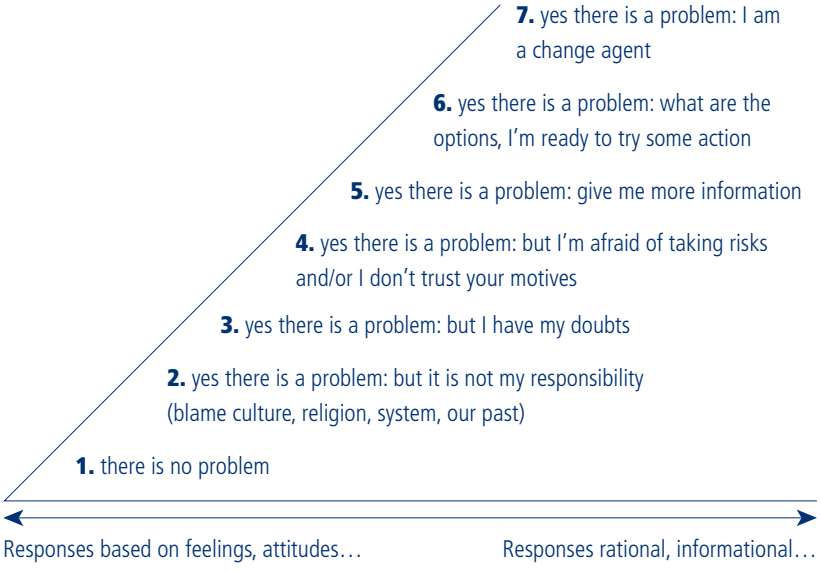
Start with introducing the purpose of this session. This session builds on the previous one, by suggesting steps to follow once a policy analysis has been undertaken. It helps participants understand the motivations and styles of different actors in the policy process, and introduces a tool for strategic planning, based on an understanding of what barriers need to be overcome.

5 mins

Step 2: The resistance to change continuum

Present the figure below as an **overhead,** and explain it. The figure illustrates the range of responses to change one can get from different people under different conditions. Low down in the continuum (on levels 1 and 2) are people (stakeholders) who are most resistant to change. They either do not acknowledge that a problem exists, or believe that the problem is not solvable. A little further up (on levels 3 and 4) are stakeholders who may be a little more open to dialogue, but are still responding on the basis of feelings, emotions and attitudes which may be difficult to change in the short run. Their resistance to change emerges from their fear of the unknown or unwillingness to take a risk, or because they do not trust the motives of those advocating for change. In order to influence these stakeholders, strategies will have to be developed to overcome their cultural or emotional responses. On levels 5 and 6 of the change continuum are stakeholders who are likely to respond to proposals for change if these are based on sound logic and backed up with good information. At the top end of the continuum are the change agents – they not only recognize that there is a problem, but are convinced that change is necessary and possible. In addition, they are willing to take the initiative to bring about change. The "policy activists" discussed in the previous session fall in this category.

The resistance to change continuum



Adapted slightly from Srinivasan L. *Tools for community participation: a manual for training trainers in participatory techniques.* New York: Prowess/UNDP Technical Series Involving Women in Water and Sanitation, 1990:162. Cited in Friedman M, Cousins C. Holding the space: gender, race and conflict in training. In: Walters S, Manicom L, eds. *Gender in popular education.* London, Zed Books, 1996.

Step 3: Preparing the role play

You should prepare this well before you introduce it to participants. For this exercise, you need to develop a role play of a recognizable situation. This will provide a good basis for participants to discuss what factors influence the characters' responses to proposals for change.

Here is one example of roles given to three participants.

Role play to illustrate the resistance to change continuum

1. You are a woman schoolteacher. You have noticed how many girls are dropping out of school because they become pregnant. Also, although people do not speak about it, you believe that there is probably an increased incidence of HIV amongst school children because the antenatal surveys in your country show increasing incidence amongst pregnant women. You want to get sex education into the schools and into youth groups. You approach a community leader to try to win his support. You also approach the principal of your school.

2. You are a community leader. You are concerned with upholding traditional culture. You are worried that many educated people are trying to undermine traditional culture. For example, recently a teacher started to suggest that sexuality education should be introduced into the school system. But you believe that it is against your culture to provide sexuality education to young people. You are afraid of this suggestion because it makes you think about your teenage child. You have never spoken to him about sexuality or how babies are conceived. You fear that he may impregnate a girl, but it goes against your culture to talk with your child about this.

3. You are a school principal. A teacher wants to introduce sex education in your school. But you do not have enough funds for new staff. You are also afraid of how the community will respond. But you do not want to appear unsupportive of new initiatives.

Step 4: Participants prepare their roles

Ask for three volunteers from the group and take them outside the room. Give them each their "character" but do not tell the others what the content/instructions for each character are. Give them about five minutes to think about how they will play their role, and to discuss how they want to set up the room. Tell them which character should start the role play.

While they are preparing, you should tell the group that there will be a role play, and that they should watch the characters and try to work on what motivates them – why they respond as they do.

Step 5: Presenting the role play

When the volunteers are ready, bring them into the meeting room. Let them present the role play for between three and seven minutes, depending on how exciting it is and whether enough issues have come up to give you substance for the group discussion.

Step 6: Role play debriefing

When the role-play is complete, first ask each character:

- How did you feel in that role?

Then ask the group:

- Was this situation real? Did you recognize it?

Ask each character:

- Why did you respond in the way that you did? Ask them specifically on what basis they were responding, so that later you can make links with the "attitudes/feelings" versus "rational/ information" in the response continuum you have already presented.

Then ask the group:

- What would influence/did influence the community leader to support sexuality education?
- What would influence/did influence the principal to support sexuality education?

Get the group to tease out what the barriers to change are, to what extent they can cope with "technical" information, and how much their attitudes and emotions need to be addressed.

Ask the group to identify where in the change continuum the three role players were. The community leader, for example, may have responded emotionally, feeling that his or her culture was under threat. Giving the community leader more information about the problem will not help to change her response. Instead, the activist needs to recognize the emotional response and see if she can explore the source of the leader's anxiety and win the leader's confidence at a personal level. He could be classified as being on level 2 (Yes there is a problem: but it is not my responsibility) or level 4 (Yes there is a problem: but I don't trust your motives) of the resistance to change continuum.

The principal, in contrast, may be receptive to change on the basis of specific information or resources. She may be on level 5 (Yes there is a problem: give me more information). For example, evidence that the HIV rate is escalating amongst school children may convince her to act. Alternatively, she may find it difficult to act because of constraints in her own context, such as lack of funds for a new staff member to do the sexuality education or lack of information about where to train current staff. In this case, as with level 6, if the activist can offer some options, some realistic suggestions, she may be willing to take action.

The teacher would be on level 7 (Yes there is a problem: I am a change agent), since she is taking responsibility herself, and trying to make change happen.

10 mins

Step 7: General discussion

Move on from the specifics of the role play to a more general discussion.

Ask participants whether they have had any experience with trying to change something at work, or elsewhere. Ask them to tell the group about it, and to tell the group where they would place the people concerned on the resistance to change continuum. Ask them whether thinking about the relevant actors using this continuum helps them to understand why a specific response to that actor was needed or why they responded in a particular way. Take a few examples before summarizing the session. In the box below are some examples of participants' sharing.

Participant experiences with change at the workplace

When the course was run in China, participants described many different situations in their workplaces.

- Their manager wanted them to work out how much an intervention would cost (level 5 or 6). This led them to gather information about cost implications.
- Their manager doubted that the problem they raised was really the issue, believing that they were actually wanting to challenge his authority (level 4). This led them to try to create opportunities to build trust with the manager, before trying to take the proposal further.
- A traditional leader argued that the intervention was not a priority and that there were more urgent things needing attention. A participant understood this to be a level 2 or 3 response, believing that the leader was concerned that any new initiative from the health services could undermine the authority of elders. This led her to engage in extensive consultation with traditional leadership and to find solutions which would allow the leadership to initiate the new proposal, so that it would be seen to reinforce their authority, rather than coming from outside.
- A participant in the Chinese course described how she had visited a remote village where she found a slogan on the wall about family planning. She felt the slogan was culturally inappropriate and hence would not be effective, based on research she had done. She wrote a letter to her provincial government. In the course, she described how government responded and accepted her suggestion. This small example was used to help participants recognize that while they were not decision-makers, they could conduct advocacy to influence decisions. The facilitator also used this story to illustrate how research findings can provide a useful basis for advocacy.

Points to highlight

Don't make assumptions

You cannot assume that people will respond to proposals for change on the basis of logic or because of good information. In some cases this is what is needed, but in other cases you have to develop strategies which overcome cultural or emotional responses in order to influence certain stakeholders. You need to understand the basis of each actor's response in order to plan a strategy that will take this into account.

The South African abortion legislation process and the change continuum: different strategies for different interest groups

In relation to the South African case study on the advocacy process to win liberalized abortion legislation (Session 2), it is clear that different strategies were used to deal with responses on different steps in the continuum. For example, a level 1 response came from some leadership who said that abortion was not practised in African tradition. In order to address this, activists brought in recognized African leadership – for example doctors who testified in parliament about how many African women come to them for help after having back-street abortions. Activists also identified poor rural women who had experience of becoming pregnant against their will, and having back-street abortions. Their stories in parliament were very emotional and provided proof that there is a problem, and also that it is a problem experienced by poor, African women. Some responded at level 4 – believing that the proposal to bring in abortion on request would promote promiscuity. Here too, hearing the very convincing personal stories of how they became pregnant (often through forced sex) was more convincing to these decision-makers than any figures or generalized information would have been.

On the other hand, some decision-makers were more concerned about the costs of introducing abortion on request to the public health services. Activists responded to this need (level 5 or 6) by initiating research into the costs of the current situation where large numbers of women used public health services for post-abortion care. They did this research under the auspices of the Medical Research Council which has credibility as being scientific and objective. They were able to use this information to argue that in the long run providing safe abortions at an earlier stage would cut costs.

1 hr 15 mins

Activity 2: Engaging with strategic planning

Step 1: Think up a meaningful scenario

Before introducing the activity to participants, in your own time develop a scenario with a problem that will be meaningful to the participants. Out of this, develop tasks for different groups, so that when you put together the inputs from all the groups they will have done some of the different steps required for strategic planning, as listed below. (Note that when preparing the handouts or one with a different story, you need to give each group their task only, so that they do not see the tasks of the other groups.)

30 mins

Step 2: Group work using Handouts1–4

Divide participants into groups and give each group one of the group tasks you have developed. There is one set of tasks given in Handouts 1–4. Give them approximately 30 minutes. Tell them to choose a reporter to present their findings to the group in point form (covering no more than one flip chart).

45 mins

Step 3: Group report-backs and discussion

Give each group a chance to report back and then open discussion to all participants. You have approximately 40 minutes for this process.

What to cover in the discussion

The four moments of strategic planning

The four groups perform four different tasks representing each of the four moments in strategic planning:

- choosing the goal
- identifying diverse strategies for winning a goal and choosing from these strategies
- identifying appropriate messages for different target groups
- identifying and accessing different kinds of resources (information, finances, skills) in order to have the necessary capacity to achieve the goal.

The intention of this is to give participants a taste of what it means to be serious about the change process. It is not intended to provide an opportunity for detailed planning. The aim of the discussion is for participants to recognize that there are decisions to make all along the way, and each decision will influence your chances of success.

Carefully consider the exact goal

The exact goal, for example, needs to be carefully considered, not just on the basis of a social justice aim, but also on the basis of "winnability" at a particular moment. This will be influenced by the current context, the nature of the policy and implementation process in that place, and the actors involved, as already discussed in Session 2. This is why the framework presented in Session 2 shows arrows going from the political and implementation process back into problem definition and solution development.

Recognizing the complexity of strategic planning

It is possible that the groups may come up with contradictory positions. For example, group 1 may decide that trying to gain changes in the school

curriculum at that moment is inappropriate and offer an alternative goal; the "messages" group may focus on working with the formal players – the leaders, principal, and so on; the "resources" group may be trying to get resources that will allow a protest campaign against the national department of education for forbidding sex education and preventing pregnant girls from completing school. Thus the discussion may give the facilitator the input needed to help participants recognize the complexity of strategic planning, and that there are many options with different strengths and weaknesses.

Once many of these points have been made, the facilitator can use the following tool as an **overhead** to summarize what the participants have already identified. At the end of the session, give participants a copy of the seven step strategy as Handout 5.

Seven step strategy for influencing policy

1. **Define your goal**
   Be specific and measurable. What exactly do you want to change/achieve? You need to develop a clear indicator of how you will measure your achievement. Are you aiming to make a gender specific intervention, or a gender redistributive intervention?

2. **Analyse the situation**
   Use policy analysis. How do the context, process and actors facilitate or constrain the achievement of your goal?

   To do policy analysis, you need to gather information:

   - talk to people/organizations; conduct interviews
   - read all relevant documents
   - assess media coverage
   - assess the perspectives, resources and organizational capacity of those who are most disadvantaged, for example women, rural people; Will they mobilize resources around this issue?

3. **Identify strategic options**
   Evaluate the information you have gathered: what does it tell you about the policy environment and what sorts of strategies may be successful?

   Develop criteria for evaluating what the impact of different options will be (for example, will a high profile media campaign scare away your allies, or win their support?)

   Debate these options with your team, yourself or others.

   Distinguish media strategies from public education strategies.

4. Select an option

Choose a strategy and develop process, outcome and impact indicators that will help you know how well you are moving with your strategy.

5 and 6. Formulate and implement a plan of action

Identify resources

- What information will you need and how will you generate it? (research to generate statistics/quantitative data on impact of the problem; on cost of the solution; perspectives of those most affected by the issue)
- What funds will you need and how will you get these?
- What skills do you need and how can you access these?
- What other organizations/individuals agree with your goal and can become your allies; what resources do they bring with them; what range of skills?
- Identify potential obstacles and create an incremental strategy with time to reformulate, so that setbacks do not undermine or end the campaign.

Develop your alliance or network

- Is this a loose network or a formal alliance with agreed forms of behaviour and accountability?
- How will you build this alliance and keep everyone on board?
- Identify indicators you could use to measure your progress building and sustaining the alliance.

Decide on your method

- Is this a process of engagement, accepting existing political or management systems and then using them to win your goal?
- Or is this a process of opposition, where methods can be different from and challenging of existing systems?

Identify your main messages

Source: Kyte R. Advocacy: *the theory and practice of advocacy for public policy change.* International Advocacy Strategies, 1997 (unpublished document).

- In the context of politics of engagement: How do you package your goal in a language that is understood and with a perspective that is accepted by those with power, i.e. to fit into their goals, and also fully understood and supportive of those your goal seeks to benefit?
- Who will be your spokesperson/people? Why?
  How will your message use the rights language? Is it helpful or a hindrance with different constituencies?

continued

- What mechanisms will you use to communicate with different constituencies (policy makers, health management, health workers, users of services, community organizations)? Such mechanisms might include use of the media (public and organizational); talks to parliament/health committees; public meetings for consumers; etc.
- Constantly rework your messages; test your explanations; always substantiate.

Work out the steps and a timetable

- Measure your progress so that you can see the value of even small steps towards your goal.

Believe in yourself and your message

- If you are not convinced no-one else will be.

7. Re-analyse the situation and change your strategy accordingly.

Main points for closing this session

It is possible to influence policy

But to do so requires policy analysis in order to understand the policy environment, as well as strategic planning to ensure that goals and strategies are appropriate and that resources are available to support any advocacy activities.

Change can be done from within the workplace – it is not only an outside activist who needs to do careful analysis and strategizing.

The strategic planning process needs to involve and be accountable to those whom the change is intended to benefit.

Note: The primary purpose of this module is to build capacity in strategic planning. It does not offer training in different components of advocacy – how to work with the media, how to build coalitions, how to speak in public, and so on. The readings provide some further material on these issues if you would like to build the course further in this direction.

Session developed by Barbara Klugman

Handout

1 Group exercise 1

You want to win support for a change in policy

You live in a small town in an agricultural area. The traditional leadership of the community is feeling threatened by the encroachment of western values into the country and into the town, particularly since a number of factories have been set up where young people are earning higher wages than most people earn doing farm work. The business leadership who are also the wealthier members of the town are excited by the new opportunities. The local women's religious group is concerned that their girls are not following the old ways.

The principal of the school takes instructions from the national government. There is no school board or community input into school policy or practice. The current national policy is that schoolgirls must leave school once they become pregnant. There is no sanction against the boys who make the girls pregnant.

There are high levels of teenage pregnancy at the local school. In addition, there is an escalating rate of HIV in your country, with the highest rates amongst young women. Police have reported increased incidents of violence against women, including rape, in the town.

You work in an activist organization (a youth group, or a human rights group – you can choose where to locate yourselves!). You want to convince this community that something needs to be done to prevent young women from becoming pregnant or suffering violence, and young people in general from the risk of HIV. You are thinking of proposing a "life-skills" and sexuality education programme for the school curriculum.

Your task is to work out possible goals

Is the goal of a "life-skills" and sexuality education programme for the school curriculum a realistic and "winnable" goal at this stage in the community?

Discuss how you have defined the problem until now, and the solution you have come up with. Given the overall context – who the actors are and so on – do you think this is the best possible solution or are there other solutions?

On the basis of this discussion:

- List three possible alternative goals.
- Identify the strengths and weaknesses of each goal in relation to whose needs it meets, whose interests it supports, and what the barriers to winning each goal might be.
- Choose one goal for your campaign. Choose one "process" indicator, one "outcome" and one "impact" indicator which you will use to measure your achievement of that goal. (Refer to examples of process, outcome and impact indicators given in Session 6 of the Evidence Module.)

Handout

2 Group exercise 2

You want to win support for a change in policy

You live in a small town in an agricultural area. The traditional leadership of the community is feeling threatened by the encroachment of western values into the country and into the town, particularly since a number of factories have been set up where young people are earning higher wages than most people earn doing farm work. The business leadership who are also the wealthier members of the town are excited by the new opportunities. The local women's religious group is concerned that their girls are not following the old ways.

The principal of the school works under instructions from the national government. There is no school board or community input to school policy or practice. The current national policy is that schoolgirls must leave school once they become pregnant. There is no sanction against the boys who make the girls pregnant.

There are high levels of teenage pregnancy at the local school. In addition, there is an escalating rate of HIV in your country, with the highest rates amongst young women. Police have reported increased incidents of violence against women, including rape, in the town.

You work in an activist organization (a youth group, or a human rights group – you can choose where to locate yourselves!). You want to convince this community that something needs to be done to prevent young women from becoming pregnant or suffering violence, and young people in general from the risk of HIV. You are thinking of proposing a "life-skills" and sexuality education programme for the school curriculum.

Your task is to work out strategic options

In any attempt to gain a new policy or practice, there are many different options. On what basis do you decide, for example, to engage in the "politics of opposition" – working from the outside to apply pressure for change on the system, as opposed to the "politics of engagement" – working with the powers that be in the hope of incremental change. What kinds of strategies are likely to have the biggest impact – public marches; stories of personal tragedy in the newspaper; behind-the-scenes negotiations with powerful individuals or groups in the town?

- Identify three possible strategies that might help you achieve your goal.
- Present the advantages and disadvantages of each strategy.
- Identify which strategy you think would be most appropriate in this context. Choose one "process" indicator, one "outcome" indicator and one "impact" indicator which you will use to measure how successfully your strategy is working at a particular moment. (Refer to examples of process, outcome and impact indicators given in Session 6 of the Evidence Module.)

Handout

3 Group exercise 3

You want to win support for a change in policy

You live in a small town in an agricultural area. The traditional leadership of the community is feeling threatened by the encroachment of western values into the country and into the town, particularly since a number of factories have been set up where young people are earning higher wages than most people earn doing farm work. The business leadership who are also the wealthier members of the town are excited by the new opportunities. The local women's religious group is concerned that their girls are not following the old ways.

The principal of the school works under instructions from the national government. There is no school board or community input to school policy or practice. The current national policy is that schoolgirls must leave school once they become pregnant. There is no sanction against the boys who make the girls pregnant.

There are high levels of teenage pregnancy at the local school. In addition, there is an escalating rate of HIV in your country, with the highest rates amongst young women. Police have reported increased incidents of violence against women, including rape, in the town.

You work in an activist organization (a youth group, or a human rights group – you can choose where to locate yourselves!). You want to convince this community that something needs to be done to prevent young women from becoming pregnant or suffering violence, and young people in general from the risk of HIV. You are thinking of proposing a "life-skills" and sexuality education programme for the school curriculum.

Your task is to develop messages

- Identify four target groups.
- What messages will you develop for each group? (What can you say to each different target group that will help them see the problem and support a campaign for "life-skills" and sexuality education in the schools?)
- How will you deliver these messages? (Media? One-to-one meetings? Letters? Marches?)

Handout

4 Group exercise 4

You want to win support for a change in policy

You live in a small town in an agricultural area. The traditional leadership of the community is feeling threatened by the encroachment of western values into the country and into the town, particularly since a number of factories have been set up where young people are earning higher wages than most people earn doing farm work. The business leadership who are also the wealthier members of the town are excited by the new opportunities. The local women's religious group is concerned that their girls are not following the old ways.

The principal of the school works under instructions from the national government. There is no school board or community input to school policy or practice. The current national policy is that schoolgirls must leave school once they become pregnant. There is no sanction against the boys who make the girls pregnant.

There are high levels of teenage pregnancy at the local school. In addition, there is an escalating rate of HIV in your country, with the highest rates amongst young women. Police have reported increased incidents of violence against women, including rape, in the town.

You work in an activist organization (a youth group, or a human rights group – you can choose where to locate yourselves!). You want to convince this community that something needs to be done to prevent young women from becoming pregnant or suffering violence, and young people in general from the risk of HIV. You are thinking of proposing a "life-skills" and sexuality education programme for the school curriculum.

Your task is to identify what resources you will need for a successful campaign

- Decide on one strategy you will use to achieve your goal.
- In relation to this strategy, identify what kinds of information you will need; why you will need it; where you will get it or how you will generate it.
- Identify whether you will need any financial resources and where or how you will get them.
- Identify what skills the campaign will need and where you will find them.

SESSION 4

Case studies of processes of policy change and implementation

What participants should get out of the session

Participants will:

- identify the factors facilitating and constraining efforts to achieve a specific new policy goal or implementation goal
- incorporate a gender analysis into this process
- gain insights into the usefulness of the framework and tools presented in Sessions 2 and 3
- recognize the effectiveness of a policy analysis and strategic planning process, and the impact of addressing gender issues throughout this process, by being exposed to one currently taking place.

1–2 hours depending on the option chosen.

Prior preparation

- Depending on which of the options for running this session you choose, prepare appropriate case studies as described under Activity 1 on p.361, or invite a suitable speaker.

Materials

- Handout 1: "Case study: South Africa"
- Handout 2: "Case study: Australia"

Readings for the facilitator

1. Plata MI, Gonzalez AC, de la Espriella A. A policy is not enough: women's health policy in Colombia. *Reproductive Health Matters,* 1995, **6:**107–113.

2. Wainer J, Peck N. By women for women: Australia's National Women's Health Policy. *Reproductive Health Matters,* 1995, **6:**114–121.

How to run the session

There are a number of different ways to achieve the objectives of this session. Three options are suggested here.

The first option

Invite someone who has been involved in a specific advocacy case to give a talk. Handouts 1 and 2 will give you a sense of the range of issues a speaker could cover.

The second option

Participants work in small groups to make a comparative analysis of policy processes in two different countries. You may select either one of the two case studies given in the handouts as one of the examples, and identify another case study of a similar process for comparison.

The third option

Groups read a real case example of the development or implementation of a specific policy from a country to which one or more participants belong. They then summarize the process based on the framework and tools learnt in Sessions 2 and 3.

Whichever option you decide upon, when choosing your case studies make sure that gender issues are included in the analysis and strategies.

Activity 1: Prepare case studies

Prepare case studies for this session. You should choose case studies which you can apply the methodologies to, so that they relate to current issues which are of importance to the participants. Ideally, choose one case study of policy or legislative change, and another of a change at the level of implementation. This will help participants see how the tools can be applied to different goals. If the participants are all from the same country, it may be a good idea to use local policy examples that they can relate to.

In the South African course, case studies have included:

- the process of winning liberalized abortion legislation
- the process of getting cervical screening onto the policy agenda and ultimately into policy
- the process of winning and monitoring political commitment to a provincial HIV/AIDS strategy.

1 hr

Activity 2: Option 1: hosting a guest speaker

Introduce participants to the purpose of the session.

Case studies are important for participants to see the methodologies presented in Sessions 2 and 3 being applied to real life situations. Having a speaker who is involved in the policy process to present the case study has the added advantage that you can get detailed insights through interaction with an real life stakeholder.

Introduce the speaker.

The talk should be about 40 minutes, followed by 20 minutes of questions and discussion. Be sure to brief the presenter to not only tell their story but also make explicit the process of change. You can share with them the questions in Option 2, so that they know what the participants are studying. Alternatively, as the facilitator you need to draw out these points in the discussion.

2 hrs

Activity 2: Option 2: comparative analysis of different campaigns to achieve similar goals

This option was developed by Centro de Estudios de Estado y Sociedad and used in the *Operationalising Cairo and Beijing* training course conducted in Argentina in 1999.

Step 1: Preparation

This step happens before the actual session

Choose two case studies of similar processes, but from different countries or on different topics. So, for example, you can compare campaigns for law/constitutional reform, or two different campaigns to change behaviour, such as an HIV prevention campaign and a campaign against violence against women. The South African abortion case study (Session 2) may be used in comparison with a case study of legal reform in another country. The example of an AIDS campaign in South Africa (Handout 1) could be used in comparison with a similar campaign in participants' own countries. Likewise, the case study of the Australian Women's Health policy (Handout 2) could be used with a local case study of health policy reform or with the Colombian case study given in the list of readings.

30 mins

Step 2: Group work with case studies

Participants are divided into groups, each group with only one case study. Groups are asked to identify:

- the contextual factors
- how the problem was defined
- solutions that were proposed
- elements of advocacy strategies (goals, strategies, messages, resources) used
- results attained.

1 hr

Step 3: Whole group discussion

Follow this work with a discussion in the whole group. Compare the two cases to identify three main reasons for failure or success of the advocacy process.

Case study: South Africa

In this case study, issues to extract include:

- the use of data to identify the problem
- the analysis of the role of the local context in exacerbating the problem (migrant labour; being on a transport route). Note also that these are key gender issues, since most men are migrants. This undermines family relationships and in particular leads to increases in extra-marital sexual relationships. Also, women are left behind and frequently reliant on limited financial remittances, which may lead them into sexual relationships in return for food, school uniforms for their children and other necessities
- the engagement with NGOs in working out solutions
- the identification of the political system – regular meetings of MECs (Members of the Executive Committee) and local councillors – as the base from which political leadership will be encouraged to speak publicly, and will also be held accountable
- that within this analysis and strategy, both women and men are targeted; that organizations which have the most outreach, particularly to women, and which can substantially undermine efforts at HIV prevention – religious groups – are central to the strategy.

Case study: Australia

Issues to extract include:

- Do not fall into the trap of assuming that because the subject here is women's health, this process automatically addresses gender differentials. This is why it's important to specifically draw attention to aspects of this process that challenge gender norms. In particular this case study illustrates that there was:
  - prior analysis to identify where gender inequalities have led to inadequate attention to women's health both in research – leading to lack of information about women's health status – and in health system priorities
  - attention to how the health system limits the ability of women to look after their health themselves, thus challenging the gendered institutional structure of the medical system which assumes health workers know best.
- The impetus for a change in policy came from a mass movement representing people who had not been heard in previous health policy development.
- Note the use of the international context (the reference to the Nairobi conference is the United Nations Women's Conference which took place in 1985, i.e. the precursor to the FCWC in Beijing).
- Note the challenge that the policy discriminated against men indicates that men, as the dominant and powerful grouping in society, had not been adequately brought on board in the process. Arguably though, those who have power seldom like to see resources spent on others.

2 hrs

Activity 2: Option 3: working with a case study from participants' countries

This activity was developed by the Yunnan Reproductive Health Research Association, and used in the *Operationalizing Cairo and Beijing* training course in Kunming, China, in 1999.

Groups read a real case example of the development or implementation of a specific policy from a country to which one or more participants belong. They then summarize the process based on the framework and tools learnt in Sessions 2 and 3.

In the course in China, the facilitators divided the participants into groups and gave each group a different national policy to consider, such as the marriage law, the one child and two child policies, and the policy on maternity leave. Each group was asked to discuss what factors influenced the development of this policy and how far the policy went in addressing gender equality.

Session developed by Barbara Klugman

Handout

1 Case study: South Africa

Here is the story of the AIDS prevention strategy of a single province in South Africa, as it was presented by a Department of Health official responsible for coordinating this strategy. It is an example of how a single strategy includes processes of addressing a wide diversity of actors in order to address the scope of the problem. It also shows how political leadership is made responsible, but also held accountable.

Northern Province of South Africa: taking the lead in addressing AIDS

Source: Manzini N. Northern Province: taking the lead in addressing AIDS. *Women's Health News and Views* (newsletter of the Women's Health Project, Johannesburg), 1998, 28:11.

The problem

The problem we identified is poor control and management of TB, STD, and HIV/AIDS in the province.

TB
1996 = 4 515 cases registered with 90.1 per cent screening coverage
1997 = 5 473 cases registered with 91.7 per cent screening coverage

HIV
1996 = 7.96 per cent prevalence rate
1997 = 8.2 per cent prevalence rate
Rate of increase greatest among young women.

Background

Northern Province is a poor province. It is 92 per cent rural, with a migrant labour system, small scattered mining industries, and tea and citrus estates with women labourers living in compounds. All these factors render it very vulnerable to these diseases. Moreover, Northern Province borders on three countries and is a gateway to and from Africa, with the N1 highway cutting across it.

Strategy

TB, STDs, and HIV/AIDS have been declared a provincial priority by the Premier – TB is the second highest prevalent communicable disease. They are to be managed as a strategic multi-sectoral project, over and above routine management. A 15-point plan was developed, signed by the Premier and launched by the Executive Council before an audience of about 10 000 on 10 July 1997.

Successes

- **TB/STDs/HIV/AIDS are on the Cabinet and the Heads of Departments' monthly agendas, for updates and support.**
- **They are a point in the speeches of all MECs.[1] So far local councillors have initiated about 20 workshops. MECs are expected to report on the public's response. For example, when a young person challenges an MEC about why no condoms are available, this MEC goes back to the MECs' meeting and asks the one responsible for health services why condoms aren't available. This creates a monitoring dynamic.**
- **DOTS[2] has been introduced in all government departments, with a 44–50 per cent cure rate.**
- **Interdepartmental committees have been established at provincial and regional levels.**
- **About 1900 teachers have been trained in life skills and have started implementing these with both girl and boy students.**
- **The Youth Commission has conducted numerous workshops, and five youth organizations obtained AIDS NGO funding.**
- **There are 38 NGOs concentrating on TB and HIV/AIDS and 26 have been funded. They work on programmes for women and girls as well as men and boys.**
- **Public places (private and government) are being used as distribution points and condom distribution has increased from 3 million to 3.65 million. Since clinics are predominantly used by women, it was important to provide condoms also at places frequented by men.**
- **Workshops run by religious groups have increased by 20 per cent.**
- **"Health workers for change" developed by the Women's Health Project has been used to improve caring attitudes – 102 workshops have been held. We hope that individuals are taking responsibility to prevent the spread of these diseases.**

[1]MEC stands for Members of the Executive Committee, the equivalent of Cabinet ministers at national level.

[2]DOTS stands for Directly observed treatment strategy.

Handout

2 Case study: Australia

This case study was developed and used by the Key Centre for Women's Health, Melbourne, Australia, in the *Operationalizing Cairo and Beijing* course run in 1999.

The development of Australia's National Women's Health Policy

During the 1970s and 1980s, the women's movement in Australia was successful in raising its concerns about women's health status, the inadequacy of existing knowledge on many aspects of women's health and the urgent need for reform of the health care system to better meet needs identified by women themselves.

From the mid 1970s, a period of intense activism followed, which included the setting up of health centres run by and for women and numerous sub-national as well as two national women's health conferences held in 1975 and 1985. The development of a National Women's Health Policy became a major focus at the 1985 conference and consultations with more than one million Australian women followed. Finally, in 1989, the Commonwealth government of Australia released the National Women's Health Policy.

For the first time, the extensive process of consultation ensured that a health policy was developed that reflected women's concerns on the health issues affecting them.

Seven priorities were identified that required action across the health system:

- **reproductive health and sexuality**
- **the health of ageing women**
- **women's emotional and mental health**
- **violence against women**
- **women's occupational health and safety**
- **the health needs of women as carers**
- **the health effects of sex role stereotyping on women.**

The policy was based on a clear recognition that women's position in society affected their health status and their access to health services which were appropriate to their needs. This policy was designed to provide a framework and a planned strategy to improve the health of Australian women and meet their health care needs to the year 2000 and to fulfil international obligations following the Nairobi conference.

The policy noted that women's health concerns extended beyond specific health problems to include the structures that deliver health care and information and the processes that influence women's interactions

with the health system. In turn, all of these affect the quality of care women receive, their access to appropriate and acceptable services and their health outcomes.

Five structural areas of the health system were found to need action:

- improvements in health services for women
- provision of health information for women
- research and data collection on women's health
- women's participation in decision-making regarding their health
- improved training of health care providers.

The implementation of this groundbreaking policy was not without its challenges. In particular, a challenge to the legality of the programme was made on the grounds that it discriminated against men. The President of the Human Rights and Equal Opportunity Commission, Sir Ronald Wilson, ruled that the programme involving women-specific services was lawful. He found that the programme redressed substantial disadvantages women faced in mainstream medical care and said that women were still substantially disadvantaged in society. In particular he referred to the many socio-economic pressures such as poverty, childcare, single parenthood, lower wages and domestic violence which impacted on women's physical and emotional health and well-being.

SESSION 5

Application exercise: developing a strategy to influence or implement a policy

What participants should get out of the session

Participants will:

- have an opportunity to practice using specific tools to undertake a policy analysis and design a strategy to change a policy or programme
- undertake this process in relation to a policy or programme the participant plans to change once returning home, whether at a national or workplace level
- internalize the intentions of the tools and the process of applying them to diverse situations
- internalize how the process of mainstreaming gender equality in health is embedded within every-day decision-making about change processes.

3 hours and 30 minutes

Materials

- Handout 1: "Instructions for completing the application exercise"
- Handout 2: "How to look at facilitating and constraining aspects of the context in problem identification and solution development"

- flip chart with the list of priority actions identified by participants in Session 7 of the Rights Module.

How to run the session

Participants can begin this application exercise after Session 2 – they can answer the first two questions at that stage. They can go on with the exercise – to step 3 – after Session 3. In planning the course, it is helpful to give them a weekend (presuming there is no course work) between when the task is set and when it has to be completed. Alternatively, if there is a weekend after the end of Activity 2 in this session, they can be allowed time to make any changes then, before their work is appraised by the facilitator.

This session consists of two major activities. The first is an individual activity where participants identify what change they would like to make in their work situation, and draw up a strategic plan. In the second, participants' plans are put up on the wall and everyone looks at these and gives their inputs.

Activity 1: Drawing up a strategic plan

2 hours and 30 minutes plus evening time and, ideally, weekend time

Step 1: Identify a programme or policy to change

Tell participants to identify a policy or a programme, or an aspect of a programme in their workplace, that they wish to change. The most important criteria for choosing are that this is something that:

- they want to change
- is within their power to influence
- is a contained and specific goal
- promotes gender specific or gender redistributive change.

Make it clear that this will be an exercise on advocacy, rather than on programme planning. This means that the exercise is about how to make change happen, rather than about what the changes will be. It is about identifying the conditions that make the process of change difficult, and working out how to overcome these constraints.

Distinguish between developing a strategic plan and developing a programme

Here are some examples of how to help participants distinguish between the development of a strategic plan, which is the task of this activity, and the development of a programme.

In the South African course, participants did a policy analysis and developed a strategic plan on:

- How to win health worker support for efforts to reduce maternal mortality. This plan considered what factors led health service management to fail to take maternal mortality seriously, and how these could be overcome. This was the purpose of this exercise, rather than developing a detailed plan of health service activities required to reduce maternal mortality; it was about winning recognition of the need to develop and implement such a plan.
- How to introduce couple workshops on sexual and reproductive rights and health. Here too, the activity was not about the steps required to run couple workshops, but on how the participant could get her organization to recognize the importance of couple workshops, and to create the resource base to enable them to take this on.
- How to persuade a Zimbabwean health centre to incorporate community education as an empowerment strategy.
- How to persuade donors to mobilize funds to support the process of mainstreaming gender within Mozambique's Ministry of Health.
- How to change the National AIDS Council Bill in Zimbabwe.

- How to shift a rural women's movement's priorities to include addressing men on sexual rights and health issues.
- How to shift one province's policy on providing only one pap smear per lifetime to concur with South Africa's national policy of three per lifetime.

Step 2: Choose realistic problems

In order to help participants choose realistic problems to address, ask them for a few examples of things they are trying to change at work, and indicate which would be appropriate for this activity.

Participants may be reminded of the priority actions they identified in Session 7 of the Rights Module. Put up the flip chart of this list. You can also draw on examples of change that they raised during the discussion on the change continuum in Session 3; these should provide good examples for participants to tackle in this session.

Step 3: The application exercise

Give participants Handout 1, which presents the task, and Handout 2 which gives an example of how they can summarize their work in table format. Advise them to use Handout 1: "Framework for analysing factors influencing policy development, content and implementation" from Session 2 and Handout 5: "Seven step strategy for influencing policy" from Session 3 for guidance and reference.

Make it clear that as there is little time, it will not be possible to do a huge policy analysis or detailed strategic plan. For this reason, you want them to identify a few contextual factors, a few actors, and so on. Make it clear that they must answer all of the questions in their handout. While the handout might seem rather laboured to them, it is a practice exercise, and by going through each step they will see how insights gained from each step really support planning.

Give the participants at least two hours to do the exercise on their own.

Activity 2: Reviewing the plans

Step 1: Questions and suggestions about the plans

Divide the group into three. Get group one to stick their individual analyses and strategic plans on the wall, far apart from each other. Each person should stand with her or his own plan. The rest of the participants walk around the room, as individuals, not in groups, and read the plans. These observers can ask the person concerned to explain anything that is not clear or to give more information. They are encouraged to share any suggestions they have with the developer of the plan by writing this on an empty page put up beside the plan for this purpose.

If group 1 is around eight individuals, this exercise can be done in about 15 minutes. After 15 minutes, ask group 1 to take down their plans, and individuals in group 2 to put their plans on the wall. Once

again give the group 15 minutes to walk around the room reading the plans and sharing ideas about them. Try to keep people moving and to ensure that there is always at least one person reading each plan, rather than five people reading one plan while another plan has no one. After 15 minutes, give group 3 the same opportunity.

Step 2: The finishing touches

Explain the process for finalizing individual analyses and plans. Tell them that they can make any changes they need to make. But give them a deadline date and time for handing it in so that the facilitator can read and comment on each plan before the course is over. Then ask the whole group if they found this exercise useful and if they got good ideas from their colleagues.

In the post-course evaluations, these plans form a point of reference. They are the basis on which to assess whether participants took any steps to implement their intended strategies after the end of the course, and whether these strategies worked.

Some of the activities reported by participants in the *Operationalizing Cairo and Beijing* training course in Kunming, China, run by the Yunnan Reproductive Health Research Association in 1999, in the follow-up evaluation were:

- "I have opened the Zhejiang hotline on Women's Sexual Health in co-operation with a women's organization in Hong Kong. This is the first hotline specialized in sexual health in China."
- "I co-operated with a provincial women's magazine to establish a women's health column, as gender is closely related to reproductive health."
- "There are distinct gender inequalities and poor accessibility of services in the grassroots family planning service provision in Guizhou. Therefore, we designed two training programmes in different aspects of contraceptive provision."
- "We have decided to apply the experience we got from the training course to our children's rights project. Besides, we are planning to apply our knowledge to the prevention of trafficking in communities."

Some of the activities reported by participants in the South African course included:

- "I was able to contribute towards clear lines of communication, accountability and clear organizational structure."
- "I implemented the restructuring of my organization (refugee services) to decentralize management and it is working well."
- "I started termination of pregnancy services which no one was willing to initiate."
- "I conducted awareness workshops in our health sub-district with traditional leaders, welfare, justice and police through the victim empowerment programme."
- "I conducted a baseline study with management and tutors on gender sensitivity."
- "I negotiated plans with management to establish a maternal health programme."
- "I invited men to attend National Women's Day activities."
- "I started working with teachers in addressing issues of rape and STDs and AIDS."

Session developed by Barbara Klugman

Handout

1 Instructions for completing the application exercise

The figure on the right indicates the marks allocated to this point out of 100.

1. Use handouts from Sessions 2 and 3 to guide you.

2. Decide on a policy or a programme, or an aspect of a programme in your workplace that you wish to influence others to change. Answer the following questions:

- **What is your goal?**
- **What indicator will you use to measure achievement of your goal? Why?**

[6/100]

3. How will your goal or its long term impact promote gender equality?

- **Will it make a difference to women's position in society (gender redistributive), or to their daily lives (gender specific), or both? It may help to explain this in relation to changes in power relations or in access to or control over resources or in relation to roles.**
- **Why do you think this goal will achieve this?**

[10/100]

4. Use the framework for analysing factors that influence policy and implementation to identify:

- **3 contextual the factors that will facilitate /support and 3 contextual factors that will constrain /create obstacles to your ability to achieve your chosen goal.**
- **3 actors (individuals or groups / organisations) who are likely to support your goal; 3 actors who are likely to oppose your goal; 1 actor who could be mobilised in either direction**
- **How different of the actors listed above see the 'problem'; are there different understandings of the problem. Which agree with your analysis of the problem? Which do not?**
- **How different actors see the solution. Are there competing solutions. How were these solutions developed or how will they be developed?**
- **in relation to the political process, how and where key policy decisions are made (if your goal is changing something within an institution, then describe how policy decisions are made in that institution) since you may have to take account of this when you strategise to influence a policy or practice**
- **Identify in relation to the bureaucratic process, how and where key implementation decisions are made since you may have to take account of this when you strategise to influence a policy or practice**

[30/100]

5. Identify 3 strategic options - 3 strategies you could pursue to achieve your goal.

[6/100]

6. Choose one strategy and explain why you have chosen it in preference to the other strategies you presented. Provide one process indicator for how you will know you are moving towards achieving your goal, one outcome indicator to see whether you have achieved your immediate goal, and one impact indicator to assess whether achieving your goal has had its intended impact (Refer to examples of indicators in session 6 of evidence module)

[10/100]

7. Formulate a plan of action. What steps you will need to take to develop and implement the strategy to make the necessary changes. List at least two ideas in relation to:

- **resources you will need (e.g. information, financial, skills) and how you will obtain them**
- **alliances you will have to make (with which individual actors, groups or institutions)**
- **methods you will use**
- **steps you will take to ensure the participation of and accountability to the people who are expected to benefit from the change.**

[30/100]

8. Develop one message and make it clear who the target audience is. This should be a message to those you are trying to influence to take up your action or make the policy or programme changes you are hoping for, not a message for the public who may ultimately be the target of your programme.

[6/100]

8. Indicate your time frame.

[2/100]

Make sure that your proposed actions are possible - you should be planning to actually start this process when you get home!

Handout 2

How to look at facilitating and constraining aspects of the context in problem identification and solution development

Category	Factors	
	Facilitating	**Constraining**
CONTEXT:		
Social	Implementation of the Beijing *Platform for Action*; transformation of the public health services	People's limited resources; distance from health sites; lack of efficient referral systems
Political	Constitution affirms the right to health	Moratorium on filling posts
Economic	Integrated PHC strategy: prioritizing reallocation of services to under-served areas	Lack of equipment; financial constraints on recruiting specialist health workers
ACTORS:		
Civil society	Strong lobbying women's groups and patients' rights groups	Under-representation of poor women's voices and those from rural communities
Political parties and organizations	Manifestos support women's empowerment and participation in decision-making processes	Few rural women in "real" decision-making positions
Labour organizations	Are in coalition with major political parties and civil society organizations	Limited capacity and small numbers of women
PROBLEM IDENTIFICATION:		
Civil society	Well-organized community-based organizations	Need to involve traditional leaders in rural areas
Political parties and organizations	Giving support and political guidance	Need for poor women's representation in political delegations
Labour organizations	Health care workers are the ones who will be required to implement any solutions	Nurses, mostly women, need to be involved during needs analysis/problem identification
SOLUTION DEVELOPMENT:		
Civil society	Women's organizations lobbying for equitable distribution of health care, since women are disproportionately affected; involvement of institutions training professionals providing services to communities	When solutions designed, do not take into consideration the role of rural women and those in informal settlements
Political parties and organizations	Most of them are in positions of power at various levels of government; targeting women members could promote policy shifts	Female members not aware of their role and not supported by male counterparts in promoting policy shifts
Labour organizations	Involvement of all health care workers – both nurses and doctors	Exclusion of private sector
POLITICAL PROCESS		
Civil society	Women lawyers could play a greater role	Lack of women lawyers in rural settings
Political parties and organizations	Most politicians represent the government in power, therefore commitments made bind all actions	When women are not part of the decision-making and implementation processes
Labour organizations	Most labour organizations have a majority women membership	Need to be informed and involved actively

SESSION 6

Consolidation on strategies to influence or implement a policy

What participants should get out of the session

Participants will:

- consolidate the main lessons learnt in this module
- see the links between the previous modules, this module and the next one.

1 hour

Materials

- overhead of list of methods or issues which individuals appear to have difficulty with, as well as any interesting, innovative or otherwise helpful ideas that came out in the individual presentations. Use "What to cover in the feedback" on p.378 for guidelines.

How to run the session

The first activity for this session is the facilitator's assessment of the assignment exercises and preparation of detailed feedback before the session. This takes at least two person-days of time for about 30 participants. The session is therefore usually scheduled in a slot after the start of the Health Systems Module. Alternately, if there is a weekend after the assignment is submitted, then the following week can begin with this consolidation exercise and be followed by the Health Systems Module.

The second activity involves distributing participants' assignments in class. This is followed by a detailed feedback and consolidation of the main lessons in this module and a discussion of its links to the other modules.

Activity 1: Facilitator's assessment and feedback

approximately two days of work for 30 participants

Step 1: Assessment

This session is essential whether or not the course involves any tests of competence. It gives individual participants an opportunity to apply what has been learnt, as well as making a direct link between the course and their day-to-day work. This is important so that the course is not forgotten once the pressures of work set in again.

Read each participant's policy analysis and plan, and write your comments on it to be handed back to the participant. The following steps would be useful for writing your comments:

- first, simply note whether all the questions have been answered
- note whether strategies identified are effective in relation to the contextual information provided
- note what barriers have and have not been taken into account.

If this exercise were being used as part of a formal appraisal strategy, for certification purposes, the facilitator would then have to assign a mark. If not, it is still helpful to the participant to have some indication of whether the facilitator thinks she or he has adequately understood the framework for policy analysis and applied this and the strategic planning tool.

Appraising participants' work for marks

In courses where students are being appraised for competence, you would allocate marks to each question in Handout 1.

Look for the following strengths

The participant:

- identified a realistic goal – one that she or he could impact upon
- drew upon the analysis of the relationship between gender and health, and other aspects of the Gender, Determinants and Rights Modules, to motivate why the goal and strategic plan will promote equality in gender relations
- identified process, outcome and impact indicators that are measurable, realistic and appropriate
- used the analysis of context, actors and political/bureaucratic processes to identify appropriate strategies
- motivated which of these strategies would work best on the basis of the previous analysis of contextual and other factors
- provided a process indicator to show how they will know that they have had some success in moving towards their goal
- provided an impact indicator to show how they will assess whether they have been successful in achieving their goal
- illustrated realistic means of accessing the resources needed to implement the strategy.

Step 2: Preparing feedback

Keep a list of methods or issues which individuals appear to have difficulty with, as well as any interesting, innovative or otherwise helpful ideas that came out in the individual presentations. Make this into an **overhead** for an input. (See "What to cover in the feedback" below for guidelines.)

Activity 2: Giving feedback

30-40 mins

Step 1: Return papers and discuss issues that they have generated

In the session, give each person his or her paper. Then provide feedback to the group, going into issues you have identified while reading the papers. Ask the group if there were things they found difficult that they want to discuss, and to share with the group what they have found helpful.

What to cover in the feedback

Here are some key issues that you usually have to address.

Indicators

It is easy to choose indicators of quantity – e.g. x number of workshops. However, the real issue to measure is whether such workshops have made any impact.

There may be some difficulty in differentiating between "process", and "outcome" indicators. Provide examples of process indicators and emphasize their importance. The idea is that the strategic plan should have limited goals for each step along the way, which can be measured by specific indicators. This way, while the overall problem the person is tackling may take a long time to improve, the person can measure whether they are making progress.

Participants sometimes choose indicators which imply that awareness campaigns or educational activities can be measured in behaviour change – whether by management or by programme beneficiaries. This is not a realistic assumption. Knowledge does not automatically lead to behaviour change and participants need to take account of this.

Gender equality

Do not accept assertions that any intervention supports gender equality. For example, interventions to get a policy on maternal death or cervical screening at an immediate level may improve women's health, but will not in and of themselves promote gender equality. You need to affirm that many interventions will not directly promote gender equality even though they do improve women's health. (Refer to the table in Session 4 of the Rights Module comparing a needs-based perspective with one which promotes women's position in society.) The aim is to build participants' accuracy and clarity in using terms like "gender equality". In one case, a participant motivated that winning commitment to cervical screening did promote gender equality, not in relation to the individual woman, but rather within the health system. She argued that

it required a change in budgeting priorities towards women, and in this way was overcoming an inequity in resource allocation. This type of specificity is helpful in moving participants away from using jargon without clear meaning.

Always encourage participants to analyse existing policy, or identify unaddressed problems, new policy goals and strategies, in a way that is sensitive to not just gender equality, but also equality on the basis of race, class, ethnicity, caste and other dimensions of social stratification.

Problem definition and solution identification

You are less interested in the content of the solution itself. The point of focus is who is proposing what solutions, and to what extent these solutions reflect the problem as identified by women, by people who are marginalized, and so on. In this way you are asking about processes more than actual problems or solutions.

You want to see the strategic plan linking the problems and solutions. Frequently there is a disjuncture between the problem and the solution proposed.

Actors

Participants often list the relevant stakeholders but do not carry this forward to indicate in what ways each stakeholder has an interest, their level of power, their position in relation to the goal (support/opposition). It is important that they do, so that they can work out which actors would be good as allies, and which need to be neutralized or brought on board with specific strategies.

Method

Again the key here is that you do not want to know how a programme will run, for example how health workers will be trained. You want to know what methods will be used to persuade management that health workers need to be trained and that their institution should take responsibility for this.

Message

Whatever their strategic plan, participants tend to come up with messages that are for the public. For example, the plan may be to get a provincial health service to run a cervical screening programme. Yet the message they give is "Have a pap smear to save your life!" This is a message targeting a woman, whereas the strategic plan is targeting the management. For them, the message might be something like "Cervical screening will save money in the long run". A strategic plan on adolescent-friendly services is often presented with a message to youth like "Your clinic welcomes you". But what is really required is a message to service providers like "Youth have a right to friendly services" or something along these lines.

Step 2: Finishing the module

Go over the objectives in the Module brief. Make clear to the participants that when people talk about mainstreaming gender in policy and planning, they are talking about the kind of systematic process that this module advocates. A good policy analysis must be "gendered". A good strategic plan must be "gendered". Gender mainstreaming is not a separate process or technical tool. Rather it is built into the day-to-day process of working out what problems need to be addressed and how.

Introduce the Health Systems Module

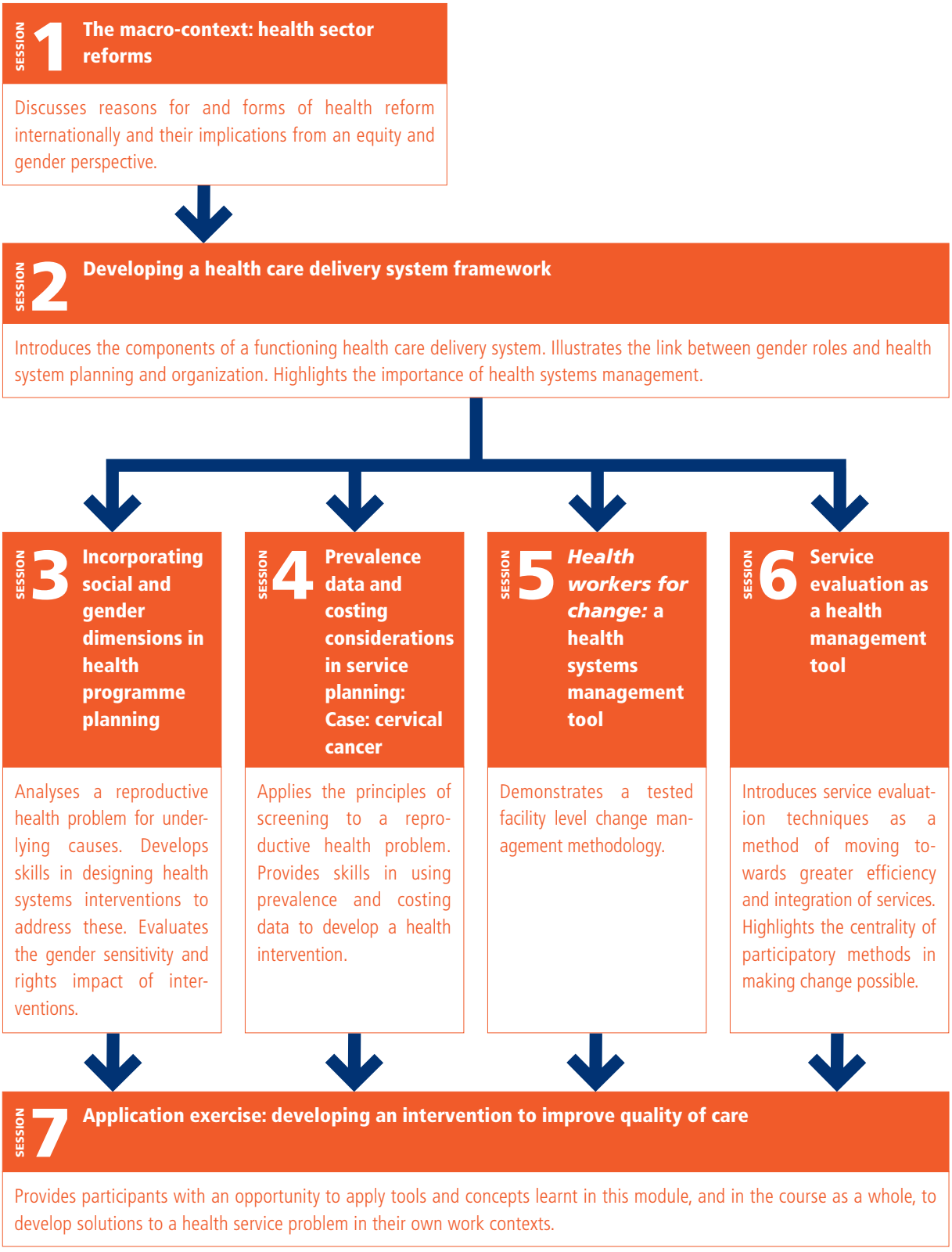
Then make the links with the next session. The Policy Module has aimed to build their confidence and capacity to make change happen. This applies in any sector, in relation to policy or implementation. The Health System Module goes on to look at challenges for making health services responsive to the needs of women, men and all users of services.

The Health System Module presents ideas for the content of these changes. All through the next module, participants should apply the policy framework and strategic planning tools from this module in order to think through the "how" of these changes. For example, they might like to implement improvement in the quality of services, which is discussed in the Health Systems Module. They should therefore think about what the barriers to implementation might be, who their allies would be, and so on, in order to strengthen their ability to make effective health system changes.

Allocate at least 15 minutes for participants to have a one-to-one discussion with you on your comments on their assignments. Make more time outside course hours if necessary.

Module 6: **Health Systems**

Structure of the Health Systems Module



MODULE 6

Module brief

What participants should get out of the Health Systems Module

Participants will:

- understand the macro-economic environment within which health services are located;
- be familiar with the components of a well functioning health care delivery system and their interrelationship. The components include: health service organization, access, infrastructure, referral systems, technical competence, provider-client relations, drug supply and equipment maintenance systems;
- have explored methods of promoting gender equality and rights in planning, methodologies for change management and interventions to improve the way a health system works;
- have applied the concepts learnt in the module to develop solutions to one health service problem in their own area of work.

The thinking behind the module

The two dimensions of health systems are interrelated

Health systems experts are concerned broadly with two dimensions of health systems: the environment within which health services are delivered and the functioning of the health system in relation to service delivery. These are interrelated.

The environment

The environment in which health services are delivered includes: how resources are raised; how these are allocated between primary, secondary and tertiary levels of care, and between rural and urban areas; who provides services (the public-private mix); policy on community participation; and whether a health service uses a district based model or not.

The macro-economic environment often determines what is possible at country level, and is part of the environment within which health systems are developed. The macro-economic environment in which health services are developing today places contradictory demands on health policy makers and programme managers. On the one hand the ICPD *Programme of Action* calls for the expansion of services to reflect a life cycle approach to reproductive health, and for the provision of comprehensive reproductive health services within a

primary health care context. On the other hand, these changes are to be realized without additional resources and, in fact, in an environment characterized by cuts in public expenditure.

Service delivery

However, resource constraints in the health sector are not a unique feature of the current period. There are countries with limited resources whose populations have achieved a better health status than countries which are richer. One reason for this is the effective functioning of the health system in relation to service delivery (the second dimension of health systems mentioned above).

The functioning of the health system in relation to service delivery is concerned with how services operate at the service delivery point and the activities that support service delivery – drug supply, human resource management, training and supervision.

The module focuses on the micro-level

This module addresses issues in the organization of health service delivery at the micro-level, rather than macro-issues related to health financing and the allocation of resources at the sector level, personnel planning, legislation to regulate costs and set national standards for service delivery.

The module begins with an overview of the macro-economic environment and puts current notions about resource constraints in perspective. **The first session describes and discusses the variety of forms that health reform is taking and their potentially differential impact on women and men.**

The health systems approach

Sessions 2 to 6 look at what can be done by a policy maker, a health service provider, a health service manager or a donor within the current reality, to make services effective, more welcoming for service users and a better environment for health workers.

These sessions take a health systems approach to reproductive health services. The underlying premise is that providing a reasonable quality of services that meet people's needs calls for a similar, if not identical, range of actions, no matter which specific health programme we are concerned with. For example, to provide contraceptive services, a drug ordering system needs to exist, and so does a transport system, a financial system, and a monitoring system. The clinic must be staffed, the staff trained, an appropriate constellation of clinic based and outreach services have to be put in place, and so on. What is needed is the ability to get these systems to function irrespective of whether you are developing an HIV/AIDS programme or a family planning programme, antenatal and delivery services or interventions to identify, treat and manage communicable diseases ranging from TB to typhoid. To implement the ICPD Programme of Action, a functioning health care delivery system is required.

The second session in this module – "Developing a health care delivery system framework" – looks at the generic components of a well functioning health care delivery service system. This session defines the building blocks required to deliver health services. Day to day scenarios of the ways in which users encounter health services are explored. We unravel the impact of a poorly functioning health care delivery system on users and providers. Moreover, this session begins to explore the roles and functions of health service personnel in ensuring that there is a functioning health care delivery system. The centrality of good management to the efficient operation of health services is underlined. In this session components of a functioning health care delivery system are described. The components are essentially the same as those that are considered to be important in addressing quality of care. In this session we take this framework further by incorporating a gender and rights perspective.

Responsiveness

This sets the stage for the rest of the sessions, which provide insights into health service management as well as some skills. All these sessions have one common feature: responsiveness – health service planning that is cognisant of and responsive to the local social reality; management that is respectful of and responsive to health service providers; and health service provision and providers that are respectful of and responsive to health service users. There is a strong focus on participatory styles of management, transparent and accountable systems, and the organization and provision of services so that they promote gender equality and rights. Like the rest of this course, this will challenge the more conventional hierarchical and bureaucratic styles of health system management.

The module concludes with a session which assists participants to apply the insights from this module to developing solutions to a health services problem they face in their own work.

Looking through a gender lens

Each session examines the health care delivery system through a gender lens, primarily through questions raised by the facilitator using the data and scenarios provided.

Gender norms frequently determine women's access to services. For example, a woman's access to or control over money will determine whether she is able to pay for transport to reach health services and pay user fees. Gender norms also have an influence on who comes to health services. For example, if it is accepted that childcare is women's responsibility, then it is women who will bring children for child health services. If these services are poorly managed, women will have to spend a long time in queues and this will add to the demands on their time. Thus, we draw participants' attention to the ways in which gender norms differentially disadvantage women, and we promote the idea that improving the efficiency and effectiveness of health care delivery will relieve women's differential burden.

Redressing inequities

The sessions go further, to examine how health care delivery systems might not only recognize and address gender inequities but also contribute to redressing them. We argue that health care delivery systems can promote women's reproductive rights and autonomy, for example by not requiring that men agree with the provision of contraceptive or abortion services to women. Health care delivery systems can promote joint responsibility for sexual and reproductive health on the part of women and men, for example by organizing services and education based on the assumption that both men and women are responsible for child care, contraception, and practising safe sex.

Institutional inequities

The health care delivery system as a social institution also reflects and reinforces inequitable gender relations. For example, women are often over-represented in nursing positions or in remote rural clinics, while men constitute the majority of decision makers. The implications of this for the functioning of health services are also highlighted in this module.

Module outline

		Objectives Participants will:	Format of activities	Time: about 15 hours
Introductory session	Introduction to the module	• be acquainted with the objectives and contents of the module	Input	15 mins
SESSION **1**	The macro-context: health sector reforms	• be familiar with the background to and components of health sector reform • understand the implications of health sector reform for the promotion of gender and social equity and rights	Interactive input	2 hrs
SESSION **2**	Developing a health care delivery system framework	• know the various components of a well functioning health care delivery system • understand that these generic components need to be in place and working in order for any health service interventions to be effective • learn about the role of managers in making these components function • begin to look at health service delivery issues through a gender lens	Role plays Whole group discussion	2 hrs all together
SESSION **3**	Incorporating social and gender dimensions in health programme planning	• be able to analyse a reproductive health problem for underlying causes • develop skills in designing health systems interventions to address these • apply gender tools to enhance the gender sensitivity and gender equality of interventions	Small group exercise Whole group discussion	1 hr 30 mins 1 hr 30 mins
SESSION **4**	Prevalence data and costing considerations in service planning: Case: cervical cancer	• be acquainted with the principles of screening and their application to service development • understand the relationship between disease prevalence on the cost of screening services • see the linkages between resource availability and epidemiological information about a disease, and decisions related to policy and services	Input Simulation game Input	20 mins 1 hr 40 mins
SESSION **5**	*Health workers for change:* a health systems management tool	• have experienced demonstration of a change management tool • have explored the interpersonal (provider-client) aspect of quality of care within a health services system framework, and from a gender perspective	Small group exercise Whole group input	45 mins 30 mins
SESSION **6**	Service evaluation as a health management tool	• understand how records of clinic organization and time use (staff and patients) can be used as a management tool to promote the provision of integrated services • be exposed to experiments which have succeeded in improving access and quality of services within existing budgets • appreciate the value of participatory research methods and management styles	Small group work concluding in a short whole group discussion	1 hr 45 mins
SESSION **7**	Application exercise: developing an intervention to improve quality of care	• have applied the tools and concepts learned in this module to develop solutions to a health problem in their work contexts	Individual work Feedback from facilitator	2 hrs 30 mins

Introduction to the Health Systems Module

What participants should get out of the session

Participants will be familiar with the structure, contents and objectives of the Health Systems Module.

15 minutes

How to run the session

This is an input session.

Introduce the module using overheads from the Module brief:

- "What participants should get out of the Health Systems Module"
- "Structure of the Health Systems Module"
- "Module outline".

Clarify that of the two broad and interrelated dimensions of health systems – the environment within which health services are delivered; and the functioning of the health system in relation to service delivery – this module will focus, for the most part, on the second.

Highlight that each of the preceding modules have provided cumulatively the concepts, skills and information needed for application in this module. The Health Systems Module will be addressing on-the-ground issues to make positive change possible in the delivery of health services.

SESSION 1

The macro-context: health sector reforms

What participants should get out of the session

Participants will:

- be familiar with the background to and components of health sector reform
- understand the implications of health sector reform for gender and social equity.

1 hr 45 mins

1 hour 45 minutes

Materials

- Handout: "Health sector reform: background, components and gender implications"

Readings for the facilitator

1. Almeida C et al. Health sector reform in Brazil: a case study of inequity. *International Journal of Health Services,* 2000, **30(1):**129–162.

2. Dahlgren G. The political economy of health financing strategies in Kenya. In: Chen LC, Kleinman A, Ware NC, eds. *Health and social change in international perspective.* Boston, Harvard School of Public Health, 1994.

3. Green A. *An introduction to health planning in developing countries.* Oxford, Oxford University Press, 1992: Chapter 5.

4. Standing H. Gender and equity in health sector reform programmes: a review. *Health Policy and Planning,* 1997, **12(1):**1–18.

5. World Bank. *World development report 1993: investing in health.* New York, Oxford University Press, 1993.

Readings for the participants

Reading 4.

How to run the session

This session is a reading exercise on the gender implications of health sector reform, which may be done in groups to maximize peer learning. The groups report back to the whole group on key learnings, with inputs from the facilitator.

Activity: The gender implications of health sector reform

Step 1: Reading and summarizing

Divide the participants into groups of three of four. Distribute the handout to each participant.

Participants read the handout individually and write a summary of the main points as a group. The points to summarize are:

- reasons for health sector reform
- components of health sector reform
- gender and rights implications of these
- some examples from participants' country settings.

Groups are not required to make a formal presentation, but will be called upon to respond to questions in the big group.

Step 2: Discussion

Elicit from the whole group:

- reasons for health sector reforms
- components of health sector reforms
- gender and rights dimensions of these
- examples of how a specific health sector reform measure in their setting may have affected women and men, and different groups of women and men, differently.

What to cover in the discussion

The macro-economic environment

For more than two decades now, international economic forces have moved in the direction of reduced resources for the health sector in developed and developing countries alike.

The increase in oil prices in 1982 marked the beginning of a global economic crisis. Combined with the adverse, and at times worsening, terms of trade with respect to primary products, developing countries were pushed into a severe resource crunch. Developing countries had to go through Structural Adjustment Programmes (SAPs) as each measure taken to deal with the initial balance-of-payments crisis steadily worsened the situation.

Conditionalities required by International Monetary Fund (IMF) loans led to cuts in public expenditure, even as foreign aid was dwindling with industrialized countries experiencing an economic slump. Forced to borrow commercially from international banks,

developing countries came under an increased debt burden and resources available for public spending were further constrained. While the defence budgets of most developing countries were not significantly cut back, health sectors were faced with serious resource constraints.

This trend, of the health sector being severely strapped for resources, has continued through the 1990s and into the new millennium.

For developing countries that have been dependent on international aid for making even basic health care available to their populations, this has been a major crisis. New demands – such as those arising from commitments made at the ICPD for a reproductive health programme – have to be translated into action within the context of a serious resource crunch.

Two approaches – or a combination of both – have been advocated by the World Bank to bridge the resource gap in the health sector:

- contain costs and increase efficiency
- increase revenues through cost sharing.

A third approach – diverting funds from non-social development sectors (for example, defence) – has nowhere been seriously considered.

Diminished resources affect different groups differently

The various cost cutting options affect different population sub-groups differently. For example:

- Reducing the number of staff may affect women staff disproportionately because they are employed in the lower rungs of the hierarchy. This may in turn affect the utilization of services by women clients/patients. Further, some of the tasks being performed by front-line workers may drop off the formal health system, adding to women's informal care giving load.
- Decentralization of financing may mean that poorer provinces and communities have less access to resources for health; and in the battle for scarce resources, women's health needs could be given a lower priority.
- The move to cut public expenditure on interventions that are not cost-effective may affect poor women disproportionately: for example the non-availability of specialist services such as infertility services.

The introduction of cost sharing mechanisms such as user charges for health services may have a detrimental effect on the use of services by poor women who do not have ready access to cash or women who do not control cash in the household and have to seek permission to spend money. There have been few studies looking at the gender impact of cost recovery mechanisms, and these do not look at different sub-groups of women who may be affected – for example, different income groups, rural/urban residence, regions of a country, age groups, race/ethnicity.

Session developed by TK Sundari Ravindran

Handout

1 Health sector reform: background, components and gender implications

Based on key points from: Standing H. Gender and equity in health sector reform programmes: a review. *Health Policy and Planning,* 1997, **12(1):**1–18; with additional inputs from Chapter 5 of Green A. *An introduction to health planning in developing countries.* Oxford, Oxford University Press, 1992.

Background

Health sector reform is not a new phenomenon. The health sectors of all countries have been experiencing changes and reforms for a long time. However, the term "health sector reform" has now come to stand for a particular set of policy prescriptions related to institutional and financial reforms and responding to a resource crunch in public spending.

The earliest calls for cuts in health sector spending date back to the 1980s, the era of Structural Adjustment Programmes (SAPs). A sharp increase in oil prices initiated by OPEC (Organization of Petroleum Exporting Countries) led to a balance-of-payment crisis in non-oil producing developing countries. Many industrialized countries also deflated their economies to cope with higher oil prices, and curtailed their imports.

Developing countries spiralled into an economic crisis as a consequence. The prices of commodities exported by developing countries fell in the world market, which meant that they had to export more in order to earn the same amount of foreign exchange. However, demand had also fallen. Unable to raise enough foreign exchange to meet the increase in oil prices, many developing countries had to devalue their currency. Still falling short, they sought IMF (International Monetary Fund) and World Back loans. IMF conditionalities meant cutting public expenditure, including in health, which, during this period, was not considered an "investment".

Developing countries also started borrowing commercially from international banks, at high rates of interests. Debt servicing took a major toll on national resources. Devaluation also meant higher costs to service debts. More local currency was required to pay back the same amount of interest in foreign exchange. This also meant that cuts in public expenditure became necessary, and the health sector became severely strapped for resources.

Components

Two complementary strategies were proposed by the World Bank for bridging the resource gap in the health sector:

- **containing costs and increasing efficiency through a combination of actions such as rationalizing drug use, using donor funds more effectively, reprioritizing areas for investing public health resources, increasing hospital efficiency, and enforcing more effective mechanisms for cost control and accountability**

- increasing revenues through cost sharing using mechanisms such as promoting the private sector, charging fees for services, pre-payment schemes, community cost sharing systems and health insurance.

In 1993, the World Bank's *World development report* focused on "Investment in health", and outlined a series of principles and prescriptions to ensure that investment by governments in the health sector made sound economic sense. The latest generation of health sector reforms (HSRs) are influenced predominantly by these prescriptions, addressed particularly at financing, resource allocation and management issues, including:

- civil service reforms aimed at improving the efficiency of human resources by reducing numbers, reworking terms and conditions, changing skill mixes and improving monitoring of performance
- developing more effective financial and management systems and defining cost-effective interventions (e.g. basic minimum packages)
- decentralization, entailing the devolution of management and service provision decisions to district and other local level bodies
- developing new health financing and cost recovery options to complement public spending
- promoting the role of the private sector – creating competition between providers and establishing regulatory and health service contracting-out systems.

Sector-wide approaches (SWAps) are a recent addition to the HSR agenda. This is an approach initiated by donors, in which donors relinquish specific project funding in return for a voice in the development of the national health sector strategy as a whole. *[1]*

SWAps represent a continuation of several elements of the classic HSR agenda. However, they also represent shifts in some aspects of donor thinking. The first shift is the acknowledgement of the importance of national ownership of reforms, and the pivotal role of governments in this process. The second shift is represented by a concern that institutional reform should improve access to health care and health outcomes for the poor. The third shift is in the emphasis on involving a wide range of stakeholders – for example NGOs, the private sector, civil society groups – in the process of negotiating strategic plans for the health sector.

Gender implications

Commentaries on the effects of health sector reforms on health outcomes have drawn attention to both the direct and indirect effects on women. In terms of direct effects, most attention has been paid to the (hypothesised) effects of the imposition of user charges and the deterioration in the quality of services following cuts in health expenditure. The better documented examples of this relate to maternity care. A number of studies have reported an increase in home deliveries and delays in seeking care leading to worse maternal and infant outcomes. *[2,3,4]*

Indirect effects include the health consequences of increasing poverty. Gender differences in access to and control over resources and power at the household and other levels, and gender based division of labour, may cause

women to be more affected. Resource constraints at the household level may increase women's work load if they have to replace goods and services bought from the market with their own labour. Women may also bear a disproportionate part of the cuts in expenditure by denying themselves essential goods and services. This will impact negatively on their well-being.

A study discussing the effects of economic crisis on women's and children's health in the Dominican Republic, notes that although it did not produce a large scale increase in mortality, it did reverse a previous upward trend in health improvement, manifest in direct health indicators such as the maternal mortality ratio and the infant mortality rate. *[5]*

Reduction in the length of affordable in-patient stays, or avoidance of hospital care and increase in self-treatment are likely to impose greater time and labour costs on women.

Another study, in Mongolia, found that along with economic crisis, maternity rest homes were closing down. These were places were pregnant women in advanced stages of pregnancy could rest and get timely health care. They helped reduce deaths due to emergency obstetric complications and the closure of these centres is reported to have led to a dramatic increase in maternal mortality. *[6]*

As for gender implications of the HSR agenda of the 1990s, there is little empirical evidence and the potential impacts outlined below are more in the nature of hypotheses.

Because the workforce in the health sector is predominantly female, women health workers may be inadvertently disadvantaged especially if retrenchment is concentrated in the female sectors. Techniques for priority setting and monitoring, such as cost effectiveness analysis, may not incorporate gender equity concerns, at least in part owing to the limited availability of sex-disaggregated information on health and on workforce participation especially, in the informal sector of the economy where many women are employed. Decentralization raises some key concerns. For example, if district level or community based management structures make decisions on allocations which result in worsening gender equity, there may be no mechanisms available to attempt to redress the balance.

A great deal of concern has been raised about the implications of user charges and the promotion of the private sector for women's use of health services. For women with limited access to cash, there is no doubt that user charges would be a barrier to seeking timely, appropriate and adequate care. However, sex-disaggregated information on the use of services before and at various time points after the introduction of user charges would help in ascertaining whether or not this is indeed the case.

Health financing options such as private health insurance pose specific disadvantages to women. A majority of women in many developing countries may not have access to the resources to pay the premium because they are employed in the subsistence sector of the economy. Some crucial women's health needs such as obstetric services are not covered by many insurance schemes or carry a high premium. Abortion and family planning services are rarely covered.

There is as yet limited experience with SWAps to comment on their gender impact. A key issue for SWAps is the need and potential for incorporating women as stakeholders in the policy process.

References

1. Cassels A. *A guide to sector-wide approaches for health development: concepts, issues and working arrangements.* Geneva, World Health Organization, 1997.
2. Kutzin J. *Experience with organizational and financial reform of the health sector.* Current Concerns SHS Paper No.8. Geneva, World Health Organization, 1995.
3. Ekwempu CC et al. Structural adjustment and health in Africa. Letter to *The Lancet,* 1990, **336**:56–57.
4. Stewart F. Can adjustment programmes incorporate the interests of women? In: Afshar H, Dennis C, eds. *Women and adjustment policies in the third world.* Basingstoke, Macmillan, 1992.
5. Whiteford L. Child and maternal health and international economic policies. *Social Science and Medicine,* 1993, **37(11)**:1391–1400.
6. Kojima Y. *Women in development: Mongolia.* Manila, Asian Development Bank, 1995.

SESSION 2

Developing a health care delivery system framework

What participants should get out of the session

Participants will:

- be familiar with the various components of a well functioning health care delivery system
- understand that these generic components need to be in place and working for any health service intervention to be effective
- learn about the role of managers in making these components function
- begin to look at health service delivery issues through a gender and social equity lens.

2 hours

Prior preparation

- Prepare the role-plays based on instructions in the Notes for the facilitator
- Prepare the room for the role play as described in Activity: The health care delivery system wheel, Step 1 on p.398

Materials

- Notes for the facilitator: "Descriptions of role plays and questions for discussion"

- 7 blank pieces of paper
- 7 envelopes labelled
- role play characters, each individual character on a separate piece of paper, taken from Note for Facilitator
- props for the role play, suggestions on p.398
- overhead: "Questions after the role plays", on p.399
- newsprint with table on p.400
- overhead: "The health care delivery system wheel", on p.407

Readings for the facilitator

1. Tarimo E. *Essential health service packages: uses, abuse and future directions.* Geneva, World Health Organization, 1997.

2. Tarimo E. *Towards a healthy district.* Geneva, World Health Organization, 1991.

3. Timyan J et al. Access to care more than a problem of distance. In: Koblinsky M, Timyan, Gay J, eds. *The health of women: a global perspective.* Boulder, Westview Press, 1993.

How to run the session

This session is a participatory activity which should take place in a large room (desks should be moved to the edges to make a large empty space in the middle of the room). Volunteers are recruited to take part in a series of seven role plays while others observe.

At the end of each role play the facilitator asks a set of questions, the answers to which bring out an aspect of health care delivery system functioning, the role of managers in relation to this aspect, and the gender issues that the role play illustrates.

The room is set out in a wheel with the various management functions as the spokes. Each role play takes place in a different space in the room with the observers moving around from point to point.

Once all the role plays have been completed we have built a wheel with spokes, representing a health care delivery system wheel that can turn, move forward and deliver quality health services. This physical representation of the wheel reinforces the concept we are illustrating. The facilitator uses this same representation of a health care delivery system to summarize the session at the end. Since each role play illustrates a particular function of the health services system, each one has to be enacted.

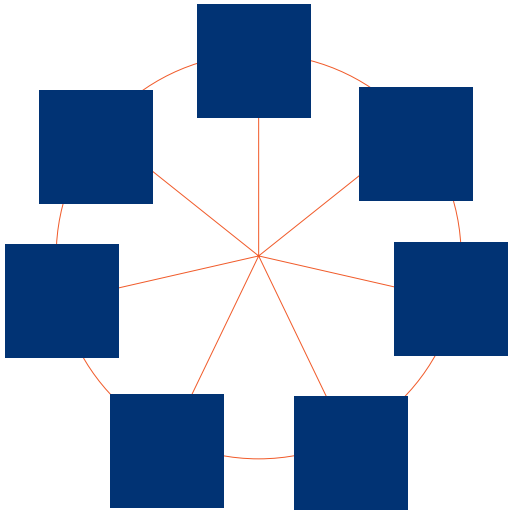
Activity: The health care delivery system wheel

Step 1: Preparations

Do this step before you start the session.

Prepare the room

Clear a large space in the middle of the room. Place a blank piece of paper on the floor at seven points so that if you joined these points they would make a circle.



Prepare the role plays

Type out each character from the "Notes for the facilitator" onto a separate piece of paper. The role plays are numbered 1 to 7 and the characters have letters assigned to them. Label each envelope so that it indicates which role play and which character it corresponds to. In this way the people acting in a particular role play know who their fellow actors are.

Provide some props

It is useful to have a few props: a telephone, some shawls, a doctor's coat, etc. Look through the characters and bring appropriate props. This helps people get into their characters and adds a touch of realism, and humour. For example, if you bring a small cushion actors can stuff it under their shirt to pretend to be pregnant.

Step 2: Assign the characters and prepare to act

10 mins

This session starts with all participants standing in a large circle around the room, with the desks moved well out of the way. Ask for 15 volunteers who are willing to participate in role plays. Give each volunteer the envelope which contains a description of the role play and of the character they are to play. You do not have to have men playing men or women playing women. Assign this at random – just give out the envelopes.

Explain to the actors and observers that seven role plays will be enacted during this session. All the roles are about service providers and service users in primary health care facilities. Tell the actors that they will

not know who the other characters are before the role play starts, but that this will quickly become clear.

Ask each actor to read her or his character and think about how they may act as this person. Give everyone a few moments to do this. Explain that you can help anyone who has a question. Maintain privacy when answering any questions, so that no one else can hear. Assist them in developing a plan for how they may act as their character by asking them questions rather than telling them what to do. For example, if someone acting the character of a nursing sister wants help, read the description with him or her and talk through how they imagine that person may feel, what circumstances they may be working in, etc.

Explain to the actors that observers need to get a flavour of the situation and that acting talent is not required. Everyone should remember that the actors are playing a role, and that what they do and say will not be seen as a reflection of their own personalities or opinions. Actors should remember also to face the audience, and talk so that everyone can hear.

Instruct observers to play close attention to what the characters do and how they interact.

Step 3: The role plays and discussions

Call everyone not acting in role play 1 to gather around the first piece of paper on the floor. Actors with a 1 marked on the envelope should do their role play.

Start by introducing the situation and the characters briefly. For example: "We are at a clinic and we have a clinic nurse (point to the person playing the nurse) and a patient (point to the person playing the patient). This clinic has a referral centre that is 40km away and this is the clerk (point to the person playing the clerk) who books appointments and does other clerical work at the referral hospital."

Let each role play run for about five minutes, making sure that the aspect of health system functioning to be addressed by it emerges (See below). Stop the role play by firmly saying "Thank you".

Overhead Then facilitate a discussion about the role play using the following questions.

Questions after the role plays

- For each actor: How did it feel to play the role you played?
- For the observers: Describe what was going on in the role play. In your experience, is this a likely scenario? If not, how would the reality differ?
- What are the gender issues in the health service setting depicted in this role play? What major issue concerning health service functioning is illustrated?
- What action could be undertaken to improve service delivery in this situation?
- Whose role is it to ensure that the kind of actions you have suggested are undertaken?

(Suggestions for further questions on the gender issues in each role play are given in the notes for the facilitator.)

The role plays correspond to the following components of a health care delivery system:

1. provider-client relations
2. technical competence
3. referral systems
4. infrastructural requirements
5. access
6. organization of services
7. supplies and equipment systems.

Write the appropriate one down on the blank pieces of paper on the floor after each role play. You would write "provider-client relations" after the first role play, "technical competence" after the second, and so on.

Ask the group whose responsibility it is to make sure this aspect of the health service works well. List this on a sheet of newsprint with the following columns:

What they should do	Clinic staff	Health service managers	Community members

This list of the functions that are required for running a well functioning health service, fills up as we go through the role plays.

Once a role play is over, move the group to the next point on the wheel and start again until you have acted out each role play and moved right around the wheel.

Discussing the list of questions at the end of each role play is the core of this session as it draws out the essentials of a well functioning health care delivery system.

Summary

- Introduce the first role play
- The role play is enacted
  Ask the group:
  - questions about the role play
  - questions about gender issues in the role play
  - to define which component of health care delivery system functioning is being illustrated
- Write the component of the health care system illustrated on the blank sheet of paper on the floor

- Ask whose responsibility it is to ensure that this component operates well
- Fill in the table
- Go on to the next role play
- Continue with this cycle for all seven role plays.

What to cover in the discussion

You will need to think on your feet, posing questions that will draw out the points we need to make about the functioning of the health care delivery system. Some examples are given below.

Role play 1: Provider-client relations

This role play is about an adolescent girl asking for contraceptives at a clinic, and the nurse's attitude to her. The role play usually ends with the nurse refusing to give the girl pills. The girl may be depicted as not challenging the decision, or as being assertive and demanding.

One gender issue that emerges from this role play concerns health providers' attitudes to appropriate sexual behaviour for girls. Girls are not expected to be sexually active in adolescence, and, even if they are, it is not seen to be appropriate for them to publicly acknowledge this by asking for contraception.

If it had been a boy asking for condoms, would the health provider have refused? Not likely. The same rules do not apply to boys and girls. It is important to show how health care delivery systems can reinforce prevailing gender norms. And it is worth developing this further to illustrate the public health consequences. For example, if girls feel they cannot use contraceptive services, providers lose an opportunity to offer them advice on barrier methods. This places girls at risk of sexually transmitted infections, including HIV, and of unwanted pregnancy. Negative attitudes on the part of service providers to providing contraceptive services for girls also represents an infringement of their reproductive and sexual rights.

Move the discussion on to what can be done to alter this situation. Some suggestions that have emerged from discussions like these have been: training to change attitudes, a better working atmosphere, and a performance appraisal system which includes provider attitudes and gender biases. These would be the responsibility of the health manager.

The discussion could also identify other attitudinal barriers that participants have encountered or are familiar with, and how these can be dealt with.

Role play 2: Technical competence

In this role play, because the nurse-aid who is standing in for the nursing-sister is not technically competent to handle the case of an infant with fever, she becomes rude to the mother.

Suggestions for change include planning to have multi-skilled people who can stand-in for each other, and not having vertical task-division; training personnel to handle difficult situations (such as the one depicted in the role play) with greater tact, training in inter-personal skills.

Would the same scenario have prevailed if the father had brought the child? The nurse-aid would still not have been able to provide appropriate care, but she may not have been rude.

It is also worth making the point that it is mothers who are expected to bring children to services, therefore when services cannot meet patients needs, it is usually women rather than men who bear the consequences. It is women who have wasted their time and money travelling to a service which cannot give her what she needs. Thus, because of gender norms, inadequate services impact differentially and detrimentally on women as compared to men. Improving the scope and quality of health care services, while not redressing gender inequality, will nonetheless improve women's lives.

In the discussion on how to improve the situation, participants often say that it is the management's responsibility to ensure that staff are appropriately allocated to clinics and that adequate training is provided to them.

Role play 3: Referral systems

The main issue in this role play is the breakdown of a referral chain for cervical cancer because the clerk in the referral centre does not answer the phone when health centres call in to make appointments for their patients.

The person who played the clerk explains her or his character to the group: The clerk has a very demanding job, of which answering the phone used to be a minor part. Following the policy decision to provide cervical cancer screening, the phone has not stopped ringing. The clerk is unable to cope, falling behind on the jobs she or he is expected to do routinely.

The issues that emerge relate to poor planning at a higher level, in not foreseeing the work load that would be generated by the new policy. Clear guidelines are needed about the roles and tasks of different staff members connected to this referral chain, and tasks redistributed if necessary. When a new policy is about to be implemented, its implications have to be discussed in a joint meeting of the staff members concerned – both those at the referral centre and at the health centres where screening is done. Clients using services should also have clear communications about what they are being screened for and what is to be done if they have a positive smear.

Gender issues around the patient's inability to find time for health care also surface in this discussion, and the implications of this for health services include being aware of women's time constraints and organizing the referral chain to take this into account (not repeated visits, once to collect the report, another time to fix an appointment with the referral centre, and so on).

Role play 4: Infrastructural requirements

In the health centre in this role play, there is no doctor on night duty. There is no ambulance and no phone, and so the lone midwife on duty has to instruct a woman in labour who arrives with heavy bleeding to make her own arrangements to go to the hospital 40km away.

The helplessness of the health provider emerges as an important issue for discussion from this role play. The community often blames and gets angry with the health provider. What are the solutions to this problem? How can such a situation be avoided?

Solutions suggested include:

- There should be a notice that at night time complicated deliveries cannot be handled at the clinic, and that women should go straight to the referral hospital.
- Danger signals in pregnancy, delivery and postpartum that require referral should form part of a public education campaign aimed at both women and men.

In the role play, the woman arrives by herself; driven by a man from her village, at her request. Where is the woman's partner?

- Men should be encouraged to take greater responsibility for women's reproductive health care. Health providers can counsel men on this, and health education campaigns can spread the message.

Encourage participants to share examples from their own experiences of where lack of infrastructure got in the way of effective health delivery. On some courses, lack of separate outpatient areas for men and women, lack of separate toilets, lack of child care facilities, lack of physical safety for clients and health providers (wherever clinics are located in remote areas) have been expressed as infrastructural constraints.

It is worth pointing out that it is frequently women who staff remote clinics and who are midwives and that it is a significant burden on providers in such a situation to deliver quality services. Further, health care for pregnant women is not the same as rare emergencies that may also require emergency transport. It is well known and predictable that a specific proportion of deliveries are likely to be complicated. Despite this, emergency transport for complications in delivery is not built into health care delivery systems. Point out that maternal mortality is high in poor countries specifically because emergency transport for women in labour is not routinely available. This is one example of the low value placed on women's lives.

Role play 5: Access

Many different kinds of barriers to access come up in the discussion following this role play. At the end of a very long morning, the provider is exhausted. A woman with a very sick baby has walked all morning to get to the health centre, and reaches it just before lunch break. She is very poor and badly dressed, and does not feel confident about going to the front of the queue to talk to the nurse about the urgency of the situation.

Besides distance as a barrier to access, there are many social barriers. Sometimes there are organizational barriers, for example when there are specific times when only pregnant women are seen, days when only immunization is done, and so on.

Better organization of services may improve access by reducing waiting time. Why was there a long queue even after midday in the clinic in this role play? There should perhaps be more staff in the mornings if there is usually a much larger crowd then than in the

afternoons. Staff's duty rosters could be reworked according to users' needs and work loads at different times of the day or week, rather than following a rigid pattern in all health centres for all times of the year.

Gender questions include: why is it that the woman had no money to take a ride to the clinic? Why is it always women who bring sick children to the hospital, and usually by themselves?

Encourage participants to share other barriers to access that emerge from their own personal or work experiences. For example, absence of female staff, whether the staff are residing in the clinic, timings of the clinic, location, etc. The focus should be on barriers on the provider side, the user side having been discussed in Modules 2 and 3.

Role play 6: Organization of health services

This role play deals with the issue of the integration of services: a woman who has brought her child for immunization would also like to have her contraceptive injection, but she is told that this will not be possible.

Draw the links between the indicators that are used to measure if we are doing our jobs and the way clinics are organized. Because clinics have to report regularly on immunization coverage, the whole system is set up to meet this objective. Even if we define the job in narrow technical terms, i.e. to have a good immunization coverage rate, we still need to look at how services are scheduled, for example at whose convenience – the user's or the provider's. This is even more the case now that we are trying to provide comprehensive reproductive health services within a rights perspective. Integration of services helps meet client needs, is sensitive to their time constraints, and also makes for better health outcomes in an overall sense – improved reproductive health status – rather than achieving narrow technical targets such as high contraceptive prevalence rates or immunization rates.

There is scope for a detailed discussion on what constitutes integration. Is it one person providing multiple services, or many different services available under one roof? There can be no hard and fast rules. At health posts and clinics serving a small population, it may be unrealistic to employ several health workers, each providing a specific service. The health provider in such a setting should be able to deal with at least the bulk of problems and be able to refer the rest. In first referral units, it may make sense to provide many specialist services under one roof.

Role play 7: Supplies and equipment systems

In this role play the health centre has run out of antibiotics, so despite the medical officer's excellent diagnostic skills, she or he cannot help an infant with acute respiratory infection get appropriate services. This is a familiar story in many health centres, which results in frustration and demoralization for health providers who may have begun their careers with dedication and enthusiasm.

Issues to bring out here include how any one dysfunctional part of the service system undermines all other parts. For example, in this role play the doctor, while starting out excited about the new training and

trying to implement what she or he has learnt, may eventually give up and even be reluctant to go on another course because the skills are not implementable. Investment in training will be lost unless the total system is addressed.

The drug procurement, ordering and supply is not functioning in the health centre in this role play. It is likely to be the DMT which needs to see to this. Firstly, they need to have made sure the drugs are bought and budgeted for at the central or regional level. Sometimes, however, drugs are ordered but the ordering and supply systems are not operational. Sometimes it is not even the drug ordering and supply, but the fact that the truck to deliver the supplies is not working. The point to make is how the system as a whole needs to be addressed.

Other issues: payment of health providers

Alternative issues that are relevant in your location can be incorporated. For example, in many countries health workers find alternative ways of increasing their income. (See Session 5, *"Health workers for change"* where this is also dealt with.)

> In China the issue came up in a role play as follows "A mother took her child to the hospital to see a doctor. The doctor said that the child needed an injection. The child did not like the idea of injection. And the mother also thought an injection was too expensive. So the mother asked the doctor whether some oral medicine could take the place of an injection. But the doctor disagreed, because an injection can make more money for the hospital. Finally, the mother had to buy an injection for her child."

Again the facilitator can illustrate many issues – the power imbalance between health care providers and patients and how this may infringe on patients' rights to make an informed choice. In the Chinese example, it is likely that alternative cheaper oral treatment is available and by refusing to give the mother this information the patient's rights have been infringed. From a health systems point of view you may explore reasons for the health provider's behaviour. Perhaps health care providers get very poor salaries or they work in an administrative system where salaries are not paid. Perhaps there is a poor supervision system where there is no monitoring of how services are provided. Again you would explore these and look at ways in which the system can be improved to try to prevent this kind of situation developing.

Other issues: accountability

Another issue that may be used as a theme for a role play is the accountability of the health care delivery system to poor women and men. In some developing countries, village and cluster health committees are being constituted to encourage the participation of women and men in planning and implementing health services. Community committees often have a majority of men, and are made up

of the more powerful groups in a community. In India, for example, poor women are yet to take part in these committees effectively. The committees are often used by health service providers to delegate responsibilities so that the providers' task is made easier, rather than for bottom-up planning or monitoring.

45 mins

Step 4: Pulling it all together

After you have completed all the role plays, invite everyone to sit down. Have an **overhead** prepared which illustrates the points on the wheel. Go through the list that you have been generating of the functions that are required and whose responsibility they are. As you go through each point on the circle the central role of good management will come out. Draw this in as spokes of a wheel. At the end you will have an illustration of the health care delivery system wheel, as in the diagram that follows.

Main points for closing this session

Pay attention to the generic systems issues

In order for health care delivery systems to function adequately, we need to focus our attention on the generic systems issues, such as drug supply, training and so on – the various points of the wheel that were developed in the role play

Good management is crucial

Good management, that builds health care provider capacity, competence and accountability, is essential and fundamental to adequately functioning health care services.

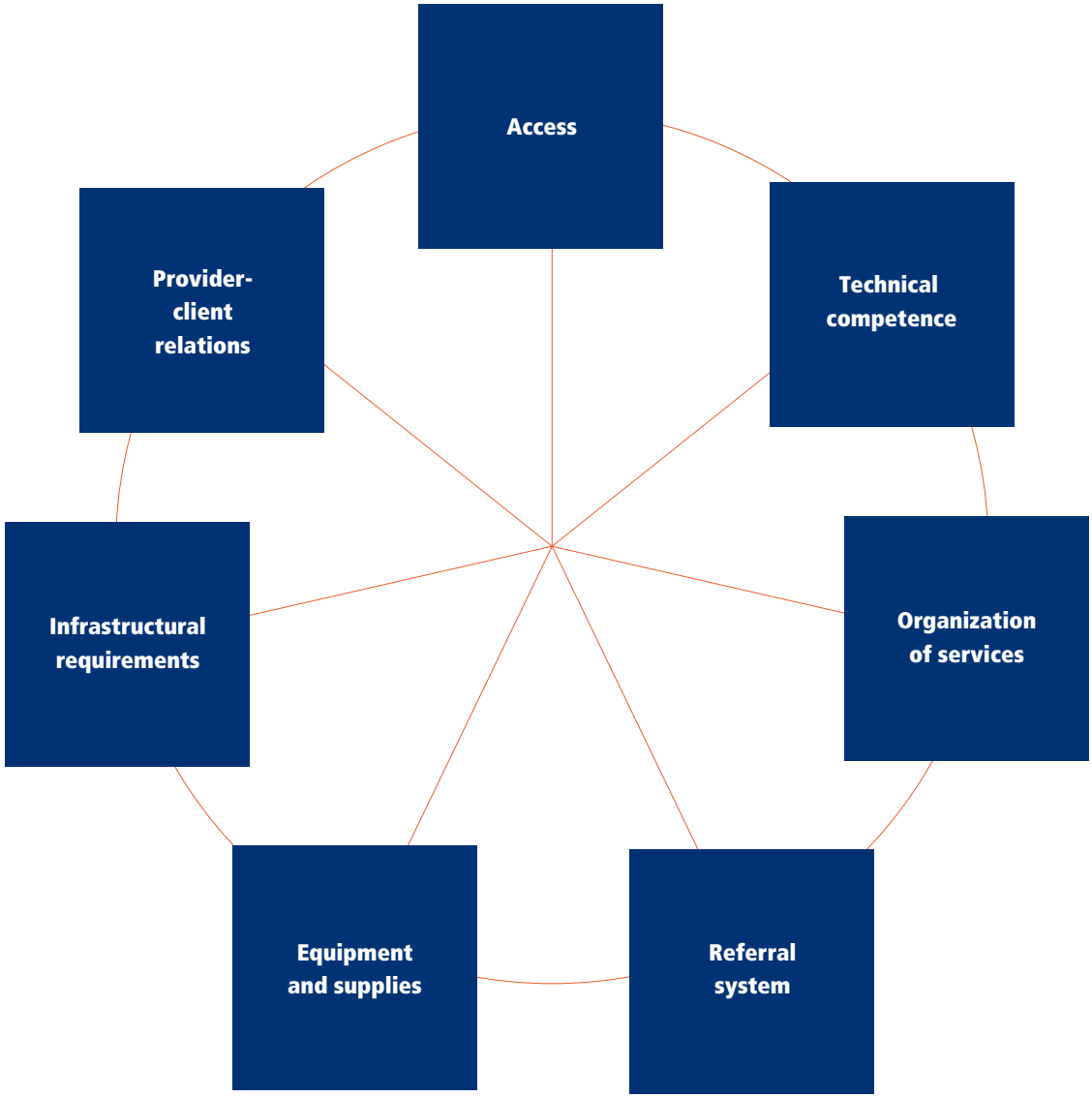
The gendered impact of poorly functioning delivery systems

Prescribed gender roles mean that when health care delivery systems function poorly, women in particular are negatively affected. Improving health care delivery systems will thus benefit women.

It is possible to increase women's autonomy and promote their reproductive and sexual rights within existing health services. Examples that come up in this activity include: encouraging men to take joint responsibility when women are in labour or for child care; and fostering women's control over their bodies by welcoming them at contraception services, irrespective of their age.

Session developed by Sharon Fonn

The health care delivery system wheel



Lecture notes for the facilitator:

Description of role plays and questions for discussion

Here are the descriptions of the seven role plays and questions that you may ask to bring out gender issues.

Type out each role play so that each character is on a separate piece of paper. Put each character description in an envelope marked with the number of the role play (1–7), and the letter of the character (A, B, C). Character b from the role play on technical competence will, for example, be contained in an enveloped marked "2b". This will help each group of actors in a particular role play know who their group members are.

Role play 1: Provider-client relations

To set the scene before this role play begins you will say:

"Today is a busy day at the clinic. There is a long queue and it is also the day many people come for family planning."

Character A

Today is a busy day at the clinic. There is a long queue and it is also the day many people come for family planning.

You are a teenager and you want to get contraception from the clinic. You know that you must rush as you can only go during break time at school. You are shy and scared about asking for what you want.

Character B

Today is a busy day at the clinic. There is a long queue and it is also the day many people come for family planning.

You are a nurse at the clinic. You have a child who is 14 years old and recently you realized she is pregnant. You are furious with her.

Questions to bring out gender issues in the discussion after the role play

- What if the teenager were a boy, would it be different?
- Who is responsible for preventing pregnancy, boys or girls?
- Is it acceptable for girls to have sex before marriage? Is it acceptable for boys to have sex before marriage? What does this mean in terms of how services are organized and in terms of trying to decrease teenage pregnancy?
- Is there any action that could be taken to promote women's control over their own bodies?
- Is there any action that could be taken that would promote sharing the responsibility for contraception between men and women?

Role play 2: Technical competence

To set the scene before this role play begins you will say:

"We are in a clinic in a remote rural area. The clinic is usually staffed by a nurse's aid and a nursing sister. Today the nursing sister is off sick. The nurse's aid (point her out) is running the clinic. It is child health day.

Character A

We are in a clinic in a remote rural area. The clinic is usually staffed by a nurse's aid and a nursing sister. Today the nursing sister is off sick. The nurse's aid is running the clinic. It is child health day.

You are the nurse's aid. You have been working here for years and are used to the system. You usually help run all services with the sister. You do not have any diagnostic skills.

Character B

We are in a clinic in a remote rural area. It is child health day.

You are a mother and you know that your baby is not well. She has a temperature and although you have been giving her paracetamol for her fever, you know she is still not okay. She is always rubbing her ears and you want someone to examine her. The clinic is the only place you can go to, as there is no other health service delivery point. While it is far and you have many chores at home and other children and a household to care for, you decide to go to the clinic.

Questions to bring out gender issues in the discussion after the role play

- **How could this situation be avoided?**
- **Who is responsible for making sure it is avoided?**
- **What are the consequences for the mother of her child not being examined?**
- **How may this impact on her time?**
- **What scenarios are likely to greet her at home when she returns?**
- **Would the same situation prevail if her husband had brought the child to the clinic? How might it be different?**
- **Would a father bring a child to the clinic?**

Role play 3: Referral systems

To set the scene before this role play begins you will say:

"This is a clinic in a rural area. The clinic has begun screening for cervical cancer. Screening must be done at the clinic and patients need to be referred to the local hospital 15km away for treatment. Here is the nurse and the patient at the clinic (point them out), over here we have the clerk who works at the hospital (point him or her out)."

Character A

This is a clinic in a rural area. The clinic has begun screening for cervical cancer. Screening must be done at the clinic and patients need to be referred to the local hospital 15km away for treatment.

You are the nurse in the clinic and you know that you need to do pap smears on people who have a normal looking cervix. When you get back an abnormal result the person must be referred for a trained person to do a colposcopic examination and biopsy. You know it is very important for women to have the examination as you can prevent death from cervical cancer in this way. When women return to get their results you encourage those with abnormal results to go to the hospital even though it is far away and they must pay themselves for the transport. You always make appointments for them when the patient is with you by phoning the hospital. It is always a problem to get the hospital to make a booking because they often do not answer the phone.

A 45 year old woman has come back to the clinic to get her pap smear results. The results are abnormal and you try to convince her of the necessity of going to the hospital. You call the hospital to make an appointment for her.

Character B

This is a clinic in a rural area. The clinic has begun screening for cervical cancer. Screening must be done at the clinic and patients need to be referred to the local hospital 15km away for treatment.

You are a 45 year old woman and a mother of five children. You look after the children alone as your husband is away working in the city. You have little time to spare with all your responsibilities at home. You had a pap smear four weeks ago because the nurse insisted. You had not found the time to return for the results and anyway you were not ill. The home visitor came to find you at home to ask you to come to the clinic for the results. You come because you do not want to seem impolite to the home visitor and you do not want her to come again.

Character C

This is a clinic in a rural area. The clinic has begun screening for cervical cancer. Screening must be done at the clinic and patients need to be referred to the local hospital 15km away for treatment.

You are the hospital clerk. You do filing and your job also includes answering the phone to make bookings for clinic patients who have to be referred to the hospital. You have quite enough work to do without being

responsible for clinics as well. The hospital is very busy and anyway you are sick of it and you have decided that you will try to ignore the phone today as you have filing to get through and must respond to the patients who arrive to ask for directions in the hospital.

Questions to bring out gender issues in the discussion after the role play

- What would motivate the clerk to be more responsive to clinic staff needs? How could this be organized? Whose responsibility is this?
- Why does this patient find it difficult to take time off to look after her own health? What would make it easier for her? Who would need to be targeted in educational interventions to facilitate her being able to have time for her own health?
- If the patient were a male would the clerk have reacted the same way?
- If the patient were economically well off or had organizational or political clout, would the clerk have reacted the same way?

Role play 4: Infrastructural requirements

To set the scene before this role play begins you will say:

"It is night at the clinic. The night call nurse (point her out) is sitting in the clinic, available for emergency cases."

Character A

It is night at the clinic. The night call nurse is sitting in the clinic, available for emergency cases.

You are the midwife on call for the clinic tonight. You are sitting in the clinic having some tea, thinking of going to bed as it is late. Night duty is always stressful. There is no one to talk to or to help if there is a problem. You have no phone in the clinic and the ambulance is located at the hospital 40km away on a bad road. It is worse now that it is the rainy season.

Character B

It is night at the clinic.

You are a pregnant woman who is having her third child. You have been in labour at home for six hours and now you see that you are bleeding. You are very scared and manage to get a man from the village to drive you to the clinic in his car. He is only helping you because you have begged him. He is concerned about the cost. You arrive at the clinic scared, in labour and bleeding.

Questions to bring out gender issues in the discussion after the role play

- What facilities are required in a clinic for them to be able to respond appropriately to this situation? What kind of systems would have to be in place to make this all happen? What could a manager do to make this happen?
- Under what circumstances would transport for women in labour be guaranteed? What would be required to make sure this always happened?

- What kind of action would promote women in this situation having more control over their own bodies and health?
- As it is both men and women who make and want babies, what kind of action would lead to men and women both having some responsibility for the healthy outcome of this pregnancy?

Role play 5: Access

To set the scene before this role play begins you will say:

"This is a busy clinic. It is almost lunch time and the queues are getting shorter at last. The nurse (point her out) is keen to take her lunch break and in the distance we see a patient (point her out) arriving hours after the clinic has opened."

Character A

This is a busy clinic. It is almost lunch time and the queues are getting shorter at last.

You come from a very poor family. Your child is sick and has been for a few days. She has diarrhoea and you can see she is getting worse. You decide that things are very bad and you must get some help. You decide to walk to the clinic which is far from where you live. You cannot ask your husband for money. You begin early in the morning and get to the clinic at 12 noon. You are late as most people arrive at 8am. By the time you get there your child is hardly able to cry any more. You must join the queue. You wait for an opportunity to talk to the nurse who is busy with patients. Everyone in the queue is better dressed than you. You feel that everyone can see you are poor. You are a bit self conscious as you wonder how you look and how you smell after such a long walk in the heat with a sick child.

Character B

This is a busy clinic. It is almost lunch time and the queues are getting shorter at last. The nurse is keen to take her lunch break.

You are the nurse. You have been working all day and still the queue is long. You see people still arriving even at midday. You watch one woman come with a sick baby and sit in the queue. As you go for lunch break you walk past the woman with the sick child and stop to shake your head: "Why has she come so late?" But you can see how sick the child is. "Why", you wonder to yourself, "did she not come earlier, and why did she not come to the front of the queue?"

Questions to bring out gender issues in the discussion after the role play

- Why would a woman not have money to pay for transport instead of walking?
- Why is it the woman who should bring a sick child to the clinic?
- What kind of action at health centres could be undertaken to promote the idea that both mothers and fathers are responsible for children's health?

Role play 6: Organization of health services

To set the scene before this role play begins you will say:

"This is a clinic which provides a range of services and is organized to provide specific services on specific days. Today, it is child health in the morning, and people with chronic diseases like high blood pressure and TB come in the afternoon. The clinic does it this way to make for efficiency from the provider's point of view."

Character A

This is a clinic which provides a range of services and is organized to provide specific services on specific days. Today, it is child health in the morning, and people with chronic diseases like high blood pressure and TB come in the afternoon. The clinic does it this way to make for efficiency from the provider's point of view.

You are the nursing sister at the clinic. It is a normal day at the clinic. Today is child health day in the morning and chronic care in the afternoon. These are always difficult days as the queues are long. You are trying to get through everything quickly. You have prepared the clinic for the two services that you are offering today and hope that you will manage.

Character B

This is a clinic which provides a range of services and is organized to provide specific services on specific days.

You are a mother and are bringing your child for immunization. You have a job and have had to take a day's leave. As you are a domestic worker you have to negotiate all leave days which is often a problem. You also want to get your contraceptive injection. You know it is due and you do not want to get pregnant. You are going to ask the nurse after she has immunized your child if you can please get your injection today.

Questions to bring out gender issues in the discussion after the role play

- **The clinic has specific services on specific days. What does this mean for patients who want to get two services in a day? What does this tell you about the assumptions we have about women's time?**

Role play 7: Supplies and equipment systems

To set the scene before this role play begins you will say:

"The medical officer in this clinic (point her or him out) has just been on a training programme on the treatment of the sick child. She or he is keen to implement what they learnt."

Character A

The medical officer in this clinic has just been on a training programme on the treatment of the sick child. She or he is keen to implement what they learnt.

You are the medical officer. It was a great course and now you know to ask the mother the symptoms, how to examine the child, to look out for five important and common diseases of childhood (malaria, respiratory disease, dehydration, malnutrition, and measles). You examine the child by taking the temperature and listening to the chest and you are sure that the child has a respiratory infection. You tell the mother that because the child is breathing so fast and from what you found in the examination you know the child needs antibiotics. You explain this to the mother and you tell her to go to the clinic pharmacy to get the drugs and you give her a prescription.

Character B

Your child has been ill and you come to the clinic to get it checked. The child has a fever and is not eating and sleeping well. You are very worried.

Character C

You work at the clinic as the pharmacy technician. You take the prescriptions and give the drugs. You know that the pharmacy has run out of many drugs. A mother comes for antibiotics and you have run out. You tell her you have none and that there is nothing you can do about it. She can come back maybe next week when you may have some more in.

Questions to bring out gender issues in the discussion after the role play

- Is the training programme for treating the sick child successful?
- What makes it successful or not?
- What aspects of the health-services system are not functioning?
- What are the consequences of this? Are the consequences likely to be different for women and for men? In what ways?

SESSION 3

Incorporating social and gender dimensions in health programme planning

What participants should get out of the session

Participants will:

- be able to analyse a reproductive health problem for underlying causes
- develop skills in designing health systems interventions to address these
- apply gender tools to enhance the gender sensitivity of interventions.

3 hrs

3 hours

Materials

- Handout 1 "But why?"
- Handout 2 "Women and sexually transmitted infections"

- about 200 cardboard circles in 4 different colours, 50 in each colour
- 5 flip charts marked "A woman is infertile because of an untreated sexually transmitted infection" in its bottom left corner
- something to stick the circles on to the flip charts with, and blank flip charts
- overhead: "Do your interventions address gender and rights", on p.418

How to run the session

This session starts with a small group activity in which participants explore a health problem (sexually transmitted infections) and develop potential interventions to address the barrier to an improved health outcome. They then evaluate these interventions for their gender sensitivity, and rework them. The second activity is a whole group discussion and consolidation of the major points by the facilitator. Note that this session builds on Module 2 Session 4 and Module 3 Session 6 specifically.

1 hr 30 mins

Activity 1: Exploring the problem of STDs

Step 1: Preparation

Do this step before you start the session.

Prepare cardboard circles, 6cm in diameter, in four different colours, about 10 of each colour for each group (40 circles per group).

10 mins

Step 2: Instructions for the activity

Introduce the session, outlining the main objectives. Divide participants into groups of about six to eight members. Distribute Handout 1 with instructions for group work. Each group does the same exercise, which consists of three major tasks:

- analysing the reasons underlying a negative health outcome
- developing possible actions that will address these reasons
- evaluating these actions for gender sensitivity and rights impact (a simple way of assessing the rights impact might be to focus on discrimination).

Give participants five minutes to read through the handout and clarify any queries they may have.

You may choose to distribute an additional handout (Handout 2) on gender issues in sexually transmitted infections if your participants are not familiar with the issues concerned.

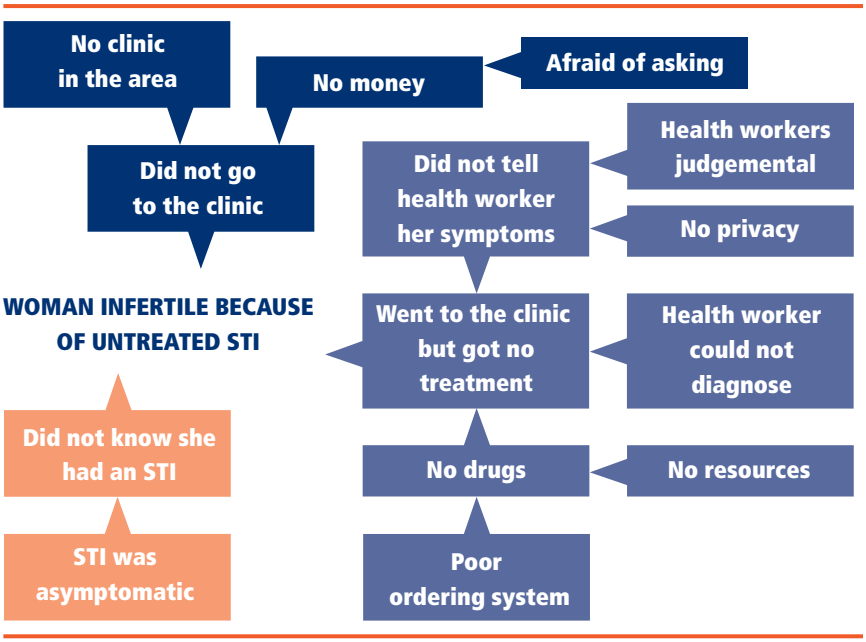
40 mins

Step 3: "But why?"

Starting with the statement "A woman is infertile because of an untreated STI" written at the bottom left corner of a large sheet of paper, groups ask "But why?", write the reason out on a circle of coloured cardboard, and stick it next to the statement. Participants use the inputs from the Social Determinants and Rights Modules, and the first two Sessions of this Health Systems Module for their analysis.

They keep asking "But why?" until the line of argument is exhausted. Each reason has to flow directly from the one before, be written on a circle of the same colour, and clustered next to each other. Then participants begin again at the original statement and explore another reason why the woman did not get her STI treated.

Participants need to describe as many reasons as possible in as much detail as possible. Each circle should contain a single specific issue. For example, "culture" is not acceptable as a reason: the group must define what about the culture is the reason in this specific instance, for example that women are expected to have sex whenever their husbands want to.



40 mins

Step 4: Actions

After this has been done, the group then looks at the chain of events for each specific reason, and thinks of actions the health care delivery services system can implement to deal with or overcome this problem. To illustrate how the groups should attempt to develop responses, one line of argument and possible actions are presented below.

Developing possible actions that health services can take

Problem identified	Possible action by health services system
Too scared to tell health worker	Ensure privacy at the clinic.
Health worker judgmental	Run workshops with health workers, e.g. *Health workers for change*, which get health workers to look at their own behaviour and challenge victim blaming. Institute spot checks to make sure health workers behave in a professional manner.
No drugs at clinic	Institute a proper drug management system.
Health workers could not diagnose STD	Organize in-service training to ensure technical competence of staff. Develop treatment protocols.
Woman never knew she had an infection	Develop health education that includes signs and symptoms of common diseases.
Husband did not say he had an infection	Ensure both men and women are targeted with information, and stress the need to treat both partners and for partner notification.
No clinic nearby	Build new clinics so that people have access. Develop a transport system for people who live far away.

1 hr 30 mins

Activity 2: Making sure we have a gender and rights perspective

1 hr 20 mins

Step 1: Report-backs and discussion

Each group in turn presents one reason and the chain of events. Ask questions after each presentation, challenging participants to clarify their line of reasoning, justify the actions they recommended and explain their feasibility and how these have a gender and rights perspective. Each report-back and related discussion should be done within 12 minutes or so, assuming there will be no more than five groups.

Experience with running this session shows that groups tend to develop actions related to health sector problems, like no drugs, no privacy, and health worker skills and attitudes. Problems related to gender, such as women not having money or being afraid to ask their husbands, are considered to be problems which the health system cannot do much about. Push participants to think through what can be done within health services so that women who are in such situations can access them: develop mobile services? have outreach workers or community volunteers? educate men?

You should plan on spending more of the discussion time on how gender and rights issues have been addressed. Services for women are often

assumed to address gender because they focus on women. Point out that this is not so, and that women's needs can be addressed without addressing gender issues (and, in fact, services for women can reinforce gender inequality) as maternal health services have tended to do for decades.

Go over each of these questions using an **overhead.**

Do your interventions address gender and rights?

- Do the interventions address gender issues? Has this been done from the users' as well as the providers' perspective?
- Do the interventions attempt to challenge existing gender and social relations?
- Have the potentially different impacts of this intervention on women and men (and on different groups of women and men) been considered?
- Have you ensured that any part of the intervention will not contribute to worsening the gender position of women (or of poor women in relation to those that are better off)?
- Could the interventions potentially violate any rights? Have you thought through the specific circumstances in which this could happen? For example, screening all women attending antenatal clinics for STIs.
- Do the interventions attempt to promote rights? Which rights do they promote?

Examples of interventions with gender implications include those requiring women to negotiate condom use, those requiring partner notification and so on. Partner notification also has rights implications. Elicit how participants plan to implement this without violating rights. Rights that may be upheld by the intervention include the right to information, access to public services, etc.

Step 2: Conclusion

In concluding, make explicit the ways in which this session draws on the Gender and Social Determinants Modules in the analysis of causes of the health problem, and the Gender and Rights Modules in examining the interventions from a gender and rights perspective.

Main points for closing this session

Success depends on taking social and gender determinants into account

Planning health interventions calls for attention to more than the medical causes and technical details of a health problem. Social and gender determinants of health have to be specifically taken into account, and suitable actions planned to address these. If not, the interventions are unlikely to achieve their health objectives.

Analyse the gender and rights implications

It is not enough, when planning an intervention, to take into account the gender and rights related factors which cause a health problem. An analysis of the likely gender and rights implications of implementing the intervention is also needed. Interventions should never contribute to worsening gender or social equity or violate human rights.

Linking to the health systems wheel

Point out that the health systems intervention that people have come up with are similar to those that were illustrated in the health systems wheel exercise. This shows how the principles of addressing generic health issues can be applied to a specific reproductive health care problem like sexually transmitted infections.

Session developed by Sharon Fonn

Handout

1 But why?

You have been given a piece of paper with the statement "A woman is infertile because of an untreated sexually transmitted infection" written in the bottom left corner. You have also been given 40 cardboard circles, ten of each colour. You have 1 hour and 20 minutes in which to analyse the reasons underlying a negative health outcome – infertility resulting from an untreated STI – and develop possible actions that will address these reasons.

40 mins

Task 1: But why?

Starting with the statement "A woman is infertile because of an untreated STI" ask yourselves "But why?" and write the reason you come up with on a cardboard circle. Stick the cardboard circle next to the statement on the big piece of paper. Keep asking "But why?" until the line of argument is exhausted. Each reason has to flow directly from the one before, be written on a circle of the same colour as the first one, and be stuck directly next to the previous reason's circle. Then begin again at the original statement and explore another reason why the woman did not get her STI treated using circles of a different colour. Each circle should contain a single specific issue. Do not use general terms such as "culture" as a reason; articulate which aspect of culture is causing the problem.

The figure below illustrates a series of reasons why for a different problem.

40 mins

Task 2: Breaking the chain

After this has been done, analyse the chain of events for each reason to identify every point at which the chain can be broken by an appropriate intervention. Develop an action that can be carried out by the health care delivery system to deal with or overcome this problem. Write these up on a flip chart or an overhead transparency. Be as detailed and creative as possible.

One line of argument and possible actions are presented in the table below, as an illustration of what you should do.

Developing possible actions that health services can take

Problem identified	Possible action by health services system
Clinic will not see adolescents	Run workshops with health workers, e.g. *Health workers for change*, which get health workers to look at their own behaviour and challenge victim blaming. Institute spot checks to make sure health workers behave in a professional manner.
No clinic nearby	Build new clinics so that people have access. Make contraceptives available in schools and through community based distribution systems.

20 mins

Task 3: Gender and rights

Look at the possible actions you have listed, and ask the following questions:

- **Do the interventions address gender issues ? Has this been done from the users' as well as the providers' perspective?**
- **Do the interventions attempt to challenge existing gender relations?**
- **Have the potentially different impacts of this intervention on women and men been considered?**
- **Have you ensured that any part of the intervention will not contribute to worsening the gender position of women (in relation to men)?**
- **Could the interventions potentially violate any rights? Have you thought through the specific circumstances in which this could happen? For example, screening all women who attend antenatal clinics for STIs.**
- **Do the interventions attempt to promote rights? Which rights do they promote?**

Prepare a brief presentation of about 10 minutes for the big group.

Handout

2 Women and sexually transmitted infections

It is estimated that 340 million new cases of curable sexually transmitted infections occurred worldwide in 1999, of which 182 millions were among women aged 15–49 years. [1] Case numbers are distributed as follows, with many women having more than one disease:

syphilis	10.63 million
gonorrhoea	33.65 million
chlamydia	50.03 million
trichomoniasis	85.78 million

Biologically, women are more susceptible to most sexually transmitted infections than men. This is because of the shape of the vagina and a greater mucosal surface exposed to a greater quantity of pathogens during sexual intercourse since the quantity of seminal fluid is far greater than the vaginal fluid involved. Younger women are more susceptible because the cervix is still immature and they have a lower production of vaginal mucus, which means they have less of a barrier to infective agents. ***[2]***

Poverty and lack of education and income earning opportunities often force women into commercial sex, which significantly increases their risk of infection. However, for the majority of women, high risk activity can simply mean being married. Social norms which accept extra-marital and pre-marital sexual relationships in men as normal, and women's lack of power to negotiate condom use and safe sex practices with their partners, are factors that make it difficult for women to protect themselves from sexually transmitted infections. ***[3]***

The fact that it is the norm for young women to have sex with or marry older men also increases the risk of infection, because age and/or delayed marriage in men is associated with a higher likelihood of premarital sex with more than one partner, including with commercial sex workers, and hence a greater likelihood of infection. Violence involving sexual assault also carries the risk of sexually transmitted or HIV infection, in addition to its other problems. ***[3]***

Not only are women at greater risk of infection, but also sexually transmitted infections in women are not easily identified or cured for a number of reasons. Over 50 per cent of sexually transmitted diseases in women are asymptomatic. Diagnosis is difficult and often requires running costly tests in sophisticated laboratories. Women's access to services is frequently poor, because management of sexually transmitted diseases is rarely provided as part of an integrated approach to women's health needs. ***[4]*** **Even where facilities are available, the stigma associated with sexually transmitted infection is a major barrier to women seeking care.**

This leads to complications that cause considerable morbidity and mortality and seriously impair the health of women, especially in developing countries for reasons mentioned above. For example, sexually transmitted infections cause pregnancy-related complications, sepsis, spontaneous abortions, premature births, stillbirths and congenital infections. Thirty-five per cent of cases of postpartum morbidity are attributable to sexually transmitted infections. Almost two-thirds of cases of infertility among women are attributable to sexually transmitted diseases. It is estimated that of all gynaecological admissions, 17–40 per cent are due to pelvic inflammatory diseases, mostly arising from sexually transmitted diseases. *[4]*

References

1. World Health Organization. *Global prevalence and incidence of selected curable sexually transmitted infections.* Geneva, WHO, 2001.
2. Howson CP, Harrison PF, Hotra D, Law M, eds. *In her lifetime. Female morbidity and mortality in Sub-Sahara Africa.* Washington D.C., National Academy Press, 1996.
3. World Health Organization. *Women of South-East Asia. A health profile.* New Delhi, WHO South-East Asia Regional Office, 2000.
4. United Nations Population Fund. *The state of world population 1997. The right to choose: reproductive rights and reproductive health.* New York, UNFPA, 1997.

SESSION 4 Prevalence data and costing considerations in service planning: Case: cervical cancer

What participants should get out of the session

Participants will:

- be acquainted with the principles of screening and their application to service development
- understand the relationship between disease prevalence and the cost of screening services
- see the linkages between the availability of resources and epidemiological information about a disease and decisions related to policy and services.

2 hours

Prior preparation

- Fill two opaque bags with marbles of two different colours. See Activity 2- Cervical cancer screening simulation, Step 1 on p.427 for detailed instructions

Materials

- Handout: "Cervical cancer screening simulation"

- overhead: "Criteria for choice of disease for screening", on p.426
- at least 315 marbles of one colour, and 85 marbles of a second colour, all of the same size
- two opaque bags (which you cannot see through) or pouches
- flip chart: "How to play the game", on p.427
- overhead with chart, on p.427
- overhead: data on age specific prevalence of cervical cancer, drawn from the cancer registry of a country from which the course has participants (example "Age specific prevalence of cervical cancer, South Africa (1994)", on p.429)
- overhead: "Reduction in the cumulative incidence of invasive cervical cancer over the age range 35–64 years, with different frequencies of screening", on p.429

Readings for the facilitator

1. Eddy D. Screening for cervical cancer. *Annals of Internal Medicine,* 1990, 113:214–225.

2. Fonn S. *Screening for cervical cancer: a unified national strategy.* Johannesburg, Women's Health Project, University of the Witwatersrand, 1993.

3. Miller AB. *Cervical cancer screening programmes – managerial guidelines.* Geneva, World Health Organization, 1992.

4. Miller AB et al. Report on consensus conference on cervical cancer screening and management. *International Journal of Cancer,* 2000, **86(3):**440–447.

5. Sackett D. Laboratory screening: a critique. Federation Proceedings. *Clinical Laboratory Developments,* 1972, **34:**2157-61.

6. Stuart S et al. Demystifying and fighting cervical cancer. *Women's Health Journal,* 1992, **3:**29–52.

Readings for participants

Readings 4 and 6.

How to run the session

This session is a simulation exercise preceded and followed by an input. You will need to spend some time before the session putting together the materials. The simulation exercise takes place in the big group, with the facilitator taking participants through it step by step.

20 mins

Activity 1: Input on screening

What to cover in your input

Screening is the presumptive identification, by simple tests, of unrecognized disorders in asymptomatic individuals. It is usually an expensive undertaking and it will only be affordable if good coverage is achieved. Explain that the activity in this session will help them see, through a simulation exercise, how the prevalence of cervical cancer influences the unit cost of a cervical cancer screening programme. Make a connection with inputs provided in the module on evidence where necessary.

Put up the table below as an **overhead,** and go over the points. Ensure everyone understands this.

Criteria for choice of disease for screening

Criterion	Reason
Common disease	Economically viable
Serious consequences if not treated	Reason for intervention
Long asymptomatic period	Time to treat
Facilities for diagnosis	Confirm screening result
Available effective treatment	Ethics
Disease of concern to the community	Consumer demand
Acceptable test	Increase utilization
Cost considerations	Ensure implementation

Source: Sackett DL. Laboratory screening: a critique. Federation Proceedings, *Clinical Laboratory Developments* 1972, **34:**2157–61.

Treatment

You should note that treatment for preinvasive disease in cervical cancer can be done using various options: surgery (cone biopsy); laser therapy; lletz - large loop excision of transformation zone using a diathermy; cryotherapy. Each of these methods attempt to remove the transformation zone of the cervix do not involve removing the uterus. Women require frequent follow up to ensure that their treatment worked and that their cervix remains normal.

Treatment for invasive disease requires that the woman is investigated and properly staged. In the early stages - stage 1 cancer and sometimes stage 2 - the usual treatment is a radical hysterectomy where the uterus and ovaries are removed. If the cancer has regressed further than this, and has speared into other organs, the treatment usually includes radiotherapy without removing the uterus.

In any form of cancer, palliative treatment should be offered, aimed at decreasing symptoms. Surgery to repair fistulae are often required in cervical disease. Treatment may include surgery and/or radiotherapy and/or chemotherapy. The most important component of palliative care is pain management, including giving morphine as required.

1 hr

Activity 2: Cervical cancer screening simulation

Step 1: Preparation

Prepare two bags of marbles. If marbles are not available or too expensive you can also fold up marked pieces of paper, or use coloured beans that are all of the same size. You will need:

- two kinds of marbles, many of one colour (X) and fewer of another colour (Y)
- two bags that one cannot see through.

In each bag put 200 marbles. In one of the bags put 25 marbles of colour Y and 175 of colour X. In the other bag, put 60 marbles of colour Y and 140 of colour X.

X denotes healthy (screen negative) people in the population, and Y denotes unhealthy (screen positive) people.

Prepare a flip chart with the following information:

How to play the game

- Cost of screening $10
- Cost of treatment $30

The aim of game is to find as many cases of disease as possible.

The winning group is the one that spends the least money.

Prepare an **overhead** with the following chart:

	Cases found		Cost of screening		Cost of screening and treatment		Cost per case detected		Cost per case detected and treated	
	Group 1	Group 2	Group 1	Group 2	Group 1	Group 2	Group 1	Group 2	Group 1	Group 2
Round 1										
Round 2										
Round 3										
Round 4										

40 mins

Step 2: The screening

This step follows straight after Activity 1.

Divide the group into two. If you want to have even smaller groups have two (or more) groups with the 25/175 split and two (or more) groups with the 60/140 split. You will have to adapt the table accordingly.

Give each member of the group the handout "Screening simulation" with instructions for group work.

Explain to the groups that they are about to simulate screening a population, by drawing marbles out of the bag without looking into the bag. Each group draws out 100 marbles. They count the number of marbles of colour Y, and the number of marbles of colour X out of the 100 they have drawn. This represents the number of women with and without the disease, respectively. They then fill in the table in the handout.

They must repeat this process four times. At the end of each round the groups remove all the diseased cases (marbles of colour Y). These people now enter a treatment track and are no longer eligible for screening. All the negative cases (marbles of colour X), however, are returned to the bag as they may develop the disease between rounds and so are still eligible for screening.

To simulate people becoming positive between each round of screening, put three of the diseased cases (Y coloured marbles) back in the bag.

Put up the **overhead** of the table as groups start counting. Fill it in after each round, getting the groups to do the calculations. Use a pen of one colour for one group and a pen of another colour for the other group so that the contrast is clear. Do this until the participants have been through four rounds.

20 mins

Step 3: Discussion

After the four rounds of counting are over and the table on the overhead has been completed, discuss with participants the differences and similarities that can be observed between the two groups, and between each round of screening.

What to cover in the discussion

- The first round of screening detects the greatest number of cases for both groups.
- The number of cases detected decreases with each round of screening, for both groups.
- If coverage were 100 per cent (i.e. they went through all the marbles in the bag and not just 100 each time) they would find all the cases on the first screen.
- Screening costs are constant but as less cases are picked up the cost per screening process (screening and treatment) increases.
- One group has a lower pick-up rate than the other. This is because of the lower prevalence rate of disease in this group.
- The lower the prevalence rate, the higher the costs of screening and treatment per case identified.

40 mins

Activity 3: Cervical cancer

20 mins

Step 1: Input

What to cover in the input

This is an input session on how the natural history of cervical cancer impacts on screening decisions. You may choose to talk briefly about what the various stages of cervical cancer are, from the early stage, CIN I (cervical intra-epithelial neoplasm), to micro invasive disease. (Use Reading 1 for basic information on cervical cancer.)

Overhead Prepare and present data on the age specific prevalence of cervical cancer, drawn from the cancer registry of a country from which the course has participants, like in the example below.

Age specific prevalence of cervical cancer, South Africa (1994)

Age group	Cases of cancer of the cervix	Total number of women	Women per case
0-19	13	6,886,182	529,706
20–24	77	1,818,478	23,617
25–29	116	1,619,920	13,965
30–34	236	1,508,410	6392
35–39	332	1,257,010	3786
40–44	339	1,035,646	2596
45–49	370	840,174	2271
50–54	375	703,047	1875
55–59	288	572,805	1989
60–64	350	456,593	1305
65+	614	1,081,752	1762

Source: Cancer Registry, South Africa,1994

Overhead Present also the following evidence on the reduction in the cumulative incidence of invasive cervical cancer over the age range 35–64 years, with different frequencies of screening.

Reduction in the cumulative incidence of invasive cervical cancer over the age range 35–64 years, with different frequencies of screening

Frequency of screening	Percentage reduction in cumulative incidence	No. of tests per woman during the 35–64 year span
1 year	93	30
2 years	93	15
3 years	91	10
5 years	84	6
10 years	64	3

Source: Miller AB. *Cervical cancer screening programmes – managerial guidelines.* Geneva, World Health Organization, 1992.

Explain how the above data can be used for making policy decisions on the age group to be covered by a cervical cancer screening programme and the frequency of screening. For example, from the table above we know that if we started screening all women from age 45 onwards, we would need to screen between 2271 and 1762 women to identify one woman with the disease, assuming 100 per cent coverage. We can make calculations for different levels of coverage, and cost the intervention. Depending on the resources available, screening may be done once in 5 years or once in 10 years, or even once in a woman's life-time, but making efforts to cover every single woman aged 45 or older.

Step 2: Brain-storming interventions

In this last part of the session, brain-storm with participants the health systems interventions which would be required in order for a cervical cancer screening programme to be effective. Add in the points below as necessary.

Interventions needed for a cervical cancer screening programme include:

- educating service providers about cervical cancer and the logic of a programme (who to screen, how often and why)
- ensuring equipment and supplies are available, sterile and in working order
- setting up referral systems for treatment
- setting up a health information system to monitor coverage, follow-up of patients and patient referral
- some form of quality control
- recruiting enough women service providers (in some cultural settings this is a must)
- training service providers in technical skills
- training service providers in counselling skills
- ensuring privacy for patients
- education programmes to ensure the target population comes for screening (it is worth making the point that men too may need to be educated)
- carrying out screening exercises during a time/season convenient for poor women.

You may want to refer back to Session 2 and the health care delivery system wheel and highlight how many of the points made here were covered there.

Session developed by Sharon Fonn

Handout

1 Cervical cancer screening-simulation

You have been given a bag with marbles. You are going to simulate screening a population, by drawing marbles out of the bag without looking into the bag as you do it.

There are four rounds of "screening" (drawing marbles). In each round, your group has to draw out 100 marbles. Put aside marbles of colour Y as and when you find them, and keep marbles of colour X separate from these. When your group has finished drawing 100 marbles, count the number of marbles of colour Y; they represent the number of women with the disease. Fill in the table below as follows:

In the first column, **Cases found,** write the number of marbles of colour Y (say this is 12).

In the second column, **Cost of screening,** write $1000, because you have screened 100 women at a cost of $10 each (100 x $10).

In the third column, **Cost of screening and treatment,** enter the figure you get when adding 1000 and (no. of cases detected x $30). If the number of cases detected was 12, the number to write in this column would be 1000 + (30 x 12) = 1000 + 360 = 1360.

In the fourth column, **Cost per case detected,** write the answer you get when you divide 1000 (from column 2) by the number in column 1. In the example we have taken, this is 1000/12= $83.33.

In the fifth column, **Cost per case detected and treated,** write the answer you get when you divide the figure in column 3 by the figure in column 1. In the example above, this is 1360/12=113.33.

The facilitator will ask you to share your findings after each round.

Repeat this process four times. At the end of each round, remove all the diseased cases (marbles of colour Y). These people now enter a treatment track and are no longer eligible for screening. All the negative cases (marbles of colour X), however, are returned to the bag as they may develop the disease between rounds and so are still eligible for screening. To simulate people becoming positive between each round of screening, three of the diseased cases (Y coloured marbles) will be returned to the bag by the facilitator.

	Cases found	Cost of screening	Cost of screening and treatment	Cost per case detected	Cost per case detected and treated
Round 1					
Round 2					
Round 3					
Round 4					

SESSION 5

Health workers for change: a health systems management tool

What participants should get out of the session

Participants will:

- experienced a demonstration of a health services management tool
- explored the interpersonal (provider-client) aspect of quality of care within a health care delivery system framework and from a gender perspective.

1 hour and 45 minutes

Materials

- Each participant should be given a copy of the manual: Fonn S, Xaba M. *Health workers for change.* Johannesburg and Geneva, Women's Health Project and World Health Organization, 1995. It is available from WHO in Geneva.
  or
- Handout: *"Health workers for change.* Workshops on obstacles to providing quality of care"

Readings for the facilitator

1. Fonn S, Xaba M. *Health workers for change.* Johannesburg and Geneva, Women's Health Project and World Health Organization, 1995.

2. Washington OO et al. The impact of health workers for change in seven settings: a useful management and health system development tool. *Health Policy and Planning,* 2001, supplement to **16.**

3. Vlassoff C and Fonn S. Health workers for change as a health systems management and development tool: conclusions and recommendations. *Health Policy and Planning,* 2001, supplement to **16.**

How to run the session

The session consists of two activities. The first demonstrates the health services management tool *Health workers for change* by running one workshop from it. The second is an input on the use of *Health workers for change* as a management tool. You will need at least one co-facilitator for the first activity, because the workshop is run for two groups at the same time.

Activity 1: The demonstration

You will need an additional room for this session, so that you can run the workshop from the *Health workers for change* (HWFC) manual for two groups at the same time.

Divide participants into two groups. Ideally each group should have at least 10 members. Each group will work through an HWFC workshop. If you have access to *Health workers for change,* read the manual and choose one of the exercises that you think suits your local circumstance and then develop that workshop.

If you do not have access to the manual, you may use the workshop that we have reproduced in the handout.

You will note that the HWFC workshop guide (or the handout) explains how the workshop should be run and how to facilitate the discussion. You can follow this, and also make the links to the health care delivery system wheel introduced in Session 2. You and your co-facilitator should run the same workshop. Close the workshops after 45 minutes and bring everyone together for the input.

Activity 2: Input on *Health workers for change*

In the big group provide an input on the *Health workers for change* workshops as a change management strategy to influence provider-client relationships. Use the summary below and the readings to prepare your input.

What to cover in your input

A response to one of the consequences of health sector reform

Health sector reform, underway in many developing countries, has resulted in cuts in health expenditure. At the same time, these reforms are supposed to address problems of poor quality of services and in improving access for poor people.

Health care provider morale is likely to be low in poorly resourced settings with low salaries, inadequate supplies and equipment, and so on. Yet reform requires personnel at all levels to embrace and implement new systems.

The *Health workers for change* manual, a health services management tool to improve quality of care, was developed with this situation in mind.

Addressing the interpersonal aspect of quality of care

Health workers for change (HWFC) began as an initiative to understand, from the health care provider's point of view, why provider-client relations are so often negative. The aim was to develop an intervention which improved the environment in which health care is delivered.

The HWFC intervention to address the interpersonal aspect of quality of care was developed through a series of research studies. These included studies with health care providers in rural South Africa, an acceptability study in four African countries, and an impact assessment study in seven primary health care sites in Africa and Argentina.

An opportunity to reflect on behaviour and attitudes

HWFC consists of six workshops. The methodology aims at "problem posing", presenting back to health workers their own conditions and asking them to reflect on these. Each activity leads into a discussion about provider-patient relations.

HWFC relies on participatory interactive learning methods to allow providers to reflect on their behaviour in a non-threatening space. It helps providers separate behaviour from intent, offering them an opportunity to think about behavioural and attitudinal change.

A social determinants perspective promotes changes in behaviour

The workshop methods also locate both the service user and provider within their respective social contexts. An attempt is also made to help service providers understand the various social, cultural and economic determinants of health. Such a framework is largely neglected in the training of health workers and in the way that services are offered. With a social determinants perspective on health problems, health workers are able to understand patient behaviour as a response to social circumstances rather than as ignorance or a refusal to comply with health workers' prescriptions. Providers become aware of their victim blaming behaviour, and methods such as role plays allow providers to develop empathy with patients. This promotes behavioural change.

The gender relations dimension

The HWFC workshops specifically address gender relations. This adds to providers' understanding of factors affecting health and health seeking behaviour in women and men. Awareness of issues such as control over decision making or resources, or even the right to have control over one's own body (for example, requiring permission to access services or access to money to utilize transport, or permission to use contraceptive technology), add an often previously unexplored dimension to the limitations many women face in relation to their health.

Ideas for action

The workshops culminate in the development of a prioritized list of practical actions that health workers themselves can initiate at the clinic level. This describes for district health managers what is required to build a district health system, and to earn the respect and trust of employees.

Real life results

Research on the impact of implementing HWFC in seven primary health care sites showed that:

- In five of the seven sites there was a decrease in the total time patients spent at the clinic.
- In four of the seven sites provider-client interactions improved. This was shown through more respectful interactions, better explanations of health conditions or drug regimens, prompt attention, greater availability of drugs, increased privacy, and not having to pay bribes.
- Facility level improvements included better team work, implementing changes identified during HWFC workshops, instituting clinic meetings to manage clinic activities, and staff taking the initiative to solve problems.
- At the system level some positive change was noted, including increased supervisory visits, greater involvement of facility level staff in budgeting, and improvements in facility functioning (improved drug ordering and management of facility controlled funds).

HWFC is a tested method of addressing the interpersonal aspect of quality of care. It illustrates that good management involves creating an environment in which staff are valued and feel they have a voice in decisions. If they are treated with respect they are much more likely to treat their clients with respect. Participatory management engenders responsiveness and communication, which are essential to good quality health care services.

Session developed by Sharon Fonn

Handout

1 *Health workers for change.* Workshops on obstacles to providing quality of care

Source: Fonn S, Xaba M. *Health workers for change.* Johannesburg and Geneva, Women's Health Project and World Health Organization, 1995:47-55.

Overcoming obstacles at work

Objective

To investigate the factors health workers identify in their work situations that affect their relationships with women clients.

Background

Health workers work within a health system and often have little decision-making power or control over their daily activities. Management in many systems is often slow or poor, and this causes understandable frustrations for health workers. Also, not receiving drugs or salaries are real problems.

In this workshop, we aim to discover, from the point of view of health workers, what problems they have at work and what things at work give them job satisfaction. We also want to define factors that are beyond their control, and those that are within their control to change. If we want health workers to treat patients with respect, then health workers need respect too.

Respect is something you have to get in order to have it for others. That is why we have said that this workshop series is best used in a situation where change is possible within the health service itself. However, there are things that can be done to make health workers more satisfied with their jobs even when there are no major changes in the health service.

Things needed	Timetable	
Pieces of paper, 10x10dm, 5 per participant and labelled 1 to 5	Explaining the exercise	10 minutes
1 pen per person	Working in small groups	20 minutes
5 sheets of newsprint and a felt-tipped pen	Totalling up	15 minutes
Something to stick paper on the walls	Discussing the results of the exercise	15 minutes
A small box, jar or hat		

Method

- **Summary**
- **Introducing the objective**
- **Dividing into small groups**
- **Getting back into a large group to do group count using "Jinja paper technique"**
- **Running a group discussion**

1. **Introduce the session by saying:**
   "We are trying in this session to find out what problems health workers have at work. Often researchers ask patients what problems they have, but very seldom do they ask health workers. We would like to know what problems you have at work, and also how you think these problems affect your interactions with women patients."

2. **Divide into small groups.**
   We think it works well to divide into groups by category of health worker, as people in a similar position have similar problems. However, you can also divide the group randomly in groups of three to four people. Ask the groups to discuss the things at work that help or get in the way of their doing a good job. Walk around and assist the groups to generate this list. They do not have to write everything down. The purpose of the small group exercise is simply to get everyone thinking.

3. **Get everyone back into a big group. Give each person five pieces of paper. One piece is labelled "1", another "2" and so on up to "5".**

Ask everyone to write down five problems, one on each piece of paper. They should write their biggest problem on the paper labelled "5". The second biggest problem goes on the paper labelled "4", and so on. They should write their least important problem on the paper labelled "1". They should not put their names on any of the pieces of paper.

Collect all the pieces. Put them into a jar or a hat or a box, and pull out one at a time. Ask for volunteers to keep the score of each category of problems. One by one call out each problem and say the number that has been given to the problem. The score keeper writes down the number value of the problem. So if "salaries" is one of the problems, one score keeper is given salaries as their category and writes down "salaries" on the top of the page, and "5" or "3" or whatever value the problem has. The score keeper repeats these steps each time "salaries" is called out. Another score keeper will keep track of the scores for all problems categorised under "equipment", another for "staff relations" and so on. Try to group problems appropriately. For example, "gloves" and "drugs" and "blankets" would all be grouped under "equipment".

After you have read out all the slips of paper, ask the people keeping score to total up the score for their subject. They should call out the scores to you, and you then write them in order of importance on a piece of newsprint.

Variation

To help those who cannot write, you will need to go to each individual and write the problems they name on the appropriate piece of paper. You need to be sure that the person can speak privately to you, so leave the room with the person if you have to. Remember that as the facilitator you must not show any value judgement in response to what people tell you. Simply show a neutral facial expression and write what they say!

4. **Ask the group if they agree generally with the order in which the problems appear.**

Again, this is not a detailed discussion but a place to start -the stimulus for a discussion. Going from the most important point to the least important point, ask the group to describe ways in which these problems affect their relationships with the women patients they see.

We developed and tested this idea as a group when we were together in Jinja, Uganda, as we were preparing to run the multicountry study in Africa. So we have called it the "Jinja paper technique".

Summarize by going through what you have covered during the workshop, describe to the group the major points that came out of the session and make sure the group agrees with your summary.

Wrap up by linking this workshop to the next by referring to the **Workshop process diagram** and making the connections between the workshops clear.

Write up

Present the list that you developed with the group and give the cumulative scoring for each problem so that the ranking of each problem is clear. If, during the workshop you combined a few issues together under a general heading, then explain in the report what constituted that problem. For example you may have put: shortage of drugs, poor maintenance of equipment, broken scale under a heading 'inadequate resources'. You need to explain this in your report so that it is clear to a reader what resources are inadequate; otherwise they are unable to know how to respond to rectify the situation.

Experiences during prior workshops

This combination comes from all the countries we worked in:

- low salaries
- inadequate equipment and supplies
- heavy workload
- poor infrastructure
- bad relationship among staff in clinic
- no telephone

In the discussions about how these problems can affect the health worker-client relationship, these are some of the things we learned:

"When I am cross with the in-charge for telling me what to do all the time, then I don't take the patient a bedpan so I can get back at the in-charge."

"If my salary is late, then it is my problem. When I get to work, it becomes the patient's problem. She must give me a little extra to see her. Sometimes I will not give enough drugs. I know she will not die, but she will also not get better properly, and must come again and pay again."

One of the researchers using this method said,

"Somehow, by doing this, people opened up. They told me such amazing things, it is much better than other methods I have used to elicit information. "

Solutions

Objective

To draw together what has been learned at the previous workshops, and to conclude by planning things that can be done at this health facility to improve quality of care.

Background

The point of this workshop series is to sensitize health workers to women's health needs, and to find out from health workers how they themselves

view their work. If the workshops have been successful there will be at least some changes, however small, that the health workers will want to make to improve things. The changes may be things health workers want for themselves, which will affect the way they relate to clients, or the changes may affect clients directly. We want to try and firm up these ideas in this workshop. Of course, some things are beyond the health workers' control, but other things are not. We will address them both. The motivation behind this workshop is to end with the health workers feeling that they have some definite course of action open to them. That given the will, they can change things themselves - that they have the power to do something.

Things needed	Timetable	
Materials for team-building game	Team-building game	30 minutes
Prepared summary list for all other workshops (see instructions in 'Method' below)	Summarizing findings from previous workshops	10 minutes
Sheets of newsprint	Break into groups to discuss solutions	45 minutes
Felt-tip pen	Joint discussion of solutions	15 minutes
Something to stick paper on the wall		

Method

Summary

- **Playing a team-building game**
- **Going through the list you have prepared**
- **Running a group discussion to generate a list of possible things to do**

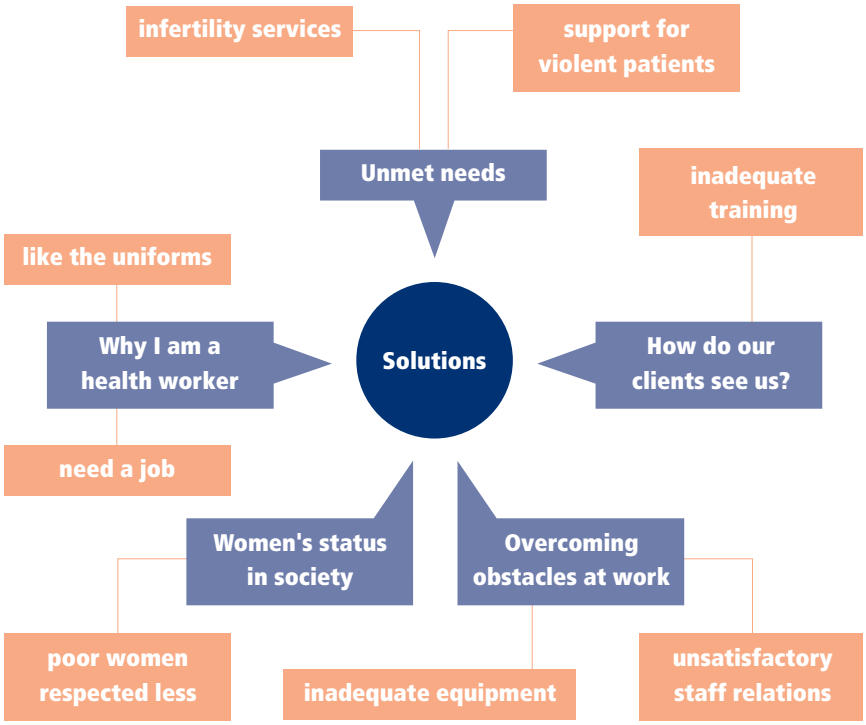
To prepare for this workshop, you need to go through all the previous workshops and write down all the factors from each workshop that the health workers have identified as influencing, in any way, their interactions with clients. So from one workshop you could put "doing this job to support my family", plus all the other things that came up. From another workshop you could put "interpersonal conflict between staff", and so on. You will eventually have a full list of factors that have come up.

1. **Begin with a team-building game (see Addendum).**

2. **Take your prepared list with you, but keep it as a prompt only for yourself. You then remind the group of the topic of each workshop (use the Workshop process diagram) and ask them to generate the list as they remember it. You can add from your prepared list anything that was not remembered by the group. When the group does not remember a point, you can say, "I went through my notes, and other things that came up were... Can I add these to our list?" Once you have compiled the list of factors, group them into common themes. You may put all work-related inefficiencies together and make another group of issues related to communication with clients. This will depend on what has come out of the previous workshops.**

Variation

If you are running out of time you can take the list you have prepared and tell the participants "I went through all our previous workshops and have listed the issues that have come up, can I list them and you can add any I have forgotten? " Then list the issues, you can write them onto the workshop's process diagram with lines linking them to the workshops that they came from, as illustrated below.



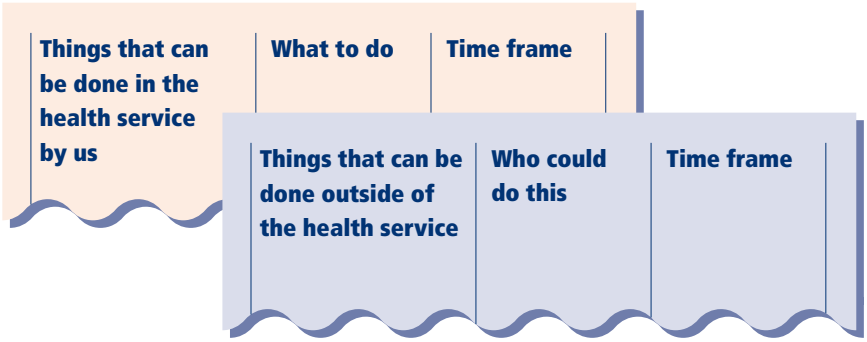
3. Divide the group into smaller groups and give each group a few of the issues. Ask them to discuss what interventions could be undertaken to rectify these issues. You can give each group some newsprint to write their ideas on. It is useful to have two sheets (see below). One with a heading "things that can be done at our health service level by us" and "things that can be done outside of this health service level." Ask the groups to put time frames to the interventions that they would like to implement.

Summarize by going through what you have covered during the workshop, describe to the group the major points that came out of the session arid make sure the group agrees with your summary. Go over the **Workshop process diagram** again and show the links between all the workshops with this last workshop. Discuss with the group how they will take this whole process forward and tell them what you are going to do. For example you may write a report or present your findings to the health service managers.

Thank everyone for their participation.

Write up

Here you need to list all the actions that the participants identified. Remember to include who they think it is should take action. Again, if you used the newsprint during the workshop, what is on it will form the basis of your report. In this workshop you have tried to get the participants to make real plans for change, so if they have made a time scale in which to take these actions, include this in your report.



Experiences during prior workshops

"On structural problems like drugs and supplies, accommodation, transport, water, electricity and refresher courses, health workers recommended that the government review the situation with the aim of improving the whole network of the health care system. Without those problems being addressed adequately and collectively, the plight of patients will worsen, and health workers' role as care providers will remain ineffective."

"Health workers expressed that attitudinal change in themselves could happen if steps were taken to address their problems at work and alleviate their plight."

"In spite of all the problems, health workers pointed out these problems are not devoid of solution. They suggested tbat for instance, in their training, the curriculum could be adjusted."

Things that can be done in the health service	What to do
Staff shortage	Petition for more posts to be created. Help find people to fill the vacancies that do exist.
Poor support from management at hospital level	Develop a method of complaining and how to follow up when complaints are not dealt with. (In Uganda, one suggestion was to discuss the problem with the community clinic committee and get them to take it up.)
Conflict between staff at the clinic	Hold monthly meetings to discuss problems. Ask an NGO to run a conflict resolution workshop with us.
Patients don't seem to follow our advice	Ask for communication skills workshop.
Infertility, teenage sexuality, violence against women	Do in-service training on counselling skills.

SESSION 6

Service evaluation as a health management tool

What participants should get out of the session

Participants will:

- understand how the records of clinic organization and time use (staff and patients) can be used as a management tool to promote the provision of integrated services
- be exposed to experiments which have succeeded in improving access and quality of services within existing budgets
- appreciate the value of participatory research methods and management styles.

2 hours 45 minutes

Materials

- Handout 1: "The study design"
- Handout 2: "Pre-intervention data"
- Handout 3: "Actions"
- Handout 4: "Post-intervention data"

How to run the session

This session is drawn from a health system intervention conducted in South Africa (Tint KS, Fonn S, Ketlhapile M. *Time flow and work load study. Northern Province.* Johannesburg, Women's Health Project, University of the Witwatersrand, 1999 (unpublished document)) and uses real data from one of the clinics. The activity consists of reading and discussions in small groups with inputs from the facilitator throughout. This happens in four steps. In each step the small groups read information from one handout, and then the facilitator engages them in a discussion. After the groups have read and discussed four handouts in this way, there is a concluding whole group discussion.

Activity: The case study

20 mins

Step 1: The study design

Divide the group into small groups of about five people. Introduce the activity and mention that the data in the handouts comes from a real study conducted by the Women's Health Project and is not hypothetical.

Give each participant a copy of Handout 1: "The study design". They have about 10 minutes to read it and discuss the questions.

Follow this up with a discussion in the big group based on the questions. (Participants stay seated in their small groups.)

What to cover in the discussion

Ask participants what they understand by the term "participatory", and what makes the intervention described in Handout 1 participatory.

They may identify the following features of a participatory intervention:

- health workers were involved in identifying the problem
- fully informed consent
- health workers were shown the results and asked to give feedback about whether the observations were accurate
- health workers participated in proposing solutions and interventions
- staff were involved in data collection and analysis. In other words (in the terminology of the Policy Module), they were involved in problem identification and in solution development.

In one instance, participants brought up the issue that clients were not involved, and remarked that the process may therefore not be considered to be fully participatory.

What are the strengths and the weaknesses of participatory interventions?

Strengths

- the commitment of health workers and their participation in making change happen may be counted upon
- there will be ownership of the results; the intervention is more likely to be sustained
- it will contribute to team-building.

Weaknesses

Participatory interventions take a great deal of time and effort.

30 mins

Step 2: Pre-intervention data

After this discussion, distribute Handout 2: "Pre-intervention data". Participants take about 15 minutes to read it and discuss the questions. As before, participants stay seated in their groups when they share answers to the questions in the big group, in response to specific questions from you.

What to cover in the discussion

Start with the frustration and resentment patients would feel because of the long waiting time, the unnecessary number of "provider stations", the short consulting times and the lack of privacy.

Then centre the discussion around the way staff time is spent on numerous unspecified tasks, while the number of patients seen per provider is quite low. This is likely to make providers feel that their time is being used inefficiently. They may feel stressed because of the long queues. Also, some staff members have less work, while others have too much to do. There may be many disgruntled staff members.

Close the discussion with suggestions for some interventions that the clinic staff may want to implement:

- Integrate services: could one staff member provide more than one service at the same provider station?
- Let one or two staff members go because of the low patient/staff ratio.
- Try to reduce time spent on unspecified activities.
- Do more community outreach work.

Step 3: Actions

Distribute Handout 3 on the actions that clinic staff took. Groups read and discuss it in about 15 minutes. There is no big group discussion on this reading.

Step 4: Post-intervention data

Distribute Handout 4 with post-intervention data and discussion questions. Groups take 20 minutes to read, and to discuss the questions. After this, groups stay seated as before. They share answers to the discussion questions in the big group, in response to specific questions from you.

What to cover in the discussion

General improvements

The first couple of discussion questions are straightforward. Things have improved, and indicators such as waiting time, utilization and direct-care time are some indicators which show this.

But what about women?

A gender critique of the interventions is more challenging. To begin with, data on utilization, direct-care time, waiting time in minutes, etc. have not been presented by sex, making it difficult to assess the overall gender impact of the interventions.

However, in so far as services were integrated, women are likely to have benefited. The provision of delivery services seems to have increased access to care for many women.

Perhaps the most obvious gender issue is time. In many countries women's time is seen as infinitely expandable, women have time to attend health services for their children even when these services are inefficient and involve long waiting times. Increasing service efficiency will benefit women (who disproportionately bear the burden of household reproductive work, caring for children, etc).

Meeting women's practical needs

Frequently within this module we have made the point that because women attend health services when they are healthy – for pregnancy and delivery related services, and for contraception - and because they are expected to be carers for the family, they suffer the consequences of

poorly functioning health care services more than men do. This is a gendered issue in society, as it relates to women's expected roles. Improving health care service functioning is a necessity for society as a whole. The benefits, however, will go some way towards meeting women's needs. This approach tries to recognize inequality in society. While it does not challenge gender norms it does take them into account. It thus meets women's practical needs.

Main points for closing this session

Ownership encourages action

Clinic staff were involved in the data analysis themselves. This gave them ownership of the findings and they are more likely to take action as a result. This is one of the driving principles of participatory methods.

Hard facts

Discussions in the clinic on organization were based on data and not on individual perceptions or feelings. Objective evidence was put forward. The data were not linked to any individual. People had to back up their opinions with data.

Data were presented dispassionately with no victim blaming. This is a way of being respectful and people are more open to listening.

In situations where gender differences persist in the work loads of male and female staff, this is a way of raising awareness on this issue in a non-threatening manner.

Finding solutions builds skills and confidence

Staff were left to develop their own solutions. This builds problem solving skills and gives people an outlet for some creativity. It can lead to a more fulfilling job. This method builds capacity. People are left with skills to apply to other problems.

Staff often gain confidence. If they are supported and allowed to innovate they can apply some of the skills learnt through this exercise to other areas of their work.

An alternative to top-down methods

For a manager or a planner, this kind of method – using data for decision making, letting people analyse their own situation and develop their own solutions – is a good option. It is a viable alternative to top-down methods of working.

Raising awareness of the impact on women

This method can be used to raise awareness on how women are disproportionately affected by inefficiencies in the delivery of health care services.

Session developed by Khin San Tint and Sharon Fonn

Handout

1 The study design

This case study presents the strategies used for facilitating the process of providing comprehensive reproductive health services integrated into primary health care services in South Africa.

Integrated services

The term "integrated services" refers to a situation where a multi-purpose provider can provide a range of services to a user during one visit. Thus a person could come and get a contraceptive method, ask a question about some other symptom, like coughing at night, and have a child immunized in one visit. Integrated services are thought to increase service access to women and vulnerable groups as all health needs can be met in a single visit. It also provides an opportunity for offering an additional service to an individual. For example a woman who has brought her child for immunization, once in a consulting room with a provider can also be asked if she has any personal health problems, needs contraception, is having any symptoms of disease ranging from TB to reproductive tract infections, as appropriate. This cuts down on missed opportunities for care.

Heath providers believe that integrated services require additional staff

The Department of Health in South Africa is developing district based comprehensive primary care services. Thus the policy environment is conducive to this kind of intervention. However in most clinics it is not the current reality. There are many reasons why health providers believe that more staff members have to be recruited to implement integrated services. Their notion of integration is providing all basic services such as family planning, antenatal care, child health services, treatment for minor ailments and chronic diseases, no matter how these services are organized and when they are provided.

The intervention

1. Clinic staff and patients were fully informed of the proposed data collection and agreement was given to proceed.

2. Data was collected on how long patients spent waiting for and receiving care and the primary reason for their visit.

3. Staff were observed and how they spent their time was noted and classified as:

- direct care (face-to-face with patients)
- indirect care (performing tasks that that are required in order to deliver services, e.g. ordering drugs, filling in clinic statistics, etc.)
- break time (official breaks, e.g. lunch, tea)

- unspecified activities (not doing any productive work during working hours, e.g. talking to friends, sitting around, etc).

4. It was noted how the clinic was organized, what rooms were used for what, what equipment and facilities were available, how patients moved from one space to another, if patients knew where to go to get what they needed, and so on.

5. All data was analysed on site and the method of analysis and results were discussed with staff.

6. Staff looked at the data and gave input on whether it was accurate or not and reasons for why things operated as they did.

7. Staff were reminded that services were supposed to render comprehensive integrated care, meaning all services must be available every day, provided by one provider in one room. A lot of discussion and clarification on the meaning of "integrated" took place as well as on the reason it was being promoted as a good system of providing care.

8. Using the data collected, staff identified what worked well and what improvements could be made.

9. Staff identified interventions that they wanted to implement and listed what was required in order for this to occur.

10. It was agreed that staff would try to implement some changes with management support.

11. The research team left and it was agreed that they would return in six to eight months to repeat data collection to see if there were any changes.

Questions

- This intervention is described as being participatory. What elements make it participatory?
- What do you think are the strengths and weaknesses of participatory interventions?

Handout

2 Pre-intervention data

Here are some of the data from the pre-intervention study.

Clinic organization

- The clinics still rendered vertical services; specific services were available at different times of the day, rendered by different staff in different rooms, although they were all under one roof.
- More than 90 per cent of the patients received a single service only.
- This indicated that the meaning of integrated services was not understood.

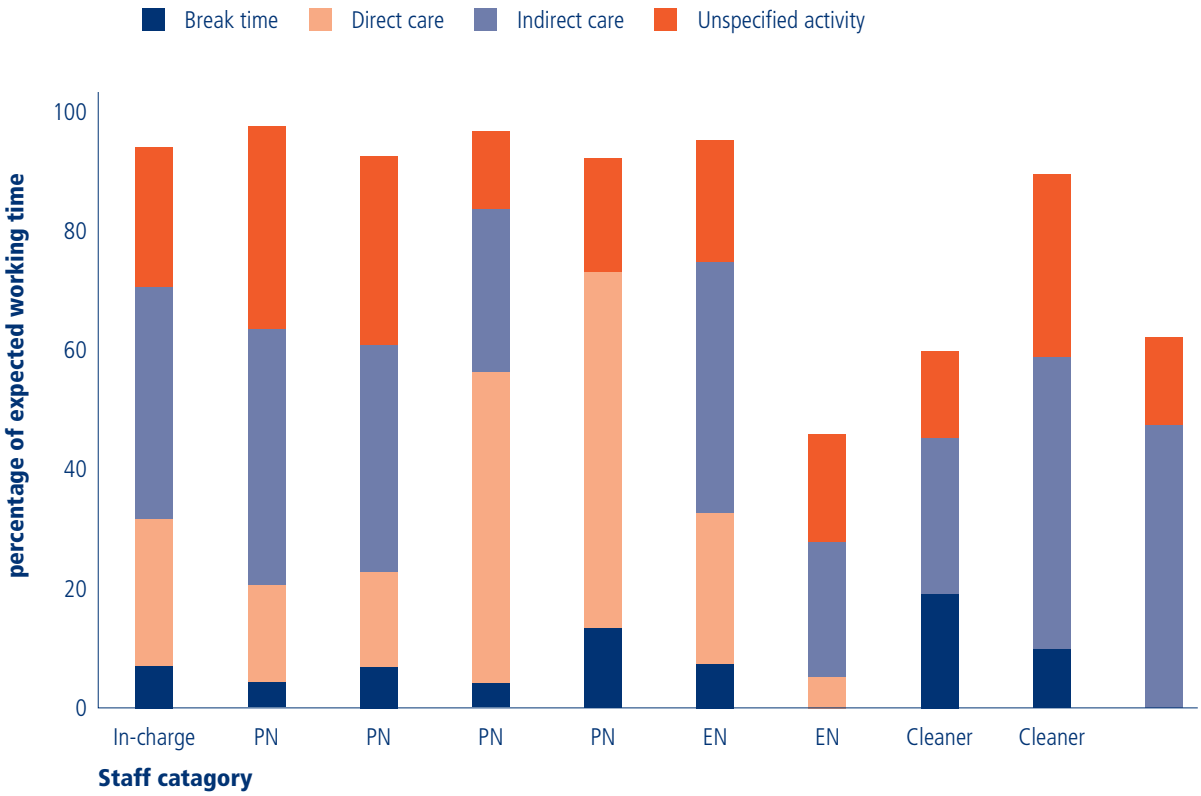
Examples of the impact of this type of organization

- A mother with a child coming to a clinic to get family planning for herself and immunization for her child spent the whole day in the clinic to get both services. She waited in the child health queue in the morning to get her child seen to. Then she waited until the afternoon family planning queuing began to get her own needs met.
- In the afternoon family planning sessions, young girls were all packed in one room and one provider injected one girl after another with Depo Provera while they were standing in a circle. There was no privacy, no discussion of problems and no choices of contraceptives were offered.
- Antenatal care was run by an appointments system on a specific day of the a week. A woman coming for antenatal care was palpated in one room, her vital signs checked in another, and she received her tetanus toxoid injection in another, being seen by many different providers in this process.

How clinic staff spent their time

The following table shows how staff spent their time. In-charge is the professional nurse in charge of the clinic. PN stands for professional nurse; this is a person trained in doing general care, diagnosis and treatment, antenatal delivery and post care. EN stands for enrolled nurse. This person has less training but can weigh children, often takes the vital signs (temperature and blood pressure, etc.), can immunize children, dress wounds, etc. Under supervision they can do additional tasks.

Individual staff time by activity in Western region (before intervention)



Additional information on staff time and work load

- Total daily attendance for 13 August 1998 was 155 patients
- The average daily attendance is 73 patients (based on previous three months' data)
- The number of staff is 19 (9 PN, 5 EN, 2 cleaners, 3 security guards)
- The ratio of staff to patients is, on average, 7 nurses for a total of 73 patients, which comes to 1:11 (the norm for the country is 1:30).
- The actual working time of all staff in the clinic as a percentage of the expected working hours is 80%
- The proportion of productive time of all staff is 48.1%
- The proportion of unproductive time of all staff is 51.9%
- The proportion of staff time used for direct patient care is 18.9%
- The proportion of staff time used for indirect patient care is 29.2%
- The proportion of staff time used for unspecified activities is 51.9%

Data on patient time

Cases found	Average waiting time in minutes	Average time for receiving care in minutes
family planning	20	3
immunization of child	38	4
dressing	20	7
antenatal care	74	10
minor ailments	35	5

Questions

- **If you were a patient coming to this clinic, how do you think you would feel (use the data to back up what you are saying) and what would you want to change?**
- **If you were a nurse working at this clinic, what would you be thinking (use the data to back up what you are saying) and what would you want to change?**
- **List interventions that the clinic staff may want to implement.**
- **In your situation, are there male and female health care providers? If so, is work distributed among them equally? If not, can you describe who does which work and discuss why you think this is the case?**

Handout

3 Actions

This handout describes how clinic staff responded to the results of the pre-intervention study. In discussion with all the staff, these are some of the issues that were clarified.

Patient time

Staff agreed that patients seemed to spend a very long time waiting. They said that long waiting times arose chiefly because all patients arrive early in the morning. By noon almost 70 per cent of the daily patients had received care and left. This has a two-fold effect. The clinic is overcrowded, uncomfortable in itself and the large volume of patients make staff feel stressed. However a breakdown of how staff spend their time – how much time they have free during a total day – suggests that staff are under stress rather than overworked. Staff said they contributed to this by waiting until all patients had arrived so that there could be a communal prayer before the clinic work began.

Staff time

Staff agreed that they spent a lot of time on indirect care: there were at least three different register books to fill in for each patient and this takes up a lot of time. For a number of months prior to the pre-intervention study there was no water in the clinic. As a result maternal delivery services and thus night duty were stopped. The duty roster had changed and everyone worked day shifts.

While staff said they provided integrated services they agreed that in fact they did not. They gave many reasons for this including:

- they had not used some skills for a long time – while they were trained to do everything they were used to providing only one service and they lacked confidence and skills in the others
- there were not enough blood pressure machines to have one in each consultation room so they only had one consultation room open
- they did not have enough cooler boxes to keep immunization vials in each room.

Some of the decisions that staff took

- Ask management to restore the water supply with immediate effect.
- Organize training for providing integrated services. Ways of doing on-the-job training were discussed. Clinic staff will use their different training backgrounds and share their multidisciplinary knowledge among themselves.
- The clinic will reorganize and reallocate staff for providing integrated services.

- Clinic staff will open more cubicles or rooms (two rooms for the time being) for all kinds of services. They can also be for a combination of services according to the demands of the community.
- Reorganize the clinic record keeping system.
- Revitalise the clinic committee.
- The clinic nurse in-charge will develop a mechanism for the screening of emergency patients to attend to first. This will be part of one of the on-the-job training initiatives, which will include training of the EN to identify the critical signs and to know when to inform the senior staff for immediate action.
- It was agreed that praying was a personal thing and that people could do it as they liked; it did not have to be a communal activity.
- A first come, first served system was started so that everyone knew who would go next except for very ill patients who would be seen first.
- A fast queue system was introduced and an EN would hand out pre-packed repeat medicines (e.g. for TB, hypertension, etc.) to people who did not want to see a nurse but came only for medicines.

Questions

- Are any of the actions on this list similar to ones that your group came up with?
- What do you imagine the costs of these interventions were? Affordable, or too expensive?
- Do you think any of these interventions will benefit women and men who use the clinic? Will it benefit women and men differently?

Handout

4 Post-intervention data

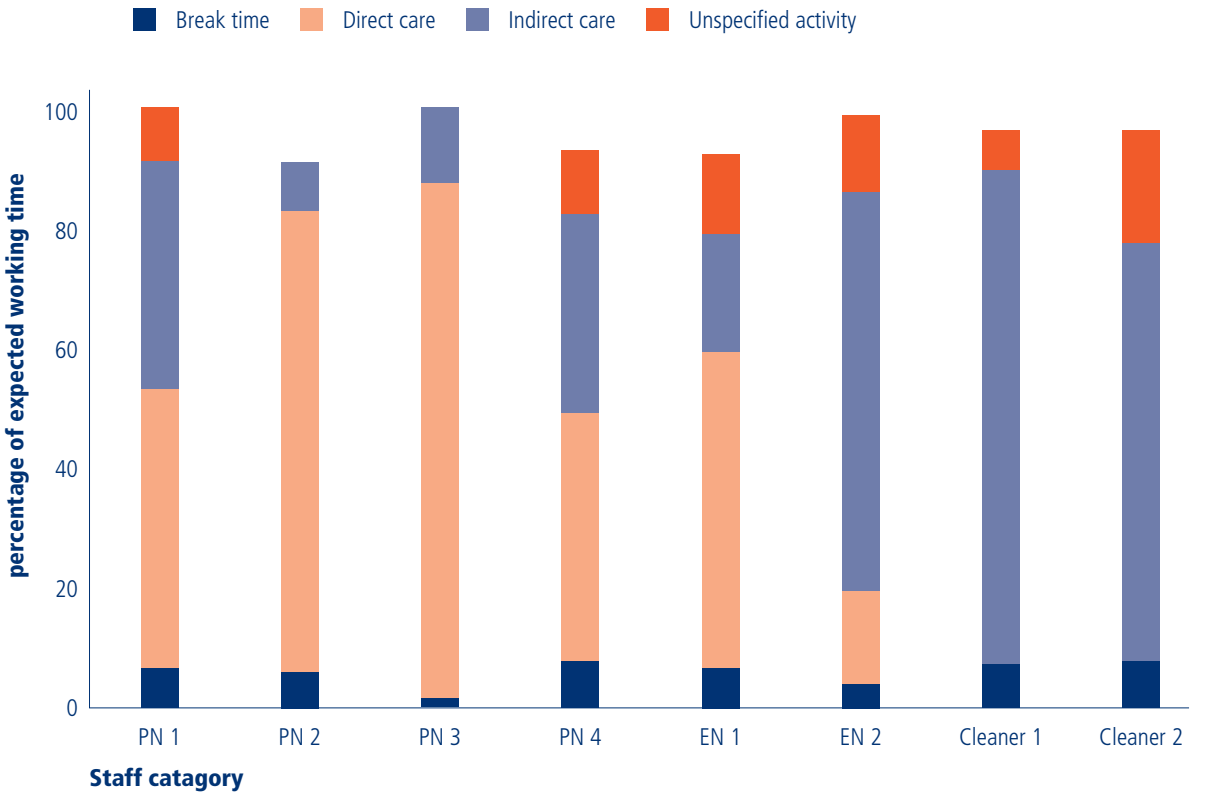
The post-intervention study revealed that:

- **The clinic provided integrated services.**
- **The total attendance had increased to 200, indicating improved clinic utilization.**
- **The staff efficiency improved according to the following observations: increased proportion of staff time for direct patient care and decreased proportion of staff time for unspecified activities; the average number of patients attended per day by each staff member increased from 18 to 23.**
- **The average patient waiting time decreased generally for all services.**
- **The average patient time for receiving care from a clinic nurse increased.**
- **The clinic organization had changed with the opening of three consultation rooms for examinations, consultations and prescribing medicine.**
- **The clinic provided a 24 hour service and maternity services. The average number of deliveries per month was 35.**
- **The clinic was cleaned and staff looked confident and the clinic functioned smoothly. The overall impression was that this was normal and routine.**
- **The clinic had developed effective and practical systems for functioning well. There was a system for providing a child immunization service every day; a first come, first served queue system was introduced. Other actions included: the integration of chronic patient services; a system of recording the daily workload; and staff meetings for decision making.**

Data on patient time

Service	Average waiting time in minutes	Average time for receiving care in minutes
immunization	14	4
antenatal	7	10
minor ailments	24	9
chronic	12	6
TB/DOTS	14	20
dressing	1	3
family planning	11	4
more than one service	14	4

Individual staff time by activity at clinic in the Western region (after intervention)



Questions

- **Look at this data and decide if things have improved or not.**
- **List the indicators that make you think things have improved.**
- **Critique the actions taken and the data in the handout from a gender perspective. Do you think any of these interventions will benefit women and men differently?**

SESSION 7

Application exercise: developing an intervention to improve quality of care

What participants should get out of the session

Participants will:

Participants will have applied the tools and concepts learned in this module to develop solutions to a health problem in their own work environments.

2 hrs 30 mins

2 hours and 30 minutes

Materials

- Handout: "Application exercise in developing an intervention to improve quality of care"

Prior preparation

Before the session begins, give participants instructions as described in Activity 1, Step 1 below.

How to run the session

In this session, participants complete an assignment outside class hours. When they submit their work, you (and perhaps your co-facilitator) will need about a day or an afternoon and an evening to mark the assignments and write comments for feedback. You return the assignments and give feedback on the following day.

Activity 1: The assignment

2 hrs

2 hours and time outside class hours

15 mins

Step 1: Preparation

After the end of Session 6, schedule 10–15 minutes for giving participants instructions for doing their application exercises and distribute the handout.

Give participants some examples of topics they may choose for this individual assignment, and emphasize that they have to

choose something they have encountered in their work and would like to see changed. Encourage them to choose real rather than hypothetical problems.

Examples of quality of care problems chosen for the application exercise

- Long waiting time for ambulance from hospital for referring complicated deliveries; reason was poor interpersonal relationship between clinic and hospital staff.
- Poor quality of care in maternity unit; high rate of infection in C-sections.
- Under-utilization of clinic services in five health centres; community members complain that there have been times when pregnant women were attended in delivery by relatives and not health centre staff.
- Lack of collaboration among NGOs, donors and different sectors within health department, resulting in the absence of a national reproductive health policy.
- Poor coverage of youth in an NGO's Newsletter readership
- Delay in the distribution of an NGO's IEC materials, resulting in accumulation of stock and material becoming dated before distribution.

Step 2: Beginning the assignment

Schedule 1 hour and 45 minutes of class time for participants to begin the exercise. This is usually scheduled for the last few hours of a working day, so that participants have the evening to complete the task. They have to submit the assignment the next morning.

Step 3: Assessment

Read all the assignments carefully and rank these as 'average', 'above average' and 'good'. In courses that are formally graded (See Introduction p.1), you may have to mark the assignments. Enlist the help of a colleague or co-facilitator who has taught in this module, so that grading is completed within a day.

Criteria for assessment

An intervention planned by a participant is considered to be good when all of the following criteria are met:

- data/indicators which described poor quality were explicitly linked to the intervention
- expected changes in indicators which would describe an improvement in quality were listed
- a system to monitor these particular indicators was described
- the gender and rights implications of the intervention were discussed in detail, and appropriately.

The intervention plan is considered average if it reflects that the person knows what she or he is doing, but has written up their ideas vaguely, with too many generalizations. The actions to improve service quality were not clearly spelt out, there was not enough detail, or it was not specific enough.

If the intervention plan gives sufficient information on the links between the problem and the actions to address these problems, but has not presented outcome indicators and systems for ongoing monitoring, then it gets a higher than average assessment.

As you go through the assignments, make notes for feedback, with special reference to common errors and misconceptions, and the extent to which a gender and rights framework has been applied. Set aside assignments which are especially well done in one or more aspects to share with the class.

Activity 2: Feedback

What to cover in the discussion

Some examples of the feedback you might give

- Use assignments which satisfied all the criteria of a good assignment as illustrations.
- Discuss assignments which had potential but did not satisfy all the criteria and show how they could have been developed further.
- When the problem was not appropriately chosen, or indicators were not valid – they did not measure what they were supposed to measure – discuss this in detail.

In one assignment, "the number of transfers to hospital was too high" was chosen as a measure of poor quality. In the discussion it was pointed out that the initial description of the problem "too many transfers" was not appropriate. Providers in more distant services, where fewer options for dealing with emergencies exist (in this case, being able to do a caesarean section), had to cope with a highly stressful situation. The purpose of referral in these circumstances was to avoid complications, and some degree of over-referral was to be expected and is acceptable. The problem needed to be redefined: it was not the number of referrals, but their potential inappropriateness. Being clear about what the problem is makes it easier to develop an appropriate intervention.

- Discuss the gender and rights dimensions of some of the interventions to reinforce this once again. We want to internalize it so that it gets routinely applied.

Criticize the work not the person

When giving feedback, do not be critical of the person but only of their work. Always give examples of what could have been done differently rather than just a critique. The manner in which feedback is given should build confidence and contribute to capacity-building; it should not be disempowering.

Revisit the objective

Conclude the session by going over the objectives in the Module brief. Make it clear to the participants that mainstreaming gender in health programming is what this module has been about. Gender mainstreaming is not a separate process. It has to be built into the process of identifying problems and solutions and implementing these solutions on a day-to-day basis. It is a world view, an approach that should inform every aspect of a health care delivery system on an ongoing basis.

Session developed by Sharon Fonn

Handout

1 Application exercise in developing an intervention to improve quality of care

You need to plan an intervention to improve the quality of care of a particular health care service that is delivered in your setting.

1. **Choose an area in your day-to-day work where you think quality is an issue.**

2. **Explain why you think that quality is a problem in this specific area. For example: what data do you have that allows you to come to this conclusion? Or, if you have no data, on what basis have you decided, or what indicators are you using, to decide that quality is a problem?**

3. **Plan and describe an intervention to improve the situation. Outline SMART (Specific, Measurable, Achievable, Replicable and Time-bound) objectives for the intervention package and specific actions that will help meet these objectives. Explain in detail what will be done, by whom, with whom, over what period of time.**

4. **Give one outcome indicator and one process indicator to monitor the intervention.**

5. **What systems will you put in place to ensure that improved quality will be maintained?**

6. **Discuss how you have addressed the underlying gender issues in developing the intervention, and what the potential gender and rights implications/ impact of your intervention may be.**

Your assignment should be no more than 5–6 typed pages (1.5 line spacing) long. There is no minimum length, except that all the above questions have to be addressed.

Example of a SMART objective and related actions and indicators

A SMART objective for a contraceptive services programme is:

- **to increase by 50 per cent, by the end of one year, the proportion of male condom users served by the clinic.**

A set of actions specifically to help meet these objectives, depending on what the underlying causes for low condom use are, would be:

- **campaigns and training workshops to influence attitudes to condom use and to demonstrate correct use, starting with young adolescents**
- **improving the quality of condoms available**

- **setting up condom distribution points that would ensure easy access and privacy.**

An outcome indicator to assess the objective is:

- **number of condom users among male users of the clinic above age 15 years / total number of male users of the clinic of age 15 and above.**

This indicator has to be measured at the beginning and end of one year, to assess if the increase over this period is 50 per cent or more.

A process indicator to assess the objective could be:

- **number of trainees covered by workshops during the year, who have a positive attitude to condom use and know how to use them correctly.**

Closing module

Module outline

		Objectives Participants will:	Format of activities	Time: 4 hours and 15 minutes
SESSION 1	Consolidation exercise	• draw together what they have learnt from the various modules of the course, using: – the tools and concepts from each of the modules to address a single intervention – international agreements for motivating changes in policy or implementation	Participatory exercise in small groups	2 hrs
SESSION 2	Revisiting hopes and expectations	• revisit hopes and expectations listed in the opening session to review the extent to which these have been met	Sharing in the big group	1 hr
		• fill in an evaluation form	Individual activity	15 mins
SESSION 3	Certification and graduation	• receive their course certificates	Whole group gathering	30 mins
SESSION 4	Taking leave	• take leave of each other in a positive way	Participatory exercise in the large group	30 mins

Module brief

What participants should get out of the Closing Module

Participants will:

- consolidate what they have learnt on the course
- apply the tools and concepts from each of the modules to a single intervention, in relation to either policy advocacy or health system planning
- evaluate the course from their immediate perspective by:
  - reflecting on the extent to which their hopes and expectations of the course have been met
  - identifying specific conceptual and practical skills they have gained
  - reflecting on the value of the networking and other gains not related to specific course content or training.

The thinking behind the module

This module is scheduled for the last day of the course. Its purpose is to help participants consolidate what they have learnt and take leave of each other in a positive way.

There are four sessions. The first is a consolidation exercise in which participants are challenged to apply all the tools, skills and knowledge they have acquired to a single reproductive health issue. This demonstrates how every module of the course has helped them see one important dimension of the issue or problem, and how together these dimensions enable them to develop a more comprehensive policy or intervention. In Session 2, participants revisit their hopes and expectations and provide feedback to the course organizers on what they have gained. Following this, participants receive their course certificates, and there is formal closure. The last activity is a fun exercise to take leave of each other in a positive way, and bring about group closure.

SESSION 1

Consolidation exercise

What participants should get out of the session

Participants will draw together insights from the six modules of this course using:

- the tools and concepts from each of the modules to address a single reproductive/sexual health intervention
- international agreements for motivating changes in policy or implementation.

2 hours

Materials

- Handout: "Questions for the consolidation exercise": 5 sets of 6, on different coloured paper for each module

- 5 sets of cards in 6 different colours with the module names written on them
- 5 packs of fun gifts, 1 gift for each participant

How to run the session

This session needs three or four co-facilitators who have taught or are well acquainted with various modules of the course.

Activity: A competition

Step 1: Preparation

Prepare five sets of six questionnaires – one questionnaire for each module, one set of questionnaires for each of five groups. The questions for each module are given in the handout. Print the questions for each module on different coloured paper. For example, purple for gender, green for social determinants, and so on.

Prepare five sets of cards, about 5cm x 2.5cm, in six different colours, one representing each module. Use the same colours as for the corresponding questionnaires. There should be five cards of each colour, with the module names written on them.

Buy some fun gifts, one for each participant. In the South African course, these are usually candy or chocolate bars. They could be any

other gift – pens, stickers, picture post-cards – something light-hearted. Put these into five separate packs, one for each of the five groups.

Step 2: Assign the statements

Divide participants into five groups and give one of the following five statements to each group at random.

Statement 1

Health services do not meet all the health needs of pregnant women. Discuss this statement in relation to each dimension of the course (based on the questions in the handout), and come up with appropriate responses.

Statement 2

Health services often fail to identify women who are in abusive relationships unless they come in as "assault cases". Discuss this statement in relation to each dimension of the course (based on the questions in the handout), and come up with appropriate responses.

Statement 3

Teenagers are not adequately catered for currently in reproductive health services. Discuss this statement in relation to each dimension of the course (based on the questions in the handout), and come up with appropriate responses.

Statement 4

The availability of abortion services (or access to abortion) is a problem. Discuss this statement in relation to each dimension of the course (based on the questions in the handout), and come up with appropriate responses.

Statement 5

The health services do not use every opportunity to address HIV infection (e.g. promoting condoms, identifying and treating STDs). Discuss this statement in relation to each dimension of the course (based on the questions in the handout), and come up with appropriate responses.

Give each group a set of six colour-coded questionnaires with the questions and tasks related to each module which group members have to apply to the specific statement they have been given.

Step 3: Ready, steady, go!

Participants start working in their groups. They have between 15 and 20 minutes for each module.

The co-facilitators stand in the centre of the room, as match adjudicators, waiting for group members to come to them with answers for each of the modules. The match adjudicator should ask the group for clarification if she or he does not understand any of the answers. If the group's answers are not satisfactory, the match adjudicator should tell them what is wrong with their answers and send them back to come up with better answers.

If the group has prepared a good enough response, they are given the coloured card for that module to signify that they have successfully completed the questions. The group then goes on to discuss and come

up with answers for another module, and so the process continues.

It is not necessary for the groups to work through the modules in any particular order. The aim is to get a full set of module cards. The first group to collect the full set is the winner.

As soon as a group gets a full set, give them their gift pack.

The competitive element adds to the excitement. The exercise is fun to do, and everyone enjoys it. No group stops trying because another group has already won the game. They feel challenged to discuss and find answers to the questions.

Session developed by Sharon Fonn

Handout

1 Questions for the consolidation exercise

Answer these questions in relation to the statement that has been handed out to your group.

1. Social determinants

Identify one determinant of the problem you are trying to address at each of the following levels:

- **international**
- **national**
- **community**
- **household**
- **individual.**

Determine if any of the following factors influence or cause this problem and how:

- **race/ethnicity**
- **class**
- **economic issues**
- **political issues**
- **socio-cultural issues.**

2. Gender

Identify ways in which gender issues are associated with and impact on this problem. Describe at least three ways in which gender issues are associated with it. Explain why you think so, using the gender tools you have learnt.

3. Rights

Does the ICPD *Programme of Action* say anything about the problem you are trying to address? If yes, give three points that the document makes.

Looking at the *Universal Declaration of Human Rights*, identify two rights that could be violated if the problem is not properly addressed, and come up with two possible actions to ensure that these rights are promoted.

Evidence

4. Given your problem, identify the three most important research questions that need to be answered to give you the evidence you need.

Amongst these three, identify at least one gender specific research question that you would like to pose.

For one of the research questions, describe:

- the sample population
- the study design
- the data collection tools you will use.

5. Policy

Give two examples of how the context affects the problem you are addressing.

Identify four key actors who will affect your ability to address this problem. Indicate:

- who the actor is
- if they are for or against addressing your problem
- how much power they have.

Give two examples of information you will need to address this problem.

Identify two strategy options you could follow to address the problem.

Choosing one of these options, identify two individuals or organizations that you will work with.

Decide on a goal to address this problem. Explain how this goal will address the gender dimensions of the problem. Is this a gender neutral, gender specific or gender redistributive approach?

6. Health systems

Examine the following elements of health service functioning in terms of their influence on the problem you are concerned with:

- provider-client relations
- access
- technical competence
- referral systems
- the organization of health services within a health facility
- drugs and equipment supply and maintenance
- infrastructural facilities.

List for each of these (choose the relevant ones), two essential interventions to address the problem.

Explain how the intervention addresses gender issues: is it a gender-specific intervention, or a gender redistributive intervention?

SESSION 2

Revisiting hopes and expectations

What participants should get out of the session

Participants will:

- revisit the hopes and expectations listed in the opening session to review the extent to which these have been met
- fill in an evaluation form.

1 hr 15 mins

1 hour and 15 minutes

Materials

- overhead with hopes and expectations from Session 1 of the Opening Module
- course evaluation forms based on Annex 5.

How to run the session

In this session, participants give feedback on the course and fill in a formal course evaluation form.

1 hr

Activity 1: Hopes and expectations

Step 1: Preparation

Make sure you have an overhead of the list of hopes and expectations that participants came up with on the first day of the course.

Prepare a course evaluation form. Annex 5 gives one example. You may modify this to suit your needs.

1 hr

Step 2: Sharing

Put up the **overhead** with the list of hopes and expectations.

Ask participants to reflect on which of these expectations were met, and which not, and on what might be done differently the next time this course is run.

Go around the room and call upon each participant to share her or his thoughts. It is crucial that every participant contributes.

This is a sharing session, and no one is allowed to challenge or debate what someone else has said. For example, if someone says, "I felt the course was too long", there is no scope for someone else to

jump in and say, "I think you are wrong; in fact the course was too short." If a participant does feel differently from an earlier speaker, she or he is welcome to share this as her or his point of view, but not as an argument.

Activity 2: Course evaluation forms

Distribute the course evaluation form (See Annex 5 for an example). Explain that the form is long because it aims at finding out about the entire course when things are still fresh in participants' minds.

Collect the forms after 15 minutes. File these safely and hand them over to the course organizer or whomever else is responsible.

Session developed by Sharon Fonn

SESSION 3

Certification and graduation

What participants should get out of the session

30 mins

Participants will receive their course certificates.

about 30 minutes

Materials

- certificates and mark sheets for all participants, in sealed envelopes

How to run the session

The process is likely to be different in different contexts. What is described below assumes that the course participants were formally assessed and are given a certificate of competence if they make the required minimum grade.

30 mins

Activity: Certification and graduation

Step 1: Preparation

In order for the certificate to be issued on this last day, you will have to have marked all the assignments and put together marks for class participation, etc. An individual mark sheet and a certificate for each participant has to be prepared and signed by the appropriate authority.

30 mins

Step 2: The ceremony

Give out certificates and mark sheets in sealed envelopes bearing the participant's name in a small ceremony, formal or informal, as the course organizers choose. A group photograph may also be given out at this time.

An innovative informal way of giving out certificates is to distribute each one randomly to the participants, and ask each participant to give the certificate in his or her hand to the appropriate person. The recipient then does the same. Whenever the chain is broken, it is started again.

Session developed by Sharon Fonn

SESSION 4

Taking leave

What participants should get out of the session

30 mins

Participants will take leave of each other in a positive way.
about 30 minutes

Materials

- paper, pins and pens, one each for every participant and facilitator in this session

How to run the session

There are two activities in this session, one for giving feedback to co-participants and facilitators at a personal level, and the second is a group exercise. Two examples have been given below, but these may be replaced with other similar activities.

20 mins

Activity 1: Positive personal feedback

Step 1: Preparation
Have ready paper, pins and pens, one each for every participant and facilitator in this session.

Step 2: Pin pieces of paper onto each other
Distribute to each participant a piece of paper, a pin and a pen. Ask participants to get up and start moving around the room. Each participant gets someone to pin a piece of paper on her or his back.

Step 3: Writing positive comments
Moving around the room, participants write one positive comment about a co-participant on the paper pinned to his or her back. Each participant may write comments on as many co-participants and facilitators as they would like to. This continues for some time, until everyone has written comments on as many others as they would like to.

Step 4: Reading the comments
Participants then remove their papers and sit down to browse through the comments. This is a fun feedback activity that can be done quickly and the paper serves as a memento from the course.

10 mins

Activity 2: One word

The group stands in a circle. Clap hands in rhythm, leaving a moment of silence between claps. Going round the circle, each person says one word that represents the course for them during the moment of silence. This continues around the circle till everyone has spoken.

Session developed by Sharon Fonn

PARTIE

Annexes

ANNEXE 1

Resources for participatory training

Underlying philosophy and the role of the facilitator

Hope A, Timmel S. *Training for transformation.* Gweru, Mambo Press, 1984.

This is an excellent resource for understanding the philosophy underlying participatory methods, and for facilitation skills. The training exercises are more general and aimed at development workers, but some of these would be relevant for use in the Social Determinants Module.

Available from:
Mambo Press
P.O. Box 779
Gweru, Zimbabwe

Mackenzie L. On our feet: Taking steps to challenge women's oppression: a handbook on gender and popular education workshops. Special issue of *Adult Education and Development.* Bonn, German Adult Education Association,1993.

Contains a discussion of methods, facilitation skills and also participatory exercises for gender training.

Section 1: "You as the educator", and Section 2: "Techniques", give a comprehensive overview of facilitation skills and participatory techniques.

Methods and techniques

Eitington JE. *The winning trainer: winning ways to involve people in learning.* Houston, Gulf Publishing Co, 1984.

Scannnell EE and Newstrom JW. *More games trainers play: experiential learning exercises,* Berkshire, McGraw Hill, 1983.

Scannnell EE and Newstrom JW. *Still more games trainers play:* experiential learning exercises, Berkshire, McGraw Hill, 1991.

Weinstein M, Goodman J. *Playfair*. San Luis Obispo, Impact publishers, 1980. Excellent resource for ice breakers, energizers and end games which are non-competitive and encourage co-operation.

Winn, JK. Icebreakers. *A source book of games, exercises and simulations.* San Diego, Pfeiffer and Co, 1991.

ANNEXE 2

Ice-breakers, energizers and course-enders

Ice-breakers

Ice-breakers are important for creating a relaxed and trusting environment in which participants feel free and comfortable to participate. Some ice-breakers help participants connect with each other, while others, such as name games, help participants get introduced to each other. An ice-breaker that does both can be used more easily with groups no larger than 30. Below are a few examples of ice-breakers we have used in different training courses and workshops.

Introducing your partner: Variation 1: name tag mixer *[1]*
As each participant enters the room, tick her or his name on the roster, but give them the name tag of another participant. Explain that participants should find the owner of the name tag and interview her or him for no more than five minutes, and then introduce that person to the rest of the group.

Introducing your partner: Variation 2: five important things to know *[2]*
Brainstorm with the group: "What would we like to know about the people here in order to work well with them?" List the suggestions on the board or flip chart and get the group to identify the five which are most important.

Participants then turn to the person sitting next to them, and, working in pairs, A asks B to talk about himself/herself, covering the five aspects listed on the board. A listens to B, and then checks with B what she or he heard. Then B does the same with A. Depending on the time available, either each person introduces her or his partner to the whole group, or participants break into small groups to do this. This ice-breaker takes at least an hour and a half.

Introducing your partner: Variation 3: nuts and bolts *[3]*
Buy five pairs each of three differently sized nuts and bolts so that you have one matching pair for each two participants (if your group has 30 participants). Give everyone a nut or bolt when they come into the meeting room. When everyone is seated, ask them to get up and find a match to their nut or bolt. This produces a lot of hilarity and movement. In 7 to 10 minutes, everyone has matched their piece of hardware. Each pair then interviews each other. Once again, the report-back can be in the big group or in small groups, depending on the time available. Big group reporting for a group of 30 would take at least an hour and half, whereas in small groups this would be achieved within 45 minutes.

The human treasure hunt *[4]*
Hand each participant a sheet of statements about men, women and sexism. Participants move around the room, stopping and talking to each other until they identify the specified number of participants who fulfil the criterion mentioned in a particular statement. They note the names of these people on their sheets. This could be done either until at least one person completes their sheet, that is, finds at least one person for each item on the list. Or, if this takes too long, the game can be stopped after a specific period, say 15 or 20 minutes. Debrief the group as a whole, asking participants how it felt to do the exercise, what they have found out about the group, and so on.

Men, women and sexism

1. Find two people who had a male elementary school teacher when they were growing up.
2. Find three people who believe it is okay for men to cry.
3. Find one person who, when growing up, had at least one purely platonic relationship with a person of the opposite sex.
4. Find two people who wish they were of the opposite sex.
5. Find two people who can recall knowing at least one adult female or male when they were growing up who did not fit the traditional model for that person's sex.
6. Find one person who has a female boss.
7. Find three people who are totally happy that they are male or female.
8. Find two people who play active sports at least once a week.
9. Find two people whose grandmothers were working women.
10. Find one person who believes it is okay for educated women to choose to be homemakers.

Tree of life *[2]*

This ice-breaker is best scheduled as an open ended session on the evening before the course starts.

Give each person 10 to15 minutes to draw the tree of her or his life.

- The roots represent the family from which we come and the strong influences that have shaped us.
- The trunk is the structure of our life today: job, family, organizations, communities to which we belong.
- The leaves are the sources of our information (newspapers, books, friends).
- The fruits represent our achievements.
- The buds represent our hopes for the future.

After each person has drawn the tree of their life, divide participants into groups of three to five to share what they have drawn. Allow participants to share for as long as they want to.

Energizers

Energizers help recharge participants. They are active games, often silly, and give rise to much excitement and laughter. There are many occasions which call for energizer games: when you find participants' attention wandering; when they have had a heavy morning and need to be energized before an equally heavy afternoon; at the end of a serious and daunting session; to help them leave with a positive feeling; and so on.

The energizers below are all taken from: Weinstein M, Goodman J. *Playfair*. San Luis Obispo, Impact publishers, 1980.

Four up
This is a game with very simple rules. It starts with everyone sitting down. Anyone can stand up whenever he or she wants to, but cannot remain standing for more than five seconds at a time. The object is for a group to have exactly four people standing at a time. If there are more than four standing at any given time, the first to have stood up of these four is out of the game. This game focuses each person's attention very carefully on the other members of the group, and lasts for two or three minutes. For a group of more than 10 people, it may be best to split into groups of 10.

Amoeba tag
One person starts as the amoeba, and tries to catch others. The person caught links hand with the first amoeba to become a two-person amoeba on the prowl. When they catch a third person, all three link hands, and are an almost mature amoeba. When they catch a fourth person, all four link hands, and are now a fully mature amoeba. And what happens to a full-grown amoeba? It splits down the middle into two amoebas, each prowling around. The multiplying and dividing happens again and again, until everyone in the group has been totally amoebafied: everyone in the room is an amoeba of two or three persons linked together.

Touch blue
This is a leaderless game, which has two commands that anyone can give. The first command is a touching command, like "touch blue" or "touch a head" and each participant has to touch something blue on another person or touch another person's head. The second command is a moving command, like "hop back two steps" or "jump once where you are".

The game starts with the "touch blue" command. After this, the touching and moving commands are called out alternately by any member of the group. When you wish to end the game, after three to five minutes, call "touch blue" once again.

Elbow fruit hop
Call upon any participant to come up and blow a whistle, and name three things. The first is a part of the body, the second is a category from which each participant can choose a member, and the third is a way to move around. So "elbow, fruit, hop" would mean each person hops around touching her or his elbow and calling out the name of any fruit. Participants continue with this until someone else comes up and calls out another sequence, say "nose, animal, shuffle". The way to end the game is to come up, blow the whistle, and call out "elbow, fruit, hop" again.

Course enders

When people have lived and worked together for two to three weeks, it is important to plan a meaningful ending that gives a sense of closure, rather than rushing through with activities until the last minute, after which participants leave abruptly. Include one or more exercises for taking leave of each other positively, something more than a formal closing ceremony and the distribution of certificates.

Wonderful circle *[4]*
Participants get into a big circle with arms around each others' waists. They start taking small steps to the left, and keep going until someone says "Stop!" Then that person shares something she or he felt good about during the course. This may be something about themselves, or an appreciation of what someone said or did that they liked a great deal. Or it may be good feelings about the group as a whole. Whatever the participant's comment, it has to be about the

people and not about activities or content, and it has to be positive.

When the person has finished sharing, they say "Go!" and everyone in the circle takes small steps in the opposite direction until someone else says "Stop!" and begins to share. This goes on until everyone who wants to has shared. When you get the sense that everyone who wants to has had a turn, ask "Is everyone done yet?" If there is someone who wants to share, that person will have to step in, saying "No – Go!" and start sharing. When the question "Is everyone done yet?" is met by more than 10 seconds of silence, then the game is over and everyone gives themselves a gigantic standing ovation.

Round of appreciation [3]

Have participants form a circle. Give each person a paper cup. The idea is to have each participant "capture" from her or his fellow group members one significant quality – and put these qualities in the cup. Going round in the circle, each participant takes turns to address one other participant: "B__, I want to take back with me your concern for others (or cheerfulness or energy, etc)". Each person is addressed by her or his name, and they should make eye contact. The game ends when everyone has had a turn.

References

[1] Scannnell EE, Newstrom JW. *Still more games trainers play: experiential learning exercises,* Berkshire, McGraw Hill, 1991:3.

[2] Hope A, Timmel S. *Training for transformation.* Gweru (Zimbabwe), Mambo Press, 1984, volume 2:18 and 36.

[3] Eitington JE. *The winning trainer: winning ways to involve people in learning.* Houston, Gulf Publishing Co, 1984:9 and 57.

[4] Weinstein M, Goodman J. *Playfair.* San Luis Obispo, Impact publishers, 1980:59, 107, 115, 170 and 172.

ANNEXE 3

Ideas for facilitating participatory sessions

The trainer as facilitator

In the participatory approach to training, the trainer is a facilitator with two major tasks:

- to ensure that the group achieves its learning objectives
- to create a democratic and participatory learning environment.

The pedagogical role of the facilitator on this course is to help participants:

- prioritize obstacles to the achievement of reproductive health
- identify the problems and find their root causes using appropriate analytical tools
- work out practical ways in which participants can set about changing the situation
- engage in a common search for solutions to problems
- understand diversity and similarity and their root causes, across gender, race, caste and class (and other social) divisions.

At the same time, she or he has to ensure that:

- all participants feel listened to, and free to participate actively
- the training context is free of gender, racial, class, caste and other biases
- everyone is active and involved
- decision making processes are such that everyone owns the decision and feels committed to carrying it out
- feelings are taken into account, and where necessary brought out into the open
- conflicts are constructively dealt with so that all are heard and new insights are included
- feedback is given and received in such a way that each person can grow and obstacles to teamwork can be overcome. ***[1]***

The facilitator does not have to be the authority on everything

The prospect of not knowing how the classroom process may develop can cause those with no prior experience in facilitating participatory learning to feel insecure. What will you do when participants ask questions that you have not thought through? What if there is conflict in the class? What if the process gets out of hand and the objectives of the session are not achieved?

There are no ready made answers to these challenges. What counts is to remember that the facilitator does not have to be "the authority", able to answer all questions and deal with every possibility. Trying to understand the source of disagreements and to engage in an open dialogue, rather than feeling personally challenged by controversy and needing to be in control, may be enlightening. That way, even if the planned objectives of the session are not achieved, everyone will have learned about another point of view and another approach to the issue.

Resistance from participants

There may be situations where participants feel uncomfortable about getting actively involved, for example in role playing or in simulation exercises, and refuse to take part in "silly" or "childish" activities and games. In our experience, such situations are extremely rare, but it would nevertheless be useful to be prepared for them. Resistance to participatory activities arises because we have all been taught that learning is serious and passive, not fun and active. It is more likely to happen if the facilitator is not convinced about the value of participatory exercises and does not

communicate that though the activity may be light-hearted, the learning resulting from it will be important.

If a participant does resist participatory methods, the facilitator may:

- tell participants that they have the option to sit out and watch if they feel uncomfortable at any stage
- explain that experiential learning methods engage all aspects of ourselves: our minds, emotions, thoughts and activities, and have been proved to be effective. [2]

We would, however, like to emphasize that there may be no reason to expect resistance. In the 10 offerings of this course thus far, in five countries with participants from over 50 countries, ranging from senior officials from ministries of health to programme and district managers, donors, doctors and nurses, there has been little resistance to participatory teaching methods.

Mixed sex groups

Dealing with mixed-sex groups may be challenging. A fine balance has to be maintained between firmly ensuring that there is equal participation by women and men and that men do not dominate, and making sure that men feel comfortable to participate. As a facilitator, it is important not to make sweeping generalizations about women as poor and suffering and men as powerful and dominating. Remember that a gender analysis challenges an ideology which both men and women perpetuate, it does blame men. You will have to address differences among the participants in language, race, class, caste or ethnicity – ensuring that there is equal participation and no domination by any one group, without any section of participants feeling alienated or insecure.

Using participatory methods is not the same as encouraging anarchy in the classroom. The figures below provide some guidelines.

How does a facilitator keep the group on track? *[2]*

- S/he asks for facts and doesn't need to always 'be right'
- If the discussion is going nowhere, s/he will ask penetrating questions to deepen it
- S/he doesn't take sides
- S/he gives practical examples
- S/he manages the discussions and doesn't get emotionally hooked into issues
- If the group is spending too long on a small point, s/he will push it forward
- S/he refers back to the group's aims and suggests goals

How does a facilitator encourage participation? *[2]*

- S/he draws on people's experiences
- S/he gives feedback in a way that is clear and specific
- S/he helps people in conflict to understand one another's views, searching for common elements
- S/he ensures that everyone gets a chance to give his or her viewpoint, and that no one dominates
- S/he encourages openness and mutual trust by drawing up ground rules early on
- S/he makes everyone feel valued
- S/he creates an atmosphere of collective inquiry

References

[1] 1. Hope A, Timmel S. *Training for transformation.* Gweru, Mambo Press, 1984, volume 1:18 and 99.

[2] Mackenzie L. On our feet: taking steps to challenge women's oppression: a handbook on gender and popular education workshops. Special issue of *Adult education and development,* Bonn, German Adult Education Association, 1993.

ANNEXE 4

Model timetables

Model timetable 1: Course duration three weeks

Week 1

	Morning (8.30–13.00)*	Afternoon (14.00–17.30)*	After class hours
Day 1	Opening module	Opening module	Official opening and party
Day 2	Gender	Gender[a]	Readings for: Social determinants Session 2
Day 3	Social determinants	Social determinants	
Day 4	Social determinants and Rights	Rights[b]	Reading for: Rights Session 4
Day 5	Rights	Rights[c]	Readings for: Evidence Session 3

* Includes a half-hour break

[a] Give out readings for Session 2 of the Social Determinants Module

[b] Guest lecture by an NGO activist on violence against women starting 16.30

[c] Group photo; give out readings for Evidence Module, Session 3

Week 2

	Morning (8.30–13.00)*	Afternoon (14.00–17.30)*	After class hours
Day 1	Rights and Evidence	Evidence	
Day 2	Evidence	Evidence	Social event
Day 3	Evidence	Evidence	Complete evidence application exercises
Day 4	Evidence and Policy	Policy	
Day 5	Policy	Policy[a]	Complete policy application exercises and readings for: Health systems: Session 1 (over the weekend)

* Includes a half hour break

[a] Give out readings for Session 1 of the Health Systems Module

Week 3

	Morning (8.30–13.00)*	Afternoon (14.00–17.30)*	After class hours
Day 1	Health systems[a] and submission of Policy application exercises	Health systems[a]	
Day 2	Health systems	Health systems	Social event
Day 3	Health systems and Policy consolidation session	Health systems application exercises	Complete health systems application exercises
Day 4	Submit Health systems application exercises. Guest lectures on current debates in reproductive health[a]	Sharing and learning from participants' experiencesa Closing module[b]	Play by a local NGO on men and violence against women
Day 5	Health systems assignments returned to participants in a feedback session; Closing module		

* Includes a half-hour break

[a] Facilitators of respective modules use this time for marking assignments

[b] Ends by 15.00

Model timetable 2: Course duration two weeks

Week 1

	Morning (8.30–13.00)*	Afternoon (14.00–17.30)*	After class hours
Day 1	Opening module	Gender	Reading
Day 2	Gender	Gender	Reading
Day 3	Social determinants	Social determinants	Reading
Day 4	Rights	Rights	Reading
Day 5	Rights	Health systems	Reading
Day 6	Health systems[a]		

* Includes a half-hour break

[a] Class ends at 14.00

Week 2

	Morning (8.30–13.00)*	Afternoon (14.00–17.30)*	After class hours
Day 1	Health systems	Policy	Reading
Day 2	Policy	Policy	Reading
Day 3	Evidence	Evidence	Reading
Day 4	Evidence	Evidence	Preparation for the consolidation exercise
Day 5	Closing module	Closing module	
Day 6	Course evaluation[a]		

* Includes a half-hour break

[a] Class ends at 12.30

ANNEXE 5

Tool for participants to evaluate the course

Reproduced below is the course evaluation tool used by participants in the courses run by the Women's Health Project, Johannesburg, South Africa.

Final evaluation

What were your expectations for the course?

Were these expectations met?

☐ Yes ☐ No ☐ Partly

Please feel free to comment:

Are you satisfied with the overall balance of topics and materials in the course?

☐ Yes ☐ No ☐ Partly

Please feel free to comment:

Were the reading materials suitable?

☐ Yes, mostly ☐ No, partly ☐ Not at all

Please feel free to comment:

Did you read the materials?

☐ Yes, mostly ☐ No, partly ☐ Not at all

Please feel free to comment:

Will you be able to use them in future?

☐ Yes, mostly ☐ No, partly ☐ Not at all

Please feel free to comment:

Was the course long enough?

☐ Yes, in fact too long ☐ Yes, just right ☐ No, partly ☐ Not at all

Please feel free to comment:

How did you feel about the daily schedule?

☐ Just right ☐ Too short ☐ Too long

Please feel free to comment:

Please rank each of the six modules of the course on the following criteria:

Gender	**Poor**	**Fair**	**Good**	**Very good**
Usefulness of content				
Effectiveness of method				
Sufficient detail				
Stimulated thinking				
Impact on my professional skills				
Impact on my personal skills				

Please comment:

Social determinants	**Poor**	**Fair**	**Good**	**Very good**
Usefulness of content				
Effectiveness of method				
Sufficient detail				
Stimulated thinking				
Impact on my professional skills				
Impact on my personal skills				

Please comment:

Rights	Poor	Fair	Good	Very good
Usefulness of content				
Effectiveness of method				
Sufficient detail				
Stimulated thinking				
Impact on my professional skills				
Impact on my personal skills				

Please comment: _____

_____

Evidence	Poor	Fair	Good	Very good
Usefulness of content				
Effectiveness of method				
Sufficient detail				
Stimulated thinking				
Impact on my professional skills				
Impact on my personal skills				

Please comment: _____

_____

Policy	Poor	Fair	Good	Very good
Usefulness of content				
Effectiveness of method				
Sufficient detail				
Stimulated thinking				
Impact on my professional skills				
Impact on my personal skills				

Please comment: _____

_____

Health systems	Poor	Fair	Good	Very good
Usefulness of content				
Effectiveness of method				
Sufficient detail				
Stimulated thinking				
Impact on my professional skills				
Impact on my personal skills				

Please comment: _____

_____

Are there any topics or themes that were not covered in the course that you wish had been included?

☐ No ☐ Yes

If yes, please list them:

Which sessions of the course were most valuable for you?

Why?

Which sessions of the course were least valuable for you?

Why?

If we had to cut something out of the course, what would you suggest we leave out?

Why?

Did you feel that the level of the course was appropriate for you?

☐ Just right ☐ Too difficult ☐ Too easy

Please feel free to comment:

Some courses make a personal impact and some don't. Reflecting on this course, do you think there are any ways in which it has changed you?

If this were a four week course, would you have been able to come?

☐ No ☐ Yes

Please feel free to comment:

Were you satisfied with logistical arrangements (place to stay, food, etc.)?

☐ Yes, mostly ☐ No, partly ☐ Not at all

Please provide us with any additional comments or reactions to the course that you believe will make it better for others.

ANNEXE 6

Facilitator evaluation form

How useful is this manual?

Please answer the following questions, adding any additional comments you would like to make, and return the sheet to: Gender, Rights and Reproductive Health, Department of Reproductive Health and Research, World Health Organization, 1211 Geneva 27, Switzerland. Or email responses to the rhpublications@who.int

Please describe the course in which you used this material:

a. Name of course:

b. In what context (university, ministry, NGO, other institution):

c. Target audience:

Did you run the course in its entirety?

☐ Yes ☐ No

If not, which modules/sessions did you use (please list)?

Did you have prior experience with participatory teaching methods?

☐ Yes ☐ No

Please list the sessions you found most useful, and why (e.g. the approach was new, the topic was new, the content was clear, the instructions were clear, the methodology worked well in the group)

Please list any session you did not find useful, and why (e.g. instructions not clear, too long, too complicated, methodology didn't work well in the group)

Would you use this manual again:

a. in its entirety?:

b. in part? (please specify)

c. in an adapted form? (please describe)

Name

Organisation

Address

E-mail

Date

Department of Reproductive Health & Research
World Health Organization
20 avenue Appia
CH-1211 Geneva 27
Switzerland
Phone: +41-22-791-4213
Fax: +41-22-791-4171
E-mail: rhrpublications@who.int
Website: http://www.who.int/reproductive-health/