PAGES FROM HISTORY

# Dr.MaryPoonenLukose (1887-1976)

Born on 2nd August 1887 into an aristocratic Christian family of central Travancore as the daughter of a medical doctor Dr. T.E. Poonen gave Mary Poonen more opportunities than an average Indian woman. But even then, she had to face a lot of trials and tribulations in her life in a male dominated society of Nineteenth century. She had her schooling in Trivandrum and passed the matriculation with high marks. The first discrimination was in the form of denying admission to take science as a subject in the college as women were denied admission in science stream. She had the opportunity to do BA History only. This was at least possible because of her fathers' contacts with high class Hindus and the Royal family. She graduated in 1909, the first lady graduate from Madras university. Her desire to become a doctor like her father was a big hurdle as no women students were allowed in medical colleges in India. However, she was determined and got her medical graduation from London University. She did her post graduation in Obstetrics and Gynaecology from UK and further training in Paediatrics. She stayed in London till 1916.

Finally the time had come for her to return to India. In the meantime her father had passed away and all their wealth had been looted. She decided to stay back in Kerala. Getting a job for a UK trained Indian 'native' Obstetrician was not easy again and this time the hurdle was in the form of racial discrimination. The post she applied for was reserved only for white people and the British Government turned down her application. Again her royal connections helped and given her excellent credentials she got an appointment as Obstetrician in the Government hospital for women and children in 1916. She was appointed as the Acting Surgeon General of Travancore in 1924. She was the first woman surgeon general in the world.

She did pioneering work in the hospital to reduce mortality and morbidity. She started training students in midwifery as well as retrain scientifically the local dais. She even delivered her first child in this hospital. It was her tremendous efforts that led to the establishment of Nagercoil TB Sanatorium and the X-ray and Radium Institute in Trivandrum. She was very active in the social sector of Trivandrum. She was the first lady legislator in Travancore in 1922 till 1937.

Her husband was an advocate, Mr. K.K. Lukose, who later became a Judge of High Court of Travancore. She had two children. She died in 1976 at the age of 90.

**Reference:**

1. *APioneerinMedicine-Dr.MaryPoonenLukose.* K. Rajasekharan Nair, Samyukta. July 2002. Vol II; 2; 117-121

Main identity

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Gender at Work E-zine, January/February 2004

Dear friends,

Last year was an important and busy year for Gender at Work. In October, Gender at Work was incorporated as an international NGO in Washington DC. In February 2003, Gender at Work together with CREA organized a consultation with 15 social change organizations from India and one from
Pakistan (see www.genderatwork.org for the February 2003 India workshop report). We also organized two workshops in South Africa one together with Masimanyane in March 2003 which brought together 12 women's organizations and one in November with partners in Cape Town and Johannesburg
including Women on Farms, Justice and Women, Center for the Study of Violence and Reconciliation, and Center for Applied Legal Studies. These workshops have enabled us to build relationships with partners, share our frameworks and shape our programs.

This year, we are launching two new programs: Change Catalysts -- an action-learning program designed to simultaneously build organizational capacity to promote gender equality and to build knowledge of institutional change for gender equality; and Innovators Circle: a multi-regional learning space that will bring together organizations from India, South Africa, Latin America and other regions for both face-to-face meetings and electronic discussions over 3 years. The purpose of the Innovators Circle initiative is to develop an explicit understanding of the dynamics of institutional change for gender equality that can be the basis for improving the practice of governments, NGOs and donors as they intervene to further gender equality. The Change Catalysts program will be cross-fertilized by a parallel program in India. We expect that the cases and analysis from the two programs will result
in a book of cases and concepts, electronic communities of practice and cross-regional networking for knowledge building and action. (See program pages for further details)

We are continuing to develop the resources on our website and have brought on board Erin Leigh as our new web editor. Also to be featured on the site shortly is a new interactive bulletin board, allowing and encouraging people to share their experiences and resources. We look forward to your comments and suggestions on what resources you want to see on the site; and information on what you are doing that is related to Gender at Work's programming.

Thanks for your continued support and interest. Contact us!
Aruna Rao and David Kelleher
Directors
Gender at Work

In this issue:
1. Gender at Work Latest:
Gender at Work Launches South African Initiative

2. Conversation with
Aruna Roy of MKSS on demanding accountability through the right to information in India.

3. In-depth with Gender at Work:
Read or listen to Gender at Work Director Aruna Rao's speech 'Institutional Change and Accountability' at a global conference on gender and human security

4. New additions to the No Borders Bookstore:

a) Cutting Edge Pack on Gender and Citizenship, BRIDGE
b) Participatory Gender Auditing: a challenge process of learning and change, Hettie Walters
c) Engendering Organizational Change, CGO and CGIAR

For the e-zine table of contents visit:
www.genderatwork.org/index.php/SEC401e570913e9f

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1. Gender at Work Latest:
Gender at Work Launches South African Initiative

In November 2003, Gender at Work organized a 2-day workshop in Cape Town with some of some of South Africa's most dynamic organisations that are working on equity issues with rural constituencies, and marginalized people in a variety of settings. The workshop provided an opportunity for the invited organisations to learn about each other and about Gender at Work, and determine how best to work together for knowledge building and generating innovative organizational practices to challenge discriminatory practices within their organizations and in the communities where they work.

To read more visit:
www.genderatwork.org/index.php/SEC401e570913e9f/35

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2. Conversation with...
Aruna Roy of MKSS on demanding accountability through the right to information in India.

The Mazdoor Kisan Shakti Sangathan (MKSS) was formed in 1990 and is based in Rajasthan, India. An NGO, the MKSS consists of poor farmers and workers, men and women, many of whom have never been to school. Yet their organisation has raised the issue of Right To Information in such a potent manner, that it has changed the discourse within the state and in the rest of India, on what had been seen for many years largely as an academic issue.

Gender at Work interviewed Aruna Roy, one of the founding activists of MKSS. She has won the Magasaysay award (valued by many as the Asian Nobel Prize) in 2000 for community leadership and international understanding.

To read more visit:
www.genderatwork.org/index.php/SEC401e570913e9f/36

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3. In-depth with Gender at Work:
Read or listen to Gender at Work Director Aruna Rao's speech 'Institutional Change and Accountability: Notes on a Strategy'

This past fall, Aruna Rao spoke at the Women's Learning Partnership conference: Clash or

Consensus? Gender and Human Security in a Globalized World. Central to Rao's speech is the need for organisations to strengthen their accountability to women's rights to truly achieve human security and women's empowerment. She asks the question 'if one were using this lens of accountability, what would gender positive institutional change mean? it would mean that power holders answer to women and a feminist constituency.' She asserts that a core group of such power holders are organisations working towards progressive change, and that these organisations must look inwardly and be accountable for their own rights-based language. If they demand women's rights, do they ensure the active participation of women? Are such organisations' internal structures based on openness and accountability to their own staff and beneficiaries, or do they mirror the systems and institutions they are trying to change. If change is going to happen on the outside, it needs to happen on the inside.

To read more visit:
www.genderatwork.org/index.php/SEC401e570913e91f37

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4. New additions to the No Borders Bookstore:

a) Cutting Edge Pack on Gender and Citizenship, BRIDGE

BRIDGE has just released a new Cutting Edge Pack on 'Gender and Citizenship'. Women and men do not enjoy their citizenship rights to the same extent, and their gender identity often impacts on the fulfillment of such rights. How are women's rights being violated, and how can they be achieved through citizenship? This BRIDGE publication is an indispensable resource on the issues, providing an overview report, a supporting resources collection - with detailed summaries, and Development and Gender In Brief - a six page primer on gender and citizenship.

To read more visit:
www.genderatwork.org/index.php/Frameworks

b) Participatory Gender Auditing: a challenge process of learning and change, Hettie Walters

This paper presents an in-depth account of an organisational process called 'participatory gender auditing' (PGA). This audit is an opportunity for organisations' to self-assess and improve their capacity to advance women's empowerment and gender equality. The PGA has already been undertaken in Hivos and SNV (Dutch development organisations), and the International Labour Organisation. The author includes the methodology of the PGA, specific tools of participation, lessons learned, and conclusions. A key conclusion is the need for ownership within an organisation's leadership and staff from the earliest phases to ensure the audit's success.

To read more visit:
www.genderatwork.org/index.php/InnChange

c) Engendering Organizational Change: A Case Study of Strengthening Gender Equity and Organizational Effectiveness in an International Agricultural Research Institute, Center for Gender in Organizations and the Consultative Group for International Agricultural Research

This case study presents findings of an action research and learning project undertaken with the Consultative Group for International Agricultural Research (CGIAR). The goal of the project was to identify means of strengthening organisational effectiveness by addressing and advancing gender equity within the organisation. It asserts that unless organisational effectiveness is one of the goals of achieving gender equity, then the initiative will be unsuccessful. Barriers to gender equity were uncovered through the cultural norms and values of the organisation, and challenged by developing

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Subject: Newsletter

- This has 21 pp 98. Should I take printouts ?

Dear Dr. Thelma and Dr. Ravi,

Please find attached the pdf version of the first issue of the Engendering Health Newsletter.

I will send you the hard copies soon.

TH
12/12/03

Warm Regards,
Anant

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lib. Gender + Health file
To

INDEX






# Engendering Health

October-December2003 Volume1 No.1


ORIGINALARTICLE

## GenderinMedical Education:Whytheneed

- *'Its Friday night in the undergraduate boys' hostel of the medical college and this is the day when one finds the maximumhostelitesinthemess room.Thisisbecausethisisthe day of the week where almost on a religious basis, a fest of pornographic movies is held starting from Hollywood skin flicks and then graduating through soft porn into hard porn.Thecatcallsandthesexist commentsreachacrescendoas thenightprogresses.*
- *September brings with it the freshbatchofstudentsintothe hostel and soon, it is time for the annualfreshersnight. The juniors are made to 'perform' for their seniors. The most popularperformanceswiththe seniors are the ones in which there are simulations of the sexual act, jokes with sexual innuendoes,andusageof locker room banter. The juniors who have not used these 'creative' ideashavetobearthebruntof moreraggingthantheir'wiser' counterparts.*
- *It is noisy in the labour ward as many women are about to deliver. As they cry out in pain, the interns on duty are busy playing cards, not at all concerned about the apparent distressthatthewomenarein; theayahsondutykeepcursing the women periodically and ask them to hurry up, some remarkingthatbeingawoman theyshouldtoleratepain, while others denigrating saying that if they had enjoyed during intercourse, why complain aboutthis.*

Allthethreeaboveexamples are an ominous pointer to the gapsthatexistinthewaystudents aretaughtinmedicalinstitutions, leadingtoalackofawarenessand sensitizationaboutsocialissues. The issue of the importance of bringing in gender issues in the field of medical education has been widely debated with the AMCHSS(inIndia)havingtaken up the mantle of devising a shortcourseinthesubject.[1] The youngmedicalprofessionalswho graduateenmassfromtheIndian

medical colleges have most of the time no clue about how to relate to a female patient & to addressherspecialhealthneeds. This is especially true of many male graduates who sometimes just blank out when they have a young lady coming in with specificcomplaints.Myexperience has shown that sometimes even the lady graduates are no better as they also struggle to be able to delve into the psyche of the woman as exemplified in the practice of Obstetrics and Gynecology, a specialty with many lady consultants. The lady graduates internalize the male values of aggression to survive professionally,whichaddstothe problem.

Many students when they join medical college come from backgroundsofhavingstudiedin 'samesex'institutionsandittakes alongtimeformanytoadjustto the atmosphere in the co-ed medicalinstitutions.Whenthisis the time when a feeling of camaraderiebetweenthestudents should be developed, either the freshers are being ragged or are beingthrustintodissectionhalls and asked to cut up cadavers reeking of formalin without any time given for adjustment. The impersonal tertiary healthcare teaching facility encourages a feeling of superiority in the medical students that is continuously reinforced and perpetuated by the system.

*"In the doctor-patient relationship, the patient is at the receiving end of the power equation. This is due to the fact that the patient approaches a doctor when he/she is in need of relief from physical/emotional distress. Therelieffrompainand sufferingatthehandsofadoctor naturallyevokesadifferentkindof responsefromthepatientthan a simple'thankyou'. Thepatientis gratefultothedoctorandismany timeswonderstruck,thankstothe mystification of medical science. Secondly the doctor legitimately probesthepatient'sbodyandmind to arrive at a diagnosis and this complete exposure of one's person to the doctor has its own implications for equality in the doctor-patient relationship. The very act of undressing before the doctor sets up an unequal power relation."*[2] Inthisunequalpower relation, the focus is only on the 'cure of the malady' with no concernforpatientswithspecial needs. The young doctor, due to lack of exposure is prompt to criticize the practices of the patients without understanding their social, economic, and culturallimitations.

Young women interns and residents are sometimes bogged down by the excessive work pressuresintheclinicalwards(as they work harder to garner the same respect as their male contemporaries) and at the same time, they can expect no sensitivity from their colleagues or seniors about their personal conflicts like family/societal pressures to get married or if alreadymarried,tobearchildren. Marriedfemaleresidentsespecially thosewithchildrenfaceproblems in attending night duties sometimes, but are rarely given thelibertyofaflexibleschedule. Many of them get caught in the cycle of overwork, fatigue and undernutrition. Addedtothisis the fact that being physically attractive might actually be an impedimentfortheladyphysician with her 'popularity' with senior staff being attributed to her 'beauty' rather than her hard workandacademicprowess.

The dehumanizing way in which the practice of Obstetrics andGynecologyiscarriedoutin many teaching institutions and the scant respect given to the patients in the wards/delivery rooms/operationroomsgivesno opportunityforastudenttolearn the art of making a lady patient comfortable before a pelvic/ gynecological examination which is almost an intrusion of the privacy of the individual, especially so in the Indian context.Thewaythewomenare herdedfortheD&Cs,MTPs,IUD insertions in almost a factory production line manner with a rare word of encouragement, succour or empathy only serves to build up a stereotype in the impressionable mind of the student.

Sometimes women present with vague and psychogenic complaints that are dismissed by the 'busy' doctor without even realizing that this could be a pointer to the trauma (physical, mental, sexual or otherwise) that the woman might be going through and is expressing indirectly. This is not only restricted to the poor women only but affects women from all strata of society. Violence against women has many forms- rape, assault, burning, incest, and sexual harassment at the workplace etc. Young medical graduates, who are predominantly uncomfortable examining female patients are unable to pick up the non verbal cues from these women as they are unable to establish the feeling of trust that is the foundation of a ideal doctor-patient relationship.

The lack of choice that the patient has in matters relating to her own health is frequently reflected in the way she is asked to eat this tablet, get that test done, and many times in the way the contraceptive choices are thrust on women without explaining the pros and cons and the side effects of each choice. This is an example of the typical top-down approach that ails our beleaguered healthcare system.

The focus in women's healthcare is on the obstetric and childbearing aspects in the reproductive age group of 15 to 45 years and many times not on the pre menarchal girl child and the post menopausal women. Many times, the elderly women who come to the outpatient departments and wait in long queues to be examined for their age related medical problems such as osteoporosis are just blatantly prescribed analgesics such as 'Nimesulide' and shooed off without even a proper examination and explanation about the reason for the symptoms.

Perhaps the only encouraging trend has been the increasing ratio of female students joining medical colleges over the years and the foray of female residents for post graduation into 'unconventional' subjects like Surgery, Orthopedics etc. that were earlier considered to be male bastions.

*"This is probably a reflection of the changing social mores and the better performances that girl candidates produce in examinations. The shift however becomes counterproductive because of the attrition rate among the women doctors after graduation due to family demands and child bearing. There should be ways and means of support to lady doctors to prevent this attrition rate due to family demands and facilitate re-entry into the profession, with continuing education and other supports at a later stage as well."*[1]

There is also sometimes the lack of role models for women in the field of academic medicine. Added to this, being physically attractive might actually turn out to be an impediment for the young lady physician who might be picked upon or harassed.

Medical graduates are usually very uncomfortable with patients from sexual minorities and often try to avoid dealing with them- this hampers the quality of health services (like counseling and STD treatment) that can be offered to this neglected segment who are stigmatized in society. It is thus, very important to address this issue in the training of medical students.

It might be useful to have a Sexuality and Reproductive Health (SRH) Course for medical students like in the Newcastle Medical School, Australia where the course has been compulsory and examinable since the first intake of students in 1978. Third year students devote two weeks to the study of sexuality. There are also four additional sessions scheduled throughout the next month. One nominated day per week is set aside for counseling and interactional skills. Aims of this course have been defined as:

- Students to acquire appropriate diagnostic reasoning skills and content knowledge in the area of human sexuality and STDs.
- Students to acquire some important consulting skills.

- Students are given an opportunity to reflect on their own sexual awareness, to examine their attitudes about human sexuality and to compare them with those of other students. [4]

There is also the issue of the paramedical workers being looked down upon by the doctors and hence the students also imbibe the art of unfair treatment to them, especially the nurses (most of whom are female) who are expected to be following each order to the hilt and are almost never thought as team mates. Undue freedom of behaviour is taken in many instances with the nurses. Unfortunately, even the women physicians fall prey to this mindset, thanks to the well-entrenched system & the trap of the male hierarchy.

The landmark legislations like the MTP Act and the PNDT Act are not part of the curriculum at medical colleges and hence most clinicians are confused about the legal implications of their everyday practice.

These are just a few of the reasons why the component of 'Gender in Medical Education' has to be considered to be a priority issue by the academia in medical education. The health activists also need to stress that their campaign towards a 'Right to Health Care' should also ensure that the healthcare in practice at all levels be just and gender sensitized.

**Note**

This article has been written based on my limited personal experiences, but it is my belief that the field level reality enunciated above remains the same across our country.

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**About *Engendering Health***

Engendering Health is a quarterly publication of Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology.

Authors are invited to send in their articles, views, suggestions on the following topics:

- *Gender and Medical Education*
- *Gender and Health*
- *Gender and Women Health*
- *Gender and Health Practice*

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## NEWSUPDATES

### BOYSDEMANDMORE THANGIRLS,EVENBEFOREBIRTH

Swedish and American researchers have solved the puzzle of why baby boys are so much bigger at birth than girls, their mothers eat more during pregnancy. Women carrying male embryos consume about 10 percent more calories, eight percent more protein and have a higher intake of carbohydrates and animal and vegetable fats. It is widely accepted that on average newborn boys are heavier than newborn girls. The findings give us a better understanding of why that is the case.

Researchers studied the diets of 200 women during their second trimester of pregnancy. They believe women carrying boys eat more because they have a higher energy requirement, which could be due to testosterone secreted by the foetal testicles. But although they produce bigger babies, mothers of boys do not put on more weight than other women during pregnancy because the gender of the baby had no effect on maternal weight. These data suggest that in utero boys are already more demanding than girls.

*(MedIndia Research Update - December 2002)*

### New genital gel could empower women against the AIDS epidemic

Proponents of the male condoms have not comprehended the trauma of women who would want to conceive without being infected by the virus from their HIV positive partners. And it seems like good news when John Moore of Cornell University in New York and his colleagues are enthused by their findings of a new viral blocker that prevents the virus from burying into human cells. The new study has backed the belief that microbicides-chemicals that hobble viruses – could act as shields against HIV. This or other microbicides, applied in cream from to the vagina or rectum could save the lives of several women who are not able to protect themselves by monogamy or by using condoms. Researchers are investigating around 60 potential microbicides that thwart HIV in a variety of ways. In the new study, researchers used a human antibody called b12 that binds an HIV coat protein and stops it latching onto cells. This antibody, unlike certain other microbicides targets only the HIV virus and does not affect healthy cells.

*MedIndiaResearchUpdate*

## RESOURCESECTION

### Gender and Health Advocacy Kits

The purpose behind WHD Advocacy Kits is to present a current issue in Gender and Health in a concise and user-friendly way. Each kit contains a fact sheet (or series of fact sheets), a brief issue paper and a power point presentation. They can be used as part of a conference presentation, as a tool to educate policy-makers or as the basis for a workshop or class session on Gender and Health issues. Upcoming kits include: Gender, Health and HIV/AIDS in the Americas; Gender, Work, and Health; and Gender Equity in Health.

You may download the whole kit free of charge. Please inform PAHO how you are using the kit, so that its efficacy can be evaluated. Please contact at mailto:hdw@paho.org/subject:Gender and Health Advocacy Kits with your comments and suggestions.

### WorkshoponGender,Healthand Development:AFacilitator'sGuide (PDFFormat)

Developed by PAHO's Woman, Health and Development Program, this guide provides a structure and some tools fro a workshop on looking at health through a gender lens, understanding men's and women's health-illness processes and improving the equality with which roles, responsibilities and rewards are distributed in health promotion and care.

*Download the Complete Workshop – PDF 1.41 MB (http://www.paho.org/english/hdp/hdw/gendertraining.htm*

# Gender Issues in Depression

Asummaryandoverviewofselectedstudiesondepression

## Introduction

Genderdifferenceindepression isoneofthestrongestfindingsin psychiatric epidemiology. The GlobalBurdenofDiseases(GBD 2000)estimatesthat5.8%ofmen and9.5%ofwomenwillexperience adepressiveepisodeinal2months period.[1]

## BurdenofDepression

Increased risk for women varies by diagnostic subtypes and issubstantialformajordepression, dysthymia (mild depression), atypical depression and seasonal winterdepression[2] .Preponderance among women is not a universal phenomenon. It is more in circumstances where significant discrimination against women is present and may also depend on genderdifferencesindiagnosinga case. The difference is virtually non-existence or even absent in traditionalsocietiesandinsocially homogenoussamples[3] .

It has also been shown that women are at greater risk of depressionandanxietyatanearly agethanmen.[4] Inadultlifewomen faceincreasedriskofdepressionin certain periods- pregnancy, menopauseetc.Duringoldagealso ductotheincreasedlifeexpectancy in women we have a larger proportion of women among the depressed.

## Aetiology and Pathogenesis (*factorsaffectingwhogetsill*)

Multi factorial origin of depression is well accepted. It's a diseaseinwhichnatureandnurture havetheirownrole.Thusbiological differencesinteractingwithsocially constructed differences between men and women contribute to gender differences in depression. Someofthesefactorsare:

## Heredity

Althoughgenetic[5]factorsretain a strong influence on liability to depression, they do not seem to contributetotheincreasedriskfor women by a direct mechanism.[6] But on the other hand genetic factors may influence the vulnerability in one gender by othermechanismslikegenetically determined personality traits, whicharetriskfactorsfordepression.

## Developmental Factors (*familial environment and experiences in growingup*)

The available evidences on developmentalfactorssuggestthat theearlytraumaticexperiencesmay bepartlyresponsibleforawomen's preponderance in the depression rates,sincetheyareatgreaterrisk for certain events such as sexual abuse, suffer from lack of self esteem and anxiety over body image. More over women appear more sensitive to depressogenic effectofthesevents.

## Temperament(*Personality*)

A number of personality features have been proposed as vulnerability factors for the developmentandmaintenanceof depression. Men are said to be more autonomic, striving for perfectionism and independence. More women are said to be sociotropic, which is related to interpersonaldependency,refersto a strong need for affiliation and supportfromothers[4]. Ithasbeen has suggested that women in situationswhichlacksocialsupport and good interpersonal relations aremoreproneto depressionwhile menwhoperceivetheirjobsaslow in decision altitude are more at risk[7].

## LifeEvents

An increased risk of onset of depression may reasonably be expectedwhensevereeventsoccur inlifedomainstowhichindividual attachastrongsenseofvalueand commitment.Individualswithfew over valued goals and lacking an intimatesenseofperceivedchoice havehigherrisksincetheyareleft with few alternatives for self – evaluationwhen their maingoals are threatened [8]. Both these situations are more likely in women's life. Events that are particularlyassociatedwithahigh- risk onset, includes those concerningawomen'shumiliation, herentrapmentinsevereongoing

difficulties and death of someone important to her [6]. Women from developing countries and lower socio-economic condition more often find themselves in some of these helpless situations.

### Social Roles and Cultural Norms

The identification of individuals at high risk for developing depression, based on socio demographic variables and data collected across different countries and cultural groups, indicate that social roles and cultural influences contribute to a women's preponderance in depression rates. A recent study to identify variables with significant influence on severity of depression found that marital status, children in the household, education and the interaction of the education with marital status are significant factors associated with severe depression in women but not with men. Married women especially with children in household have more role demands and suffer from chronic family stress than men. It can be assumed that higher education might go along with additional female role demands such as to be autonomic, or having a good occupation. Similar studies from developing countries in addition showed infertility, poverty[8] and drinking of spouse strongly related to depression in women.

### Hormonal Influences

Women have higher concentration of monamine oxidase (depressogenic) in the brain and more precarious thyroid status [5]. In addition low estrogens and high progesterone status has been postulated as possible mediating factor in postpartum depression, premenstrual accentuation of affective instability and women's vulnerability to depressant effect of steroidal contraceptive.

### Gender Differences in Care and Careseeking

*Pathways to care*

It varies across socioeconomic situations and from country to country. To the majority of the world's population access to specialised psychiatric treatment is non-existent. A large proportion of these diseases are treated in the primary care settings and rest end up with traditional practitioners. In primary care depression is highly prevalent and almost twice as common in women as in men since women with depression approach primary care facility for depression while men approach more of referral facility at a much advanced stage[2]. Studies have shown that factors related to lower rate of detection by primary care physicians were patient's sex (women), marital status (widow or widower) and employment status (retired)[9].

A challenging aspect in diagnosis of depression in the primary care setting is the somatization of depression [10] (presenting as unexplained somatic complaints). Community studies have shown that more women present with somatic symptoms in al PHC while men approach referral centres with alcoholism and substance abuse associated with depression. This often leaves the depressive illness underrecognised and under treated in women. Depressive symptoms were perceived as more dangerous and private than somatic problems. It also put the sufferer in a socially disadvantaged position by affecting prospects for marriage, marital breakdown, unemployment and ultimately compromising the self-esteem. Thus a better understanding of how depressed patients view their symptoms in different settings may be key to improved diagnostic rates [6].

Even in specialised psychiatric clinics it's a well accepted facts that women present with more vegetative symptoms like fatigue, loss of sexual interest, sleep and appetite disturbances while men report more psychomotor changes, feeling of worthlessness and decreased concentration [7]. Women experienced higher level of anxiety and hostility and anger.

Treatment of depression is often complicated by co morbidities like substance abuse, which is increasing around the world. Although women with depression are less likely to have problems with alcohol or cannabis, they are more likely to misuse sedatives and other prescription drugs. Substance use is underrecognized in women and they have lesser chance to get counselling or other treatment for this [11]. This can adversely affect the outcome of treatment for depression.

### An Overview of Gender Issues in Outcome

Women especially in developing countries drop out from treatment more often due to decreased access and resources to care. It is also common in India among women to discontinue treatment when they get married to hide their illness due to the stigma. Similarly pregnancy is another commonly cited reason for stopping drugs.

In the drug treatment arena, there are lot of conflicting reports on effectiveness of one treatment over other for men and women e.g. a randomized triple blind control trial with 12 weeks follow up showed that women taking Sertraline (a newer widely used anti depressant with lesser side effects) had lower drop outs and better response than women taking Imipramine (classical tricyclic anti depressant). But the finding in men showed a better response to Imipramine and no difference in dropout with Sertraline. [12]

### Long-term Care and Rehabilitation

Social factors in long term care and rehabilitation are especially unfair to women in resource poor settings. A woman frequently faces sexual abuse in asylums and has fewer choices for rehabilitations. In developing countries they also find difficulty in independent living, out of hospitals and nursing homes. These issues add on as risk factors for recurrent episodes and relapses.

One of the unfortunate consequences of depression is high risk for suicide, which is more frequent in men; at the same time more women attempt suicides. A trend analysis study done in Australia on decrease in suicides and simple anti depressant prescribing [13] (mostly by general practitioners) showed a significant negative association that is more pronounced in women. This study clearly indicates the effect of anti depressant treatment from a primary care setting and its added benefits for women.

### Pregnancy and Depression

During post partum period up to 85% of women experience some kind of mood disturbance. Some of them experience a more disabling and persistent kind of mood disorder. Although post partum depression is common, patients and their caregivers [3] frequently overlook it.

Recent studies (Including the Avon longitudinal study) has looked seriously on antenatal depression and found that self reported symptom scores for depression are higher in pregnancy (18th and 32 nd week) than in postnatal period and that the distribution of total scores and individual symptom did not differ before and after childbirth [14]. So its necessary to include a psychological component to antenatal screening programmes. One year follow up study in Eastern Turkey [15] found prevalence higher than in industrialised countries and significant association between Post Natall Depression (PND) and poor family relationship, low socio economic factors, early age pregnancy, unplanned pregnancy, premenstrual syndromes, miscarriages and lack of ant inatal care. This study also showed that number of daughters in previous deliveries as a risk factor while numbers of sons is not. Similarly delivering a daughter has an increased chance of depression than a son showing strong gender preference and lack of social and family support given on delivering a baby girl.

A prospective study of postnatal depression in Goa [16] found similar risk factors in addition to antenatal depression and marital violence. Thus gender bias and the limited control a woman has over her health make pregnancy a stressful experience for many women

### Implications for Programmes and Policies

- Redesign medical training to make health care providers more gender sensitive and thus facilitate better diagnosis and management.
- Improve capacity to diagnose depression and other common mental disorders in the primary care setting with special emphasis on gender difference in symptomatology and presentation.

- Integrate diagnosis and treatment of common mental disorders in women to already existing maternal health programmes. This will bring these programmes closer to a complete life cycle approach. (e.g. Including a mental health component in RCH programme)
- Public health approach for primary prevention and address risk factors many of which are gender specific.
- Strong legislation, policies and programmes to address gender discrimination, gender based violence and gender role stereotyping as these are the underlying significant risk factors for depression among women.
- Encourage research to explore gender issues beyond sex difference in the study of disease in general.

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# Research Reports through Gendered Lens – 'ACCESSTOHEALTHCAREANDWOMEN'

## CurrentStatusofServiceDeliveryintheHealthand Family Welfare Sector in Kerala with Particular ReferencetoReproductiveandChildHealthProgram

**K.R.Thankappan,P.SankaraSarma, V.MohananNairandRajappanPillai, AMCHSS,SCTIMST**

**Sites:** five districts from the state, two from the north two from the south and one from the central region.

**Samplesize:** A total of 5000 households (3500 rural and 1500 urban) were selected by a multistage random sampling collected information from selected 70 sub centers, 20 mini primary health centers, 10 block primary health centers, 4 community health centers and 4 first referral units from the five districts. The information included infrastructure facilities in those institutions, drugs and supplies, staff strength, and services provided from those institutions.

The average number of antenatal visits was found to be 8 in the total sample. The cost of an antenatal visit was reported to be around rupees 200. There is a need to reduce the number of antenatal visits. Institutional delivery was found to be 98.8% for the entire sample. Only Malappuram districts reported home deliveries (6.7%). All the other four districts had 100 percent institutional deliveries. Female obstetricians conducted more than 80% of deliveries in our sample. In a poor state like Kerala over dependence on specialists is a concern because it raises the cost of health care. Over 95% of women preferred to have their deliveries conducted by a female provider. Majority of deliveries (52%) were conducted in private sector hospitals. Since more than two third of hospital beds in Kerala is in the private sector this is not high as one would expect. Barring Malappuram district home deliveries are becoming extremely rare in Kerala. Sub centers and primary health centers are also not conducting deliveries particularly in southern districts. This is the reason for the overcrowding of tertiary level maternity hospitals in government sector. In spite of having a high proportion of institutional deliveries the state does not have data on maternal mortality ratio. This could be collected from hospitals easily provided the private hospitals would also report maternal mortality to the state health authorities.

Low birth weight was found to be 13.3 %. Medical termination of pregnancy was reported to be very expensive in both government and private sector. Infrastructure facilities in many institutions were reported to be inadequate. Many sub centres did not have minimum facilities to accommodate the junior public health nurse. This might be one of the reasons for the low proportion of house visits. Unless inpatient facilities are provided in primary health centre, the only government institution in a Panchayath with a medical officer, people will be pushed to private sector hospitals.

Given above are some excerpts from results of the study. Looking through the gendered lens it can be seen that the cost of care is increasing for women and the reason is lack of accessibility to quality care at government hospitals.

## Poverty and Gender Dimensions of Tuberculosis in SouthEastAsiaRegion(Sear)Countries

**T. K. Sundari Ravindran, Shiney C. Alex and Betty SusanNinan**

**Objective:** The review attempted to understand the many ways in which poverty, gender and biology interact to create differential risks and vulnerability to tuberculosis, differences in health seeking behavior, utilization of tuberculosis services, and the social and economic consequences of the disease across social groups and between women and men.

**Findings:** Some studies mention a greater proportion of women delaying making the first contact with a health provider, for reasons that include: lack of decision making power, limited access to cash and lack of attention paid by husband and in laws to the women's ill health. Women may not delay seeking treatment any more than men, but may still have a longer delay to receiving treatment, because they seek health care from providers who are more easily accessible and also from providers who are more easily accessible and

switch providers a few times before seeking services from TB treatment services. Fear of stigma and limited access to resources may contribute to this pattern of health seeking. Default rates were found less for women but reasons for default differed between men and women. The DOTS strategy may have to be modified to better reach out to women and men.

### Situational Analysis of MTP Services in Kerala: Community Perspectives

**Dr.Mala Ramanathan, Dr.P.S.Sarma and C.S.Krishna Kumar**

This study is a component of the Abortion Assessment Project of India that is being coordinated by CEHAT, Mumbai. It forms a part of a multi-centric study by six institutions, assessing the provider perspectives on MTP services in the country.

**Objectives**: to examine the community perspectives of abortion, its legal status, and the available abortion providing centers in kerala

**Methodology**: Focus group discussions. In Kerala, this study was conducted in two districts: Kollam and Malappuram

**Findings**: Women sought health care for reproductive health problems in both private and the public sector. In Kollam district where public facilities were better functioning, women preferred them. In Malappuram this was not so an the private sector was more often sought and utilized. Women felt that conditions prevailing in government hospitals were inadequate. They were not clean and the staff had to be paid for services and supplies that had to be used for the procedures bought from outside and drugs were often not available and had to be bought. The absence of a woman doctor in the government facility also seriously restricted the type of health care sought at the facility. Women were aware of specific abortion services in their neighbour hood. In Kollam, abortion services were few but available in both the public and the private sector. But in Malappuram abortion services were almost absent in public sector. In the public sector supplies had to be bought and staff to be paid, it added additional burden to the already difficult decision of abortion. There was also stigma attached. The legal status of abortion is also not known to many. ❑

## ANNALS OF MPH
## Gender Watch

**Prevalence and Correlates of Hypertension among the Middle Aged Population**
**Author** : Manu G. Zachariah **Batch** : 2000
**Setting** : Urban community in Trivandrum district

**Gender Watch** : Reported morbidity of hypertension was found to be higher among women(25.2) compared to men (21.5%). Obesity and being overweight was found to be more prevalent among women compared to men (men 6.7, women 14.6). but prevalence of hypertension was higher among men (56.4%) while in women it was 52.3%. Mean Systolic blood pressure was higher among women where as diastolic blood pressure was higher among men. Awareness and treatment among women differed by about 10% more among women compared to men

**The Extent and Determinants of Treatment Non-Compliance among Pulmonary TB Patients in RNTCP-DOTS, Trivandrum**
**Author** : Betty Susan Ninan **Batch** : 2000
**Setting** : Trivandrum District

**Gender Watch:** For 34.5% of patients someone else was collecting the drugs. The reasons for sending others were the present illness and fatigue, going for work, stigma, shyness to be directly observed, personal household duties and disability. The proportion of men who send others to collect the drugs was 29.9% compared to 53.8% of women [p <0.001]. For age groups 15-20 years and >60 years, the proportion of those sending somebody to collect was more [P<0.01]. Only 77.5% were collecting the drugs on a thrice-weekly basis in the intensive phase. But there were no significant difference between those coming thrice weekly and those who were not. For only 15.5% of patients had DOT providers and among them only 15.6% were directly observed. Following bivariate analysis to identify associations, multiple logistic regression identified lack of family support, lack of friends/relatives to collect on one's behalf, going for work during the treatment, lower educational status as significant correlates of non-compliance. Drug supply was 100%. Default tracing mechanisms were minimal and not prompt. Stigma was more for younger patients especially unmarried women.

# Bulletin Board

## GenderMainstreamingMedicalEducation ashortcourseforMedicalEducators

November10thtoNovember21st2003

### BACKGROUND

Achutha Menon Centre for Health Science Studies (AMCHSS), Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum, Kerala, has initiated a project to mainstream gender perspectives in medical education.

It is medical education and training that informs individual practice and the delivery of health services. The lack of a gender perspective in medical education has led to a failure to inquire into and act upon gender based differentials in health across different social groups. These include potentially different health risks and vulnerabilities, presenting symptoms, treatment compliance, and health outcomes. The absence of a gender perspective could therefore result in avoidable morbidity, mortality and disability. It could cause delays in diagnosis or inappropriate treatment for certain disorders. It contributes to the implementation of health programmes and services which do not address the major factors associated with a health problem, or meet population health needs, resulting in wasted expenditures.

### THE COURSE

As part of the project to mainstream gender perspectives in medical education, it is planned to organise a series of workshops for change agents drawn from among medical educators who can influence the process of gender mainstreaming medical education.

### OBJECTIVES

#### General Objectives

To create a cadre of medical educators who are gender sensitive and act as change agents to initiate mainstreaming of gender in the medical curriculum.

#### Specific Objectives

(i) To gain a common understanding of gender and rights concepts

(ii) To apply the above concepts to medical curricula, teaching, learning, research, service delivery and policy

(iii) To develop a plan for implementing a process of curricula change within their own Institutions and eventually work towards gender mainstreaming the formal curricula for under graduate medical education

### THE INSTITUTION

The Achutha Menon Centre for Health Science Studies (AMCHSS), Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum, is the course organiser. The AMCHSS is a wing of Sree Chitra Tirunal Institute for Medical Sciences and Technology and is dedicated to public health training. The Centre currently offers graduate and post-graduate programs in public health, and specialized short courses.

### COLLABORATION AND FINANCIAL SUPPORT

This project is funded by the MacArthur Foundation, while WHO-South East Asia Regional Office is a collaborator and is providing financial support to run the pilot training workshop for medical educators from India and from the WHO-South East Asia Region countries in November 2003.

## COURSE STRUCTURE

The course is structured into three modules- the 'concepts module', the 'application module' and the 'planning for action module'. The training is structured to give the participants the analytical tools, evidence, and skills to mobilize and sensitize others and to implement changes in their own institutions, and in a broader way.

### I. Concepts Module

(i) Social Construction of Gender
(ii) Gender as a Social Determinant of Health
(iii) Gender Analysis in Health
(iv) Specific Gender and Health Issues

### II. Application Module

(i) Gender and Cultural Stereotyping in Health Service Settings
(ii) Rights, Ethics and Doctor-Patient Relationship
(iii) Gender Sensitive and Client Centered Health Service Settings
(iv) Application of Gender Analysis to Health Information
(v) Core Competencies of a Medical Graduate with a Gender and Rights Perspective

### III. Planning for Action Module

(i) Facilitating Participatory and Experiential Learning
(ii) Making Change Happen within Our Settings
(iii) Planning for Projects and Initiatives

## FACULTY

The course faculty is constituted of a multidisciplinary team. The team includes national and international experts in gender and rights training and/or with experience in mainstreaming gender in medical curriculum.

## CORE COMMITTEE

A core committee has been formed to advice on curriculum planning and training. This core committee includes the following persons: Dr. T.K. Sundari Ravindran, Dr. Amar Jesani, Dr. Mala Ramanathan, Dr. Sukanya R., Ms. Padma Prakash, Dr. Kamaxi Bhate, Dr. Thelma Narayan and Dr. Bhargavi Davar.

## ELIGIBILITY CRITERIA

Participants in the short course will be teachers of undergraduate medical students, having a track record of making changes, and interested in gender issues.

Apart from medical professionals, social scientists and nursing professionals who teach undergraduate medical students can also apply.

Selection of participants will be done based on their interest in and ability to effect changes within their own settings.

## COURSE SCHEDULE

The first course is scheduled from November 10-21, 2003 at the Achutha Menon Centre for Health Science Studies.

The scheduling of subsequent courses will be announced shortly.

## FOR DETAILS

Those who are interested to participate in the future courses may please contact the following persons for details :

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## Announcing
# MAKINGPREGNANCYSAFER:
## A SHORT-COURSE FORHEALTHMANAGERS

### BACKGROUND

Acutha Menon Centre for Health Science Studies (AMCHSS), Sree Chitra Tirunal Institute for medical sciences and Technology, Trivandrum, Kerala, has initiated a project on research, training and advocacy for gender sensitization of medical education and capacity building of health professionals for reduction of maternal mortality and morbidity.

Up to now, the programs and policies that have been developed either as part of a global trend or indigenously, like the Child survival and safe mother hood program (Safe motherhood initiative) or the Reproductive and Child health program or the Family welfare program have been developed and implemented with little or partial success within the country. One of the reasons for this limited success has been the lack of incorporation of a social and gender perspective in the policies or in the programs that evolve as consequences of the policy. This is because of the overwhelming emphasis on medical solutions to health problems that have social, as well as individual level causes. One way to overcome this lacuna at the policy and programmatic level would be training of health professionals both those working within the medical services delivering health care to the communities as well as those who develop the policies that guide these programs to recognize this gap. This training program aims at reducing the gap in health knowledge by incorporating a Public health perspective that is gender sensitive to the understanding of maternal mortality and morbidity.

### THE INSTITUTION

The Achutha Menon Centre for Health Science Studies (AMCHSS), Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum, is the course organiser. The AMCHSS is a wing of Sree Chitra Tirunal Institute for Medical Sciences and Technology and is dedicated to public health training. The Centre currently offers post-graduate programs and specialized short courses in public health.

### THE COURSE

As part of this project it is planned to organise a series of workshops for making pregnancy safer.

### WHO WOULD BE THE 'TARGET AUDIENCE' OF THE COURSE?

The people who are most likely to change at the delivery interface or act as community interface in terms of promoting women's ability to be safe in pregnancy with some evidence of understanding research or work in this area. People from health management institutions, managers in health system, trainers of managers, trainers of health care providers, members of medical associations like FOGSI, middle level persons from donor agencies, research organizations and NGOs doing research, teachers of nursing schools, members of nursing associations, rural management professionals etc. are the ideal participants as the group should have some basic knowledge of health, especially on reproductive and maternal health, but need not necessarily be clinicians. If they are administrators of health programs, should have some kind of work experience in health field and aware of health issues and terminologies.

### OBJECTIVES

'To build commitment, knowledge and skills (leadership, management and advocacy skills) at each level of the health system for action to make pregnancy safer and pregnancy related care effective'.

Module I : How big is the problem?

- Concepts and definitions
- Magnitude of the problem of maternal mortality and morbidity
- Assessing this magnitude—qualitative and quantitative methods

**Module II : Why and what to do about it?**

I. To understand the socio economic determinants of maternal mortality and morbidity.

II. To illustrate health system functioning affecting maternal mortality and morbidity and to develop potential interventions.

III. To review the current state of knowledge on common practice for pregnant women- abortion, ANC, delivery practice etc.

IV. Review appropriateness of health care providers roles and responsibilities, training and accountability (from a policy perspective).

V. Look at data on interventions from other countries.

VI. To assess implementation of program which have tried to address women's health and to list the weakness.

VII. To investigate methods of improving quality of care.

VIII. To review existing resources on routine maternal care comparing India and other places.

IX. To define what a MIS which promotes quality of care would include.

X. How to influence key stake holders/ gate keepers to improve quality of care.

**Module III : Have we made a difference ?**

MIS- Input, process indicators, action indicators, various tools of auditing

## FACULTY

The course faculty is constituted of a multi disciplinary team. The team includes national and international experts in the field of gender, public health, health policy training.

## ELIGIBILITY CRITERIA

Selection Criteria :

- Qualified medical and nursing graduates, Post Graduate in social work/ management, master's degree or equivalent - with prior training / project work in this area.
- Interested in improving quality.
- Having responsibility in key areas.

## COURSE SCHEDULE

The first course is scheduled in early 2004. The scheduling of subsequent courses in November 2004 and April 2005 will be announced shortly.

## FOR DETAILS

Those who are interested to participate in the pilot course may please contact the following coordinators for details :

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# WHO GENDER POLICY

**Integrating Gender Perspectives in the Work of WHO Background and Rationale**

1. Fifty years after the WHO Constitution was adopted, it is increasingly well recognized that there are differences in the factors determining health and the burden of ill health for women and men. The dynamics of gender in health are of profound importance in this regard and they have long been overlooked.

2. Gender roles and unequal gender relations interact with other social and economic variables, resulting in different and sometimes inequitable patterns of exposure to health risk, and in differential access to and utilization of health information, care and services. These differences, in turn have clear impact on health outcomes. Evidence documenting the multiple connections between gender and health is rapidly growing.

3. It will be the Organization's policy to ensure that all research, policies, programmes, projects, and initiatives with WHO involvement address gender issues. This action is also in harmony with the decision, now being implemented across the UN system1, that integration of gender considerations, that is gender mainstreaming, must become standard practice in all policies and programme.

4. WHO is also committed to advancing gender equality in its own workforce, as well as in scientific and technical advisory bodies, and among temporary advisers and consultants. Integrating considerations into technical programmes and achieving equality between women and men in staffing are complementary policies.

**Goal and Objectives**

5. The goal of this policy is to contribute to better health for both women and men,through health research, policies and programmes which give due attention to gender considerations and promote equity and equality between women and men.

**Objectives:**

- increase coverage, effectiveness and efficiency of interventions;
- promote equity and equality between women and men, throughout the life course, and ensure that interventions do not promote inequitable gender roles relations;
- provide qualitative and quantitative information on the influence of gender on health and health care; and
- support Member States on how to undertake gender-responsive planning, implementation and evaluation of policies, programmes, and projects.

6. These objectives will be achieved through the incorporation of gender analysis in the work of WHO at Headquarters, and in Regional and Country Offices. This analysis will examine the differences in the relationships between women and men and their roles, and how these differences impact on:

- protective and risk factors;
- access to resources to promote and protect mental and physical health, including information, education, technology and services;
- the manifestations, severity and frequency of disease, as well as health outcomes;
- the social and cultural conditions of ill health/ disease;
- the response of health systems and services;
- the roles of women and men as formal and informal health care providers.

This analysis will include identification of ways to overcome constraints so that improved health outcomes for women and men can be achieved.

**Organizational Arrangements for Implementation**

7. Successful realization of this policy will require consistent and active participation by all staff at Headquarters, Regional and Country offices and collaboration and effective linkages across Departments and levels of WHO.

8. Senior management will take the necessary steps to ensure the policy is translated into action in both technical and management aspects of WHO programmes.

9. This policy applies to all work throughout the Organization: research, programme planning, implementation, monitoring, evaluation, human resource management, and budgeting. Effective implementation of the policy will require senior level commitment and validation, organizational support for activities to advance the knowledge and skills of staff for efficient gender analysis in their area of work. Directors will be expected to institutionalize mechanisms for building capacity among their staff providing information, training or technical support staff needed to assure the policy's success.

10. General guidance and support will initially be provided by the Gender Unit of WHO/ FCH, in collaboration with gender focal points in other departments/ clusters/ regional offices. However, all programmes will be expected to collect disaggregated data by sex, review and reflect on the gender aspects of their respective areas of work, and initiate work to develop content-specific materials.

11. Regional and country offices will be expected to develop their own mechanisms, appropriately staffed and resourced, and collaborate with HQ to develop strategies to promote the integration of gender issues in health systems, working mainly with Ministries of Health, other sectors, NGOs and civil society.

12. The HQ Gender Unit will assist and support the development of methodologies and materials for gender analysis, standardized terminology to ensure coherent communication about gender issues, a strategy for appropriate capacity building across the

Organization, and mechanisms for monitoring and evaluation. The Gender Unit will also have responsibility for on-going collection and dissemination of information, such as case studies of "good practice" in mainstreaming gender in health, as well as contributing to the building of an appropriate evidence-base on gender-related health issues in the Organization.

13. The resources and administrative and operational mechanisms for implementation and monitoring effectiveness of this policy throughout the Organization will be set forth in directives of the Director General and Cabinet.

*[condensed from WHO Gender Policy]*

## USEFUL LINKS

Q web: A world wide Web Network for exchange of knowledge, experience and ideas on woman's health and gender issues

Contact: qweb@kvinnoforum.sc

Areas of interest : Gender Equality, Society and women's health, Sexuality and Reproduction, Adolescence, Violence and Abuse, Trafficking.

**In India and Africa , Women's Low Status Worsens Their Risk of AIDS by Barbara Crossette**

*http:/www.Changemakers.net/library/temp/nyt022601.cfm*

The poverty and powerlessness of women in Africa and Asia are combining to make them increasingly vulnerable to research groups are now calling a women's disease. Despite years of international conferences and declarations abo In many cultures and in the most disadvantaged societies girls and women do not have the power to reject unwante In many cultures and in the most disadvantaged societies girls and women do not have the power to reject unwante

**Convention on the Elimination of All Forms of Discrimination against women (CEDAW)**

*http://www.un.org/womenwatch/daw/cedaw/index.html*

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the Assembly, is often described as an international bill of rights for women. Consisting of a preamble and 30 articles, it constitues discrimination against women and sets up an agenda for national action to end such discrimination.

Notable Feature(s): Access to Division for the Advancement of women resources, including those specifically on eliminating discrimination against women.

Contact Information:
UN Division for the Advancement of Women
2UN Plaza, DC2-12th Floor
New York, NY 10017
USA FAX: 212.963.3463
Email:draw@un.org

**International Centre for Research on Women (ICRW)**

*http://www.icrw.org/*
*http://www.icrw.org/projects/prowid/prowidregions.htm*

The International Centre for Research on Women is a private nonprofit organization founded in 1976 and based in With and office in India. The International Centre for Research on Women is a non-profit organization that seeks to in women in poverty, advance women's equality and human rights, and contribute to the broader economic and social accomplishes this, in partnership with others, through policy-oriented research, capacity buiding and advocacy on women's economic, health and social status in low and middle income countries.

ICRW bases its work in sustainable development on a number of key principles:

Supporting women as economic providers and innovators, nutures and caregivers, community leaders and ensuring women's control of

economic resources, guaranteeing reproductive rights, health and nutrition, capabilities and increasing political power, fostering equity and respect for the human rights and diginity of all.

Notable Feature(s): A vast collection of research , analyis, and reporting on programmes about women in development, challenges and opportunities, skills and legal status in communties around the world, links to policy and advacacy, HIV/AIDS, poverty reduction, nutrition governance, environment, violence against women, reproductive health, and norms and institutions.

Contact Information:
Internationla Centre for Research on Women (ICRW)
1717 Massachusetts Avenue, NW
Suite 302,Washington, DC 20036, USA

### Shaan online: IPS e-Zine on Gender and Human Rights

*http:/www.ipsnews.net/hivaids/index.shtml*

Shaan is an initiative of IPS, inter press Service News Agency (IPS), the world's leading provider of information on this special magazine produced by Inter press service (IPS), in cooperation with the United Nations Development (UNIFEM), the impact of HIV/AIDS on women who are denied their human rights, is told through their own voices. IPS is backed by a network of journalists in more than 100 countries. Its clients include more than 3,000 media organs of thousands of civil society groups, academics, and other users.

Notable Feature(s): Poverty, Women and HIV/AIDS, one of several sections addressing women around the world, including one on activities.

Contact Information:
e-mail: webmaster@ipsnews.net

### Women and Population

*http:/www.fao.org/waicent/faoinfo/sustdev/wpdirect/default.htm*

News, handbooks, and reports on best practices annd action plans for: agriculture, gender equality, environment, food issues.

Contact Information:
Food and Agriculture Organization of the U.N (FAO) Sustainable Development Department, Viale Delle Terme Di Caracalla,
Rome 00100 Italy
Telephone: (+39 6) 57051
Fax: (+39 6) 570 53064
E-mail: SD-Dimensions@fao.org

### Women and Trade

*http://www.unifem.undp.org/trade/index.htm*
*http:// www.unifem.undp.org/economic.htm*

The Impact of trade liberation reaches almost every community in the World, both directly and indirectly women particular, are affected in many ways. Since the founding of the WTO in January 1995, a number of organizations are been working on trade liberalization and its consequences for sustainable livelihoods, including women's livelihoods. The term " sustainable livelihoods" was first used by the Brundtland Commission in our common Future (1987) to be in resource ownership and access, basic needs and livelihood security especially in rural areas. This concept has legitimization through several major international forum. Agenda 21 from the 1992 UN Conference on Environment (UNCED) noted the integrative power of the concept in linking socioeconomic and ecological issues to policy-making .

Notable Feature (S): Special UNIFEM focus on "Strengthening Women's Economic Capacity" and tools to eradicate poverty.

Contact Information:
Women and Trade
United Nations Development Fund for women
304 East 45th Street, 15th floor
Newyork, NY 10017, USA
Phone: 212/906-6400
Fax: 112/906-6705
Email: unifem@undp.org
Women of the world- country specific resource directory
http://www.un.org/womenwatch/world/index.html
contact Information:
Email womenwatch@ un.org

### Women of Uganda Network (WOUGNET)

*http://www.wougnet.org*

WOUGNET is a place to share news, information and activities on women related issues in Uganda. Its goal is to provide information and communications technologies (ICTS) for women organisations and individuals.

Notable Feature(s): Subscribe to mailing list for exchange of news and activities related to women in Uganda; lin global organizations and resources about women and education, women and business, women and health, human rights and other topics; useful bulletin board of announcements, news, conferences, research and advocacy. ❑

# Editorial

Medical education in India has expanded with 183 colleges of modern medicine (a majority in the private sector), producing over 20 000 doctors of modern medicine per year. Although health policy documents till early 80's talked about the social role of medical education, technology oriented education was what got imparted to these several thousands of trainees. More recently, even the lip service to this social role of medical education has been eroded with the 2002 health policy document not providing any strong social or other perspective to the creation and evolution of medical professionals. In the last 20 years it has become more elitist than ever due to entry of private players in the commercialization. There has been a steady increase in the proportion of women entering the modern medicine but at higher levels of education only one third of the students are women in post graduate education and in the super specialty fields it is even less (2%)

Despite great expansion, medical education is the least studied, documented and discussed for its gender content or sensitivity. The numbers of books on medical education are also few in number. Social activists have done some work on medical education and much of the work is found in various committee review reports, but none of this has found its way back to any efforts at reform. From the initial stages, the MPH programme at AMCHSS,SCTIMST has had a strong component of gender in its training of MPH. Being a national institute in medicine and public health, SCTIMST can contribute much in medical education and influence change in gender sensitization

An absence of gender sensitivity in medical education has serious implications for the practice of medicine and affects lives of men and women in many ways. The medical curricula do not quickly accommodate the changing regulatory mechanisms into practice-viz. the Supreme court regulation regarding sexual harassment in the work place or the social, ethical and legal debates surrounding the issue of sex determination. Gender sensitization would provide a key to making medical education socially relevant again without removing from it the clinical moorings.

Keeping this in mind, we are undertaking a study to sensitize health to issues of gender by undertaking an exercise to critique the content and method of medical education and developing strategies for intervention

This newsletter is also part of that effort at gender sensitization of health professionals within the country. We plan on bringing this out every quarter with at least two articles relevant to the issue of gender and health education and related issues. We will also bring to you abstracts of articles and policy documents published elsewhere but are relevant to the issue at hand, important links and contacts, abstracts of key projects and other activities related to or relevant to gender. The road ahead is least traveled and challenging. We have fewer fellow travelers today down this path but we hope to convince many more en route. I assure you that this journey that we are embarking on towards engendering health will be informative and thought provoking for you. Do write in and let us know what you would like and what you are not happy with and what changes you would welcome.

**AmarJesani**

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COM H-74.

**PART IX**

Dear friends,

Good morning!
Nothing gives me more pleasure on an ordinary Monday morning to meet with women and men who are committed to women's rights!
Thank you all for coming and for sharing your talents, expertise and experiences.
Changing the world in order to improve the lives of women is not an easy task. It takes a lot: commitment, resources, political will and maybe above all: courage. Courage to stand up and speak out. Although we might have our differences in what we believe is the right path to follow, it is a joint path that we have taken and our solidarity will get us there! So, welcome to you all!

I looked into a pile of documents that Cordaid and its predecessors -Cebemo, Lenten Campaign, Caritas Nederland and Memisa- prepared over the last 20 years or so, on the role of women in development initiatives and on issues around gender. An interesting and rich history, or should I say, her story, emerges. There has been true commitment over the years. But we know that commitment, as important as it is, is not enough to change the world. We also need policies, instruments, indicators and resources! That is where this workshop will be about.

I would like to briefly review with you Cordaid's gender policy. It is clear that there are no simple solutions to the challenges that we have been facing in designing and implementing our policies and practices. It's dilemma's that emerge from that overview. I would like to ask you to keep those dilemma's in mind in working together the coming days. This workshop is an excellent opportunity to move forward on some of those. I will get back to the dilemma's later on. Let me first give you a short overview on the debate on gender in Cordaid, to refresh our memory and also to honour the work that has been done so far.

This overview starts from 1996, but it is clear that in the years before within the different organizations, thoughts had been given to the role of women in society and also on how that could translate into policies and practices working in the field of development. Within Bilance, those thoughts have been articulated most explicit in the organizations agenda. Bilance stressed its gender goal in all its activities: project funding, development education, lobbying and fundraising.
Its gender goals were stated as follows:

> *"to bring about changes in existing power relationships so that women and men gain equal opportunities to develop themselves and just development is furthered."*

Bilance aimed at making at least 50% of its funds available for activities that benefited women, preferably by improving their position, participation and influence on decision- making.

The Bilance gender policy was translated into 4 minimum requirements for funding, amongst them:
- the vision of the partner organisation in terms of awareness on gender issues,
- the need for active participation of women in the organisation;
- the necessity of making a situational analysis, addressing the needs and interests of women and men separately, and:
- a translation from analysis to expected results, indicated separately for men and women.

Bilance also conducted internal program evaluations around this theme, to see what learnings there were. In 1999 the internal evaluation was aimed at elaborating a Cordaid gender policy, bringing togehter the merging organisations: Bilance, Mensen in Nood and Memisa. I would like to share the main conclusions of that evaluation with you.

Cordaid Gender Equality workshop research file
In
12/5/04

**PART IX**

On gender policy:
The study noticed a gap between gender policy and practice. Gender policy objectives were in general not made operational. And the other way round: there was also no mechanism for translation of experiences in the local context in the South to policy development.

On gender instruments the conclusions were:

- Clearly defined gender instruments did not exist.
- Gender was mainly given attention in general instruments. The commitment and capabilities of (Cordaid) staff were therefore crucial for the attention for gender.
- Use of gender instruments by Cordaid staff relates to the attention for gender in their own organisation (Cordaid).

On monitoring and evaluation it became clear that concrete indicators to evaluate the gender policy did not exist. There was no answer to the question how to measure equal opportunities for women and men and a just development. Also, the absence of concrete objectives and indicators hampered monitoring and evaluation of gender results. Another hampering factor was the fact that in Cordaid much more attention was given to the approval-phase of projects than to monitoring of the implementation and results. Much more information could be obtained from reports and evaluations, if agreements on gender were monitored, and evaluations were systematised and translated into policy.

In the dialogue with partners, there was no systematic approach with regard to gender. Methods or frameworks for gender analysis were not available or not used.

The past years we have been working to adress these issues. And where, will you ask, does this take us in 2004? We made progress. Of course, there were also some backlashes. Tiredness on issues of gender has sometimes taken hold of policies and practices. And sometimes we have assumed knowledge and commitment where there is none, also because we did not invest enough in it.
On the other hand, much of our thinking about our development strategy is very sensitive to the role of gender relations in society.

Cordaid believes that promoting gender equality is an important part of its development strategy that seeks to enable all people – women and men alike – to escape poverty, to develop their talents, express their needs and ideas, and negotiate these with the broader society.
Poverty is also a structural lack of opportunities, influence, rights, freedom and scope for personal development. Therefore, Cordaid aims at structural poverty alleviation, which combines direct aid with sustainable improvement of social relations and is aimed at fair distribution, economic growth, democratisation and ecological sustainability.

Structural poverty alleviation implies a transformation in the division of wealth, influence and well-being from the rich to the poor and marginalized groups in societies. This includes a process of change in which gender inequality is one of the main factors at play, at all levels. If there is transformation in gender relations towards more equality between men and women, we can truly speak of structural, sustainable poverty alleviation.

Gender related transformation involves men as much as women. The approach following from this vision implies that in all 'mainstream' activities, the possible outcomes are established for their contribution to changes of gender relations, whether it means working with men, women or mixed groups. This agenda of change and transformation has consequences for the practice of Cordaid and for the monitoring and evaluation of that practice. Cordaid is operating at three distinctive levels (target group, partner organisations and the level of Cordaid itself). At each of these levels an agenda for change of existing unequal relations is formulated.

**PART IX**

Based upon this agenda of change, Cordaid has formulated the following two objectives:

- Achieving equal access for women and men, boys and girls to (natural) resources, and equal access to the enjoyment of the outcomes of the use of these resources
- Making a contribution to increasing decision-making power for women and girls in order to remove inequality between women and men, in other words: to strengthen womens and girls voices

Now, in 2004 we feel that these objectives need to be further elaborated. They are not sufficiently consistent with our agenda for change. This is one of the key issues that we want to work on the coming days.

In order to achieve the two above mentioned objectives, Cordaid strives for results at partner level:

- By 2006 80% of our partner organisations will be gender sensitive, which implies that
  - they have developed a clear gender vision
  - they can make gender analyses
  - at least 25% of higher positions in the organization are held by women
  - gender analysis is translated into concrete actions
  - gender expertise is present in the organisation
  - women from target groups are involved in decision making processes
- 15% of Cordaid's partners are women organisations

And at Cordaid level, learning processes are set up in relation to Cordaid themes (peace & conflict, access to markets, urban poverty alleviation, HIV/Aids and health & care). And, of course, in our human resources policy for example, we have set indicators regarding the number of women and men in certain positions.

We also developed instruments:
In 2003 we have developed the gender thermometer. It looks totally different from any thermometer that you have ever seen! And it was intended to be like that: we want to challenge people to use the instrument and to make measurement more fun.

Up till now, we have not yet used the instrument throughout the organization. The Latin America department has experimented with the instrument and the Africa department is developing qualitative criteria, because the thermometer as such does not provide these. At this time we have the quantitative gender criteria that I mentioned a few minutes ago, but we feel that there should be more to it. The qualitative criteria should be directly linked to our agenda for change and our objectives regarding our gender policy. We need to articulate this agenda of change, sharpen our objectives and criteria, to make the tool even more useful to all of us.

And here we face the dilemma's that I mentioned earlier. Those dilemma's mainly address the earlier mentioned gap between policy and practice and our quest for instruments to help us bridge that gap.

- There is the issue of mainstreaming. Mainstreaming is also called: "male streaming", or "away streaming". It means that we put in a lot of energy to mainstream gender in general policies, at the same time knowing that it will be difficult to follow that up, and not to fall into the trap of instrumentalization. Mainstreaming endangers our perspective of thinking in terms of unequal power relations and unequal opportunities between women and men. We need that perspective to work effectively on the role of women at all levels of society. We also need that perspective to keep paying attention to the suffering of many women, due to those unequal power relationships.

  And do not get me wrong: I am not victimizing women, but I would also not want us to think too easy about the harmful effects on women of some traditional beliefs and practices, religious fundamentalisms and paternalistic societal mechanisms. *Aids Response*, one of our partners

here presents, puts is rightly as it states that "does not only deal with the traditional patriarchal setting of the church, but also with the traditional matriarchal setting of non professional health care for sick and dying.

We feel that contextualizing policies and practices is a key element to effective development initiatives. Now, how can that work for gender policies and practices? How can we translate the realities of local contexts and the demands of you, our partners, into our gender instruments. We need more insight into the effects of those instruments and the prerequisites for use. For example: in emergency aid as well as in other interventions, womens needs should be addressed from their perspective. Now, how does that work? How can we operationalize those needs? I know that work has been done on that, building on experiences that we have in more structural interventions. Still, it is not common practice to tailor emergency interventions also to the needs of women. How can we assist each other in designing those mechanisms and instruments?

As a large organization, working on 5 themes, in 40 countries, with 1000 organizations, we have wonderful opportunities for learning. How can we capitalize on those opportunities: how do we upgrade strategies and spread learning experiences. We know that toolkits, instruments and checklists are useful, but we also know that those alone are not sufficient. We need better insight in what works and what doesn't work in certain contexts and we need to clarify what our role can be in facilitating those joint learning processes. Recently, in a different setting, we have had positive experiences with peer reviews, could that be one of the ways that we can improve our joint learning processes? Huairou Committee, one of the international grass roots women networks (also present here today) might serve as a good example of peer learning. They have been very well able to mobilise and enhance grass roots women knowledge and strategies and ultimately link these strategies to the global debates....

And finally: what can our identity, being a non governmental catholic agency, add to our agenda for change? How can we harmonize the realities of women that we work with and for into our agenda and how can we best voice their concerns in the international community that we are part of. How can we work together with women in the Netherlands and elsewhere? And also: how can we play an effective role in advocating for womens rights in our catholic community. With Cairo and Beijing +10 coming up, we have an opportunity to reflect on our role and views.

Well, I think that should be enough food for thought for the coming days! My colleagues, Marjolijn Wilmink, Helen Beyersbergen and Lucia Helsloot, have put together an excellent agenda for this meeting. I would like to thank them for their input to this process. Their energy revitalises our thinking!

I am convinced that the coming days will reaffirm our commitment to womens rights.

Lilianne Ploumen

Com H-74.

PART IV-N

## Women's Voice Malawi
### Case Study

**Introduction**

Women's Voice is a local non-profit organization which is devoted to the promotion and protection of justice and welfare of women and children,s rights through:

- Training
- Civic education
- Action oriented research
- Forums for dialogue and
- Advocacy and lobbying.

**The organization has the following objectives:**

- To educate women and children their legal and human rights.
- To advocate for gender equality
- To collect and disseminate information on women and children's rights
- To carry out research on problems faced by women and children in all areas.
- To urge Government to amend and repeal all laws that are repressive and discriminate against women and to urge government to ratify and incorporate into Laws of Malawi all International Instruments on women and children's rights.

**Level of interaction**

The level of interaction is both at local as well as National. At local level, most of Women's Voice activities are community based. At National level the organization is actively involved in issues of policy advocacy in issues mainly concerning women.

**Size**

Women's Voice is a national organization with Community offices and projects in 4 districts of Malawi. The organization has 16 paid up staff, 9 Board Members and 430 Community based volunteers.

**Summary of Experiences**

As the name suggests, most of the programmes and activities were women focused, the member'sof staff were all women. The organization was following a Women in Development (WID) approach where all the strategies were women focused and the organization was there to address the problems of women and nothing else.

**Actual Case Study**

The organization ever since its inception, it was using a WID approach and through out this period, the projects were somehow meeting resistance from men in society and somehow it was very difficult to make headway and register impact. Women were empowered but they could go no where with their empowerment because men were very hostile and could not open up to accommodate the changes in their women because they were not part of the change and transition..

Later in 2000, through donor demand for a more gendered approach and of course through our experiences in the field, Women's Voice decided to adopt a new strategic direction and decided to move from a WID approach to a GAD approach where all the projects and decisions were to benefit both men and women and in the long run reduce the disparities rather than advancing it.

Gender Equality
Workshop resource file
12/5/04

## PART IV-N

With this need for a new direction, Women's Voice went through a gender Audit through the Tanzanian Gender Networking programme (TGNP) with the funding from Southern Africa AIDS Training Programme.

With this transition Women's Voice moved completely from WID to GAD, in so doing, it meant that all projects were to benefit both men and women. Community volunteers were both men and women unlike before. With this approach, Women's Voice activities started gaining an overwhelming support from the catchment area as well as from the chiefs.

Women's Voice started treating men as colleagues and partners in development. All in all Women's Voice adopted the following as a strategy to ensure that Gender is mainstreamed in all its programming:

- Decided to reshape the mainstream rather than adding activities to accommodate men
- Strongly focused on equality than women as a target
- Focused on broad policy and made changes
- Moved beyond responding to Gender differences and decided to increase attention to reduce disparities

**Focus**

Changes in the organization helped Women's Voice to work in a more gender aware manner and experience gained at the community level..

As the organization was changing in terms of area intervention, the number of staff (human Resource) was also increasing to meet the demands out there.
The staff was also developing in their expertise and hence was able to analyze situations and able to adopt what is relevant and what will help Women's Voice if the organization was to make impact.

One of the issues analyzed was the gender disparities which was their and the resistance which the organization was meeting out in the field.

With the Gender Audit which the organization did, this helped the organization to identify and examine the impact of external and internal factors on gender issues in its programming.

This helped Women's Voice to promote gender equality objectives in its internal operations and in its programming.

That is when Women's Voice then mainstreamed gender in its programming as much as possible in such a way that all its projects moved beyond responding to gender differences and decided to increase attention to reduce disparities, this assured that projects will benefit men and women.

At personnel level, the organization looked at recruitment as a starting point. Before the organization went through this transition, women occupied almost all the posts, but this is not the same anymore. Now 40% of the staff are men.

All the Programme staff have gone for a gender mainstreaming course to ensure that all programme staff speak the same language and wear gender lens in planning, implementation and monitoring of all projects

Two donors played a very big role in this kind of positive transition from a women focus to a more gendered approach and these are CORDAID and SAT.

PART IV-N

CORDAID in its institutional Assessment of the organization made strong recommendations that Women's Voice has to consider Gender strongly in its programming. CORDAID reporting guidelines also emphasized for organizations to strongly report from a gender perspective and as much as possible provide gender disaggregated data for project beneficiaries.

SAT programme has also helped the organization a lot.
SAT has offered trainings in Gender mainstreaming to all programme staff at Women's Voice and it has also helped the organization to change in broad policies by helping it to undergo the situation analysis from a gender perspective. It also helped the organization examine the extent to which gender equality has been mainstreamed in various facets of the organization like at:

- Organizational policies
- Strategies and activities
- Existing Gender expertise in the organization
- Personnel policies
- Information management
- Decision making in the organization
- Culture of the organization.

Com H-74.

**Working Group Urban Liveability**

- Mrs. Hèlen Yamo, Femmes Africa Solidarité Switzerland
- Mrs. Aleli Marcelino, Philippines
- Mrs Safia Abdi, Cordaid Regional Office Kenya
- Mrs. Sri Husnaini Sofjan, AWAS
- Mrs Anna Schilizzi, Cordaid
- Mr. Marc v.d. Linden, Cordaid
- Mrs. Josta ten Broeke, Cordaid
- Mrs. Nele Odeur, Cordaid (May 10, 2004 only)
- Mrs. Marloe Dresens, Cordaid
- Mr. Adriaan Fokker, Cordaid
- Mrs. Margriet Nieuwenhuis, Cordaid

**Working Group HIV/AIDS**

- Mrs. Makoko Chirwa, Women's Voice Malawi
- Ms. Loretta Joseph, AIDSResponse South Africa
- Mrs. Esther Mwaura-Muiru, Groots Kenya
- Mrs. Joanna Kerr, AWID USA
- Mr. Piet van Gils, Cordaid
- Mrs. Lieke de Winther, Cordaid
- Mrs. Carla de Wit, Cordaid
- Mrs. Lucia Helsloot, Cordaid
- Mrs. Anneke v.d. Meij, Cordaid
- Mrs. Barbara Berger, Cordaid
- (Mr. Nico Keijzer, Cordaid)

**Working Group Health and Care**

- Mrs. Angela Dwamena-Aboagye, ARK Foundation Ghana
- Mrs. Radium D. Bhattacharya, GAP-SRCDE, India
- Mrs. Thelma Narayan, Community Health Cell India
- Mrs. Annemiek van Voorst, Voorstrategie, the Netherlands
- Mrs. Stephany Kersten, Cordaid
- Mrs. Rens Rutten, Cordaid
- Mr. Bert Ruitenbeek, Cordaid
- Mrs. Margriet de Kruif, Cordaid
- Mr. Remco v.d. Veen, Cordaid
- Mr. Frans Wierema, Cordaid

Cordaid Gender-Equality workshop 10-11/5/2004

file
12/5/04

**Working Group Peace and Conflict and Human Rights**

- Mrs. Emma Lindsay, Femmes Africa Solidarité Switzerland
- Mrs. S. Sawitri, LKTS Indonesia
- Mrs. Ira Febriana, Indonesia
- Mrs. Leonor Esguerra, Corporación Mujeres que Crean, Colombia
- Mrs. Aline Batarseh, Women's Studies Centre, Israel
- Mrs. Maria Teresa Rodriguez, Fundacion Guatamala
- Mr. Laurens den Dulk, Cordaid
- Mrs. Astrid Frey, Cordaid
- Mrs. Jeanne Abdulla, Cordaid
- Mrs. Elly Reinierse, Cordaid
- Mrs. Lia van Broekhoven, Cordaid
- Mrs. Dorine Plantenga (only May 11, 2004)

**Working Group Access to Markets**

- Mrs. Lawrencia K. Wonnia, SEND Ghana
- Mrs Merecedes Canalda, ADOPEN Dominican Republic
- Mrs. Sandy Schilen, Groots International USA
- Mrs. Manuela Janssen, Cordaid
- Mrs. Martine Benschop, Cordaid
- Mrs. Edith Boekraad, Cordaid
- Mrs. Hetty Burgman, Cordaid
- Mrs. Inge Barmentlo, Cordaid
- Mr. Ben Krommendijk, Cordaid
- Mr. Tony Fernandes, Cordaid

**Working Group Emergency Relief & Linkage**

- Ms. Christiana Thorpe, FAWE Sierra Leone
- Mrs. Francoise Bigirimana, Burundi
- Mrs. Nicole Spijkerman, Cordaid Maluku, Indonesia
- Mrs. Jan Peterson, Huairou Committee USA
- Mrs. Greet Robbe, Cordaid
- Mrs. Sasja Kamil, Cordaid
- Mrs. Marloe Geurts, Cordaid
- Mr. Marcel Krabbendam, Cordaid (May 10 afternoon, May 11, morning)

Mrs. Monika Haekel

# ADOPEM

## Dominican Association for Woman's Development

## Affiliated to

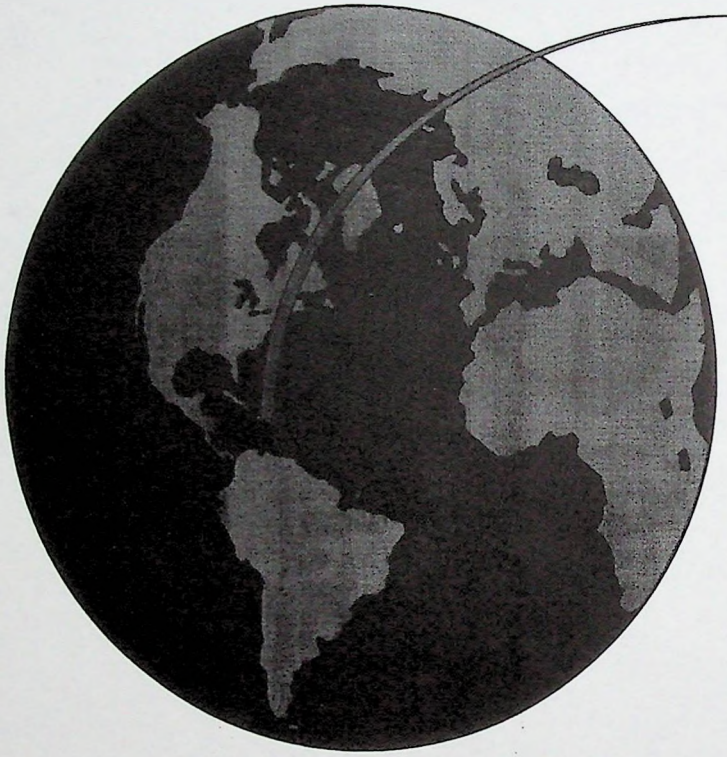
## Women's World Banking

## (WWB)

ADOPEM

Com H-34.

# GEOGRAPHICAL LOCATION



# HALF-CLOSE OF THE DOMINICAN REPUBLIC

| | | | |
|---|---|---|---|
| **Population** | | : | **8.7 Millions** |
| **Territory** | | : | **48,511 Km$^2$** |
| **Currency** | | : | **Peso** |
| **Change** | | : | **US$ 1 = RD$ 45** |
| **Economically Active Population (PEA)** | | : | **3.6 Millions of People** |
| **Unemployment rate** | | : | **15%** |
| **Inflation** | **2000** | : | **7.70 %** |
| | **2001** | : | **4.38 %** |
| | **2002** | : | **9.00 %** |
| | **2003** | : | **30.00 %** |



# Mission

***To improve women's living conditions and their family, in the Dominican Republic incorporating to the formal sector through financial and developing services that work for most.***



***"Changing the way world Work"***

ADOPEM


FINANCIAL
NGO
DEVELOPMENT
NGO

## *WHY GIVE SPECIFIC ATTENTION TO WOMEN?*

- In the Dominican Republic as much of the places in the world women's don't have many opportunities to access credit, education, participation.
- Women are 52% of the all population in the DR
- Women have 26% more participation in micro business that men in the DR
- Statistical 100 pesos that get to women's hands impact directly into a family, food, education and held, only 20 pesos if that money get to mans hands

## *ADOPEM IMPACT IN SERVICES FOR WOMEN*

- Important Information:
  - Born in 1982
  - 2% of the PEA
  - More than 50,000 loans a year
  - More than a financial service
  - Won different prizes

# *CORDAID CONTRIBUTION*

## *CORDAID PARTICIPATION*

| | |
|---|---|
| Date of Disbursement | Dec. 4, 2001 |
| Amount | NLG612,500.00<br>US$ 254,692.11 |
| Rate (Interest) | 8% plus inflation |
| Term | 2001 – 2005 |
| Payment of Interest | Every six months |
| Payment of Capital | 4 payments every six months<br>(30 months after the first disbursement) |

*POSITIVE:*

- More than 750 women with loans
- Best time to receive the money
- Good term, in domestic currency, not foreign exchange risk

*NEGATIVE:*

- Difficulties to get new facilities
- Difficulties to renegotiate the terms because inflation

# *Doña Estela Perez*


- *Lives in a rural zone*
- *She has 5 sons*
- *Initiates her business by the necessity to be in her house, because her younger daughter with 13 years old become pregnant*
- *Got abuse by her first husband*
- *Initiates selling vegetables*
- *Knows ADOPEM and install her own grocery store*
- *Began with a loan of RD$1,000 (US$30) in 1998 and actually she has a loan of RD$12,000 (US$360)*

ADOPEM

# *Florentina Angeles Reyes*

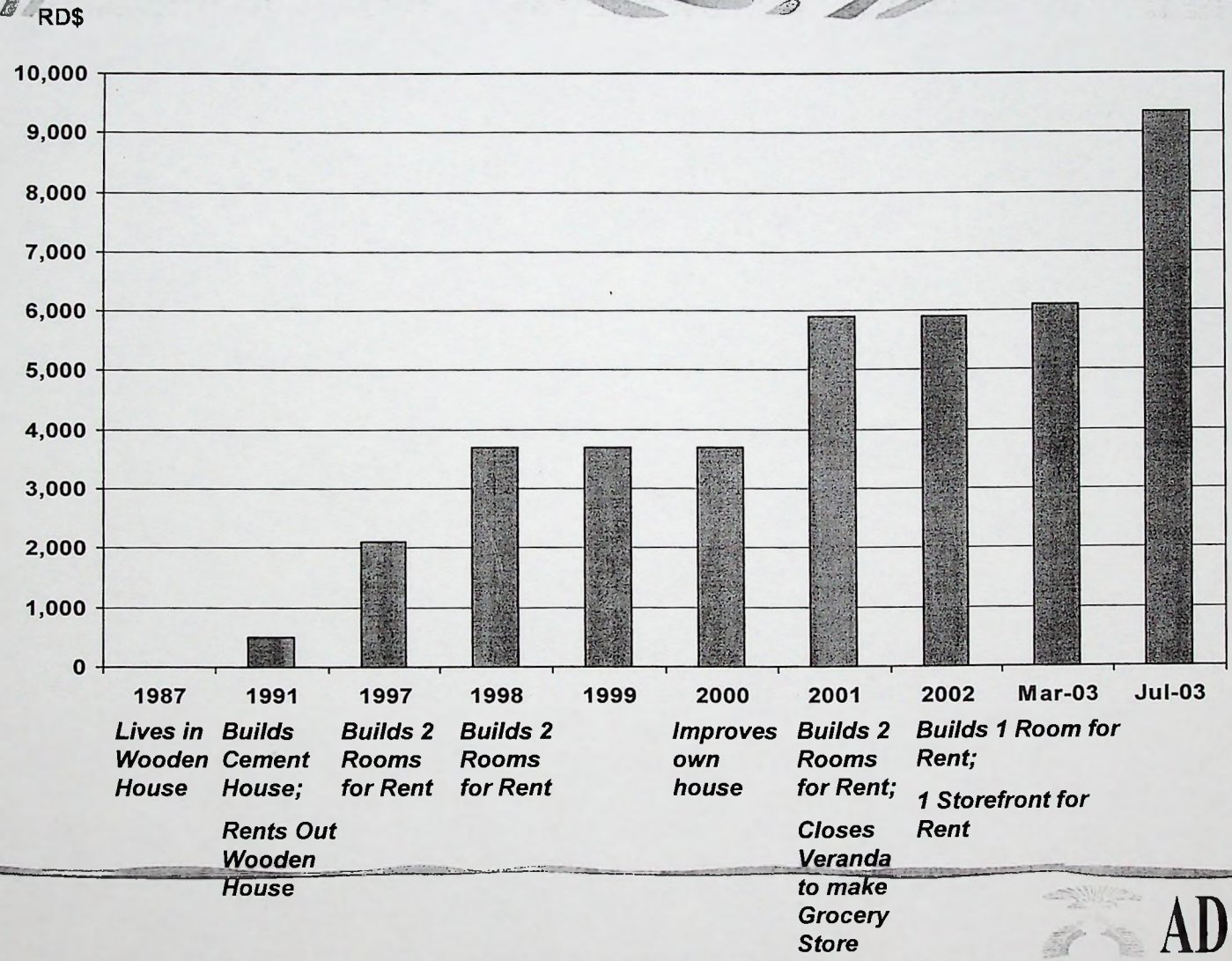
- *Florentina is 43 years old and lives with her husband who is 71 years old and two of her three children and her grandson.*
- *Florentina has three businesses:*

1. *Lunch business: sells 15 to 20 lunches each day to a nearby factory. Also sells to walk-in customers. Operates out of her kitchen.*
2. *Grocery Store: Sells home made fruit juices, daily food stuffs. Store is located in front of her house.*
3. *Rental Property: currently has 7 rooms and 1 wooden house rented as accommodation; 1 store front. All located in family compound.*

- *She has been borrowing from ADOPEM since 1997 and has invested the money in property.*

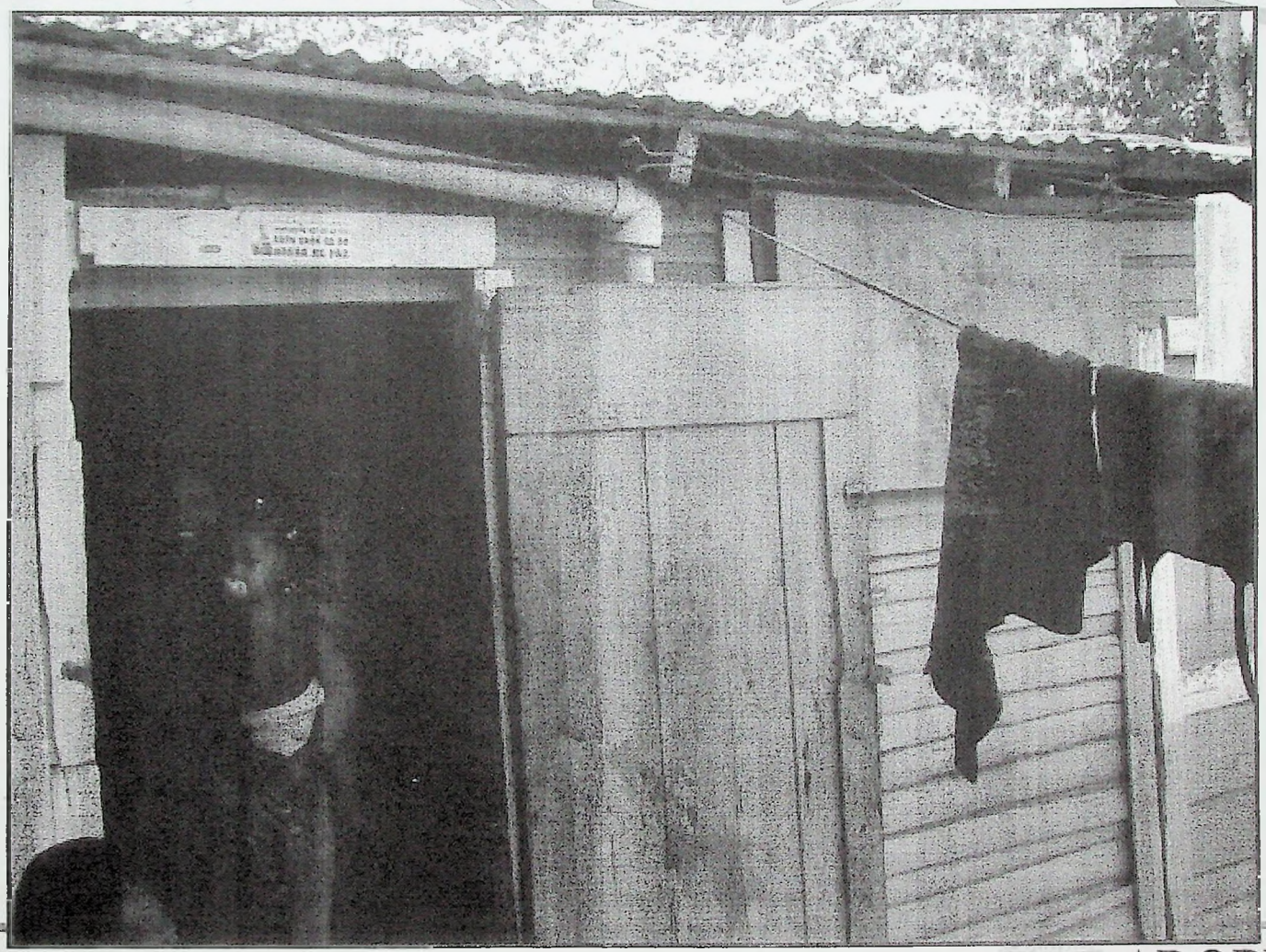
ADOPEM

# *Florentina: Growth in Rental Income Per Month*




ADOPEM

# *Florentina: First Rental Income. Wooden House*



ADOPEM

# *Florentina: Main House Plus Rental Rooms*

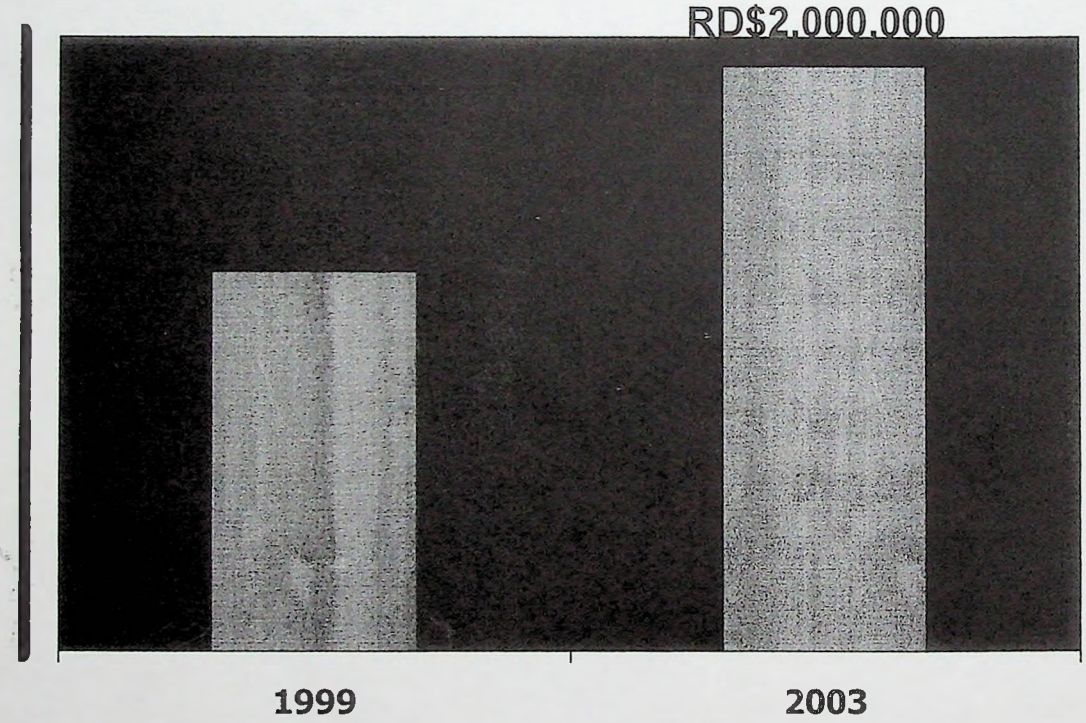
ADOPEM

# *Florentina: Most Recent Addition.*

## *Store front plus accommodation above*


ADOPEM

# *Florentina: Growth in Property Value*




***"When I feel that I cannot work, when I am old, I will have my rent with which I can buy food and not be hungry."***

ADOPEM

# *Bethania's Five Businesses*

1. **Organizing ROSCAs (SANEs): E.g. Bethania organizes 5 participants. Each contributes RD$100 every day for 60 days, equivalent to RD$6,000 each or RD$30,000 total. The payout is RD$5,000 every 10 days. As the ROSCA organizer, Bethania is entitled to the first payout of RD$5,000 without contributing any money.**

2. **Selling Clothes: Bethania buys RD$5,000 worth of merchandise every two weeks, sells it for RD$8,000, giving an estimated ROI of 40% per month.**

3. **Lending Money: Bethania lends small amounts of money e.g. RD$500 to RD$2,000 for short terms (2 weeks) to people that she knows. She charges 20% every 2 weeks.**

4. **Deposit Collecting: Bethania minds money for some local shopkeepers. For example, a shopkeeper comes to Bethania's house each day and gives her RD$200 to guard. He does this each day for 60 days, equivalent to RD$12,000 total. At the end of 60 days she gives him back RD$10,000 and keeps RD$2,000 as a fee.**

5. **Child Minding: Bethania minds a neighbor's child for RD$1,000 a month.**

***WE HAVE A GREAT COMMITMENT TO THE DOMINICAN WOMMEN'S PARTICIPATION***

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**ITDG GENDER WORK**

**BACKGROUND**

The political, social and economic, legal and cultural influences on pastoral society have in many ways affected the gender balance in a negative sense for women. Despite being managers of homesteads pastoral women do not have access to the traditional forms of regenerative wealth. There is also gross underrepresentation of women in management committees and decision-making positions that have resulted in the creation of policies that fail to address their needs and concerns as women are currently unlikely to be elected to positions of management committees. Therefore, Community decisions on resource management are always made by men, despite the fact that the burden of family labor and responsibilities is predominantly borne by women and girl child.

The structurally weak, inadequately resourced and poorly coordinated women institutions - with limited capacities to assume roles of community leadership has made women groups unrecognized by state institutions. The groups also lack strategic integration into local, district and national level policy making processes. Other elected women still find it difficult to speak out their grievances in front of their husbands and fathers while others find it more difficult to put their argument forward to outsiders. As a result they rarely gain the opportunity to effectively influence decisions or engage in implementation.

In Marsabit, Turkana and Samburu ITDG-EA, through its Rural Livelihood projects, continues to witness and document the marginalization of pastoral women under the current socio-cultural, political and economic setup. In particular, ITDG-EA acknowledges that over generations, societies have assigned roles, access and ownership of resources on gender lines. This has led to impoverishment and marginalization of women as opposed to men.

To change the *status quo,* ITDG-EA recognized that promoting the positive role of women in development is a pre-requisite to sustainable development. It identified gender sensitization and economic empowerment as an urgent matter at community level. The other pastoral sectors that needed to be addressed in respect to gender issues were energy, agriculture, water and sanitation, shelter, environment and income generating activities.

Hence, ITDG-EA with funding from CORDAID thus embarked on streamlining gender awareness in its pastoralist project in Northern Kenya. The various interventions were designed to build capacity of the women, empower them with knowledge so that they are able to engage in decision-making processes that affect their livelihoods, increase their skills in income generating activities and natural resource management.

The following case studies therefore highlight ITDG-EA specific experiences in Nothern Kenya:

## The Bubisa Women Group

### Introduction

Bubisa is located in northern Kenya about 600 kilometers north of Nairobi and 150 kilometers from the Kenya /Ethiopia border. It is a dry season watering point for pastoralists in this area, which with time has become a settlement especially for pastoralists dropouts and in particular women headed households dependent on relief agencies for their livelihood security. The settlement has a very high proportion of female-headed pastoralist drop out households in a community that is very paternalistic in terms of resource control and decision-making.

In recent periods changing weather patterns, increased conflict over water and pasture as well as interventions associated with modern development such as construction of boreholes, schools and health facilities have necessitated the establishment of permanent settlements, interfering with the pastoralist way of life. In addition most relief based interventions targeting the pastoralists have brought about a change in food taste with most of the settled communities preferring maize based meals and thus creating a dependence on externally sourced food stuffs. This has resulted in an increasing number of dropouts from the nomadic way of life. This has consequently resulted in increased poverty of the communities and especially for pastoralist dropouts in the settled areas.

### Women Group Profile

Bubisa Women group is a women initiative to pool together resources and skills to tackle the high levels of poverty affecting most of the members of the group. Out in the dry patched land of northern Kenya towards the border with Ethiopia survival is the norm as the inhabitants of the area try to eke out a living from the hostile environment. Traditionally, residents of this area are nomadic pastoralists moving from place to place in a systematic pattern governed by seasonal changes of the weather in search of pasture and water for their livestock. In addition other problems facing the community in this area include low literacy levels, low school enrolment, some negative cultural practices e.g. Female Genital Mutilation, girl marriage and traditionally accepted multiple sexual partners enhancing the spread of HIV Aids and other sexually transmitted diseases.

To improve their welfare, women from this area came together and registered a women self help group in 1996 with the overall objective of cushioning their members from the devastating effects of poverty prevalent in the area as well as empowering them to take control over decisions that affect their lives. The group is based in Bubisa location of Maikona division of Marsabit District in northern Kenya. It is made up of 17 members aged between 25-45 years, 8 of who are household heads fending for themselves and their children with little or no resources at all.

Most of these women have been rendered poor as a result of cattle rustling due to banditry activities and diseases that affect their livestock. They are pastoralist dropouts who have adopted other coping strategies towards improving their livelihoods and that of their children. The age-old traditional livestock lending culture in the community, which provided support for the poor and women headed households has been eroded with time. Even for men headed households, women still tend to suffer more during difficult times as most of them are left at home with the children to take care of while husbands move away with livestock in search of pasture and water for the livestock particularly during prolonged drought.

### Activities

The group since its formation has been involved in various activities for the benefit of their members. To date the group has undertaken the following activities:

**Environmental Conservation through Rehabilitation of Degraded sites**

**Process**

Of the group's activities, the most ingenious initiative by the women group so far has been the environmental conservation work. This involved the construction of a stone wall to protect the centre from strong winds and enable natural re-vegetation of the degraded site. Groundwork included the creation of good will among the stakeholders - Bubisa Water User Association (WUA), EMC, local leaders and Bubisa women's group. To ensure that implementation was participatory, the expected roles of the various stakeholders were defined through consultative forums. During the consultative meetings, the community members demonstrated knowledge of the project and the urgent need to have it started.

A total of 45 members, 10 men and 35 women were involved in the process. Both men and Women were responsible for piling of stones, loading and offloading of stones. Women also contributed food, water and milk. ITDG-EA provided funds for barbed wire and cement for foundation while the community raised funds for cedar posts.

Work commenced with the collection of stones from a nearby area with the full support of the area chief and clan elders. Two Dhabelas (the *Yaa* elders), the Marsabit project team and the Marsabit District Trade Officer collected the foundation stones. A hired tractor ferried stones while between 12 and 13 women were on the construction site on a day-to-day basis playing various roles - loading/unloading of the tractor with stones, making tea or doing actual construction of the wall.

The construction of a stonewall is an activity that Gabra women cherish, following their experience in the construction of enclosures for camel calves, structures traditionally called *mona*. By the end of the year, a total of 1,730-metre perimeter wall was complete, with less than 500 metres of the intended enclosure remaining.

**Results and Impacts**

The community reported some positive impact following the construction of the enclosure so far covered. The wall acted as a windbreak, reducing the impact of wind erosion at the centre. Despite the prevailing stressful environment associated with pro-longed drought, there was evidence of natural regeneration on the inside of the enclosure. This part had accumulated manure, seeds and patches of green vegetation that had not been disturbed by livestock. Despite all the odds the wall was finally completed by the end of the year.

**Lessons Learnt**

Such community efforts need to have some short-term benefits to encourage them to continue with the work, which may take many generations for the full benefits to be realised. In Bubisa after two years the community is already benefiting from reduced effects of sandstorms and greening of their environment, which has given them a vision of what their area could look like in a few years time with sustained efforts in environmental conservation. It is hoped that efforts like those of Bubisa Women group would spur other community groups and development agencies to undertake environmental work to mitigate against the imminent environmental degradation resulting from infrastructural development activities.

**Energy Conservation through Energy Saving Mud Stoves**

There is recognition of the central role of women in household energy and the different energy needs and contributions. The Technology that has been developed for energy conservation is commercial oriented and by far specialized in male dominated activities. ITDG-EA recognized the

need for fuel saving technologies and A 5-days training workshop on fuel-efficient stoves was held at Bubisa centre with a focus on mud stoves (*jiko sanifu* types) as a response to the communities' needs.

A total of 19 participants drawn from Torbi women's group (3), Thagado women's group (3), *Yaa* Galbo (1) and Bubisa women's group (12) benefited from this training. The Energy Programme of ITDG-EA facilitated training in collaboration with two members from the Ministry of Agriculture, Marsabit. Bubisa women's group banda was used for accommodation. The women's group also provided catering services to participants empowering the group for effective contribution to livelihood.

Technology Transfer (PTT) approach was used during the training. Participants shared their experience on the problems of energy at household level and narrated the various options they used to address wood scarcity. Participants constructed five demonstration stoves within kitchens of Bubisa participants during the training session with minimal supervision from the facilitators, suggesting that the technology offered was simple for trainees to adopt.

**Results and Impacts**

A follow-up conducted by the project team observed an increase in the adoption of the new technology beyond the group members. Totals of 6 and 8 stoves had been made and were in use at Bubisa and Torbi centres by the end of the reporting period. The women reported increased use of one load head from 3 to 5 days per household.

As a result of the adoption of the energy saving technology by women groups in Bubisa, there has been a reduction in the amount of fuel wood used. Trees have also regenerated drastically due to reduced demand for wood.

Through this technology women in Bubisa can now cook food faster and in a cleaner environment due to reduced smoke emission.

**Kubi Bagassa Women's Group**

*Introduction*

Kubi Bagassa Water Users Association (WUA) was formed in 1997 with the objective of managing day-to-day operations of the borehole, including determining user fees and recruitment of a pump attendant. A general meeting was held following which officials, who were all men, were elected to manage the borehole. Since then, the borehole has experienced a number of breakdowns, which the WUA has had difficulties to address due to management and financial factors, despite daily collections from water users. The users pay KShs 1.00 for an animal watered and for a 20-litre Jerry can of water drawn. On average, therefore, the management collected between KShs 700 and 800 per day.

Frequent breakdown and shortage of diesel forced women to travel to the neighbouring Dirib Gombo borehole (3 km away) and Dirib Gombo shallow wells (8 km away) for water for domestic use. Animals were also forced to water in the same sources.

The financial and management problems faced by the committee composed of men were:

- Unavailability of diesel to run the engine.
- Lack of accountability of monies collected.
- Frequent breakdown of the genset due to poor and/or failing to service it. The pump attendant lacked technical skills and was hardly paid.

- Lack of a forum for the committee to deliberate on borehole matters; the executive had no knowledge of its obligations and roles;
- Poor record keeping; the committee kept no record of transactions at the borehole including daily collections, and the purchase of fuel and spare parts.
- Poor maintenance/improper management of the borehole.

*The Process of Change*

Early September 2000, a meeting was convened to address the management of the borehole. After lengthy deliberations, women expressed interest in sharing the management of the borehole. Consequently, they were allowed to collect and manage the sale of drinking water, charging KShs 1.00 per Jerry can. The women formed a group to undertake the management of their collections. Men were left to handle collections from watering animals.

The new resolution became operational immediately. That month, the women's group collected KShs 6,360. In early October, the borehole ceased functioning from lack of fuel. The men, in charge of purchasing fuel, had no money to do so and could not account for the disposition of funds collected the previous month. The women's group invested KShs 3,000 in the purchase of diesel and cautioned men against interfering with their collections. They then took on the responsibility of collecting for watering of animals. The women turned down the request put forward by men that they be responsible for purchasing diesel. Instead they undertook purchasing and supervision of use of the fuel. That was when the committee composed of men decided to pass over full control of the borehole to the women's group in October 2000.

*Results*

The women's group has a total of 53 members. Since the women's group took over the management of the borehole, they have opened an account with Kenya Commercial Bank, Marsabit branch. By December they had deposited over Kshs 4,000 in their account. The bank has handed over the certificate of registration of the borehole management to the women's group. Cases of engine breakdown have reduced and access to water by the community improved.

A major achievement was that the DC chose to celebrate the World Water Day at Kubi Bagassa. This showed support of the administration to this group.

They recently acquired a new genset from UNICEF.

The women's group in conjunction with ITDG-EA, the Department of Culture and Social Services and the Water department is revising user by-laws. The group also approached ITDG-EA for leadership and micro-enterprise business training, which was done. The training was facilitated by ITDG-EA in collaboration with the Department of Water.

*Challenges*

The new management faces the following challenges:

Threats and intimidation from the local administration, particularly the area chief and councilor;

Inadequate capacity to effectively address management issues, particularly because for a long time, men have benefited from capacity building workshops. As indicated above, this gap is being addressed by on-going training facilitated by ITDG-EA.

The challenges have been summarized as below:

'Our main problem here in Kubi Bagasa is neither lack of enough funds to buy diesel nor less committed water users but is simply the extension of our male hegemony right from the *Manyattas* to the water points." Says Mrs. Lokho, a community women leader. According to her, their husbands, in cahoots with the area chief, have formed a habit of running away with all water revenues every time they become water cashiers. "They have never appreciated our efforts to maintain the *Manyattas* with sufficient water by keeping the borehole running as this is our only source of water," she explains. "Every time they hear the sound of the engine, our men would come running to displace women from the water points accusing us of collaborating with some foreigners to deny them access to their rightful property. They would keep the engine running for as long as they could keep their eyes awake and as long as there is enough diesel. When the diesel runs out or the engine breaks down they would simply disappear with all collections to the *Manyattas* leaving us to struggle looking for funds besides footing miles away in desperate search for water. After all, the goats and the camels can do without water for a couple of days unlike the daily domestic water requirements that stops at the woman." The women leader explains.

The problem started when the local community voted out the male dominated and corrupt management committee in favour of the local women group that had been operating in the area for quite some time. "It was a miracle that the water users group considered us for this work as our role was simply to pay and draw water. We were grossly underrepresented in water management committee and the few who were considered were mere spectators as they could not speak in front of their husbands". The women leader explains. According to her, there were neither records nor accounts for the water users group before they took over the borehole as men used to stuff coins into their pockets just to show off to their suitors how richer they are.

However, things worsened when the local administrator physically ejected the women from the borehole replacing them with his relative who had no idea on how to operate the machine. In the process the young man pressed the wrong button thereby blowing off the mortar, the switchboard and the water pumps resulting to a loss worth kshs. 700,000. We are not sure if he was instructed to do so, says the local women leader, but the way all men have disappeared leaving us stranded here is quite telling.
Initially, women used to borrow fuel from a local petrol station and pay back the money after daily collections but this time round they have been shot on the foot, as they can't raise over Kshs 700,000 to repair the machine.

The consequences have however, been disastrous, over 400 women who were being served by this borehole now walk over 10 kilometers in search of water from a nearby borehole which is also unreliable due to its frequent breakdown. They wake up at late night risking their lives from wild animals trying to beat the usually long queue. The 10-litre container they use in drawing water is barely sufficient enough to sustain the household needs. Mothers are at pain to choose

between watering the lactating and young animals, and providing drinking water for their children and the old.

The two nurseries and vegetable gardens they had started two years ago had gone to waste. Women have no time to rest and majorities are contracting pneumonia due to morning colds. The women leader painfully narrates how one of their members who recently gave birth could not wash her baby for four days leave alone getting bath herself due to lack of water. To her, their husbands prefer watering the lactating animals and the sick ones to attending to their sick wives. There are many horrible experiences our members have gone through since the machine broke down. She concludes.

The local chief and his men have extended their chauvinism further by discouraging people from paying up their debts. Even the chief himself owes the borehole over kshs 5,000 of unpaid water bills. But despite this huge bill the chief is still spreading rumours among local community that the machine requires a lorry of coins to enable its repair, which is far much expensive for the community to contribute. As the women insubordination persists, poor women in Kubi Bagasa continue to suffer.

Similarly, a 100,000-litre tank constructed by ALRMP that has been serving the community risk cracking and total degeneration if it remains dry without water for the next few months. Women are also afraid of vandalism of the machine altogether if not attended to soonar as they is no watchman at the site. Hence a Kshs. 2 million water project risk total collapse for lack of 600,000 to repair the machine.

However, according the Umbrella Group chairman, the Area District Commissioner has written a warning letter to the chief instructing him to keep off the borehole or else risk stern disciplinary action from his office. This was confirmed during the recent awareness meeting when the DC firmly instructed the women the local community to report to him if the chief comes back. However, when the women approached the ministry of water for assistance the ministry decried lack of funds for purchase of spare parts but are willing to provide transport facilities if required.

Kubi Bagasa was the first borehole in its kind to be managed by local women in the whole district. It has been a showcase both at the local, district and regional on the importance of women's involvement in water management. Its collapse shall strike a big blow not only umbrella group but also to the wider women fraternity who have been campaigning for women inclusion in water management and the ones who have been fighting insubordination and Stigmatization in the whole pastoral community. Mr. Orto, Group umbrella chairman concludes.

- Environmental conservation in which they have provided protection for young shoots of ASAL adapted trees species from browsing animals like camels and goats through erection of a wall enclosure using readily available stones. This work has been very successful and has even been featured in the *Baobab*[1] development magazine as an example of an ingenious community response to environmental degradation.

- Energy conservation through use of appropriate energy conservation techniques. Two group members after participating in a workshop on construction of energy saving mudstoves have trained other community members on the same resulting in increased use of the fuel saving stoves and a resultant reduction in pressure for firewood on the environment.

- Income generating activities is one of the major activities of the women giving them access to resources directly under their control as well as providing services to the community.

- The group has engaged an adult literacy teacher to provide literacy classes to their members and other community members.

- The group through drama and poetry is involved in raising community awareness on negative cultural practices as well as HIV/AIDS.

**Results and Impacts**

**Environmental Conservation**

The community has benefited from reduced sandstorms and women can now cook outside the manyattas even during the day.

**Lessons Learnt**

Such community efforts need to have some short-term benefits to encourage them to continue with the work which may take many generations for the full benefits to be realised. In Bubisa after two years the community is already benefiting from reduced effects of sandstorms and greening of their environment, which has given them a vision of what their area could look like in a few years time with sustained efforts in environmental conservation. It is hoped that efforts like those of Bubisa Women group would spur other community groups and development agencies to undertake environmental work to mitigate against the imminent environmental degradation resulting from infrastructural development activities.

[1] A publication of the Arid Lands Information Network December 2001 vol 33.

Com H-74.

PART IV-O

## ITDG Kenya
## Case Study

### BACKGROUND

The political, social and economic, legal and cultural influences on pastoral society have in many ways affected the gender balance in a negative sense for women. Despite being managers of homesteads pastoral women do not have access to the traditional forms of regenerative wealth. There is also gross underrepresentation of women in management committees and decision-making positions that have resulted in the creation of policies that fail to address their needs and concerns as women are currently unlikely to be elected to positions of management committees. Therefore, Community decisions on resource management are always made by men, despite the fact that the burden of family labor and responsibilities is predominantly borne by women and girl child.

The structurally weak, inadequately resourced and poorly coordinated women institutions - with limited capacities to assume roles of community leadership has made women groups unrecognized by state institutions. The groups also lack strategic integration into local, district and national level policy making processes. Other elected women still find it difficult to speak out their grievances in front of their husbands and fathers while others find it more difficult to put their argument forward to outsiders. As a result they rarely gain the opportunity to effectively influence decisions or engage in implementation.

In Marsabit, Turkana and Samburu ITDG-EA, through its Rural Livelihood projects, continues to witness and document the marginalization of pastoral women under the current socio-cultural, political and economic setup. In particular, ITDG-EA acknowledges that over generations, societies have assigned roles, access and ownership of resources on gender lines. This has led to impoverishment and marginalization of women as opposed to men.

To change the *status quo,* ITDG-EA recognized that promoting the positive role of women in development is a pre-requisite to sustainable development. It identified gender sensitization and economic empowerment as an urgent matter at community level. The other pastoral sectors that needed to be addressed in respect to gender issues were energy, agriculture, water and sanitation, shelter, environment and income generating activities.

Hence, ITDG-EA with funding from CORDAID thus embarked on streamlining gender awareness in its pastoralist project in Northern Kenya. The various interventions were designed to build capacity of the women, empower them with knowledge so that they are able to engage in decision-making processes that affect their livelihoods, increase their skills in income generating activities and natural resource management.

The following case studies therefore highlight ITDG-EA specific experiences in Nothern Kenya:

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PART IV-O

## The Bubisa Women Group

### Introduction

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In recent periods changing weather patterns, increased conflict over water and pasture as well as interventions associated with modern development such as construction of boreholes, schools and health facilities have necessitated the establishment of permanent settlements, interfering with the pastoralist way of life. In addition most relief based interventions targeting the pastoralists have brought about a change in food taste with most of the settled communities preferring maize based meals and thus creating a dependence on externally sourced food stuffs. This has resulted in an increasing number of dropouts from the nomadic way of life. This has consequently resulted in increased poverty of the communities and especially for pastoralist dropouts in the settled areas.

### Women Group Profile

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To improve their welfare, women from this area came together and registered a women self help group in 1996 with the overall objective of cushioning their members from the devastating effects of poverty prevalent in the area as well as empowering them to take control over decisions that affect their lives. The group is based in Bubisa location of Maikona division of Marsabit District in northern Kenya. It is made up of 17 members aged between 25-45 years, 8 of who are household heads fending for themselves and their children with little or no resources at all.

Most of these women have been rendered poor as a result of cattle rustling due to banditry activities and diseases that affect their livestock. They are pastoralist dropouts who have adopted other coping strategies towards improving their livelihoods and that of their children. The age-old traditional livestock lending culture in the community, which provided support for the poor and women headed households has been eroded with time. Even for men headed households, women still tend to suffer more during difficult times as most of them are left at home with the children to take care of while husbands move away with livestock in search of pasture and water for the livestock particularly during prolonged drought.

### Activities

## PART IV-O

The group since its formation has been involved in various activities for the benefit of their members. To date the group has undertaken the following activities:

**Environmental Conservation through Rehabilitation of Degraded sites**

**Process**

Of the group's activities, the most ingenious initiative by the women group so far has been the environmental conservation work. This involved the construction of a stone wall to protect the centre from strong winds and enable natural re-vegetation of the degraded site. Groundwork included the creation of good will among the stakeholders - Bubisa Water User Association (WUA), EMC, local leaders and Bubisa women's group. To ensure that implementation was participatory, the expected roles of the various stakeholders were defined through consultative forums. During the consultative meetings, the community members demonstrated knowledge of the project and the urgent need to have it started.

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**Results and Impacts**

The community reported some positive impact following the construction of the enclosure so far covered. The wall acted as a windbreak, reducing the impact of wind erosion at the centre. Despite the prevailing stressful environment associated with pro-longed drought, there was evidence of natural regeneration on the inside of the enclosure. This part had accumulated manure, seeds and patches of green vegetation that had not been disturbed by livestock. Despite all the odds the wall was finally completed by the end of the year.

**Lessons Learnt**

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**Results and Impacts**

A follow-up conducted by the project team observed an increase in the adoption of the new technology beyond the group members. Totals of 6 and 8 stoves had been made and were in use at Bubisa and Torbi centres by the end of the reporting period. The women reported increased use of one load head from 3 to 5 days per household.

As a result of the adoption of the energy saving technology by women groups in Bubisa, there has been a reduction in the amount of fuel wood used. Trees have also regenerated drastically due to reduced demand for wood.

Through this technology women in Bubisa can now cook food faster and in a cleaner environment due to reduced smoke emission.

**Kubi Bagassa Women's Group**

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The financial and management problems faced by the committee composed of men were:

- Unavailability of diesel to run the engine.
- Lack of accountability of monies collected.

- Frequent breakdown of the genset due to poor and/or failing to service it. The pump attendant lacked technical skills and was hardly paid.
- Lack of a forum for the committee to deliberate on borehole matters; the executive had no knowledge of its obligations and roles;
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- Poor maintenance/improper management of the borehole.

*The Process of Change*

Early September 2000, a meeting was convened to address the management of the borehole. After lengthy deliberations, women expressed interest in sharing the management of the borehole. Consequently, they were allowed to collect and manage the sale of drinking water, charging KShs 1.00 per Jerry can. The women formed a group to undertake the management of their collections. Men were left to handle collections from watering animals.

The new resolution became operational immediately. That month, the women's group collected KShs 6,360. In early October, the borehole ceased functioning from lack of fuel. The men, in charge of purchasing fuel, had no money to do so and could not account for the disposition of funds collected the previous month. The women's group invested KShs 3,000 in the purchase of diesel and cautioned men against interfering with their collections. They then took on the responsibility of collecting for watering of animals. The women turned down the request put forward by men that they be responsible for purchasing diesel. Instead they undertook purchasing and supervision of use of the fuel. That was when the committee composed of men decided to pass over full control of the borehole to the women's group in October 2000.

*Results*

The women's group has a total of 53 members. Since the women's group took over the management of the borehole, they have opened an account with Kenya Commercial Bank, Marsabit branch. By December they had deposited over Kshs 4,000 in their account. The bank has handed over the certificate of registration of the borehole management to the women's group. Cases of engine breakdown have reduced and access to water by the community improved.

A major achievement was that the DC chose to celebrate the World Water Day at Kubi Bagassa. This showed support of the administration to this group.

They recently acquired a new genset from UNICEF.

The women's group in conjunction with ITDG-EA, the Department of Culture and Social Services and the Water department is revising user by-laws. The group also approached ITDG-EA for leadership and micro-enterprise business training, which was done. The training was facilitated by ITDG-EA in collaboration with the Department of Water.

*Challenges*

The new management faces the following challenges:

Threats and intimidation from the local administration, particularly the area chief and councilor;

Inadequate capacity to effectively address management issues, particularly because for a long time, men have benefited from capacity building workshops. As indicated above, this gap is being addressed by on-going training facilitated by ITDG-EA.

The challenges have been summarized as below:

PART IV-O

**The Agony of Women Water Users in Kubi Bagasa.**

'Our main problem here in Kubi Bagasa is neither lack of enough funds to buy diesel nor less committed water users but is simply the extension of our male hegemony right from the *Manyattas* to the water points." Says Mrs. Lokho, a community women leader. According to her, their husbands, in cahoots with the area chief, have formed a habit of running away with all water revenues every time they become water cashiers. "They have never appreciated our efforts to maintain the *Manyattas* with sufficient water by keeping the borehole running as this is our only source of water," she explains. "Every time they hear the sound of the engine, our men would come running to displace women from the water points accusing us of collaborating with some foreigners to deny them access to their rightful property. They would keep the engine running for as long as they could keep their eyes awake and as long as there is enough diesel. When the diesel runs out or the engine breaks down they would simply disappear with all collections to the *Manyattas* leaving us to struggle looking for funds besides footing miles away in desperate search for water. After all, the goats and the camels can do without water for a couple of days unlike the daily domestic water requirements that stops at the woman." The women leader explains.

The problem started when the local community voted out the male dominated and corrupt management committee in favour of the local women group that had been operating in the area for quite some time. "It was a miracle that the water users group considered us for this work as our role was simply to pay and draw water. We were grossly underrepresented in water management committee and the few who were considered were mere spectators as they could not speak in front of their husbands". The women leader explains. According to her there were neither records nor accounts for the water users group before they took over the borehole as men used to stuff coins into their pockets just to show off to their suitors how richer they are.

However, things worsened when the local administrator physically ejected the women from the borehole replacing them with his relative who had no idea on how to operate the machine. In the process the young man pressed the wrong button thereby blowing off the mortar, the switchboard and the water pumps resulting to a loss worth kshs. 700,000. We are not sure if he was instructed to do so, says the local women leader, but the way all men have disappeared leaving us stranded here is quite telling.
Initially, women used to borrow fuel from a local petrol station and pay back the money after daily collections but this time round they have been shot on the foot, as they can't raise over Kshs 700,000 to repair the machine.

The consequences have however, been disastrous, over 400 women who were being served by this borehole now walk over 10 kilometers in search of water from a nearby borehole which is also unreliable due to its frequent breakdown. They wake up at late night risking their lives from wild animals trying to beat the usually long queue. The 10-litre container they use in drawing water is barely sufficient enough to sustain the household needs. Mothers are at pain to choose

between watering the lactating and young animals, and providing drinking water for their children and the old.

The two nurseries and vegetable gardens they had started two years ago had gone to waste. Women have no time to rest and majorities are contracting pneumonia due to morning colds. The women leader painfully narrates how one of their members who recently gave birth could not wash her baby for four days leave alone getting bath herself due to lack of water. To her, their husbands prefer watering the lactating animals and the sick ones to attending to their sick wives. There are many horrible experiences our members have gone through since the machine broke down. She concludes.

The local chief and his men have extended their chauvinism further by discouraging people from paying up their debts. Even the chief himself owes the borehole over kshs 5,000 of unpaid water bills. But despite this huge bill the chief is still spreading rumours among local community that the machine requires a lorry of coins to enable its repair. which is far much expensive for the community to contribute. As the women insubordination persists, poor women in Kubi Bagasa continue to suffer.

Similarly, a 100,000-litre tank constructed by ALRMP that has been serving the community risk cracking and total degeneration if it remains dry without water for the next few months. Women are also afraid of vandalism of the machine altogether if not attended to sooner as they is no watchman at the site. Hence a Kshs. 2 million water project risk total collapse for lack of 600,000 to repair the machine.

However, according the Umbrella Group chairman, the Area District Commissioner has written a warning letter to the chief instructing him to keep off the borehole or else risk stern disciplinary action from his office. This was confirmed during the recent awareness meeting when the DC firmly instructed the women the local community to report to him if the chief comes back. However, when the women approached the ministry of water for assistance the ministry decried lack of funds for purchase of spare parts but are willing to provide transport facilities if required.

Kubi Bagasa was the first borehole in its kind to be managed by local women in the whole district. It has been a showcase both at the local, district and regional on the importance of women's involvement in water management. Its collapse shall strike a big blow not only umbrella group but also to the wider women fraternity who have been campaigning for women inclusion in water management and the ones who have been fighting insubordination and stigmatization in the whole pastoral community. Mr. Orto, Group umbrella chairman concludes.

**District Water Umbrella Association**

- Environmental conservation in which they have provided protection for young shoots of ASAL adapted trees species from browsing animals like camels and goats through erection of a wall enclosure using readily available stones. This work has been very successful and has even been featured in the *Baobab*[1] development magazine as an example of an ingenious community response to environmental degradation.

- Energy conservation through use of appropriate energy conservation techniques. Two group members after participating in a workshop on construction of energy saving mudstoves have trained other community members on the same resulting in increased use of the fuel saving stoves and a resultant reduction in pressure for firewood on the environment.

- Income generating activities is one of the major activities of the women giving them access to resources directly under their control as well as providing services to the community.

- The group has engaged an adult literacy teacher to provide literacy classes to their members and other community members.

- The group through drama and poetry is involved in raising community awareness on negative cultural practices as well as HIV/AIDS.

**Results and Impacts**

**Environmental Conservation**

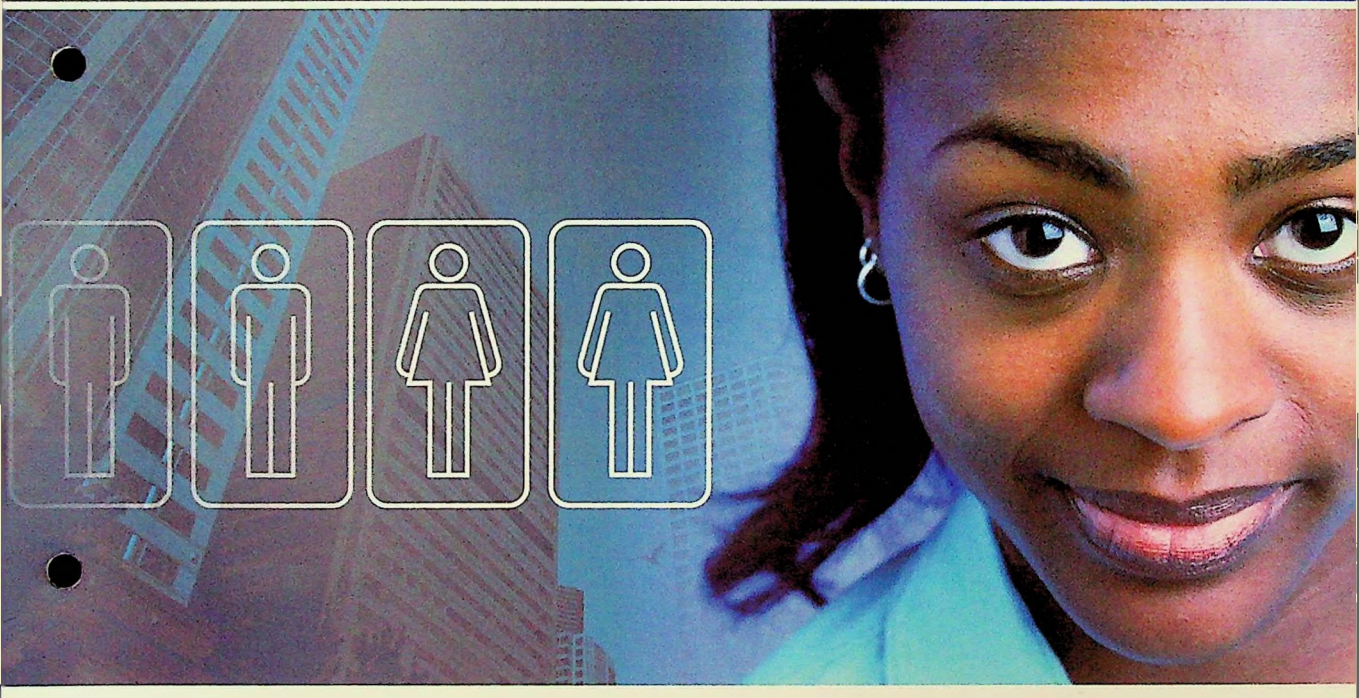
The community has benefited from reduced sandstorms and women can now cook outside the manyattas even during the day.

**Lessons Learnt**

Such community efforts need to have some short-term benefits to encourage them to continue with the work which may take many generations for the full benefits to be realised. In Bubisa after two years the community is already benefiting from reduced effects of sandstorms and greening of their environment, which has given them a vision of what their area could look like in a few years time with sustained efforts in environmental conservation. It is hoped that efforts like those of Bubisa Women group would spur other community groups and development agencies to undertake environmental work to mitigate against the imminent environmental degradation resulting from infrastructural development activities.

[1] A publication of the Arid Lands Information Network December 2001 vol 33.

# How Women-friendly is your City?



How advanced is your city in terms of gender equality?

Is your administration ahead or behind in implementing these measures?

What remains to be done to achieve women's full and equal participation and their access to services and resources?

Judge your city's performance – and what you still need to do...

To how many of the following items can you answer YES?

**Evaluate your municipality!**

In _____

(your city's name)

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## Political Structures, Mechanisms and Resources

| | YES | NO |
|---|---|---|
| National laws on women's rights and gender equality | | |
| National laws on gender quotas or parity at the municipal level | | |
| Affirmative action policies in municipal political parties | | |
| Parity in committees, commissions and para-municipal enterprises | | |
| Network of elected women representatives | | |
| Council-adopted policy on gender equality (developed through public consultation and carried out via annual municipal plan of action) | | |
| Public consultation policies with mechanisms to encourage women's participation | | |
| Policies and commitments to fight violence against women and to increase their safety | | |
| Gender perspective in all programs (including annual municipal budget and sectoral budgets) | | |
| Support of national and international municipal associations (training, networking, etc.) | | |

## Administrative Structures, Mechanisms and Resources

| | YES | NO |
|---|---|---|
| Gender Equality/Women's Office (with adequate human resources and budget), within central administration, in charge of gender mainstreaming | | |
| Annual gender equality action plan (with specific goals, indicators and budget) | | |
| Training in gender mainstreaming (for elected officials and staff, men and women) | | |
| Access to gender-disaggregated data on all urban issues | | |
| Gender impact assessment of urban policies, programs and service delivery | | |
| Equal opportunity program for hiring (with specific targets for different types of jobs) | | |
| Information service in boroughs and neighbourhoods/districts | | |
| Process to handle citizen requests and complaints from women and men | | |

## Participation and Partnership Structures and Mechanisms

| | YES | NO |
|---|---|---|
| Women's advisory council, commission or committee within council to monitor implementation of gender equality policy | | |
| Thematic council commissions (with public hearings) | | |
| Public consultation process in boroughs, neighbourhoods or districts | | |
| Public consultation process with specific mechanisms to encourage women's participation | | |
| Women's advisory councils in the boroughs, neighbourhoods or districts | | |
| City-wide civic education campaigns | | |
| Projects and activities improving women's access to services and resources (e.g., walking safety audits, local-to-local Dialogues between men and women elected officials and women's groups) | | |
| Permanent partnership committees on specific issues (safety, transportation, housing) bringing together women's groups, community organizations and other public stakeholders, men and women | | |
| Regular city-wide public assemblies, as well as at the borough, neighbourhood and district level | | |
| TOTAL | | |

***Results of your City's Evaluation***

How many of these **27** optimal gender-equality and good-governance measures are already in place in your municipality?

If you checked YES to between **0** and **7** items, you need to get cracking and study what other cities are doing.

You're on the right road if YES was your answer to between **8** and **16** items. Keep up the good work.

YES was your answer to between **17** and **27** items? Congratulations! But please don't rest on your laurels.

If you think your city would make a good case study, please fill out the online questionnaire at the City of Montreal's *Femmes et ville* site at: www.montreal.qc.ca/femmesetville

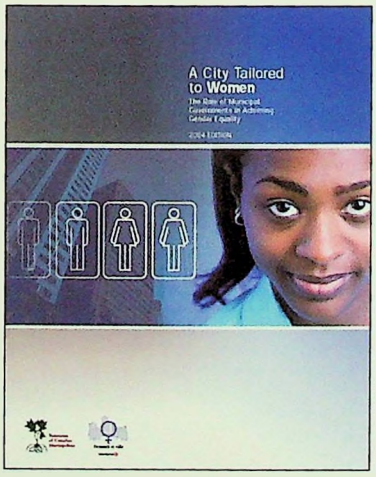
Thank you for your contribution!

This questionnaire is taken from:
**A City Tailored to Women**
*The Role of Municipal Governments in Achieving Gender Equality*
*2004 edition*

To obtain a copy or to consult this document online (as of May 15, 2004), visit:
www.icmd-cidm.ca or
www.ville.montreal.qc.ca/femmesetville

Federation of Canadian Municipalities

Femmes et ville
Montréal



Cordaid

Dear all,

We are very happy that you are coming all the way to Holland in order to participate in Cordaid's Gender Workshop. We think that it would be nice if you have the opportuntiy to see and taste something of our country during your stay. Therefore we love to invite you for a tour through the "smallest village of Holland" on Sunday May 9, 2004. The "smallest village of Holland" is "Madurodam", for more than 50 years Holland's smallest city. The canal houses of Amsterdam, the Alkmaar cheese market and parts of the Delta Works, all replicated in minute detail on a 1:25 scale. All is set in beautiful gardens (see also www.madurodam.nl). See the airplanes on the new Amsterdam Airport Schiphol. Watch windmills turn, ships sail and modern trains traverse the city on the world's largest miniature railway.

My collegue, Mrs Birgit Deuss, and myself will pick you up at your hotel on Sunday May 9, 2004 at 13.00 hrs (Delta Hotel) / 13.30 hrs. (Sebel Hotel). From there on we will take the tram (a real Dutch way of transport) to "Madurodam" (10 minutes). We will be back at the Hotel around 17.30 hrs. Anybody interested in coming with us, is requested to gather in the lobby of the Hotel at the times mentioned above.

Hope to see you Sunday (May 9, 2004)!

Yours sincerely,
Cordaid
Hèlen Beijersbergen
Management Assistant
Quality Assurance and Strategy Department

Email: hbh@cordaid.nl
Telephone: ++ 31 (0)70-3136316

Cordaid file
12/5

Com H-74.

## Helen Beyersbergen

**From:** Helen Beyersbergen
**Sent:** maandag 26 april 2004 11:42
**To:** Women's Voice Malawi, Mrs. Makoko Chirwa; ADOPEN, Mrs. Mercedes Canalda de Beras-Goico; ADOPEN, Mrs. Mercedes Canalda de Beras-Goico II; ADOPEN, Mrs. Mercedes Canalda de Beras-Goico III; ARK Foundation, Mrs. Angela Dwamena-Aboagye; AWID, Mrs. Johanna Kerr; Community Health Cell, Mrs. Thelma Narayan; Cordaid Malaku, Mrs. Nicole Spijkerman III; Cordaid Maluku, Mrs. Nicole Spijkerman; Cordaid Maluku, Mrs. Nicole Spijkerman II; Cordaid Nairobi, Mrs. Safia Abdi; Veldkantoor Nairobi; Corporación Mujeres que Crean, Mrs. Leonor Esquerra; FAWE, Ms. Christiana Thorpe; FAWE, Ms. Christiana Thorpe; Femmes Africa Solidarité, Mrs. Bineta Diop; Francoise Bigirimana; GAP-ISRCDE, Dr. Ms. Radium D. Bhattacharya; GAP-SRCDE, Dr. Ms. Radium D. Bhattacharya; Huairou Committee, Mrs. Jan Peterson; LKTS, Mrs. S. Sawitri; LKTS, Mrs. S. Sawitri II; Mrs. Aleli Marcelino; Mrs. Ira Febriana; Mrs. Ira Febriana II; Response, Mrs. Loretta Joseph; SEND Ghana, Ms. Lawrencia Wonnia; SEND Ghana, Ms. Lawrencia Wonnia II; Women's Studies Center, Mrs. Aline Batarseh
**Cc:** Marjolijn Wilmink
**Subject:** Cordaid Gender Workshop Logistics during the week-end

Dear all,

This is just to inform you that Marjolijn Wilmink will be visiting the hotel your will stay during your visit in the Netherlands with regard to the Cordaid Gender Workshop on May 10-11 2004. She will visit your hotel in order for you to present to her any questions you have with regards to the workshop or the logistics.
Marjolijn will be visiting the Sebel Hotel on Sunday evening May 9, 2004 at 19.00 hrs. She will visit the Delta Hotel at 20.00 hrs.

For emergency situation only, Marjolijn is available in the week-end at the following telephone number: 070-3927753.

Yours sincerely,
Cordaid
Hèlen Beijersbergen
Management Assistant
Quality Assurance and Strategy Department

Email: hbh@cordaid.nl
Telephone: ++ 31 (0)70-3136316

Cordaid file
12/5

Com H 3.4.

Cordaid

Dear all,

As promised I still would sent you some details on the hotel- and conference location of the Cordaid Gender Workshop on May 10-11, 2004.

You are situated in either the Delta Hotel, or the Sebel Hotel. Both are in the Hague, nearby Cordaid's office.

The addresses are:

**Delta Hotel**
Anna Paulownastraat 8
2518 BE The Hague
Tel.: ++ 31 (0)70-3624999
Fax.: ++ 31 (0)70-344440
Email: dhdh@xs4all.nl

**Sebel Hotel**
Zoutmanstraat 40
2518 GR The Hague
Tel.: ++ 31 (0)70-3459200
Fax.: ++ 31 (0)70-3455855
Email: info@hotelsebel.nl
www.hotelsebel.nl

Enclosed you will find an overview of which participants stay in the Delta Hotel and which in the Sebel Hotel.

Upon arrival at "Amsterdam Schiphol Airport" you have to travel by train to the Hague. You will find "the Schiphol Railway Station" on the Schiphol area, just follow the signs to the Schiphol Railway Station. Buy a ticket from Schiphol Railway Station to "The Hague Hollands Spoor Station". This train leaves about every 10 minutes and will cost you about € 6,40. Ofcourse Cordaid will reimburse these costs. The trip to the Hague will take you about 20 minutes. Upon arrival at "The Hague Hollands Spoor" you either go to the Delta Hotel or the Sebel Hotel.

For the Delta Hotel you take tram 8 from "the Hague Hollands Spoor". You can buy a ticket with the tram driver. This will cost you about € 2,50. You get of at the tram stop 'Mauritskade/Alexanderstraat'. Then you walk into the direction of the "Piet Heinplein". This will take you about 4 to 5 minutes.

For the Sebel Hotel you take tram 17 (direction "Statenkwartier") from "the Hague Hollands Spoor". You can buy a ticket with the tram driver. This will cost you about
€ 2,50. You get of at the tramstop "Elandstraat" and walk into the Zoutmanstraat (the tram goes in there as well).
You will find the Sebel Hotel on your left hand side (no. 40).

Ofcourse you can also take a taxi from "The Hague Hollands Spoor" to your hotel. Taxis are available in front of the "The Hague Hollands Spoor Railway Station". Ask the taxi driver to take you to one of the addresses as written above. This will cost you about € 15,-.

Cordaid will pay for your return ticket, local transport, visa costs, accommodation for a maximum of 5 nights, food and beverages. Cordaid will NOT pay for:
- fees and additional DSAs
- international telephone calls
- over 3 beverages per day at your hotel

**The Conference location**
The Conference location for the Gender Workshop on May 10 and May 11, 2004 is "Concordia Theatherzalen". This is nearby Cordaid's office, just a 5-minute-walk. On Monday morning May 10, 2004, we will gather at Cordaid's office in order to walk together to the "Concordia Theatherzalen". To

Cordaid fax 12/5/04

be sure, here is the address of "Concordia": Hoge Zand 42, 2512 EM The Hague, tel.: ++ 31 (0)70-3022680, Fax: ++ 31 (0)70-3022681. Email: info@theater-concordia.nl

The workshop will start at 09.00 hrs, so we request you to be at Cordaid's office at 08.45 hrs. The address of Cordaid is: Lutherse Burgwal 10, the Hague.
Tel.: ++ 31 (0)70-3136300, Fax.: ++ 31 (0)70-3136301, Email: hbh@cordaid.nl. One of our people will be picking you up at 08.30 hrs. at the hotel in order to bring you, by foot or by tram, to Cordaid's office.

To be sure: you can also take a tram to Cordaid. Ask the people at the hotel which tram you should take to go to the "Grote Markt". Get off at the "Grote Markt" stop, from there it is one minute walk to the "Lutherse Burgwal". As said, Cordaid is located at no. 10. Enclosed you will find a full description on how to get to Cordaid's office.

On May 10, 2004, the workshop ends at 18.00 hrs. Afterwards you will be invited to have dinner.
On May 11, 2004 the workshop will start again at 09.00 hrs, and therefore we again request you to be at Cordaid's office at 08.45 hrs. At 12.30 hrs there is a lunch, after which you will all go to the Cordaid office on foot. The workshop ends at 17.00 hrs at Cordaid's office.

I hope this information is sufficient. If you have any questions, please do not hesitate to contact me.

Yours sincerely,
Cordaid
Hèlen Beijersbergen
Management Assistant

Quality Assurance and Strategy Department

Email: hbh@cordaid.nl
Telephone: ++ 31 (0)70-3136316

Overview Delta and Sebel Hotel...

Cordaid
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| Name | Organisation | Country | Conf. Participation | Arrival | | Departure | |
|---|---|---|---|---|---|---|---|
| | | | received? | day | time | day | time |
| Mrs Helen Yamo | FAS | Switzerland | yes | May 9 | 16.30 | May 12 | 08.30 |
| Mrs. Emma Lindsay | FAS | Switzerland | yes | May 10 | | May 12 | |
| Mrs. Angela Dwamena-Aboagye | ARK Foundation | Ghana | yes | May 10 | 06.10 | May 15 | 14.20 |
| Ms. Lawrencia Womie | SEND | Ghana | yes | May 8 | 06.00 | May 13 | 15.00 |
| Ms. Christiana Thorpe | FAWE | Sierra Leone | yes | May 7 | 07.30 | May 12 | 07.10 |
| Ms. Francoise Bigirimana | | Burundi | yes | May 9 | 8.00 | May 16 | 18.00 |
| Mrs. Makoko Chirwa | Women's Voice Malawi | Malawi | yes | May 9 | ? | May 15 | ? |
| Ms. Loretta Joseph | Response | South-Africa | yes | May 8 | 10.00 | May 14 | 14.50 |
| Aleli Marcelino | Sarilaya | Philippines | yes | May 9 | 10.40 | May 14 | 14.25 |
| Mrs. Radium Bhattacharya | GAP | India | yes | May 9 | afternoon | May 14 | |
| Mrs. Thelma Narayan | CHC | India | yes | May 9 | | May 12 | |
| Mrs. S. Sawitri | LKTS | Indonesia | yes | May 9 | 06.35 | May 14 | 12.00 |
| Ms. Ira Febriana | | Indonesia | yes | May 9 | 06.35 | May 14 | 12.00 |
| Ms. Nicole Spijkerman | Cordaid Molukken | Molucs | yes | May 9 | evening | May 12 | morning |
| Mrs. Leonor Esquerra | Corporacion Mujeres que Crean | Colombia | yes | May 9 | | May 15 | |
| Mrs. Mercedes Canalda | ADOPEN | Dominican Republic | yes | May 9 | | May 11 | |
| Mrs. Aline Batarseh | Women's Studies Centre | Israel | yes | May 7 | 09.35 | May 12 | 19.50 |
| Mrs. Safia Abdi | Cordaid Kenya | Kenya | yes | May 9 | 18.00 | May 11 | ? |
| Mrs. Jan Peterson | Huairou Commission | USA | yes | May 9 | 14.45 | May 14 | 15.30 |
| Mrs. Esther Mwaura-Muiru | HC Groots Kenya | Kenya | yes | May 9 | 20.00 | May 14 | 10.45 |
| Mrs. Sri Husnaini Sofjan | HC AWAS | ? | yes | May 9 | 14.45 | May 14 | 13.40 |
| Mrs. Maria Teresa Rodigruez | HC Fundacion Guatemala | Guatemala | yes | May 9 | | May 13 | morning |
| Mrs Sandy Schilen | HC Groots International | USA | yes | May 9 | 14.45 | May 14 | 15.30 |
| Mrs. Joanna Kerr | AWID | USA | yes | May 8 | 12.00 | May 11 | 18.00 |
| Mrs. Hettie Walters | IAC | Nederland | yes | May 9 | | May 11 | |

| | |
|---|---|
| | Delta Hotel |
| | Sebel Hotel |

**Public transport**

The best way to get to Cordaid is by public transport. Take the bus (25, 123, 126 or 130) or the tram (2 or 6) from *Den Haag Centraal Station* (CS) and get off at the *Grote Markt* stop. From *Den Haag Hollands Spoor* (HS) take tram 10 to the *Grote Markt* stop. From here it is a one minute walk to the *Lutherse Burgwal*. Cordaid is located at No. 10.

**On foot**

From *Den Haag Centraal Station* (CS)

The *Lutherse Burgwal* is a quarter of an hour's walk. At the station, take the side exit on platform 1. Cross the *Rijnstraat* at the tram tracks and go down the *Turfmarkt*. Keep straight on past a big white building (*het Ministerie van VROM*). Turn right at the *Spui* and take the first street on the left, the *Gedempte Grach*. This joins up with the *Gedempte Burgwal*. The fifth street on the right is the *Lutherse Burgwal*. Cordaid is located on the left at No. 10.

From *Den Haag Hollands Spoor* (HS)

The *Lutherse Burgwal* is a quarter of an hour's walk. From the station, you walk straight into the *Stationsweg*. After the bridge, this joins up with the *Wagenstraat*. Then take the second street on the left, the *Stille Veerkade*. Turn right at the T-junction into the *Paviljoensgracht*. This joins up with the *Lutherse Burgwal*. Cordaid is located on the right at No. 10.

**By car**

Cordaid's advice is to use public transport. Parking facilities in the vicinity of the *Lutherse Burgwal* are extremely limited.

From Rotterdam, take the A13 and at the Ypenburg junction, follow the signs for Den Haag/Voorburg. From Amsterdam, take the A4 and take the A12 from Utrecht. From all directions: at the *Prins Clausplein* junction, follow the sign for Den Haag and turn onto the *Utrechtse baan*. Take Exit No. 2 in the direction of *Den Haag Centrum* (parking). Then turn left immediately, cross *the Prins Bernard- viaduct* and keep straight on. Cross the *Spui*. Turn right at the T-junction. This is the *Paviljoensgracht* which joins up with the *Lutherse Burgwal*. Cordaid is located on the right at No. 10.