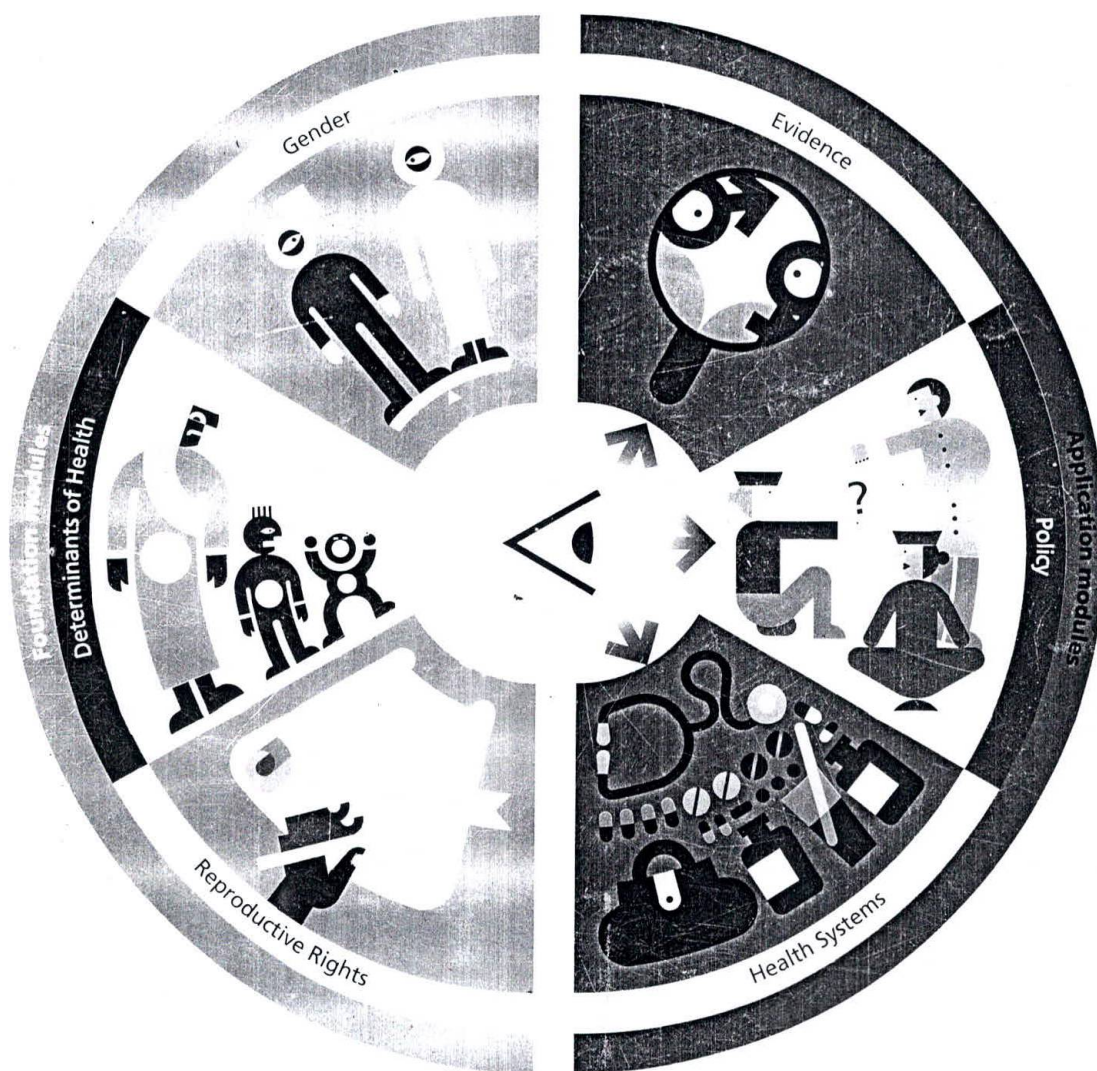


Gender and rights in reproductive and maternal health:

Manual for a learning workshop



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Preface

Globally, more than half a million maternal deaths occur each year, the majority of them in developing countries. Within countries, it is the poor and disadvantaged who suffer most. The majority of these deaths are preventable, even where resources are limited.

Reducing maternal mortality has become a public health priority. Goal 5 of the Millennium Development Goals (MDGs) calls for improvements in maternal health. It also calls for a reduction in the maternal mortality ratio by 75% of the 1990 level by 2015. To achieve this goal, a comprehensive approach to reproductive health and improvements in service delivery and accessibility are needed. However, these measures will not be sufficient by themselves.

Maternal mortality is like a litmus test on the status of women, their access to health care, and the adequacy of health systems in responding to their needs. High maternal mortality is a complex phenomenon, but all too often, it results from discriminatory practices against girls and women. Women's lack of power vis-à-vis men constrains decision-making about their health needs. It also constrains the level of investment in maternal health services and the quality of care women receive. Many studies indicate that women's low status is a major barrier to obtaining reproductive health services. In other words, fundamental inequalities between men and women and the neglect of women's rights contribute to the morbidity and mortality of women. Poor women are doubly disadvantaged in their access to services, as well as in their access to and control over economic resources.

It is crucially important to increase awareness of gender equality, to provide analytical and practical tools for health programme managers and others to address gender and reproductive rights. Moreover, it is vital to ensure both men's and women's participation in these efforts.

This manual aims to achieve exactly this objective. It is based on the 3-week training curriculum developed by WHO Geneva, *Transforming health systems: gender and rights in reproductive health*, a training curriculum for health programme managers. The longer course has been successfully conducted in various settings worldwide. However, experience has highlighted the usefulness of a shorter workshop. The course was thus condensed into a 5-day workshop to be conducted as a regional event. It was hosted by the Government of Malaysia in Kuala Lumpur from 28 November to 2 December 2005. The workshop was expanded to the 6-day format presented in this manual on the basis of the experience and feedback from participants in the Kuala Lumpur workshop.

The manual is intended for use in facilitating a 6-day workshop on gender and rights in reproductive and maternal health for health managers, policy-makers and others with responsibilities in reproductive health. Other stakeholders working on advocacy and policy and programme change in reproductive health, such as nongovernmental organizations (NGOs) and international partners may also find it useful. Although designed as a stand-alone course, it could be integrated with pre- or in-service programmes on health systems, rights and gender.

Learning modules

Objectives of the workshop

At the end of the workshop, participants will:

- be acquainted with the underlying gender, social, economic and political determinants of reproductive health;
- have gained conceptual clarity on a rights-based and gender-sensitive approach to policies and programmes for maternal health;
- be able to apply the knowledge and skills gained to develop strategies to address gender and rights issues in maternal health within their own settings;
- be able to review national maternal-mortality-reduction efforts and identify key issues that need greater attention from a gender and rights perspective; and
- have an understanding of gender- and rights-related factors within the health system.

	Objectives Participants will:	Format of activities	Time
DAY 0 (a.m.) Session 1 Official opening and introduction to the course	<ul style="list-style-type: none"> be introduced to each other, to key facilitators and to the objectives and structure of the course 	<p>Official opening</p> <p>Brief ice-breaking exercise</p> <p>Exercise on expectations</p> <p>Input on course: history, objectives and structure</p>	<p>30 mins.</p> <p>40 mins.</p> <p>20 mins.</p> <p>30 mins.</p>
DAY 1 (a.m.) Session 2 Maternal health: dimensions of the problem	<ul style="list-style-type: none"> gain a regional overview of the topic and develop a common understanding of the urgency of addressing the problem be introduced to concepts of sexual and reproductive health and rights, and locate maternal health issues within this broader picture 	<p>Participants to share with their partners experiences of their encounters with maternal mortality (MM) and morbidity. Then some will share this with the whole group. An attempt will be made to identify associated factors</p> <p>Input on dimensions of the MM problem and key issues</p> <p>Participants to read definitions of sexual and reproductive health and rights, followed by a discussion, and summary by facilitator</p>	<p>30 mins.</p> <p>30 mins.</p> <p>1 h.</p>
DAY 1 (a.m.+p.m.) Session 3 Determinants of maternal health	<ul style="list-style-type: none"> be able to identify social determinants of maternal health and locate gender as one of these, and be aware that it is affected by and interacts with other determinants 	<p>Introduction to gender concepts and tool for gender analysis</p> <p>Spider's-web exercise and subsequent discussion</p>	<p>1 h.</p> <p>1h. 30 mins.</p>
DAY 1 (p.m.) Session 4 Identifying gender and poverty dimensions underlying medical causes	<ul style="list-style-type: none"> be able to analyse medical causes of maternal mortality and morbidity to identify their gender and poverty dimensions 	<p>Exercise to identify gender and poverty dimensions of medical causes of maternal mortality and morbidity</p>	<p>1 h. 30 mins.</p>
DAY 2 (a.m.) Session 5 A rights-based approach to making pregnancy safer	<ul style="list-style-type: none"> become aware that the promotion or violation of rights is easily identifiable and relevant to everyone's life understand the relationship of reproductive rights with human rights understand the impact that the promotion of rights or violation of rights can have on reproductive and sexual health be able to use a public-health- and rights-based approach for identifying and solving problems 	<p>Participants work in pairs, followed by large group discussion</p> <p>Brief input on basic concepts of human rights and rights related to safe pregnancy</p> <p>Input, individual work and group work interspersed with plenary discussion</p>	<p>45 mins.</p> <p>30 mins.</p> <p>1h. 45 mins.</p>
DAY 2 (p.m.) Session 6 "Engendering" indicators	<ul style="list-style-type: none"> be introduced to the concept of "engendering" indicators have some exposure to developing "engendered" indicators 	<p>Input by facilitator</p> <p>Group work to develop gender-sensitive indicators followed by presentations and discussion</p>	<p>45 mins.</p> <p>2 h. 15 mins.</p>

<p>DAY 3 (all day) Session 7</p> <p>Applying a gender and rights perspective to the functioning of a health centre (field visit)</p>	<ul style="list-style-type: none"> become familiar with observing and analysing various elements of a health facility with a gender and rights lens understand what elements are needed to make a health facility address gender and rights concerns 	<p>Participants to visit health facilities in small groups and carry out systematic observation of the quality of care, including whether attention was paid to gender and rights</p> <p>After returning from the field visit, participants will report back for a detailed discussion on what they have presented</p>	<p>3-4 h.</p> <p>1 h. 30 mins.</p>
<p>DAY 4 Session 8</p> <p>Health service delivery issues</p>	<ul style="list-style-type: none"> begin to look at health service delivery issues through a gender and rights lens understand gender and rights issues within service delivery for specific components of maternal and reproductive health care be familiar with health systems issues related to maternal health from MDG Task Force report 	<p>Role plays: the health system wheel exercise (modified to focus on the relevant maternal health issues)</p> <p>Input and participant seminars</p>	<p>1 h. 30 mins.</p> <p>1 h. 30 mins.</p>
<p>DAY 4 Session 9 Financing maternal health services</p>	<ul style="list-style-type: none"> have an understanding of the implications of different financing mechanisms for equitable access to pregnancy-related health services be introduced to costing safe motherhood and to innovations in financing pregnancy-related health care 	<p>Input by facilitator, followed by discussion</p> <p>Group reading of hand-out given as homework, and discussion in the plenary session</p>	<p>1 h.</p> <p>2 h.</p>
<p>DAY 5 Session 10</p> <p>Assessing policies and interventions from a gender and rights perspective</p>	<ul style="list-style-type: none"> learn about the characteristics of policies and interventions that integrate gender and rights concerns become familiar with a framework for analysing policies be introduced to strategies and good practices in reducing maternal mortality and morbidity 	<p>Brainstorming on what is a policy, and on "gender and rights"-sensitive policies</p> <p>Input on framework for analysing and influencing policy</p> <p>Panel presentation by selected participants</p>	<p>1 h. 30 mins.</p> <p>1 h. 30 mins.</p> <p>1 h. 30 mins.</p>
<p>DAY 5 Session 11 (p.m.) and DAY 6 (a.m.)</p> <p>Making change happen within our own settings</p>	<ul style="list-style-type: none"> reflect on their role as individuals in effecting change, and address emotional and psychological issues related to making changes apply what they have learnt in the course to identify one specific intervention that they can implement in their own setting 	<p>Sharing of individual experiences in making change happen and summary input by facilitator</p> <p>Briefing for working on one specific intervention that they can implement in their own setting. Start and continue as homework (making posters)</p> <p>Group poster presentations</p>	<p>45 mins.</p> <p>45 mins. plus homework</p> <p>2 h.</p>
<p>DAY 6 Session 12 (a.m.) Closing session</p>	<ul style="list-style-type: none"> consolidate what they have learnt on the course evaluate the course from their immediate perspective 	<ul style="list-style-type: none"> Input session consolidating all the modules Evaluation questionnaires to be completed by participants Formal closing 	<p>15 mins.</p> <p>30 mins.</p> <p>45 mins.</p>

Participants will:

- be introduced to each other and to the key facilitators;
- receive a brief introduction to gender issues;
- learn something about the history and background of the course; and
- be informed about administration and logistics.

[time: 2 hours]

- a hand-out containing statements for the ice-breaking exercise (see Box 1 below); and
- a set of cards and pens for each participant.

There are three major activities to be covered in this session. The session should ideally be scheduled for the evening before the actual workshop starts, to allow participants to get to know and to feel at ease with each other.

[time: 30 minutes]

Step 1: Facilitator's welcome

[time: 10 minutes]

Welcome participants and introduce yourself and other facilitators. Brief participants on the introductory activity.

Step 2: The human treasure hunt

[time: 30 minutes]

Hand each participant a sheet of statements about men, women and sexism (Box 1 gives some examples that may be suitably modified). Participants move around the room, stopping and talking to each other until they meet the specified number of persons who meet the criterion mentioned in a particular statement. They note the names of these people on their sheets. The game can be stopped after about 10 minutes. Debrief the group as a whole, asking participants who they identified as persons fulfilling the criterion mentioned in each statement. There should then be a discussion on what they have found out about the group. This should be quick and not take more than 10 minutes.

This exercise also has another purpose – that of introducing some gender concepts. These can be drawn out of responses to statements given in the human treasure hunt. For example, most people answer in the negative when asked whether their grandmother was a

working woman (statement 5). Most would not have had a kindergarten teacher who was male (statement 1), and so on. This facilitates the introduction of the concept of "gender division of labour". Many women may not be engaged in active sports, and this can be used to introduce the concept of gender norms and roles. Mention that these issues will be discussed in some detail during the next day's sessions.

Box 1. The human treasure hunt

- (1) Find someone who had a male kindergarten teacher when s/he was growing up.
- (2) Find one woman who is engaged in active sports.
- (3) Find one man who takes an active role in his children's school activities (for parents).
- (4) Find one person who has always had female bosses.
- (5) Find two people whose grandmothers were working women.
- (6) Find one person who has a woman employed as a driver or security officer in his/her place of work.

Activity 3: Introduction to the course

Step 1: Expectations

[time: 20 minutes]

Give each participant a card and a pen and ask them to write down their expectations for the course. Pin these on to a bulletin board and go over them after mentally categorizing them. Some of the categories of expectation that usually emerge are:

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

Step 2: Introduction to the course objectives and structure

[time: 20 minutes]

This is an appropriate moment to introduce course objectives and content. These may be presented in five minutes through a PowerPoint presentation. As you present the content, explain at what point in the programme and how expectations about knowledge and processes will be met. The facilitator of this session must be familiar with the course content and methodologies as well as the timetable.

Fulfilling some expectations depends more on the participants than on the facilitators (for example, "Learning from each others' experiences"). Some expectations are not likely to be met. These may be about the content of the course, or extracurricular activities. It is your responsibility to clarify which expectations the course cannot meet and to explain that it is not usually possible to meet all the expectations of a diverse group. But it may well be possible to accommodate some expectations – for example, a visit to a local nongovernmental organization – even if these were not originally planned.

Step 3: Administrative and logistical matters

[time: 10 minutes]

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

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

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

Go over the content of the course files with participants. Explain the various assignments and homework that will be a part of the course.

Adapted from Transforming health systems: gender and rights in reproductive health. Opening module, various sessions. Geneva, World Health Organization, 2001.

Session 2:

Maternal health: defining the problem

What participants should know

Participants will:

- gain a regional overview of the topic and develop a common understanding of the urgency of addressing the problem; and
- be introduced to concepts of sexual and reproductive health and rights, and locate maternal health issues within this broader picture.

[time: 2 hours]

Materials

- Hand-out: “Definitions of reproductive health and reproductive rights”
- PowerPoint presentation: Regional overview on maternal health issues
- Flipchart for writing down key points from participants’ sharing of ideas on maternal mortality and morbidity

How to run the session

This session consists of three activities. The first is an experiential exercise intended to spark participant involvement with issues around maternal and reproductive health at a personal level, and to become aware of the urgency of the issue. The second is an input providing an overview of the dimensions of maternal mortality and morbidity in the Region. The third is an interactive input to introduce concepts of sexual and reproductive health and rights. This highlights the linkages between the goals of improving maternal health and promoting sexual and reproductive health and rights.

Activity 1

[time: 30 minutes]

Participants are requested to turn to their neighbours and share their encounters with maternal mortality and/or morbidity. These may be their own experiences as health providers, or as individuals, or based on what they have heard from colleagues, families or community. This should take only about 10 minutes.

After 10 minutes, call upon participants to volunteer to share what they have discussed with their neighbours. Write down on a flipchart:

- characteristics of the woman involved (age, socioeconomic status, parity, etc.);
- cause of death – clinical as well as social;
- place of death; and
- whether the death could have been avoided.

Take about five examples and draw on these to highlight the human tragedy that maternal mortality and morbidity represent. Note down the social determinants related to mortality or morbidity in these examples (to discuss later in Session 3).

[time: 30 minutes]

Give a PowerPoint presentation providing an overview of:

- maternal mortality reduction in the MDG;
- maternal mortality and morbidity rates and causes in the Region;
- inequalities and differences across geographical areas and population groups; and
- an agenda for action to change the situation.

An overview paper may be prepared and circulated as a hand-out if considered useful.

[time: 1 hour]

It is important to point out the link between maternal health issues and the broader concept of reproductive health before finishing this session.

Hand out definitions of reproductive health, sexual health, reproductive rights and sexual rights. These must include paragraphs 7.2 and 7.3 of the International Conference on Population and Development (ICPD) Programme of Action and paragraph 96 of the Fourth World Conference on Women (FWCW) document from Beijing. You may note that the language of sexual rights is not used in the FWCW document. However, people in the field talk about paragraph 96 of the FWCW document as “the sexual rights paragraph” because it is about applying human rights to the area of sexuality.

Participants should read the definitions and clarify any doubts. You then make the link between reproductive and sexual rights and health and maternal health – highlighting how one cannot be achieved without the other. Safe pregnancy and child-bearing depend on the woman’s ability to decide whether and when to get pregnant and how many children to have. They also depend on her ability to terminate unwanted pregnancies safely, her access to care following a miscarriage, and so on. A woman’s reproductive and sexual health throughout her lifetime influences and is influenced by maternal health and overall health status.

Session developed by T.K. Sundari Ravindran, drawing on ideas from Transforming health systems: gender and rights in reproductive health. Opening module. Geneva, WHO, 2001.

Session 3: Determinants of Health

Participants will:

- be introduced to gender concepts and to a gender-analysis tool; and
- identify social determinants of maternal health and locate gender as one of these, and be aware that it is affected by and interacts with other determinants.

[time: 2 hours 30 minutes]

Materials:

- Hand-out 1: Concepts for gender analysis
- Hand-out 2: Gender-analysis tool
- PowerPoint: Introduction to gender concepts and gender-analysis tool
- Word document to project (overhead or LCD): Case study of a woman experiencing maternal mortality or serious morbidity
- a ball of twine or wool and a pair of scissors

This session consists of three activities. The first is an interactive discussion with inputs from the facilitator on gender concepts and the gender-analysis tool. The second is a participatory exercise known as “the spider’s web”. It involves reading out a case study of a woman suffering from ill-health, and unravelling the factors that contributed to it. The activity illustrates how so many factors are intertwined, using the analogy of the spider’s web. The third activity is a whole-group discussion to help participants understand both the links and the differences between sex, gender and other social determinants of health.

[time: 1 hour]

Step 1: Definitions

[time: 30 minutes]

Start with a brainstorming session on what participants understand by “gender” and write their responses on a flipchart. Ask participants whether they know how “gender” differs from “sex”, and elicit a few examples of such differences.

Distribute Hand-out 1 to participants and allow them about 10 minutes to read it individually. It contains definitions of commonly used gender concepts: the gender-based division of labour, gender roles and norms, access to and control over resources, and power. Clarify any doubts or questions that participants may have.

Conclude this step with a summary PowerPoint presentation with definitions of sex and gender and of gender concepts given in Hand-out 1.

Step 2: Gender-analysis tool

[time: 30 minutes]

Distribute Hand out 2, which contains one gender analysis tool and also an example of how the tool is applied to make a gender analysis of one health condition: malaria.

Put up an overhead or PowerPoint slide of the gender analysis tool (matrix) and take participants through the matrix. Give enough time for questions and clarifications.

[time: 1 hour 30 minutes]

Step 1: Divide up the room before the session begins

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

Floor plan:

SOCIOCULTURAL	GENDER
ECONOMIC	
POLITICAL	SEX

Step 2: Briefing

[time: 10 minutes]

Explain that this session builds on the earlier session in which the various social determinants of maternal health were identified after participants shared their personal experiences. Explain also that it aims to show the interlinkages between different determinants of maternal health, including gender. Get participants to stand in a wide circle around the floor plan. As facilitator, you will be standing at the centre of the floor plan. You should be facing the screen on which the case study will be projected.

Step 3: Case study

[time: 20 minutes]

Project the case study, which has the potential to provoke discussions on sex and gender and social, cultural, economic and political determinants of maternal health. One example of a case study is given in Box 2 and used here as an illustration.

Box 2: Jasmine's story

Jasmine was only 20 years old when she died. The first of three daughters of a poor agricultural labourer, Jasmine had studied only up to second standard. Her father could not afford it. The school was two kilometres away from her street and it was not considered appropriate for her to go unescorted. Her father also thought that educating a daughter was like “watering the neighbour’s garden”.

When she was 16 years old, Jasmine was married to a rich man of the peasant caste. She was his second wife. Jasmine’s father was only too pleased at his daughter’s good fortune.

Jasmine bore two children in quick succession. The first was a girl and the second, the much awaited male heir. This she did even before her nineteenth birthday. Both the children were born at home. When her son was just eight months old, Jasmine discovered that she had missed her periods for more than two months. She did not want to be pregnant again because her son was sickly, so she talked to a traditional midwife.

The traditional midwife suggested going to a private practitioner 10 kilometres away for an abortion. Jasmine had never gone anywhere outside unescorted, and she had to wait for a day when the midwife was able to come. Jasmine went there under the pretext of having her son immunized. The private practitioner was willing to perform the abortion, but her charges were unaffordable for Jasmine.

Jasmine returned home desperate. She attempted an abortion on her own, inserting a sharp object into her vagina. Within a week, Jasmine became very sick. When the pain started to become severe, Jasmine knew that she would need medical assistance. However, she hesitated to ask her husband to take her to the town hospital, because she did not know what explanation to give him. Her relationship with him was strained; she had heard that he was “seeing” another woman because Jasmine had become “sickly”. So Jasmine took some medicine for fever bought from a local store, and kept quiet. A couple of days later, Jasmine died of high fever without receiving any medical help.

Demonstrate how the spider’s web exercise works with one or two examples. Stand at the centre of the room with a ball of wool or twine. The participants take turns to read the case study in parts, and after each sentence or each couple of sentences, you call out, “But why?”

For example:

Facilitator: Jasmine stopped schooling after her second grade. But why?

Participant 1: Her school was three kilometres away from the village.

Facilitator: But why?

Participant 2: The village was a poor one, far away from the capital city.

The person giving this last answer has identified a reason that could be classified as economic – the backwardness of the village, or as political – the village’s lack of bargaining power to secure resources.

As soon as the participant identifies that the reason is that the village is powerless, the facilitator asks, "So how would you classify this factor?" The participant may say "economic". As soon as he or she says this, the person goes and stands in the square marked "economic". The facilitator, standing at the centre with the ball of twine, holds one end of the twine, and throws the ball to the participant standing in the "economic" square. You may probe further, and ask "Can you classify it as any other factor?" Another participant may say "political". She or he should go and stand in the "political" square, and the person standing in the "economic" square throws the ball to her or him, while holding on to the twine. Now all three are linked by the twine.

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

This continues, until by the end we are left with a complex spider's web of factors underlying Jasmine's death.

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

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

Step 4: Cutting the web

[time: 20 minutes]

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

Facilitator: If you were a local activist, where would you cut the web?

Participant: I would intervene to help Jasmine become economically independent.

Facilitator: If you were the nurse at the local clinic, where would you cut the web?

Participant: I would be sensitive to the ways in which gender influences women's ability to prevent unwanted pregnancies. I would do all I could to ensure that women seeking abortion services were not sent back home without receiving the service.

Facilitator: If you were from the Department of Health of the national government, where would you cut the web?

Participant: I would advocate for liberalizing the laws on abortion.

And so on.

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

Activity 3: Whole-group discussion and reflection

[time: 40 minutes]

Step 1: Participants give feedback

[time: 15 minutes]

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

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

Step 2: Facilitator summarizes

[time: 25 minutes]

Where to start

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

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

Where is it most feasible?

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

The social-determinants perspective

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

Adapted from Transforming health systems: gender and rights in reproductive health. Module 2, Session 4. Geneva, WHO, 2001.

Participants will:

- be able to analyse medical causes of maternal mortality and morbidity to identify their gender and poverty dimensions.

[time: 1 hour 30 minutes]

- Hand-outs 1-4, each describing one situation of maternal morbidity
- Flipcharts

This session starts with a small group activity in which participants explore a health problem and identify gender and poverty factors underlying many medical causes of maternal mortality or morbidity.

[time: 50 minutes]

Step 1: Instructions for the activity

[time: 10 minutes]

Divide participants into four groups. Distribute Hand-outs 1-4 with instructions for group work. Each group does the same exercise but for different maternal health problems. Their main tasks are:

- to analyse the reasons underlying a negative maternal health outcome; and
- to identify and circle in red factors that are related to poverty; and circle in blue factors that are related to gender.

Step 2: "But why?"

[time: 40 minutes]

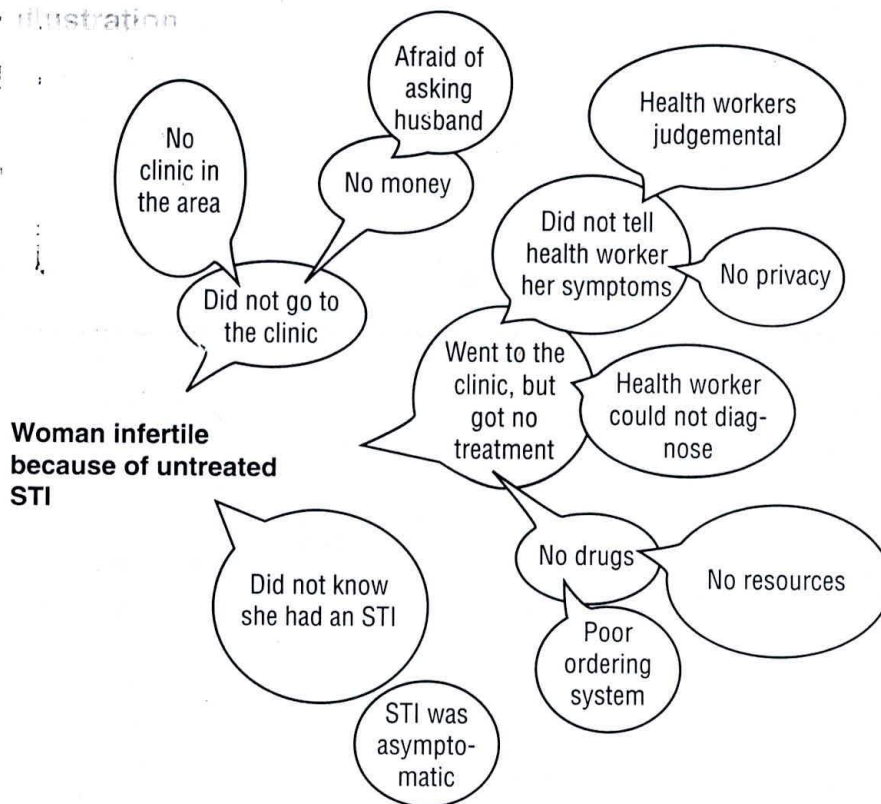
Starting with the statement written at the bottom left corner of a large sheet of paper, groups ask "But why?" They write the reason in a bubble next to the statement.

They keep asking “But why?” until the line of argument is exhausted. Each reason has to flow directly from the one before, to be written in a bubble and to be clustered next to the others. Then participants begin with the original statement and explore another reason why the woman experienced a negative maternal health outcome.

Participants must give as many reasons as possible in as much detail as possible. Each circle should contain a single specific issue. For example, “culture” is not acceptable as a reason: the group must define what it is about the culture that is the reason in this specific instance. For example, it could be that women are expected to have sex whenever their husbands want to.

The following is an illustration of how this exercise is done for a problem related to infertility.

Illustration



[time: 40 minutes]

Each group in turn presents one problem and the chain of events. Ask questions after each presentation, challenging participants to clarify their line of reasoning. Explain how gender and poverty influence the health conditions. Each report and related discussion should be completed within 10 minutes or so. The facilitator summarizes at the end of each presentation and discussion.

New activity based on an exercise from WHO. Transforming health systems: gender and rights in reproductive health. Module 6, Session 3. Geneva, WHO, 2001.

Participants will:

- become aware that the promotion or violation of rights is easily identifiable and relevant to everyone's life;
- understand the relationship of reproductive rights with human rights;
- understand the impact that the promotion of rights or violation of rights can have on reproductive and sexual health; and
- be able to use a public health- and rights-based approach for identifying and solving problems.

[time: 3 hours]

- Hand-out 1 of the Universal declaration of human rights – this can be downloaded from www.unhchr.ch/html/intlinst.htm
- Hand-out 2: “A case study for analysing a reproductive health intervention”
- Overhead or Word file for projection: Four quadrants
- Flipchart or board to write on
- PowerPoint presentation on the Right to Health and its application to maternal health
- Essential reading as homework on the day before the session:
 - (a) Freedman L.P. Shifting visions: “delegation” policies and the building of a “rights-based” approach to maternal mortality. *Journal of the American Medical Women's Association*, 2002, 57(3): 154-158 (enclosed)
 - (b) UNICEF. Saving women's lives: a call to rights based action. UN Regional Office for South Asia, 2000: 9-19

This session consists of three activities. The first is conducted in pairs to identify rights violations, followed by a discussion with the whole group. The second activity is an interactive input by the facilitator on the “Right to health and rights related to safe pregnancy and delivery”. In the third activity, participants work individually and in groups, interspersed with facilitator inputs.

[time: 45 minutes]

Step 1: Working in pairs

[time: 15 minutes]

The first activity should take place with no reference or access to any human rights document. Participants work in pairs to identify situations in which they feel a sexual or

reproductive right was violated. These may be based on their own personal experiences or on the experiences of others.

Ask each participant to spend two minutes alone recalling one incident when s/he felt that a right was violated, and to share this with his/her neighbour. The person sharing the recollection should try to name which rights she or he thinks were relevant to the story and in what ways.

Step 2: Whole-group feedback

[time: 15 minutes]

Ask participants to volunteer to share stories about what they consider to be violations of rights that impact on sexual and reproductive health, or about the violation of reproductive and sexual rights. Some examples that have previously come up include:

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

Step 3: The Universal declaration of human rights

[time: 15 minutes]

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

Go over each of the rights listed on the board or flipchart and ask participants to identify which article in the UDHR most closely addresses it.

[time: about 30 minutes]

Prepare a PowerPoint presentation on the right to health and rights related to safe pregnancy and motherhood. The main points to be covered in this presentation include:

- the meaning of the right to health;
- the state's obligation to respect, protect and fulfil individuals' right to health;
- application of human rights principles to maternal and reproductive health: some examples of rights involved; and
- an explanation of what the "value-added" is when a rights-based approach is adopted to sexual and reproductive health programming, with illustrative examples.

[time: 1 hour 45 minutes]

Step 1: A methodology for maximizing the public health and human rights elements of policies and programmes

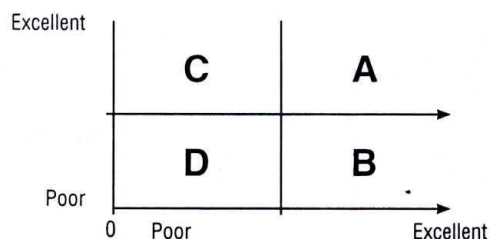
[time: 20 minutes]

Introduce participants to the following methodology.¹ It attempts to maximize both the public health and human rights quality of policies and programmes. There are four steps:

- (1) Considering the extent to which a policy or programme represents good public health.
- (2) Considering the extent to which it is respectful of and promotes rights.
- (3) Considering how to get the best balance between health and rights.
- (4) Considering whether this is the best approach for dealing with the public health goal that the policy or programme seeks to address.

This [overhead] chart helps you go through the steps:

Four quadrants: The quality of human rights and public health in a programme



Sector explanations:

A: best case

B: need to improve HR quality

C: need to improve PH quality

D: worst case: need to improve both PH and HR quality

- vertical axis: human rights quality
- horizontal axis: public health quality
- quadrant A: optimal human rights and optimal public health
- quadrant B: excellent public health, but human rights aspect needs to be improved
- quadrant C: human rights aspect is fine, but public health suffers
- quadrant D: bad public health and bad human rights

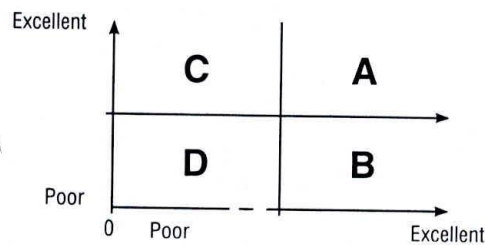
¹ This methodology is adapted from: International Federation of Red Cross and Red Crescent Societies and the François-Xavier Bagnoud Centre for Health and Human Rights. *The public health-human rights dialogue*. In: Mann J.M., Gruskin S., Grodin M.A., Annas G.J., eds. *Health and human rights: a reader*. New York, Routledge, 1999: 46-53.

The assumption is, generally, that in designing and implementing a health policy or programme, quadrant A is where one would prefer to be. A programme or policy that is respectful of rights, while still achieving its public health goal, is going to be better than one that limits or restricts rights.

How do we use the chart to work through a policy or programme in order to maximize both the public health and human rights aspects?

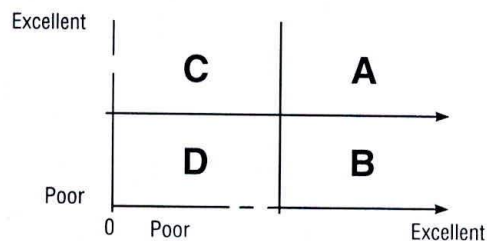
The first step: What makes a good public health intervention?

Mark the extent to which the policy promotes and is good for public health as a point P along the horizontal axis (see Figure 1 below). If the point lies within quadrant B, this indicates good public health quality, and the further right the point, the better it is. If the point lies within quadrant D, this indicates poor public health quality, and the further left the point, the poorer the quality.



The second step: Consider the rights aspect of the policy

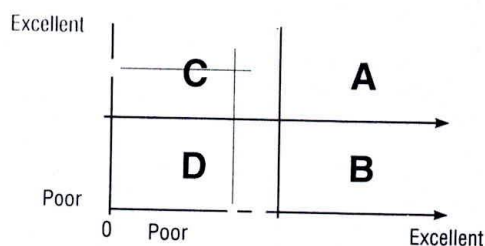
Consider the rights aspect of the policy and mark this as a point Q along the vertical axis (see Figure 2 below). If the point lies within quadrant C, this indicates good human rights quality, and the further north the point, the better the human rights quality is. If the point lies within quadrant D, this indicates poor human rights quality, and the further south the point, the poorer it is.



Suggest that determining the human rights value of a policy or programme can be done by considering each of the rights in the UDHR and determining for each right whether it is positively or negatively impacted upon, or irrelevant. Ask participants to remember government obligations as well as the Siracusa principles. Make it clear that sex-based discrimination in the UDHR should be integrated across the various relevant rights in the UDHR.

The third step: Where public health and human rights intersect

Draw a vertical line from P on the horizontal axis and a horizontal line from Q on the vertical axis. The point of intersection of these two lines, R, gives the quadrant in which the policy lies for its public health and human rights quality (see Figure 3 below).



The goal is to be in quadrant A or move towards it by working through the various aspects of the policy.

Step 1: Assessing the quality of public health

[time: 1 hour 25 minutes]

Step 1: Assessing the quality of public health

[time: 10 minutes]

Give each participant a copy of a case study of a health intervention with instructions for analysing its public health and human rights quality. The hand-out given here is an example. While the steps for analysis stay the same, you may wish to substitute this case study with another.

Participants complete the public health analysis of the intervention. They may discuss this with their neighbours before reaching a decision.

Step 2: Whole-group discussion on public health quality

[time: 20 minutes]

After participants have analysed the public health quality of the intervention, they move into a whole-group discussion.

Ask participants these questions, which are linked to the public health quality of the intervention:

- What are the reasons for focusing on this population?

- presumption that they are at a higher risk of being infected;
 - large number of sex partners from whom and to whom they could presumably receive or transmit infection;
 - real or perceived lack of power to negotiate condom use with clients;
 - increased likelihood of having other STIs: assumption that they are more likely than other people to contract HIV and spread it to others (their clients); and
 - politically expedient: looks like something is being done.
- Why not focus on testing clients?
 - Is there likely to be pre- and post-test counselling?
 - What test is likely to be used? How accurate is the test given at six-monthly intervals likely to be?
 - Will all sex workers be tested? Which sex workers are likely to be identified?
 - What happens to sex workers once they are found to be infected?
 - If their sex workers' cards are removed, are these women likely to find other sources of financial support immediately? Why do women generally engage in sex work? Will this need go away if they are found to be infected? Will revoking their cards impact on sex workers' ability to use health and other services?
 - Does this approach in any way control the clients' rate of transmission to these women?
 - Given the health commissioner's concerns, is this approach likely to be effective in preventing heterosexual transmission?

Put up your [overhead] transparency of "Four quadrants: The quality of human rights and public health in a programme". What is the level of consensus among participants on the public health quality of the intervention? Call out at each point beginning with O along the horizontal axis of the chart, running your pen along the axis. Ask participants to raise their hands when they think you have reached the quality of the intervention. Mark this point on the horizontal axis. Let this point be P.

Step 3: A rights analysis using the UDHR

[time: 10 minutes]

Now ask participants to carry out a rights analysis of the intervention using the UDHR. Are any of the rights being restricted? If yes, are these restrictions valid under the Siracusa principles? Participants work individually, consulting with their neighbours if they want to. Make it clear that sex-based discrimination, which a gender analysis would reveal, is included in this analysis.

Step 4: Whole-group discussion on human rights quality

[time: 20 minutes]

Facilitate a discussion in the large group on the human rights quality of the intervention.

Rights to be considered and discussed include Articles 1, 2, 3, 5, 6, 7, 8, 9, 12, 13, 20, 21, 22, 23, 25, 27 and 29. While many of these rights may not be immediately relevant to the example provided, a discussion will allow consideration of the proposed intervention from a rights framework.

Step 5: Where do the quality of public health and human rights intersect for this intervention?

[time: 10 minutes]

Put up your [overhead] transparency of “Four quadrants: The quality of human rights and public health in a programme” again, with point P now marked on it. Determine the consensus for the human rights quality of the intervention. Call out at each point, beginning with O, along the vertical axis of the chart, running your pen along the axis. Ask participants to raise their hands when they think you have reached the quality of the intervention. Mark this point Q on the vertical axis.

Draw a vertical line through point P and a horizontal line through point Q. Mark the point of intersection R. In the case provided in the hand-out, this point R is likely to lie in quadrant D. In other words, the intervention is of poor public health as well as poor human rights quality.

Step 6: Discussion: How to move towards quadrant A

[time: 15 minutes]

Focus the discussion on what specific changes would be needed for this intervention to move towards quadrant A.

- How can we make the public health objective respond to the problem in a manner that is as targeted, precise and gender-sensitive as possible?
- How can we make the response to the problem more effective?
- Is the policy/programme overly restrictive or intrusive – for example, does it reach too many or too few people?
- What changes do participants propose to reduce the severity, scope and duration of the burdens arising from the policy?
- What does improving human rights do to the public health quality of the intervention?

Participants may propose a number of different options. You can discuss each of these in relation to whether they are of a better public health and human rights quality than the example. Anonymous voluntary testing and counselling sites available to the general population, including sex workers, and the promotion of condom use are usually seen as having better human rights and public health quality. However, there may be debates about feasibility and coverage.

Policies and programmes that respect rights are actually better and more effective. Human rights and public health concerns are not incompatible.

Considering human rights in health policies and programmes

Considering human rights in the design, implementation or evaluation of health policies and programmes is a useful way to determine whether existing health policies and programmes promote or violate rights (especially gender equality) and to judge their effectiveness.

Public health decisions and human rights

Public health decisions are often made for political expediency, without consideration of their effects on human rights, and even to some degree their effect on public health.

Responsibility

- People working in public health have a responsibility to look at whether human rights are promoted, neglected or violated by actions taken in the name of public health.
- The links to the government that exist for anyone working in public health, whether as an agent of the state or because they receive government funding, impose a dual obligation to promote and protect health, as well as to promote and protect human rights.
- People working in public health have the power to decide to restrict rights, so this responsibility has to be taken seriously.

Health policies or programmes that violate rights have long-term negative consequences in that they make it harder for people and communities to trust any policies or programmes.

Adapted from Transforming health systems: gender and rights in reproductive health. Module 3, Sessions 1, 2 and 3. Geneva, WHO, 2001.

Participants will:

- be introduced to the concept of “engendering” indicators; and
- have some experience with developing “engendered” indicators.

[time: 3 hours]

- Hand-out 1: “Definitions of some maternal health indicators”
- Hand-out 2: Instruction for group work on “engendering” reproductive health indicators
- PowerPoint presentation on “engendering” indicators

Indicators to monitor maternal health goals: report of a technical working group, Geneva, 8–12 November 1993. Geneva, World Health Organization, 1997

There are three activities. The first is a brief discussion in the large group to identify definitions of some commonly used maternal health indicators. The second activity is an input session by the facilitator. The third is a group activity to evolve “engendered” indicators to monitor some reproductive health programmes.

[time: 45 minutes]

Step 1: What is a health indicator?

[time: 15 minutes]

Begin by defining what health indicators are, and give some examples. A health indicator is usually a numerical measure that provides information about a complex situation or event. When you want to know about a situation or event and cannot study each of the many factors that contribute to it, you use an indicator that best summarizes the situation. For example, to understand the general health status of infants in a country, the key indicators are infant mortality rates and the proportion of infants of low birth weight.

Ask participants to tell you the difference between rates and ratios, and explain these concepts if necessary.

An indicator is a rate or proportion when the numerator is included in the population defined by the denominator.² For example, the literacy rate in a population has literate persons in the numerator and total population in the denominator.

An indicator is a ratio when it is an expression of a relationship between a numerator and a denominator in which the two are usually two separate and distinct quantities.³ For example, the population sex ratio has as numerator the number of males in the population, and in the denominator the number of females in the population.

Elicit from participants the definitions of some commonly used maternal health indicators. You may choose some from Hand-out 1.

[time: 30 minutes]

Provide an input on the meaning of “engendered” indicators and ways in which indicators may be developed or modified to capture the gender dimensions of maternal and reproductive health.

[time: 2 hours 15 minutes]

Step 1: Group work

[time: 45 minutes]

Divide participants into four groups. Each group is given a hypothetical reproductive health project for which they must develop indicators (Hand-out 2).

Step 2: Reporting back

[time: 1 hour 30 minutes]

One person from each group reports back to the whole group on:

- the reproductive health project under consideration;
- indicators to be used and their definitions;
- the attempt made to bring gender and rights dimensions into one or more of the indicators;
- mode of collection of information on these indicators; and
- how often the information will be collected (for example, census information is collected once in a decade).

Each presentation should last no more than 10 minutes and may be followed by a 10-minute discussion. Some of the indicators that may emerge from each of the groups are outlined below.

² Last J.M. et al. *A dictionary of epidemiology*. New York, Oxford University Press, 1995.

³ *Ibid.*

- proportion of female adolescents reporting condom use (this may be further refined, for example, to specify regularity of condom use, access to condoms, or whether a condom was used in their most recent sexual encounter);
- 15–19-year-olds as a proportion of all abortion-related obstetric and gynaecology admissions; and
- proportion of women in the 15–19 age group who have had one or more children or are currently pregnant.

- percentage distribution of maternal deaths by place of death;
- proportion of women who died at home or on their way to the hospital because the hospital was too far away;
- percentage distribution of maternal deaths in hospital, by time between admission and death; and
- proportion of women reporting a delivery complication who delivered in a health facility.

- percentage distribution of all women using contraceptives, by method used;
- proportion of women and men reporting that they were given adequate information on the various contraceptive options available;
- proportion of contraceptive users who are men;
- proportion of contraceptive users reporting at least one follow-up contact with the health facility or health worker; and
- proportion of satisfied users at the end of X months following acceptance.

- proportion of clinic users who are aware of the symptoms of one or more RTIs/STIs;
- number (and/or proportion) of clients seeking treatment for RTI/STI;
- proportion of clients (by sex) whose partners have also sought treatment;
- proportion of those diagnosed with an RTI/STI who completed treatment (reasons for not completing treatment: cost? access? quality?); and
- proportion of those who completed treatment who are cured of the problem.

Which of the indicators addressed above had the potential to address the gender/rights dimensions of the issue? For example, in the Adolescent Reproductive Health project, information on condom use should be collected from both girls and boys. In addition to finding out the proportion of girls aged 15–19 who are currently pregnant or have had a child, the proportion of boys aged 15–19 who have either fathered a child or are responsible for a current pregnancy could also be an indicator. This information may be collected by asking girls who are mothers or are currently pregnant about the age of the father. Antenatal records in health centres could routinely collect data on the age of the father.

In the Safe Motherhood project, a gender/rights dimension may be added to the indicator on the distribution of maternal deaths in hospital by time duration between admission and

death. This can be done by asking about reasons for delay. Similarly, reasons for non-use of a health facility by women reporting a delivery complication would give insights into whether gender-based discrimination, through the lack of access to resources and power, or through roles and norms, played a role in this delay.

To add a gender dimension to indicators for the Family-Planning and RTI/STI programmes, indicators should be analysed by the sex of the respondent. Finding out reasons for non-use of any contraceptive method, or non-use of health services for RTI/STI from both women and men could also help bring out the role of gender in this.

Adapted from Transforming health systems: gender and rights in reproductive health. Module 4, Session 6. Geneva, WHO, 2001.

Participants will:

- become familiar with observing and analysing various elements of a health facility with a gender and rights lens; and
- understand what elements are needed to make a health facility address gender and rights concerns.

[time: 4 hours 30 minutes]

- Hand-out: "Guidelines for observation during visit to health facility"

This session consists of two parts. The first activity is a visit to a health facility. The second is a whole-group discussion and a detailed summary by the facilitator.

[time: 3 hours]

Step 1: Preparation

Before the session begins, give participants instructions as described in Step 2. If available, distribute brochures about the health facility and the services offered so that participants begin to familiarize themselves with the services offered by the clinic.

Step 2: Instructions for the activity

[time: 10 minutes]

Divide participants into four groups and distribute the hand-out. The hand-out will give clear instructions on what to observe and how to present the information when reporting back.

Explain that each group will visit one specific health facility. The group's task consists of observing, and when needed, interacting with clients/patients and health providers to gather details about the quality of health services, and the extent to which gender and rights issues have been taken into account when planning for the delivery of health services. In particular, they must observe the following elements of quality of care:

- client-provider interaction;
- information/counselling for client; and
- essential supplies, equipment and medication needed, plus norms and standards.

Tell them they have approximately two-and-a-half hours for the visit and then they must write up a group report for presentation to the class the next morning [30 minutes].

Step 3: Reporting back and discussion

[time: 1 hour 30 minutes]

The reporting-back session takes place on the same afternoon as the visit. Each group in turn has approximately 10 minutes to present its findings. The presentation should highlight:

- a general description of what the group observed about the health facility and its internal and external environment, staff presence, workload, and so on;
- what was present and what was missing in terms of quality-of-care elements listed below; and
- what needs to be done to make the clinic and the health facility address gender and rights concerns.

After each presentation, make sure you allocate sufficient time for discussing gender and rights issues.

What to cover in the discussion

- What are the gender- and rights-related aspects you identified in the service/clinic you visited?
- How do gender and rights impact on the internal and external environment, staff presence, workload, and so on? For instance, are there separate toilets for men and women? Are there any separate rooms for consultation and counselling? Are the women accompanied by their husbands? If yes, does this mean there is gender equality? In terms of service providers, are there more female than male workers? If yes, why? What does this show? Usually reproductive health (RH) services are dominated by female workers. Could this also influence men's access to these services?
- It is also important to raise issues related to rights, such as privacy and confidentiality and whether these are maintained during the consultation. If the consultations take place in separate rooms, we may assume there is privacy, but what if the personal medical dossiers are not kept locked and anyone who walks in can easily read them?
- Another issue is informed consent and whether people are informed about the health examination or the treatment they may undergo. This is also linked to a person's right to information and self-determination. People should obtain sufficient information about the medical examination they are undergoing or a treatment they may have to follow in order to make an informed choice. Information, education and communication (IEC) materials in the waiting rooms and consultation rooms can also help raise people's knowledge and information about specific health issues.
- Time may also be a constraint for people to access services. For instance, different opening times for specific services may be an extra burden for women who may have to come back several times to the clinic to obtain different services.



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It is important to highlight that gender and rights aspects are not obstacles, but that they help improve the quality of health services. Summarize some of the main gender and rights points brought up during the discussion. In particular, mention that quality-of-care problems are often not just due to technical details or medical causes, but they are also related to ignoring gender and rights issues within a health service setting.

Session developed by Ashraf Badri, Sundari Ravindran and Manuela Colombini.

Session 4: Health service delivery

Health service delivery

What participants will do

Participants will:

- begin to look at health service delivery issues through a gender and rights lens;
- understand gender and rights issues within service delivery for specific components of maternal and reproductive health care; and
- be familiar with health systems issues related to maternal health from the MDG Task Force report.

[time: 3 hours]

Preparation

- Prepare the role-plays based on instructions in the Notes for the facilitator.

Materials

- Notes for the facilitator: “Descriptions of role-plays and questions for discussion”
- Role-play characters, each individual character on a separate piece of paper, taken from Notes for the facilitator
- Essential reading 1: Summary report of MDG Task Force 4: Who has got the power? Transforming health systems for maternal and child health care (2005) – to be read the previous evening as homework

This session consists of two activities. The first is a participatory activity, which should take place in a large room (desks should be moved to the edges to make a large empty space in the middle of the room). Volunteers are recruited to take part in a series of role-plays while others observe. At the end of each role-play, the facilitator asks a set of questions, the answers to which bring out an aspect of health care delivery system functioning and the gender and rights issues that the role-play illustrates.

The second activity is a presentation by participants of the key health system issues pertaining to maternal health care. This should be based on the Summary report of MDG Task Force 4. The facilitator pulls the session together with concluding remarks highlighting the need to have a “health systems” approach to improving maternal health care.

[time: 1 hour 30 minutes]

Step 1: Prepare the role-plays

Type out each character from the “Notes for the facilitator” on to a separate piece of paper. The role-plays are numbered 1 to 5 and the characters have letters assigned to them. Label each envelope so that it indicates which role-play and which character it corresponds to. In

this way, the people acting in a particular role-play know who their fellow actors are.

It is useful to have a few props: a telephone, some shawls, a doctor's coat, etc. Look through the characters and bring appropriate props. This helps people get into their characters and adds a touch of realism and humour. For example, if you bring a small cushion, an actor can stuff it under his/her shirt to pretend to be pregnant.

Step 2: Assign the characters and prepare to act

[time: 10 minutes]

This session starts with all participants standing in a large circle around the room, with the desks moved well out of the way. Ask for volunteers who are willing to participate in role-plays. Give each volunteer the envelope containing a description of the role-play and of the character they are to play. You do not have to have men playing men or women playing women. Assign this at random – just give out the envelopes.

Explain to the actors and observers that a series of role-plays will be enacted during this session. All the roles are about service providers and service users in primary health care facilities. Tell the actors that they will not know who the other characters are before the role-play starts, but that this will quickly become clear.

Ask each actor to read about her or his character and think about how they may act as this person. Give everyone a few moments to do this. Explain that you can help anyone who has a question. Maintain privacy when answering any questions, so that no one else can hear. Assist them in developing a plan for acting as their character by asking questions rather than telling them what to do. For example, if someone acting the character of a nursing sister wants help, read the description with him or her. Then, talk through how they imagine that person might feel, what circumstances they might be working in, etc.

Explain to the actors that observers just need to get a flavour of the situation and that acting talent is not required. Everyone should remember that the actors are playing a role, and that what they do and say will not be seen as a reflection of their own personalities or opinions. Actors should also remember to face the audience, and to talk so that everyone can hear. Instruct observers to play close attention to what the characters do and how they interact.

Step 3: The role-plays and discussions

[time: 50 minutes]

Call everyone not acting in Role-play 1 to gather around the first piece of paper on the floor. Actors with a "1" marked on the envelope should do their role-play.

Start by introducing the situation and the characters briefly. For example: "We are at a clinic and we have a clinic nurse (point to the person playing the nurse) and a patient (point to the person playing the patient). This clinic has a referral centre that is 40 km away and this is the clerk (point to the person playing the clerk) who books appointments and does other clerical work at the referral hospital."

Let each role-play run for about five minutes, making sure that the aspect of health system functioning to be addressed by it emerges (see below). Stop the role-play by firmly saying, "Thank you".

On your own. Then facilitate a discussion about the role play using the following questions:

Questions after the role-play

- For each actor: How did it feel to play the role you played?
- For the observers: Describe what was going on in the role-play. In your experience, is this a likely scenario? If not, how would the reality differ?
- What are the gender issues in the health service setting depicted in this role-play? Are any rights violated? Which rights, if any, have been respected or promoted?
- What action could be undertaken to improve service delivery in this situation?

The role-play's focus on the health care delivery system

- (1) provider–client relations;
- (2) access; and
- (3) infrastructural requirements.

What to cover in the discussion

You will need to think on your feet, posing questions that will draw out the points we need to make about the functioning of the health care delivery system. Some examples are given below.

Role-play 1: Provider–client relations

This role-play is about a pregnant woman with pre-eclampsia who does not get any instructions or advice from her doctor about her condition.

One gender issue that emerges from this role-play concerns health providers' lack of awareness of gender issues that may prevent the woman from taking appropriate steps to deal with her health problem, should complications develop. There is also an issue of the provider's unwillingness to engage with a person of a lower class and caste who, according to the provider, is not able to articulate her problems or understand what the provider says.

Move the discussion on to what can be done to alter this situation. Some suggestions that have emerged from discussions like these have been: training to communicate better and to change attitudes, a better working atmosphere, additional human resources such as counsellors (these could be volunteer, lay counsellors) and a performance appraisal system that includes provider attitudes and gender biases. These would be the responsibility of the health manager.

The discussion could also identify other attitudinal barriers that participants have encountered or are familiar with, and how these can be dealt with.

Role-play 2: Access

At the end of a very long morning, the provider is exhausted. A woman who appears to be very sick has walked all morning to get to the health centre, and reaches it just before lunch break. She is very poor and badly dressed, and appears to be bleeding. Her clothes are stained and she smells bad. This is a woman with several children, who has had a backstreet abortion and has developed an infection. She does not feel confident about going to the front of the queue to talk to the nurse about the urgency of the situation. She tries to catch the nurse's attention, but feels that she is watching her with distaste. The woman's impulse is to go away and never come back.

Questions to ask include: Why might she have had a backstreet abortion? Why has she come at such a late stage? Why is it that the woman had no money to take a ride to the clinic?

Identify the many barriers to access this woman has encountered at various stages: access to contraception restricted because of husband's unwillingness and/or lack of money to buy regular supplies; lack of access to safe abortion because of legal restrictions on the method, and also inability to afford a private practitioner; lack of time or lack of awareness of symptoms of infection, which led to delayed care-seeking for post-abortion infection, etc. Almost all of these are rooted in gender and poverty.

Encourage participants to share other barriers to access that emerge from their own personal or work experiences. For example, absence of female staff, whether the staff reside in the clinic, timings of clinics, location, etc. The focus should be on barriers on the provider's side.

Then, take the discussion forward to identify ways in which the situation in the clinic, as well as the policy environment, may be altered to improve access to safe abortion.

In the health centre in this role-play, there is no doctor on night duty. There is no ambulance and no phone, and so the lone midwife on duty has to instruct a woman in labour who arrives with heavy bleeding to make her own arrangements to go to the hospital 40 km away.

The helplessness of the health provider emerges as an important issue for discussion from this role-play. The community often blames and gets angry with the health provider. What are the solutions to this problem? How can such a situation be avoided? Suggested solutions include:

- There should be a notice stating that, at night, complicated deliveries cannot be handled at the clinic, and women should go straight to the referral hospital.
- Danger signals in pregnancy, delivery and postpartum that require referral should form part of a public education campaign aimed at both women and men.

Encourage participants to share examples from their own experiences of when lack of infrastructure got in the way of effective health delivery. On some courses, lack of separate outpatient areas for men and women, lack of separate toilets, lack of child care facilities, lack of physical safety for clients and health providers (where clinics are located in remote areas) have been expressed as infrastructural constraints.

It is worth pointing out that it is often women who staff remote clinics and who are midwives and that it is a significant burden on providers in such a situation to deliver quality services. Moreover, health care for pregnant women is not the same as rare emergencies that may also require emergency transport. It is well known and predictable that a specific proportion of deliveries are likely to be complicated. Despite this, emergency transport for complications in delivery is not built into health care delivery systems. Point out that maternal mortality is high in poor countries, specifically because emergency transport for women in labour is not routinely available. This is one example of the low value placed on women's lives.

Step 4: Pulling it all together

[time: 30 minutes]

Pay attention to the generic systems issues

In order for health care delivery systems to function adequately, we need to focus our attention on the generic systems issues. These include drug supply, training and so on – the various points of the wheel that were developed in the role-play.

Good management is crucial

Good management, which builds health care provider capacity, competence and accountability, is essential and fundamental to adequately functioning health care services.

The gendered impact of poor functioning systems

Prescribed gender roles mean that when health care delivery systems function poorly, women in particular are negatively affected. Improving health care delivery systems will thus benefit women.

It is possible to increase women's autonomy and promote their reproductive and sexual rights within existing health services. Examples that come up in this activity include: encouraging men to take joint responsibility when women are in labour, or for child care; and fostering women's control over their bodies by welcoming them at contraception services, irrespective of their age.

Activity 2: Health care delivery systems – from a gender perspective

[time: 1 hour 30 minutes]

Participants are divided into four or five groups and assigned to read specific sections of the Summary report of MDG Task Force 4 as homework for the previous evening. Each group has to prepare a presentation of no more than 10 minutes based on what they have read. All presentations are first given, and then there is a discussion for 40-50 minutes.

The facilitator then concludes the session, highlighting the need for addressing health system factors impeding maternal health.

Notes for the facilitator

Descriptions of the seven role-plays and questions that you may ask to bring out gender issues are set out below.

Type out each role-play so that each character is on a separate piece of paper. Put each character description in an envelope marked with the number of the role-play (1-7), and the letter of the character (a, b, c). Character b from the role-play on technical competence will, for example, be contained in an enveloped marked "2b". This will help each group of actors in a particular role-play to know who their group members are.

Proposed script

To set the scene before this role-play begins, you will say:

“Today is a busy day at the clinic. There is a long queue and it is also the day many people come for family planning.”

Today is a busy day at the clinic. There is a long queue and it is also the day many people come for family planning.

You are a woman from a low income household. You are in the sixth month of pregnancy and have been suffering from bloated face and water retention in your feet and legs for about 10 days now. You feel really unwell, and it has taken you an entire week to find time, put together the money and get permission to come to the health centre. You are shy and scared of telling the doctor about your problems.

Today is a busy day at the clinic. There is a long queue and it is also the day many people come for family planning.

You are a female doctor at the clinic. A pregnant woman with signs of pre-eclampsia has just come to you. Many such cases come to you, but they come at their own convenience, many days after the problem develops. Moreover, they do not take any action despite your spending a lot of time persuading them to seek hospital deliveries. You are in a hurry, and you just examine her and give a prescription. There is no use wasting time with such women: they never listen.

- What are the likely consequences of the woman's and the doctor's behaviour?
- What does the provider's behaviour indicate about her sensitivity to gender and social issues that may affect the patient?
- Is there any action that could be taken that would promote a better interaction between the provider and the patient and improve pregnancy outcome?

To set the scene before this role-play begins, you will say:

“This is a busy clinic. It is almost lunch time and the queues are getting shorter at last. The nurse (point her out) is keen to take her lunch break and in the distance we see a patient (point her out) arriving hours after the clinic has opened.”

This is a busy clinic. It is almost lunch time and the queues are getting shorter at last.

You come from a rural farming family. You have five children and your husband has been strongly opposed to contraception. You have been bleeding for several days and it shows no signs of stopping. During the past couple of days you have been feeling feverish and rather sick. You had an abortion performed by a paramedic doing private practice last week and have been waiting for the bleeding to stop. You decide that things are very bad and you must get some help. You decide to go to the government clinic, which is a long way from where you live. You cannot ask your husband for money to go to a private facility, because he does not know you have had an abortion.

You miss a connecting bus, have to walk a considerable distance, and get to the clinic at 12 noon. You are late, as most people arrive at 8 a.m. By the time you get there you are hardly able to walk. You must join the queue. You wait for an opportunity to talk to the nurse, who is busy with patients. Your clothes are soiled with blood, and you know that you smell bad. You feel that everyone is watching you. You try to catch the nurse's attention, but she seems to be looking at you with distaste. Your impulse is to go away and never come back again to this clinic.

Character B

This is a busy clinic. It is almost lunch time and the queues are getting shorter at last. The nurse is keen to take her lunch break.

You are the nurse. You have been working all day and the queue is still long. You see people still arriving even at midday. You watch one woman come and sit beside the queue. She is trying to catch your attention. You can see how sick she is; her clothes are stained with blood. You think she may have attempted an abortion. "Why," you wonder to yourself, "do women do things like this to themselves?"

Questions to bring out gender inequalities

- Why might she have had a backstreet abortion? Why not prevent the pregnancy?
- Why has she come at such a late stage?
- Why is it that the woman had no money to take a ride to the clinic?
- Why would a woman not have money to pay for transport instead of walking?
- What would be the best course of action for a health centre to undertake to encourage women to come as soon as a problem develops?

Role-play 3: Introducing a night-call nurse

To set the scene before this role-play begins, you will say:

"It is night at the clinic. The night-call nurse (point her out) is sitting in the clinic, available for emergency cases."

Character A

It is night at the clinic. The night-call nurse is sitting in the clinic, available for emergency cases.

You are the midwife on call for the clinic tonight. You are sitting in the clinic having some tea, thinking of going to bed as it is late. Night duty is always stressful. There is no one to talk to or to help if there is a problem. You have no phone in the clinic and the ambulance is located at the hospital 40 km away on a bad road. It is worse now that it is the rainy season.

Character B

It is night at the clinic.

You are a pregnant woman who is having her third child. You have been in labour at home for six hours and now you see that you are bleeding. Your husband has left you for another woman and you are all by yourself with no one to help. You are very scared and manage to get a man from the village to drive you to the clinic in his car. He is only helping you because

you have begged him. He is concerned about the cost. You arrive at the clinic scared, in labour and bleeding.

- What facilities are required in a clinic for staff to be able to respond appropriately to this situation? What kind of systems would have to be in place to make all this happen? What could a manager do to make this happen?
- Under what circumstances would transport for women in labour be guaranteed? What would be required to make sure this always happened?
- What kind of action would ensure that women in this situation had more control over their own bodies and health?
- As both men and women make and want babies, what kind of action would lead to men and women both having some responsibility for the healthy outcome of this pregnancy?

Adapted, with new case studies and additional activities, from Transforming health systems: gender and rights in reproductive health. Module 6, Session 2. Geneva, WHO, 2001.

Session 2: Financing maternal health services

What participants should know after the session

Participants will:

- be familiar with different mechanisms for financing health care;
- have an understanding of the implications for different financing mechanisms for equitable access to pregnancy-related health services; and
- be introduced to costing of pregnancy-related health care.

[time: 3 hours]

Learning objectives

- Hand-out: Instructions for group work
- Essential reading 1: Weissman E., Sentumbwe-Mugisa O., Mbonye A.K., Lissner C. Costing safe motherhood in Uganda. In: Berer M. Ravindran T.K.S., eds. Safe motherhood: critical issues, London, Reproductive Health Matters, 1999: 85-92
- Essential reading 2: Reducing maternal and child mortality in Bolivia. Executive Summary series, PHRplus, PHR Resource Centre, Bethesda, MD (undated)
- PowerPoint presentation: Financing maternal health care: mechanisms, implications and innovations

How to run the session

This session consists of two activities. The first activity is an input from the facilitator, a PowerPoint presentation on innovations in maternal health care financing, prepared based on the sample PowerPoint presentation provided.

The second is a reading exercise on costs of and innovations in the financing of maternal health care that promote access to care for women from low-income and marginalized groups. The groups report back to the whole group on key learning, with inputs from the facilitator.

[time: 1 hour]

The facilitator starts a discussion on why it is important to understand how maternal health services are financed. Policies around financing mechanisms determine resource availability for maternal health programmes. Any attempt at improving maternal health services (for example, based on discussion in the earlier session) and making them more gender- and rights-sensitive has to contend with financing issues. Some financing mechanisms help ensure access to health services for low-income and marginalized groups and can help promote quality of care. However, others may create barriers to access and utilization, and compromise quality of care.

This is then followed by a PowerPoint presentation, which:

- gives an overview of different methods of financing health care;
- discusses the consequences of different methods of health financing for maternal and reproductive health services; and
- introduces information on some innovations (to be dealt with in detail in the next activity).

[time: 2 hours]

Step 1: Reading and summarizing

[time: 45 minutes]

Divide the participants into four groups. Assign members of two groups to read Essential reading 1, and members of two other groups to read Essential reading 2 as homework.

The next day, in the class session, participants work in groups and share the main points they gathered from the reading. The group then prepares answers to the questions given in the hand-out.

Step 2: Discussion

[time: 1 hour 15 minutes]

Elicit from the groups that have read Essential reading 1, responses to the following questions:

- Describe the essential steps used in the mother-baby package costing study done in Uganda: what was the range of services considered? How were the incremental costs assessed?
- What were the current and incremental per capita costs for providing enhanced maternal and newborn health services in Uganda?
- What were the main components of cost?
- Do you have some idea of the current cost of maternal health care in your country? If only a small increment could be made in overall spending for maternal and newborn health, where would you choose to put the additional money?

The main issues to highlight are: the need to carry out simple costing studies; using costing studies to set priorities and to think through additional revenue requirements and ways of financing these.

Now the groups that read Essential reading 2 are called upon to respond to the following:

- What was the mechanism for financing that was used?
- What potential implication did it have for increased access and utilization of maternal health services?
- Do participants have some concerns about this financing mechanism? What are they?
- What is the potential for implementing such innovations (or modified versions of them) within their respective country settings?

main points for discussion

For more than two decades now, international economic forces have moved in the direction of reduced resources for the health sector in developed and developing countries alike. This trend of the health sector being severely short of resources has continued through the 1990s and into the new millennium.

The introduction of cost-sharing mechanisms, such as user charges for health services, may have a detrimental effect on the use of services by poor women. These women do not have ready access to cash, or do not control cash in the household and have to seek permission to spend money. There have been few studies looking at the gender impact of cost-recovery mechanisms, and these do not look at different subgroups of women who may be affected. They could include, for example, different income groups, rural/urban residence, regions of a country, age groups and race/ethnicity.

Paying through tax revenue represents the fairest mechanism for financing essential maternal health services: antenatal care, delivery care, postpartum care, and contraceptive and abortion services. In order to expand these services to include a wider range of sexual and reproductive health services, vital for good maternal health, countries are experimenting with social insurance and pre-payment schemes. There is much to learn from these experiences and to advocate for their application within our countries.

In order to have some idea about the volume of revenue to be raised through various financing mechanisms, it is important to have a basic idea of the costs involved. WHO had developed a simple and practical methodology for costing mother-baby packages,⁴ which policy-makers and planners may find useful.

Session developed by T.K. Sundari Ravindran.

⁴ For more details on how to carry out a costing exercise, refer to the "Mother-Baby Package Costing Spread Sheet" from http://www.who.int/reproductive-health/economics/mother_baby_package_costing_spreadsheet/mother_baby_package_costing_spreadsheet.pdf.

Participants will:

- learn about the characteristics of policies and interventions that integrate gender and rights concerns;
- become familiar with a framework for analysing policies; and
- be introduced to strategies and good practices in reducing maternal mortality and morbidity.

[time: 4 hours 30 minutes]

- Hand-out 1: “How different policies identify and address gender inequalities” – conceptual definitions of gender-unequal, gender-blind, gender-specific and gender-redistributive policies
- Hand-out 2: Exercise on different policy approaches to gender
- Hand-out 3: A framework for analysing policies
- PowerPoint presentation: Gender and rights in policies and interventions
- Essential reading as homework: Lerberghe, W. Van, Brouwere, V. De. Of blind alleys and things that have worked: history’s lessons on reducing maternal mortality. In: Brouwere, V. De, Lerberghe, W. Van, eds. Safe motherhood strategies: a review of the evidence. ITG Press, Antwerp, 2001 (Studies in Health Services Organisation and Policy, 17: 7-33).

This session consists of three activities. The first is a brainstorming session followed by a discussion to draw out participants’ understanding of policy and develop a definition from this. The second activity is a group exercise followed by a summary presentation by the facilitator. The third activity is a panel presentation by selected experts on history’s lessons related to strategies and good practices for the reduction of maternal mortality and morbidity.

[time: 1 hour 30 minutes]

Step 1: What does “policy” mean?

[time: 15 minutes]

Ask the group what the word “policy” means to them, and write their ideas up on an overhead chart or flipchart.

What to cover in the discussion

The meaning of the word “policy” differs in different countries. In general, people think of it narrowly, to cover government legislation and/or government regulations. For the purposes of this course, since it aims to encourage changes in practice wherever the participants are situated, a broader definition of policy would be helpful. The discussion should generate a very broad list of what policy can mean, including:

- the goals/aims/visions of a government, group or organization;
- the plan of action adopted in relation to those goals;
- a decision;
- a group of decisions;
- an orientation;
- the fact that policy evolves in the process of implementation, so that frequently the intention of formal policy, such as legislation, is not what is actually delivered in practice; and
- the fact that policy is manifested in practice (i.e. as an approach) or in writing (e.g. a white paper, law or mission statement).

Encourage broad definitions of policy at various levels. If participants do not come up with this kind of definition, ask questions such as: “What about households? Do households have policies?” Participants may come up with ideas such as the male head of a household allocating a set amount of money to his wife to cover domestic costs for the month. They may come up with a household rule that children have to come home in the evenings by a set time; or a woman doing all the cooking; or men being served food first. In this way they can see that ongoing practices are a form of policy.

Ask also about policies in the workplace, such as how many days’ leave a person can take, or grievance procedures.

Most of the examples presented in this curriculum are about government policy – whether in legislation or in public health services. However, a broader perspective on policy is necessary to empower not only participants who work for government, but also those in NGOs, partner organizations or other structures. They must be enabled to develop the skills and the recognition that they can initiate or influence policy change.

Distinguish between formal policies and informal or unspoken policies. For example, in many countries urban health services have better facilities, more equipment and more staff than rural health services. There may be no formal policy that a department of health will give priority to urban health services over rural ones. However, in effect, the failure to insist that equal attention is given to rural health services means that whatever the written policy, the actual policy is to discriminate against rural health services and therefore the people who rely on them. If the health system only employs men at management level because that is the standard thing to do, then arguably their practice suggests an unwritten policy to exclude women.

In this way, absence of a decision or failure to address a problem is also a type of “policy-in-practice”. For example, if there is no legislation or regulation or even health system practice to ensure that the poorest people in society can afford health services, then this can be called a de facto policy. In this way, “non-decisions” are also policy.

Step 2: How do policies identify and address gender inequalities?

[time: 1 hour]

In addition to having a shared understanding of the term “policy”, participants need to be able to work out whether and how different policies identify and address gender inequalities.

Prepare a list of examples of different policies. Box 3 provides some examples to give you ideas. You may use these, or include other examples to make a new hand-out.

Participants are given Hand-outs 1 and 2. Explain briefly the three different approaches to gender of various policies from Hand-out 1. Participants then have to allocate each policy to one of the gender approaches to policy. They have 10 minutes for this exercise.

In the large group, go through each policy. Tell participants that the categories help one to get a general idea of whether a policy recognizes gender norms, and if and how it tries to change these. Ideally, we should be trying to develop policies that promote gender equity and equality or, at a minimum, make women’s lives easier. Therefore, gender-specific is better than gender-blind or gender-unequal, and gender-redistributive is our aim.

Box 3: List of policies

1. Maternal health policy: trains midwives to improve their clinical skills to prevent maternal morbidity and mortality.
2. Water supply policy: establishes a mechanism to provide taps close to villages so that women will not have to walk as far to fetch water.
3. Human resource policy: includes provision for child care facility at the workplace.
4. Land policy: removes restrictions on women’s right to inherit land.
5. Occupational health policy: protects women and men from working in places that are hazardous to their reproductive health.
6. Senior management recruitment policy in a department of health: requires all managers to have a PhD.
7. Community-based AIDS care programme: says that a health care system cannot take responsibility for caring for people with AIDS, so that home-based care must be instituted.
8. Information, education and communication policy: establishes messages and methods to advocate to women and men about mutual respect and equal rights in sexual decision-making as a means of promoting safer sex practices.

Ask participants which policy approach they allocated to policy 1. Listen to various responses and attempt to reach a consensus. Then ask how they would improve upon this policy to make it gender-redistributive and rights-based. This is the most interesting part of the exercise, and there may be more than one way in which policies can be improved upon. The facilitator should think through a gender- and rights- integrated version for each of the policies given in the hand-out. For example, a gender-blind recruitment policy that requires all health managers to be PhDs can be altered to a policy that takes into account relevant experience or holds a qualifying test to select candidates. Better still, it could also have provision for helping women candidates complete their PhDs within the first three or four years after recruitment. Do this for each of the policies listed in Hand-out 1.

Activity 2: Exhibiting

[time: 1 hour 30 minutes]

Give a PowerPoint presentation that introduces a basic framework for policy analysis (see Hand-out 3 for essential contents).

One of the commonly used frameworks for policy analysis uses “context–actors–process” as the three main dimensions around which to examine a policy. The purpose of policy analysis is to identify the factors facilitating and constraining (government) action/inaction. The intention is for participants to be able to analyse policies to understand why they were developed at a particular time, and what shaped the policy content. This will also help them understand whether and why the policy takes account of or tries to change gender norms. Once they have gained confidence in retrospectively analysing policies, they will be able to think about how to influence and shape policy content themselves.

Illustrate the framework with several real-life examples (see accompanying “Notes for the facilitator” for an example from South Africa). Make the presentation interactive by stopping at various points and eliciting examples that participants can think of from their countries.

Activity 3: Panel presentation

[time: 1 hour 30 minutes]

This panel presentation should involve about four participants from diverse settings or countries, and ideally also from diverse backgrounds. Each panellist should give a presentation of no more than 10 minutes on:

- one policy in their country that was successful in achieving a maternal or reproductive health objective;
- the context, actors and the process of policy development and implementation;
- some reflections on factors that contributed to the success of this policy; and
- thoughts on how this policy approached or addressed gender (gender-unequal, -blind, -specific or -transformative?) and which rights are being promoted by the policy.

After all four panellists have spoken, the facilitator will take one round of questions lasting about 20 minutes. These questions may be clarificatory or information-seeking in nature. Next, it is the task of the facilitator to link this panel presentation with the previous activities, by asking panellists to respond on:

- the context, the actors and the process through which these strategies came into existence; and
- the extent to which the strategies have addressed gender and rights issues related to maternal health.

This discussion could last for about 30 minutes, followed by concluding remarks by the facilitator.

Adapted, with new activities, from Transforming health systems: gender and rights in reproductive health. Module 5, Sessions 1-3. Geneva, WHO, 2001.

In 1996, the Choice on Termination of Pregnancy Act was passed in South Africa. This Act provides for abortion on request up to 12 weeks; and under a broad set of circumstances, in consultation with a health worker, up to 20 weeks. Adolescents do not require parental consent; trained midwives can carry out abortions.

Many people have asked how it was possible to bring about this law, and to what extent the process can be followed in other countries. It is important to recognize that the same activities will not lead to the same results in different contexts.

These are some of the key factors in relation to the institutional and political context, which facilitated bringing about this law in South Africa:

- The South African Constitution provides for equality on the basis of gender. It also provides for security in and control over the body, and the right to make decisions concerning reproduction. In relation to health care, it includes the right to have access to health care services, including reproductive health care. There is a profound commitment to human rights in the Constitution, law and policy. There is a commitment to religious rights, but not at the expense of individual rights to equality. Thus the context was favourable to gender-redistributive policy – to redistributing reproductive rights so that women too would be able to exercise these rights.
- There is a poor-quality and inequitable but functioning health system, so that the provision of abortion is possible. This in turn depends on the government's ability to implement its general commitment to improving health services.

Key cultural factors that influenced bringing about the law in South Africa included:

- South Africa's population is religious, with diverse but predominantly Christian religions. There is a strong discourse of African patriarchal "tradition". However, at the time of the legislative process, the predominant discourse of civil society organizations was of human rights, including women's rights, and particularly the right to equality. Thus, in the legislative process, it was possible to mobilize around women's right – particularly the right of black women who had previously been disenfranchised and discriminated against – to abortion. Previously, only white people and rich people had access to abortions. However, given the significant role of religion and the concept of African traditional values, it was necessary to ensure that religious leaders and people who represented "African" values spoke in favour of the new laws.

A significant immediate contextual factor was the change of government in 1994 after years of apartheid discrimination:

- The new, democratically elected government had committed itself to immediate social and legal change on all fronts. It wanted to be seen to be acting. In addition, its platform of human rights included a moral imperative to end population control (whether control of fertility or movement). This was therefore a very enabling contextual environment in which to argue for women's right to control their fertility through access to abortion, as part of a broader reproductive rights and health strategy.

The role of the International Conference on Population and Development

- Since South Africa had been isolated from international trends because of sanctions, the International Conference on Population and Development (ICPD) and other international agreements did not play a significant role in influencing this decision. However, the global trend towards macroeconomic approaches that promote fiscal restraint has meant a lack of available funds to implement the commitment to increased access to health care, including the provision of new services, e.g. abortion services. Links between NGOs in different parts of the world did impact on the development of the new law, since South African NGOs accessed know-how from different countries on how to word legislation. Lessons learnt from different countries were taken into account and shared with legislators.

Actors

- Women's rights and health groups and other organizations: In South Africa at the time of the abortion legislative process, women's organizations and women's advocacy NGOs formed an alliance of NGOs (the Reproductive Rights Alliance) working in the medical, legal, human rights and women's health advocacy fields to gain maximum benefit from organizational interventions.
- Professionals: Health, human rights and medically oriented groups mobilized for liberalized abortion legislation.
- Policy activists helped define the problem from women's perspective and develop policy proposals (solutions). They then engaged with the formal political process by working from the outside (giving information to the media, mobilizing mass-based organizations) and from the inside (giving information directly to parliamentarians, giving evidence at hearings).
- Civil society: A consultative process initiated as part of the Women's Health Conference in 1994 mobilized mass-based organizations, policy activists and future government bureaucrats from rural and urban areas. The Conference emphasized the participation of black women because of historical discrimination on the basis of race. This process developed a consensus on priority problems facing health system transformation and in relation to sexual and reproductive rights and health. It developed policy proposals, including on maternal health, contraception, access to abortion, cancer treatment, STIs, HIV/AIDS, etc. It also developed proposals to address discrimination, including on ageing, lesbian health, access to water, and so on.

An abortion reform NGO developed draft legislation as the basis for lobbying. There was some disagreement between different interest groups about the best possible solution. For example, doctors and NGOs (with lawyers) argued that nurses should not be allowed to perform abortions. This could be interpreted as doctors trying to hold on to their medical preserve and being supported by other professionals such as lawyers.

In contrast, women's rights and health groups argued that nurses should be allowed to perform abortions in the first trimester, in order to ensure access to abortion for rural women, since there are few doctors in rural areas. Ultimately the law agreed that midwives should be able to perform abortions, in keeping with the new government's commitment to equity of access.

The process of solution development in South Africa paid little attention to issues related

to implementation. Those involved in developing the new policy had never been in government, and had little experience of health systems. The law does not address how it will take account of limited health system capacity for referral, drug supply and so on.

Moreover, little consideration was given to whether or not health workers would support the liberalized abortion law. While there was some information indicating that nurses would not support the change in law, the new law did not indicate how it would address nurses' concerns. The process of developing the new law did not include consultation with nurses' organizations to gain their input and build their sense of ownership of the new law. Once the law was implemented, many nurses became gatekeepers, not referring women who needed abortions. No institutionalised system to promote health-worker support and to require health workers to implement the law was established.

Another factor that was not considered in solution development was how to ensure that women would be told about the law and their new rights and how to access these.

The interests of politicians became apparent in the South African political process when the parliamentary process was postponed. When a women's health activist asked a parliamentarian why this had happened, he said that the political party wanted to wait until local elections were over, for fear that this legislation would make them lose votes.

In order to persuade politicians that a liberalized law was in the interests of their constituency, activists brought poor black women who had been criminalized for having abortions to speak at parliamentary hearings, rather than speaking on their behalf. They mobilized religious figures to speak in favour of the legislation on the basis of addressing women's suffering and meeting their health needs. They also mobilized people from diverse ethnic backgrounds to show that there was a groundswell of support from different constituencies.

Key pieces of technical information influenced the politicians deciding on South Africa's abortion law. There was historical research that showed that all South African cultures and races had been performing abortions for centuries. Medical research showed the costs carried by the public health sector for treatment for incomplete (illegal and unsafe) abortions, thus providing a monetary motivation for liberalized law.

Information on how liberal abortion law looks in other parts of the world served to support parliamentarians in shaping a new law. Information on the links of South African anti-abortion groupings to right-wing terrorist groups in the United States of America served to undercut their legitimacy.

The South African strategic planning process was weak in relation to addressing the concerns and needs of the bureaucracy. Neither politicians nor NGO activists took adequate account of likely barriers to implementation. Their focus was on the political process, ignoring that once the Act had been promulgated it would have to be implemented by a bureaucracy.

Inadequate identification of health system leadership below national level was another weakness. Health service providers were not identified as a constituency to be mobilized before the new legislation to ensure their support for and capacity to implement it. The legislation, or subsequent regulations, should have addressed such issues as:

- time-frames, financial allocations and human resources;

- how to implement a new service in the context of health system restructuring, with major changes under way through decentralization and changes in financing systems;
- training of midwives in the procedures;
- building management support for the new legislation to ensure that it would be implemented in the context of health system restructuring;
- winning the support of health care providers so that they would not see this Act as yet another burden, or as running against their values;
- building the knowledge base of communities so that they could put pressure on the bureaucracy to deliver services;
- winning the support of health care providers in an ongoing and systematic way; and
- training doctors and nurses in the procedures.

As a result, after the law was promulgated in 1996, implementation was very slow. Service providers complained of lack of management support. Nurses at clinic level often operated as gatekeepers instead of referring women appropriately. Communities did not know about the rights provided by the law, and did not always support them.



Source: Klugman B. In: *Transforming health systems: gender and rights in reproductive health*. Module 5, Session 3. Geneva: WHO, 2001.

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Participants will:

- reflect on their role as individuals in effecting change, and address emotional and psychological issues related to making changes; and
- apply what they have learnt during the course to identify one specific intervention that they can implement in their own setting.

[time: 3 hours 30 minutes]

Hand-out 1: Instructions for preparing posters describing one intervention, which participants can implement within their own settings for promoting gender and rights in maternal and reproductive health care

Activity 1 starts with sharing by participants of a situation in which they have been agents for change. This is followed by Activity 2, in which participants develop interventions they can implement within their own settings for promoting gender and rights in maternal and reproductive health care.

[time: 45 minutes]

Start by introducing the purpose of this session, based on the objectives given. Then request participant volunteers to share briefly their experiences of being change agents in a professional or personal capacity. By “change agent” we mean a person who when faced with a problem situation, identifies that a change or innovation is needed and takes initiative to get this done. Keep each sharing session short (no more than three minutes). Ask for a range of experiences, personal and professional, mainly around changing attitudes, trying something that has not been done before, and so on. After four or five people have shared experiences, summarize, highlighting that:

- many of us are and have been change agents in our lives;
- being a change agent is not a “comfortable” position to be in, as it involves risks such as disapproval from colleagues and superiors, possible failure and loss of face, additional workload, stress and so on; and
- it also brings a great deal of satisfaction to be in a position to “make a difference”.

Activity 2: Working on an intervention plan that has been initiated

[time: 45 minutes, plus homework]

Preparation

On Day 0, immediately after participants have been briefed on administrative and logistical issues, Hand-out 1 is distributed to participants. They are requested to think through an intervention that they can implement in their own contexts for promoting gender and rights in maternal and reproductive health. They are informed that they will have to present their plan as a poster on the afternoon of Day 5. Participants work in groups. This may be by area of interest, by organizational affiliation, or by the geographic area in which they are working. Some may wish to work individually, and this is also possible.

The task is to identify the “what” of change first: What would they like to do within their own settings to reduce morbidity and mortality associated with pregnancy and childbirth? But it is equally important to think through the “how” of change:

- Who will they approach and how will they do this in order to win support for what they propose to do?
- Who is likely to support them? What is in it for them?
- What are some of the barriers they may encounter? How will they work around these or overcome them?
- What financial and non-financial resources will they need? How will they raise these?

Participants are expected to have thought through ideas during the course of the work. In this session, they can start writing them down in preparation for designing the poster, and discuss their ideas or clarify doubts with facilitators. The poster must be completed as homework.

Activity 3: Presenting the intervention plan that has been developed

[time: 2 hours]

Presentation

Groups/individuals take turns to put up their posters, about four to six at a time. They stand by their posters as others walk around reading their posters and asking questions/making comments. After about 20 minutes, another set of four posters goes up, and the process is repeated. By the end of the session, all groups/individuals will have received comments on their plans.

Adapted from Transforming health systems: gender and rights in reproductive health. Module 6, Session 7. Geneva, WHO, 2001.

Participants will:

- consolidate what they have learnt on the course; and
- evaluate the course from their immediate perspective.

[time: 1 hour 30 minutes]

Forms for written evaluation of workshop by participants

[time: 15 minutes]

The course co-coordinator/director presents a consolidation of the key learning from the course, taking participants through Days 1 to 5.

[time: 30 minutes]


Distribute the course-evaluation forms. Explain that the form is long because it aims at finding out about the entire course while things are still fresh in participants' minds.

Collect the forms after 30 minutes. File these safely and hand them over to the course organizer or whoever is responsible for them.

[time: about 45 minutes]

In this session, the workshop is brought to a close. Depending on the setting, this may be a formal closing ceremony or an informal leave-taking. Certificates may be given out (if relevant to the context), and time allocated for distribution of mementos, spontaneous sharing of participants' experiences in the workshop and vote of thanks by organizers.

HAND-OUTS



This is an exercise to allow participants to become better acquainted with others taking part in the workshop. Move around the room, talk to others and find people with the characteristics mentioned below. Write down their names beside the statement. You have about 10 minutes to find all the people.

- (1) Find someone who had a male kindergarten teacher when s/he was growing up.
- (2) Find one woman who is engaged in active sports.
- (3) Find one man who takes an active role in his children's school activities (for parents).
- (4) Find one person who has always had female bosses.
- (5) Find two people whose grandmothers were working women.
- (6) Find one person who has a woman employed as a driver or security officer in his/her place of work.

Session 2

Reproductive health and rights

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

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

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

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

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

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

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

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

The impact of socially constructed gender roles is felt significantly in the area of sexuality and sexual behaviour. Women are expected to make themselves attractive to men, but to be more passive, guarding their virginity and never initiating sexual activity. In some societies, this is because women are held to have less sexual drive than men. In other societies, the ways women are controlled are based on the idea that without restrictions, women's sexual desires might get the better of them. Men are often expected to take the initiative in sexual activity, and are believed to be, by nature, unable to control their sexual desires when aroused. It is therefore considered to be the responsibility of women to protect themselves from inappropriate male attention and desire.

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

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

For example, women may have access to health services, but no control over what services are available and when. Another common example is women having access to an income or owning property, but having no control over how the income is spent or how the property is used. There are many different types of resources that women have less access to, and less control over. These include:

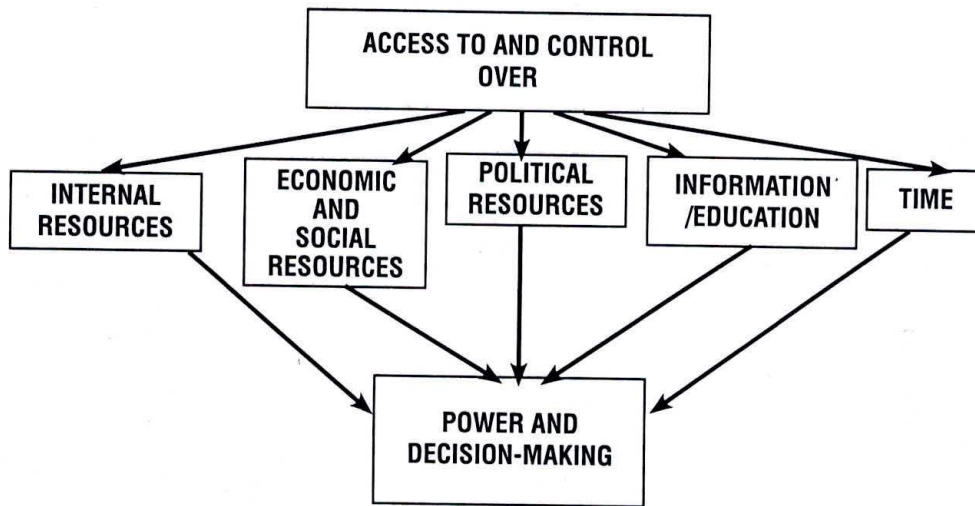
- work
- food
- credit

- money
 - social security, health insurance
 - child care facilities
 - housing
 - facilities to carry out domestic tasks
 - transport
 - equipment
 - health services
 - technology and scientific developments
-
- positions of leadership and access to decision-makers
 - opportunities for communication, negotiation and consensus building
 - resources that help vindicate rights, such as legal resources
-
- community resources
 - social networks
 - membership in social organizations
-
- inputs to be able to make decisions to modify or change a situation
 - formal education
 - non-formal education
 - opportunities to exchange information and opinions
-
- hours of the day available to use as they choose
 - flexible, paid work hours
-
- self-esteem
 - self-confidence
 - ability to express one's own interests

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

Male power and control over resources and decisions is institutionalised through the laws and policies of the state, and through the rules and regulations of formal social institutions. Laws in many countries of the world give men greater control over wealth and greater rights

in marriage and over children. For centuries, religious institutions have denied women the right to priesthood, and schools often insist that it is the father of the child who is her or his legal guardian, not the mother.



Gender analysis of a health problem: the impact of different characteristics of gender on men's and women's health⁵

Relation to x health problem:	Are there sex differences in:	How do biological differences between women and men influence their:	How do the different roles and activities of men and women* affect their:	How do gender norms/values affect men's and women's:	How do access to and control over resources affect men and women's:
Vulnerability:					
Incidence/prevalence					
Health-seeking behaviour					
Ability to access health services		[may not be applicable]			
Preventive and treatment options, responses to treatment or rehabilitation					
Experience with health services and health providers		[may not be applicable]			
Outcome of health problem, e.g. recovery, disability, death					
Consequences (economic & social, including attitudinal)					

* Of different classes, ethnic groups, ages or other relevant differences between men and women

⁵ Adapted from: Gender and Health Group, Liverpool School of Tropical Medicine, *Guidelines for the Analysis of Gender and Health*. Liverpool School of Tropical Medicine and Department for International Development, United Kingdom, 1999: 26-27; 37-39; 40-42; Hartigan, P, Gomez, V, da Silva, J, de Schutter, M, 'Module 3: The origin of health needs'. *Workshop on Gender, Health and Development: Facilitator's Guide*, Pan American Health Organization, Washington D.C., 1997:35-66; Ravindran, TKS and Mishra US. *Information needs for gender analysis in health*, Paper presented at the meeting on Gender and Health, Geneva, World Health Organization, 2000 (unpublished); Klugman, B, Fonn, S, and Tint, KS. *Reproductive Health for All: Taking Account of Power Dynamics Between Men and Women*, Johannesburg: EC/UNFPA Initiative for Reproductive Health in Asia, Europe, AIDS and Women's Health Project, 2001.

Application of the

Gender analysis tool

The matrix below uses the example of malaria to illustrate how to use the Gender and health analysis tool as a basis for analysing health and health-seeking behaviour. This immediately alerts you to potential gender biases and issues that may need attention in policy or programming. The matrix has been filled in using one review article on gender and malaria⁶ and includes only enough information to give you an idea of how to use the matrix. Boxes have been left blank where information was not supplied in the article. In an actual gender analysis, you would draw on a wider range of information sources and use the matrix for summary purposes.

In relation to malaria:	Are there sex differences in	How do biological differences between women and men influence their:	How do the different roles and activities of men and women affect their:	How do gender norms/values affect men's and women's:	How do access to, and control over resources affect men's and women's:
Vulnerability: Incidence**/ prevalence ** (male/female)	No significant sex difference reported in incidence or prevalence Rate of infection increases in pregnancy	Pregnant women are more "attractive" to mosquitos, and may have an increased infection rate	May influence exposure, e.g. India: men sleeping on farms away from home unlikely to use bednets; women harvesting maize before daylight in peak biting time or running food stall at night	Clothes worn can affect proportion of body exposed; men may spend more leisure time outdoors	
Health-seeking behaviour	Women in 20-49 age group are seriously underrepresented in malaria cases reported from health facilities	Asymptomatic nature of malaria in pregnancy means that pregnant woman not likely to seek care	Bednet maintenance and, consequently, re-impregnation is generally women's responsibility, but can be hampered by costs or time required (i.e. links to resources)	In some communities men are given priority use of bednets to ensure that as breadwinners, they have a good night's sleep; in many cases men get priority because of higher status	Economic factors are major determinants in acquiring bednets; women more inclined to buy nets than men, but less likely to control household income so have to use own income, which is limited; economic factors are also main reason for non-use of services

⁶ Allotey P.A., Ravindran T.K.S. *Gender analysis in the control of malaria: the insecticide-treated bed net intervention*. Key Centre for Women's Health, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne, Australia, 2001.

In relation to malaria:	Are there sex differences in	How do biological differences between women and men influence their:	How do the different roles and activities of men and women affect their:	How do gender norms/values affect men's and women's:	How do access to, and control over resources affect men's and women's:
Vulnerability: Incidence**/ prevalence ** (male/female)	No significant sex difference reported in incidence or prevalence Rate of infection increases in pregnancy	Pregnant women are more "attractive" to mosquitos, and may have an increased infection rate	May influence exposure, e.g. India: men sleeping on farms away from home unlikely to use bednets; women harvesting maize before daylight in peak biting time or running food stall at night	Clothes worn can affect proportion of body exposed; men may spend more leisure time outdoors	
Ability to access health services	Study from Papua New Guinea shows that the effect of distance on access is different for different age-sex groups; the effect of distance is most pronounced for adolescent boys	[May not be applicable]		Routine chemoprophylaxis and treatment of malaria in pregnancy is hampered by the range of cultural, social and economic factors that also hinder antenatal care attendance. These include: women more likely to use traditional healers; may not attend antenatal care because of pregnancy-related taboos; where there is a preference for the male child, mothers may take their male infants with malaria more often to health centres, and be prepared to walk further with them.	
Experience with health services and health providers	Burkina Faso study shows that female patients have more difficulty in communicating with health workers	[May not be applicable]	Women, as mothers, are the target of programmes to get children to health centres, but tendency for women to be blamed for the failure of such programmes	Cases of women refusing examination by male providers; Burkina Faso – inadequate histories taken of women but not of men; New York – delayed diagnosis of women but not of men	In areas where there has been a resultant shift from subsidized bednets to full payment, their use has declined and hence vulnerability increased. Gender a critical factor here, both because women have less control over household income and because they are more inclined to give priority to buying bednets

In relation to malaria:	Are there sex differences in	How do biological differences between women and men influence their:	How do the different roles and activities of men and women affect their:	How do gender norms/values affect men's and women's:	How do access to, and control over resources affect men's and women's:
Vulnerability: Incidence**/ prevalence ** (male/female)	No significant sex difference reported in incidence or prevalence Rate of infection increases in pregnancy	Pregnant women are more "attractive" to mosquitos, and may have an increased infection rate	May influence exposure, e.g. India: men sleeping on farms away from home unlikely to use bednets; women harvesting maize before daylight in peak biting time or running food stall at night	Clothes worn can affect proportion of body exposed; men may spend more leisure time outdoors	
Preventive and treatment options, responses to treatment or rehabilitation		Non-involvement of women in vaccine trials may result in vaccines that have unforeseen side-effects in women	Women, as carers, more likely to be willing to seek care	Preventive programmes are usually community-based; where social norms mean that women cannot participate, there has been limited success	Financial considerations are usually the most important in whether a full course of treatment is completed – links to women's lesser access to income
Outcome of health problem	Male mortality higher than female mortality in the 0-4 and 5-14 year age groups. From 15 years onwards, there are more female deaths from malaria. High mortality rates reported in pregnant women	Poor prognosis during pregnancy	India study showed male mortality rate significantly lower than female for falciparum malaria	In societies where there is a preference for the male child, the outcomes may be unfavourable to girls even when malaria incidence rates are the same for both	Poor outcomes for pregnant women may be further exacerbated by gender factors within the sociocultural context and economic status of the women, which present barriers to health service utilization and good health
Consequences (economic & social, including attitudinal)	Cambodia study shows that when men had malaria the household was more severely affected economically. Women's workload also increased	[May not be applicable]	See Column 1	No information available	See Column 1

** Of different classes, ethnic groups, ages or other relevant differences between women and between men: Evidence shows that higher income groups are more likely to take preventive action; though also more likely to show resistance because of incorrect use of drugs.

Jasmine was only 20 years old when she died. The first of three daughters of a poor agricultural labourer, Jasmine had studied only up to second standard. Her father could not afford it, the school was 2 km away from her street and it was not considered appropriate for her to go unescorted. Her father also thought that educating a daughter was like “watering the neighbour’s garden”.

When she was 16 years old, Jasmine was married to a rich man of the peasant caste. She was his second wife. Jasmine’s father was only too pleased at his daughter’s good fortune.

Jasmine bore two children in quick succession: the first was a girl and the second, the much awaited male heir. This she did even before her nineteenth birthday. Both the children were born at home. When her son was just eight months old, Jasmine discovered that she had missed her periods for more than two months. She did not want to be pregnant again because her son was sickly, so she talked to a traditional midwife.

The traditional midwife suggested going to a private practitioner 10 km away for an abortion. Jasmine had never gone anywhere outside unescorted, and she had to wait for a day when the midwife was able to come. Jasmine went there under the pretext of having her son immunized. The private practitioner was willing to perform the abortion, but her charges were unaffordable for Jasmine.

Jasmine returned home desperate. She attempted an abortion on her own, inserting a sharp object into her vagina. Within a week, Jasmine became very sick. When the pain started to become severe, Jasmine knew that she would need medical assistance, but hesitated to ask her husband to take her to the town hospital, because she did not know what explanation to give to him. Her relationship with him was strained. She had heard that he was “seeing” another woman because Jasmine had become “sickly”. So, Jasmine took some medicines for fever bought from a local store, and kept quiet. A couple of days later, Jasmine died of high fever, without receiving any medical help.

Session 4

Gender and poverty: barriers

Causes of maternal mortality

Group exercises

Your group has been given a flipchart with one of the following statements written in the bottom left corner:

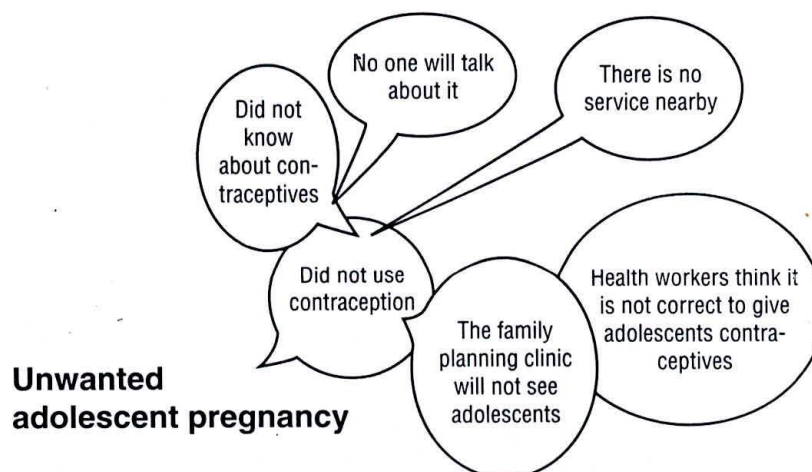
- “A woman with pre-eclampsia delivers at home and develops complications”
- “An adolescent girl dies of complications due to unsafe abortion”
- “A woman who delivers at home has postpartum haemorrhage and is brought to the hospital in shock”
- “A pregnant woman dies soon after arrival at the tertiary hospital due to prolonged obstructed labour”

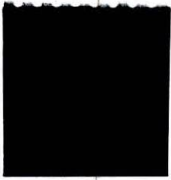
You have 40 minutes in which to analyse the reasons underlying a negative health outcome and to identify reasons that are related to gender and poverty. All charts will be put up and discussed in the large group.

[time: 25 minutes]

Starting with the statement (e.g. “A woman with pre-eclampsia delivers at home and develops complications”), ask yourselves “But why?” Write the reason you come up with, on a bubble drawn next to the statement on the big piece of paper. Keep asking “But why?” until the line of argument is exhausted. Each reason has to flow directly from the one before, and must be written directly next to the previous reason’s circle. Then begin again at the original statement and explore another reason why the woman did not deliver in a health facility. Each circle should contain a single specific issue. Do not use general terms such as “culture” as a reason; articulate which aspect of culture is causing the problem.

The figure below illustrates a series of reasons why for a different problem.





[time: 15 minutes]

- Identify and circle in red factors that are related to poverty; and circle in blue factors that are related to gender.
- Think through reasons why you have identified a reason as related to “gender” or to “poverty”. Write down your reasons on the chart paper.

Session 5: Human Rights

Universal Declaration of Human Rights

Article 1.

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2.

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3.

Everyone has the right to life, liberty and security of person.

Article 4.

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5.

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6.

Everyone has the right to recognition everywhere as a person before the law.

Article 7.

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8.

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9.

No one shall be subjected to arbitrary arrest, detention or exile.

Article 10.

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11.

(1) Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.

(2) No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12.

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13.

(1) Everyone has the right to freedom of movement and residence within the borders of each state.

(2) Everyone has the right to leave any country, including his own, and to return to his country.

Article 14.

(1) Everyone has the right to seek and to enjoy in other countries asylum from persecution.

(2) This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15.

(1) Everyone has the right to a nationality.

(2) No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16.

(1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

(2) Marriage shall be entered into only with the free and full consent of the intending spouses.

(3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17.

(1) Everyone has the right to own property alone as well as in association with others.

(2) No one shall be arbitrarily deprived of his property.

Article 18.

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19.

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20.

(1) Everyone has the right to freedom of peaceful assembly and association.

(2) No one may be compelled to belong to an association.

Article 21.

(1) Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.

(2) Everyone has the right of equal access to public service in his country.

(3) The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22.

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23.

(1) Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.

(2) Everyone, without any discrimination, has the right to equal pay for equal work.

(3) Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

(4) Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24.

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25.

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

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26.

(1) Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

(2) Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

(3) Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27.

(1) Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

(2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28.

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29.

(1) Everyone has duties to the community in which alone the free and full development of his personality is possible.

(2) In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

(3) These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30.

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

Read the following case study and then evaluate its public health quality using the questions to guide your thinking.

Case study

In this particular country, the health commissioner is concerned with preventing heterosexual transmission of HIV/AIDS. She decides to add an HIV test to the routine testing for sexually transmitted infections (STIs) given to sex workers every three months. Sex workers are given a card to carry, which says they are disease-free. If they are found to be infected with an STI, their card is temporarily revoked for a three-month period. The HIV test will be added to the STI tests at the six-month interval. If a woman is found to be HIV-infected, the card will be permanently revoked.

Take 10 minutes to complete the public health analysis of this intervention. You may discuss it with your neighbours if you wish. Ignore the rights aspects for the moment. Go through the following steps:

- State the public health problem being addressed.
- State the goal of the proposed action.
- Determine the public health quality of this intervention. Is this good public health? Will it achieve the stated goals?

Bear in mind the various elements of a good public health intervention listed earlier in the session: effectiveness, coverage, feasibility, cost, community involvement. You should consider all of these when determining the quality of any public health policy or programme. Once you have considered them for this analysis, identify the place on the horizontal axis of the chart, "Four quadrants: The quality of human rights and public health in a programme" which you think represents the public health value of the programme. Mark this point P.

After the whole-group discussion and voting on the public health quality of the intervention, take 20 minutes to complete the human rights analysis of this same intervention. You may discuss this with your neighbours if you wish. Ignore the public health aspects of this intervention for the moment. Go through the following steps:

- Look at the UDHR (starting with Article 1) and consider every right that is being violated or promoted by this intervention.
- Think through how exactly the right is being impacted upon in the short term as well as in the long term.
- Remember to consider for each right, government obligations to respect, protect and fulfil it.
- Recall the rights that can never be restricted (as discussed in Session 2).

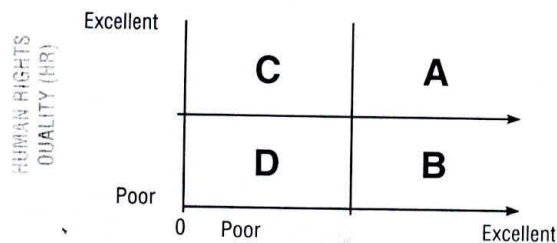
- Pay attention to the severity, scope, frequency and duration of whatever violation you see.

Once you have completed the analysis, identify the place on the vertical axis of the chart that you think represents the human rights value of the programme. Mark this point Q.

Assessing the overall quality of public health and human rights

Draw a vertical line through P and a horizontal line through Q. R, the point of intersection of these lines, represents the overall public health and human rights quality of the intervention.

Four quadrants: The quality of human rights and public health in a programme



Sector explanations:

A: best case

B: need to improve HR quality

C: need to improve PH quality

D: worst case, need to improve both PH and HR quality

After this, there will be a whole-group discussion. You will vote to arrive at the point on the vertical axis that represents the group's consensus on the human rights quality of the intervention. In this way, you will identify the quadrant the intervention fits into, which will indicate the combined quality of its health and human rights components.

Indicator		Data needed & equations	Type		Data Source		
			P	I	1	2	3
1	Family Planning						
1.1	Average birth interval	Months since last live birth		X		X	X
1.2	Contraceptive prevalence rate (modern methods)	$\frac{\text{Number of women or partners using any modern method} \times 100}{\text{Estimated number of women of reproductive age}}$		X		X	X
1.3	New contraceptive acceptors annually	Number of women or partners accepting a modern method during the reference year	X		X		
1.4	Contraceptive acceptance rate	$\frac{\text{Number of women/partners accepting a method} \times 100}{\text{Estimated number of women of reproductive age}}$	X		X		
1.5	Annual continuation rate	$\frac{\text{Acceptors during the reference year continuing at the end of a year} \times 100}{\text{Total new acceptors}}$	X		X		
1.6	Crude birth rate	$\frac{\text{Number of births in the reference year} \times 1000}{\text{Estimated mid-year population}}$		X			
1.7	Age-specific fertility rate	$\frac{\text{Number of births during the year to women within age group} \times 1000}{\text{Estimated number of women in the age group}}$		X			
1.8	Average number of children (live births) born in last three years	$\frac{\text{Number of live births in last 3 years}}{\text{Estimated number of women of reproductive age}}$		X			
1.9	Average age at first birth for women under 25 years	$\frac{\text{Age at first birth for women} < 25 \text{ years old}}{\text{Estimated number of women} < 25 \text{ years old}}$	X				X
2		Maternal					
2.1	Number of pregnancy-related deaths	Deaths of women during pregnancy or within 42 days of termination of pregnancy irrespective of the cause of death		X		X	X
2.2	Number of maternal deaths	Deaths of women during pregnancy or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes		X		X	X
2.3	Maternal mortality ratio**	$\frac{\text{Number of maternal deaths} \times 100\,000}{\text{Estimated number of live births}}$		X		X	X
2.4	Percentage of women attended at least once during pregnancy by trained personnel**	$\frac{\text{Women attended at least once during pregnancy} \times 100}{\text{Estimated number of live births}}$	X		X	X	X
2.5	Percentage of births attended by trained health personnel**	$\frac{\text{Births attended by trained health personnel} \times 100}{\text{Estimated number of live births}}$	X			X	X
2.6	Availability of facilities providing essential obstetric care per 500 000 population**	$\frac{\text{Number of facilities providing essential obstetric care}}{500\,000 \text{ population}}$	X		X		X

Source: *Maternal-Baby Package: Implementing safe motherhood in countries: Practical guide*. WHO, Geneva, 1996.

Indicator	Data needed & equations	Type		Data Source				
		P	I	1	2	3		
2.7	Percentage of population living within 1 hour travel time of health centre/hospital offering essential obstetric care**	$\frac{\text{Population living within 1 hour travel time to health facility} \times 100}{\text{Total population}}$		X			X	X
2.8	Percentage of complicated obstetric cases managed at essential obstetric care health facilities**	$\frac{\text{Complicated cases managed in essential obstetric care facilities during the reference period} \times 100}{\text{Estimated number of complications in the population during the reference period}}$		X		X		
2.9	Case fatality rate for obstetric complications***	$\frac{\text{Number of maternal deaths due to direct obstetric causes} \times 100}{\text{Number of direct obstetric complications}}$		X		X		X
2.10	Caesarean deliveries as % of all births in the population	$\frac{\text{Number of caesarean deliveries in the reference period} \times 100}{\text{Estimated number of live births in the reference period}}$		X		X		
2.11	Prevalence of anaemia and moderate/severe anaemia by gestation <ul style="list-style-type: none"> • 2nd trimester anaemia moderate/severe anaemia • 3rd trimester anaemia moderate/severe anaemia 	$\frac{\text{Number of women in 2nd trimester with Hb } < 11\text{g/dl} + \text{Number of women in 3rd trimester with Hb } < 7\text{g/dl}}{\text{Estimated number of live births}}$			X		X	X
2.12	Percentage of pregnant women screened for syphilis	$\frac{\text{Number of pregnant women screened for syphilis} \times 100}{\text{Estimated number of live births}}$		X		X		

P = Process indicator, I = Impact indicator, 1 = Service data, 2 = Surveillance/routine reporting, 3 = Surveys
 * 15-49 years
 ** See Indicators to Monitor Maternal Health Goals: Report of a Technical Working Group. Geneva, World Health Organization, 1994, WHO/FHE/MSM/94.14.
 *** This indicator refers to a given facility and should not be aggregated at the national level.
 Apart from the quantitative data mentioned above, interviews and focus group discussions with mothers (possibly led by local women's organizations) may complement the findings of the suggested indicators.

Your group has 45 minutes to work on one of the following four problems. Nominate a reporter who will report back to the whole group. Your small group discussion should come to a close five to ten minutes before the half-hour is up to allow time for the reporters to write up their presentations.

A new project for the improvement of the reproductive health of adolescents is being initiated in your district. The project is planned for a three-year period. The objectives are:

- to promote condom use;
- to prevent unsafe abortions; and
- to promote postponement of child-bearing.

The following are some indicators routinely used for monitoring this project:

- proportion of (sexually active) adolescent boys reporting condom use (this may be further refined, for example, to specify regularity of condom use, access to condoms, or whether a condom was used in their most recent sexual encounter);
- 15–19-year-olds as a proportion of all abortion-related obstetric and gynaecology admissions; and
- proportion of women in the 15–19 age group who have had one or more children or are currently pregnant.

Alter one or more of these indicators or develop new ones so that they address gender/ rights dimensions.

Concern has been raised about the number of maternal deaths reported in your area. A safe-motherhood project aimed at reducing maternal deaths over the next three years is to be implemented very soon. The specific objectives are:

- to prevent delay between the development of a serious complication in pregnancy and reaching a health facility providing emergency obstetric care; and
- to prevent delay within health facilities in initiating appropriate treatment.

The following are some indicators routinely used for monitoring this project:

- percentage of women who died at home or on their way to the hospital;
- percentage distribution of maternal deaths in hospital, by time between admission and death; and
- percentage of women reporting a delay or complication when referred to a health facility.

Alter one or more of these indicators or develop new ones so that they address gender/ rights dimensions.

Group work 3: Improving family planning services

In your province, more than 80% of contraceptive users have adopted female sterilization. Your brief is to improve the quality of family-planning services offered in the five primary health centres under your supervision over the next three years. You design a project that aims to:

- widen contraceptive choice for women and men;
- improve follow-up services; and
- improve client satisfaction.

The following are some indicators routinely used for monitoring this project:

- percentage distribution of all contraceptive users, by method used;
- proportion of contraceptive users reporting at least one follow-up contact with the health facility or health worker; and
- proportion of satisfied users at the end of X months following acceptance.

Alter one or more of these indicators or develop new ones so that they address gender/ rights dimensions.

Group work 4: Preventing RTI/STI

A new RTI/STI prevention and control project is being implemented in your health facility. The objectives of the project are to:

- improve awareness of the signs and symptoms of RTIs/STIs;
- promote treatment seeking among those with symptoms of RTIs/STIs; and
- encourage partner notification and treatment.

The following are some indicators routinely used for monitoring this project:

- proportion of clinic users who are aware of the symptoms of one or more RTI/STI;
- number (and/or proportion) of clients seeking treatment for RTIs/STIs; and
- proportion of clients (by sex) whose partners have also sought treatment.

Alter one or more of these indicators or develop new ones so that they address gender/ rights dimensions.

During your visit to the health facility, you will be working in four groups. Each group will visit one specific health facility or different clinics within the same health facility.

Your task is to observe, and when needed, interact with clients/patients and health providers. The aim is to gather details about the quality of health services, and the extent to which gender and rights issues have been taken into account when planning for delivery of health services.

We would like each group to observe the following elements of quality of care (see table below). You must write up a group report for presentation to the class the next morning. This presentation should highlight:

- a general description of what your group observed about the health facility and its internal and external environment, staff presence, workload, and so on;
- what was present and what was missing in terms of the quality-of-care elements listed below; and
- what needs to be done to make the clinic and the health facility address gender and rights concerns.

The presentation should be no longer than 10 minutes. You can prepare a written report for submitting to the facilitator and also transparencies or PowerPoint presentations.

Table: Elements of quality of care

Element	Definition of element: some examples
Client-provider interaction	<ul style="list-style-type: none"> • Takes into account the ways in which gender may cause vulnerability and risk, and also affect treatment seeking and compliance • Ensures privacy and confidentiality • Respects patient's dignity • Treats all clients with respect, irrespective of clients' social and economic position • Does not persuade or coerce client in any way • Carries out a two-way conversation without being judgmental, and facilitates informed decision-making
Information/counselling for client	<ul style="list-style-type: none"> • Information materials available • Counsellor does not assume ignorance on the part of the client and acknowledges the client's own knowledge base • Privacy and confidentiality maintained during and after counselling • Counsellor respects client's culture and value systems • Counselling available to all (e.g. FP counselling not restricted only to married women) • Counselling includes asking clients about issues related to gender roles and norms, access to and control over resources, and decision-making power • Topics covered in counselling include information on the nature of the problem, ways to prevent it, treatment options available and treatment proposed by the provider • Sufficient time for provider to counsel client

<p>Essential supplies, equipment and medication needed, plus norms and standards</p>	<ul style="list-style-type: none"> • Physical space well organized, with clear instructions available to patients on where to get what information • Adequate waiting space • Table, speculum, gloves • Electricity, water supply, toilets (in working condition and not locked up) for women and men • Consistent supply of drugs, supplies, and necessary equipment maintained • Medications and supplies stored properly • Proper disposal of bio-hazardous waste • Protocols for management available and prominently displayed • Clinic organization takes into account the specific needs of women and men because of gender and other social inequalities: e.g. clinic timings take into account women's workload and availability of transportation; special needs of those without literacy skills taken care of: e.g. oral or pictorial instructions, local language sign boards, help desk or someone available at reception to help
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You have been assigned to read, as homework, either a reading on costing a mother-baby package in Uganda, or one on financing maternal and child health services in Bolivia. For the reading on costing, think through and note down your responses to the following:

- What were the essential steps used in the mother-baby package costing study done in Uganda? What was the range of services considered? How were the incremental costs assessed?
- What were the current and incremental per capita costs for providing enhanced maternal and newborn health services in Uganda?
- What were the main components of cost?
- Do you have some idea of the current cost of maternal health care in your country? If only a small increment could be made in overall spending for maternal and newborn health, where would you choose to put the additional money?

For the reading on financing maternal and child health services in Bolivia, think through and note down your responses to the following:

- What was the mechanism for financing used?
- What potential implication does it have for increasing access to and utilization of maternal health services?
- Do participants have some concerns about this financing mechanism? What are they?
- What is the potential for implementing such innovations (or modified versions of these) within their respective country settings?

Tomorrow you will be working in groups, and will share the main points you gathered from the reading. [The group then prepares “group” answers to the questions above.]

You will not be required to make a formal presentation, but will be requested to contribute to the large group discussion. The brief notes may then be submitted to the facilitator for inclusion in the report.

To be given out on the day before the session

Session 11

Policy approaches to gender equality

Gender-unequal

Many policies do not recognize differences between women and men. Some policies, which we might call “gender-unequal”, actually privilege men’s well-being over women’s. These are policies that directly deny women’s rights or give men rights and opportunities that women do not have. For example, a policy that denies a married woman the right to medical insurance in her own name makes her dependent on her husband for access to medical insurance. If her husband is unemployed, then she (in addition to her husband) is denied access to medical insurance. A policy that requires a man’s consent before a woman can be sterilized is also gender-unequal in that it deliberately gives men power over women. This approach is not given in the table in the hand-out, but if there are such health policies in your country, you could include this approach.

Gender-blind

Gender-blind policy is blind to gender differences in the allocation of roles and resources. Thus, what may appear to be a good policy – for example, one that brings clinics close to people’s homes – may not impact equally on men and women. This is because women may not control transport to reach the clinic, or may not have funds to pay for services. A recruitment policy that gives both educational levels and years of experience as its criteria may seem to be a fair policy. However, it does not recognize that, while certain women may have good work experience and competence, they may not have had the same opportunities as men for formal education, and the policy will discriminate against women. For this reason we can call it gender-blind – not intentionally discriminatory, but reinforcing gender discrimination nevertheless.

Gender-specific

Gender-specific policy is aware of the practical gender needs of women and men, and tries to address them. For example, it could involve creating a separate outpatients area run by women doctors for women patients so that they can discuss their reproductive health problems freely. Alternatively, it could involve designing educational interventions to help adolescent boys deal with peer pressure in smoking or consuming alcohol.

Gender-redistributive

Gender-redistributive policy tries to change the allocation of roles, resources and power between men and women in society. For example, this could mean raising awareness among men of the reproductive health consequences of women’s work burden and the problems of repeated pregnancy. It could mean promoting male methods of contraception, including investment in research on male methods of contraception.

In this table, each column represents a different policy approach to gender. Below the table, there is a list of different policies. Decide where each policy fits in the table and fill in its number under the appropriate column.

Gender-unequal	Gender-blind	Gender-specific	Gender-redistributive

- (1) Maternal health policy: trains midwives to improve their clinical skills to prevent maternal morbidity and mortality.
- (2) Water supply policy: establishes a mechanism to provide taps close to villages so that women will not have to walk as far to fetch water.
- (3) Human resource policy: includes provision for child care facility at the workplace.
- (4) Land policy: removes restrictions on women's right to inherit land.
- (5) Occupational health policy: protects women and men from working in places that are hazardous to their reproductive health.
- (6) Senior management recruitment policy in a department of health: requires all managers to have a PhD.
- (7) Community-based AIDS care programme: says that the health care system cannot take responsibility for caring for people with AIDS so that home-based care must be instituted.
- (8) Information, education and communication (IEC) policy: establishes messages and methods to advocate to women and men about mutual respect and equal rights in sexual decision-making as a means of promoting safer sex practices.

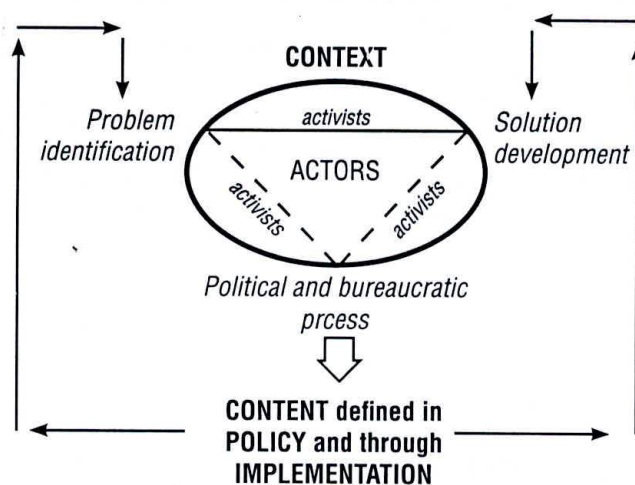
Session 10

A framework for policy analysis

[A slightly simpler version of this framework was originally published in Klugman B. Mainstreaming gender equality in health policy. Agenda, 1999: 48–70.]

This framework draws on some of the key conceptual developments in policy analysis over the last decade. In particular, it draws on Walt and Gilson's [1] recognition of the role of context, actors and political process in influencing policy content, and on Kingdon's [2] conceptualization of the existence of "multiple streams" of problems, solutions and politics and the need for "policy entrepreneurs" to create links between these streams.

Figure 1: The framework



Context can be divided into:

- social context (e.g. position of women, level of educational attainment in society, social stratification);
- political context (e.g. nature of political regime, role of civil society, political participation of women);
- economic context (e.g. nature of economy, resource base, whether equity is a priority in resource allocation);
- cultural context (e.g. predominant values and norms on gender, reproduction and sexuality, and extent to which inequalities including gender are institutionalized);
- immediate context (e.g. recent change in government and related ideological shifts, recent international agreements such as the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) or the ICPD Programme of Action); and
- international context (e.g. proportion of partner funds in national budget, bargaining power within the global geopolitics).

An issue may be identified as important and as deserving attention in some specific contexts and not in others. Also, contextual factors play a major role in influencing whether a policy

initiative finds a great deal of support or opposition, or receives no attention at all. Any attempt at influencing policy therefore should analyse the nature of contextual factors at any given point in time.

In order to develop a coherent strategy, it is essential to identify which actors or stakeholders share your goals for policy change, and which are against them. Which of these have power or influence and which do not? Which are mobilized and which are not? Could certain groups be mobilized in support of your goal? Some examples of actors in the policy development or implementation process include:

- politicians and political parties;
- government officials;
- NGOs;
- community groupings/“people’s organizations”;
- specific constituencies (e.g. professional organizations, religious organizations);
- the media; and
- research institutions.

Some of these actors will support a policy or implementation goal, while others will oppose it. Some will have more resources and power than others, and will therefore have more influence. Some will be mobilized and others will not. An analysis of actors is necessary to identify potential allies and opponents, who could be mobilized in support of a specific change process, and their resources or lack thereof. Specific strategies need to be identified so as to work with those who support the policy and to deal with those who do not.

Frequently, women are not mobilized into organizations that make their voices heard. It is important to identify whether or not there are any organizations of poor or marginalized women and how to support their participation in a change process.

The framework identifies the process of problem identification as very significant in ensuring that the final policy and its implementation are aimed at promoting social and gender equity. When people who do not have the interests of the majority at heart define a problem, the problem definition may not recognize the specific interests of the majority. Mainstreaming gender in health means making sure that women’s perspectives, experiences and priorities shape problem definitions. It means focusing on equity – putting the needs of those who are most disadvantaged first, whether these are children, women, men or specific groups of people.

The following box highlights issues related to the process of problem identification and definition. These need to be taken into consideration when looking at how a policy came about, or when attempting to plan a policy or implementation intervention. Again, it uses the South African experience in order to show how the issue of abortion was first identified as a problem, in order to get it on to the political agenda.

Box 1: Problem identification: whose problems?

Who defines the problem?

- Need to ensure that ordinary people's perspectives – women's, men's, adolescents' (and within this, marginalized groupings of men, women and adolescents) – are heard and that legislation and programmes are designed to meet their needs, as they perceive them.
- Need to ensure that inequality does not silence the experience or the voices of certain groupings, for example, poor women who are either not recognized as having the right to input, or who do not have the confidence to express their views.
- Need to ensure that the way the problem is defined identifies and addresses how the issue impacts specifically on poor women's position in society, as well as their daily life experience. Focal issues, as raised in the Gender module, are their power, their roles, their access to and control over resources.

The role of the process of policy development

There are many institutions in society, such as universities, private sector bodies, and government technical staff, whose task is to develop solutions to society's problems. There are often many different ways of solving a problem. It is important to look at what the solutions tabled were, who tabled them, why, and whose interests they represent, in trying to understand how a policy was developed.

Solutions need to address equality – to ensure that barriers to the sexual and reproductive rights of those with the least power and resources, notably women, are addressed. Solutions need to address equity – to ensure that the policy or programme applies to all people, and will be implemented in such a way that the inequalities in the allocation of resources and power between men and women and between different social groups are reversed.

It is essential to establish mechanisms during the process of advocacy to gather information about how those who are poorest or suffer discrimination experience the issue, and what sorts of solutions would improve their overall situation.

Frequently, neither problem identification nor solution development is carried out in a way that involves those experiencing the problem. Rather, it often addresses the interests of particular interest groups, such as:

- consultants wanting to do more research;
- politicians wanting to maintain their political support; and
- donors wanting to support a programme that fits their country's policies or their institution's values: for example, a vertical programme providing only contraception services, or only sexually transmitted disease services, irrespective of the impact on ordinary people.

Who is responsible for making and implementing legislation or policy in a specific country, area or workplace?

In the context of a country, this would include:

- politicians;
- government at different levels and all bodies responsible for implementing the legislation or policy; and
- others in a “policy elite” such as powerful business people or religious leaders.

Grindle and Thomas [3] have identified four different concerns that seem to be the major factors that influence decisions made by politicians and senior government officials. These are:

- the meaning of change for political stability and political support;
- the technical advice they receive;
- their relationships with international actors; and
- the impact of their choices on bureaucratic interactions, i.e. how policy or implementation decisions affect their power at work, their levels of responsibility, and so on.

It is important to work out what factors influence those who are in power, so that advocacy activities address their concerns, in a language that they understand.

References

1. Walt G., Gilson L. *Reforming the health sector in developing countries: the central role of policy analysis*. *Health Policy and Planning*, 1994, 9(4): 353–370.
2. Kingdon J. *Agendas, alternatives and public policies*. New York, HarperCollins, 1995.
3. Grindle M., Thomas J. *Policy makers, policy choices, and policy outcomes: the political economy of reform in developing countries*. *Policy Sciences*, 1989, 22: 213–248.

Session 11, Handout 11.1

Making change happen within your institution

Instructions for preparing your poster

You need to plan an intervention to reduce morbidity and mortality related to pregnancy and child birth, or to improve accessibility, availability, affordability and quality of health services related to making pregnancy safer. The intervention must address gender and rights concerns. You may choose to carry out one limited activity or an intervention consisting of several components.

- (1) Think of an area of your work in which you think it will be possible for you to implement an intervention that fulfils the objectives stated above.
- (2) Define your goal. What exactly do you want to achieve/change?
- (3) Mention the major steps of the intervention(s) chosen to achieve the above goal. The time line for this intervention can be kept at one year, to begin with.
- (4) Analyse the situation within your institution. Who or what will support your cause? Develop a plan to involve these supporters in your intervention at some level. For example, if you know of a colleague from another department who may be supportive, make it a point to consult with this person and keep him/her informed of developments. You could think of constituting an advisory group, if making this formal would help. Include these steps in your intervention. Who will oppose it, or what factors will act as barriers? You may want to go back and modify the intervention accordingly. For example, if you know that some colleagues will oppose it, you may want to think through how this opposition can be neutralized.
- (5) List also potential allies outside your institution with whom it would be important to network. Develop your alliance or network, and set up mechanisms (committees, regular meetings or e-group forming) to keep them informed. Include these in your major steps identified above.
- (6) To summarize, your final plan should contain the following:
 - AREA OF WORK
 - GOAL
 - INTERVENTION STEPS PLANNED
 - ALLIES/POTENTIAL SOURCES OF RESISTANCE WITHIN YOUR ORGANIZATION
 - EXTERNAL ALLIANCES/NETWORKS

Write these up in poster format.

⁸ This hand-out is to be distributed during Session 1 on Day 0.