GENDER EQUITY PROGRAMS

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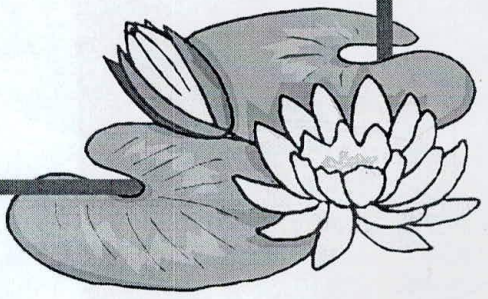


Gender Equity Programs

*OBJECTIVES:

By the end of the Workshop, the participants will:

1. Discuss the difference between gender and sex
2. Describe how gender influences health and development
3. Practice exercises to prepare checklists integrate gender concepts in their existing work
4. Prepare rights-based plans for integrating gender concepts in their personal and professional plans
5. Identify individuals in the networks to develop checklists gender sensitivity in existing programs and lead the gender equity initiative.

TIME: 6 hours 30 minutes
Methods and Materials: Discussions, Bombing the city, games, role plays, group work, preparing checklists
Key words: Defining gender and sex, vulnerability, options, violence, sexual reproductive health mainstreaming, checklists

BACKGROUND NOTES:

DEFINING GENDER AND SEX

Sex refers to physiological attributes that identify a person as male or female

- Type of genital organ (penis, testicles, vagina, womb, breasts)
- Type of predominant hormones circulating in the body (estrogen, testosterone)
- Ability to produce sperm or ova (eggs)
- Ability to give birth and breastfeed children

Gender refers to widely shared ideas and expectations (norms) concerning women and men. These include ideas about "typically" feminine or female and masculine or male characteristics and commonly shared expectations about how women and men should behave in various situations. These ideas and expectations are learned from: family, friends, opinion leaders, religious and advertising and the media. They reflect and influence the different role, social status, economic and political power of women and men in the society.

The Code for Enabling Gender Equity for enabling HIV/AIDS Prevention is:

- Celebrating the difference of the two sexes
- Respecting the uniqueness of being male and female as people equally entitled to the benefits of living and
- Being equally responsible for making commitments for preventing HIV/AIDS.

THINKING ABOUT GENDER EVERDAY

- *"'Men are gold, women are cloth.' The expression, used as the title of a report on Cambodian attitudes towards sex and HIV, means that women, like a white cloth, are easily soiled by sex. This causes a sharp decrease in their value, as the stain is hard to remove, whereas men can have repeated sexual experiences and be polished clean, like gold, each time."*
- *"Women should wear purdah to ensure that innocent men do not get unnecessarily excited by women's bodies and are not unconsciously forced into becoming rapists. If women do not want to fall prey to such men, they should take the necessary precautions instead of forever blaming men."*

- *– Malaysian member of Parliament during debate on reform of rape laws*
- *"The child was sexually aggressive" – Canadian judge suspending sentence of man who sexually assaulted a 3-year-old girl in 1991*
- *"A man who beats his wife must have a good reason for it; surely she did something to provoke it." – Nicaraguan Supreme Court judge speaking in a public forum in 1996*
- *"…through questions related to her sexual life it is possible to tell if the woman is responsible for the attack, because in most cases, it is the woman who provokes the aggression" – agent from the Mexico City Attorney General's Office*
- *"Are you a virgin? If you are not a virgin, why do you complain? This is normal." – assistant to public prosecutor in Peru answering a woman who reported sexual abuse by police officers while in custody*
- *I am divorcing her since she cannot give me a son. We already have two daughters. {Several Indian men}*
- *What family planning? Vasectomy? Do you want my manhood to decrease? I am a man. I have the freedom to drink, rape my wife, hit her when she does not work hard enough and cook good food for me!" {Voices of men from different parts of India.}*
- *What are you crying for? Are you a boy? Boys are strong they do not cry*
- *It is okay for a man to drink alcohol. . After all, he is the one who works hard in the filed. He does the heavy work.*

REFLECT ON THE FOLLOWING… …IS THIS JUST? IS THIS HUMAN RIGHTS??

- *"I am legally married to my wife and if I have sex with her when she is not ready, that is not rape. A woman is there to serve and dance to the tune of her husband, full stop." – 47-year-old man in Tanzania*
- *"[No] matter who and how a woman is, her intellect is very small.– old man in Ghana*
- *"The female condom will increase immorality among women and single mothers. It is worse than the male condom, giving women the opportunity to do what they want. We are going to preach against these condoms…" – parish priest in Kenya*

WHEN IT COMES TO VIOLENCE AGAINST WOMEN, THERE ARE NO DEVELOPED COUNTRIES !

INSA

Key points about Gender	Few Examples	Linking to HIV/AIDS
Gender has to do with relationships, not only men and women but also among women and among men A quick way to remember the difference between sex and gender is that sex is biological and gender is social. This means that the term sex refers to innate characteristics, while gender roles are learned gradually and can change. Sex inborn and gender is made. Gender doesn't only apply to people who are heterosexual: it affects people who are heterosexual, bisexual, homosexual or lesbian and people who choose to abstain from sex. Men and women can manipulate gender-based ideas and behaviors for their own benefit, presumably without harming anyone but at the same time reinforcing stereotypes It is difficult to be 100% gender-sensitive; we are almost all influenced by gender in our ideas and actions. Gender sensitivity doesn't mean that we no longer recognize differences between men and women. Some differences remain because of biology; we may choose to retain others even in equal relationships (e.g. men opening doors for women to be polite).	Mothers teach daughters not to contradict men; fathers teach sons 'not to act like women' by crying when they are hurt. Size of the penis, vagina refers to Sex. Females being soft and males being strong are about gender. Homosexual males are seen negatively by society {gender} Women crying or flirting to get some thing done It is not easy to stop the practice of Dowry Pregnant women ask men to carry heavy loads for them	Women do not raise their voices even when sexually abused. It is taken for granted that men can have multiple sexual partners. The anatomy of a female makes her more prone to HIV infection during sex with an infected partner. {Sex}. The He-man gender- version of a male socially permits him into unsafe sex. Enabling sexual Rights helps prevent HIV infection and leading of healthy sexual lives. Women are viewed as objects of sexual pleasure putting her at risk for HIV infection and sexual abuse. Hence Women are more susceptible to HIV infection Women dependence on men's decision-making powers makes her susceptible to HIV infection.

Culture, media, gender and vulnerability to HIV

"A culture is a way of life of a group of people--the behaviors, beliefs, values, and symbols that they accept, generally without thinking about them, and that are passed along by communication and imitation from one generation to the next. Our concepts of an "ideal" also come from our cultural ways of thinking. For example an ideal male must be "strong" and an ideal female must be "sacrificing, caring".

In what way do culture and our concept of ideal male and ideal female make us vulnerable to HIV infection?

"Strong man" may mean, the sole head of the family, the physical power and social power, dominant, knowledgeable, etc. This attitude may make the man indulge in risk behavior which makes him vulnerable to HIV infection."

"Caring female" may mean taking care of the family, should not be dominant, should adjust to any situation, should not find faults, and should satisfy the needs of her husband. She may not be able say NO. These things make her vulnerable to HIV infection, since the power structure defined by our culture restricts women to say NO whenever she wanted to. She may be vulnerable to HIV infection if she cannot say NO to unsafe sex."

Our culture is to be valued. We can use our culture to prevent HIV infection. The value for abstinence, the value for staying faithful, and the value for building strong relationships is part of our culture. We also need to be careful when culture and media can also increase our vulnerability to HIV.

Information related to Gender and HIV / STIs and AIDS.

Young women are among the most vulnerable groups for HIV/STI; for example:

- In Young teenagers, the mucous cells of the Vagina and cervix are not yet fully developed and thinner, providing a less barrier to viruses.
- Young women often have older sexual partners, who most likely have had a longer sexual history that increases the chances of these partners having acquired an STI or HIV Infection that they can pass on through unprotected sex.
- Young women's ability to influence sexual decision-making is often highly restricted, due both to gender-based norms and relative powerlessness due to their younger age.
- Young women, who have been deprived of education, lack both skill and opportunities for obtaining well-playing jobs, and who have little financial support from their families, may turn to trading sex for cash, goods or other resources. Both their sex and age will make negotiating safe sex difficult.

Young men are also vulnerable to HIV / STI transmission, for example:

- Peer pressure may be intense during adolescence and gender-based norms often encourage young men to 'prove their manhood' by having multiple partners.
- Young men may find it difficult to use condoms. For example, embarrassment may prevent them from purchasing or asking condoms. Focus groups in South Africa revealed that some young men did not want to use condoms because they feared embarrassment if the condom might come off because it is too big for their penis.

- The stigma and discrimination still prevalent regarding homosexuality in many places makes it difficult for young homosexual men to express their sexual orientation openly, and this makes it more difficult for them to obtain needed SRH information and take action to reduce their SRH risks.

- Drug abuse increase vulnerability to HIV infection in two ways: it may increase feelings of 'being in control' and willingness to risks, such as unsafe sex; and sharing of unsterilised injecting equipment can lead to direct transmission of the virus. UNAIDS estimates that 80% of drug injectors are male.

- Less frustration tolerance to withstand opportunities for sexual pleasure. They succumb since they have not been gender-nurtured to withstand not getting what they want.

A BRIEF ON GENDER THEORY

Gender theory, an interdisciplinary approach to cultural studies, focuses on the definitions and fixity of sexual identity. Gender theorists are based in Lacanian thought. They see sex and gender as opposing ideas: one is natural the other artificial. Sex is the biological identification of male or female, whereas gender is a social construct, which relies on stereotypes to reinforce socially proscribed roles. It developed partially from conflicts within feminist criticism, but it grew alongside feminist theory throughout the 1980s and 1990s. Although its focus is in cultural history, gender theory is used to explicate popular films and literary works as cultural artifacts; in doing so, theory effectively "marks" or politicizes gender and sexual issues. This allows public recognition of differences, thereby motivating social change.

Gender theory grew parallel to, and as an offshoot of, feminist theory in the mid-to-late 1980s. The question of why gender studies is relevant to health, literature and other spheres of life is answered by those critics who use gender as a key to unlock both cultural history and literary meaning by analyzing the role that gender plays--whether visible or not--in texts.

Like other social criticisms that emerged from the 1960s and 1970s, gender theory is a political tool. In unmasking gender, critics de-naturalize the term and reveal artifice. On the other hand, by *"not focusing on gender, we allow things to go unmarked. If something is not marked, then it is not noted and, therefore, does not exist."*

By analyzing gender in texts, critics remind the public that health, literature and other spheres of life not only reflects culture but transmits it as well. Health, literature and other spheres of life helps reinforce traditional standards of gender and sexuality. For this reason, questions of gender need to be marked and noted--with recognition it will be possible to modify cultural expectations and practices.

Gender theory has been a viable critical method since the mid 1980s. However, it can be difficult to locate a thorough definition of the theory and its main perspectives. For example, *The Johns Hopkins Guide to Literary Theory and Criticism* fails to note gender at all. Criticism can be leveled at gender theory. Primarily, its political motivations may over-ride its critical task. Identity politics can be vague, and it is problematic to define oneself as a member of a gender group when you resist gender classification. Additionally, gender theory is inclusive and, therefore, is open to great variation. It is easy to deride or cast aside theory that appears too vague or encompassing. However, gender theory is a valuable guideline when examining our work in community health.

Adapted from Source Morgan, JA. "Gender and Cultural Analysis: Marking the Territory." Musings, Polemics, & Good Sense. 2003. access date. <http://www.home.earthlink.net/~nomo1521/id6.html

Source: http://mohfw.nic.in/popindi.htm

GENDER DEMOGRAPHICS - INDIA

Population Growth, Crude Birth, Death Rates & Sex Ratio India, 1901-2001

Year	Population (in million)	Percentage Decadal variation	Average annual exponential growth rate(percent)	Crude Birth Rate	Crude Death Rate	Sex Ratio (Female per 1000 males)
1901	2384	-	-	-	-	972
1911	2521	5.75	(+) 0.56	49.2	42.6	964
1921	2513	-0.31	(-) 0.03	48.1	47.2	955
1931	2790	11.00	(+) 1.04	46.4	36.3	950
1941	3187	14.22	(+) 1.33	45.2	31.2	945
1951	3611	13.31	(+) 1.25	40.8	27.4	946
1961	4392	21.51	(+) 1.95	41.7	22.8	941
1971	5482	24.80	(+) 2.20	41.2	19.0	930
1981	6833	24.66	(+) 2.22	37.2	15.0	934
1991	8464	23.85	(+) 2.14	32.5	11.4	927
2001	1027.0	21.34	(+) 1.93	24.8	8.9	933

Source: Registrar General, India - Census figures

For detail contact http://www.censusindia.net/

Expectation of Life at Birth

Census Year	Male	Female
1901	23.63	23.96
1911	22.59	23.31
1921	19.42	20.91
1931	26.91	26.56
1941	32.09	31.37
1951	32.45	31.66
1961	41.89	40.55
1971(1)	46.40	44.70
1980(2)	54.10	54.70
1989(2)	58.10	58.60
1990(2)	58.60	58.70
1991(3)	58.10	58.60
1992(3)	58.60	59.00
1993(3)	59.00	59.70
1994(3)	59.40	60.40
1995(3)	59.70	60.90
1996-2001 (P)	62.30	65.27
2001-2006(P)	63.87	66.91
2006-2011(P)	65.65	67.67
2011-2016(P)	67.04	69.18

Source : Office of the Registrar General India and Statistical abstract India 1997, CSO, N.Delhi

Note: (1)Based on 10% rural and 20% urban sample

WRITE DOWN HOW THE COMMUNITY AND FAMILY REACT TO THE FOLLOWING SITUATIONS:

SITUATIONS	FEMALE	MALE
When the pregnancy test shows the sex of the baby		
When the child is born		
When the child keeps crying at night		
When the child has a fever		
When the child breaks a favourite show-piece		

Demographic Indicators – State-wise

States/Union Territory	2001 Census (Provisional)				Crude Birth Rate (2000) SRS	Crude Death Rate (2000 SRS	Natural Increase (CBR-CDR) SRS	Infant Mortality Rate (2000) SRS	Total Fertility Rate (1999) SRS	Couple Protection Rate (%) 31.3.2000
	Population (in million)	Annual Exp. Growth Rate (%)	Female Literacy (%) 7 yrs.& above	Sex Ratio (Females per 1000 Males)						
India	1,027,015	1.93	54.20	933	25.8	8.5	17.3	68	3.2	46.2
Andhra Pr	75,728	1.30	32.70	978	21.3	8.2	13.1	65	2.4	52.8
Assam	26,638	1.73	43.03	932	26.9	9.6	17.3	75	3.2	15.2
Bihar	82,879	2.50	33.57	921	31.9	8.8	23.1	62	4.5	21.2
Chattisgarh	20796	1.66	52.40	990	26.7	9.6	17.1	79		
Gujarat	50597	2.03	58.60	921	25.2	7.5	17.7	62	3.0	52.8
Haryana	21083	2.47	56.31	861	26.9	7.5	19.4	67	3.2	49.4
Jharkhand	26909	2.09	39.38	941	26.5	9.0	17.5	70		
Karnataka	52734	1.59	57.45	964	22.0	7.8	14.2	57	2.5	56.3
Kerala	31839	0.90	87.86	1058	17.9	6.4	11.5	14	1.8	39.6
Madhya Pr.	60385	2.18	50.28	920	31.2	10.2	21.0	88	3.9	45.9
Maharashtra	96752	2.04	67.51	922	20.9	7.5	13.4	48	2.5	49.3
Orissa	36707	1.48	50.97	972	24.3	10.5	13.8	96	2.7	37.6
Punjab	24289	1.80	63.55	874	21.5	7.3	14.2	52	2.5	65.5
Rajasthan	56473	2.49	44.34	922	31.2	8.4	22.8	79	4.2	36.1
Tamil Nadu	62111	1.06	64.55	986	19.2	7.9	11.3	51	2.0	50.4
Uttar Pr.	166053	2.30	42.98	898	32.8	10.3	22.5	83	4.7	38.0
West Bengal	80221	1.64	60.22	934	20.6	7.0	13.6	51	2.4	32.2
Arunachal Pr.	1091	2.33	44.24	901	22.3	6.0	16.3	44	2.8	14.0
Delhi	13783	3.81	75.00	821	20.3	5.1	15.2	32	1.6	27.0
Goa	1344	1.39	75.51	960	14.3	7.4	6.9	23	1.0	23.9
Himachal Pr.	6077	1.62	68.08	970	22.1	7.2	14.9	60	2.4	46.9
J&K	10070	2.55	41.82	900	19.6	6.2	13.4	50	NA	14.4
Manipur	2389	2.63	59.70	978	18.3	5.6	12.7	23	2.4	17.8
Meghalaya	2306	2.62	60.41	975	28.5	9.2	19.3	58	4.0	4.7
Mizoram	891	2.56	86.13	938	16.9	5.2	11.7	21	NA	34.3
Nagaland	1989	4.97	61.92	909	11.8	2.3	NA	NA	1.5	8.2
Sikkim	540	2.85	61.46	875	21.8	5.7	16.1	49	2.5	21.5
Tripura	3191	1.46	65.41	950	16.5	5.4	11.1	41	3.9	23.4
Uttaranchal	8480	1.76	60.26	964	20.2	6.9	13.3	50		
UTs										
A&N Islands	356	2.39	65.46	846	19.1	5.1	14.0	23	1.9	38.4
Chandigarh	904	3.39	75.29	773	17.5	3.9	13.6	28	2.1	33.5
D&N Haveli	220	4.65	42.99	811	34.9	7.8	27.1	58	3.5	27.5
Daman & Diu	158	4.42	70.37	709	23.7	6.6	17.1	48	2.5	29.3
Lakshadweep	61	1.59	81.56	947	26.1	6.0	20.1	27	2.8	7.2
Pondicherry	974	1.87	74.13	1001	17.8	6.5	11.3	23	1.8	58.4

– *UNDP (1997)*

Human poverty is more than income poverty; it is the denial of choices and opportunities *for living a tolerable life...*

In the past decade the number of women living in poverty has increased disproportionately to the number of men, particularly in the developing countries. While poverty affects households as a whole, because of the gender division of labor and responsibilities for household welfare, women bear a disproportionate burden, attempting to manage household consumption and production under conditions of increasing scarcity.

– *Beijing Platform for Action; 1995*

GENDER AND POVERTY

Gender is central to how societies assign roles, responsibilities, resources, and rights between women and men. Allocation, distribution, utilization, and control of resources are thus incumbent upon gender relations embedded in both ideology and practice. Gender analyses do not merely focus on women, but also look at the ways in which men and women interact with each other and the gendered nature of their roles, relations, and control over resources. **Unfortunately, even today in most parts of the world there exist gender biases that disadvantage women. Therefore, it is sometimes inevitable that gender justice becomes synonymous with the rights of women and any discussion on gender and poverty in essence becomes a discussion on women and poverty.** This is because, as with all other issues, women and men experience poverty in different ways.

If we accept the definition of poverty as the denial of choices and opportunities for a better life, then feminization of poverty is less a question of whether more men than women are poor than of the severity of poverty and the greater hardship women face in lifting themselves and their children out of poverty. The wide range of biases in society—among them unequal opportunities in education, employment, and asset ownership—mean that women have fewer opportunities. Poverty accentuates gender gaps, and when adversity strikes, it is women who often are most vulnerable (UNDP, 1997: 64). This increased vulnerability is most visible in cases of disaster, conflict, or involuntary resettlement.

Despite these generalities, it is important to recognize that women are not a homogeneous group, nor is the concept of gender static. Gender varies across cultural, geographical, and historical contexts. It is contingent upon factors such as age, class, and tribe. Also, the position of women in society is not static. It shifts in response to and also affects the economic, social, political, cultural, and environmental situation of the community. This diversity is often visible in intergenerational differences: processes of globalization have increased the pace of change to such an extent that significant changes are now being felt from one generation to the next.

Starting with discrimination against the girl-child, even before she is born, the life of the 235 average Indian woman is one of deprivation in every sphere. The overall status of women in an Indian family is lower than that of men. The girl-child gets less nutrition, health care, and education: a lesser childhood than the boy-child. She becomes a woman while still young, often missing out on adolescence and moving into early motherhood—quickly, and often at a young age. She has no say in any of these crucial events of her life, although they adversely affect her growth and development.

Intrahousehold inequalities and discrimination therefore determine the status of women and the "extent of poverty" in which women live. In addition, the socioeconomic status of the woman's family and community also determine her vulnerability in the larger society. For example, in tribal societies in India that have a very high incidence of income poverty, women enjoy higher social status than their counterparts in other social groups. However, because of the overall socioeconomic position of tribal groups in the larger society, they become more vulnerable to discrimination and violence perpetrated by those belonging to other groups, especially non-tribal groups.

Another factor affecting the status of women in India is their region of origin, i.e., the place where they are born. Two girls born in similar low-income-poverty families in Kerala and Bihar are likely to enjoy different life opportunities in terms of access to nutrition or education. The root of gender inequality, reflected in the higher incidence of poverty among women in India, is social and economic, not constitutional. The Constitution is firmly grounded in principles of liberty, fraternity, equality, and justice. Women's rights to equality and freedom from discrimination are defined as justifiable fundamental rights. The Constitution explicitly clarifies that affirmative action programs for women are not incompatible with the principle of nondiscrimination on grounds of sex. "The Constitution does not merely pay lip service to an abstract notion of equality. It reflects a substantive understanding of practical dimensions of freedom and equality for women" (Menon-Sen and Kumar, 2001: 10). However, persons from the very socioeconomic backgrounds that perpetuate the inequity often implement implementation of constitutional provisions that are meant to empower women.

GENDER RELATED ISSUES

Situation : M is a young lady attending college. She studies hard because it is her dream to become an engineer. She wants to design computer games for children. One day she visits the health Centre with bruises on her face and arm. When the health staff asks her what happened, she said that some college boys tried to touch her and when she resisted, they slapped her.

What plans can you make to address this issue?

INTEGRATING GENDER IN OUR WORK

OPTION 1: ADDRESS GENDER BASED VIOLENCE AGAINST WOMEN (VAW)

Types of Violence

Emotional and psychological abuse may include:

- Telling someone she/he is ugly
- Denial of love/affection/sex
- Humiliation
- Refusing to help someone in need
- Name-calling, shouting at the person
- Damaging their favourite possessions (clothing a pet)
- Threatening physical or sexual violence
- Insulting or cursing a person who has refused to have sex
- Writing threatening letters to someone after she/he ends a relationship.

Physical violence may include:

- Slapping, beating pinching, hair pulling burning, strangling
- Threatening or attacking with a weapon or object
- Throwing objects at person
- Physically confining (locking in a room or tying up)
- Ripping of clothes

Sexual violence may include:

- Beating a person to force him/her to have sex
- Touching a person's sexual body parts against his/her will
- Using vulgar and abusive language to coerce someone into having sex
- Putting drugs into a person's drink so that it is easier to have sex with him/her
- Refusing to use contraceptives or condoms.

Definitions:

Violence against women: "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." (*Declaration on the Elimination of Violence against Women* adopted by the United Nations General Assembly in 1993)

Article 113 of the Platform for Action adopted at the Fourth UN World Conference on Women (Beijing 1995) states that violence against women encompasses but is not limited to:

• Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; this is often denoted as 'domestic violence'

• Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution.

• Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

Information on violence

Young people may be exposed to many forms of violence throughout their lives [24]:

- Psychological abuse which includes suffering insults, humiliation, bullying, 'Eve teasing' (an Asian term meaning harassment of young women, for example on the street), confinement, withholding of basic needs (such as food), etc.
- Physical abuse, which includes beating, kicking, pulling hair, biting, acid throwing and other types of dowry-related attempts at murder of young brides, 'honors killings', female genital cutting
- Sexual violence, which includes economically coerced sex, date, marital and gang rape, incest, forced pregnancy and trafficking in the sex industry.

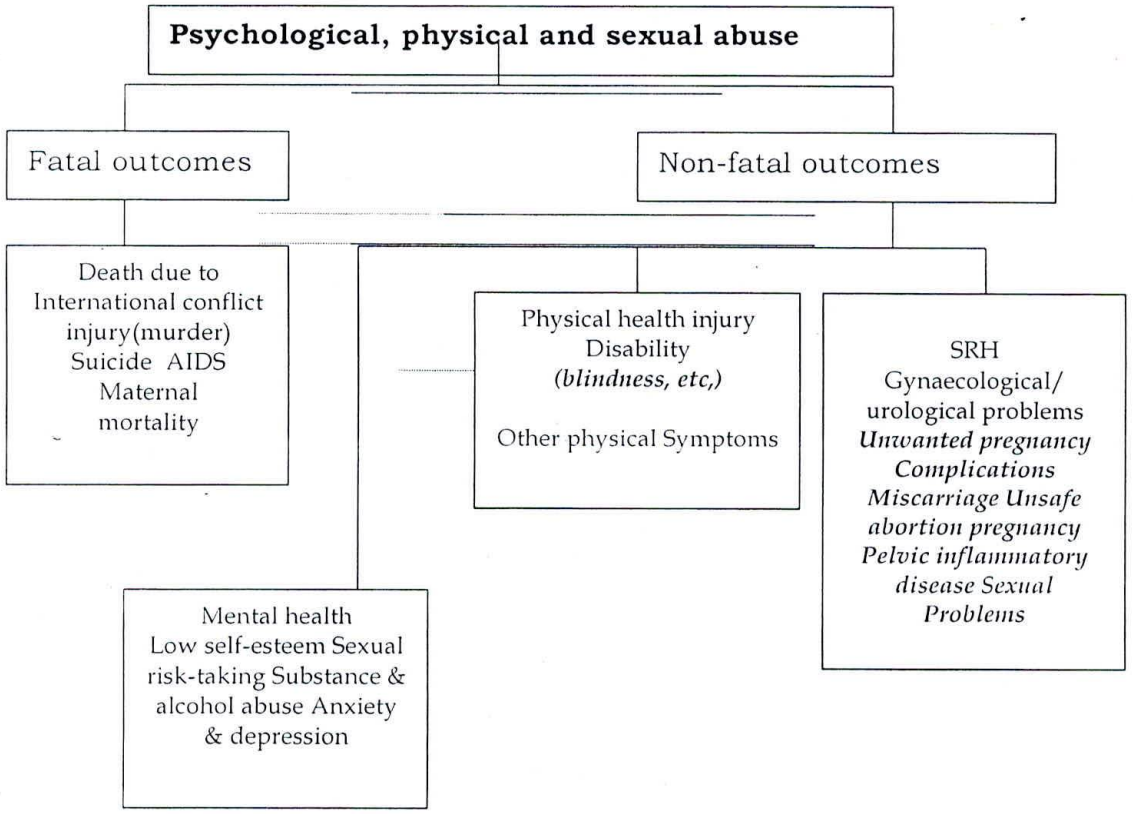
Some statistics:

- *Worldwide, 15-50% of all women in most societies have suffered a physical assault at least once by an intimate partner during their lives*
- *About 40-60% of sexual abuse cases worldwide involve young women under the age of 16 years*
- *Sexual abuse also affects adolescent boys. Studies in 19 countries from multiple regions showed reports of such abuse among 7-34% of young women and 3-29% of young*
- *In 1998, 69% of homicides involved victims 15-44 years old, six males per female victim. Boys are the most frequent victims and perpetrators*
- *Every day, 288 young people somewhere in the world commit suicide, often because of Sexually Reproductive Health-related problems such as physical abuse, sexual violence, relationship problems, alcohol and drug abuse, HIV/STIs, unwanted pregnancy, unsafe abortion, and anxiety concerning their sexual orientation*

Violence Against Women (VAW)

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of whether occurring in public or in private life.

Some possible results of different types of violence against individuals



COMMUNITY HEALTH EDUCATION ON GENDER BASED VIOLENCE MUST INCLUDE:

- People find it difficult to talk about physical and sexual violence, especially violence in the home against women and children. It is only when we start talking about it more publicly that community 'tolerance' for such violence will begin to be reduced.
- Explain that there is a tendency for victims of violence to feel that they are to blame for what happened to them; For example, a girl who is raped might think she caused it because she allowed some sexual activity such as kissing. However, this does not mean the violence was justified: there is no excuse for forcing someone to do something that can harmful his/her health against his/her will.
- Explain that there are people of authority in our communities who may make public statements that seem to condone violence: it is up to other people in the community to oppose them, for example, by speaking at public meetings, phoning in to radio talk shows, writing letters to the editor of a newspaper, etc.

- Emphasize that young people have the right to be free from violence.
- Mention whether young people in your community can go for help if they are faced with a situation of violence or the consequences of violence such as rape.
- State that young people should do all they can to resist being pressured or forced into doing something sexual that they are not comfortable with. Give some examples and ask the participants if they can add others:
- Girls: Give clear messages about what you want : say no firmly, perhaps giving reasons for saying no that reinforce the message: do not go far away from other people so that you can always call for help if you need it: avoid going out with men who are aggressive or disrespectful: seek help from a trusted adult in cases on incest.
- Boy: Do not assume that a date should end in sexual intercourse; do not assume that having bought a girl something means she 'owes' you sex in return; accept that a girl means no when she says no.
- Girls and boys: avoid drinking or taking drugs since this can lessen your self-control ; stay with a group of friends if you notice that you are feeling unable to control yourself; seek help from adults to change situations that place you at risk.

SUMMARY

- Point out that people have experiences that can place them at risk as well as experiences that can help them avoid risks.
- Risk factors and situations occurring earlier in life may continue to have an impact much later in a person's life; some situations can lead to multiple health problems for example, a boy who has an untreated Sexually Transmitted Infections in adolescence could become infertile; a girl who does not tell her parents about a teacher who is sexually harassing her could be raped, become pregnant and get HIV infection.
- That is way it is important to address Sexual Reproductive Health {SRH} problems from a life-cycle approach; young people need skills and services that can have an impact both on their current and future lives. It is important for young people to request training to build their skills, such as assertiveness, negotiating skills, conflict resolution and decision-making.

OPTION TWO: INTEGRATE INTO EXISTING SEXUAL REPRODUCTIVE HEALTH PROGRAMS OR ADOLESCENT HEATH PROGRAMS

Adolescents have the right to ask for and receive all the information and services they need: comprehensive sex and family life education: access to contraceptives and condoms if they are sexually active: addresses where they can obtain help in cases of violence (including emergency contraception following rape of grips); addresses where they can obtain help for SRH problems such as unwanted pregnancy. Complications of unsafe abortion, antenatal and mother-child care, HIV/STI testing and treatment; referrals to self-help groups for people living with HIV infection and dealing with gender related drug and alcohol abuse.

Relevant texts from international documents related to gender and sexual reproductive health:

- "In all cases women should have access to quality services for the management of complications arising from abortion. Postabortion counselling, education and family planning services should be offered promptly." (*Programme of Action*, International Conference on Population and Development, 1994, paragraph 8.25)

- "...In all circumstances in which abortion is not against the law, such abortion should be safe." (*Programme of Action*, International Conference on Population and Development, 1994, paragraph 8.25)

- "States parties should include in their reports how they supply free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women.

- Many women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include antenatal, maternity and post-natal services. The Committee notes that it is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources." (*General Recommendation 24.27*, 20th session, UN Monitoring Committee for the Convention on the Elimination of All Forms of Discrimination against Women)

INTEGRATING GENDER INTO COMMUNITY HEALTH
OPTION THREE:

Why is gender important in water supply and sanitation projects?

Water supply and sanitation (WSS) projects undertaken by the World Bank over the past few decades have suggested a strong positive link between a focus on gender and women's participation, on the one hand, and the degree of project success and of WSS management sustainability, on the other. Among the major lessons learned are the following:

- Women are the primary collectors, transporters, users, and managers of domestic water and promotersof home and community-based sanitation activities.Yet, in many societies women's views are not systematically represented in decision-making bodies. WSS projects provide major opportunities to close this gap.
- Focusing on gender leads to benefits that go beyond good WSS project performance as manifested in such aspects as better procurement, O & M, cost recovery, and hygiene awareness. Those other benefits include the following:

  - *Economic benefit: Better access to water gives women more time for income-generating activities, the needs of family members, or their own welfare and leisure. The economy, as a whole, therefore also benefits.*
  - *Benefit to children: Freed from the drudgery of water collection and management, children, especially girls, can go to school. Hence, the impact can be expected to be intergenerational.*
  - *Empowerment of women: Involvement in WSS projects empowers women, especially when project activities are linked to income-generating activities and productive resources such as credit.*

Focus on gender has multiplier effects
Women have primary roles in the collection, transport, use, and management of water and the promotion of sanitary practices, and yet are hardly involved in decision-making in the sector practices, and yet are hardly involved in decision making in the sector

MAKING MAINSTREAMING GENDER AN EVERYDAY ACTIVITY

	GLIMPSES similar to your situations in community health	PLANS?
	Poverty underlies the poor health status of most of the Indian population, and women represent a disproportionate share of the poor. Women's relatively low status (particularly in the north) and the risks associated with reproduction exacerbate what is already an unfavorable overall health situation.	
	The social distance between women and the health care service center or provider because of gender, caste, or class is even greater than the geographic distance, which itself is a deterrent.	
	Millions of women simply lack the freedom to go out and seek medical help. According to the second National Family Health Survey, (International Institute for Population Sciences, 1998-1999), only 52 percent of women in India are ever consulted on decisions about their own health.	
	When children fall sick, the likelihood that medical help will be sought for boys is greater than for girls. This difference is often as great as 10 percent. The health status of the girl child is evident in higher malnutrition levels.	
	In rural Punjab, 21 percent of girls in poor families suffer severe malnutrition compared to 3 percent of boys in the same families. Indeed, poor boys are better fed than rich girls (UNDP, 1995). A study in the Delhi slums revealed that 40 percent to 50 percent of the female infants below the age of one year were malnourished. And in female children in the age group 5-9, the rate of malnutrition increased to 70 percent (Mahbub ul Haq Development Centre, 2000:127).	
	The average Indian woman is 100 times more likely to die of maternity-related causes than is a woman in the industrialized world. About 15 percent of pregnant women in India develop life-threatening complications (Mahbub ul Haq Development Centre, 2000: 127). Maternal mortality in India, estimated at 407 maternal deaths per 100,000 live births, results primarily from infection, hemorrhage, eclampsia, obstructed labor, abortion, and anemia. Lack of appropriate care during pregnancy and childbirth, especially the inadequacy of services for detecting and managing complications, explains most maternal deaths.	
	Iron-deficiency anemia is widespread among Indian girls and women and affects 50 percent to 90 percent of pregnant women.	
	The work that women perform influences their health status. Women in India, especially in agricultural areas, are expected to perform a variety of strenuous tasks within the house- These occupations often have seriousconsequences for undernourished females, including adolescents, whose bone structure is not yet fully developed and who may be required to carry heavy loads or to adopt unnatural postures for prolonged periods.	
	Exposure to heavy smoke from kitchen fires, which causes a variety of respiratory difficulties.	
	Women are also susceptible to unusually high rates of physical assault such as rape, burning, and beating.	
	A woman's labor is the main input in families. Women carry a double burden: they work at home and work for a living, yet seldom have control over the money they earn.	
	"The land is not ours, the forest is not ours, the water is not ours—what then is ours? They either belong to the government or to men. What do we get when all these are taken away?" —Basanti Bai, a displaced woman from the Bargi Dam area of Madhya Pradesh. India is not resource poor, but its women are.	
	Gender inequality in access to and control over economic	

	patrilineal societies, land and property are passed from male family head to male heir. In most parts of India, as in other parts of Africa and Asia, women may have use rights over the land and forest, but are rarely allowed to inherit the land they use.	
	Emphasis on female seclusion, or *parda*, and women's everyday lack of mobility reduces their access to judicial, administrative, and economic institutions. Moreover, government functionaries, themselves products of the same social milieu, obstruct the implementation of any laws that would favor women. Prevailing biases affect the recording of women's shares, court judgments, and the government's land distribution under land reform or resettlement schemes.	
	Because women do not hold titles to land and property, they are not seen as persons who have rights to compensation or alternative land. The policies reinforce these gender biases, as do the people implementing the projects.	
	Persons who are resource-poor are voiceless and can be oppressed, which is what happens with women. Even in the face of extreme violence and torture, they are unable to leave and seek other options. So the cycle of poverty and violence continues.	
	Estimates suggest that more than 2 million women participate in commercial sex work, and that 25 percent of the women are less than 18 years old.	
	Slum life also means insecurity of tenure and an absence of sanitation and water. A lack of toilets is a major problem. In the villages, women could use the open fields. In the cities, with no alternatives available, they are forced to squat wherever they can. Women and girls have been found to be most vulnerable to abuse during this activity. The lack of sanitation and water and the living in hazardous conditions, with the added pressures of earning a livelihood, definitely affects the health of the women. However, social attitudes toward women's health in urban areas remain largely unchanged. Women are still held back by the culture of silence.	

All Issues are Women's Issues and Women's Issues are Everyone's Issues...
Addressing gender and poverty in India would mean....

- Linkage of economic growth to an expansion of opportunities for women;
- Stronger gender focus in planning and implementation;
- Amelioration of Intrahousehold imbalances;
- Amelioration of regional gender imbalances;
- Availability of inputs for the health care, education, and empowerment of all women;
- Recognition and documentation of the contributions of women to the economy;
- The right of women to own, access, and control land and property;
- True participation of women by empowering them to do so, thereby moving beyond "tokenism"; and
- Gender equality as a people's issue, not the exclusive concern of women.

IT DOES NOT MATTER IF I AM FEMALE OR MALE.....I AM A HUMAN

Building Positive Frustration Tolerance Level for enabling HIV/AIDS prevention

In life, no one ever gets everything he or she wants. As a result h/she gets frustrated.

Frustration is the feeling experienced when a person does not get what he/she wants. *Frustration tolerance* is the ability to cope with the feeling of frustration.

Positive frustration tolerance is the ability to deal with the frustration in constructive ways that do not harm the person or other persons.

In general, boys and girls need to be nurtured through getting things they want which are good for them. They need to be nurtured even through not getting every thing they want and be facilitated to cope with feelings of frustration. This is a core area to work on for enabling gender equity, since there are areas of equitable give-and-take to be addressed. Enabling children to make decisions on given options helps in building frustration tolerance and grooms them to make acceptable decisions.

Plan how you will mainstream gender , the use the check list given following this to verify whether it is good practice.

GOOD PRACTICE CHECKLIST IN OUR WORK

Key Gender Issues for the Initial Social Assessment (ISA) in our work

- Identify and describe the target population. Disaggregate demographic data by gender. Consider how women and men differ in their roles and their economic, educational, and health status.
- Examine the differences between subpopulations. Point out differences in the roles, status, and well being of women and men within these groups.
- Assess the target population's needs and demands in relation to the project. Consider whether women and men have different priorities and how these differences might affect the proposed project.
- Assess absorptive capacity. Consider how women and men will participate in the project their motivation, knowledge, skills, and organizational resources and how the project will fit into their culture and society.
- Identify government and nongovernmental agencies and organizations with a focus on women or interest in improving the status of women that might contribute to the project.

Key Questions And Action Points In the Mainstreaming Project Cycle

This checklist follows a gender analysis framework and is flexible and adaptable. The premise of gender analysis is that women and men have different roles and status in the household, the community, and society, and therefore have different needs and priorities. Gender-differentiated data are collected to identify those different needs and priorities, as well as different knowledge, attitudes, and practices in the prospective project area. The information from the gender analysis will inform the design of the project and contribute to its efficiency and effectiveness. In examining the feasibility of a project and designing the project, two questions arising from the gender analysis should be asked:

- What are the practical implications of the different roles and status of women and men in the project area for the feasibility of the project and for the effective design of the project? How will the project recognize and accommodate the different roles of women and men?
- What is the strategic potential of the project for improving the status of women? How will the project affect women and men? How can the project contribute to long-term strategies for the empowerment of women?

The checklist should be used in the initial social assessment during the fact-finding phase of project preparatory technical assistance (PPTA) and in the social analysis (summarized in Box follwing)during the PPTA.

The ultimate purpose of the gender analysis is to assist in the design of development projects that will maximize the participation of both female and male beneficiaries and the benefits to them. The checklist is not all-inclusive. It can be used in addition to general data necessary for project design.

Gender analysis will be carried out in two steps. Background data on gender-differentiated characteristics of the client population will be collected and analyzed in relation to the socioeconomic and cultural characteristics of the project area. The analysis will be used in planning projects and in all stages of the project cycle.

Key Gender Issues for the Social Analysis and Design in project cycle

Participatory approach: Consult and involve women and men in project design and implementation.

Gender analysis

- Record the activities of women and men, and their respective access to and control of resources
- Analyze this information against the demographic, economic, cultural, social, legal, and institutional context.
- Apply the information and analysis to all phases of the project cycle.

Benefit monitoring and evaluation: Develop indicators that define the benefits to women and men.

Social analysis: On the basis of the gender analysis, establish the needs, demands, absorptive capacity, and institutional arrangements of the target population, and the potential adverse effects of the project on vulnerable groups in the population.

Cooperation with nongovernment organizations (NGOs), including those for women or with a focus on WID.

Gender Issues In The Health Sector

Key questions Household activities

- What is the gender division of labor among the client population? How are productive and reproductive roles (such as sexual division of labor within households, production of goods and services, and income earning) interrelated? Data should show differences in roles between older and younger women and men, and between boys and girls. In other words, who does what, where, how, when, and for how long?
- What are the broad income levels of the client population? Are there differences in income between females and males?

- Identify key facts about the social structure and organization (community organization, cultural perception and attitudes, marriage rules, land ownership pattern, etc.), by gender and socioeconomic status.
- What services (health, education, water and infrastructure, agricultural extension, law and justice) are provided in the project area and to whom? Consider differences in socioeconomic status as well as gender.
- What is the legal status of women? Do women have rights to self-determination (e.g., divorce, property rights, custody of children, decisions about reproductive matters)?
- Are divorced women socially stigmatized among the client population? Is sex segregation a norm? Are there restrictions on male/female interaction? Is there any reluctance on the part of women to consult male health care providers?

Health status of the project population

- What are the most serious illnesses in the project area(s)? Are there gender differences in the incidence of particular diseases? What are the main causes of these illnesses (consider sanitation, diet, activity patterns)? What factors, other than reproductive, contribute to gender differences in the incidence of disease?
- What are the occupational health hazards in the targeted community? Consider exposure to pesticides, harmful chemicals from textile dyeing, toxic waste materials from electronics industries, etc. Are there gender differences? Are there particular risks to pregnant or lactating women?
- What is the extent of women's workload, and are patterns of sickness among women (malnutrition, anemia, and other diseases) explained by their occupational context?
- What information exists and can be collected regarding the mental health of women and men? Are there gender related differences in incidence?
- What roles do women and men play in community health care?
- How do women and men explain common diseases and health problems?
- Who makes decisions in families about taking children to a health-care provider for treatment? Who decides whether medicine will be purchased?
- Does the project mainly emphasize women's health in terms of their role as mothers? Is there a need for a broader focus on women's health?

Diet

- What type of diet is common in the client population? Do women and men, girls and boys have different access to food?
- Is food bought or grown? Are changes from subsistence to cash production affecting food supply or changing dietary patterns? What is the significance for the health status of women and men?
- For how many months do women usually breast-feed their children? Is there a difference in the duration of breast-feeding for girl and boy children? What are the cultural attitudes toward the duration of breast-feeding? Is bottle-feeding a common practice? What socioeconomic factors contribute to decisions to bottle-feed infants?
- According to cultural beliefs, is breast-feeding during pregnancy an acceptable practice?
- Are there food taboos for women during pregnancy and lactation?
- Are there differential patterns of growth between boys and girls in the same age group? Different diseases? Are these differences related to differential feeding patterns of girls and boys or other factors?
- What is the incidence of anemia among pregnant women in the target population?

Key questions

Maternal risk factors and women's health

- What is the incidence of maternal deaths? What are the main maternal risk factors? What are the major clinical, environmental, and socioeconomic causes? Which age groups are the most at risk? What percentage of births is assisted by medically trained midwives?
- What are the childbearing years for women?
- What health problems among the client population predominantly affect women or are female-specific?
- Is violence against women prevalent in the project area? What community or health services are offered to abused women?
- Are there women-to- women services in maternal and child health programs (including reproductive health and family planning)? Does lack of women-to- women maternal and child health services constrain women from using health services?

Sexually transmitted diseases

- Are sexually transmitted diseases (STDs) a problem in the targeted community, for men? for women? Are there societal attitudes that constrain the population from recognizing or reporting such occurrences? Are there cultural constraints on measures to protect against the spread of STDs?
- How prevalent is HIV/AIDS among the client population? Is heterosexual transmission common?
- Is there a relationship between poverty and female sexuality that may contribute to the transmission of HIV/AIDS?
- If HIV/AIDS is a serious health problem, who care for AIDS sufferers?

Objectives and target groups

Objectives and target groups

- Ensure that project objectives explicitly address inequality in access to health care and inadequate responses of health systems.
- Ensure that the project objectives explicitly address the different health needs of males and females.
- Ensure a broad focus on women's health, and not a limited focus on motherhood.
- Ensure that the target groups identify their own health needs, by involving them in the design of the project. Also consider involving nongovernmental or community- based organizations.

Data collection

- Collect sex-disaggregated data on health standards of males/females, women's/men's role in the health sector, the numbers and training levels of male and female health workers, preferences for male or female health workers, women's/men's use of and capacity to benefit from health-care services, etc.
- Collect sex-disaggregated data on decision-making pat-terns for family health needs, particularly for reproductive health.

Institutional strengthening

- Integrate gender in the project capacity- building activities in management and human resource development for women in the health sector.
- Assist the executing agency in recognizing the need and taking action to increase the number of female health service providers by recruiting and training women for all areas of health delivery, as village and community health workers, health educators, doctors, health administrators and managers, nurses, and midwives.

- Provide gender with medical training to traditional birth attendants.
- Train schoolteachers working in the project area, as part of the project, to support gender initiatives aimed at changing food, hygiene, and sanitation habits, and attitudes regarding family planning that are detrimental to women or their families. è Refocus the staff and services toward client needs. Train health personnel to provide integrated ser-vices which include gender (e.g., family planning, safe abortion, violence, TB immunization).
- Provide training in gender sensitization and in gender planning and participatory approaches for the executing agency.
- Facilitate trust and partnership building between the communities and the formal health system using the gender education. Improve the organization and training of local health services by establishing small gender based projects to facilitate joint actions by communities and the health system.
- Link the health project to gender related policies and sectors, e.g., water and sanitation, education, agriculture.

Participation

- Improve the knowledge of the target groups about gender and health matters, to enable them to participate in the improvement of health and associated services. Nongovernmental or community-based organizations may be involved in such initiatives.
- To draw more women into the project, use interpersonal communication and the services of local women field workers. Engage NGOs to facilitate the involvement of women in project design and implementation.
- Ensure that women have access to all training activities provided by the project, by setting a quota for their participation.

Monitoring and evaluation

- Promote the development of qualitative and process- oriented gender-sensitive indicators of inputs, outputs, and outcome for program design and for monitoring and evaluation.

Gender Issues In Family Planning

- Among couples or extended families, who makes fertility decisions?
- Are there sex-based differences in knowledge and attitudes regarding fertility decisions?
- What traditional methods, if any, do local women/ men use to control fertility?
- Is the use of contraceptives legal in the country? Do women have access to contraceptives regardless of age, marital status, and number of children? Do women require the permission of males to obtain contraceptives or an abortion? What is the cost of contraceptives? How accessible are contraceptives to women and men?
- What is the family planning acceptance rate in the target population? What is the percentage of new acceptors each year? Which methods are most widely accepted?
- Are there information/education programs on family planning? Who offers them in the project area NGOs and/or public sector programs? Are they adapted for low literacy populations? Do the programs target women or men, or both genders? Are the female and male users aware of the pros and cons of each method?
- How acceptable are the family planning messages to women? to men? Are the messages culturally appropriate?

- Does family planning emphasize sterilization? Are there social or cultural problems associated with sterilization for women or men?
- Are there "quality of care" issues associated with the promotion of family planning? How do these affect women and men?
- How common is infertility? Which main groups suffer from infertility? What are the main causes and effects?
- How common is abortion (legal or no legal)? Is it legal? Which groups are primarily concerned? What are the effects on women's health?
- Is sonar scanning or amniocentesis used in association with abortion for the sexual selection of offspring?
- What are the cultural and social attitudes toward unmarried mothers? toward children classified as "illegitimate"?

Key strategies

- Design separate gender appropriate communication strategies for women and men.
- Design messages about development and population strategies, health, and fertility that are acceptable to both women and men.
- Develop curriculum guidelines and instruction materials for school programs on nutrition, hygiene, and family planning for boys and girls. Nutrition and reproductive health education for adolescent girls, in particular, will reduce maternal risk factors when they grow up.
- Use the mass media to provide follow-up information on project activities for nutrition, health, and family planning that will reach and be interesting to women.
- Involve women's organizations, women's groups or clubs, schools, unions, neighborhood associations, cooperatives, etc., to reach as many women in the project area as possible.
- Initiate information and education campaigns to promote the idea that men and women share equal responsibility for health in the family.
- Design communication strategies that target men with messages about birth spacing, family health, and family planning.
- Promote the responsibility of men as husbands and fathers in family planning and family health, through focus group discussions with health and family planning workers, community and religious leaders, NGOs, etc.
- Introduce special services for men, such as "exclusive" clinic hours and husbands' day at the clinic.
- Consider networking with NGOs to promote men's involvement in reproductive health.
- Assist women and men, in a gender-sensitive and culturally sensitive manner, in learning about their reproductive systems and functions, and obtaining accurate information about the different techniques, advantages, and disadvantages of contraception. Provide alternative means of contraception to women and men.
- Ensure that health practitioners are assisted in monitoring any possible side effects and problems arising from the use of contraceptives.

- How effective are health services for women and men in the client population? At the primary level? Secondary level? Tertiary level? Are primary levels being bypassed for higher levels of care?
- What socioeconomic or cultural constraints do people face in accessing health services at each level? Are there differences in access between women and men?
- What associated health services (water supply and sanitation improvement, other disease control measures) do women and men in the client population have access to? To what extent do women and men actively participate in planning and managing such programs?
- Are changes being proposed in the provision of health services that will change gender relations? How will the changes affect women? Will the changes be acceptable to women/men?
- What formal health delivery systems are available to the client population, both clinical and nonclinical? To what extent do women use them? What is the ratio of female users to male users?
- Are there women health workers in the community? What are their roles?
- Is recourse to traditional medicine and traditional healers common in the project area? Is traditional medical knowledge mainly the province of men or women? Are traditional practitioners mainly male or female? Are there female traditional birth attendants?
- What traditional health measures are practiced locally? Do health delivery systems make use of traditional knowledge? Would an inventory of traditional notions and practices assist the program?
- What are the constraints preventing more women from being trained or being appointed as health providers?
- What factors reduce women's access to health services? Consider factors such as timing of services, lack of time for women, distance, lack of money for transportation, restrictions on women's movement in public, lack of female staff in clinics, lack of privacy for examination, complicated or intimidating procedures, poor facilities.

Key strategies

- Collect sex-disaggregated data on the use of formal and informal/traditional health services and access to medicine.
- If the intention is to strengthen basic health services, then focus on supporting primary health care units.
- Locate family planning clinics or health centers where they are conveniently accessible to women. Ensure that hours of service delivery fit in with women's work schedule.
- Improve the knowledge of the client population about health matters, to enable them to participate in improving health and associated services. NGOs or community-based organizations may be involved in such initiatives.
- Establish an emergency transport system in communities by supporting the currently most feasible methods of emergency transport and community commitment to transport women to hospital.
- Lower the cost of primary health services for poor individuals.
- Discuss gender issues, particularly the need for active participation by women as health providers and recipients of health services, with the executing agency/government ministry.
- Consider how women's groups and networks can be encouraged to assist women in learning about health issues and supporting one another.
- Consider whether the executing agency can link up with NGOs for service delivery, such as for the training of field workers, to involve men and women in the community. Provide enough funds for this.
- Ensure that the executing agency places sufficient emphasis and devotes adequate resources to training women as health providers at all levels of the health delivery system.
- Consider assisting the executing agency in recognizing the need and taking action to increase the number of female health service providers by recruiting women for all areas of health delivery, as community health workers, health educators, doctors, health administrators and manager, nurses, midwives, and paramedics.

- Encourage the executing agency to make use of the services of community groups or NGOs in the delivery of health-based services and family planning.
- If necessary, ensure that women are trained as health providers at all levels of the health delivery system.
- Set quotas for the number of women to be trained by the project and/or to be appointed to positions in the project, including supervisory positions.
- Train health workers to treat and support preventive measures for the health problems that primarily afflict women (such as backaches caused by carrying heavy loads on the head, anemia from poor diet or frequent childbirth, eye and lung diseases caused by cooking smoke, lack of rest during pregnancy).

Strategies For Gender Mainstreaming In Health Projects

Analyze and understand how inequality between women and men affects their health

Initiatives that start with an appropriate understanding of gender inequality—the different ways in which the socioeconomic and cultural aspects of being male or female affect the health risks of individuals and their access to health services—are generally better able to promote and mainstream gender issues.

Address gender inequality in access to health care and responses of the health system

All good practices in regard to gender mainstreaming in health projects show that gender inequality in access to health care and the responses of the health system need to be ad-dressed. It is important to recognize that women are barred from access not simply by limited or nonexistent services. Other socioeconomic and cultural factors prevent access, e.g., women's heavier workload, their lack of independent income, the unwillingness of families to invest in women's health, and cultural attitudes. In addition, the responses of the health sys-tem can be improved not just through more facilities, drugs, and staff but through a health system that has been reorganized and reoriented to promote access and client focus. Planners should recognize women's role as providers and promoters of preventive as well as curative health care in the household and the community. Women must be seen as agents of change, and not only as beneficiaries of development interventions.

Consult with all stakeholders, including women, and build partnerships with women's organizations

Consultation with all stakeholders is critical because it leads to a better understanding of issues and therefore a better identification of needs. Consultation and dialogue make the process transparent, valid, and credible, and thus help build consensus. The process itself can raise awareness about health and about the need to address aspects of gender inequality that affect women's health. All categories of stakeholders need to be identified and women's representation must be ensured. Women's organizations can play an important role in this respect.

Promote gender equality in strengthening national capacity

Capacity strengthening is needed in different places (e.g., government, NGOs, women's organizations) and at different levels (local, regional, and national). Capacity needs to be developed for different kinds of activities: from policy development by the national government and sector programs to management and administration, human re-source planning, service delivery, management information system, and support for authentic consultation with civil society. The capacity to refocus services to client needs and manage change at all levels is critical. There is a need to ex-pose decision makers at the highest level to gender-equality objectives and dialogue with stakeholders.

AN EXAMPLE OF GENDER SENSITIVE POLICY DEVELOPMENT

Asian Development Bank's policy

ADB's policy on Gender and development {GAD} will adopt mainstreaming as a key strategy in promoting gender equity. The key elements of ADB's policy will include the following.

- *Gender sensitivity*:: to observe how ADB operations affect women and men, and to take into account women's needs and perspectives in planning its operations.
- *Gender analysis*: to assess systematically the impact of a project on men and women, and on the economic and social relationship between them.
- *Gender planning*: to formulate specific strategies that aim to bring about equal opportunities for men and women.
- *Mainstreaming*: to consider gender issues in all aspects of ADB operations, accompanied by efforts to encourage women's participation in the decision-making process in development activities.
- *Agenda setting*: to assist DMC governments in formulating strategies to reduce gender disparities and in developing plans and targets for women's and girls' education, health, legal rights, employment, and income-earning opportunities.

ADB will aim to operationalize its policy on GAD primarily by mainstreaming gender considerations in its macroeconomic and sector work, including policy dialogue, lending, and TA operations. Increased attention will be given to addressing directly gender disparities, by designing a larger number of projects with GAD either as a primary or secondary objective in health, education, agriculture, natural resource management, and financial services, especially micro credit, while also ensuring that gender concerns are addressed in other ADB projects, including those in the infrastructure sector. More specifically, ADB will

i. Provide assistance to DMCs in GAD policy support; capacity building; and awareness, formulation, and implementation of policies and programs directed at improving the status of women
ii. Facilitate gender analysis of proposed projects, including program and sector loans, and ensure that gender issues are considered at all appropriate stages of the project cycle, including identification, preparation, appraisal, implementation, and evaluation
iii. Assist its DMCs implementing commitments made at the Beijing World Conference on Women to achieve the targets set for women into the 21st century.
iv. Explore opportunities to directly address some of the new and emerging issues for women in the region and
v. Promote increased GAD awareness within ADB through training workshops and seminars, development of suitable approaches, and staff guidelines to implement the revised policy on GAD.

INSA INDIA IS PART OF THE ATHENA NETWORK:
ADVANCING GENDER EQUITY AND HUMAN RIGHTS IN THE GLOBAL RESPONSE TO HIV/AIDS

Network mission

The Network's mission is to:

- Advance the recognition, protection, and fulfillment of women's and girls' human rights, comprehensively and inclusively, as a fundamental component of policies and programs to address HIV/AIDS.
- Improve the life quality and longevity of women and girls living with HIV/AIDS.

- Ensure gender equity in HIV/AIDS-related research, prevention, diagnosis, treatment, care, and support.
- Promote and facilitate the leadership of women and girls, especially those living with HIV/AIDS, in all aspects of HIV/AIDS-related policies, programs, and research.
- Bridge the communities around the world that are addressing gender, human rights, sexual and reproductive health, and HIV/AIDS.

If you would like to join ATHENA, please send an e-mail with the following information to: athenainitiative@gmail.com

- Full name and e-mail address
- Organization that you represent, including its mailing address
- Statement that you endorse the ATHENA mission statement

I AM A HUMAN

" I am a human being, whatever that may be, I speak for all of us who move and think and feel and whom time consumes. I speak as an individual unique in a universe beyond my understanding, and I speak for all people. I am hemmed in by limitations of sense and mind body, of place and time and circumstances, some of which I know but most of which I do not. I am like a person journeying through a forest, aware of occasional glints of light overhead with recollections if the long trail I have already traveled, and conscious of wider spaces ahead. I want to see more clearly where I have been and where I am going, and above all I want to know way I am where I am and why I am traveling at all.

CONTINUE LEARNING ABOUT GENDER FROM THE SOURCES USED BELOW:

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