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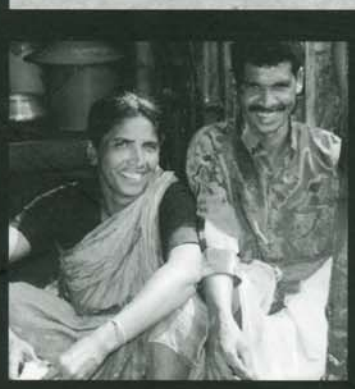

A TRAINING MANUAL

# Reproductive Health for All

## Taking Account of Power Dynamics between Men and Women

WOMEN'S HEALTH PROJECT

UNIVERSITY OF THE WITWATERSRAND

AIDOS
Associazione Italiana
Donne per lo Sviluppo

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*The views and opinions expressed in this manual are those of the authors and do not imply necessarily the expression of any opinion on the part of the European Commission and the United Nations Population Fund.*

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# Reproductive Health for All

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# PREFACE

This training manual was developed within the framework of the regional dimension project "Gender Equity and Reproductive Health and Rights in Asia", coordinated by the Italian Association for Women in Development (AIDOS), under the EC/UNFPA Initiative for Reproductive Health in Asia (RHI).

The project intends to contribute to the success of the RHI in applying a common gender strategy and in meeting its overall goal by developing a region specific training programme on gender and reproductive health for all partners involved in the initiative and other NGOs and women's organisations.

AIDOS was selected to carry out this component of the RHI because of its specialisation in dealing with women in development and gender issues and its integrated, holistic approach to reproductive health issues in the execution of projects in various countries.

Special partner in the production of the manual has been WHP, the Women's Health Project of the School of Public Health, University of Witwatersrand, in Johannesburg, South Africa. The modular structure and the contents of the various activities is the work of a group of experts from this organization, which was asked to be a partner because of their wealth of experience in mainstreaming gender in programme planning, design, monitoring and evaluation, in advocacy and training, in developing information and training materials in the field of reproductive health. The WHP has a multinational staff, with programme officers from different regions, and has collaborated with several UN agencies.

The objectives, the overall methodology and the bibliography to be used were discussed in a meeting of AIDOS and WHP staff, held in Johannesburg in April 2000.

The manual, which is directed at programme officers of international and local NGOs and Government officers who work in the area of Reproductive Health, is expected to be used as a prototype for the production of training manuals in the various countries which are part of RHI. The adaptation of the manual and the training activities will be carried out in each country by selected experts from partner NGOs, who participated in a training of trainers workshop organised by AIDOS and WHP in Chiang Mai, Thailand, from November 5th to 15th 2000.

The NGOs responsible for the adaptation of the manual at country level are: BRAC in Bangladesh, RHAC in Cambodia, WOREC in Nepal, SHIRKAT GAH in Pakistan, FPASAL in Sri Lanka and CGFED in Vietnam. A special programme has been designed for Lao PDR. The training workshop was followed by a three day consultation meeting with a larger group, which involved members of some of the local NGOs with whom the training will be done, representatives of European NGOs, which act as executing agencies under the RHI, and observers from UNFPA.

The training manual, while it is original in its approach and contents, draws from the experience of several other organisations and individuals, whose work has been analysed and utilized. AIDOS and WHP would like to thank all the institutions that have contributed materials and given the copyright for the additional readings that accompany the various activities included in the training modules.

AIDOS is particularly grateful to UNFPA coordinators of the RHI, Mr. Hedi Jemai, Ms. Wilma Goppel and Ms. Patrizia Franceschinis, for their continuous support and collaboration during project implementation.

Daniela Colombo
AIDOS President

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# Overall objectives

- To understand the impact of gender relations on health within the current socio-economic context.
- To understand the impact of gender relations on health, health seeking behaviour and health services.
- To understand the genesis of the ICPD Platform of Action, specifically the historical development from the population control approach to a needs-based approach to the current rights-based approach and the significance of this to promoting equity.
- To have a common understanding of the meaning of the key reproductive rights-related concepts in the ICPD, FWCW and 'plus five' documents: sexual and reproductive rights and health; gender equality and equity; empowerment; life cycle approach; holistic approach; integration; male responsibility.
- To explore how a gender equity and rights approach can be incorporated into sexual and reproductive health programming.
- To re-evaluate programmes within the Asia Reproductive Health Initiative.

## How different activities address each of the course objectives

| | Social construction of gender relations | Impact of 'population control' approach | Understanding key concepts from ICPD and FWCW | Comprehensive quality services |
|---|---|---|---|---|
| **Module 1** | | | | |
| Construction of gender | ✓ | | ✓ | |
| Sex & gender | ✓ | | ✓ | |
| Division of labour | ✓ | | ✓ | |
| Access to & control of resources | ✓ | | ✓ | |
| Gender & health | ✓ | | ✓ | ✓ |
| Gender in institutions | ✓ | | ✓ | ✓ |
| **Module 2** | | | | |
| Reproductive decision-making | | ✓ | | |
| Poverty & population numbers | | ✓ | | |
| Population policy vs human rights | | ✓ | ✓ | ✓ |
| **Module 3** | | | | |
| Reproductive rights | | ✓ | ✓ | |
| Sexual rights | | | ✓ | |
| Empowerment | | | ✓ | |
| Rights, gender and quality of care | | | ✓ | ✓ |
| **Module 4** | | | | |
| Gender in planning | ✓ | | | ✓ |
| Comprehensive services | | | ✓ | ✓ |
| Sexual health | | | ✓ | ✓ |
| Individual behaviour change | | | ✓ | ✓ |
| Men's involvement | ✓ | | | ✓ |
| IEC | | | ✓ | ✓ |
| Appraisal of programmes | ✓ | | ✓ | ✓ |

# INTRODUCTION TO THE COURSE

## Purpose of this manual

The International Conference on Population and Development and the ICPD Platform of Action is an internationally agreed set of definitions, concerns and methods of improving reproductive health and entrenching reproductive rights. The ICPD Platform of Action demands a re-orientation of thinking, programming, planning and delivery on reproductive health and reproductive health services. The ultimate aim of this manual is to assist people to develop programmes and projects that promote gender equity and human rights. This manual complements existing manuals as it makes overt the link between gender, rights and health and health programming. This, according to the various referees who have seen it in development, is the unique contribution this manual has to make.

## Who the manual is for

This manual has been developed for skilled trainers. It is anticipated that trainers will follow, and adapt as appropriate, the modules and activities presented. Trainers are required to have an understanding of gender, reproductive and sexual rights and health. Trainers should be skilled in participatory adult learning methods and able to facilitate group learning. Trainers require advanced conceptual skills to assist participants to critically assess their reproductive health programmes.

## Target group for training

The target group for the training is senior planners and managers in government, non-governmental agencies, funding agencies and so on, who are responsible for improving the reproductive and sexual health of the people they serve. Programme managers would also benefit from this training. While this week long training is not aimed at policy makers and politicians, certain activities can be used in a short advocacy intervention for such an audience. Many of the methods are also appropriate for and can adapted by NGOs for use at community level.

## Content and methods

The manual describes a set of methods and processes that allows participants to draw from their own experience. The methods are highly participatory in nature. The manual describes in detail the process that the trainers should follow. The content is generated by participants. Thus this training, because of the methods used, is locally appropriate. The manual gives examples of how the process may be played out; however this is as a guide to the trainer and is not prescriptive. Further, where examples of what an activity may contain are given, these are not complete. The examples are simply a guide to facilitators to illustrate to them how a session can be developed.

## Testing and adaptation

The manual, as described in the preface of this publication, was developed by Women's Health Project. Thereafter during a 10 day training and testing workshop with resource people from Pakistan, Vietnam, Nepal, Sri Lanka, Cambodia and Bangladesh the manual was tested and refined. Improvements to the training manual were incorporated. Thus we present a tested prototype manual in which the principles illustrated within each exercise remain constant but the scenarios, case studies and data should be adapted to be locally specific and relevant. Listing some of the issues that were discussed during the adaptation process may illustrate to a trainer using this manual how they too may adapt and use this training. The case studies that people will use in the 'Sexual and reproductive rights; empowerment' section are: domestic violence, inheritance laws, trafficking of women, and child abuse.

One country described the need to ensure greater content on sexual satisfaction and will adapt the course accordingly, while another will do this through looking at incest and sexual harassment. Collecting local and relevant data, whether literacy rates or contraceptive coverage and so on, will provide interesting data to discuss. UNFPA publications and web sites are a good source for finding such data. It is a good idea to look at national policies or review how policies or programmes might have changed by comparing pre to post ICPD policies.

Some changes may be required to the tone. For example the current manual suggests the use of energisers, which often include singing and moving around. In the adaptation discussions it became clear that for some audiences doing meditation-based energisers, like breathing exercises, may be more appropriate.

## Note to facilitators

Facilitators should prepare by reading through the entire manual. References to key readings that will enhance the conceptual framework within which the facilitator works have been included. Facilitators should take the time to read these. Facilitators who are not sure about certain activities may want to do a trial run to test them out. Each activity has a section called 'Materials' – read this and ensure that you have all that is required. 'Handouts' and 'Overheads' have been included and the format of the manual means that you can simply photo-copy these for participants. If you adapt the course you will need to prepare your own locally specific overheads or handouts. Please note that for Module 4 participants are required to bring IEC materials and copies of their programme plans to the workshop. Remember to tell participants well in advance that they will need to bring these with them. The course should be an enjoyable journey of critical analysis.


# Activity 1

## Getting to know the issues and each other


**20 minutes**

## Why do this activity?

This activity has two purposes. The first is to get participants comfortable with each other and to create a light-hearted and relaxed atmosphere. It helps to break down barriers and hierarchies between participants. Also, by the end of the exercise, each participant will have spoken to at least six other participants, making speaking again easier.

The second purpose of this activity is to get participants thinking about the issues that the course focuses on. Participants may have walked into the course worrying about personal family matters, or thinking about a proposal they have to submit to a donor. This step helps to orient everyone.

While it may seem strange to begin the course before people have formally introduced themselves (activity 2), in reality beginning with this activity means that even the formal introductions in activity 2 are heard better by participants, and they feel more relaxed in doing them.

## How to do this activity

Divide the participants into two groups. Get one group to form an inner circle and the other group to form an outer circle. People from the inner circle turn to face someone in the outer circle. You need even numbers of participants.

This is how the whole exercise works: You will give the group a word. The people on the inside circle must then talk about that word – anything that they want to say about that word – for half a minute. Their partner (facing them on the outside circle) may not interrupt. When you call or ring a bell to show the time is over, the partner has one minute to talk about the same word from her/his perspective. When that time is over, ask the people in the outside circle to all take a step to the right, so that they are facing a new person. You start the process again with a new word. Continue in this fashion.

Note that you should choose words that will be particularly meaningful to this group of people, given the kind of work that they do, the social/cultural environment they live in etc. You want to choose words which push participants to talk about things they may not usually talk about. At the same time you do

not want to cause great embarrassment or discomfort.

You should start with words that are more neutral and move on to words that require reflection on questions of human rights and values. Some words are suggested below:

- Health services
- Rural life
- Water supply
- Women's role in the family
- Literacy
- Maternal deaths
- Donors
- Family planning
- Men's role in parenting
- AIDS
- Human rights
- Violence against women
- Abortion
- Sex work

You should do between six and ten words, depending on how much time you have and how well you think the exercise is working. The exercise usually makes people laugh. They get very frustrated when you tell them to stop, and you have to be very firm that it is time to move on to their partners' chance. When you stop, you can ask the group if they enjoyed the activity. Then ask them to take their seats.

Explain to the group that the issues they have been discussing are the issues that will be covered in this course.

Say that now that you are all comfortable with each other, it's time to make formal introductions. Go on to activity 2 to do the introductions.


- A watch or clock so that you can stop participants after each minute.
- A loud voice! or loud whistle! or a bell so participants can hear you when you tell them to stop talking.


# Activity 2

## Names & clarifying hopes and expectations


**1 hour and 10 minutes**

## Why do this activity?

This activity will help people to get to know each others' names and some basic information about each person. This information will help participants and the facilitator understand how the course content is relevant to each individual's work situation.

If this course is being run with participants who all know each other well, then the facilitator might rather want to explore more personal questions.

This activity will also give participants an opportunity to talk about what they are hoping to gain from this course. This will allow the facilitator to ensure that participants' expectations match the content of the course, and where expectations cannot be met by the course, she / he can make this clear, so that participants do not have unrealistic expectations and land up being disappointed by the course.

## How to do this activity

Write down the following questions on a flipchart:

- Name?
- Organisation you work for?
- What work do you do there?
- What are you leaving behind while you are attending this course?

Ask participants firstly to write their names (as they want to be addressed during the course) in a thick pen on a piece of cardboard folded in half. They should put this up in front of them so everyone can read their names.

Then give them five minutes to think about their answers to the questions you have written up. Explain that you do not want a lot of detail, but just a few sentences to help us know each other.

In relation to the question 'What are you leaving behind while you are attending this course?', tell the participants that you want to know what personal or work-related things will be worrying them.

Then go around the room giving each person a chance to answer the questions.

When they are all done, tell participants that you asked them to share what they are leaving behind so that they could be aware of what is on their minds. Now, however, they must really leave these things behind. They have a special opportunity to focus on one issue for the week of the course. They should use this time to focus on the course and on what lessons they can learn from it to take back to the workplace.


- An A4 piece of cardboard folded across the middle so that it can stand on a table. This is for participants to write their names on.
- Felt-tip pens so that the names can be read by everyone in the room.


# Activity 3

## Developing a group contract


**30 minutes**

## Why do this activity?

Often participants in one course come from different work cultures with different ways of behaving in group settings – for example, some NGOs may allow free and open discussion while others might have a culture in which only the management speak. Also, in many organisations, those in decision-making positions have a greater right to speak and generally to 'take up space' in a meeting than those who are not managers.

However, this course is about building a culture of equality. This means that the course itself has to be run in a way which accords all participants equal respect and an equal chance to express their opinions.

For this reason, it is necessary to set up some ground rules for how the course will be run, and to make sure that everyone on the course is happy with and agrees to abide by these rules.

Since the course promotes the idea of participation, it is important that these ground rules are developed in a participatory way, which is why this activity involves everyone in developing the 'group contract'.

There may be other things, such as whether or not people can smoke in the workshop room or whether they should keep their cellphones switched off, which need to be agreed upon in advance, so that little irritations do not undermine people's ability to enjoy the course or to concentrate during the course.

## How to do this activity

Ask participants to talk to the person next to them about:

- Their anxieties about the course process;
- What they can contribute to ensure that the group works well during the course.

Then open the discussion to plenary. On one piece of paper on the wall write down what makes people anxious. This might include things like:

- Fear that they will be too shy to participate;
- Fear that there will be too much work;
- Women who fear that men will not listen to the women;
- Men who fear that men will be accused of being bad people;
- Fear of being attacked for having a different view from other participants;
- Fear that personal stories told in this workshop will then be spread to workmates or social friends.

Once you have a list of anxieties, ask the group what they can do to ensure that these problems are addressed. Explain to the group that you want to develop a list that sets out how the group will relate to each other, to meet these anxieties and to ensure that the group discussion goes well.

Write up a list on a new piece of paper. This list might include things like:

- No individual should dominate discussions;
- People should raise a hand if they want to speak and wait for the facilitator to ask them to do so;
- No smoking in the meeting;
- No personal attacks; people should respect each others' right to speak;
- Everything personal that is said in the course will be kept confidential;
- We are all responsible to speak when we have something to say;
- We are all responsible for our own learning.

Once the group is happy with the list, you can label it "Group Contract" and ask if everyone is happy to abide by this agreement.

The group contract should stay up for all to see throughout the course.

During the course, if there are problems with group dynamics, remind participants of the relevant commitments in the group contract.


# Activity 4

## Introduction to course content and methods


**30 minutes**

## Why do this activity?

On the first day of a course it is not easy for participants to take in a lot of detail about the course as a whole. But they do need to know where the course aims to go, so that they do not get anxious in the first day or two that their needs will not be met.

Providing an outline of the course and its methods also gives the facilitator an opportunity to go back to the expectations raised by the participants in activity 2, and to show where different expectations will be met.

## How to do this activity?

Put up the overhead on 'Overall Course Objectives'. Go through each of these objectives, spelling out the content of each objective and clarifying any questions participants may have on each objective.

Then put up the overhead 'Structure of the Course'. Explain that the course is not structured so that there is one section for each objective. Some objectives are dealt with throughout the course, such as building a common understanding of key concepts, and re-evaluating their own programmes.

Explain that the course structure aims to build concepts, one upon the next. Briefly explain what each module does. As you do this, refer back to participants expectations of the course, raised in the previous activity, so you can show where the course addresses these.

### Main points you can make to describe the course structure:

- Module 1, 'Gender and Health' begins by ensuring that all participants mean the same thing by 'gender' and have a shared agreement on why it is important to promote gender equality. It goes on to show how differences between men and women influence their health. It asks participants to consider to what extent their own organisations aim to promote gender equality.

- Module 2, 'From meeting population targets human rights and health' explores how the idea of 'overpopulation' developed and lead to the establishment of family planning programmes in many parts of the world. It gets participants to consider the impact of these programmes on health services. Using case studies of real examples, participants compare how health services based on population control policies compare with policies set up to meet individuals' health needs or to promote their human rights.
- Module 3, 'Sexual and reproductive rights; empowerment' focuses on some of the key concepts that have now been recognised as essential for promoting health and wellbeing of both women and men: reproductive rights, sexual rights and empowerment. It gives participants the actual agreements made by countries of the world at the United Nations, and asks them to work out to what extent they are implementing these commitments in their own work, and what they could do to take this further.
- Module 4, 'Promoting equity in programme planning' turns directly to health information and service programming. It looks at the diverse factors which influence health, and what the role of health services is in addressing health problems. It then asks participants to look at how health promotion activities can take steps to entrench a human rights and gender equality approach. Finally, it asks participants to apply everything they have learnt during the course, as well as their own experience, to evaluate a programme from their own NGO.

If participants are not familiar with a concept like 'gender', then the facilitator should keep this introduction very simple, not using concepts that participants will not understand. For example, the facilitator can talk about 'relationships between women and men in society'; and 'women's position in society' rather than about 'gender' or 'gender inequality'.

The last issue to raise with participants is that this course will not be run in the conventional course format of lectures. Rather, each activity will ask participants to draw on their own experience. They will be given things to read, activities to present, statements to comment on, etc. The methods of each activity have two intentions. The first is to draw on every participant's own experience, so that we can all learn from each other, since experience in the field is more powerful than any other form of knowledge. Secondly the methods aim to help participants think actively about the issues all of the time, rather that simply writing down the opinions of a lecturer, and taking home these notes. Participants will also think about how these issues relate to their own work situation.

This method should give all participants greater confidence to promote health and human rights in their work context.

Close this session by making clear to participants that this is why their participation is essential to the course – both to ensure high quality of course content, and to ensure that they can make maximum use of the course.


- Overhead 1: Overall objectives of the course
- Overhead 2: Structure of the course

# Overall objectives of the course:

- To understand the impact of gender relations on health within the current socio-economic context
- To understand the impact of gender relations on health, health seeking behaviour and health services
- To understand the genesis of the ICPD Platform of Action, specifically the historical development from the population control approach to a needs-based approach to the current rights-based approach and the significance of this to promoting equity
- To have a common understanding of the meaning of the key reproductive rights-related concepts in the ICPD, FWCW and 'plus five' documents: sexual and reproductive rights and health; gender equality and equity; empowerment; life cycle approach; holistic approach; integration; male responsibility
- To explore how a gender equity and rights approach can be incorporated into sexual and reproductive health programming
- To re-evaluate programmes within the Asia Reproductive Health Initiative

# Structure of the course

## Module 1:

Gender and Health

## Module 2:

From meeting population targets to human rights and health

## Module 3:

Sexual and reproductive rights; empowerment

## Module 4:

Promoting equity in programming

# MODULE 1



## GENDER AND HEALTH

## Module objective:

- To have a common understanding of the concept of 'gender'
- To understand the impact of gender relations on health within the local socio-economic context.

## Why this module?

Common understanding of the construction of gender relations

The module builds a common understanding of how gender relations are constructed, maintained, and reinforced. It further increases sensitivity to a broad range of gender issues at personal, interpersonal, institutional and community levels by bringing out traditional and modern cultural assumptions and the impact they have on both men and women. It is of vital importance to address gender inequalities because of the impact these have had on women's and men's health. The module identifies the social, cultural, economic, and political factors which make women or men sick. Before undertaking any programming, it is essential to understand the nature of the problem. In identifying the actions that need to be taken for an AIDS prevention programme amongst adolescents, for example, it is necessary to understand the nature of adolescent sexual relations. A wide range of gender-related issues may influence adolescent sexual relations, ranging from incest and coerced sex to social pressure on young men to express their masculinity through sexual relations, to reliance of young women on older men for goods or protection which makes it difficult for them to practice safer sexual behaviour. Without understanding the causes of a problem, it is not possible to target interventions appropriately. For this reason, the first module of this course aims to build the ability of participants to undertake a gender analysis. It provides a set of tools that they can use to analyse any health situation.

Build ability to undertake gender analysis

Gender equity and equality in organisations

The increased interest in gender equity and equality as a matter of social justice, as well as a requirement for effectively addressing diverse health problems, leads many organisations to establish 'gender' programmes or to attempt to address gender issues in their programming. However, the first step before addressing gender issues in outreach should be to analyse one's own organisation and to take steps to promote gender equity and equality internally. This is important both to build commitment to gender equity and equality as a social justice issue – a necessity if programming staff are to do effective outreach but also as a signal to an organisation's partners that it is indeed serious about this endeavour. For this reason, the module ends by providing a tool and supporting participants in using it to conduct a gender analysis of their own organisations and to make initial decisions about what steps they will take towards implementation.

## Activities:

Activity 1: Social construction of gender (2 hours)

Activity 2: Differentiating sex from gender (1 hour)

Activity 3: Division of labour (40 minutes)

Activity 4: Access to and control of resources (1 hour)

Activity 5: Linking gender and health (1 hour 30 minutes)

Activity 6: Mainstreaming gender equality in institutions (2 hours 10 minutes)


**8 hours 20 minutes**


# Activity 1

## The social construction of gender[1,2]


**2 hours**

## Why this activity?

Socialisation into gender norms and roles

This activity explores how individuals are socialised into their roles as men and women and to identify the various agents and institutions in society that reinforce these gender roles. This is done by looking at how participants, as young children, were introduced to gender norms and roles. This activity is useful to help participants recognise how the process of socialisation works such that both men and women in a particular society share that society's understanding of how men and women are socialised and the value attached to these socially determined roles. It also highlights how both men and women are agents in the process of socialisation. The activity aims to illustrate how gender is constructed, maintained and reinforced.

Concept of gender

The concept of 'gender' is relatively new. In addition, it does not exist as a single word in many languages. For this reason it is important to develop a shared language on how to talk about culturally determined power relations and role differences between men and women. It may be that in some countries or with some groups, the word 'gender' is not used at all, but rather the concept is described in a way that makes sense to all participants. This activity as well as activity 2 should be used to develop a shared language and understanding between the facilitator and participants. Whatever word or words are used, they need to make clear the meaning of 'gender' as it is used in this manual. The way we are using gender is described as follows:

Definition

### What is meant by gender?[3]

'The term *gender* refers to the economic, social and cultural attributes and opportunities associated with being male and female. In most societies, being a man or a woman means not only having different biological characteristics,

[1] Xaba, M. and Varkey, S. *Women's Health Project Gender and Health Course: Facilitator's Guide*. Women's Health Project. School of Public Health. University of the Witwatersrand. Johannesburg 2000.

[2] International Training Initiative on Gender and Reproductive Health, *Transforming Health Systems, Gender and Rights in Reproductive Health: A curriculum for Health Managers*. WHO Geneva 2001 (forthcoming).

[3]Department for Democracy and Social Development, Health Division, *Handbook for Mainstreaming. A Gender Perspective in the Health Sector*, Swedish International Development Cooperation Agency, 1997: chapter 1:1.

but facing different expectations about the appearance, qualities, behaviour and work appropriate to being male or female. Relations between women and men – whether in the family, the workplace or the public sphere – also reflect understandings of the talents, characteristics and behaviour appropriate to women and men. *Gender* thus differs from sex in that it is social and cultural in nature rather than biological. Gender attributes and characteristics vary among societies and change over time."

Gender norms are the way that society expects women and men to behave. These norms are not only about differences in how women or men, girls or boys should behave. They are also about the different values associated with being a girl or a boy, a woman or a man. For example, in some societies families rejoice when a boy is born, but mourn when a girl is born. This indicates that boys and girls are not only considered to be different from each other, but that the gender norm is that boys are valuable to society, whereas girls are not. As another example, in most societies it is considered acceptable for a man to beat his wife or daughters, but not acceptable for a woman to beat her husband. This indicates that women have less value than men.

Gender roles are one part of gender norms. "Roles" refers to the activities which are considered appropriate and acceptable for boys or girls; men or women. We will explore gender roles in more detail in Activity 3.

# Objectives

- to identify the social processes and institutions which shape our understanding of what it means to be a boy or a girl, a man or a woman
- to understand how individuals experience the moment of recognition that they are a boy or a girl
- to understand that the concept of 'gender norms' refers to the values society associates with being a boy or a girl, a woman or a man
- to identify how gender norms not only identify a difference between being a girl or boy, man or woman, but value manhood over womanhood

# How to do the activity

This session consists of three steps. The first is an individual activity in which each participant writes down his/her first experience of realising that he or she was 'different' from members of the opposite sex. The second activity consists of sharing these experiences in pairs. The third activity is a plenary discussion which centres around the specific experiences narrated, and tries to collate the information to build a general picture of how each of them were socialised into gender roles.

## Step 1: 15 minutes

Individual work

Ask each individual to think as far back as possible in their lives and recall one incident when they first realised that being different from boys if they are girls, and vice versa, meant that they were expected to behave differently and were treated differently. Emphasise that we are asking them to remember differences about behaviour, not about physical differences. If they are

thinking of things that have to do with changes at puberty, that is physical and perhaps they are not thinking back far enough.

They must try to remember :

- what the incident was about
- how old they were
- who was involved
- where the incident took place
- how they felt about it

### Step 2: 10 minutes

Small group work

Ask participants to get into pairs and share their stories.

### Step 3: 1 hour 35 minutes

Plenary discussion

Call the group back together. On a flip chart have columns for age, people involved, where, what the incident was about, and feelings associated with it. Ask each pair to report on the other person's story to the large group and write the essential details under the specific columns.

Go through each column. Discussing results from each variable (age, people involved, where, what the incident was about, feelings associated with it), ask the group to identify similarities and differences, and make these clear if they do not come out.

Note to facilitator

## Points to bring out in discussion

### Age

The youngest age is usually interesting to note as it makes the point about how early socialisation begins. The usual range is 5 – 10 years.

### People involved

Family members, peers, teachers and people in the school and the church are usually the first groups of people who influence a child's life. To start moving beyond childhood ask the question, "Later on in life who continued to treat you differently from boys/girls or had different expectations from you?" Colleagues at work, men and women in social circles, the media are usually mentioned.

### Where

This often corresponds with the kinds of people involved. The home or family for example, at play, school or church for peers and teachers and adults in general. Later in life, the list of where the reinforcement of similar messages occur, gets extended to include the work place, social circles and the media. Make the point that these are social institutions which reinforce social norms and values that girls and boys, women and men are not only different from each other, but also that they are not equal; that boys and men have more value than women. You should be able to use an example given by a participant to illustrate this, particularly where participants describe how they felt at the time.

## What the incident was about

Usually this includes:

a) Division of labour along sex lines: the kind of household chores girls are expected to do as opposed to boys, such as girls working inside the home and boys outside, girls working for others in the home, e.g. cooking, dish washing, cleaning the house and washing of clothes, girls doing things for the boys that boys can do but are not expected to do like serving the food, cleaning up after themselves and doing their washing.

b) Physical segregation of boys and girls: in many cultures especially in Asia, physical segregation starts at an early age. Experiences narrated often include being told not to play with members of the opposite sex, or not to engage in any activity that will bring them in physical contact with members of the opposite sex.

c) The kinds of games girls and boys play, where girls are encouraged to be soft and gentle and boys to be rough, toys that are bought also differ.

d) The place where play takes place: often girls are inside the house or within earshot and eyesight while boys can go far and be unreachable. This may be linked to the household chores, e.g. the reason why girls are not to go far may be because they simultaneously have to be seeing to the cooking pots. It may also be that the tasks girls have to perform leave so little time for play in between that they cannot afford to go very far.

e) Mobility: under the pretext of protecting girls, their movements are controlled, and known by everyone, while it is acceptable that boys can be anywhere without anyone knowing where they are.

f) Emotional responses: girls and boys are expected to respond differently to the same stimulus; while it is acceptable for girls to cry, for boys it is seen as "weakness", girls are encouraged to bear pain because it is a way of life while boys are expected to avoid situations that will inflict pain on them.

g) Intellectual responses: girls are to be seen not heard and there is an expectation that girls are not to talk or express their opinion. This is often mentioned in relation to school and how teachers pay more attention to boys because they expect more from them. One participant from Japan told the story of how, when she obtained the highest marks in class, her teacher called her and asked her to agree that instead he would give the highest marks to the boy who was second. He explained that it would not be good for the boy to come second and the girl would not be treated well by boys if she did better than them.

## How they felt

In most groups, women express negative feelings towards the specific incident. Feelings of resentment, anger, disappointment, frustration, confusion, feeling "less than the other", rejection, isolation, and loneliness. Men, on the other hand, have often expressed positive feelings: "feeling better than", "feeling like a man", feeling powerful and respected.

Main points

## Main points to come out:

From the exercise participants will have seen how society treats boys and girls differently, and expects them to behave differently from each other. Society also values boys and girls differently. These differences are known as 'gender' differences. At this point you can use the definition of 'gender' presented under 'Why this activity' to explain the concept to participants. You can also come to an agreement about what wording you will use for 'gender' for the rest of the course.

In addition, draw out the following points:

- Gender norms and roles are learnt, and are not 'natural': boys and girls are systematically taught to be different from each other.
- Socialisation into gender norms begins early in life.
- This includes learning to be different in terms of:
  - Appearance and dress
  - Activities and passtimes
  - Behaviour
  - Emotions displayed
  - Responsibilities
  - Intellectual pursuits and so on.
- Gender norms are taught and reinforced by various social institutions: the family, the school, the church, society as represented by peers and neighbours, to mention a few.
- Women play as significant a role as men in socialising girls and boys into their gender roles.
- Society prescribes specific roles for girls and boys, women and men, but values them differently. In almost all societies girls and women are valued less than boys and girls. This unequal value is the source of discrimination and oppression for women and accounts for the inferior status given to women in society.


- Paper and pens for each participant.
- Prepared sheets of flipchart paper with age, people involved, where, what the incident was about, and feelings associated with it, written on.
- Felt-tip pens.
- Something to stick the flipchart to the wall with.


# Activity 2

## Differentiating between sex and gender[4]


**1 hour**

## Why do this activity?

Difference between sex and gender

This activity defines the concepts of sex and gender. The process helps participants to conceptualise and understand that there are two kinds of differences between women and men, namely sex and gender. Sex is physical, biological difference between women and men. Gender is not physical; gender refers to the expectations society has of people because they are female or male. While women and men's biological systems are different, and particularly their reproductive systems, many ideas about women's role in society have been shaped by culture so that many functions related to childcare and domestic work generally have come to be seen as 'women's work'. In addition, they have been given a lower value in society than work done by men. This is part of a broader ideological process in which men are given a higher social value than women – as reflected in many societies' preference for boy children. There are many and diverse ways in which this poorer valuation of women impacts on their health and on health service provision. However, before considering these, participants need an understanding and ability to analyse where biology ends and society begins. This activity aims to achieve this objective.

## Objectives

- to understand which differences between women and men can be explained on the basis of biology or 'sex' differences
- to understand which differences between women and men are based on social values or 'gender norms'
- to recognise that norms and values which are socially constructed can be changed

[4] Exercise on Statements About Gender, adapted from Williams, S., Seed, J. and Mwau, A., *The Gender Training Manual*, Oxford, Oxfam, 1994:87-89

# How to do the activity

## Step 1: 20 minutes

Plenary

Ask the group if they have heard of the words 'sex' and 'gender'. Give a simple definition of each: Sex refers to the biological differences between men and women; Gender refers to the way that society expects men and women to behave. Write each of these definitions on the top of separate sheets of flipchart paper and put them on the wall.

Handout

Distribute Handout: General statements about women and men.

Ask participants to read the ten statements and to write 'S' against those statements that they think refer to sex and 'G' against those that refer to gender. For example, the statement 'Women suffer from menstrual pains, men do not' is an 'S' statement, because women are born with wombs and men do not have wombs, therefore they don't menstruate.

Read out the statements one by one. For each ask people who have an 'S' written next to the statement to raise their hands, then ask those with a 'G' to raise their hands. This way the group will see if there is consensus or not.

Plenary discussion

Talk about each statement as you go along, asking people to motivate why they think this is a sex or gender statement. Push the group to reach consensus on whether this is a 'sex' or 'gender' statement. This process helps to draw out all of the complexities of the issue. Write the statements up on the flipchart under the appropriate definition as you go along. It is possible that the participants will conclude that some statements are both sex and gender – if so write them so they straddle both pieces of paper.

Statements 1, 5 and 8 are 'S', the rest are 'G'.

## Step 2: 20 minutes

Handout

Now the group moves to how 'sex' and 'gender' link to health issues. Distribute Handout: Health-related statements about women and men. Again people are asked to mark the handouts as either 'S' or 'G' and again you distribute them and read out the questions, getting the group to indicate how people understood the statements. Through group discussion develop a group consensus and again list the statements on the appropriate sheet as statements that refer to either sex or gender. In this case statements 2, 3, and 9 are 'S'; Statement 6 is both 'S' and 'G', the rest are 'G'.

## Step 3: 20 minutes

Plenary discussion

Consolidate the activity by using the overhead 'Sex and Gender' to help participants develop a clear understanding about the difference between sex and gender, or use the flipchart definitions you already have up. This section will also give them a deeper understanding of the concept of gender. While running this discussion, draw on the examples given by participants during activity 1. These examples will allow you to illustrate the different characteristics of gender. You can do this as follows:

Cover up the bottom part of the overhead, so that participants can only see the definitions of gender and of sex. Tell them that what they have done in the previous two exercises is to define the difference between sex and gender. They saw that there are very few characteristics that are biologically deter-

mined; most are socially constructed. You will now try to unpack the different characteristics of 'gender' based on the previous discussions.

Now move the paper covering the rest of the overhead so that you show one concept at a time, starting with 'Relational'. Explain the word to participants, using the explanations in the box below. Give an example from the stories participants told in Activity 1. Then ask the participants to give their own examples of how gender manifests in that characteristic. For example, under 'historical', participants may point out that whereas in some cultures in the past women were expected to do all the cooking, over time men have started to cook too; or in some cultures women were not sent to school whereas now they are – these are changes over time and illustrate that gender roles are historically specific.

Go through each of the characteristics on the overhead one at a time in this way.

Note to facilitator

## The following are characteristics of gender[5]

Relational: It is relational because it refers not to women or men in isolation, but to the relationships between them and how these relationships are socially constructed.

Hierarchical: It is hierarchical because the differences established between women and men, far from being neutral, tend to attribute greater importance and value to the characteristics and activities associated with what is masculine and to produce unequal power relations.

Historical: It is historical because it is nurtured by factors that change over time and space and thus can be modified through interventions.

Context specific: It has contextual specificity because there are variations in gender relations depending on ethnic groups, class, culture etc. It is therefore necessary to recognise diversity in the analysis of gender relations.

Institutional: It is institutionally structured because it refers not only to the relations between men and women at the personal level, but also within social institutions such as schools or health systems and in the overall social system that is supported by values, legislation, religion, etc.

Gender relationships are personal and political: Personal, because gender roles that we have internalised define whom we are, what we do and how we think of ourselves. Political, because gender roles and norms are maintained and promoted by social institutions and challenging these implies challenging the way society is currently organised.

Indicate to them that in the next session you will be exploring how gender relationships have to do with access to and control of and over resources and benefits.

[5] Women Health and Development, *Workshop on Gender, Health and Development*, Washington D.C., Pan American Health Organisation, 1997:29


- Flipchart, and overhead transparency.
- Copies of the Handouts for each person.
- Two sheets of flipchart paper with the simple definitions of sex and gender written at the top.


ARROW, 'Section 2: Framework for Change', *Women-centred and gender sensitive experiences, changing our perspectives, policies and programmes on women's health in Asia and the pacific: Health Resource Kit*, Kuala Lumpur, Asian-Pacific Resource and Research Centre for Women, 1996.

INSTRAW, *Gender Concepts in Development Planning*, UN, 1995 7-35


- Overhead: Sex and Gender


- Handout 1: Sex or gender? - general statements
- Handout 2: Sex or gender? - Health-related statements

# Sex or gender? - General statements

**Read the statements and write 'S' against those that you think refer to sex and 'G' against those that refer to gender.**

1. Women give birth to babies, men do not. ❑
2. Little girls are gentle, boys are rough. ❑
3. In one case, when a child brought up as a girl learned that he was actually a boy, his school marks improved dramatically. ❑
4. Amongst Indian agricultural workers, women are paid 40-60 per cent of male wages. ❑
5. Women can breast-feed babies, men can bottle-feed babies. ❑
6. Most building site workers in Britain are men. ❑
7. In Ancient Egypt men stayed at home and did the weaving. Women handled family business. Women inherited property, men did not. ❑
8. Men's voices break at puberty, women's do not. ❑
9. According to the United Nations, women do 67% of the world's work, yet their earnings for it amount to only 10% of the world's income. ❑
10. In one study of 224 cultures, there were five in which men did all the cooking and 36 in which women did all the house building. ❑

Williams, S., Seed, J. and Mwau, A., *The Gender Training Manual,* Oxford, Oxfam, 1994: 87-89.

# Sex or gender? - Health-related statements

**Read the statements and write 'S' against those that you think refer to sex and 'G' against those that refer to gender**

1. The majority of hospital managers in most countries are men and most of the ward managers are women. ❑
2. Boys and men suffer from haemophilia, whereas girls and women are usually only carriers. ❑
3. Women suffer from pre-menstrual tension, men do not. ❑
4. More health research funds go to research on men than on women. ❑
5. More women are raped as compared to men. ❑
6. Women are more susceptible to sexually transmitted diseases than men. ❑
7. When infertility occurs in a couple, it is often presumed to be the fault of the woman. ❑
8. The rates of behaviour disorder and hyperactivity for boys is 2-3 times the rates for girls. ❑
9. Women undergo tubal ligation, men do not. ❑

Xaba, M. and Varkey, S., *Women's Health Project Gender and Health Course: Facilitator's Guide*. Women's Health Project. School of Public Health. University of the Witwatersrand. Johannesburg 2000.

## Sex and gender

'Sex' refers to biological differences between men and women.

'Gender' refers to socially constructed differences between men and women.

## Characteristics of gender

Relational

Hierarchical

Historical

Context specific

Institutional

Gender relationships are personal and political

# Activity 3

## Division of labour

timing

**40 minutes**

## Why do this activity?

The concept of 'gender' is complex. The following activities deepen participants' understanding of the concept of 'gender'. This activity provides them with tools for gender analysis, to understand the concepts of 'division of labour' and 'gender roles'. The ability to analyse the division of labour in a specific social context, including differences in payment between men and women, is a central building block for gender analysis. It allows participants to see that women's work and men's work are differently valued. The undervaluation of women's work is one aspect of women's overall lower social status. The failure of men to share in domestic work means that women often work extremely long hours, especially where they are also engaged in wage work or agricultural activities. The activity allows participants to identify how women's domestic roles give them an unequal and stressful burden to carry which may have negative implications for their health.

## Objectives

- to identify the different roles that men and women play
- to identify the different values associated with these roles
- to identify the impact of the different roles played by men and women on their health
- to identify how the low valuation of women's roles impacts on their health
- to be able to use the concepts of 'division of labour' and 'gender roles'

## How to do the activity

### Step 1: 20 minutes

Handout

Distribute Handout: The 24-hour day[6].

[6] Adapted from Williams, S., Seed J. and Mwau, A., *The Gender Training Manual*, Oxford, Oxfam, 1994:181.

Small group work

Ask the participants to form groups of about 4 - 6 people. Each group should choose one social group of which they have personal knowledge - such groups may be farmers, shanty-town dwellers, etc. Ensure that each group has chosen a different social group.

Ask the group to imagine a typical day in the lives of a wife and husband from the social group they have chosen.

Using the framework provided in the handout, ask the group to list the tasks performed by the wife and husband in a household over 24 hours on a sheet of flipchart paper. The participants need to fill in the activity the person is doing at the time indicated, whether it is paid work, and what the pay is per hour.

Once they have filled in the table, they need to calculate the number of hours each person works, and the total pay they receive per day.

Put the tables from all the groups on the wall.

### Step 2: 5 minutes

Walk around the room with participants and make a note of common points from the charts on the wall.

### Step 3: 10 minutes

Plenary discussion

Bring the groups to plenary. Using the questions below, draw out the common points from the tables.

1. What was your first impression when you saw the woman's and the man's chart?
2. What differences do you notice in the way in which men and women spend their day?
3. What differences do you notice in the way in which men and women spend their spare time?
4. What do you notice about what work is paid and what work is not paid?
5. What are the consequences of this for men's and women's income?
6. What are some of the consequences of these differences for women's health?
7. What are some of the consequences of these differences for men's health?
8. What are some of the consequences for society?
9. Discuss factors that could distribute the workload more evenly and how to address any other imbalances.

## The sort of points that may come out are:

- Women and men do different things during the day.
- Women usually work longer hours.

- Men usually have more leisure time.
- Women have more varied tasks, sometimes doing more than one thing at a time.
- Even when women work outside the home, they also do a substantial amount of household work as well.
- Men's work is usually outside the home.
- More of women's work is unpaid compared to men's work.
- Women are usually paid less money than men for the paid work that they do.

## Main conclusions to draw out

Note to facilitator

In concluding this section, you should introduce participants to the concept of the 'division of labour'. This refers to the different socially constructed roles of men and women. Thus women taking responsibility for cooking, and men for cattle, is an example of a 'division of labour' which is normative in many societies. The different tasks that are considered 'men's work' and 'women's work' are called 'gender roles'. Girls are raised expecting to perform such gender roles as cleaning the house, while boys are raised expecting to perform such gender roles as fixing cars or looking after cattle. In contemporary society, people often make the distinction between 'productive' and 'reproductive' roles. You may want to discuss this with your participants if they are familiar with these terms. 'Productive' work refers to work which is outside of the home and contributes to the economy; 'reproductive' work refers to work which allows people to grow up and contribute to the economy. This means not only the work to raise children, but the daily work of cooking, cleaning, ironing and the like which are necessary to allow workers to go out each day to produce. While increasingly women do productive work as men do, they still take most responsibility for reproductive work.

The division of labour into gender roles is not only about differences between what society expects men and women to do. It is about the social understanding of the value of the roles that women and men play.

The division of labour between women and men in most cultures is unequal; gender roles are not equally valued. Men's roles are considered more important than women's roles. This is reflected in that many of women's roles are not paid for and that even in the workplace, women's work tends to be paid less than men's work. Thus gender roles are a part of the overall cultural values of a society and hence one aspect of gender norms.

The long hours that women work, and the lack of recognition of the value of this work can undermine both women's physical and mental health.

This suggests that it is time for men to start sharing reproductive work, that is domestic tasks, with women.

Draw out that the division of labour between women and men in most cultures is unequal, such that women's excessive workload has a negative impact on their health. That is, unequal gender roles are damaging to women's health.

### Step 4: 2 minutes

Handout — Give out Handout: The lie of the land

Action — Ask one participant to read the cartoon.

The purpose of this cartoon is to illustrate that researchers, women themselves and men – all members of society – often fail to see that domestic labour constitutes work.

### Step 5: 3 minutes

Handout — Give out Handout: Working women

Allow time for participants to read it.


- Flipchart paper.
- Felt-tip pens.
- Something to stick pieces of paper to the wall with.
- Copies of Handouts for each participant.


- Handout: The 24-hour day
- Handout: The lie of the land
- Handout: Working women

# The 24-hour day

| MAN'S ACTIVITY | PAID YES/NO | WAGE PER HR | WOMAN'S ACTIVITY | PAID YES/NO | WAGE PER HR |
|---|---|---|---|---|---|
| 1 am | | | 1 am | | |
| 2 am | | | 2 am | | |
| 3 am | | | 3 am | | |
| 4 am | | | 4 am | | |
| 5 am | | | 5 am | | |
| 6 am | | | 6 am | | |
| 7 am | | | 7 am | | |
| 8 am | | | 8 am | | |
| 9 am | | | 9 am | | |
| 10 am | | | 10 am | | |
| 11 am | | | 11 am | | |
| 12 noon | | | 12 noon | | |
| 1 pm | | | 1 pm | | |
| 2 pm | | | 2 pm | | |
| 3 pm | | | 3 pm | | |
| 4 pm | | | 4 pm | | |
| 5 pm | | | 5 pm | | |
| 6 pm | | | 6 pm | | |
| 7 pm | | | 7 pm | | |
| 8 pm | | | 8 pm | | |
| 9 pm | | | 9 pm | | |
| 10 pm | | | 10 pm | | |
| 11 pm | | | 11 pm | | |
| 12 pm | | | 12 pm | | |
| TOTAL HRS WORKED | | TOTAL DAY'S EARNINGS | TOTAL HRS WORKED | | TOTAL DAY'S EARNINGS |
| | | | | | |

Country:

Social Group:

# The lie of the land


Williams, S., Seed, J. and Mwau, A., *The Gender Training Manual.* Oxford, Oxfam, 1994. 185

# Working Women

## Women and girls are Kenya's breadwinners

- Women in rural Kenya work on average about 56 hours a week, men only about 42. Children between the ages of 8 and 16 also work many hours. If time spent for education is counted, girls spend about 41 hours a week in economic activity, boys 35 hours.
- Women shoulder the heaviest burden in household work, including firewood and water collection: 10 times the hours of men. This carries over to girls, whose household work takes about 3.7 times the hours of boys.
- Women in households that farm such cash crops as tea and coffee work the most of any rural women - 62 total hours a week. As Kenya's farming becomes more cash-oriented, women tend to shoulder more work, not less.

Source: Githinji 1995, as quoted in UNDP, Human Development Report 1995, Box 4.1, Page 92.

## Women do 56% of the work in Venezuela

- In Venezuela, women are a minority in the labour force, but they work more total hours than men, according to a study of urban time use by the central bank. Time is divided into five categories: income-earning activities, household activities, personal care, studying, and social activities and leisure.
- Men have a distinct advantage over women in income earning activities: 6 hours a day as compared with only 2.25. But women's time in household work is a striking 11.5 multiple of men's time. Men's overall advantage shows up in 10% more time enjoyed in social activities and leisure.
- In 1988, women and men spent 12.3 billion hours in work that is counted to be of economic value: men 8.9 billion hours and women, 3.4 billion. But if all working hours are counted, women contribute 12.9 billion hours and men, 9.7 billion. So 56% of Venezuela's work is done by women.

Source: Urdanta-Ferran 1994, as quoted in UNDP, Human Development Report 1995, Box 4.2, Page 93.

## More paid work doesn't reduce unpaid work

- Bangladesh had one of the largest increases in the share of women's participation in the labour force- from 5% in 1965 to 42% in 1995. This has been important for export growth, with women as the main workers in the garment industry. But women still spend many hours in unpaid work. A survey of men and women in formal urban manufacturing activities shows that women put in on an average 31 hours a week in unpaid work - cooking, looking after children, collecting fuel, food and water. They spend 56 hours in paid employment. Men spend an average of 14 hours a week on unpaid activities such as house repair, and 53 hours on paid employment. Thus women in formal sector employment work an average of 87 hours a week, as compared to 67 hours a week by men.
- In OECD countries men's contribution to unpaid work has been increasing. But a woman who works full time still does a lot of unpaid work. Once she has a child, she can expect to devote 3.3 more hours a day in unpaid household work. Married women who are employed and have children under 15 carry the heaviest work burden - almost 11 hours a day.

Source: Zohir 1996 and UNDP 1995 as quoted in UNDP, Human Development Report 1999, Box 3.3, Page 81

International Training Initiative on Gender and Reproductive Health, *Transforming Health Systems, Gender and Rights in Reproductive Health: A Curriculum for Health Managers*, WHO Geneva 2001 (forthcoming).


# Activity 4

## Access to and control of resources


**35 minutes**

## Why do this activity?

This activity identifies how men and women have differential access to resources – whether economic, political / decision-making, informational, internal, or of time[7]. It unravels how different types of resources, as a result of gender norms in society, are distributed in favour of men, and thereby limit women's ability to develop to their full potential, and in many cases actually undermines women's health. This tool, linked with division of labour from the previous exercise, is necessary in order to build participants' ability to identify the diverse dimensions of gender inequality underlying health problems and health services that they want to address.

## Objectives

- to describe the range of resources which people use
- to identify the different impact of having access to a resource as opposed to control over a resource
- to identify the patterns of women and men's access to and control over resources in their country and community
- to identify the impact of women's lesser control over resources on their health

## How to do this activity

### Step 1: 5 minutes

You should have decided what roles you want participants to play – see Handout: Role play.

[7] Information on types of resources taken from Women Health and Development, *Workshop on Gender, Health and Development*, Washington D.C., Pan American Health Organization, 1997: 43-47

Ask for two people, preferably a man and a woman, to volunteer to do a role play. Take them to one side and give each of them their role and ask them to think about how they will play this role. Do not let the other actors or the participants see the roles. Tell the actors that they will have about 3 minutes for the role play.

Then tell the group that they will be watching a role play. Remind them that a role play is when participants act different parts. They are not presenting their own views, but the roles that they have been asked to play.

### Step 2: 10 minutes

Ask the actors to perform the role play. Do not allow them more than 3 minutes.

Ask the actor playing the woman:

'How did you feel playing this role?' and let her respond.

Ask the actor playing the man:

'How did you feel playing this role?' and let her respond.

Ask the group:

'Is this a real situation? Do things like this happen?' and let them respond.

Run a short plenary discussion asking the group:

'In the role play, what resources were being contested?'

Main points

Draw out from the role play which resources the man has control over and which, if any, the woman has control over. At this point the participants may not be familiar with the language of 'access and control' which you will introduce in the next step, so keep the points simple. The sorts of points which may come out of the role play include:

- the woman had access to the land. It was her husband's land. However, she did not have the right to ownership or control over the vegetables she grew on the land. Although she usually sold the vegetables and kept the money, her husband had the right to sell them and keep the money if he wanted to because he owned the land.
- also gender norms in their community were that men had control over decision-making in the home. So the man had the right to decide what to do with money from the sold vegetables.
- the man had access to information about where to get good prices for vegetables which the woman may not have had since she was based at home and did not move around as the man did.

### Step 3: 40 minutes

The issues which came up in the role-play give you an entry point for this step, which is a more formal process of guiding participants though understanding one of the central reasons why the social construction of gender is about discrimination rather than just difference.

Begin by discussing the meanings of 'access' and 'control' and why having access to a resource is different from controlling it.

Definitions

Access is the ability to use a resource.

Control is the ability to make binding decisions about the use of a resource. The distinction between access to and control of certain resources is important because the ability to *use* a resource does not necessarily imply the ability to make decisions about the use of that same resource. For example, a woman may use land to grow food on. But the land may belong to her husband who decides whether to keep or sell the land, and who owns the products of his wife's agricultural work from that land. A woman may have access to a donkey for transport, but if she does not decide who can use the donkey when, then she does not have control over it. If, for example, she needs to go to a clinic using the donkey, but her father-in-law who owns the donkey wants to use it to go to visit friends, then the woman's needs may be ignored – thus she has access to the donkey, but not control over its use.

Indicate that the fact that women and men are socially assigned different roles and responsibilities (the division of labour between women and men) has direct implications for the level of access to and control over resources they have, which in turn affects their health and their ability to access health services.

Overhead

Put up Overhead: Relationship between control over resources and power.

Use this overhead to make the point that people who control resources have greater power in society than those who do not. Indicate that one feature of the gendered division of labour is that different roles are associated with differential access to and control over resources. It is predominantly men who have control of most resources, and women who do not, although the actual way this works differs between societies.

These overall resources include those necessary for the promotion and protection of one's health as well as the health of others.

Handout

Go on to look at the different types of resources – give participants Handout: Range of resources. Alternatively or in addition you can use the overhead provided.

Take participants through each dimension of the handout, leaving time for them to give examples of the different types of resources which are at stake. In relation to each resource ask how access to that resource might impact on health.

The capacity to have access to and control over resources develops and strengthens internal resources that can enhance personal development; hence these resources have been included.

Note to facilitators

## Examples of how access to, or control over resources might impact on health

### Economic resources

- A woman may have access to funds through her husband who earns a wage or sells the household's agricultural products for money. However, if it is her husband who decides if she can have the money she wants, then she does not have control over this resource. This means

that if she wants to go to a clinic, but there are fees for services, then her husband determines her access to health care, or to transport to get there even if services are free.

- A woman may have the right to live (access) in a house which belongs to her father, husband or son. However, in many situations women are legal minors. When the man who owns the house dies, the woman does not inherit. Her right to continue living in the house depends on the man who inherits. Thus she does not control her own security in relation to her home.

- It is not only women who may have lesser control over economic resources. Age may determine when a man gains control over resources; class determines the quantity of economic resources that some men can access and control, in comparison to other men. Workers, for example, usually do not own the factories where they work, hence they have access to a means of earning income, but they do not control that means of earning income. Amongst workers, however, it is usually women who earn least income, since 'women's work' is given less value in society than 'men's work'.

## Political / decision-making resources

- Women tend to have less access to political resources, such as the opportunity to stand for parliament. Women also have less access to control over decision-making about who goes to parliament. Most political parties are dominated by men at leadership level, thus it is men who will decide whether or not a woman can stand to be elected for parliament.

- This applies likewise to decision-making positions in private sector companies, in trade unions, and in most religious groups. In all cases the leadership tend to be men and it is they who control decision-making.

- Control over decision-making determines priorities in any institution: those who control local government may determine whether money should be spent on outreach from health centres or on a new sports field. If there are few women in decision-making positions, women's needs and priorities may not be heard. However, gender is not the only determinant of who controls decision-making resources. National leadership tend to be urban so that rural people in general have less control over political decision-making; rural women even less so.

- The right to make decisions within the home is also a resource. In most homes, men have control over decisions about how the household's income will be spent; and how the women and children will behave. For example in households which have access to bed nets to protect from malaria carrying mosquitoes, men may control who uses them – men often use them rather than pregnant women or children for whom malaria is more dangerous.

## Information / education

- Women often have less access to information and education than men. For example, in most parts of the world boys have substantially greater access to education than girls; in countries where many men are migrant workers, they may have greater access to information from

newspapers and television than women in rural areas.

- Given decision-making roles within the household, it is usually not women who control decision-making about their children's access to education and whether girls will have the same educational opportunities as boys; or about what sorts of information comes into the household - whether money is spent on TV or radio or newspapers.

- Decisions about which radio stations are listened to or which TV programmes are watched, are also often controlled by men, when both men and women are in the household. This may influence women's access to satisfying recreation or information such as about political processes and opportunities for participation, or skills training provided through the media. Women's lesser access to the internet, the fastest growing information resource, compounds their marginalisation.

- Who has control over information? Production of information is one of the most powerful positions in society – whether it is the spokesperson for a tribal leader, or the owner of a multi-national television company like CNN. Most of these positions are held by men. Likewise in governments or NGOs which play educational roles, one needs to know who is deciding what information the public needs, and how to communicate that information? Are they aware that women and men of different ages may have different health information needs? Do they use their control over media to ensure messages which promote equality between women and men, or do they use their power to reinforce existing gender norms?

### Time

- Time is a resource in so far as one can make choices about how to use it. The previous activities on the division of labour between men and women showed the unequal allocation of time spent on work (in addition to the problem that women's labour in the home is not given any monetary value). In addition, time is not elastic – there are only so many hours in a day. If all of these hours are spent on work, this means there is less time for leisure, for further education, or for community activity. Thus women's lack of control over time further limits their options in life.

- Control over time also arises in relation, for example, to access to health services. If a person has little time, they are not likely to use up time in making use of health services. Also, the opening times of a health service may determine whether or not a health service can meet various groups' needs. For example, if men or women are employed in the formal workforce, and the clinic is only open during the hours at which they are at work, then they will not be able to access the clinic, unless their workplace allows them control over their time – to work flexible hours, for example, so they can access a health centre.

### Internal resources

- Discrimination can undermine a person's sense of their own value. For example, if a woman does not have control over her own body – if the gender norms are such that she cannot decide or even negotiate if or when to have sexual relations, or if or when to have a child – the feeling of worthlessness can make it hard for her to take control over other dimensions of her life. If a women or a child is beaten up by her

husband or other family members, this reinforces society's view that she is of little value and does not need protection. This undermines her ability to act, rather than being permanently acted upon by others. Thus a sense of self-esteem, of value and of confidence are crucial resources to allow a person to take advantage of what opportunities there may be for personal development.

- Even in a context where a person has little control over any of the above resources, if she has a sense of her own value, she is more likely to get involved in group activities, such as a women's group, which could further build her ability to take control over her life.

### Step 4: 5 minutes

Put up the Overhead: Differential access to and control of resources between men and women in selected South and East Asia countries.

Tell participants that the issues identified in the role play and through this activity's discussions are similar all over the world. The overhead illustrates differences in access to and control over resources between a number of countries. This shows that the problem is not peculiar to specific countries.

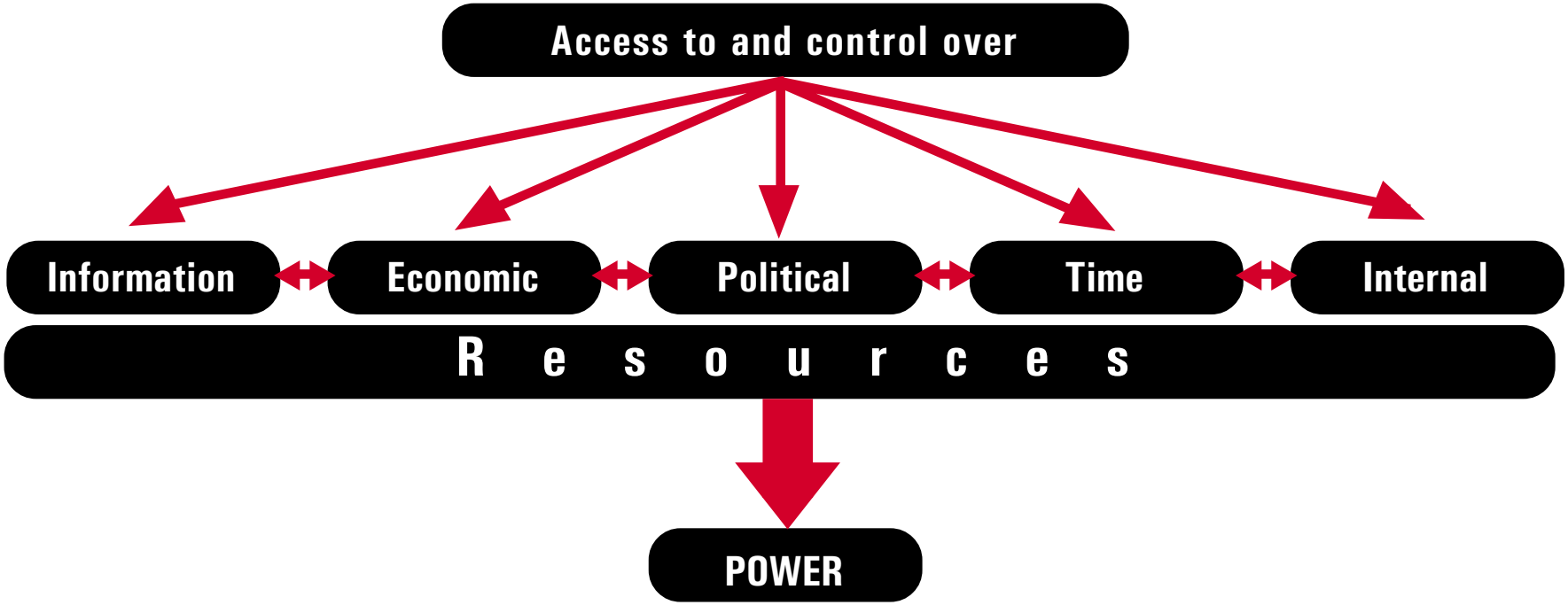

- Copies of Handouts for each person.


Gurumurthy, A., Women's Rights and Status. Questions of analysis and measurement, *Gender in Development* Monograph series 7. UNDP 1998.


- Overhead: Relationship between control over resources and power
- Overhead: Differential access to and control of resources between men and women in selected South and East Asian countries


- Handout: Range of resources
- Handout: Role-play on access to and control over resources gives you some roles for volunteer actors to play. Decide if you want to use this role-play or to make different roles so that the role play will give you examples and issues you can use when describing the different kinds of roles and resources in society. The role play should also illustrate men and women's differential access to and control over these resources.
  You do not make copies of the handout for participants. You just give each volunteer a copy of his or her role.

## Relationship between control over resources and power



# Differential access to and control of resources between men and women in selected South and East Asia countries

| | Primary school enrolment[1] | | Secondary school enrolment[1] | | Percent illiterate >15 years[1] | | Adult +15 economic activity rate 1995/97[2] | | Percent women in the adult labour force 1995/97[2] | Percent parliamentary seats in single/ lower chamber occupied by women 1999[2] | Percent women at ministerial level 1998[2] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | W | M | W | M | W | M | W | M | | | |
| Bangladesh | 66 | 77 | 13 | 25 | 71 | 48 | 56 | 89 | 38 | 9 | 5 |
| Cambodia | 104 | 123 | 17 | 31 | - | - | 76 | 82 | 53 | 8 | - |
| Lao PDR | 101 | 123 | 23 | 34 | 68 | 37 | 75 | 89 | 47 | 21 | 0 |
| Nepal | 96 | 129 | 33 | 51 | 77 | 42 | 57 | 86 | 40 | 6 | 3 |
| Pakistan | 45 | 101 | 17 | 33 | 70 | 41 | 13 | 82 | 13 | 2 | 7 |
| Sri Lanka | 108 | 110 | 78 | 72 | 11 | 6 | 41 | 78 | 36 | 5 | 13 |
| Vietnam | 111 | 115 | 46 | 48 | 9 | 5 | 29 | 82 | 49 | 26 | 0 |

[1] UNFPA, *The State of the World Population, Lives Together Worlds Apart, Men and Women in a Time of Change,* New York, 2000.
[2] United Nations, *The World's Women 2000, Trends and Statistics,* New York, 2000.

# Range of resources

## Economic Resources

- Work
- Credit
- Money
- Transportation
- Equipment
- Food
- Child care facilities
- Facilities to carry out domestic tasks
- Technology
- Social security, health insurance
- Housing
- Health services

## Political Resources

- Positions of leadership and mobilisation of actors in decision-making positions
- Opportunities for communication, negotiation and consensus-building

## Information/Education

- Inputs to be able to make decisions to modify or change a situation, condition or problem
- Formal and informal education
- Non-formal education
- Opportunities to exchange information and opinions

## Time

- Hours of the day available for discretionary use
- Flexible paid hours

## Internal Resources

- Self-esteem
- Self-confidence
- The ability to express one's own interests

Women, Health and Development, *Workshop on Gender, Health and Development,* Washington D.C. Pan American Health Organisation, 1997: 45

# Role play on access to and control over resources

## Role 1:

You are a woman. You work on your husband's lands growing vegetables for the family to eat. Your husband does not work on the land. He works in the village. Your family eats some of the vegetables and the rest you sell at the market and this gives you some spending money. Otherwise you have no money of your own. Your husband does not give you money, he simply brings food and other necessities from the village. You need to have some money available, so that you can buy small gifts for your children, or pay for the clinic when you need to go. Your husband comes home and tells you that a friend of his has offered to sell your vegetable crop in a bigger town.

## Role 2:

You are a man. You have a job in the village. Your wife grows vegetables. A friend of yours has offered to sell the vegetables in a bigger town for good money. You want to do this because you need more money to buy a new suit for your best friend's wedding.


# Activity 5

## Linking gender and health[8]


**1 hour 30 minutes**

## Why do this activity

Understanding different health needs for men and women

The first three activities highlighted that not only are there physical differences between men and women, but also social differences. These differences generate different needs. Women and men have different health needs. Women have many health needs arising out of their reproductive roles. Moreover, given that there are some biological differences between men and women such as their different hormonal make-up, disease may follow different patterns in men or women's bodies, and require different approaches.

Men and women's exposure to circumstances that threaten their health often differ because of the division of labour – for example they may face different hazards in the workplace. Women also have a range of health needs arising out of their subordinate position in society – overwork, domestic violence, and the impact of poor self-esteem on mental health. Likewise men may be vulnerable to different health problems from women as a result of their gender roles. Deaths amongst young men from violence or traffic accidents, for example, are usually much higher than amongst young women. Thus addressing health requires more than just addressing the presence of viruses and germs. It requires understanding of social factors, in particular that gender differences and inequalities cause ill health and affect health-seeking behaviour.

## Objectives

- to conduct a gender analysis of the causes and consequences of a health problem
- to identify how gender norms, and men and women's differential access to and control over resources impact directly on their vulnerability to and ability to address health problems
- to identify the different ways in which society responds to the same health problem when it is a man or a woman who has the health problem

[8] Xaba, M. and Varkey, S., *Women's Health Project Gender and Health Course: Facilitator's Guide*. Women's Health Project. School of Public Health. University of the Witwatersrand. Johannesburg 2000.

# How to do the activity

## Step 1: 45 minutes

Divide the group into three small groups. Allocate one topic for discussion to each group from the following topics or other topics which you think are relevant for your participants:

- HIV/AIDS
- Rape
- Infertility

Handout

Distribute the Handout: Impact of gender on men's and women's health.

Ask participants to fill in the table in the handout in relation to their topic.

## Step 2: 45 minutes

Handout

Get each group to report their main findings to plenary and facilitate a discussion on each topic. The readings provided give some background as to why each of the above issues is gender-related. You should prepare the broad points you expect to come out from each group so that you can alert the group to issues they may not identify. The tables give you a few ideas of the kinds of points participants may make.

Plenary

Once you have discussed each topic, you can draw general conclusions. The main point to bring out is that the impact of gender-norms (in particular roles of women in the society, their poor valuation by society, and their limited access to and control over resources) makes women more vulnerable to certain health problems, less able to address these problems, and makes their consequences more severe for women. The analysis will also show the negative impact of gender norms on men.


- Copies of Handout for each participant.


Antrobus, P., *Gender and Women's Health Information Package No 2: Linking gender and women's health conceptually*. Arrow. Kuala Lumpur 1997.

*Guidelines for the Analysis of Gender and Health*. Liverpool School of Tropical Medicine and DFID. 1999: 5-10; 26-33

Doyal, L., *Gender equity in health:debates and dilemmas*. www.msoc-mrc.gla.ac.uk/SocialScienceMedicine/WorkshopP/DOYAL-FI.pdf

Smyke, P., *Women and Health*, London, Zed Books, 1991. AIDS: 96-103; Infertility:73; Rape: 53-55.


- Handout: Impact of gender on men's and women's health

## Health problem you are analysing: HIV/AIDS - Ideas of possible points

| | Women | Men |
|---|---|---|
| How do gender norms/values affect vulnerability to this problem? | • a woman may not take initiative for safer sex even if her partner is HIV positive | • idea that masculinity requires men to have many partners makes them vulnerable |
| How do the roles and activities of men and women influence vulnerability to this problem? | • sex work which many women do because of poverty<br>• dependence on husbands for income makes it hard to insist on safer sex even when husband has other partners | • migrant labour increases the chance that a man will seek sex outside of marriage<br>• economic position means can buy sex or win sexual partners by spending money on them |
| How does control over economic resources influence how men and women respond to having this problem? | • less resources to ensure good nutrition; to pay for care | • more likely to seek treatment<br>• can buy nutritious food; care |
| How does control over decision-making influence how men and women respond to having this problem? | • may not be able to decide to see health worker; or to rest, or other actions that are husband's or father's decisions | • can make all necessary decisions, but still vulnerable, as are women, to decisions made by (mostly men) politicians e.g. about access to drugs for treatment |
| How does access to information influence how men and women respond to having this problem? | • may have less access to information about how to live healthily or about treatment available | • if workplace has health centre, or because of greater mobility in public life, may have more information about healthy lifestyles and treatment |
| How does control over time influence how men and women respond to having this problem? | • less time to seek health care | • more leisure time and rest which is necessary to keep healthy |
| How do gender norms/values affect the consequences of having this problem? | • women blamed for being transmitters of HIV; assumed women are promiscuous<br>• husband unlikely to care for her | • probably has a wife or mother who will look after him |
| How do men and women respond when someone else has this problem? | • care for husbands and children who are sick | • man's control over household allows him to throw out wife when he finds she is HIV positive |

## Health problem you are analysing: Rape - Ideas of possible points

| | Women | Men |
|---|---|---|
| How do gender norms/values affect vulnerability to this problem? | • social acceptance of violence against women<br>• family considered 'private' by authorities allows abuse by family members<br>• women often blamed | • men a lesser target<br>• social acceptance of institutionalised male violence e.g. in prisons |
| How do the roles and activities of men and women influence vulnerability to this problem? | • being kept in the home with less access to outside world makes rape private and hence women more vulnerable<br>• sex workers vulnerable especially where it is illegal | • poor men more likely to be involved in crime and hence prison than wealthy men |
| How does control over economic resources influence how men and women respond to having this problem? | • less chance of going for medical care or paying lawyer in court case<br>• reliance on public sector health workers who may be less sympathetic | • more funds to pursue legal recourse |
| How does control over decision-making influence how men and women respond to having this problem? | • family or husband may determine whether woman can report to police or go for treatment or HIV prophylactics or have an abortion if made pregnant through rape | |
| How does access to information influence how men and women respond to having this problem? | • less likely to know legal rights<br>• less likely to know about such things as possibility of taking anti-retroviral to protect from HIV | • more likely to believe that what has been done is unacceptable and against the law and to know rights and options |
| How does control over time influence how men and women respond to having this problem? | • less likely to be able to take time off to use health service or to recover emotionally | |
| How do gender norms/values affect the consequences of having this problem? | • women often considered impure after rape and blamed although it's not their fault with major implications for their self esteem and mental health | • society (eg media) is shocked by rape of men and more sympathetic to men who are raped than to women |
| How do men and women respond when someone else has this problem? | | • often blame them, thus blaming the victim; may end relationship with woman who has been raped |

## Health problem you are analysing: Infertility - Ideas of possible points

| | Women | Men |
|---|---|---|
| How do gender norms/values affect vulnerability to this problem? (Note the major cause of infertility is sexually transmitted diseases - STDs) | • assumption that husband has the right to sex with wife means she can't negotiate condom use so can't protect from STDs | • taboos against talking about sex may make it hard to discuss safer sex with partner increasing vulnerability to STDs |
| How do the roles and activities of men and women influence vulnerability to this problem? | • sex work which many women do because of poverty<br>• dependence on husbands for income makes it hard to insist on safer sex even when husband has other partners | • migrant labour increases the chance that a man will seek sex outside of marriage<br>• economic position means he can buy sex or win sexual partners by spending money on them |
| How does control over economic resources influence how men and women respond to having this problem? | • less income to afford in-vitro fertilisation | • more likely to afford or to access funds for costs of treatment or adoption |
| How does control over decision-making influence how men and women respond to having this problem? | • may not have a say in response e.g. if husband decides to divorce her or take another wife because she's infertile | • can make his own decisions about whether to go for treatment, adopt etc |
| How does access to information influence how men and women respond to having this problem? | • may not know options for adoption<br>• may not know options for infertility treatment<br>• alternatively women's networks may increase information access | • more likely to access information |
| How does control over time influence how men and women respond to having this problem? | | |
| How do gender norms/values affect the consequences of having this problem? | • woman almost always blamed for infertility<br>• women not considered adult if has no child<br>• husband may divorce | • man not considered manly without children so may lose self esteem |
| How do men and women respond when someone else has this problem? | • presume it is the woman's fault | • presume it is the woman's fault |

# Impact of gender on men's and women's health

Health problem you are analysing: _____

Consider whether there are differences in vulnerability, responses and consequences for women and for men by filling in one point per box below. Note: not all questions may apply to the problem you are addressing

| | Women | Men |
|---|---|---|
| How do gender norms/values affect vulnerability to this problem? | | |
| How do the roles and activities of men and women influence vulnerability to this problem? | | |
| How does control over economic resources influence how men and women respond to having this problem? | | |
| How does control over decision-making influence how men and women respond to having this problem? | | |
| How does access to information influence how men and women respond to having this problem? | | |
| How does control over time influence how men and women respond to having this problem? | | |
| How do gender norms/values affect the consequences of having this problem? | | |
| How do men and women respond when someone else has this problem? | | |

# Activity 6

## Mainstreaming gender equality in institutions

timing **2 hours and 10 minutes**

## Why do this activity?

Reasons for institutional gender inequality

Gender inequality is embedded in most institutions in society. This is for two reasons. Firstly most institutions are controlled by men, and usually by particular groups of men (educated, wealthy, inherited leaders etc.). Over time, the institutional goals, management styles, inter-personal culture and the like become consolidated, so that whether women take up leadership posts or not, the 'way of doing business' is already set. Secondly, institutions reflect the general social culture - the gender norms of society. If society does not value women's input, social institutions are unlikely to do so. If society does not give women access to decision-making, institutions are unlikely to do so. If society does not give priority to women's health, health institutions are unlikely to do so. For these reasons, one can understand institutions as 'gendered structures'[9] - that is that the way in which institutions work reflects gender inequalities entrenched in society.

Addressing the causes

Yet many considerations of gender in relation to health tend to remain focused on women as users of services, or as service providers, rather than assessing how health institutions reinforce gender inequalities and, in doing so, undermine social justice while at times also undermining women's health.

The NGOs participating in this training are mostly providing services - whether adolescent education, or programmes to address maternal health. Before they begin to look at how to address the gender-related causes of these problems, they need to make sure that they are promoting gender equality in their own practice. This activity supports participants in conducting a gender analysis of their own organisation, and in identifying immediate actions they can take to promote gender equality.

## Objectives

- to conduct a gender analysis of an institution
- to identify practical actions to promote gender equality in that institution
- to have planned how to implement at least two actions once returning to work

[9] Elson, D. and Evers, B., *Sector Programme Support: The Health Sector. A gender-aware analysis*. Genecon Unit, Graduate School of Social Sciences, University of Manchester, Draft, 28 January 1998:14.

# How to do this activity

## Step 1: 10 minutes

Overhead

Introduce the topic with a short input. Use the Overhead: Mainstreaming Gender Equality to support your input, draw linkages with the previous sessions which showed how gender inequality is embedded in society's norms / values, rules and systems. For this reason it is also likely to be embedded inside our own institutions.

Since cultural practices and values can be changed, it is our responsibility to analyse our own institutions to identify if and how they promote gender inequality, and what steps can be taken to challenge such inequalities.

Mainstreaming gender inequality

The strategy to change the way that institutions operate is known as 'mainstreaming gender equality'. The word 'mainstream' is used in order to indicate that issues of gender inequality should be dealt with in every aspect of organisational structure and programming, rather than in a separate, 'add on' activity - that is gender inequality should be addressed in the mainstream of organisation and programming. This is a reaction to what often happens in organisations, which is that an organisation continues with its 'main' business, while having some small additional activities to target women. In this approach, the organisation does not consider how the overall goals, rules for running the institution, and programmes of the institution may impact negatively or fail to address women, and may not promote gender equity and equality. In the Platform of Action of the United Nations' Fourth World Conference on Women held in Beijing in 1995, two aspects of a mainstreaming strategy were emphasised (a summary overhead of the information below is provided to help with this input): [10]

Firstly, in terms of the content of development programmes: 'main-streaming' requires that the resources, opportunities and benefits of the development process are distributed equitably [to men and women]. This requires the integration of equality concerns into the analyses and formulation of policies, programmes and projects, with the objective of ensuring that these have a positive impact on women and reduce gender disparities.

Secondly, in terms of the process or how an institution or programme works: the process needs to ensure that women's interests, needs, experiences and visions contribute towards the definition of development approaches, policies and programmes and in determining the overall development agenda. This requires strategies to enable women to formulate and express their views and participate in decision-making across all development issues.

Definition

Thus the term 'mainstreaming gender' refers to

- processes to ensure women's participation in development activities;
- content of development policies and activities such that women have equitable access to the resources and opportunities they generate, and benefit equitably from the implementation of such activities.

[10] Department for Democracy and Social Development, Health Division, *Handbook for Mainstreaming. A Gender Perspective in the Health Sector*, Stockholm, Swedish International Development Cooperation Agency, 1997: Ch1:3.

Sometimes people argue that this 'mainstreaming' approach to addressing gender inequality means that it is wrong to have projects that target only women. However, given the depth of inequality facing women it is sometimes necessary to target women alone for activities. These may aim to simply build women's confidence and capacity to engage in 'mainstream' development activities. The issue of 'empowerment' of women is addressed further in module 3. Alternatively, it may be appropriate to take on activities which improve women's economic or educational or health status, simply as a means to overcoming the negative impact of gender inequality. Thus initiatives which specifically target women may be necessary, and are complementary to 'mainstreaming' initiatives.

It is not possible to decide on which strategies to use to promote gender equity and equality without first analysing the situation. One has to first conduct a 'gender analysis' of an institution to see to what extent it does reflect social norms of inequality. Once that analysis is done, then steps can be taken to change the assumptions, rules and systems which perpetuate gender inequality within the organisation. Module 4 provides skills in how to identify gender inequalities in relation to health programmes. This activity focuses only on institutions themselves.

### Step 2: 30 minutes

Handout

Go through the key points in the ICPD and Beijing Declaration with regard to mainstreaming gender, provided in Handout: Gender equality, equity and empowerment of women: institutional requirements. Ask a different person to read each paragraph. After each paragraph ask participants if they think that this is a reasonable requirement of the international community. If not, let the group discuss why not. Do they not accept that this is necessary for social justice? or do they think it is not possible because of practical considerations such as that women are not allowed to work outside of the home; or not many women have higher qualifications and hence cannot take leadership positions etc.? If people raise these concerns point out that promoting gender equality means challenging these culturally discriminatory practices. This is a very slow process and requires interventions at many different levels.

### Step 3: 1 hour

Small group work

Once you have been through all of the quotes, divide participants into groups such that people from the same NGO are in the same group. If all participants are from the same NGO then put them into groups of 4 - 6 people each; if they are all from different NGOs it may be best for them to work individually. However, there is only enough time allocated for four groups to report back.

Handout

Give out Handout: Activity on mainstreaming gender in our organisation. Ask participants to work through each of the steps. Point out that the second page of the handout gives them ideas for actions that can be taken. Walk around to support the groups and hurry them along if they are not keeping within the time-frame suggested in the handout.

Note to facilitator

This exercise is useful even in women-only organisations. You will need to advise participants from women-only organisations how to do the exercise. All of the questions apply, except for the first and third bullets, since these assume there are men and women in the organisation. Tell participants that instead of considering differences between men and women, they should consider differences based on caste, ethnicity, religion, or other cultural dimensions. For example, in looking at the organisation's organogram or who fills leadership positions, participants should ask whether one religious group or one caste has greater representation than others.

The last bullet asks all participants, even if they are in organisations of men and women, to go back and reflect on all the bullets in relation to other social groups. This is because in most societies gender is not the only basis of discrimination. While this course focuses on gender, it is always important to analyse diverse causes of discrimination and to address these in an integrated way. Explain this to participants before they begin their group work.

### Step 4: 30 minutes

When they are finished or the time is up, bring the groups back to plenary. Ask each group to read to the participants what they have committed to do when they go back to work (that is their answers in step 3 of the handout. If they have made commitments as individuals, then each individual should say what they will do when they go back to work).

Ask each group or participant to give you these commitments. You can then use them when you do a post-course evaluation, to see if they did undertake the actions they had committed to.

Note to facilitator

Students will need to do some reading to prepare for Module 2. See Module 2, Activity 3 to prepare the readings. If this activity (Module 1 Activity 6) is the last activity of the day, then divide participants into groups and give each group a different handout on population policy - that is the handouts for Step 1 of Module 2 Activity 3 - to read overnight.


- Flipchart paper.
- Felt-tip pens.
- Copies of Handouts for each person.


Hadjipateras, A., 'Putting gender policy into practice: lessons from ACORD', *BRIDGE, raising gender awareness among policy-makers and practitioners: Issue 5: Approaches to institutionalising gender* http://www.ids.ac.uk/bridge/dgb5.htm


- Overhead: Mainstreaming gender equality


- Handout: Gender equality, equity and empowerment of women: institutional requirements
- Handout: Activity on mainstreaming gender in our organisation

# Mainstreaming gender equality

'Mainstreaming' is a strategy for gender equality. It requires:

- Equitable distribution of the resources, opportunities and benefits of the mainstream development process
- The inclusion of the interests, needs, experiences and visions of women in the definition of development approaches, policies and programmes and in determining the overall development agenda.

A mainstreaming initiative does not preclude initiatives specifically directed toward women or toward equality between women and men. Such positive initiatives are necessary and complementary to a mainstreaming strategy.

# Gender equality, equity and empowerment of women: institutional requirements

"Political will and commitment at all levels are crucial to ensure mainstreaming of a gender perspective in the adoption and implementation of comprehensive and action-oriented policies in all areas. Policy commitments are essential for further developing the necessary framework which ensures women's equal access to and control over economic and financial resources, training, services and institutions as well as their participation in decision-making and management. Policy making processes require the partnership of women and men at all levels. Men and boys should also be actively involved and encouraged in all efforts to achieve the goals of the Platform for Action and its implementation." (Beijing+5: 49.)

"Programme support to enhance women's opportunities, potential and activities need to have a dual focus: on the one hand, programmes aimed at meeting the basic as well as the specific needs of women for capacity building, organizational development and empowerment; and on the other, gender mainstreaming in all programme formulation and implementation activities. It is particularly important to expand into new areas of programming to advance gender equality in response to current challenges." (Beijing+5: 53)

"Develop and use frameworks, guidelines and other practical tools and indicators to accelerate gender mainstreaming, including gender-based research, analytical tools and methodologies, training, case studies, statistics and information" (Beijing+5: 116a)

"Promote and protect the rights of women workers and take action to remove structural and legal barriers as well as stereotypical attitudes to gender equality at work, addressing *inter alia:* gender bias in recruitment; working conditions; occupational segregation and harassment; discrimination in social protection benefits; women's occupational health and safety; unequal career opportunities and inadequate sharing, by men, of family responsibilities." (Beijing+5: 118b)

"Governments and employers are urged to eliminate gender discrimination in hiring, wages, benefits, training and job security with a view to eliminating gender-based disparities in income." (ICPD 4.7)

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

Source for 'Beijing+5: 'Unedited final outcome document as adopted by the plenary of the special session: Further actions and initiatives to implement the Beijing Declaration and the Platform of Action', Twenty-third special session of the General Assembly, 10 June 2000.

# Activity on mainstreaming gender in our organisation

## Step 1:

Conduct a gender analysis of your organisation by asking the following questions:

- Identify all the different positions in your organisation's organogram. Which of these positions are filled by men? Which by women?
- Are these functions conducted by people with particular class or ethnic backgrounds?
- What is the proportion of representation of women in decision-making positions?
- What are the rules and systems for decision-making processes: are they top-down? Are they participatory? Are there opportunities for fieldworkers, administrators and others who are not in management to take initiative; to contribute to key decisions of the organisation?
- Who has access to the organisation's resources e.g. transport? computers? telephones? contacts with political leaders? contacts with the media?
- Who makes decisions about who has access to resources?
- Does the organisation have mechanisms to actively encourage women's participation throughout the organisation and strategies to increase their representation at decision-making levels? What are they?
- Does the organisation have mechanisms to build staff capacity to undertake gender analysis at the policy, programme, and institutional levels, and capacity to design and carry out programming that supports gender equality? What are they?
- Go back to each of the questions and briefly consider whether your organisation has inequalities between religious groups, ethnic groups, castes or other groups.

## Step 2:

What steps could your organisation undertake to address any inequalities you have identified? Try to identify at least one action in relation to each of the questions above.

## Step 3:

Choose two of the actions you have identified in step 2. Decide what you will do from the day you go back to work, to help your organisation take these actions. You can make this commitment as a group, or each person in the group can commit to two actions.

Continued from previous page.. Mainstreaming gender

## NOTE: an organisation may require diverse actions to mainstream gender equality. These can include:

- *a formal gender analysis* in order to identify all the processes which need to be addressed;
- *staff education processes* to build their understanding that gender inequality is a violation of human rights and has a negative impact on women and on the organisation and its work;
- *changes of specific policies* such as policies on hiring procedures which may discriminate against married or unmarried women, or policies that only people with post-graduate degrees are eligible for certain leadership positions etc.; or policies that do not allow for maternity leave or parental leave for men;
- *enforcement of existing policies* such as policies on sexual harassment in the workplace *;*
- *changes of procedures / practices* such as the times at which meetings are held if they are held after hours when women have domestic responsibilities; or the participation of people outside of leadership in interviewing prospective recruits to the organisation etc.; or the involvement of junior staff in staff evaluations and monitoring of performance of leadership etc. *;*
- *development of a policy on mainstreaming gender in the organisation* to specify which of these activities will be undertaken, by when, who is responsible and how the implementation of the policy will be monitored *;*
- *establishment of a committee to manage the entire process ;*
- *allocation of resources to support the entire process*.

# MODULE 2



## From meeting population targets to human rights and health

## Module objective:

History of the rights-based approach

- To understand the genesis of the ICPD Platform of Action, specifically the historical development from the population control approach to a needs-based approach to the current rights-based approach and the significance of this to promoting equity.

## Why this module?

Impact of population control orientation on reproductive health services

Many reproductive health services were initially developed as part of an international movement to control population growth in poor / underdeveloped countries. Family planning services were set up targeting the poor with the aim of controlling their fertility. This frequently had a negative impact on the quality of health services, since services were established to meet a national demographic goal, rather than to meet the needs of individual women. Often funds were directed to addressing primarily contraceptive provision, at times within mother and child health services, but with no thought to related health needs, such as detecting and treating sexually transmitted diseases, let alone to the broader health needs of women and men. There was no consideration of a human rights approach – the need to support men and women in meeting their own aspirations and in using health services to empower them to be able to protect and promote their own health, as well as to be able to make reproductive choices.

Not all population policies have been implemented in this manner, but in order to analyse and improve current reproductive health services, it is important for participants to understand how and why they began, with what intentions, and how these influenced the possibilities of developing and maintaining gender-sensitive, human rights-oriented sexual and reproductive health programmes.

### Activities:

Activity 1: Who decides if a woman should have children and how many? (2 hours)

Activity 2: The relationship between population numbers and poverty (1 hour)

Activity 3: Comparing policies: population control versus human rights and health (2 hours 30 minutes)


**5 hours 30 minutes**


# Activity 1

## Who decides if a woman should have children and how many?


**2 hours**

## Why do this activity?

Understanding the factors influencing reproductive decision-making

There are many different factors which influence reproductive decision-making. Many different institutions and individuals believe that they have a right to influence whether or not women in general, or specific women, have babies. Yet it is the individual woman who becomes pregnant, has to face the many health hazards of pregnancy and childbirth, and who usually carries most or all responsibility for raising the child. This exercise explores the different pressures that women face in relation to reproductive decision-making. The aim of the exercise is to help participants recognise the source of such pressures. In later activities we will then look at how these pressures are often built into policies and laws, and what can be done to challenge them in order to secure both women's health and their right to make decisions about reproduction for themselves.

## Objectives

- identify the range of groups and individuals which believe they should have a say in whether and when women have children
- understand that control over women's reproduction is a gender norm which reflects and also contributes to women's lower position in society
- identify the contradiction between society wanting to control women's reproduction while women have to take the consequences of pregnancy, childbirth and child care

## How to do the activity

### Step 1: 5 minutes

Plenary

Introduce this module before going on to Activity 1:

Explain to the group that Module 1 looked at the way in which women's and men's roles and value in society are socially constructed. It went on to consider the health impact of these differences and inequalities. This module

goes on to look more specifically at how society understands questions of reproduction – decisions about having children, and health service responses to this. In particular, this module considers the meaning of population policy in the pre-ICPD era when demographic goals were often given priority over social justice goals. It looks at what past population policies have tried to do, and how they have impacted on women, men and young people's health and on health services. It also talks about women's health policies – what they are trying to achieve and how they often differ from population policies. It ends by looking at some of the recent agreements that the governments of the world have made about population and women's health issues and asks participants to see what the barriers are in their context for implementing these agreements.

Group work

Depending on the level of information the participants have, you can pitch your introduction differently. For example, if participants know about the United Nations and about the ICPD and FWCW, you can reference these here, and particularly the concepts of sexual and reproductive rights and health. If not, rather leave discussion of these until later in the module when we deal with them directly.

## Step 2: 10 minutes

Activity 1[1]begins with preparations for a dramatic presentation. Prepare for this activity in advance by choosing roles, either from the Handout: Different people's perspectives on women's fertility decisions, or by developing new roles to fit your context. You should choose roles that are recognisable to the participants, depending on their social context, the national population and health policies, and cultural norms. Ask one volunteer to be the representative "woman". Tell her that she can circulate and listen in on any of the groups while they plan their arguments. Tell her not to talk to the groups at all. Give her instructions from the Handout: Different people's perspectives.

Divide the rest of the participants into six groups. Give each group a different role. They must prepare a short argument for the person playing that role to put their views forward on how the woman should use her fertility –what reproductive decisions they think she should make and why. Explain to them that each group must choose one person to play their role. Explain that the person playing their role will not be arguing with the other groups, but simply presenting his or her position to the woman. Give them 10 minutes to prepare their opinions.

Note to facilitator

On the following page are some examples of roles you can give different groups, those in the right hand column arguing that women should control their fertility for different reasons, and those in the left hand column arguing that women should not control their fertility, again for different reasons. Decide in advance which roles to use, ensuring that you have chosen some roles which argue that women should have many children and other roles which argue that women should control their fertility – at least one from a population control perspective and one from a women's health or rights perspective. The roles are spelt out in more detail in Handout: Different people's perspectives on women's fertility decisions. Take out the roles you have chosen so you can give one to each group, or develop your own in the same way.

[1] 'The Uterus Wars' exercise adapted from: Mertus, J., Flowers, N. and Dutt, M., *Local Action, Global Change: learning about the human rights of women and girls*, New York, Unifem and the Center for Women's Global Leadership, 1999: 71.

| Positions that foster women having many children: | Positions that propose women control their fertility: |
|---|---|
| • a traditional authority opposing any form of family planning<br>• a family elder encouraging many children as security for old age, a necessity for economic survival, and/or a major component of a woman's social status<br>• a youth activist arguing for the woman to have many children because the group that this woman belongs to (e.g. religious group or caste or ethnic group) needs more numbers in order to succeed in its goal of becoming the ruling party in the country. | • a government health official advocating restricting the number of children for health reasons<br>• a women's group member encouraging family planning so that the woman has time for further study or employment or leisure activities rather than having to look after many children<br>• a government population official arguing that the country cannot sustain women having many children<br>• a government family planning official offering food and medical support in return for sterilization |

## Step 3: 15 minutes

Role play

If you choose more than six roles you will need more groups, which will impact on the amount of time for discussion in step 4.

Set up the scene for the role play by asking the woman to sit in the centre with the representatives from each group sitting in a semicircle around her, facing the rest of the participants.

Tell the participants to start the role play, allowing each person a chance to give their group's view about how the woman should use her fertility. She may ask questions at the end of each argument, but should not express any opinion.

## Step 4: 1 hour 30 minutes

Questions

### Run a general discussion using the following questions

1. When the role-play is over, ask each actor, one at a time, 'How did it feel to play your role?'
2. Then ask the whole group, 'Is this a real situation? Does this happen?'
3. Finally ask the woman, 'How did it feel to be the "woman"?'
4. When she has answered, go on to ask the group, 'Do many women get such conflicting messages?'
5. What are some of the pressures on or incentives offered to the woman?
6. What would the implications be for the individual woman of following each of the different pieces of advice given by each role?

7. Why are all of these arguments focused on women rather than men? Imagine these arguments were made to persuade a man to have a vasectomy: would they be persuasive? In particular explore the role of women's lower status in society.
8. Do women really get to make choices about their reproduction? Why or why not?
9. What factors interfere with choice?
10. Do women have the right to choose?

Main points

## Main points to bring out:

The main points to bring out of this discussion are that many groups believe that society should control women's fertility – some believe they should have many children; some believe they should have few children. Some simply believe that this is not a decision for a woman to make – her husband or his family should make this decision. This is because of women's position in society. Usually men provide the family name and give their name to their children – this is symbolic of the gender norm that believes that men have the right to make decisions about children. Society seldom tries to tell men how many children to have. Instead, it focuses on women.

Different cultures, ethnic groups or classes may express their views about women's reproductive decisions differently. Frequently women are confronted with different perspectives from different actors in society – health officials, population officials, family, religious leaders. Sometimes these groups also approach women of different classes differently – often these groups feel that it is acceptable to try to force poor women, while they would not put such pressure on middle-class women.

The woman's personal needs, choices and health are often not the major consideration. Nevertheless, women have to cope with the consequences of pregnancy, childbirth and caring for children. This raises the question of women's right to control reproduction. This is explored further in Module 3, where participants will discuss human rights including reproductive rights.

Ideally men and women should be able to discuss their reproductive hopes and make decisions together about if and when they want children. But no-one can make these decisions for women since it is they who carry the baby and take responsibility for the baby's upbringing.


- Description of roles people will play.
- Copies of Handout for each person.


- Handout: Different people's perspectives on women's fertility decisions

# Different people's perspectives on women's fertility decisions

Facilitator to decide in advance which roles to use, to cut these up and give one role description to each group, ensuring that some roles argue that women should have many children and other roles argue that women should control their fertility.

You are a woman.

Your have had two children. Different community members will be telling you their opinions about what reproductive decisions you should make. Do not tell them your views. Do not give them your opinion. If you need to ask questions to clarify you can do that. But do not engage in a discussion or argument with them. Rather just listen to each opinion.

## Positions that foster women having many children:

You are a traditional authority, for example a tribal leader.

This woman has two children. You want to persuade her to follow your ideas about her reproductive decisions:

- You want this woman to have many children.
- You believe that 'family planning' is part of modern society which is undermining traditional culture. It is also taking responsibility away from men who, in your culture, should be able to make all decisions regarding when and how many children to have.

Before you present your views to this woman tell her who you are (that is what role you are playing.)

You are a family elder.

This woman has two children. You want to persuade her to follow your ideas about her reproductive decisions:

- You want this woman to have many children.
- You believe that women are only recognised as adults when they have children – you feel that this woman needs to have many children in order to take her rightful place as a respected woman in the society. You are also aware that those old people in your community who did not have children or had few children, did not get adequate economic support and general help in their old age.

Before you present your views to this woman tell her who you are (that is what role you are playing.)

You are a youth activist.

This woman has two children. You want to persuade her to follow your ideas about her reproductive decisions:

- You want this woman to have many children.
- You believe that the group that this woman belongs to (e.g. religious group or caste or ethnic group) needs more numbers in order to succeed in its goal of taking over political power and becoming the ruling party in the country.

Before you present your views to this woman tell her who you are (that is what role you are playing.)

## Positions that propose women control their fertility:

### You are a government health official.

This woman has two children. You want to persuade her to follow your ideas about her reproductive decisions:

- You want this woman to have only a few children.
- You are concerned that women who have many children suffer serious health risks such as anaemia, nutritional deficiencies, prolapse of uterus and bladder, stress, and even maternal mortality.

Before you present your views to this woman tell her who you are (that is what role you are playing.)

### You are a member of a women's group which is involved in 'development' activities.

This woman has two children. You want to persuade her to follow your ideas about her reproductive decisions:

- You want this woman to make her own choices about whether or not to have children and how many to have. At the same time you do believe that family planning is good for this woman because having fewer children leaves her time for further study or employment or leisure activities rather than having to look after many children.

Before you present your views to this woman tell her who you are (that is what role you are playing.)

### You are a government population official.

This woman has two children. You want to persuade her to follow your ideas about her reproductive decisions:

- You want this woman to have few children.
- You believe that the country cannot sustain women having many children. Already many people do not have access to schools or health services and many are unemployed. You think that people should have less children because the economy of the country cannot meet the needs of the current population, let alone a growing population.

Before you present your views to this woman tell her who you are (that is what role you are playing.)

### You are a government family planning official.

This woman has two children. You want to persuade her to follow your ideas about her reproductive decisions:

- You want this woman to use family planning.
- Your job requires you to find a target number of women each month who will agree to be sterilised. You think that since this woman already has two children, she should now be sterilised. You offer her food and medical support in return for sterilisation.

Before you present your views to this woman tell her who you are (that is what role you are playing.)


# Activity 2

## The relationship between population numbers and poverty


**1 hour**

## Why do this activity?

Policies assume that population growth causes poverty

Many pre-ICPD population policies have been based on an underlying assumption – that is that poverty is caused by population numbers. This activity helps participants to think through the causes of poverty. It aims to illustrate how high fertility frequently results from poverty, rather than causing it.

Factors influencing fertility

However, this does not mean that all poor countries will have similar levels of fertility. There are many complex factors which influence fertility, so the exercise helps participants recognise that there is not a direct causal relationship between poverty (or specific indicators such as level of literacy, life-expectancy, degree of urbanisation or GNP per capita) and fertility levels. Fertility levels have always differed across societies, irrespective of levels of poverty – there are diverse factors based on the cultural response of people to the environment in which they live and their social values, which influence the fertility levels. Within this, as discussed in activity 1, there are frequently social pressures for women to have sons, another cultural issue which may influence fertility levels.

Challenging notions of 'overpopulation'

Since the 'overpopulation' argument says that people are poor because they have too many children, the activity goes further in challenging this, by pointing out the enormous differentials in consumption of the world's resources. Since the ICPD, population policies should be addressing this issue.

Access to resources is a key development issue

The aim is to raise the issue of inequality in access to resources as a key development question – thus moving the debate away from population numbers and towards questions of equity. In doing so, however, it also alerts participants to questions of sustainability – rather than arguing that the whole world should be consuming the level of resources consumed currently by rich countries, we need to bring the question of sustainability into play – can the world afford the current levels of consumption in 'rich' countries?

Population policies have had a direct impact on issues of gender equality and of reproductive health and health services. These are explored in detail in Activity 3. However, before looking at this, it is essential for participants to understand and critique the assumptions behind many of the pre-ICPD population policies.

# Objectives

- identify how poverty can influence fertility for example because of reliance on children's labour or on children for security in old age
- recognise that fertility rates differ from culture to culture with many diverse causal factors so that there is no direct relationship between poverty and a specific fertility rate
- identify that consumption patterns are not the same within and between countries
- identify the role of inequitable distribution of resources in poverty, in particular how rich countries consume most global resources and likewise within countries the rich consume more resources than the poor
- use data to illustrate the above issues

# How to do the activity

## Step 1: 20 minutes

Overhead

Make an overhead transparency from Overhead 1 (see 'Materials') and put it up. Alternatively make copies for participants and give them out.

Ask the participants: 'What does this table tell us about the relationship between poverty and fertility rates?'

Plenary discussion

Tell the participants to discuss this question with the person next to them. Give them about three minutes. The purpose of this is to let them work out their thoughts in a comfortable situation, rather than having to immediately express themselves in plenary.

Then ask people to come back into plenary and give you their views. You do not have to get each couple to report, simply let any participants tell the class their views. If there are differences of opinion then allow for debate.

Main points

### Main points to bring out:

In this overhead, you can see that a high birth rate can be associated with people wanting children to support them. This material allows you to discuss the role of children – that often poor families rely on children to help with agricultural work, other economic activities, and domestic work such as fetching water. This is also often gendered, with young girls carrying much of the domestic responsibility, and boys being given work such as herding. In addition, in countries which do not provide any social pension for people, children become social security – people want to have children who will look after them in their old age. This is exacerbated in situations of high infant and child mortality, another result of poverty. Where infant and child mortality are high, people will have even more children, in the hope that at least some children live. All of these are examples of how poverty promotes high fertility.

The 'problem' in society is poverty and it is poverty that programmes need to address. The reason for exploring this issue is to recognise the complexity of the relationship between poverty and fertility – in particular that poverty may

well be a factor which influences people's desire for children, rather than numbers of children causing poverty. The argument that poverty arises because people have too many children is a classic argument of those in favour of 'population control'. This activity aims to help people see that if anything, poverty may lead people to have more children, rather than the other way around.

However, the reasons why people have children are very complex and you therefore need to move the discussion beyond the above points.

## Step 2: 20 minutes

Overhead

After some discussion on the first overhead, put up the second overhead, and ask participants again to discuss the following question with the person next to them: What does this table tell us about the relationship between poverty and fertility rates?

After a few minutes ask the question again in plenary and open up discussion.

Plenary discussion

This table may lead to the opposite conclusion from the first, since it shows that a region with poor development indicators such as Tamil Nadu in India has a lower total fertility rate than another region in India (Punjab) and another country (Costa Rica) both of which have some better development indicators than Tamil Nadu. This tells us that the reason why a specific area or group of people have a specific fertility rate is complex. While improvement in economic security or in women's position in society may cause a lowering of the fertility rate in a particular area, one cannot compare different parts of the world and assume that a similar level of fertility indicates a similar level of development (as reflected in economic security or women's status in society). The previous activity raised the many complex cultural and practical factors influencing whether or not women have children. These differ between societies and of course between classes and cultural groups within societies. These determine fertility levels in a particular society. For this reason, it is important not to suggest simplistic relationships between poverty and fertility. Two equally poor societies may have very different fertility rates because of different cultural histories, and other social and economic factors.

Main point

This is the main point to draw out of the discussion. The reason we are using this overhead is to caution participants against accepting arguments that overpopulation causes poverty. Rather, we would like them to recognise that there are many factors which influence fertility levels. People have reasons for having children, and they would certainly not have children if children were the cause of their impoverishment. One dimension of poverty is limited access to health services and to contraceptives. In this context poor people may have more children than they want although women may resort to abortion. In general the poor have more children than the rich, based on a mixture of practical needs and cultural values. But in one society 'more' children may be three children; in other societies 'more' children may be seven children.

Note to facilitator

The second overhead at first glance seems to contradict the first overhead. The first one suggests that people have children for the economic support that children offer. The second one suggests that there is no relationship between poverty as measured in Gross National Product, and fertility rates. Participants may find this confusing. Your task is to go through the issues one step at a time.

The first overhead helps to open discussion about what conditions motivate individuals to have children. These are similar throughout the world. But the actual fertility rates differ from country to country, and the second overhead seeks to illustrate that. Within any country, the poor are likely to have more children than the rich. But countries with the same levels of poverty may have very different levels of fertility because fertility reflects a very wide range of responses to specific social, economic and cultural conditions.

## Step 3: 20 minutes

Finally, in this activity, you want to alert participants to the other side of the 'overpopulation debate'. Those proposing that poverty is the result of 'over-population', frequently forget to analyse who actually uses the world's resources.

Overhead

Put up Overhead: Who uses up the world's resources, and ask participants: who uses up the world's resources?

Again either allow participants a few minutes to talk with the person next to them, or if the conversation has been flowing well, continue in plenary.

Main point

The main point you want to draw out of this discussion is that part of addressing poverty means addressing inequality – why it is that in some countries some people have access to and consume large quantities of the country's wealth, while others live in poverty.

The United Nations International Conference on Population and Development, held in Cairo in 1994, considered many issues beyond that of fertility levels and population numbers. For example, it considered the unequal consumption of the world's resources between rich and poor countries – how most of the world's resources are consumed in rich countries, and those countries also contribute most to pollution, thus damaging the long term sustainability of the planet for everyone. 'Global inequalities in income and living standards have reached grotesque proportions. The combined wealth of the world's three richest families is greater than the annual income of 600 million people in the least developed countries.'[2] Thus inequality, and particularly differences in consumption patterns need to be considered when trying to understand why some are rich and some are poor.

Overhead

Put up the Overhead: ICPD on Consumption and Production Patterns and read it to participants. Tell participants that these quotes come from the Programme of Action of the International Conference on Population and Development and reflect the consensus of countries of the world. It is now internationally recognised that overconsumption of resources is a problem which needs to be addressed, as are production patterns which damage the environment or use up resources which cannot be replaced and are therefore unsustainable.

You can use the discussion of this overhead to close off the discussion, since it returns you to the main objectives of this activity.

[2] *Mail and Guardian*, 16 July 1999.

Main point

The main point to bring out is to reinforce the recognition that population numbers are not a helpful starting point in understanding how the world's resources are consumed.


Egero, B., 'Reproductive change is a social process'. In Egero, B. and Hammarskjold, M. (eds.) *Understanding Reproductive Change*, Lund, Lund University Press, 1994.


- Overhead: Impact of economic needs on birthrates
- Overhead: Is there a causal relationship between total fertility rate and development?
- Overhead: Who uses up the world's resources?
- Overhead: ICPD on Consumption and Production Patterns

# Impact of Economic Needs on Birth Rates

| Country | GDP per capita US$ | Birth rate | Reason for having children: Economic support |
|---|---|---|---|
| Mexico | 7,450 | High | 72% |
| Singapore | 25,295 | Medium | 29% |
| USA | 29,240 | Low | 4% |

Adapted from East-West Population Institute, cited in Asian and Pacific Women's Resource Collection Network, *Health*, Asia and Pacific Women's Resource and Action Series, Kuala Lumpur: Asian and Pacific development Centre, 1990:70.

# Is there a causal relationship between total fertility rate and development?

| | Tamil Nadu (India) | Punjab (India) | Costa Rica |
|---|---|---|---|
| GNP per capita US$ | 291 | 668 | 1850 |
| Life expectancy at birth | 61 | 69 | 76 |
| Adult literacy | 64 | 57 | 93 |
| Total fertility rate | 2.3 | 3.5 | 3.1 |

Egero, B., 'Reproductive change is a social process'. In Egero, B. and Hammarskjold, M. (eds.) *Understanding Reproductive Change*, Lund, Lund University Press, 1994: 14

# Who Uses Up the World's Resources?

"If the world has one car for every two people in 2050 , as in the United States today, there would be 5 billion cars. Given the congestion, pollution, and the fuel, material and land requirements of the current global fleet of 501 million cars, a global fleet of 5 billion is difficult to imagine. ..Or consider a world of 10 billion with everyone following an American diet, centred on the consumption of fat-rich, livestock products, ten billion people would require 9 billion tons of grain, the harvest of more than four planets at Earth's current output levels".

Brown, L. and Flavin, C., 'A new economy for a new century' in Worldwatch Institute, *State of the World*, New York: W.W. Norton and Co, 1999:3 – 21, p15.

# ICPD on Consumption and Production Patterns

There is general agreement that persistent widespread poverty as well as serious social and gender inequities have significant influences on, and are in turn influenced by, demographic parameters such as population growth, structure and distribution.

There is also general agreement that unsustainable consumption and production patterns are contributing to the unsustainable use of natural resources and environmental degradation as well as to the reinforcement of social inequities and of poverty with the above-mentioned consequences for demographic parameters.

Widespread poverty remains the major challenge to development efforts. Poverty is often accompanied by unemployment, malnutrition, illiteracy, low status of women, exposure to environmental risks and limited access to social and health services, including reproductive health services which, in turn, include family planning. All these factors contribute to high levels of fertility, morbidity and mortality, as well as to low economic productivity.

Source: Programme of Action of the International Conference on Population and Development, Cairo 1994, paragraphs 3.1 and 3.13


# Activity 3

## Comparing policies: population control versus human rights and health


**2 hours 30 minutes**

## Why do this activity?

This activity builds on activity 2 by moving from the individual experience explored in activity 2, to the policies which may underlie that experience.

**Population policy approach to health and health services**

Population policies have shaped the reproductive experience of women and men in many developing countries. They have also influenced their health and their access to health services. In many cases, they have not given attention to the reproductive choices of individuals, particularly of women, nor to their general health needs. Rather, in many cases, they have had a goal of lowering national population growth rates through mass provision of contraceptives, with little attention to the appropriateness of a particular contraceptive for a specific woman's health needs or reproductive situation. Frequently such contraceptive provision has taken no account of other health needs, for example of the need to identify and treat sexually transmitted diseases, without which a woman might become infertile. But such general health concerns have not been the focus of population programmes.

**Alternative approaches**

Throughout the world, there have been reactions against such programmes by women's rights and health organisations and by some health professionals. These groups have developed alternative approaches to reproduction.

**Meeting needs**

Some focus on meeting women's and men's health needs more generally – both their reproductive health needs, and their ability to have such health needs met alongside other health needs. They may provide alternative health services or improved access to information, or attempt to improve the quality of care in existing family planning or health services.

**Promoting human rights**

Some go beyond focusing on needs to take a human rights perspective, attempting rather to change the overall cultural environment in which reproductive decisions are made, particularly focusing on gender equality. These promote the rights and ability of women to make their own reproductive decisions, and the ability of men to take responsibility for their reproductive behaviour.

Main point

This activity aims to build participants' awareness of different policy approaches.

This will be followed up in the next activity by looking at how a human rights perspective has been shaped in the Programme of Action of the International Conference on Population and Development.

# Objectives

- to identify the impact of many pre-ICPD population policies on individual rights
- to compare the different impacts on health and quality of health services of population policies and women's health policies
- to distinguish between a needs-based approach and a rights-based approach

# How to do the activity

Note to facilitator

The day before this activity you should already have divided up participants and given them their readings for Step 1, as described below. This is because they may need more time than allocated here to read and think about the population policy you have given them.

## Step 1: 40 minutes

This activity has a few steps: the groups read and discuss examples of population policies and then discuss these in plenary. They then read and discuss examples of women's health policies and then discuss these further in plenary. Thereafter there is a more open plenary discussion.

Small group work

Begin by dividing participants into groups of no more than 6 people each. Give each group a different handout describing a country's population policy – See handouts on countries Den, Jull and Kim or use handouts you have made. Be sure to include the population policy of your country, but with a different name. The names of the countries are changed on the handouts so that participants do not get distracted by debating their own detailed knowledge of any specific country. At the end of the exercise you can tell participants which country each handout actually refers to if they want to know – see list of handouts below.

Note to facilitator

These are descriptions of population policies which may have changed in recent years, especially after the International Conference on Population and Development held in Cairo in 1994, which challenged the target-driven approach of many old population policies, as well as their failure to consider underlying causes of poverty such as inequality in access to education and health services and in consumption of resources. The idea is for people to look at old population policies in order to understand what the dominant population policy approach aimed to do and how it affected health services. Be careful not to generalise about all pre-ICPD policies. This activity is analysing a specific type of pre-ICPD policy - as reflected in the case studies - in order to understand the impact of this paradigm.

Ask the group to read the handout and then discuss the questions on the handout.

## Step 2: 30 minutes

Return to plenary and facilitate a discussion of each of the questions below with the group as a whole. There is no need to take report-backs from each group, they will contribute their thoughts as part of an integrated group discussion.

Questions

### Run a general discussion using the following questions

1. How did these population policies impact on the right of couples and individuals to choose if, when and how many children they have? Why?
2. What were the implications of these population policies for health services? Why?
3. What examples are there in the policies of blaming women for over-population?
4. Why were so few population control programmes directed towards men?
5. Is there any example of the role of international donors and national governments when it comes to national decision-making in relation to these population policies?

Notes to facilitator

### Some of the points that should come out of this discussion are:

- These population policies target groups, ignoring the specific rights and needs of the individual in relation to reproductive decision-making. This can lead to vertical, 'family-planning-only' services, ignoring other health service needs; it can also lead to the use of the most efficient and cheapest contraceptive methods, without consideration for which are most appropriate for individual women or men thus undermining quality of care.
- Population policies like these aim to remove responsibility for poverty from governments or economic systems and rather to blame those who are the victims of poverty. Women have lower social status than men, and society sees women as minors, who can be told what to do; thus government feels freer to tell women how to behave than to tell men how to behave, as if women have to carry all of society's needs themselves. In societies where there's a cultural preference for sons, and government has a population policy for small families, the whole burden lies on women and women's bodies. Women are trapped between different pressures as the exercise in Activity 1 illustrated. Men are in charge of social institutions such as tribal authorities or local government, and as such are less likely to accept pressure from government to control fertility. Women on the other hand often have their own reasons to control their fertility, related to their health, the burden of childbirth and of responsibility for raising children as well as other options that may be available to them such as finishing school, further education or employment.
- Until the Cairo Conference (which will be discussed in Module 3) most policymakers and the international community supported the idea that countries were not able to improve their conditions because of over-population. The international community has frequently offered donor aid for vertical services, rather than for integrated health services, and has frequently pressured national governments to have population policies if they wanted to receive other kinds of financial support.

## Step 3: 20 minutes

Handout

Again divide into groups and give each group a handout on a women's health policy – see handouts on countries Nak, Pok and Tik.

Ask the group to read the handout and then discuss the questions on the handout.

## Step 4: 20 minutes

Plenary discussion

Return to plenary and facilitate a discussion of each of the questions below with the group as a whole. There is no need to take report-backs from each group, they will contribute their thoughts as part of an integrated group discussion.

1. What have been the primary concerns of the women's health policies in the handouts?

2. What qualities define a woman-sensitive health policy? To what extent do these policies focus on meeting women's needs and to what extent on changing women's position in society?

Main points

### The main points that should come out of this discussion are:

- The primary concern of women's health policies is to focus on women as people with a range of needs, not only as mothers. In addition, they have been concerned with providing a human rights orientation in service provision, that is in ensuring women's right to information, to confidentiality, and to respect and dignity.

- Women's health policies aim to provide high quality health care that meets women's diverse health needs (both reproductive health needs and other health needs) in an environment that bolsters their confidence and self-esteem.

- Good quality health services may not be enough to ensure women's health. There may be a range of laws and practices which also have to change. For example, laws which recognise violence against women, including marital rape, and make it possible for women to get justice and to get an abortion if they so choose.

Note to facilitator

Tell participants that very few countries have a specific women's health policy, but that the principles the participants have seen in these policies should apply to all health policies and services which address women.

## Step 5: 30 minutes

Once you have concluded the discussion on women's health policies, you need to move to a comparison of the population policies and the 'women-friendly' policies. Ask participants:

1. What are the most notable differences between the population policies' approach to health services and the women's health policies' approach?

2. To what extent do these policies focus on meeting women's needs and to what extent on changing women's position in society?

**Table** The table on page 82 has been developed to support you so that you can illustrate the differences between health services designed to address population control, and those designed to address women's health from a needs perspective and from a human rights perspective.

Why does the table distinguish between 'needs' and 'rights'? Many health policies are 'needs' oriented – that is they aim to help address health problems. Few policies actually manage to challenge women's position in society – to promote women's equality to men; their access to and control over resources – yet it is these steps which are necessary to improve women's overall well-being. A human rights approach not only meets immediate health needs but empowers women with information, as well as publicly promoting equality between women and men, for example in relation to sexual and reproductive decision-making.[3]

## Step 6: 10 minutes

Women's organisations are using many different kinds of strategies to promote a human rights approach to women's sexual and reproductive health. This step provides a few examples for participants in order to encourage them to think about activities they could undertake. This prepares the ground for Module 4 on programming. There is not time for a long discussion. The idea is simply to show that there are things that can be done.

**Overhead** Put up the Overhead: Activism to move from population control to human rights. Tell the participants that these are examples of actions that NGOs have taken in different countries to promote a move away from a population control orientation and towards a human rights approach. Give the participants a few minutes to read the overhead to themselves. Tell each participant to discuss with their neighbour whether any of the actions described in the overhead would be appropriate in their own country or organisational context. Do not take a plenary discussion. Simply close the activity by encouraging participants to think about the analysis they have done in this activity, and about actions that they could take. Tell them that they will have an opportunity to think about this more concretely in Module 4.

**Handouts** At the end of this activity, give the participants the reading provided in Handout: Population control has not gone away and Handout: Women's Declaration on Population Policies for them to read in their own time.


- Copies of Handouts for each person.
- A number of population policies are provided in the handouts for Step 1 of this activity. If the population policy of the participants you are training is not included, you should make a similar handout describing the population policy in their country.

[3] The reference to meeting women's needs as opposed to changing women's position in society is often described in the literature as meeting women's practical needs on the one hand, or promoting their strategic needs or interests on the other. However, given the targets of this course, spending time on complex concepts like practical and strategic gender interests does not seem appropriate.

Also, see if the country's population policy changed after the Cairo Conference. Here you would use the old policy, but in the discussions you could refer to the contents of the new policy. However, in the handout you make, do not name the country, rather make up a name – the reason for this is explained under Step 1.

A number of women's health policies with a human rights orientation are provided as handouts for Step 3. Very few countries have stand-alone women's health policies, but some general health policies are women - sensitive. If your country's approach to women's health and to reproductive health matches the third column on the table, then you could make a handout about it. If not, stick to the handouts provided.


de Jong, J., 'The role and limitations of the Cairo International Conference on Population and Development', www.msoc.gla.ac.uk/SocialScienceMedicine/WorkshopP/DEJONG-F.pdf

Dixon-Mueller, R., 'Chapter 1: Human rights, women's rights, and reproductive freedom: the evolution of ideas', *Population policy and women's rights: Transforming reproductive choice*, Westport, Conn, Praeger, 1993.

Garcia-Moreno, C. and Claro, A., 'Challenges from the women's health movement: women's rights versus population control'. In Sen, G. Germain, A. and Chen, L (eds.) *Population Policies Reconsidered: Health, Empowerment and Rights*, Boston: Harvard School of Public Health and International Women's Health Coalition, 1994: 47-61.

Petchesky, R., 'From population policy to reproductive health: feminist fault lines.' *Reproductive Health Matters* 1995; 3(6): 152-161.

Plata, M. I. Gonzalez, V. C. and de la Espriella A., 'A policy is not enough: women's health policy in Colombia.' *Reproductive Health Matters* 1995 3(6):107 – 113.

Wainer, J. and Peck, N., 'By women for women: Australia's National Women's Health Policy.' *Reproductive Health Matters* 1995 3(6): 114 – 121.


- Handout: Population policy of Den (Vietnam[4])
- Handout: Population policy of Jull (India[5])
- Handout: Population policy of Kim (Malaysia[6])
- Handout: Women's Health Policy of Nak (Columbia[7])
- Handout: Women's Health Policy of Pok (Brazil[8])
- Handout: Women's Health Policy of Tiq (Australia[9])
- Handout: Women's Declaration on Population Policies


- Overhead: Activism to move from population control to human rights

[4] Extracts taken from Annika Johansson, Nguyen The Lap, Hoang Thi Hoa, Vinod K Diwan and Bo Eriksson, 'Population policy, son preference and the use of IUDs in North Vietnam', © *Reproductive Health Matters,* 6 (11), 1998:66-76. Reprinted with kind permission

[5] Extracted from TK Sundari Ravindran, 'The politics of women, population and development in India', ©*Reproductive Health Matters,* 1993 (1):26-38. Reprinted with kind permission

[6] Extracted from Abdullah, R., 'Changing population policies and women's lives in Malaysia', ©*Reproductive Health Matters*, 1993 (1): 67-77. Reprinted with kind permission

[7] Extracted from Garcia-Moreno, C. and Claro, A., 'Challenges from the women's health movement: women's rights versus population control'. In Sen, G. Germain, A. and Chen, L (eds.) *Population Policies Reconsidered: Health, Empowerment and Rights*, Boston: Harvard School of Public Health and International Women's Health Coalition, © 1994: 47-61. (p50) Reprinted with kind permission

[8] Extracted from Garcia-Moreno, C. and Claro, A., 'Challenges from the women's health movement: women's rights versus population control'. In Sen, G. Germain, A. and Chen, L (eds.) *Population Policies Reconsidered: Health, Empowerment and Rights*, Boston: Harvard School of Public Health and International Women's Health Coalition, © 1994: 47-61. (p50) Reprinted with kind permission

[9] Jill Astbury, Key Centre for Women's Health, 'The development of Australia's National Women's Health Policy': Klugman, B., 'Session 4: Case studies of processes of policy change and implementation'. In International Training *Initiative on Gender and Reproductive Health, Transforming Health Systems, Gender and Rights in Reproductive Health: A curriculum for Health Managers*, Geneva, World Health Organization, 2001 (forthcoming).

# Differences in health services: population control versus human rights approach

| Population control | Meeting women's needs | Promoting women's equal position in society |
|---|---|---|
| **Defining women's health** | | |
| A narrow bio-medical meaning as maternal health, or the health of women of reproductive age, focusing on birth and child bearing without death or disease and on contraception. | Provision of services of a high standard which are women-centred – based on women's experiences and needs. Recognition that women's health needs go beyond reproduction. | A broad understanding which is centred on the right of women to make their own autonomous choices about reproduction and sexuality. |
| **Goals** | | |
| Demographic reduction or increase of fertility and population (main goal). Improve women's and children's health and family welfare (secondary). | Improve women's health; provide women with a range of services ensuring choice, for example in methods of contraception. | Women's control over their bodies; sexual and reproductive decisions. Right to information, privacy, confidentiality. Gender equality generally as it impacts on health e.g. access to food security, education, control over income etc. |
| **Assumptions** | | |
| Population size/ growth is the main determinant of poverty, under-development and environmental sustainability. Population control will reduce fertility. | Poverty is due to the economic growth model of development. Focus is on meeting basic needs and not on population control. Improving women's status and providing quality reproductive health programmes will help to reduce fertility. | The interaction of inequalities based on class, on other social divides such as caste or ethnic group, and on gender lead some to be poor and others to be wealthy; some to be empowered and others to be disempowered. These inequalities can and should be challenged in order to achieve social justice. A more equitable distribution of resources, such as in access to education and health services is part of this challenge. |
| **Service range** | | |
| Contraception; infertility (if pro-natalist); maternal health; abortion (if culturally acceptable and ante-natalist). | Within sexual and reproductive health: contraception; maternal health; abortion; STDs, RTIs; HIV/AIDS; sexuality; violence against women; cancer screening; services provided in the context of gender-power relationships (e.g. husband, father, state). These services provided as part of broader primary health care provision so that reproductive health needs can be met alongside other service needs (e.g. chronic diseases, mental health. occupational health). | Information and counselling services to build women's confidence to challenge their subordinate position to their sexual partners and in society. Community-based activities to organise women to challenge social inequalities; organisation of men to understand and take on their role in promoting women's equality in sexual and reproductive decision-making and in society generally.<br>Focuses beyond services to legal rights e.g. maternity leave, against rape etc. |
| **Age and marital status** | | |
| Married women; reproductive age (15-44 years). | Women of all ages throughout their life-cycle, married and unmarried. | |
| **Service delivery standards** | | |
| Quality of care is usually not emphasised as focus is on quantity of women visited. | High quality of care is promoted as a part of professional health standards at the core of service delivery. | High quality of care is promoted both as a health right but also as a women's rights issue – with a focus on respect, dignity, confidentiality and choice. |
| **Information and education** | | |
| Communication is top-down, focusing on directions for contraceptive use. Persuasion and motivation are the information processes. Provider gives advice on what is best. | Full information provided on risks and benefits of contraceptive technologies so women can exercise choice. | Focus on understanding the body and sexuality in order to make decisions and be in control of one's life. Promotion of women's sexual and reproductive rights. Attention to men's responsibility in relation to sexual and reproductive rights and health. |
| **Participation** | | |
| Policies usually top-down with providers driven by targets or other policy considerations. | Health workers understood to have more knowledge than users, but an effort to ensure women's needs are met. | Mobilisation of women for better health policy. Use of peer education to build and empower women for action. Efforts to draw on community input regarding priorities for health service provision and evaluation of services. |

Adapted from ARROW, 'Tool: A women-centred reproductive health framework', Section 3: Perspectives for Change, In ARROW, *Women centred and Gender-sensitive Experiences: Health Resource Kit*, Kuala Lumpur,Asian-Pacific Resource and Research Centre for Women, 1996.

# Population policy of Den

Modern contraception was introduced in Den on a limited scale in the 1960s, but it was not until 20 years later that family planning was actively promoted to reduce rapid population growth. The highest IUD prevalence rate in the world is found in Den, where it became the method of choice when the country launched its two-child policy in the early 1980s.

The two-child policy is promoted in Den through intensive education campaigns in mass organisations and the media. The most recent government decree of 1988, reinforced in 1993, stipulates that each family should have no more than two children spaced at least 3-5 years apart (except for certain minority groups). Contraceptive services and legal abortion are provided free of charge through an extensive public health network. In some provinces, particularly in the north of the country, various incentives and fines are applied to ensure compliance with the two-child norm.

In 1988, over half of Denese couples practised contraception, of whom 62 per cent reported IUD use, while other modern methods were uncommon. Despite efforts in recent years to diversify contraceptive choice, the pattern of use has changed very little and the IUD remains by far the most commonly used method in the country. From the 1960s to 1994, the average number of children (total fertility rate) for a Denese woman decreased from over six to just over three children per woman, indicating that Den is in the midst of a demographic transition.

Parallel with the fertility decline, abortion rates have increased dramatically during the last decade. With an annual rate of over 100 abortions per 1000 women of reproductive age, or a total abortion rate of 2.5 per woman, Den currently has one of the highest reported rates of induced abortion worldwide, second only to the former Soviet Union and Romania.

Several authors have noted an inconsistency in the demographic pattern in Den. With such high contraceptive prevalence and abortion rates, fertility should be lower than it is. This 'demographic puzzle' could be due to over-reporting of contraceptive use and abortion, and/or to lower use-effectiveness with the copper IUD than has been demonstrated internationally and in clinical trials in Den.

## The IUD in context

Son preference is a prominent feature of Denese culture, particularly in the north of the country where the Confucian influence has been strongest. In the Confucian tradition, sons were responsible for taking care of their old parents, while girls were likened to 'flying ducks', lost to their parental family

continued from previous page...Den

at marriage. To maintain the line of descent, the worship of ancestors was essential and only a man could perform the ancestral rituals and pray for the souls of the dead. If a man died without a son, his lineage was broken and all his ancestors and unborn dependants would die with him. The wife who was not able to give her husband a son could expect him to take a second wife.

Den has undergone profound economic and social change in recent years. Since the 'open door' policy was launched in 1986 by the Party Congress, market-orientated reforms have increased production and transformed society at an unprecedented rate. In the rural areas these reforms have meant a change from a collective to a family- based economy. The implications for family structure and for gender roles ... is a matter of great interest and debate among both Denese and foreign researchers. However, the need for sons is still strongly felt in rural north Denese culture, and the two-child policy introduced new and potentially contradictory demands on women's fertility.

Agricultural province in the River Delta in the north of Den has one of the highest population densities in the country and was one of the earliest provinces to implement the two-child policy, applying incentives and fines stringently, leading to some of the highest abortion rates in rural Den. In 1992 we explored the consequences for women in this province of the potential conflict between this policy and the culturally defined need for sons. Women who had had 'only' daughters expressed much worry and distress at not having produced a male heir. At the same time they felt themselves to be under strong pressure from their local authorities to keep within the two-child limit.

Local regulations stipulate[d] that couples having a third or higher order birth had to pay a fine of up to 250 kgs of rice, which corresponds to 3-4 months' production. They also received low priority in the allocation of land for agriculture and housing, and were not entitled to the same social benefits as couples with only one or two children.

## Questions for discussion:

1. What were the implications of this population policy for the right of couples and individuals to choose if, when and how many children they have? Why?

2. What were the implications of this population policy for health services? Why?

# Population policy of Jull

The Jullese government adopted a policy of reducing the birth rate as its way of dealing with the economic crisis of 1966. ... What it did was to transform the problem of high fertility – of which women and children were the victims – into the problem of 'women having too many children' - of which women were the perpetrators... During the 1966 crisis, there was external pressure on Jull, namely from the World Bank, to step up efforts at fertility reduction as part of the agreement to overhaul Jull's then economic policies. Population was the second of eleven areas for which specific policy directives and targets were adopted. In order to hasten the pace of fertility reduction, the existing family planning programme was transformed in 1966 from one that provided services to those who requested them, into a population reduction programme with specific demographic goals.

The target of reducing the crude birth rate from 39 to 32 per 1000 by 1974 was set. This was translated into a number of family planning 'acceptors' to be recruited by the programme. Family planning services were integrated with maternal and child health (MCH) services as part of the Primary Health Care Strategy, and services were offered free of cost at government health facilities. MCH service providers at the community level were required to fulfil a specified quote of family planning 'acceptors'. Quotas were accompanied by an elaborate system of financial incentives for acceptors and service providers at all levels, for institutions' delivery in family planning services.

It should be pointed out that a dramatic increase in external aid for the transformed programme followed, from USAID and other sources. USAID sent in a ten-man advisory team, provided family planning training in US universities, and gave loans and grants for equipment and supplies. ...

Since 1966, the 'integration' of family planning with maternal and child health (MCH) services has diverted scarce resources and personnel away from women's maternal health needs, and has also encouraged the shift of responsibility for family planning exclusively onto women. Driven by the need to fulfil specific quotas of family planning acceptors and threatened with punitive action for failing to do so, MCH service providers at the community level give top priority to recruiting 'cases' for family planning. Antenatal care is reduced to tetanus toxoid immunisation in the best of circumstances, and post-partum care is unheard of.

Further, since family planning services are made available only through MCH services, unmarried adolescents and other single women are denied access to contraceptive services.

...There are no check-ups or counselling before method introduction. ...There is also practically no follow-up after method adoption, even in the case of sterilisation. Very often women developed fever and pus formation in the wound, but did not know what to do about it. This is mainly because they have been discharged without any instructions regarding possible complications or post-operative hygiene, and because no health personnel have visited them at home to check or dress the wound.

continued from previous page... Jull

One of the most detrimental factors in service provision has been the limited choice of methods available. Women are expected to be mute recipients of whatever the programme makes available to them. What is available is decided on the basis of programme efficacy, not on women's needs or preferences. Those who have no children can have the oral pill, those with one child may have an IUD inserted, and those who have two or more children are given no choice other than sterilisation. ... In effect, the family planning programme has largely been a sterilisation programme, which the incentive system is partly responsible for. Under the incentive system, performance is evaluated according to the number of 'sterilisation equivalents' achieved. ... The system of target-setting and incentives has indirectly condoned unethical medical practices. Health facilities are known to have pressured women seeking abortion into accepting sterilisation. IUDs have been inserted and women sterilised after delivery without their knowledge. Information about possible adverse effects and check-ups for these are at times deliberately withheld in order to meet targets.

Unless women are guaranteed the freedom to refuse, change or stop using contraceptive methods, for their own reasons, they will be strongly discouraged from using them, in spite of perceived benefits. Thus, a large number of women have an unmet need for family planning. Unwanted pregnancies are a common feature, and abortion the only solution. Abortion is legal and supposedly available free of cost at government health facilities, yet backstreet abortions are preferred and widespread. Why? There is usually a long waiting period which may extend beyond three months of gestation. Second, it seems to be common practice, although not official policy, that for women with more than two children, health facilities insist on sterilisation as a condition for abortion.

These programme characteristics have made family planning services the least credible and most distrusted of all the health services provided by the government. ... in addition.. There is tremendous social pressure against interfering with natural processes before minimum fertility goals have been achieved, which includes at least two sons. Husbands' disapproval of birth control, which is viewed as encouraging promiscuity, was mentioned by many women. Then there is the most difficult barrier of all to overcome, namely women's lack of decision-making power in a male-dominated society.

## Questions for discussion:

1. What were the implications of this population policy for the right of couples and individuals to choose if, when and how many children they have? Why?

2. What were the implications of this population policy for health services? Why?

# Population policy of Kim

In the 15 years up to early 1984, when the new population policy was approved by Cabinet, Kim had been experiencing a steady decline in its annual population growth rate. From an average annual rate of 3 per cent between 1960 to 1965, growth had declined to 2.4 per cent by 1980. This decline was due to the interrelated factors of higher educational level, rapid urbanisation, later marriage and well established family planning programmes.

Kimian women were voluntarily choosing to have fewer children than their mothers, particularly younger, well-educated, urban women from two ethnic groups. Official demographic projects in 1984 were that Kim's population would stabilise at 39 million people by the year 2150 if current fertility trends continued.

The government's announcement of its intention that demographic trends should change and the country aim for larger population to 70 million people by the year 2100 came as a shock to the Kimian public. Since 1966, the government had had a population policy which had been incorporated into all of Kim's five-year development plans. This policy focused on improvement of the health and welfare of women and children, increasing per capital income levels, improving living standards and specifically reducing the population growth rate from three per cent per annum to two per cent during the period 1965-85. Funding for family planning programmes had been substantial in this period, with the World Bank alone directly contributing US$42 million between 1973 and 1982. In addition there were loans, assistance from the UN Fund for Population Activities (UNFPA) and the government's own contribution.

...The government's stand, that a large population was an asset to development, was an unusual position to take in Asia, where most population policies have been clearly anti-natalist.

The main way the policy proposed to slow down the rate of fertility decline, was to encourage more women to marry and have children. ...The strategy proposed ... was the promotion of a national family development programme... Family planning was to be treated as one of the services within this programme. Incentives for childbearing were also recommended and instituted. Maternity leave and tax relief were raised from the previous limit of three children up to five children. These benefits, however, only affected the small number of women in the paid labour force, not the many urban self-employed women or women in agriculture.

... according to this document, women were required to be economically productive and rear and manage a larger family at the same time. ... soon after the Prime Minister's announcement of the 70 million population policy, came his controversial and contradictory statement that Kimian women should 'go for five children' and that if the family was well off, women should not work but stay at home to raise them.

To what extent has this new population policy resulted in a change in family planning programmes and what impact has this had on women's access to services? ... The country's fairly conventional, field-oriented family planning programme, in which motivators with monthly acceptor targets visited homes and villages to encourage individuals to space their births, was redesigned. ... The new operational

continued from previous page... Kim

strategy .. was to provide contraceptive services if requested, but not to seek out people in need of these services. Clinic staff were to wait in clinics for clients to request contraceptives in order to 'develop' their families. Family planning as a priority health activity thus became de-emphasised in the mid-1980s. ... Fieldworkers reported that women were commonly telling them that they were being refused oral contraceptives or IUD insertion at government clinics if they had few children and were not yet 40 years of age. There were also reports of shortages of supplies of the pill, and of government clinics being forced to borrow supplies. ... No programme policy existed to deny women access to services but workers were thought to be initially confused about what they should do in order to implement the new population policy.

Another impact of the policy was on access to safe abortion. Although Kim allows legal abortion only on very restricted grounds, government hospitals, the larger family planning clinics and private practitioners had quietly been providing both free menstrual regulation and dilation and curettage fairly liberally since the mid-1970s. An immediate impact of the new policy was that abortions could not be obtained so readily at government centres, and were restricted to legally justifiable cases. The private sector continued to provide this lucrative service, but for poor women with few resources, there was little chance of a safe abortion.

To what extent the population policy affected women's roles and status is difficult to assess. For women who decided that they wanted to delay or limit their pregnancies and were then refused family planning services in government clinics, the lack of access to the means to control their fertility could have been a disempowering experience. Better-off women could have proceeded to a private sector family planning service, whereas poor women would not as easily have had this choice.

Due to the unequal division of labour in the home, women's workload would increase with additional children unless husbands took on more domestic responsibility. However, the family development programme did not outline any plan for promoting the sharing of reproductive work by men. Thus, while the new policy called on women to increase both their domestic and reproductive roles, its implementation disregarded the consequences of the reality that most poor women and many better-off women also worked outside the home.

Although the new population policy stated that childcare facilities would be improved as a supporting strategy, it was only in 1992, ten years after the need for the new policy was first announced, that poor women's need for government-sponsored childcare services in rural areas began to be discussed in the media.

## Questions for discussion:

1. What were the implications of this population policy for the right of couples and individuals to choose if, when and how many children they have? Why?
2. What were the implications of this population policy for health services? Why?

# Women's Health Policy of Nak

Willingness on the part of the Nak government, support from the Pan American Health Organization, and the action of feminists have led to a national women's health policy. The policy lays out five programmes: promotion of self-help; reproductive health and sexuality; prevention and care for victims of violence; mental health; and occupational health.

'Health for women, Women for health' explicitly aims to reduce inequalities between women and men and sees women as 'subjects of the decisions over their lives, their body, their sexuality and their health'.

Women, it contends, should be participants in planning and implementing health programmes. The policy stresses the importance of a gender perspective in understanding health and illness, as well as poverty and other forms of inequity. It emphasises the need for a comprehensive approach to women's health, but also recognise the individuality of women. 'The woman has the right to treatment and care from the health services as a whole being, with specific needs – according to her age, activity, social class, race and place of origin, and not to be treated exclusively as a biological reproducer. She has the right to respectful and dignified treatment by health workers of her body, her fears and her needs for intimacy and privacy'.

The policy recognises the problem of violence against women, which it notes is the main cause of death among women 15-44 years of age. It also recognises the need for special attention to adolescents. Regarding sexual and reproductive health it goes beyond the Constitution, which gives couples the right to decide on the number of children they will bear. The policy states that the decision is the right of individuals. It stresses that family planning should be available to all, regardless of age or civil status, with information and counselling provided. It supports a national strategy for education on sexuality 'to promote a healthy, pleasurable and responsible sexuality,' independent of its link to reproduction.

## Questions for discussion:

1. What are the primary concerns of this women's health policy?
2. Find an example of how this policy focuses on meeting women's needs and to what extent on changing women's position in society?

# Women's Health Policy of Pok

The Comprehensive Programme for Women's Health Care (PAISM) in Pok was created in 1983 to provide services for women beyond the existing maternal and child health services. The programme includes prenatal care, delivery and post-partum care, family planning, breast and cervical cancer screening, diagnosis and treatment of sexually transmitted disease, and infertility services, a well as occupational and mental health services. It also expands coverage to include adolescents and postmenopausal women rather than only women of reproductive age. PAISM emphasises that women need access to preventive as well as curative care, and to information about their bodies and their health. It notes that this knowledge should be empowering to women.

PAISM was the result of an alliance between the Ministry of Health and the women's movement. Feminists were involved in the development of technical guidelines and educational materials, and continue to promote PAISM and to lobby for its implementation. They have also been involved, at national, state and municipal levels in attempts to implement the policy (Costa 1992). The Newsletter of Pok's National Network for Reproductive Rights (1992) suggests that three elements made PAISM possible: health care reform which was moving towards decentralisation of health care and addressing health needs; the presence of feminists in government; and the action of the women's movement, which pressed for comprehensive services and for a wider choice in contraceptives. Implementation of PAISM has faltered, but examples in one state and in one municipality show that where there is political will and pressure from women, much can be achieved.

## Questions for discussion:

1. What are the primary concerns of this women's health policy?

2. Find an example of in what way this policy focuses on meeting women's needs and to what extent on changing women's position in society?

# Women's health policy of Tiq

During the 1970s and 1980s, the women's movement in Tiq was successful in raising its concerns about women's health status, the inadequacy of existing knowledge on many aspects of women's health and the urgent need for reform of the health care system to better meet needs identified by women themselves.

From the mid 1970s, a period of intense activism followed which included the setting up of health centres run by and for women and numerous state, as well as two national, women's health conferences held in 1975 and 1985. The development of a National Women's Health Policy became a major focus at the 1985 conference and consultations with more than one million Tiqan women followed. Finally, in 1989, the Commonwealth government of Tiq released the National Women's Health Policy.

For the first time, the extensive process of consultation ensured that a health policy was developed that reflected women's concerns about the health issues affecting them.

## Seven priorities were identified that required action across the health system:

- Reproductive health and sexuality
- The health of aging women
- Women's emotional and mental health
- Violence against women
- Women's occupational health and safety
- The health needs of women as carers
- The health effects of sex role stereotyping on women

The Policy was based on a clear recognition that women's position in society affected their health status and their access to health services which were appropriate to their needs. This Policy was designed to provide a framework and a planned strategy to improve the health of Tiqan women and meet their health care needs to the year 2000 and to fulfil international obligations following the Nairobi conference.

continued from previous page... Tiq

The Policy noted that women's health concerns extended beyond specific health problems to include the structures that deliver health care and information and the processes which influence women's interactions with the health system. In turn, all of these affect the quality of care women receive, their access to appropriate and acceptable services and their health outcomes.

Five structural areas of the health system were found to need action.

## Areas for action

- Improvements in health services for women
- Provision of health information for women
- Research and data collection on women's health
- Women's participation in decision-making regarding their health
- Improved training of health care providers

The implementation of this groundbreaking policy was not without its challenges. In particular, a challenge to the legality of the programme was made on the grounds that it discriminated against men. The President of the Human Rights and Equal Opportunity Commission ruled that the programme involving women-specific services was lawful. He found that the programme redressed substantial disadvantages women faced in mainstream medical care and said that women were still substantially disadvantaged in society. In particular he referred to the many socio-economic pressures such as poverty, childcare, single parenthood, lower wages and domestic violence which impacted on women's physical and emotional health and well-being.

## Questions for discussion:

1. What are the primary concerns of this women's health policy?

2. Find an example of how this policy focuses on meeting women's needs and to what extent on changing women's position in society?

# Activism to move from population control to human rights

NGOs have used a range of different strategies:

Community mobilisation

- NGO builds capacity of community organisations
  - to work with community women to identify health needs; provide information
  - to improve accessibility of health services
  - to support women in holding government accountable

  (ReproSalud: Peru)

Strengthening public health services

- NGO works with provincial public health services to
  - identify barriers to quality of care
  - implement methods to improve quality
  - build the confidence and capacity of health providers
  - monitor improvements over time

  (Women's Health Project, South Africa)

Policy advocacy

- NGOs lobby government which agrees to pilot the removal of targets and incentives. Family planning providers no longer have to identify a set number of people to 'accept' contraception each month.

  (HealthWatch: India)

- NGOs create partnerships and formal mechanisms for joint government / NGO monitoring of implementation of international agreements

  (ARROW: Malaysia)

HERA, *Confounding the Critics: Cairo, Five Years On*, Conference Report, Cocoyoc, Mexico, 15 – 18 November 1998.

# Women's Declaration On Population Policies

In preparation for the 1994 International Conference on Population and Development

## Introduction

In September 1982, women's health advocates representing women in Asia, Africa, Latin America, the Caribbean, the U.S. and Western Europe met to discuss how women's voices might best be heard during preparations for the 1994 Conference on Population and Development and in the conference itself. The group suggested that a strong positive statement from women around the world would make a unique contribution to reshaping the population agenda to better ensure health and rights. The group drafted a 'Women's Declaration on Population Policies,' which was received, modified and finalized by over 100 women's organizations across the globe.

The Declaration is now being circulated by the initiators to women's health advocates, other women's groups and women health professionals, outside and inside government, for their signatures. In addition, the initiators invite other networks, organizations, governments, and individuals, including men, to endorse the Declaration.

## Preamble

Just, humane and effective development policies based on principles of social justice promote the well-being of all people. Population policies designed and implemented under this objective need to address a wide range of conditions that affect the reproductive health and rights of women and men. These include unequal distribution of materials and social resources among individuals and groups, based on gender, age, race, religion, social class, rural-urban residence, nationality and other social criteria; changing patterns of sexual and family relations; political and economic policies that restrict girls' and women's access to health services and methods of fertility regulation and ideologies, laws and practices that deny women's basic rights.

While there is considerable regional and national diversity, each of these conditions reflects not only biological differences between males and females, but also discrimination against girls and women, and these conditions affect, and are affected by, the ability and willingness of governments to ensure health and education, to generate employment, and to protect basic human rights for all. Government's ability and willingness are currently jeopardized by the global economic crisis, structural adjustments programs, and trends towards privatization, among other factors.

To assure the well-being of all people, and especially of women, population policies and programmes must be framed within and implemented as a part of broader development strategies that will redress the unequal distribution of resources and power between and within countries, between racial and ethnic groups, and between women and men.

Source: Germain, A., Nowrojee, S., and Pyne, H.H., 'Setting a new agenda: sexual and reproductive health and rights', in Sen, G., Germain, A. and Chen, L. (eds.) *Population Policies Reconsidered: Health, Empowerment and Rights*, Boston, Harvard University Press, 1994:31-34.

Population policies and programmes of most countries and international agencies have been driven more by demographic goals than by quality of life goals. Population size and growth have often been blamed inappropriately as the exclusive or primary causes of problems such as global environmental degradation and poverty. Fertility control programmes have prevailed as solutions when poverty and inequity are root causes that need to be addressed. Population policies and programmes have typically targeted low income countries and groups, often reflecting racial and class biases.

Women's fertility has been the primary object of both pro-natalist and anti-natalist population policies. Women's behaviour rather than men's has been the focus of attention. Women have been expected to carry most of the responsibility and risks of birth control, but have been largely excluded from decision-making in personal relationships as well as in public policy. Sexuality and gender-based power inequities have been largely ignored, and sometimes even strengthened, by population and family planning programs.

As women involved directly in the organization of services, research and advocacy, we focus this declaration on women's reproductive health and rights. We call for a fundamental revision in the design, structure and implementation of population policies, to foster the empowerment and well-being of all women. Women's empowerment is legitimate and critically important in its own right, not merely as a means to address population issues. Population policies that are responsive to women's needs and rights must be grounded in the following internationally accepted, but too often ignored, ethical principles.

## Fundamental Ethical Principles

1. Women can and do make responsible decisions for themselves, their families, their communities, and, increasingly, for the state of the world. Women must be subjects, not objects, of any development policy, and especially of population policies.

2. Women have the right to determine when, whether, why, with whom, and how to express their sexuality. Population policies must be based on the principle of respect for the sexual and bodily integrity of girls and women.

3. Women have the individual right and the social responsibility to decide whether, how, and when to have the children and how many to have; no woman can be compelled to bear a child or be prevented from doing so against her will. All women, regardless of age, marital status, or other social conditions have a right to information and services necessary to exercise their reproductive rights and responsibilities.

4. Men also have a personal and social responsibility for their own sexual behaviour and fertility and for the effects of that behaviour on their partners and their children's health and well-being.

5. Sexual and social relationships between women and men must be governed by principles of equity, non-coercion, and mutual respect and responsibility. Violence against girls and women, their subjugation or exploitation, and other harmful practices such as genital mutilation or unnecessary medical procedures, violate basic human rights. Such practices also impede effective, health-and rights-oriented population programs.

6. The fundamental sexual and reproductive rights of women cannot be subordinated, against a woman's will, to the interest of partners, family members, ethnic groups, religious institutions, health providers, researchers, policy-makers, the state or any other actors.

7. Women committed to promoting women's reproductive health and rights, and linked to the women to be served, must be included as policy-makers and programme implementors in all aspects of decision-making including definition of ethical standards, technology development and distribution, services, and information dissemination.

To assure the centrality of women's well-being population policies and programmes need to honour these principles at national and international levels.

## Minimum Programme Requirements

In the design and implementation of population policies and programmes, policy-makers in international and national agencies should:

1. Seek to reduce and eliminate pervasive inequalities in all aspects of sexual, social and economic life by :
   - Providing universal access to information, education and discussion on sexuality, gender roles, reproduction and birth control, in school and outside;
   - Changing sex-role and gender stereotypes in mass media and other public communications to support more egalitarian and respectful relationships;
   - Enacting and enforcing laws that protect women from sexual and gender-based violence, abuse, or coercion;
   - Implementing policies that encourage and support parenting and household maintenance by men;
   - Prioritising women's education, job training, paid employment, access to credit, and the right to own land and other property in social and economic policies, and through equal rights legislation;
   - Prioritising investment in basic health services, sanitation, and clean water.
2. Support women's organisations that are committed to women's reproductive health and rights and linked to the women to be served, especially women disadvantaged by class, race, ethnicity or other factors, to:
   - Participate in designing, implementing and monitoring policies and programmes for comprehensive reproductive health and rights;
   - Work with communities on service delivery, education and advocacy.
3. Assure personally and locally appropriate, affordable, good quality, comprehensive reproductive and sexual health services for women of all ages, provided on a voluntary basis without incentives or disincentives, including but not limited to:

- Legislation to allow safe access to all appropriate means of birth control;
- Balanced attention to all aspects of sexual and reproductive health, including pregnancy, delivery and post-partum care; safe and legal abortion services; safe choices among contraceptive methods including barrier methods; information prevention and treatment of STDs, AIDS, infertility, and other gynaecological problems; childcare services; and policies to support men's parenting and household responsibilities;
- Non-direct counselling to enable women to make free, fully informed choices among birth control methods as well as other health services;
- Discussion and information on sexuality, gender roles and power relationships, reproductive health and rights;
- Management information systems that follow the woman or man, not simply the contraceptive method or service;
- Training to enable all staff to be gender sensitive, respectful service providers, along with procedures to evaluate and reward performance on the basis of the quality of care provided, not simply the quantity of services;
- Programme evaluation and funding criteria that utilize the standards defined here to eliminate unsafe or coercive practices, as well as sexist, classist or racist bias;
- Inclusion of reproductive health as a central component of all public health programmes, including population programs, recognizing that women require information and services not just in the reproductive ages but before and after;
- Research into what services women want, how to maintain women's integrity, and how to promote their overall health and well-being.

4. Develop and provide the widest possible range of appropriate contraceptives to meet women's multiple needs throughout their lives:
   - Give priority to development of women-controlled methods that protect against sexually transmitted infections, as well as pregnancy, in order to redress the current imbalances in contraceptive technology research, development and delivery;
   - Ensure availability and promote universal use of good quality condoms;
   - Ensure that technology research is respectful of women's right to full information and free choice, and is not concentrated among low income or otherwise disadvantaged women, or particular racial groups.
5. Ensure sufficient financial resources to meet the goals outlined above. Expand public funding for health, clean water and sanitation, and maternity care, as well as birth control. Establish better collaboration and co-ordination among UN, donors, governments and other agencies in order to use resources most effectively for women's health.
6. Design and promote policies for wider social, political and economic transformation that will allow women to negotiate and manage their own life choices and participate fully in all levels of government and society.

# Necessary Conditions

In order for women to control their sexuality and reproductive health, to exercise their reproductive health, and to exercise their reproductive rights, the following actions are priorities:

## 1. Women Decision-Makers

Using participatory processes, fill at least 50 percent of decision-making positions in all relevant agencies with women who agree with the principles described here, who have demonstrated commitment to advancing women's rights and who are linked to the women to be served, taking into account income, ethnicity and race.

## 2. Financial Resources

As present expenditure levels are totally inadequate, multiply at least fourfold the money available to implement the programme requirements listed in this Declaration.

## 3. Women's Health Movement

Allocate a minimum of 20 percent of available resources to women's health and reproductive rights organizations to strengthen their activities and work toward the goals specified in this declaration.

## 4. Accountability Mechanisms

Support women's rights and health advocacy groups, and other non-governmental mechanisms mandated by and accountable to women, at national and international level, to:

- Investigate and seek redress for abuses or infringements of women's and men's reproductive rights;
- Analyse the allocation of resources to reproductive health and rights, and pursue revisions where necessary;
- Identify inadequacies or gaps in policies, programmes, information and services and recommend improvements;
- Document and publicise progress.

Meeting these priority conditions will ensure women's reproductive health and their fundamental right to decide whether, when and how many children to have. Such commitment will also ensure just, humane and effective development and population policies that will attract a broad base of political support.

# MODULE 3

## SEXUAL AND REPRODUCTIVE RIGHTS; EMPOWERMENT

## Module objective:

- To have a common understanding of the meaning of the key reproductive rights-related concepts in the ICPD, FWCW and 'plus five' documents: sexual and reproductive rights and health; gender equality and equity; empowerment; life cycle approach; holistic approach; integration.

## Why this module?

Understanding international consensus on rights and sexual and reproductive Health

The International Conference on Population and Development (ICPD) held in Cairo in 1994 marked a major shift in how the international community speaks about population matters. It has also lead to some changes in how governments and international agencies implement programmes. In some cases, however, people are using new 'Cairo' language to speak about old practices. Thus, for example, the Cairo Programme of Action emphasises that all reproductive health services should be integrated and should be provided within primary health care. Yet frequently donors and government officials talk about 'reproductive health' when they are referring to vertical family planning programmes. For this reason it is important that NGOs working in the field of sexual and reproductive rights and health have an opportunity to interrogate the original texts, and to consider the intentions and the value of these agreements from the perspective of promoting human rights and health. The key definitions agreed in Cairo are repeated and taken further in the Platform for Action of the Fourth World Conference on Women (FWCW) held in Beijing in 1995. Having considered the concept of gender inequality in Module 1, from this module onwards additional key concepts within the ICPD and the FWCW documents are considered by participants in terms of their intentions and the challenges they raise for implementation in the local context.

### Activities:

Activity 1: Reproductive rights (1 hour 30 minutes)

Activity 2: Sexual rights (1 hour)

Activity 3: Empowerment (1 hour)

Activity 4: Human rights, gender equality and quality of care (30 minutes)


**4 hours**


# Activity 1

## Reproductive rights


**1 hour 30 minutes**

## Why do this activity?

Human rights, gender equity and reproduction

This activity consolidates the findings of the previous module. In the last activity, participants identified the contents of a needs-based and a rights-based approach to reproductive health services. This module shows that the international community, through the United Nations, has committed itself to move away from the problems associated with services focused on reducing fertility. It has agreed on a concept of reproductive rights which all countries should try to ensure for their citizens. This concept is in both the ICPD Programme of Action and the FWCW Platform of Action. Familiarity with this definition allows participants to draw on international agreements when motivating changes in their programming, as well as broader policy and programming changes in their countries.

## Objectives

- link the contents of a human rights approach to health services as discussed in Module 2 Activity 3 to the concept of reproductive rights
- identify the range of behaviours necessary to facilitate reproductive rights
- know where to find reproductive rights in the ICPD Programme of Action
- identify how international consensus agreements could be useful in national or local advocacy

## How to do the activity

### Step 1: 30 minutes

Handout

Distribute Handout: Reproductive Rights which provides the definition of reproductive rights and a series of questions. If at this point the group is working comfortably as a group, you can use these questions to run an open

discussion in plenary. If the group is big or some people in the group are very quiet in plenary, then divide into smaller groups and ask each group to have their own discussion on the questions provided. In that case, the timing provided here will not allow for group report-backs.

## The following ideas should emerge from participants' discussions on each question.

Main points

### Why is the issue of freedom from 'discrimination, coercion and violence' central to the concept of reproductive rights?

For many people sexual relations are associated with violence. Rape in marriage, for example, is not recognised by all countries as a violation. Amongst young people in some countries, there is little clarity amongst young men about what constitutes choice – if a young woman says she does not want sexual intercourse, the young man may not believe her, and may push her into intercourse anyway. Incest is another major problem facing both young boys and girls. All of these situations, while in the first instances breaches of 'sexual rights', which will be discussed in the next activity, may also lead women to become pregnant, in which case they are also breaches of women's reproductive rights. The concept of reproductive rights is intended to cover all of these situations, emphasizing that a person should never become pregnant against their will or without having had the opportunity to make a decision as to whether or not they want and are able to take responsibility for a child.

### Why are 'the needs of their living and future children and their responsibilities towards the community' relevant to individuals' reproductive decision-making?

Every child has rights. A child should be loved and cared for to enable him or her to grow up with a sense of self-esteem and the possibility of contributing positively to society. In addition, children have the right to basic necessities such as housing, food, clothing, education and health care (Convention on the Rights of the Child 1989). Before becoming pregnant, a woman should consider whether she wants a child and will give the child the love and care that the child requires. Likewise, before making a woman pregnant, a man should consider whether he wants a child and will give the child the love and care that the child requires. From this perspective, having a child needs to be considered in relation to responsibilities for existing children. The issue of 'future children' is a reference to the long-term sustainability of the world's consumption of resources. People and countries which consume disproportionate quantities of the world's resources and particularly of non-renewable resources are using up resources that will then not be available to future generations. While this is seldom in the minds of individuals making personal decisions about child-bearing, it is an important issue especially at the national level. Countries whose economies and populations are 'overconsuming' such as the United States of America should be promoting an awareness of this problem. It is important to promote people's responsibility in knowing that they can take care of their own children, and in promoting awareness of the problem of over-consumption of resources.

### Why are 'mutually respectful and equitable gender relations' a prerequisite for reproductive rights?

Reproduction usually results from sexual relations between men and women. Without mutual respect between them, there may not be the possibility of open communication about each of their reproductive desires, and about the implications of having or not having a child for each of them as well as for any children they may already have, and for any other family members for whom they may be responsible. The impact of having children is usually very different for women than for men. There are health implications for the woman, and mutual respect is required for the man to play a role in ensuring as little negative health impact as possible on the woman. A woman's husband or partner should ensure that she has enough food; that she has access to health services; that she does not carry out any work that may endanger her health during pregnancy etc. In addition, having a child raises the question of who will undertake child-care – both earning the necessary funds and looking after the child on a daily basis. This should be the responsibility of both the man and woman, and mutual respect and equitable gender relations are necessary for them to be able to openly discuss the best ways of meeting the child's needs, such that burdens and benefits are equitably shared between them.

## Step 2: 50 minutes

When the discussion is completed, give participants copies of

Handout

- The Universal Declaration of Human Rights and
- The Convention on the Elimination of All Forms of Discrimination Against Women.

Plenary

Explain to participants the significance of the international agreements: the population conferences, such as the ICPD held in Cairo, and the 'women's' conferences such as the FWCW held in Beijing happen every 10 years. Countries come together to see how they are doing and what they can improve. The definition of reproductive rights was agreed upon in this way. Countries are supposed to implement these agreements. Also multi-national agencies, such as the United Nations Population Fund, are supposed to change their policies and programmes to match the agreements made at the population conferences. However, these 'ten-year' conferences are not legally binding.

The only international agreements which are legally binding are treaties such as the Declaration of Human Rights, The Convention on the Elimination of All Forms of Discrimination Against Women, known as CEDAW, or the Convention on the Rights of the Child. Countries choose to sign and ratify these agreements, after which, they are accountable to implement them. United Nations bodies which monitor these agreements ask each country to report on implementation every few years. In this way they are monitored. NGOs can send the monitoring bodies information to help them monitor. These NGO reports are called 'shadow reports'. This helps to hold governments accountable.

If your participants' country has signed or ratified these agreements, then your participants can use this to lobby their countries to implement the agreements. If their country has not signed, NGOs can advocate for them to sign, and thereby become part of international consensus.

Tell participants that they can find their own country's reports on the internet.

Note to facilitators

## UN Conventions and Conferences[1]

The main difference between conventions or treaties (used interchangeably) and conferences is that conventions or treaties legally bind the states that signed them whilst conferences express a consensus and political will to act on an issue of interest. When a convention is adopted, the international community starts to act to make the treaty legally binding upon signatory states. This is done through the process of ratification. Once the agreed number of states has ratified a convention, it is deemed to be binding on all signatory states. Since there is no international structure for enforcement, each individual state, represented by its government, must accept the binding rules of the convention and act to change the law in their own country. This in itself may be a slow process.

For example, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), like many other human rights treaties, lays down governmental obligations corresponding to individual rights and freedoms. These are worked in abstract terms to provide a general legislative framework to be applied worldwide. Once the convention is agreed and its terms come into force they are not renegotiated as circumstances change. Following CEDAW's ratification by 20 states in 1981, the signatory governments are bound to incorporate its terms into national law. This means that the core obligation is to adopt human rights norms as part of domestic law and apply them in policy and practice.

Conferences aim at raising the visibility of an issue and forge a political commitment by individual governments and the international community around a topic of particular interest. These commitments are generally broader than governmental legal obligations. The consensus reached at international conferences, as an expression of the world's conscience, can be a powerful instrument for promoting change. For example, the Programme of Action of the International Conference on Population and Development (ICPD) and the Platform for Action adopted at the Fourth World Conference on Women (FWCW) are international consensus agreements that strongly support gender equality and women's empowerment.

The consensus documents of the ICPD and other conferences are intended to lead to action. Five-year reviews have assessed progress towards the agreed goals, identified obstacles and set new benchmarks. The 'ICPD+5' follow-up, for example, took place in 1998 and 1999 in a series of events culminating in a special session of the General Assembly. The special session adopted a document on key actions for the further implementation of the ICPD Programme of Action. While endorsing all of the provisions of the ICPD Programme of Action, it went beyond that document in certain areas, including the reproductive rights of adolescents and of women in emergency situations.

A similar process of assessing implementation is in place for countries that have ratified human rights treaties. They are required to report regularly on the action that they have undertaken to ensure the exercise and enjoyment of the specified rights. Established bodies monitor the implementation of rights instruments. Treaty bodies offer recommendations and interpretations to assist in monitoring, reviewing and evaluating the international human rights treaties. Their recommendations can take several forms. Some clarify treaty

[1]Adapted from: Tomasevski, K., *A Primer on CEDAW for International Development Co-operation Personnel,* SIDA, 1998 and UNFPA, *The State of the World Population, Lives Together Worlds Apart, Men and Women in a Time of Change,* New York, 2000.

provisions, for example, by specifying actions that states, groups or individuals should take. These monitoring bodies can also define standards and recommend actions needed to protect or expand a right. NGOs may also submit 'shadow reports' when a state is before a treaty body.

The Committee on the Elimination of Discrimination against Women monitors implementation of the CEDAW. Only a small number of countries report to the committee each year. The impact of recommendations and rulings gains from their general relevance and cumulative application.

The Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women was ratified by ten countries and entered into force on 22 December 2000. The Optional Protocol is a legal instrument that will enable victims of gender discrimination to submit complaints to the Committee on the Elimination of Discrimination against Women. By accepting the protocol, a state would recognise the Committee's competence to receive and consider complaints from individuals or groups of individuals within its jurisdiction in cases where they have exhausted domestic remedies. The Committee may also conduct inquiries into grave or systematic violations of the Convention.

Small group work

Divide participants into groups of two or three each. Ask participants to skim through the two treaties you have handed out (the Declaration of Human Rights and CEDAW) and look for rights which are relevant to reproductive rights. Make clear that they do not have time to read the treaties in detail. They should just try to pick up a few examples of rights that are necessary in order for people to enjoy reproductive rights. This step will help them to see how the enjoyment of reproductive rights requires a range of different rights which are agreed upon by the international community.

Walk around and listen to the groups. If they are battling then help them along by showing them one article in the Declaration that is relevant.

Note to facilitators

## Examples of ideas that may come out of looking at the treaties:

The Universal Declaration of Human Rights Article 3 talks about 'security of the person' which links to the discussion participants had on the definition of reproductive rights. They discussed 'coercion and violence'. This article protects people from coercion and violence by committing to 'security of person'. Article 4 on slavery is relevant in the situation of trafficking in women where again they would have no control over whether or not to have children. Article 5 says that 'No one shall be subjected to ....degrading treatment'. Participants may identify this as a right that can be used to promote a new approach to health service users – that they should be treated with dignity and respect. Article 6 can be linked to the issue of whether women are able to make their own reproductive choices, or whether their husbands make these decisions. If women are legal minors, they cannot have reproductive rights, since their lives are controlled by their fathers or husbands or sons. Article 8 says that 'All are equal before the law and are entitled without any discrimination to equal protection of the law'. This can be applied to the right of all people irrespective of ethnic group or sexual orientation to equal access to health services. Article 19 on 'the right to freedom of opinion and expression' may be important when developing information and education programmes that question cultural practices which discriminate against women.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) preamble notes that all people are entitled to all the rights and freedoms described, irrespective of their sex. Article 5 requires governments 'to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women'. This supports educational activities as well as advocacy for gender equality including in relation to reproductive decision-making. Article 10 ensures that there should be no discrimination in 'access to educational information to ensure the health and well-being of families, including information and advice on family planning' which may be particularly important where women are not allowed outside of the home. Article 11 provides for 'the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction', which is important given that people's reproductive capacity may be impaired by exposure to certain chemicals such as lead.

## Step 3: 10 minutes

Plenary

Bring the group back to plenary. Ask them if they can imagine using any of these agreements to promote changes in their own country. Ask for examples. Remind participants how the definition of reproductive rights includes that government is responsible for policies and programmes on reproductive health. They can use this provision when advocating for government to improve its policies or programmes. In order to make their demands legally binding, they can link them to articles in the Universal Declaration of Human Rights or CEDAW.


- Copies of handouts for each participant.
- When preparing for this activity, check whether your participants' countries have signed or ratified the Declaration of Human Rights and CEDAW. Also get some of the participants countries' reports so that you have copies with you for participants to look at during a break. It would also be useful to know about the constitution and key legislation and policies of their countries so that you can identify in which ways the countries are following the international treaties and conference agreements, and where they are not.


Health, Empowerment, Rights and Accountability, 'Reproductive Rights', *Women's Sexual and Reproductive Rights and Health Action Sheets,* New York: Hera Secretariat, 1997.

Petchesky, R., 'Rights and needs: rethinking the connections in debates over reproductive and sexual rights', *Health and Human Rights*, 2000; 4 (2): 17-29.


- Handout: Reproductive Rights
- Handout: The Universal Declaration of Human Rights
- Handout: The Convention on the Elimination of All Forms of Discrimination Against Women

# 'Reproductive rights'

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

## Questions for discussion

- The definition of reproductive rights includes freedom from 'discrimination, coercion and violence'. Do people experience discrimination, coercion or violence in reproductive relationships? In what way? Why is it important for government and NGOs to address discrimination, coercion and violence?
- Why are individuals expected to consider 'the needs of their living and future children and their responsibilities towards the community' when making reproductive decisions? Do men usually do this? Do women usually do this?
- The definition of reproductive rights includes 'mutually respectful and equitable gender relations'. Are most reproductive relationships mutually respectful and equitable? In what ways? Why is it necessary for government and NGOs to promote mutually respectful and equitable gender relations?

Programme of Action of the International Conference on Population and Development, Cairo 1994, paragraph 7.3 and repeated in the Fourth World Conference on Women Platform of Action, Beijing, paragraph 95.

# Universal Declaration of Human Rights

Adopted and proclaimed by General Assembly Resolution 217 (A) (III) of 10 December 1948.

## PREAMBLE

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, therefore, The General Assembly, Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

### Article I

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 to 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.

# Convention on the Elimination of All Forms of Discrimination against Women

Adopted and opened for signature, ratification and accession by General Assembly Resolution 34/180 of 18 December 1979

- Noting that the Charter of the United Nations reaffirms faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women,
- Noting that the Universal Declaration of Human Rights affirms the principle of the inadmissibility of discrimination and proclaims that all human beings are born free and equal in dignity and rights and that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, including distinction based on sex,
- Noting that the States Parties to the International Covenants on Human Rights have the obligation to ensure the equal rights of men and women to enjoy all economic, social, cultural, civil and political rights,
- Considering the international conventions concluded under the auspices of the United Nations and the specialized agencies promoting equality of rights of men and women,
- Noting also the resolutions, declarations and recommendations adopted by the United Nations and the specialized agencies promoting equality of rights of men and women,
- Concerned, however, that despite these various instruments extensive discrimination against women continues to exist,
- Recalling that discrimination against women violates the principles of equality of rights and respect for human dignity, is an obstacle to the participation of women, on equal terms with men, in the political, social, economic and cultural life of their countries, hampers the growth of the prosperity of society and the family and makes more difficult the full development of the potentialities of women in the service of their countries and of humanity,
- Concerned that in situations of poverty women have the least access to food, health, education, training and opportunities for employment and other needs,
- Convinced that the establishment of the new international economic order based on equity and justice will contribute significantly towards the promotion of equality between men and women,
- Emphasizing that the eradication of apartheid, all forms of racism, racial discrimination, colonialism, neo-colonialism, aggression, foreign occupation and domination and interference in the internal affairs of States is essential to the full enjoyment of the rights of men and women,
- Affirming that the strengthening of international peace and security, the relaxation of international tension, mutual co-operation among all States irrespective of their social and economic systems, general and complete disarmament, in particular nuclear disarmament under strict and effective international control, the affirmation of the principles of justice, equality and mutual benefit in relations among countries and the realization of the right of peoples under alien and colonial domination and foreign occupation to self-determination and independence, as well as respect for national sovereignty and territorial integrity, will promote social progress and development and as

a consequence will contribute to the attainment of full equality between men and women,

- Convinced that the full and complete development of a country, the welfare of the world and the cause of peace require the maximum participation of women on equal terms with men in all fields,
- Bearing in mind the great contribution of women to the welfare of the family and to the development of society, so far not fully recognized, the social significance of maternity and the role of both parents in the family and in the upbringing of children, and aware that the role of women in procreation should not be a basis for discrimination but that the upbringing of children requires a sharing of responsibility between men and women and society as a whole,
- Aware that a change in the traditional role of men as well as the role of women in society and in the family is needed to achieve full equality between men and women,
- Determined to implement the principles set forth in the Declaration on the Elimination of Discrimination against Women and, for that purpose, to adopt the measures required for the elimination of such discrimination in all its forms and manifestations,

Have agreed on the following:

# PART I

## Article 1

For the purposes of the present Convention, the term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

## Article 2

States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:

(a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realization of this principle;

(b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;

(c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;

(d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;

(e) To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise;

(f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;

(g) To repeal all national penal provisions which constitute discrimination against women.

### Article 3

States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women , for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.

### Article 4

1. Adoption by States Parties of temporary special measures aimed at accelerating de facto equality between men and women shall not be considered discrimination as defined in the present Convention, but shall in no way entail as a consequence the maintenance of unequal or separate standards; these measures shall be discontinued when the objectives of equality of opportunity and treatment have been achieved.
2. Adoption by States Parties of special measures, including those measures contained in the present Convention, aimed at protecting maternity shall not be considered discriminatory.

### Article 5

States Parties shall take all appropriate measures:

(a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women;

(b) To ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children, it being understood that the interest of the children is the primordial consideration in all cases.

### Article 6

States Parties shall take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women.

## PART II

### Article 7

States Parties shall take all appropriate measures to eliminate discrimination against women in the political and public life of the country and, in particular, shall ensure to women, on equal terms with men, the right:

(a) To vote in all elections and public referenda and to be eligible for election to all publicly elected bodies;

(b) To participate in the formulation of government policy and the implementation thereof and to hold public office and perform all public functions at all levels of government;

(c) To participate in non-governmental organizations and associations concerned with the public and political life of the country.

### Article 8

States Parties shall take all appropriate measures to ensure to women, on equal terms with men and without any discrimination, the opportunity to represent their Governments at the international level and to participate in the work of international organizations.

### Article 9

1. States Parties shall grant women equal rights with men to acquire, change or retain their nationality. They shall ensure in particular that neither marriage to an alien nor change of nationality by the husband during marriage shall automatically change the nationality of the wife, render her stateless or force upon her the nationality of the husband.
2. States Parties shall grant women equal rights with men with respect to the nationality of their children.

# PART III

### Article 10

States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women:

(a) The same conditions for career and vocational guidance, for access to studies and for the achievement of diplomas in educational establishments of all categories in rural as well as in urban areas; this equality shall be ensured in pre-school, general, technical, professional and higher technical education, as well as in all types of vocational training;

(b) Access to the same curricula, the same examinations, teaching staff with qualifications of the same standard and school premises and equipment of the same quality;

(c) The elimination of any stereotyped concept of the roles of men and women at all levels and in all forms of education by encouraging coeducation and other types of education which will help to achieve this aim and, in particular, by the revision of textbooks and school programmes and the adaptation of teaching methods;

(d ) The same opportunities to benefit from scholarships and other study grants;

(e) The same opportunities for access to programmes of continuing education, including adult and functional literacy programmes, particularly those aimed at reducing, at the earliest possible time, any gap in education existing between men and women;

(f) The reduction of female student drop-out rates and the organization of programmes for girls and women who have left school prematurely;

(g) The same opportunities to participate actively in sports and physical education;

(h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.

### Article 11

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:
   (a) The right to work as an inalienable right of all human beings;
   (b) The right to the same employment opportunities, including the application of the same criteria for selection in matters of employment;
   (c) The right to free choice of profession and employment, the right to promotion, job security and all benefits and conditions of service and the right to receive vocational training and retraining, including apprenticeships, advanced vocational training and recurrent training;

(d) The right to equal remuneration, including benefits, and to equal treatment in respect of work of equal value, as well as equality of treatment in the evaluation of the quality of work;

(e) The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave;

(f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

2. In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties shall take appropriate measures:

(a) To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave and discrimination in dismissals on the basis of marital status;

(b) To introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority or social allowances;

(c) To encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities;

(d) To provide special protection to women during pregnancy in types of work proved to be harmful to them.

3. Protective legislation relating to matters covered in this article shall be reviewed periodically in the light of scientific and technological knowledge and shall be revised, repealed or extended as necessary.

## Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

## Article 13

States Parties shall take all appropriate measures to eliminate discrimination against women in other areas of economic and social life in order to ensure, on a basis of equality of men and women, the same rights, in particular:

(a) The right to family benefits;

(b) The right to bank loans, mortgages and other forms of financial credit;

(c) The right to participate in recreational activities, sports and all aspects of cultural life.

## Article 14

1. States Parties shall take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including their work in the non-monetized sectors of the economy,

and shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas.

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:

(a) To participate in the elaboration and implementation of development planning at all levels;

(b) To have access to adequate health care facilities, including information, counselling and services in family planning;

(c) To benefit directly from social security programmes;

(d) To obtain all types of training and education, formal and non-formal, including that relating to functional literacy, as well as, inter alia, the benefit of all community and extension services, in order to increase their technical proficiency;

(e) To organize self-help groups and co-operatives in order to obtain equal access to economic opportunities through employment or self employment;

(f) To participate in all community activities;

(g) To have access to agricultural credit and loans, marketing facilities, appropriate technology and equal treatment in land and agrarian reform as well as in land resettlement schemes;

(h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.

# PART IV

## Article 15

1. States Parties shall accord to women equality with men before the law.

2. States Parties shall accord to women, in civil matters, a legal capacity identical to that of men and the same opportunities to exercise that capacity. In particular, they shall give women equal rights to conclude contracts and to administer property and shall treat them equally in all stages of procedure in courts and tribunals.

3. States Parties agree that all contracts and all other private instruments of any kind with a legal effect which is directed at restricting the legal capacity of women shall be deemed null and void.

4. States Parties shall accord to men and women the same rights with regard to the law relating to the movement of persons and the freedom to choose their residence and domicile.

## Article 16

1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:

   (a) The same right to enter into marriage;

   (b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent;

(c) The same rights and responsibilities during marriage and at its dissolution;

(d) The same rights and responsibilities as parents, irrespective of their marital status, in matters relating to their children; in all cases the interests of the children shall be paramount;

(e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;

(f) The same rights and responsibilities with regard to guardianship, wardship, trusteeship and adoption of children, or similar institutions where these concepts exist in national legislation; in all cases the interests of the children shall be paramount;

(g) The same personal rights as husband and wife, including the right to choose a family name, a profession and an occupation;

(h) The same rights for both spouses in respect of the ownership, acquisition, management, administration, enjoyment and disposition of property, whether free of charge or for a valuable consideration.

2. The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory.

# PART V

## Article 17

1. For the purpose of considering the progress made in the implementation of the present Convention, there shall be established a Committee on the Elimination of Discrimination against Women (hereinafter referred to as the Committee) consisting, at the time of entry into force of the Convention, of eighteen and, after ratification of or accession to the Convention by the thirty-fifth State Party, of twenty-three experts of high moral standing and competence in the field covered by the Convention. The experts shall be elected by States Parties from among their nationals and shall serve in their personal capacity, consideration being given to equitable geographical distribution and to the representation of the different forms of civilization as well as the principal legal systems.

2. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals.

3. The initial election shall be held six months after the date of the entry into force of the present Convention. At least three months before the date of each election the Secretary-General of the United Nations shall address a letter to the States Parties inviting them to submit their nominations within two months. The Secretary-General shall prepare a list in alphabetical order of all persons thus nominated, indicating the States Parties which have nominated them, and shall submit it to the States Parties.

4. Elections of the members of the Committee shall be held at a meeting of States Parties convened by the Secretary-General at United Nations Headquarters. At that meeting, for which two thirds of the States Parties shall constitute a quorum, the persons

elected to the Committee shall be those nominees who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.

5. The members of the Committee shall be elected for a term of four years. However, the terms of nine of the members elected at the first election shall expire at the end of two years; immediately after the first election the names of these nine members shall be chosen by lot by the Chairman of the Committee.

6. The election of the five additional members of the Committee shall be held in accordance with the provisions of paragraphs 2, 3 and 4 of this article, following the thirty-fifth ratification or accession. The terms of two of the additional members elected on this occasion shall expire at the end of two years, the names of these two members having been chosen by lot by the Chairman of the Committee.

7. For the filling of casual vacancies, the State Party whose expert has ceased to function as a member of the Committee shall appoint another expert from among its nationals, subject to the approval of the Committee.

8. The members of the Committee shall, with the approval of the General Assembly, receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide, having regard to the importance of the Committee's responsibilities.

9. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention.

### Article 18

1. States Parties undertake to submit to the Secretary-General of the United Nations, for consideration by the Committee, a report on the legislative, judicial, administrative or other measures which they have adopted to give effect to the provisions of the present Convention and on the progress made in this respect:

(a) Within one year after the entry into force for the State concerned;

(b) Thereafter at least every four years and further whenever the Committee so requests.

2. Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Convention.

### Article 19

1. The Committee shall adopt its own rules of procedure.

2. The Committee shall elect its officers for a term of two years.

### Article 20

1. The Committee shall normally meet for a period of not more than two weeks annually in order to consider the reports submitted in accordance with article 18 of the present Convention.

2. The meetings of the Committee shall normally be held at United Nations Headquarters or at any other convenient place as determined by the Committee.

### Article 21

1. The Committee shall, through the Economic and Social Council, report annually to the General Assembly of the United Nations on its activities and may make suggestions

and general recommendations based on the examination of reports and information received from the States Parties. Such suggestions and general recommendations shall be included in the report of the Committee together with comments, if any, from States Parties.

2. The Secretary-General of the United Nations shall transmit the reports of the Committee to the Commission on the Status of Women for its information.

### Article 22

The specialized agencies shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their activities. The Committee may invite the specialized agencies to submit reports on the implementation of the Convention in areas falling within the scope of their activities.

## PART VI

### Article 23

Nothing in the present Convention shall affect any provisions that are more conducive to the achievement of equality between men and women which may be contained:

(a) In the legislation of a State Party; or

(b) In any other international convention, treaty or agreement in force for that State.

### Article 24

States Parties undertake to adopt all necessary measures at the national level aimed at achieving the full realization of the rights recognized in the present Convention.

### Article 25

1. The present Convention shall be open for signature by all States.
2. The Secretary-General of the United Nations is designated as the depositary of the present Convention.
3. The present Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.
4. The present Convention shall be open to accession by all States. Accession shall be effected by the deposit of an instrument of accession with the Secretary-General of the United Nations.

### Article 26

1. A request for the revision of the present Convention may be made at any time by any State Party by means of a notification in writing addressed to the Secretary-General of the United Nations.
2. The General Assembly of the United Nations shall decide upon the steps, if any, to be taken in respect of such a request.

### Article 27

1. The present Convention shall enter into force on the thirtieth day after the date of deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.
2. For each State ratifying the present Convention or acceding to it after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into

force on the thirtieth day after the date of the deposit of its own instrument of ratification or accession.

### Article 28

1. The Secretary-General of the United Nations shall receive and circulate to all States the text of reservations made by States at the time of ratification or accession.
2. A reservation incompatible with the object and purpose of the present Convention shall not be permitted.
3. Reservations may be withdrawn at any time by notification to this effect addressed to the Secretary-General of the United Nations, who shall then inform all States thereof. Such notification shall take effect on the date on which it is received.

### Article 29

1. Any dispute between two or more States Parties concerning the interpretation or application of the present Convention which is not settled by negotiation shall, at the request of one of them, be submitted to arbitration. If within six months from the date of the request for arbitration the parties are unable to agree on the organization of the arbitration, any one of those parties may refer the dispute to the International Court of Justice by request in conformity with the Statute of the Court.
2. Each State Party may at the time of signature or ratification of the present Convention or accession thereto declare that it does not consider itself bound by paragraph I of this article. The other States Parties shall not be bound by that paragraph with respect to any State Party which has made such a reservation.
3. Any State Party which has made a reservation in accordance with paragraph 2 of this article may at any time withdraw that reservation by notification to the Secretary-General of the United Nations.

### Article 30

The present Convention, the Arabic, Chinese, English, French, Russian and Spanish texts of which are equally authentic, shall be deposited with the Secretary-General of the United Nations.


# Activity 2

## Sexual Rights


**1 hour**

## Why this activity?

Inequality within sexual relationships

Sexual relationships are a source of both pleasure and danger in most societies. Sexuality is a central part of human experience and should contribute towards our sense of wellbeing, and towards strengthening our intimate relationships. However, inequalities between men and women in sexual decision-making frequently undermine the quality of sexual relationships, and at worst put women in danger of ill-health, and indeed, of death. But both men and women, whether in heterosexual or homosexual relationships, can be endangered by the inability of individuals to communicate openly about sex and sexuality.

Lack of information about sexuality can undermine people's ability to understand their bodies and sexuality and hence to enjoy the sexual experience. Inequality between sexual partners can also put the partner with less power – usually women – into a position where they are afraid to talk to their partners – for example to discuss with their partners the need to practice safe sex. Women frequently describe how they will not suggest using a condom for fear that their partner will beat them up; they do not tell their partners that they have a sexually transmitted disease for fear that their partner will accuse them of being promiscuous. These difficulties indicate that HIV prevention activities cannot stop at telling people to 'abstain', 'be faithful', or 'use a condom', which is the current 'ABC' message in many countries. This is not enough, because people may not be able to implement these in a context of gender inequality. Hence it is important to challenge the underlying gender inequality within sexual relationships.

At the Fourth World Conference on Women held in Beijing in 1995, the international community asserted that:

> 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)

Challenging unequal gender relations

This position is frequently referred to as 'sexual rights' although the actual words 'sexual rights' are not in the Beijing Platform. It reinforces that for women to control their sexuality, unequal gender relations have to be challenged even in the intimate terrain of sexual relations.

Many health issues which are linked to sexuality, such as HIV/AIDS, require interventions which are different from reproductive health interventions, and even target different people. For this reason it is important for participants to be able to conceptualise sexual health separately from reproductive health, and sexual rights separately from reproductive rights. The content of sexual health is discussed further in Module 4, Activity 3.

Mobilising around sexual rights

While many NGOs are familiar with the concept of 'reproductive rights', they have seldom considered the meaning of 'sexual rights' or the reasons why it may be necessary to mobilise around sexual rights. This activity helps to consider why sexual rights are important and what sorts of activities can be undertaken to promote sexual rights.

Note to facilitators

Like the concept 'gender', the concept of 'sexual rights' may not be easy to translate into one word. You need to identify an appropriate word or group of words which capture the meaning of sexual rights, as agreed upon in Beijing. The concept of the right to decide if, when and how to have sexual relations is the key point – that is, women's right to control their own bodies and sexual relations; and men's right to control their own bodies and sexual relations.

# Objectives

- distinguish between reproductive rights and sexual rights
- identify how lack of sexual rights leads to vulnerability towards HIV/AIDS and violence against women
- identify actions that government, their own organisation and they as individuals could take to promote sexual rights

# How to do the activity

## Step 1: 10 minutes

Put up an overhead you have made showing newspaper articles that address issues of sexual rights, or give these out as handouts (see 'materials'). Remind participants about how common such occurrences are. Tell them that because so many human rights abuses are in the area of sexuality, the international community has developed a position on the right of individuals to control their own sexuality.

Overhead

Put up the Overhead: Sexual Rights.

Read the paragraph to participants. Tell them that the concept of sexual rights is being used to help people see how the underlying issues behind problems such as HIV/AIDS and violence against women are gender inequality. You are going to give them a handout which is the text of a pamphlet that is being used in a Sexual Rights Campaign in South Africa.

### Step 2: 10 minutes

Give out Handout: The Sexual Rights Pamphlet.

Ask participants to read the pamphlet individually, after which you will discuss it as a group.

### Step 3: 40 minutes

Plenary

Ask the participants the following questions, and have a discussion after each question. If participants find any questions difficult to answer, give them a few seconds to discuss the question with a neighbour. You may want to write up the questions on a piece of paper so that participants can follow them easily.

Questions

#### 1. Do similar conditions (AIDS; violence) exist in this country?

The likelihood is that most participants live in communities where there are social justice and health problems related to sexuality, such as sexual violence – whether incest or rape – and transmission of sexually transmitted diseases. There may be other problems such as trafficking in women – selling of women and children into sex work against their will.

#### 2. What do you think that a sexual rights approach is aiming to achieve?

The sexual rights approach used in the pamphlet is aiming to identify how gender inequality makes sexual relationships dangerous for women, since they become vulnerable to abuse and disease. It argues for the need to promote equality so that both women and men can have control over their bodies and sexuality, as described under 'what does sexual rights mean' in the pamphlet. The campaign described in the pamphlet aims to involve both decision-makers and people at community level in building a culture of sexual rights both at the individual level and in social institutions such as the education, justice and health systems.

#### 3. Why are sexual rights different from reproductive rights?

Whereas reproductive rights concern the right of people to choose if, when and how many children to have, sexual rights are relevant at all times of people's lives, whether or not they have children, whether or not they want children. Sexual rights are also relevant at all ages, since children can suffer sexual abuse, and people are sexually active into old age, when they are no longer concerned with childbearing.

#### 4. What are the barriers to promoting sexual rights in your community?

In identifying barriers to promoting sexual rights, consider barriers at the individual level (such as women's own sense of self, their confidence etc. and men's sense of how they should behave sexually in order to meet their own expectations of masculinity) as well as social barriers, such as cultural assumptions about how men and women should behave sexually. Also consider institutional barriers such as whether there is legislation against sexual violence against women, whether there is sex education in the school curricula etc.

### 5. What could government do to promote sexual rights?

Governments are responsible for providing laws and policies which promote sexual rights. These include provision of sexuality education in schools, laws against violence against women, including against rape and rape in marriage, and laws against trafficking in women. They are also responsible for providing services which promote sexual rights for example access to services for sexually transmitted diseases for all people, whether adolescent or older, women or men; active policing to prevent sexual violence against women or trafficking, etc.

### 6. What could your organisation do to promote sexual rights?

Organisations can commit to incorporating the concept of sexual rights in the work they currently do. Organisations can do advocacy for government to change laws and policies so that they are in keeping with international agreements. They can do advocacy for governments to implement existing policies.

Organisations can build community awareness of the concept of sexual rights and build the capacity of women and men to protect their own sexual rights and act responsibly towards their sexual partners. While women tend to have more power in sexual relationships, organisations can also empower men in understanding and promoting sexual rights. For example, a man might feel that he has to pretend to be sexually experienced, because this is what society expects of men. This might prevent him from asking questions to learn about sexuality and safer sex.

Organisations can offer health services which promote sexual rights.

### 7. What can you do to promote sexual rights?

Individuals can commit to talking more openly with their sexual partners about their sexual relationships. They can commit to using condoms or only having sex with one partner. They can commit to educating their family members about the importance of acknowledging and promoting sexual rights and the related responsibilities. They can commit to challenging abuses of sexual rights as they come across them in their personal or working lives.

Participants may be uncomfortable with talking at this personal level. As the facilitator, it is important to point out that we cannot promote sexual rights in our organisation or community if we are not comfortable talking about it and practising it in our own lives.


- Flipchart paper.
- Felt-tip pens.
- Copies of handouts for each participant.
- Prepare an overhead or a handout of excerpts from articles from

newspapers about issues relevant to sexual rights. This could include articles about rape, trafficking in women, discrimination on the basis of sexual orientation, sexual harassment in the workplace, female genital mutilation, or sexuality education in schools.

Alternatively the evening before this activity, or by lengthening the time for this activity, you could give participants newspapers and magazines and ask them to cut out relevant articles.

Another option, instead of newspaper clippings, would be to show participants a video that addresses issues related to sexual rights. Or you could prepare an overhead of data from the participants' country on sexual rights issues.


Klugman, B., *'Sexual rights in Southern Africa: A Beijing discourse or a strategic necessity?' Health and Human Rights.* 2000; 4(2): 132-159.

Geeta Rao Gupta, 'Strengthening alliances for sexual health and rights', *Health and Human Rights*, 1997; 2(3): 55-64.

Health, Empowerment, Rights and Accountability, 'Sexual Rights', *Women's Sexual and Reproductive Rights and Health Action Sheets,* New York: Hera Secretariat, 1997.


- Hand out: The Sexual Rights Pamphlet


- Overhead: Sexual Rights

# Sexual Rights

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

Platform for Action of the Fourth World Conference on Women, United Nations, Beijing 1995: paragraph 96.

# The Sexual Rights Pamphlet

## The sexual rights campaign: For mutual respect in sexual decision making

Together let's address:

- HIV/AIDS
- Violence against women
- Adolescent sexual health

The campaign is a joint effort of: The National Network on Violence Against Women (NNVAW); National AIDS Convention Of South Africa (NACOSA); National Association of People Living With AIDS (NAPWA); Planned Parenthood Association of South Africa (PPASA); The Joint Enrichment Project (JEP); Young Men's Christian Association (YMCA); Women's Health Project (WHP) and community based organisations throughout South Africa.

## HIV / AIDS

Joyce (Linyenye village, 34 years): "For me contracting HIV/AIDS is not so far fetched. Before I received training on sexual rights, I couldn't negotiate for the use of the condom, even when my husband had penile discharges and sores. When I asked, he told me he had been pinched by the zip of his trousers. That is all the discussion we ever had about it. But I knew what was going on..... I knew what was the matter....."

Radio Mungana Lonene talk show respondent: "I understand all about sexual rights, but there's nothing I can do about it. My husband does not entertain the rights thing. He has 5 girlfriends. But I can't leave him. I'm terrified because I don't work. He feeds, clothes and gives me shelter. I can't even talk about the condom. He will ask me where I know it from. I'm trapped. Where will I go and what will I eat?"

South Africa is facing an AIDS epidemic.

- An estimated 4.2 million South Africans are infected with HIV/AIDS. In more practical terms, 1 in every 10 South Africans is infected with HIV.
- In 1999, it was estimated that there were 1,700 new infections per day.
- Young women less than 20 years and in their 20s are the most affected. They are twice as infected as other age groups over 30 years.

### The problem in terms of Sexual Rights

Women often cannot negotiate for safer sex because of gender inequality, poverty and culture. These factors undermine their position is society and thus make them vulnerable to HIV/AIDS and unwanted pregnancies.

## VIOLENCE

Maria (Katlehong 40, previously married to a priest): "He will beat me on a Friday to such an extent that I would be incapacitated. On Sunday he would dress up in his priestly regalia and go to deliver a sermon in church. When asked about my whereabouts, he would tell the church elders and the women that I was not at home. He lied because he feared that the church elders and the whole congregation would find out about his violent behaviour. When he wanted sex, he wanted it there and then. He would beat me when I happened not to be at home when he wanted to have sex. The violence lasted for 15 years. 3 years ago I got out of the abusive relationship. I spoke up and got support. That assisted me to divorce him."

Violence against women has reached epidemic levels in South Africa.

- South Africa has the highest ratio of reported rape cases per 100 000 people in the world.
- It is estimated that one in six women are in abusive relationships and one woman is killed by her partner every six days.
- Many young women report that men used violence when initiating sex with them.
- In 4 provinces in South Africa, abuse by a partner or ex-partner increased by more than 50% between 1998 and 1999. The range of abuse included sexual, physical, economic and emotional.

### The problem in terms of Sexual Rights

As a result of unequal power relations between women and men, young women are vulnerable to coerced or unwanted sex, which places them at risk of unwanted pregnancy and sexually transmitted diseases, including HIV. Women also suffer from low self-esteem.

## WHAT DOES "SEXUAL RIGHTS" MEAN?

*"The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relationships and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences"* (Fourth World Conference on Women, Beijing, 1995). The South African government committed to this agreement.

### Sexual Rights means that women and men have a right to:

- Control over their bodies
- Only have sex when, with whom and how they want to
- Decide about their sexuality
- Not be forced to have sex through the use of violence or non-physical force
- Have sexual enjoyment
- Be protected from the risk of disease such as HIV and other sexually transmitted diseases
- Have access to responsive services that help them deal with concerns in relation to their sexual health

All these must be present, they are not mutually exclusive.

## THE SEXUAL RIGHTS CAMPAIGN AIMS TO:

- Build a new vision of masculinity in which real men:
  - take responsibility for their sexual behaviour · do not force women into sex
  - do not expose women to disease or unwanted pregnancy
- Build a new vision of femininity in which all women can:
  - claim their sexual rights
  - build a culture of equality and mutual respect in sexual relations between men and women
  - end women's and girls' vulnerability to violence, AIDS and unwanted pregnancy
  - reclaim sex as a positive and pleasurable experience

### The Sexual Rights Campaign involves the following steps:

- Advocacy to national and provincial politicians and decision-makers
- Identification of priority actions to promote sexual rights amongst the police and justice sector, the health sector, the education sector and youth
- Training of trainers and running of sexual rights workshops in which individuals and groups identify and subsequently take up specific actions to promote sexual rights at community level
- Outreach to the public through print media, radio talk shows and posters
- Bringing together all of the findings of this process for the development of a Sexual Rights Charter (mid-2001)

## DISSEMINATION OF THE CHARTER AND WINNING COMMITMENT OF DIFFERENT SECTORS TO IMPLEMENT THE CHARTER IN THEIR DAILY WORK AND LIVES

### What your sector can do to make a difference:

Build a culture of sexual rights in your own sexual relationship.

### Parliamentarians

- Make promoting sexual rights your business
- Talk about sexual rights in every talk you give
- Help to build a new culture of gender equality

### Government managers

- Give talks and run workshops so that your staff embrace the concept of sexual rights and promote it in their lives and work
- Ensure that your sector's systems and rules promote gender equality

### Government and civil society

#### Justice and Safety and Security

Train police and magistrates to:

- Respect and promote women's equality
- Implement all aspects of the Domestic Violence Act
- Target those who abuse sexual rights

#### Education

Build the commitment and competence of teachers to:

- Promote equality between girls and boys in the classroom
- Implement lifeskills and sex education in schools that promotes equality in sexual relations between girls and boys
- Identify and challenge all instances of sexual abuse by students or teachers

#### Health

- Run gender-sensitising workshops for all staff to enable them to provide supportive and effective care to women, men and adolescents to address violence, STDs/HIV/AIDS, unwanted pregnancies and other issues around sexuality
- Ensure all health managers and health workers use the protocol for implementing the Domestic Violence Act

#### Trade and industry and Labour

- Create the conditions for women's employment such that they are not reliant on men for income
- Help workers and management understand the impact of the absence of sexual rights on the workplace (sexual harassment, high levels of HIV, violence, absenteeism, etc.) and promote a culture of sexual rights

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# Activity 3

## Empowerment


**1 hour**

## Why do this activity?

**Women's status in society**

The international community has come to recognise that it is necessary to support women in gaining the confidence and skills to be able to protect and promote their own sexual rights and health; but that this cannot be achieved within a narrow approach of service provision. Rather, active steps need to be taken to change the conditions of women's lives and their status in society.

**Understanding empowerment**

The empowerment of women can be facilitated, but it is not a 'top-down' exercise. Empowerment is about accessing power which is held by those who control 'material assets, intellectual resources and ideology'. Women are frequently powerless, in that they control neither material resources nor decision-making power. They may not even have control over the resources they use daily – from the land they work, to their labour, to their bodies.

**Approaches to empowerment**

The exercise provided asks participants to consider three different approaches to empowerment - integrated development, economic empowerment, and consciousness raising. They all emphasise different dimensions of empowerment. A lesson from experience is, however, that 'different aspects of empowerment are linked and that progress in one area cannot be sustained without attention to others. For example, reproductive rights cannot be fully exercised where women's lack of independent economic resources undermines their freedom to make choices.' (Oxaal 1997)

**Women's empowerment requires collective action**

Organisations of women, or other popular organisations which recognise the need to empower women, have to develop strategies to enable women to make decisions for themselves, and to take action for themselves. While NGOs, as intermediary organisations, can sometimes facilitate this role, it usually requires the existence of popular organisations – that is organisations at the grassroots in order to achieve anything beyond some strengthened capacity at the individual level. Since women's empowerment requires changes in social values, it usually requires collective action. Empowerment is a process rather than only an end-point. Thus, well before changes in policy or programming have been achieved, women may have built their confidence in their right to demand change and to participate in processes of shaping the policy agenda.

NGOs need to interrogate their role in promoting improvements in women's status in society. In addition, however, they need to interrogate what role they can play in the empowerment of women to achieve such changes. They need to consider how men can contribute towards women's empowerment.

This activity aims to help NGOs understand the types of activities which can support women's empowerment, and to consider how such activities might go beyond building solidarity amongst women and meeting basic needs, and towards building women's ability to promote fundamental changes in their social status in society.

It aims to help them identify what roles are appropriate for men to play in women's empowerment activities.

# Objectives

- to describe and assess different approaches to empowerment
- to describe why empowerment is central to the achievement of sexual and reproductive rights and health
- identify actions that their own organisations can take to promote women's empowerment
- identify the roles that men can play in empowerment of women

# How to do this activity

## Step 1: 10 minutes

Handout

Introduce this session by talking about the commitment of the ICPD to women's empowerment and that the international community has come to recognise that it is necessary to support women in gaining the confidence and skills to be able to protect and promote their own sexual rights and health; but that this cannot be achieved within a narrow approach of service provision. Rather, active steps need to be taken to change the conditions of women's lives and, most importantly, their status in society.

Distribute the Handout: Empowerment and women's status (ICPD). Ask a participant to read out the handout. Then explain that the handout again refers to agreements amongst countries of the world about what they should be aiming to achieve. Brief the participants on the concept of empowerment using the points below.

Point out that one of the complex issues NGOs face is around their role in relation to empowerment. Different NGOs play different roles.

- Some provide services;
- Some undertake advocacy for changes in policies or programmes;
- Some monitor government delivery on its commitments to international agreements such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) or its delivery of national policies;

- Some support grassroots organisations in mobilising, identifying their priorities for action, and getting their voices heard.

Within each of these activities, the question arises as to how NGO activities should support the empowerment of women:

1. the process of building women's confidence and ability to speak for themselves and

2. the process of changing gender norms, that is the way society values and treats women.

While the first process is usually done by women with women, both men and women need to facilitate the second process - changing social values.

Empowerment is critical for the achievement of gender equality as well as sexual and reproductive rights and health. As the previous activities have shown, a central requirement for achieving human rights is the ability to act. The activity on gender (Module 1, Activity 2) identified 'internal resources' as important resources to control. This means that women and men need to have confidence and self-esteem. This is central to empowerment. However, even with control over these resources, without control over decision-making, economic, informational and other resources, one cannot achieve gender equality or sexual and reproductive rights and health. This exercise therefore explores different dimensions of empowerment and different approaches to achieving empowerment. Participants should consider the limitations of different approaches.

A related question that NGOs need to consider is how they ensure that all of their work supports the process of improving the position of women in society, irrespective of the specific interests of their donors or of government.

Main points

Tell participants that this session will consider

- what sorts of actions can empower women
- how NGOs can promote women's empowerment in all of their activities.

Note to facilitator

It is important that participants do not feel that men are being left out. Men have critical roles to play in creating an enabling environment for women's empowerment. Both as individuals, in their sexual, family and community relationships, and through the work that they do, men should be working towards gender equality. And gender equality requires women's empowerment.

However, it is also legitimate for women to organise alone, without men, for some activities to promote empowerment.

Many men also feel disempowered at times. For men to take a stand against gender inequality requires their own empowerment. Men describe how they are ridiculed when they do domestic work, or when they show emotions. They too need the confidence and capacity to act to promote equality. Some organisations are directing their attention to men's role in disempowering women. They are trying to get men to self-reflect, empowering men to change gender norms about how men should behave. In this way, they are working with men to create an enabling environment for women's empowerment.

As the reading suggests, many activities required for women's empowerment go far beyond issues of consciousness, to questions of control over various kinds of resources. Here too, men have a role to play.

Encourage participants to think about the roles of men and women when they do this activity so that you avoid a situation in which men feel left out and do not recognise that both men and women have responsibility for promoting women's empowerment.

Also, walk around and listen to the group discussions. Push participants to critique the different approaches.

## Step 2: 50 minutes

Handout

Divide participants into groups, ideally with everyone from one NGO in the same group. Give them Handout: Empowerment: Three Approaches. Ask them to read this handout and then discuss the questions on the handout.

There is no need for a report-back on this exercise.


- Copies of Handouts for each participant.


Readings for facilitator

Batliwala, S., 'The meaning of women's empowerment: new concepts from action', in Sen, G., Germain, A. and Chen, L., (eds.) *Population Policies Reconsidered: Health, Empowerment and Rights*, Boston, Harvard University Press, 1994:127-138

Catino, J., 'Broad-based partnerships for ICPD implementation', in *Meeting the Cairo Challenge: Progress in Sexual and Reproductive Health*, New York, Family Care International, 1999: 26-33.

Galdos, S. and Feringa, B., 'Creating partnerships at the grassroots level: the Reprosalud Project, Peru', in *Confounding the Critics: Cairo five years on*, Conference Report, Cocoyoc, Mexico, HERA, 15-18 November, 1998: 26 – 32.

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Oxaal, Z. and Baden, S., 'Gender and empowerment: definitions, approaches and implications for policy', *Bridge Report* No. 40, Institute for Development Studies, Sussex Univerity, 1997.

Pearce, J., 'NGOs and social change: agents or facilitators?', *Development in Practice*, Vol 3 No 3, 1993: 222-227.

Rowlands, J., 'Empowerment examined'. In Eade, D., (ed.) *Development with Women*, Oxford: Oxfam GB, 1999:141-150.


- Handout: Empowerment and women's status (ICPD)
- Handout: Empowerment: Three Approaches

# Empowerment and the Status of Women

"The empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself. In addition, it is essential for the achievement of sustainable development. The full participation and partnership of both women and men is required in productive and reproductive life, including shared responsibilities for the care and nurturing of children and maintenance of the household. In all parts of the world, women are facing threats to their lives, health and well-being as a result of being overburdened with work and of their lack of power and influence. ..The power relations that impede women's attainment of healthy and fulfilling lives operate at many levels of society, from the most personal to the highly public. Achieving change requires policy and programme actions that will improve women's access to secure livelihoods and economic resources, alleviate the extreme responsibilities with regard to household, remove legal impediments to their participation in public life, and raise society's awareness through effective programmes of education and mass communication. In addition, improving the status of women also enhances their decision-making capacity at all levels, in all spheres of life, especially in the area of sexuality and reproduction..." (ICPD 4.1)

All countries should make greater efforts to promulgate, implement and enforce national laws and international conventions to which they are party, such as the Convention on the Elimination of All Forms of Discrimination against Women ... and to implement fully the Declaration on the Elimination of Violence Against Women ... Countries are urged to sign, ratify and implement all existing agreements that promote women's rights. (ICPD 4.5)

"Countries should act to empower women and should take steps to eliminate inequalities between men and women as soon as possible by: a) Establishing mechanisms for women's equal participation and equitable representation at all levels of the political process and public life in each community and society and enabling women to articulate their concerns and needs; b) Promoting the fulfilment of women's potential through education, skill development and employment, giving paramount importance to the elimination of poverty, illiteracy and ill health among women; c) Eliminating all practices that discriminate against women; assisting women to establish and realize their rights, including those that relate to reproductive and sexual health; d) Adopting appropriate measures to improve women's ability to earn income beyond traditional occupations, achieve economic self-reliance, and ensure women's equal access to the labour market and social security systems; e) Eliminating violence against women; f) Eliminating discriminatory practices by employers against women, such as those based on proof of contraceptive use or pregnancy status; g) Making it possible, through laws, regulations and other appropriate measures, for women to combine the roles of child-bearing, breast-feeding and child-rearing with participation in the work-force". (ICPD 4.4)

# Empowerment: Three Approaches

"Three experimental approaches to empowering women have been undertaken in South Asia: integrated development, economic empowerment, and consciousness-raising. While these approaches differ from each other in concept, most organizations working on the ground take a mix of approaches. Common to all three is the importance placed on group formation to build solidarity among women.

The *integrated development approach* views women's development as key to the advancement of family and community. It therefore provides a package of interventions to alleviate poverty, meet basic survival needs, reduce gender discrimination, and help women gain self-esteem. This approach proceeds either by forming women's collectives that engage in development activities and tackle social problems such as dowry, child marriage and male alcoholism, ... or by employing an 'entry point' strategy, pursuing a specific activity, such as a literacy class or health programme, to mobilise women into groups.

The *economic empowerment* approach attributes women's subordination to lack of economic power. It focuses on improving women's control over material resources and strengthening women's economic security. Groups are formed using two methods: organising women around savings and credit, income generation, or skill training activities; or by occupation or location. These groups may work in a range of areas, including savings and credit, training and skills development, new technologies or marketing, as well as provide such ancillary supports as child care, health services, literacy programmes, and legal education and aid.

The *consciousness-raising* approach asserts that women's empowerment requires awareness of the complex factors causing women's subordination. This approach organises women into collectives that tackle the sources of subordination. Education is central and is defined as a process of learning that leads to new consciousness, self-worth, societal and gender analysis, and access to skills and information. In this approach, the groups themselves determine their priorities. Women's knowledge of their own bodies and ability to control reproduction are also considered vital. The long-term goal is for the women's groups to be independent of the initiating NGO. This approach uses no particular service 'entry point' and attempts to be open-ended and non-directive. It gives considerable emphasis to fielding 'change agents' who are trained to catalyse women's thinking without determining the directions in which a particular group may go."

Source: Batliwala, S., 'The meaning of women's empowerment: new concepts from action'. In Sen, G., Germain, A. and Chen, L., (eds.) *Population Policies Reconsidered: Health, Empowerment and Rights*, Boston, Harvard University Press, 1994:127-138

continued from previous page...Empowerment: Three Approaches

# Questions for discussion

1. To what extent do each of these approaches aim to meet women's needs in their daily lives, and to what extent do they attempt to improve women's status in society? To what extent do they challenge inequality between women and men?
2. Can economic empowerment facilitate gender equality in general? For example, do women who own their own land, or earn and control their own incomes necessarily have sexual and reproductive rights?
3. Can consciousness raising alone facilitate gender equality in general? For example, can women who are confident of their own right to control their sexuality always do so? Can women who are confident that they have the right to choose if and when to have children always do so? If not, why not? What other factors need to be addressed?
4. Consider how your organisation approaches the question of women's empowerment.
5. What specific steps does it take in its programmes?
6. What approach does it take? Integrated development? Economic empowerment? Consciousness-raising? How?
7. Does your organisation's approach adequately promote women's ability to function as equals in society? If so, how?
8. Does it specifically promote women's right to make decisions about reproduction and sexuality? If so, how?
9. Does it recognise that women should drive their own processes? If so, how?
10. Does it build men's understanding of and commitment to women's equality and empowerment?
11. What else could it do?
12. Do donor goals conflict with the processes, time and investment required of an 'empowerment' approach? How?
13. Do their relationships with government (politicians or health officials) contradict their goals in relation to supporting the ability of women to mobilise for change? How?


# Activity 4

## Human rights, gender equality and quality of care


**30 minutes**

## Why do this activity?

Gender, human rights and service quality

This activity gets participants to think about and debate the concepts of gender, human rights and service quality. Participants have to take a stand about a reproductive health issue. Frequently people working in the health field are not familiar with the concepts of gender equality or human rights. Usually they are more confident about quality of care. By exploring these in a game format they begin to understand how the concepts apply to their own area of work. The activity clarifies positions on these issues but most importantly the inter-linkages are demonstrated. In particular, gender equality is a human right. It is helpful for people to tease out how human rights, aside from gender equity and equality, intersect with gender considerations. This activity is a lot of fun and people have to get up and move around and argue. From this point of view the exercise is also an energiser.

## Objectives

- to identify the inter-linkages between gender relations, human rights and service quality

## How to do this activity[1]

### Step 1: 20 minutes

Find an open space to do this – either an empty space in a room or go outside. Write 'Gender', 'Human Rights' and 'Quality of Care' in large print on three flipchart sheets. Mark three areas in the room. Either place these labels on three walls or you can place the labels on the floor. Ask all the participants to stand in the centre of the space. Say to participants that NGOs often have to

[1] Adapted from PATH, 'Take a stand', *Interpersonal Communication and Counseling: a Training-of-Trainers' Curriculum*, Washington, DC, PATH, 1995.

deal with the following problem which undermines sexual and reproductive rights and health. Tell them that you have marked three areas and show them where they are. Tell them you are going to read a statement about a problem and they must move to one of the three areas depending on if they think the issue that the statement brings up is a gender issue, a human rights issue or a quality of care issue. Once you have read the statement ensure all people move to one spot or another; tell them they have to TAKE A STAND.

Once they have moved ask someone from one spot to explain why they are standing where they are, then ask a member of another group. Thus you allow participants to explain their position. You may find that some debate develops. Allow this to go on for a bit. Then say, 'let's look at another issue' and read another statement. Again ensure everyone moves, then begin the discussion again. Suggest that if people are convinced by an argument, they move to join another group. Again, do not let it go on too long and move on to another statement. You can go on as long as you like. It is good to stop the exercise when it is still fun.

The point that needs to come out is that frequently all the issues are actually of concern. There are inter-linkages between them; addressing gender equality is a human rights issue and will often lead to better quality services.

Some people are not comfortable with human rights or with gender equality but may in fact be arguing for abortion services (for example) from a quality of care point of view. If you have groups who are working in advocacy it is worth pointing out that it can be strategic at some points to call something a quality of care issue, even if it is at heart a human rights and gender equality issue because it may allow more people to support a particular change in service composition.

Below are some statements that have been used in this exercise as well as the points that may come up in relation to each statement. This is included to give you ideas about how to use this exercise. You may want to develop your own statements that are appropriate to local circumstances. It is a good idea when you are preparing statements that you have an idea about how to stimulate discussion. You can do this by having questions ready that will challenge a point of view. The statements below have been annotated to assist you in preparing.

Before each statement say 'Is the following action a problem of gender inequality, poor quality of care, or a human rights violation?'

## Possible statements:

- Providing only Depo Provera (long acting injectable hormonal contraceptives) for poor people;
- Excluding pregnant girls from school;
- Requiring parental permission before issuing contraceptives to girls;
- Promoting condoms only as other methods of contraception do not protect against HIV infection;
- Paying dowry;
- Providing maternal health services only where there is a hospital which can do Caesarean sections;

- Not providing services for domestic violence because it is a private issue to be discussed within families only;
- Not providing post-abortion care.

### Step 2: 10 minutes

Overhead

At the end of the session put up the overhead to show the linkages and use an example from the debate during 'step 1' to illustrate the linkages.

Note to facilitator

## Arguments which may come up with some statements:

- **Exclusive promotion of Depo Provera (long acting injectable hormonal contraceptives) for poor people**

  People saying it is a 'quality of care' issue may argue: a fundamental of quality of care is choice to suit individual health needs – only one method does not offer any choice. People saying 'human rights' may argue: this assumes that poor people should not have a method that can fail, it says they cannot control their own lives and medical technology should control them; or poor people have the same rights as any others, they too should have a choice of methods. People saying 'gender' may argue: this specifically denies poor women a choice. It discriminates against women. It uses women's bodies as a site of national policy action rather than allowing women to take control over their bodies themselves.

- **Excluding pregnant girls from school**

  This is not a health service issue and hence people are unlikely to identify 'quality of care'. However, people may argue that better quality of care would mean health services are more accessible to teenagers which would make them less likely to get pregnant in the first place. People saying 'human rights' may argue: all people have the right to schooling. People saying 'gender' may argue: this discriminates specifically against girls; girls do not get pregnant alone, there is a man involved and he is not bearing any consequences. Or they may say that denying schooling to pregnant girls is part of the overall ideology that girls are not supposed to get ahead in life – that education for girls is not important.

- **Requiring parental permission before issuing contraceptives to girls**

  People saying it is a 'quality of care' issue may argue: the responsibility of health services is to make sure there are no contra indications to any method, give complete information and make sure it is understood, and then let the patient decide. Informed choice is all that is required. Good quality services respect individuals' confidentiality. Each patient should have their needs met and denying contraception to a girl may have negative health consequences. People saying 'human rights' may argue: each individual has the right to control their own bodies. People saying 'gender' may argue: the consequences of unwanted pregnancy are borne by women; young girls often suffer by being excluded from school, ostracised by family members and/or society. Not giving contraception to girls will disadvantage girls particularly. Parents may not understand this and if you put parental needs and desires above a young girl's then

you will perpetuate discrimination against girls.

- **Promoting condoms only as other methods of contraception do not protect against HIV infection**

  People saying it is a 'gender' issue may argue that 'promoting condoms only as method of contraception' limits women's ability to control their bodies as condoms are a male controlled method. They may argue that the fact that there are no accessible methods, controlled by women, currently available to protect against both pregnancy and HIV, reflects gender discrimination in terms of priority given to technology research.

  People saying 'human rights' may argue that everyone deserves to be fully informed but after that they can make up their own minds; someone else should not decide for them.

  People saying 'quality of care' may argue that one of the cornerstones of quality services is choice; fully informed choice and range of methods to choose from, would require more than the promotion of condoms only.

- **Paying dowry**

  People saying it is a 'gender' issue may argue that it promotes social norms within a marriage that values girls less. It also perpetuates preference for sons as parents do not have to pay dowry for sons.

  People saying that this is a 'human rights' issue may argue that a dowry payment treats girls as commodities and promotes marriage as an institution where women cannot make their own decisions about themselves and their bodies.

  This is not a health service issue, but the low status of women in society makes women more vulnerable to illnesses and limits their access to health care.

- **Providing maternal health services only where there is a hospital which can do caesarian sections**

  People saying it is a 'quality of care' issue may argue that availability of caesarean sections means providing emergency care and this improves quality. However access to maternal services will be very limited.

  People saying it is a 'gender' issue may argue that it becomes very difficult for a woman to have her regular antenatal care visits if she has no money or time to go to hospital and no support from her husband.

- **Providing services for domestic violence is not possible as it is a private issue and discussed only in the families**

  People saying it is a 'human rights' issue may argue that everyone should be free from coercion and violence, and it is a basic human right to have a service when the person needs one.

  People saying this is a 'gender' issue may argue that domestic violence is due to lack of mutual respect and unequal power relationship between man and woman. Not having services perpetuates the silence about this issue.

  People saying it is a 'quality of care' issue may argue that 'comprehen-

sive services' means including all services that people will need.

- **Not providing post abortion care**

  People saying it is a 'quality of care' issue may argue that not providing this service means that comprehensive care is not provided.

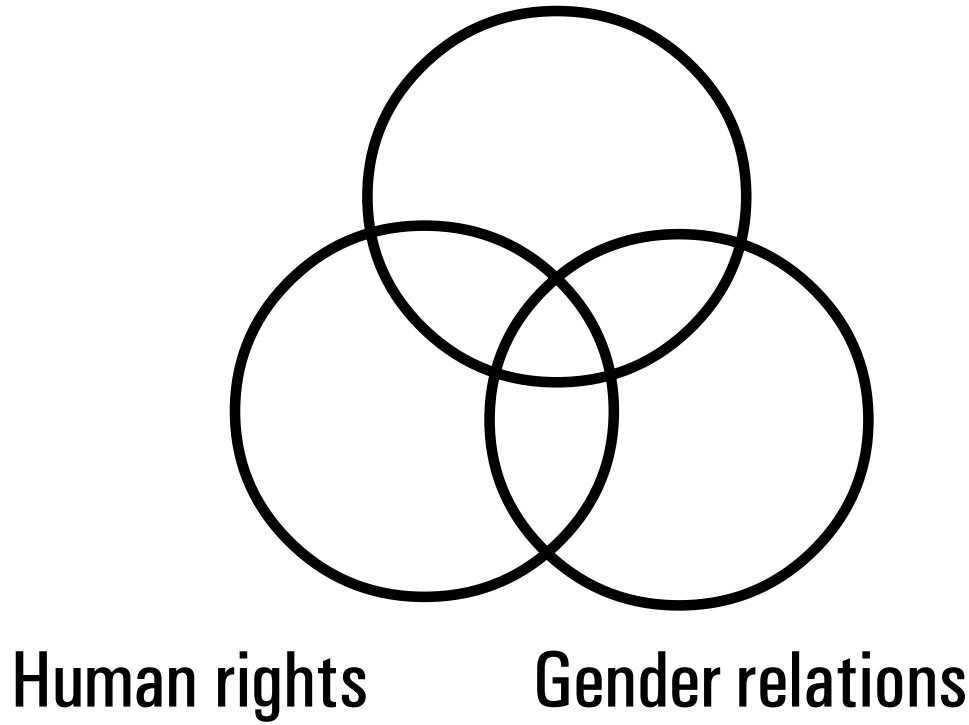
  People saying this is a 'human rights' issue may argue that it is the right of a person to have comprehensive and good quality care.

  People saying this is a gender issue may argue that this discriminates against women. As only women can get pregnant and have abortions only they are at risk of possible complecations. Abortions often result from gender inequalities. Not providing this service means that health services fail to meet gendered needs.


- Flipchart.
- Felt-tip pens.


- Overhead: Overlapping of gender, human rights and quality of care

Human rights, gender equality and quality of care



# MODULE 4



## PROMOTING EQUITY IN PROGRAMMING

## Module objectives:

- To understand the impact of gender relations on health seeking behaviour and health services
- To explore how a gender equity and rights approach can be incorporated into sexual and reproductive health programming
- To re-evaluate your own programmes

## Why this module?

ICDP programme of action

The concepts in the ICPD Programme of Action (POA) provide guidelines on what needs to be achieved. However, implementation is complex. This module attempts to translate the theory into practice. The module reviews reproductive health programmes, building on an understanding of the impact of socially ascribed roles and responsibilities on health, health seeking behaviour and health service provision. Specifically it asks if reproductive health programmes are promoting some of the main components of ICPD, those components that made it different from previous reproductive health initiatives. Thus it asks:

ICDP components

- Is programming promoting gender equity?
- Is programming promoting human rights?
- What constitutes comprehensive services and are we providing them?
- Is a life-cycle approach used?

The module has seven exercises that raise questions about how to incorporate concerns about rights and gender equity into programming. Five of these are general in nature and lay the groundwork for the last two exercises in this training where participants analyse their own IEC messages and reproductive health programmes.

### Activities:

Activity 1: Incorporating social and gender dimensions in health service planning. (2 hours)

Activity 2: What constitutes comprehensive services? (2 hours))

Activity 3: Sexual health. (45 minutes)

Activity 4: Promoting individual behaviour change and health outcomes through programme actions (2 hours)

Activity 5: Men's involvement and responsibilities (45 minutes)

Activity 6: Evaluating IEC messages (2 hours)

Activity 7: Evaluating our RH programme (3 hours)


**12 hours 30 minutes**


# Activity 1

## Incorporating social and gender dimensions in health service planning


**2 hours**

## Why do this activity?

Analysing causes of poor health outcomes

This activity prompts planners of services to explore the broad range of reasons, both social and biological, for poor health outcomes. The activity prompts participants to ask themselves again and again 'why is this happening?' The activity assists participants to break down reasons for poor health outcomes step by step. This allows them to see the causal links leading to specific health problems. Once these are made obvious it is easier to ask if programmes are dealing with a specific health problem in a holistic way. Participants can then reassess programmes and decide if other complementary interventions are possible. While any health problem can be used this activity uses the unmet reproductive health needs of adolescents as this is a frequent problem. Thus the issue of concern for this activity is unwanted adolescent pregnancy. Please note that you could identify another health problem to suit the local situation. For example domestic violence or vesicovaginal fistulae may be common and health services may be attempting to deal with them, so you could apply this same exercise to these issues.

## Objectives

- To understand the social and biological causes of poor health outcomes
- To describe interventions that could address the identified causes of poor health outcomes

## How to do this activity

Small group exercise

This is a small group exercise where participants explore a health problem and develop potential interventions to address the barriers to improved health outcomes. Each group does the same activity. Allow participants to work in groups of about six people. All groups work with the same statement. Give the groups a piece of flipchart paper and some small circles made of card (see materials below).

## Step 1: 45 minutes

Give the group the starting statement - 'A young girl, about 15 years of age, is pregnant. The pregnancy is unplanned and unwanted.'

Note to facilitators

A summary of this statement, - 'unplanned pregnancy' - is written on the bottom left hand corner of the flipchart. The groups then discuss why this is the case. Each argument has to flow directly from the one before.

A group member must write each reason in one of the circles of card and stick it next to the statement - they keep asking 'but why' until the line of arguing is exhausted.

Thereafter they begin again at the original statement and explore another reason why this young girl is pregnant. The groups should use one set of coloured circles to explain one line of argument. When they begin another line of argument they should use another colour. It will then be easy to follow.

Figure 1 presents just a few examples of how the group may develop part of an argument. Note that the links must be clear and comprise only one issue. For example you cannot write 'culture' as this will mean different things to different people. Go around and assist the groups in being explicit. For example, ask them 'what about culture? Is it early age of marriage, is it that women may not initiate discussions about sex?'

Figure 1


Continually go around and assist the groups in developing their arguments. Challenge them to explain what they mean, assist a group that is arguing to develop alternative ideas as different lines of argument.

## Step 2: 45 minutes

**Breaking the chain**

Once groups have developed a composite picture ask them to look at the chains of events they have built and identify places where the chain could be broken by some kind of action. What action could be taken to prevent this problem occurring in future? Table 1 is an illustration of how they may develop such actions. Encourage them to think broadly, not only within the narrow confines of health care services. Again for each possible action the groups should indicate the actions organisations like their own could undertake and those that governments or international agencies can do. The group can either develop a table or they can fill in the actions with arrows on the large sheet of paper.

**Small group work**

Again go from group to group to assist them in developing interventions.

### Table 1: Possible actions

| Problem Identified | Possible remedy that my organisation can do | Possible remedy other actors can undertake |
|---|---|---|
| Sex and conception not discussed in families | ● Educate parents about the importance of preparing children for sexual development and basic sexuality education.<br>● Identify alternatives to home based education.<br>● Set up community groups run by trained educators. Include sexuality education in school curriculum. | Include sexuality education in school curriculum. |
| Not spoken about by girls | ● Give girls information about 'your body' and basic sexuality education.<br>● Give girls training on assertiveness and on building self-confidence. | Promote girls' sense of confidence e.g. adding this to the school curriculum. |
| Not spoken about by boys | ● Give boys information and education on basic sexuality and promote boys' responsibility for their sexual behaviour. | Promote boys' sense of responsibility for sexual behaviour e.g. adding this to school curriculum. |
| No service | Provide adolescent friendly service. | Promote access to health services. Remove legal restrictions on provision of services to adolescents. |
| Health providers do not welcome adolescents | ● Train health providers in both technical skills and in interpersonal relations<br>● About public health consequences of unwanted pregnancy<br>● About patient rights. | Ensure this aspect of training is included in health care providers' training curriculum. |

## Step 3: 30 minutes

**Plenary discussion**

For the last half hour of this session bring everyone together. Ask participants

- If doing this exercise made them think differently in any way and if so how?
- What they thought the point of the session was?

Allow some discussion. Close by saying that this was an introductory exercise which is linking the previous day's work on the ICPD POA, equity and rights to programming.

**Main points**

The point to emphasise at the end of this session is that social as well as medical factors need to be taken into account. Unpacking all the components of a particular health problem may assist in developing a more comprehensive approach. A conventional approach to preventing unwanted pregnancy may be to provide family planning services. However this may not be enough. The example above points to the need to promote girls' self esteem. A young girl or boy may have gone to a service and not been able to get a method of birth control or they may have got a method, say condoms for example, but don't have the confidence to negotiate using them.

Note that this conclusion links to the work done in previous sessions, where participants identified how a range of social factors including gender differences caused health problems and influence people's ability to address those problems. This gender analysis needs to be undertaken when trying to address any health problem. Gender analysis is particularly appropriate in sexual and reproductive health problems since power relations between men and women directly influence sexual and reproductive behaviours.


Work out how many groups you will have. In preparation you need to have:

- One very large sheet of paper from a flip chart per group.
- About 40 circles of coloured cardboard (six cm diameter) per group.
- Something to stick the circles onto the large sheet of paper with.
- A felt-tip pen for each group.


Timyan, J., Griffey Brechin, S. J., Measham, D. M. and Ogunleye, B., 'Access to care: More than a problem of distance.' In Koblinsky M. Timyan J. and Gay J., *The Health of Women. A Global Perspective*. 1993. Westview Press Inc.Boulder. San Francisco and Oxford. 217-234.


# Activity 2

## What constitutes comprehensive services?


**2 hours**

# Why do this exercise?

Meeting changing reproductive health needs

Objective 7.5 c of ICPD, Chapter VII Reproductive Rights and Reproductive Health is: 'To meet the changing reproductive health needs over the life cycle and to do so in ways sensitive to the diversity of circumstances of local communities.' The Actions (7.6) say 'All countries should strive to make accessible through the primary health care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include: family planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breastfeeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available as required.'

Reproductive health needs across the life cycle

Frequently, however, services are single issue, donor funded initiatives, that do not take a life cycle approach. Here we attempt to describe a picture of a woman's life to demonstrate that she has multiple and complex needs that change over time. It allows the group to identify a set of health needs across a woman's life span. Starting from a normal woman's needs, rather than from the ICPD document, participants build this list themselves. This illustrates the logic of how ICPD came up with such a long and comprehensive list.

# Objectives

1. Participants generate a list of services that would be provided for women and men in a comprehensive reproductive health service
2. To show the similarity between this list, generated from the case study

of every day life, and the ICPD document

3. To discuss which of these services are and are not provided in reality
4. To explore reasons why these are not provided
5. To link the contents of this activity to the modules on gender and policy and rights already completed in this course

# How to do this activity

This activity follows these steps: small group work; participants walk around; plenary.

## Step 1: 1 hour 20 minutes

Distribute handout: Case story. Note that here is an option to tailor the material to local circumstances – if this story is not applicable please develop another. Read the story; you can either read the story aloud or get a participant to read it.

Small group work

Divide participants into smaller groups of about 4 people. Give each group cards of both colours (see materials) and ask them to go through the story step by step. They need to identify the various problems and health consequences this woman has encountered in her life. On the cards of one colour they write the problem, one problem per card. They should finish the entire story and generate a pile of health problems. Then they put the story aside. Participants then deal with each problem they have identified one at a time and identify possible interventions (health care interventions, or other interventions that could have an impact on health) that may have either prevented or alleviated the problem identified from the story. There may be more than one intervention for each problem. They should write the interventions on the second set of coloured cards, again one intervention per card. Stress that participants must be very specific when they describe the interventions that are required. For example, they must not write 'reproductive health services', but must indicate exactly what they mean, e.g. prenatal, delivery and post natal services, etc. They must write each intervention on a separate card. Tell participants that they have one hour for this activity. They need to stick the problem cards up and place the interventions that relate to each problem next to the problem card.

## Step 2: 40 minutes

Ask participants to walk around the room and look at the lists and interventions generated by the other groups. At this point participants should ask members of the other groups to explain things that are not clear. The explanations should be written onto the cards. This is another method to force people to be explicit about what interventions they are suggesting. For example a group may have written 'increasing justice' - once prompted they may write rather 'linking rape survivors to para-legal workers'.

Walk around the room with the participants and collect all the intervention cards that are generated, taking only one of each if interventions are repeated.

### Step 3: 40 minutes

As the facilitator you firstly categorise the interventions and secondly discuss which are and are not usually available and why.

During the plenary the facilitator must firstly catagorise the interventions that the groups have generated. To do this the facilitator should literally take similar interventions from each of the boards and group them together, allocating an appropriate heading to the interventions that you have grouped. For example, you may group the interventions as follows:

## Possible grouping of interventions:

### Education interventions

Media on women's health
School-based education on reproductive biology
Posters on maternal health services
IEC on contraception for men and women

### Services for reproductive age group

Pre- and post-natal care and delivery services
Contraception services
Diagnosis and treatment for maternal morbidity e.g. vescico-vaginal fistulae

### Services for all ages

Diagnosis and treatment of sexually transmitted disease
Counselling services

### Social services

Social workers for victims of domestic violence
Paralegal workers

As a facilitator you need to look at what the groups come up with so as to categorise the interventions. Remember that you are trying to illustrate the broad range of services that are required in order to provide comprehensive reproductive health services that deal with the entire life cycle. As you take the interventions and categorise them, explain your reasoning to the group and ensure group consensus. For example, you may say 'Do you agree that all these are services for women of reproductive age?'

Once you have categorised the interventions that the groups have come up with, illustrate to them that these interventions are similar to the ICPD definition of comprehensive reproductive health services. At this point hand out to participants handout: 'ICPD Actions 7.6'. As you may run short of time you can also suggest they read it after the session.

Now move to the second part of this exercise. Go through the categories and ask if each of these categories of care are in fact provided. You should focus on overall categories and also on specific services within categories. To guide you, here are some of the issues that may come up in discussion.

## Categories that may not be provided:

### Services for older women.

When you ask the group why this is so, they may come up with the following reasons:

- women are only valued as child bearers, therefore health services are

available to assist them in having children only, after which they are not catered for;

- older women are not in positions where policy or service delivery issues are decided upon, therefore their health concerns are not thought about;
- menopause is stigmatized so people cannot raise the issue;
- resources are limited so choices have to be made, valuing women as mothers may mean money is not spent on older women;
- donors are not interested in older women.

### Services for violence against women.

When you ask the group why this is so, they may come up with the following reasons:

- services are often biomedical in nature and do not include psychosocial issues;
- donors give money for biomedical services;
- providers are not trained in how to deal with this issue;
- discussing domestic violence is taboo, no-one will bring this issue up;
- service providers themselves may be victims of violence, and avoid the issue;
- talking about violence will bring up issues of women's rights, this can be difficult.

## Within categories certain services may be left out:

### Within services for the reproductive age group, frequently services for complications of pregnancy (like vescico-vaginal fistulae) are not included.

When you ask the group why this is so, they may come up with the following reasons:

- governments/donors are interested only in child health services so MCH services look at children's health and not women's health;
- international agencies only measure maternal and child mortality and not morbidity so maternal morbidity is a hidden issue;
- talking about 'private things' like urine leaking or being smelly is too difficult, so this issue is not raised.

### In some countries lots of money goes into family planning but not into maternal health services.

When you ask the group why this is so, they may come up with the following reasons:

- government population policy determines what services are financed and individual women's rights and needs are put lower on the agenda than demographic goals;
- donor funding may determine what is available.

It is at this point that you should draw out the linkage between the modules on gender (e.g. women are valued mainly as mothers), policy and rights (e.g. wanting to decrease population size rather than meet women's needs) and show how an understanding of the content covered in the previous modules of this training manual can impact on the health and health services provided

for the population.

It would be useful to gather data for your country to illustrate some of these issues. For example you may want to make a table on the maternal mortality rate, access to family planning services compared to access to delivery services etc. Prepare an overhead with these data or prepare it as a handout for participants.

Main points

The aim of this exercise is to illustrate the concept of comprehensive services, namely that providing services that prevent pregnancy and those that deal with pregnancy are only one part of reproductive health services. Women and men have a range of needs and therefore require a range of services. Given their limited time and resources, all services should be available to women and men at one time by one provider. This applies not only to reproductive services but to all primary health care services.


- Prepare cardboard cards about 10cm wide and 4cm in length – 2 different colours.
- Each group needs a set of cards in two colours, about 10 cards in one colour and 20 cards in another colour.
- Something to stick the cards to the wall with, some for each group.
- Copies of Handout for each person.


'Life Cycle Approach', *Sexual and Reproductive Health briefing cards*. Family Care International.


- Handout: Case Story
- Handout: ICDP Platform of Action 7.6

# Case story

## My name is Sahiba and this is my story.

I am the third girl child in my family. My parents were hoping that at least this time it would be a boy. I do not remember much regarding my childhood except that I was always busy helping my mother and looking after my younger siblings. I grew up quite a weak child. The worker at the anganwadi (crèche) used to tell our mothers to breastfeed the girls as much as the boys.

I was put in our village school. I liked going there. But there were some days when the work at home was too much and I had to stay. I was a bright student. When I completed my primary school, the principal came over to my home and told my parents that I should be sent to the secondary school, which was 10kms away. My father said that would be impossible as it was too far and anyway it was pointless to 'water someone else's garden'.

One day I discovered blood stains. I hid it from everyone, as I was scared. My grandmother found out. Suddenly there seemed to be a lot of discussion regarding my marriage, just like it happened to my older sisters. I was married to a man three times my age, as the dowry was more affordable. Within our first year I fell pregnant, but it was stillborn. My husband beat me for killing a boy child, and for not paying enough in my dowry. When I fell pregnant I prayed for a safe delivery. The daai (midwife) was there at the time of delivery. I have a vague recollection of what happened ..... I was rushed by bus....admitted into hospital..... lost a lot of blood..... was very painful. After that pregnancy whenever I laughed or coughed I leaked and it was always a problem, I was worried about the smell of urine. This has been a problem all my life. The doctor said that with more babies this would become worse and so it has. As the child was a girl there was no way I could not have more children. People were happy for the girl baby, but said that it is time now for a boy. The beatings continued even when I fell pregnant. I was growing thinner and thinner. When I took the child for immunisation, the sister would say that I should use a contraceptive. But I was scared.... My husband would not approve.. and certainly not my mother-in-law. It took many years to become pregnant again and it was only after another woman spoke about treatment for the smelly discharge that I asked to go to the clinic where I got tablets to drink. After that my husband would come more often to me and I had more children.

Now I am much older - a bit weak but still able to work in the fields. One day I noticed that my monthly bleeding was irregular and weak. A women who I worked with on the fields, said that her neighbour had recently died of the same problem, as the blood when it stopped went into her brains. I just did not know what to do and whom to speak to. I knew that the blood was in my head because of the times that I felt so hot in the face and would sweat. I was terrified. One day the sister came and gave a talk about our bodies and illnesses. There are so many things I did not know!!!! My life is over, but I hope that my children grow up strong and educated - This is what I pray for every day.

# ICPD Platform of Action 7.6

"All countries should strive to make accessible through the primary health care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include: family planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available as required."


# Activity 3

## Sexual Health Services


**45 minutes**

## Why do this activity?

Safe sex

ICPD notes that 'Reproductive health implies that people are able to have a safe and satisfying sex life' (Para 7.2). Thus sex should not put one at risk of violence or physical harm, including risk of contracting diseases or of more long-term consequences that may threaten physical and mental health, such as unwanted pregnancy. The issue of safety is increasingly relevant, as the world faces the AIDS pandemic. Increasingly the notion of safe sex is being addressed but it is often limited to preventing the transmission of disease. It should go further than this and include issues such as coerced sex as well. High rates of sexual violence, whether incest or rape, as well as the AIDS epidemic, put the question of sexual rights and health squarely on the agenda.

Sexual satisfaction

Sexual satisfaction, however, is seldom addressed. Social institutions usually avoid acknowledging that sexuality is one of the fundamental aspects of human experience. Yet there are many dimensions of sexual relations which give rise to health problems. Poor sexual experience may result due to a lack of information about anatomy and sexual response, or as a result of lack of skills in communicating with one's partner about sexual matters. While poor sexual experience may not be considered a 'health' problem, the lack of self-esteem which can arise from this frequently undermines individuals' confidence and ability to fulfil their full potential. From the perspective of the World Health Organisation, which defines health as a state of complete physical, mental and spiritual wellbeing, lack of sexual responsiveness and satisfaction would contribute to lack of overall wellbeing.

Sex-related health issues

However, public health services seldom recognise the importance of addressing sex-related health issues, focusing rather on reproductive issues. This session attempts to help participants identify what sorts of health services are necessary in order to address sex-related health problems.

## Objectives

- To understand that achieving sexual health requires programming activities that are different from services related to contraception and maternal health
- To identify the range of possible services that may be required to promote sexual health

# How to do the activity

## Step 1: 15 minutes

**Small group work**

Divide participants into groups of 3 or 4. Give each group a scenario – see examples in Handout: Events which require health services. You can give each group one of the scenarios. Ask them to identify what sorts of health service and information this person would need. If you have more groups than scenarios some groups can use the same scenario – see if groups come up with different ideas.

## Step 2: 20 minutes

**Plenary discussion**

Bring the groups back to plenary. Ask each group first to read the description of their person to the plenary. Then ask them to list what specific health services they identified that this person needs. Write down these services on a flipchart. As each group adds service needs, you add these to your list. Also write down who these services should be targeting.

### In the end, your plenary discussion may cover some of the following issues:

| Services Needed | Target of these services often not considered in conventional services | What may be required to make such services available |
|---|---|---|
| Identification and treatment of sexually transmitted diseases | Young unmarried people<br>Widows<br>Children<br>Men | Sensitise health workers that all people can be sexually active.<br>Sensitise providers to issues of child abuse.<br>Ensure privacy at services. |
| Counselling and referral for people involved in sexual abuse | Women<br>Children<br>Offenders of sexual violence | Set up networks to allow for referral.<br>Make contact with police, legal aid, etc. |
| Education on sex, sexual arousal and sexual health | Men<br>Women<br>Youth | Training for staff.<br>Network with other organisations who can do this. |

Note that what you discuss will depend on the scenarios you use. As with all aspects of this module you should make sure the scenarios are appropriate to your local situation.

Show the group that these services are all needed in order to address health problems related to sex and sexuality. They are known as 'sexual health services'. Make clear that such services should be available at any health centre, not as separate services but as part of the range of services available to any individual when they visit a health centre. You can also point out that such services are necessary at all stages of the life-cycle, not only during the reproductive years. This is why focusing on reproductive health alone is not enough. Sexual health needs to be addressed in its own right, amongst people of all ages.

### Step 3: 10 minutes

**Handout**

Give participants Handout: ICPD and FWCW on sexual health and related services. Read them the paragraphs.

**Plenary discussion**

Ask participants whether the services they have listed are available in their community. Ask what could be done to improve access to sexual health services.

Write up their answers on a flipchart.


- Flipchart.
- Felt-tip pens.
- Copies of Handouts for each person.


HERA, 'Sexual health', *Women's Sexual and Reproductive Rights and Health Action Sheets*, New York, Health, Empowerment Rights and Accountability, 1998.


- Handout: Events which require sexual health services
- Handout: ICPD and FWCW on sexual health and related services

# Events which require sexual health services

NOTE TO FACILITATOR: Each group gets only one of the scenarios below.

## Scenario 1:

You are a male sex worker. You always use a condom. Last night your client assaulted you and had sex with you without a condom. You are afraid that you may have contracted a sexually transmitted disease. In your community, there is a clinic. It offers family planning to married women. It also offers immunisation for children. In addition, people come to the clinic with health problems such as diarrhoea and 'flu.

- Will the clinic meet your needs?
- What specific services do you need?

## Scenario 2:

You are a nine year old girl. Your uncle came to live with your family two months ago. From when he arrived, he would try to touch your breasts whenever your family members were not in the room. Yesterday evening you were in the fields picking apples. Your uncle came up to you and tried to rape you. You ran away. In your community, there is a clinic. It offers family planning to married women. It also offers immunisation for children. In addition, people come to the clinic with health problems such as diarrhoea and 'flu.

- Will the clinic meet your needs?
- What specific services do you need?

## Scenario 3:

You are a fifty two year old woman. Your husband is a migrant worker. You know that he has a few girlfriends in the city where he works. You have heard on the radio about AIDS and you are afraid that your husband might have AIDS because he has many partners. You don't know what to do. In your community, there is a clinic. It offers family planning to married women. It also offers immunisation for children. In addition, people come to the clinic with health problems such as diarrhoea and 'flu.

- Will the clinic meet your needs?
- What specific services do you need?

## Scenario 4:

You are a man of 35, married with 2 children. Since the birth of your second child you have noticed that your wife often makes excuses when you want to have sex. You have come to realise that she only valued sex because it would result in her having children. Now she has finished her family she sees no need for sex. While sex is enjoyable for you it seems not to be enjoyable for her. You know that it could be enjoyable for both of you but you do not know how to achieve this. You want to overcome this problem. In your community there is a clinic. It offers family planning to married women. It also offers immunisation for children. In addition, people come to the clinic with health problems such as diarrhoea and 'flu.

- Will the clinic meet your needs?
- What specific services do you need?

## Scenario 5:

You are a boy, actually a young man. All the boys talk about how men have sex. You do not know much about sex, except what you have seen on the TV. You also know that people talk about AIDS. You want to be a man. In your community there is a clinic. It offers family planning to married women. It also offers immunisation for children. In addition, people come to the clinic with health problems such as diarrhoea and 'flu.

- Will the clinic meet your needs?
- What specific services do you need?

# ICPD and FWCW on sexual health and related services

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.' (ICPD part of 7.2).

'Programmes to reduce the spread of HIV infection should give high priority to information, education and communication campaigns to raise awareness and emphasise behavioural change. Sex education and information should be provided to both those infected and those not infected, and especially to adolescents. Health providers ... need training in counselling on sexually transmitted diseases and HIV infection, including the assessment and identification of high-risk behaviours needing special attention and services; training in the promotion of safe and responsible sexual behaviour, including voluntary abstinence, and condom use; training in the avoidance of contaminated equipment and blood products; and in the avoidance of sharing needles among injecting drug users. Governments should develop guidelines and counselling services on AIDS and sexually transmitted disease within the primary health-care services. Wherever possible, reproductive health programmes, including family-planning programmes, should include facilities for the diagnosis and treatment of common sexually transmitted diseases, including reproductive tract infection, recognising that many sexually transmitted diseases increase the risk of HIV transmission. The links between the prevention of HIV infection and prevention and treatment of tuberculosis should be assured.' (ICPD para 8.31).

'Ensure that policies, strategic plans, and all aspects of the implementation of reproductive and sexual health services respect all human rights, including the right to development, and that such services meet health needs over the life cycle, including the needs of adolescents, address inequities and inequalities due to poverty, gender and other factors and ensure equity of access to information and services'. (ICPD, five year review, 52b)

'Provide-well-funded shelters and relief support for girls and women subjected to violence, as well as medical, psychological and other counselling services and free or low-cost legal aid, where it is needed, as well as appropriate assistance to enable them to find a means of subsistence'. (FWCW 125a)

'Develop counselling, healing and support programmes for girls, adolescents and young women who have been involved in abusive relationships, particularly those who live in homes or institutions where abuse occurs'. (126 c)

Note that the above paragraphs are those which relate most closely to health services. Both documents contain a wider range of commitments for government and community action on both AIDS and violence against women.


# Activity 4

## Promoting individual behaviour change and positive health outcomes through programme actions


**2 hours**

## Why do this exercise?

Understanding factors facilitating individual health choices

Usually behaviours that improve health rely on individuals making healthy choices. Simply providing information, for example, 'smoking causes cancer' or 'having unprotected sex puts you at risk of infection with the human immunodeficiency virus' is not enough. Information is only one part of what is required. Facilitating factors can assist individuals in making healthy choices. Thus programmes that also makes condoms available, or policies that make cigarettes expensive or forbid the sale of cigarettes to minors also put in place conditions that assist people to use the information they have to make healthy choices. In this exercise a range of possible interventions to promote sexual health are explored with a special emphasis on rights. In the first days of this course participants were introduced to the concept of rights. This exercise explores how this concept can be operationalised. What practical actions, at service level, can be undertaken to promote a rights perspective? This exercise is built from the results of a research project on unwanted pregnancy. During this research youth (both boys and girls) generated a list of actions that they could take to prevent unwanted pregnancies. The list of actions is presented in the handout below 'Matching outcomes and actions'. Participants are given a table of 'actions' that can be taken in response to a set of problems - I do not want to have a baby at this time in my life; I am afraid that I am pregnant / that my partner is pregnant; I have / my girlfriend (wife) has missed a period and we do not want a child. In the column a set of possible desirable actions are presented which could be followed by either a man or a woman to address this problem. It is likely that for many people the usual response to this kind of problem is to take no action. In this exercise we aim at prompting programme planners to imagine how to develop an intervention that will motivate appropriate action in relation to unwanted pregnancies.

Operationalising the concept of rights

Facilitating appropriate actions

## Objectives

- To understand the range of actions, besides those that deal with biomedical issues, that are required to address reproductive health
- To identify what is required to build a supportive environment in

reproductive health services in order to assist people to make healthy choices

# How to do this exercise

## Step 1: 30 minutes

Handout

Distribute Handout: Matching outcomes and actions to participants.

Ask participants to look at the table and list in the empty box the kind of programme actions that are required which would assist youth to make the decisions to behave in the way described. Encourage participants to develop a detailed list of what programmes need to do in order to achieve the desired behaviour. If people would prefer to work in groups of two or three then work like that.

## Step 2: 1 hour 30 minutes

After individuals have completed the table go round the room and one by one ask participants to describe an aspect of a programme intervention that they have come up with. They should not repeat what someone else has said but rather add to the list.

Plenary discussion

As people add ideas, write them on the flipchart, grouping them into categories. The kind of categories that are likely to come up are: health education; services that are youth friendly; health services (e.g. family planning, abortion, pregnancy testing); community-based distribution; programmes to promote male responsibility; youth assertiveness training; school-based education, etc. Here is an example of how a completed handout may look.

| Behavior: Use contraceptives | |
|---|---|
| **Project activities aimed at men/boys** | **Project activities aimed at women/girls** |
| Have services where men feel welcome.<br>Ensure privacy.<br>Train staff to be welcoming.<br>Have condoms easily available.<br>Have community-based distribution programmes with male staff.<br>Community-based programmes for fathers to encourage them to talk to their children about sex.<br>Engage people of influence (e.g. religious leaders) to promote sex education.<br>Sex education in schools. | Have services where women feel welcome.<br>Ensure privacy.<br>Train staff to be welcoming.<br>Have community-based distribution of contraceptives, with young as well as older staff.<br>Community-based programmes for mothers to encourage them to talk to their children about sex.<br>Engage people of influence (e.g. religious leaders) to promote sex education.<br>Sex education in schools. |

| Behaviour: Negotiate contraceptive use during sex | |
|---|---|
| **Project activities aimed at men/boys** | **Project activities aimed at women/girls** |
| Promote the idea that both partners are responsible for the outcome of sexual activity.<br>Always give condoms to men when treating sexually transmitted diseases.<br>Ensure men have access to the number and causes of maternal mortality, e.g. get local opinion leaders or community radio to disseminate this information when men will be listening.<br>Run community programmes which include information on women's rights to control their own bodies.<br>Get a role model (e.g. local sports star) to talk about using condoms. | Promote the idea that both partners are responsible for the outcome of sexual activity.<br>Give condoms to women and girls at health services; this will promote the idea that women too may initiate discussion about condom use.<br>Provide complete privacy so that those women who have to hide the fact that they are using contraceptives can do so.<br>Run community programmes which include information on women's rights to control their own bodies.<br>Get a local role model (e.g. TV personality) to talk about using condoms/contraception. |

Once everyone has contributed ask the group if they agree with the categories you have generated. Ask them if all are needed or if you could just provide one and not the others. Discuss what the implications would be if this happens. For example, what will happen if there is health education but no services, or if there are services and no education, or if there are services but youth or boys or single girls do not feel comfortable using them.

Main point

At the end of the exercise ask the group to say what they think the most important point about this exercise is. Explain where rights fit in – that the right to control your own body requires certain conditions – knowledge, services and a conducive environment. This conducive environment includes: services where you can ask questions and not feel judged; relationships where partners can talk freely to each other and decide jointly what to do, whether to have sex or not, whether to use contraceptives or not and what action to take in case of an unplanned pregnancy. A conducive environment would also include, for example, general societal acceptance of the notion that both men and women are equally responsible for a pregnancy; often it is people of influence such as religious leaders, politicians, influential NGOs etc. who are able to influence popular opinion.


- Flipchart paper.
- Felt-tip pens.
- Copies of Handout for each person.


Lauglo, M., 'Gender, Reproductive Health and Reproductive Rights'. Paper prepared for the WBI Core Course. World Bank Institute, Washington D.C. (unpublished) 1999.

Nutbeam, D., 'Evaluating health promotion – progress, problems and solutions.' *Health Promotion International* 1998 Vol. 13 no.1 27- 44

Welbourn, A., 'Gender, sex and HIV: How to address issues that no-one wants to hear about.' In Preiswerk, Y. (ed.) *Tant qu'on la sante. Comission nationale suisse pour L'UNESCO*, Berne 1999. 195-227.


- Handout: Matching outcomes and actions

# Matching outcomes and actions

Here is a scenario: a couple does not want to have a child at this time and want to either prevent an unwanted pregnancy or take action to deal with an unwanted pregnancy. There are actions that they could take in such a situation. You have a reproductive health project which aims to increase men and women's reproductive health by ensuring that they adopt healthy respectful behaviours in relation to reproductive choices. Taking just 2 behaviours that couples could adopt, please list ALL the project components that could promote this.

| Behaviour: Use contraceptives | |
|---|---|
| Project activities aimed at men/boys | Project activities aimed at women/girls |
| | |

| Behaviour: Negotiate contraceptive use during sex | |
|---|---|
| Project activities aimed at men/boys | Project activities aimed at women/girls |
| | |


# Activity 5

## Men's involvement and responsibility


**45 minutes**

## Why do this activity?

Addressing gender inequality

During the 1990s, addressing gender inequality became central to the activities of many governments, development agencies and NGOs. There were two broad approaches. Firstly, in some cases agencies were motivated by the desire to ensure that an initiative was effective – ignoring women might limit the impact of an initiative. For example, an initiative in agriculture would not succeed in a specific community if it did not take account of the fact that women were responsible for planting, weeding, etc. Therefore women needed to participate in any decision-making and skills training around these activities. This approach argued that all activities should ensure women's equal participation. However, this approach did not question women's overall position in society. It did not attempt to change policies and programmes in order to challenge gender norms - that is, women's unequal status and lesser access to and control over resources.

Women participate in activities

Women benefit equally from activities

Secondly, another and more recent approach has been to say that one cannot ignore women since social justice must be central to any development initiative. Social justice demands that any initiative aims to improve women's overall position in society – how society values women and their access to and control over resources. For example, within this approach an agricultural project would involve both men and women in changing inheritance and land ownership rules so that women could also own land. It would also work to ensure that women controlled any profits made from their agricultural work, rather than all profits being taken by men.

Implications for men

These two positions have different implications regarding men. The first position means that both men and women should be involved in activities. The second position focuses more on outcome or impact – did any initiative improve women's position in society? In some cases this may mean working with women and men; in some cases with women alone. Whoever the target of the activity, this perspective implies challenging men's power and control over resources.

The ICPD Programme argues for men to take responsibility for their own sexual and reproductive behaviour. To do this requires that men have access to information and services. However, this is not enough. Since it is women's health which is most at risk in relation to reproduction, the 'men's involve-

ment' approach requires men to take actions to ensure that women are able to exercise their sexual and reproductive rights and protect their health. This activity aims to help participants understand the expectations of the ICPD in relation to men, and to consider to what extent men in their own communities are barriers to women's rights and health or actually foster women's rights and health.

# How to do the activity

## Step 1: 25 minutes

Handout

Give out Handout: Maternal health initiative. Divide the participants into groups. Suggest that one person in each group reads the case study aloud.

Small group discussion

The group should then discuss the questions in the handout. Tell the groups that you want them to identify specific examples in relation to the question, 'Are there situations in your community where men's failure to take responsibility endangers women's health?' If so, what are they? You do not want vague answers.

The group should write up their answers to the last question only on a sheet of flip chart paper and stick it up on the wall where they are sitting – the last question is: 'What could be done to build men's sense of responsibility in these cases?'

## Step 2: 5 minutes

Plenary

Give participants 5 minutes to walk around the room and read the findings from each group on the last question.

Handout

Note that the handout on the maternal health initiative does not indicate which country this is. This is because participants often get caught in debating issues specific to that country, rather than the issue intended for the activity. However, once the activity is over, you can tell participants that this handout is about a safe motherhood project in Nepal[1] which was started in April 1997 between the Family Health Service Division of the Department of Health Services in Nepal and DFID, the Department for International Development of the United Kingdom.

## Step 3: 15 minutes

Give participants Handout: Male responsibilities and participation. Suggest that one group member reads each paragraph aloud. After each paragraph the group can briefly discuss their responses to this paragraph. Ask participants if this is being done in their countries, and if it is the law. Your questions should be directed to the actual text in the handout. For example, in relation to paragraph 4.28 you could ask whether there are child support or 'maintenance' laws, and whether these are enforced, so that men have to provide financial support for their children.

Note that this is taken from the Programme of Action of the International Conference on Population and Development. It is the consensus agreed by

[1] Klugman, B., *Gender equality in sexual and reproductive rights and health: A case study of the Department for International Development, United Kingdom.* Report prepared for the Swedish International Development Cooperation Agency for the OECD/DAC Expert Group on Gender Equality and Women's Empowerment, March 1998: 19-20.

countries of the world through the United Nations. For that reason, it is helpful for participants to be aware of the minimum agreements made by their countries to take action to involve men in ensuring not only their own reproductive health, but specifically the reproductive health of women.


- Flipchart paper.
- Felt-tip pens.
- Copies of Handouts for each person.


Berer, M., 'Men', *Reproductive Health Matters,* 1996 (7): 7 – 10.

HERA, 'Men's role and responsibility for sexual and reproductive rights and health', *Women's sexual and reproductive rights and health: Action Sheets*, New York, HERA Secretariat, 1998.


- Handout: Maternal health initiative
- Handout: ICPD: Male responsibilities and participation

# Maternal health initiative

Country x has a maternal mortality rate that is among the highest in the world. This project aims to reduce the maternal mortality rate. The social assessment undertaken to understand the problem identified non-health service potential barriers to the success of any programme to address maternal mortality. These include:

- physical difficulties in getting to district hospitals (length of journey, difficulty of terrain, lack of communal transport facilities etc.);
- negative perceptions of existing health facilities;
- not knowing about the process of childbirth and possible complications, leading to treatment not being sought or being sought too late;
- poverty;
- women not being able to get to or to stay in hospital or take time away from work; low status of women;
- husbands/ families not considering women's health important enough to justify time and expense of her going to hospital.

The project developed in response to this has two components: service provision and user demand. Within the 'user demand – increasing access' component, there are three sections. The first is awareness-raising, including developing materials targeting specific stakeholders, involving local groups performing street theatre for presentation in villages, and developing and showing videos that address emergency obstetric care. The second section is to develop a referral system between the community and the district / zonal hospital through training those already responsible for supporting pregnant women, as well as health workers, in identifying danger signs during pregnancy and childbirth that require immediate referral to hospital. Health care workers in the health post must also be given the basic skills to identify danger signs. The third section is the establishment of an emergency transport system in communities through supporting the current most feasible method of emergency transport – stretchers with bull carts. It will put in place a system of 'call up' whereby a team of individuals (men) can be available at short notice to convey a patient to hospital.

## Discuss the following issues and then answer the question

- In this case, to what extent should men be responsible for ensuring women's access to health services?
- What are the implications for women's health if the men do not carry out this responsibility?
- Should the community take action against a man who fails to carry out this responsibility?
- Are there situations in your community where men's failure to take responsibility endangers women's health? If so, what are they?

## Question for Discussion

1. What could be done to build men's sense of responsibility in these cases?

# ICPD: Male responsibilities and participation*

## Basis for Action

4.24 Changes in both men's and women's knowledge, attitudes and behaviour are necessary conditions for achieving the harmonious partnership of men and women. Men play a key role in bringing about gender equality since, in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of Government. It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life.

## Objective

4.25 The objective is to promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles.

## Actions

4.26 The equal participation of women and men in all areas of family and household responsibilities, including family planning, child-rearing and housework, should be promoted and encouraged by Governments. This should be pursued by means of information, education, communication, employment legislation and by fostering an economically enabling environment, such as family leave for men and women so that they may have more choice regarding the balance of their domestic and public responsibilities.

4.27 Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children.

4.28 Governments should take steps to ensure that children receive appropriate financial support from their parents by, among other measures, enforcing child-support laws. Governments should consider changes in law and policy to ensure men's responsibility to and financial support for their children and families. Such laws and policies should also encourage maintenance or reconstitution of the family unit. The safety of women in abusive relationships should be protected.

4.29. National and community leaders should promote the full involvement of men in family life and the full integration of women in community life. Parents and schools should ensure that attitudes that are respectful of women and girls as equals are instilled in boys from the earliest possible age, along with an understanding of their shared responsibilities in all aspects of a safe, secure and harmonious family life. Relevant programmes to reach boys before they become sexually active are urgently needed.

*Chapter 4c: 'Male responsibilities and participation' in the Programme of Action adopted at the International Conference on Population and Development', United Nations, Cairo, 1994.


# Activity 6

## Evaluating IEC materials


**2 hours**

## Why do this exercise?

Understanding the consequences of unequal power relations

The initial days of this training course investigated the social roles that men and women play – for example that women look after children; men do it less. It also looked at how women in society have less access to either resources (land, money, information), or less control over how resources are used, than men do. This means that they do not have the same power or bargaining positions. These unequal power relations have consequences for men and women's lives, including their sexual and reproductive health. In the most extreme form, for example, women who have no income may sell their bodies for sex and in that circumstance will not be able to negotiate condom use and/or may be at risk of sexually transmitted disease including HIV. In a less extreme form, women may take all the responsibility for child care and providing food and thus be busy all the time and have little or no time to rest or to seek health care when they are ill. Men on the other hand may not bond with their children and so not have the opportunity to parent. These social roles are re-enforced all the time. Even IEC messages which are supposed to promote health may in fact re-enforce roles that can lead to poor health.

Analysing IEC messages

This activity attempts to unpack what lies behind IEC messages. A goal of the ICPD POA is that 'Efforts should be made to emphasise men's shared responsibility and promote their active involvement in responsible parenthood and sexual and reproductive behaviour (including prevention of STDs and unwanted pregnancies). Male responsibility in family life must be included in the education of children from the earliest ages.' (POA 4.25, 4.26, 4.27)

We ask if IEC messages promote ICPD aims – specifically, do they:

- Promote male responsibility?
- Promote women having more control over their own lives?

In doing so, the activity aims to build participants' ability to promote gender equality when developing IEC activities.

# Objectives

- To be able to analyse IEC materials
- To understand how such materials can challenge gender norms and promote human rights
- To be able to assess the materials used in our organisations from a gender and human rights point of view

# How to do this activity

The activity has two sections. It begins by trying to develop a common understanding between participants about what male responsibility is, what messages may promote gender equality and what messages increase women's self determination. Thereafter it discusses the specific IEC messages developed in your own organisation.

## IEC materials

Enclosed are pictures or posters that form part of IEC material developed elsewhere in the world. Each picture is described below, as well as the reason for its inclusion.

### 1. Picture from a health promotion calendar: a man playing with a child while women talk.[2]

This poster was produced by community women who were discussing what actions are required at community level to improve women's health. The picture comes off a calendar produced as part of a radio story that was distributed to community members on tape. Listening groups were started to discuss health-seeking behaviour in Sierra Leone.

This poster is included because it promotes the idea that men can take on and enjoy childcare and that it is legitimate for women to have leisure time.

### 2. Picture of a man carrying a woman to the clinic[3]

This poster was produced by community women who were discussing what actions are required at community level to improve treatment of malaria. The picture comes off a calendar produced as part of a radio story that was distributed to community members on tape. Listening groups were started to discuss health-seeking behaviour in Sierra Leone. Men control most elements of family life and thus a sick woman often has to ask for permission to go to a clinic. They thought that not only should a man permit his wife to go but he should actively assist

[2] 'On the Road to Health.' *The Healthy Woman Counselling Guide.* The Gender, Health and Communication Team, Sierra Leone. UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR). 1998.

[3] 'On the Road to Health.' *The Healthy Woman Counselling Guide.* The Gender, Health and Communication Team, Sierra Leone. UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), 1998.

her.

This poster is included because it promotes the idea that men can play an active role in promoting women's health.

### 3. 'TEM DTS? / Treat STDs'[4]

This is a poster froxm Mozambique developed by the Mozambique Department of Health. Partners are going to the clinic together to get treatment.

This poster is included because it promotes joint responsibility.

### 4. WHP workshop manual poster 'Who does my body belong to?'[4]

This poster is part of peer education materials on various reproductive health issues. It comes out of a section on men's and women's bodies. At the end of the physical and biological description of the human body, this poster is used to promote discussion.

This poster is included because it raises issues about who should have control over a person's body. It raises the issues of power structures and institutions that exist in society that may be in control of individual choice. It is included here because it opens up this area for discussion and allows open debate about a difficult area.

We have described to you, the facilitator, what the point of each illustration is. However, this is to guide you in allowing the group to discuss these issues and discover these points for themselves. Do not tell the groups about the posters – let them explore them through the questions. At the end, if you like, you can give them background about the posters.

### Step 1: 30 minutes

Small group work

Divide the group into smaller groups of about 5 people. Give each group one of the enclosed IEC materials. Ask the group to please look at the IEC material they have. Distribute handout: Questions on IEC materials and ask the group to use these as guides to analysing the poster they have.

### Step 2: 1 hour

Plenary discussion

Bring the group back to plenary. Give each group an opportunity to show their materials and to tell the rest of the group what conclusion they drew. In this way each group gets to see the IEC material that the other groups were working with. The participants also begin to develop a shared understanding of how IEC materials can promote (or not) joint responsibility for sexual and reproductive health. How long this takes depends on how many groups you have but you should aim to give about 15 minutes for discussion of each poster. If more than one group had a particular poster ask the second group if they have anything to add to what the first group said – try to encourage them not to repeat anything. If this happens budget about 10 minutes extra for each poster.

[4] STD Treatment Centre, *'TEM DTS?' Programa Naçional de Controlo das DTS/SIDA* – Direccao Naçional de Saude – Ministerio da Saude – Mocambique.

[5] Xaba M, Boikanyo E, Moore S., 'Your Body', *Health Information Workshop Manuals*, (2nd Edition) Women's Health Project, Department of Community Health, University of the Witwatersrand, 2000.

Main points

Here are some of the points that you may want to draw out in discussion.

Regarding the target group you will notice that sometimes the target is men and sometimes it is women and sometimes it is both. Promoting gender equity does not always mean having to target men and women equally.

Sometimes the messages that are aimed at men and women are specific. For men one may want to emphasise the caring, nurturing role. Thus in the one picture a man is shown playing happily with his child. Men's socialisation, which does not promote this caring role, is being challenged in this picture. In the same picture a message specific to women's roles is shown. Women have a right to leisure time. So messages often need to be specific to each sex.

There are examples where gender norms are being challenged. For example we see women having leisure time while men are taking care of children.

Joint responsibility is promoted, for example where men and women are going to get treatment for sexually transmitted diseases as couples.

Societal norms are being challenged. For example older people are shown as sexual and may need to get treatment for sexually transmitted diseases.

Women's rights are being put up for discussion, for example in the poster which lists the various institutions that may influence who may decide about women's bodies. This educational material may open up discussion on some of the following issues:

- Religion may dictate what may happen with women's bodies such as determining if women may use contraception;
- Husbands may decide when women have sex or children;
- Women may have to agree to use contraception to keep their jobs, or lose their jobs if the employer finds out she is pregnant;
- Doctors may decide what is good for a woman without explaining issues to her or getting informed consent.

## Step 3: 30 minutes

Small group work

The second aspect of this exercise aims at analysing the IEC materials used or developed in the participants' own organisation. Participants should work in small groups using Handout: Analysing our IEC materials to analyse the IEC materials that you asked them to bring.

After they have looked at their IEC interventions and materials ask the group to decide

- if their materials are promoting gender equality and human rights, and if so, in what way;
- if, after this analysis, there is anything they would change.

Plenary discussion

At the end of the session ask people to come together and give a short report-back to the group on the two points above.


- Participants must be instructed in advance to bring IEC materials developed in their organisations with them.
- Flip chart paper.
- Felt tipped pens.
- Something to stick paper onto the wall.
- Copies of Handouts for each person.


Patel, P., and CHETNA team, *Narrowing the Gender Gap by Enhancing Men's Involvement in Reproductive Health,'* Ahmedabad, Centre for Health Education, Training and Nutrition Awareness, 1998

M Berer. M., 'Men', *Reproductive Health Matters*, 7 May 1996: 7-10.


- Handout: Picture from a health promotion calendar: a man playing with a child while women talk
- Handout: Picture of a man carrying a woman to the clinic
- Handout: 'Treat STDs'
- Handout: 'Who does my body belong to?'
- Handout: Questions on IEC Materials
- Handout: Analysing our IEC Materials

# Questions on IEC materials

1. Who is pictured in the poster?

2. What is the poster saying to you?

3. Who is the target of this poster?

4. Does it have any information about women's roles and men's roles?

5. Are these reinforcing conventional roles or challenging them?

6. Does the image promote joint responsibility?

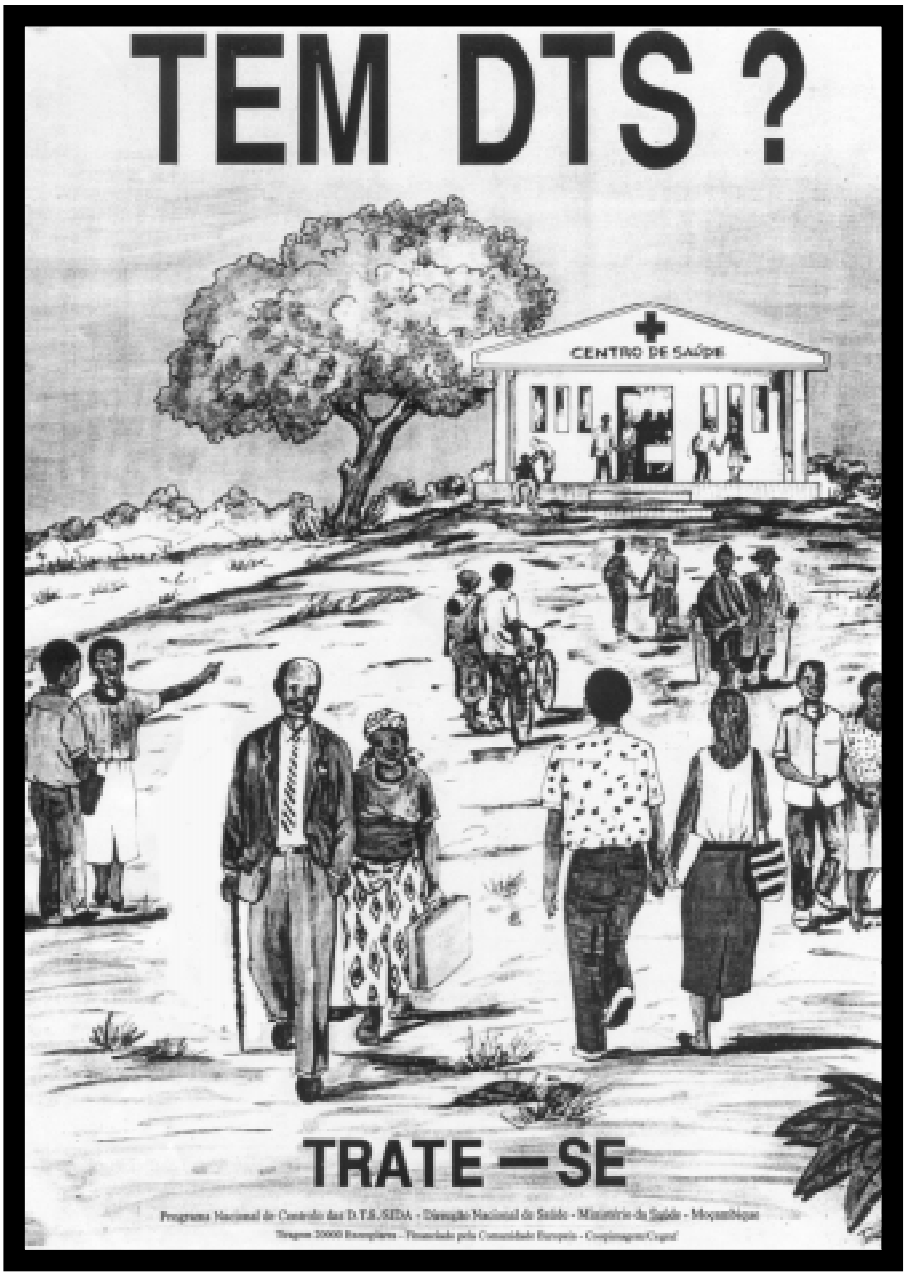
7. Why do you say this?

# Analysing our IEC materials

1. Who is the target of this message – men or women or both?
2. What is the intention of this message – what does it want people to do?
3. Why is it for women (or men)?
4. Could this message be for both men and women?
5. If this message is for men, how would it have to be changed for it to be for women or vice versa?
6. Is there anything in the IEC material that talks about gender roles (what women should do, what men should do)?
7. If so what does it say?
8. Does this message promote women's rights? If so how, if not why not?
9. Does this message promote joint responsibility for sexual and reproductive health?
10. If yes how does it do that?
11. If no, could it be changed to promote joint responsibility? How?
12. If you were young, or old, would you think this was for you?
13. Does it matter if one age group does not think this is for them?
14. How were these materials prepared? Were women and men consulted about their needs, were the messages included, and were the materials tested?
15. What changes would you make?

'On the Road to Health.' *The Healthy Woman Counselling Guide*. The Gender, Health and Communication Team, Sierra Leone. UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR). 1998.

'On the Road to Health.' *The Healthy Woman Counselling Guide*. The Gender, Health and Communication Team, Sierra Leone. UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), 1998.




STD Treatment Centre, 'TEM DTS?' Programa Naçional de Controlo das DTS/SIDA – Direccao Naçional de Saude – Ministerio da Saude – Mocambique.


Xaba, M., Boikanyo, E. and Moore, S., 'Your Body', *Health Information Workshop Manuals*, (2nd Edition) Women's Health Project, Department of Community Health, University of the Witwatersrand, 2000.


# Activity 7

## Appraisal of reproductive health programmes


**3 hours**

## Why do this exercise?

This is the closing session of the training. Participants are asked to apply the concepts and ideas that have been discussed during this course to their own programmes. Where appropriate and possible, participants are encouraged to adapt their current programme or apply some of the insights gained during this week of training to their future work.

The extent to which gender sensitivity is incorporated in health programming varies. Many programmes are being re-oriented. This activity is to see whether the existing rationale, programme objectives, plans of action, delivery of activities and monitoring of the progress of the NGOs supported within the Initiative for Reproductive Health in Asia has a gender perspective.

Appraisal of gender sensitivity in programming

Participants will appraise their programmes guided by a set of questions. These are not designed to be comprehensive and can be adapted according to the nature of the programme. These questions do not require a yes or no answer. Rather, the discussion that the questions provoke should allow participants to identify gaps in their programmes, or areas that could be improved, sometimes in small but significant ways. Then participants are asked to generate ideas about how they may better address gender equity and rights.

As the facilitator of this session you should familiarise yourself fully with the questionnaire guide and make linkages between the questions and the components of the training to which they relate so that you can assist participants as they go through this exercise.

## Objectives

- To be able to analyse our programme/project from a gender and human rights point of view
- To be able to assess if modifications to this project would promote gender equity and human rights
- To plan how such modifications could be undertaken

# How to do this activity

## Step 1: 1 hour 30 minutes

Small group work

Divide participants into groups so that they work with people from their own organisation. Ideally each organisation should form one group. Each group should identify one of its programmes or projects to analyse. Give out Handout: Questionnaire for assessing gender and rights perspectives of our programme. The groups must go through it systematically and analyse their chosen programme or project.

During this time you will need to go from group to group and assist them. Your job is to draw on all the content of the training course and assist participants to apply this to their programmes. You will be required to ask probing questions to assist participants to interrogate their own programmes and the circumstances in which the project beneficiaries live in order to draw out the gender issues that could be addressed.

## Step 2: 30 minutes

Plenary discussion

Allow about 10 minutes for each group. Each group should present:

- One example from their analysis of an aspect of gender that has not been taken into account in their current programme;
- The implications of this not being taken into account;
- What changes they want to make in order to take this into account.

During this plenary you as the facilitator must again ask probing questions about how participants think the circumstances they describe are a result of gender inequality, how the intervention they propose will take into account gender inequality, or how it will challenge gender norms, etc. Watch the time during this session. Take a few examples and discuss them in some detail to ensure that people are on the right track, rather than giving everyone a turn to present.

## Step 3: 1 hour

Small group work

Distribute the Handout: Plan for implementing changes to promote gender equality. Explain to participants that in the first part of this activity they identified areas where they could improve their programme or project. This last session is for them to identify and define what adjustments they imagine they could make to their programme and how to go about it. Using the handout explain that they should fill in the name of the programme or project that they have been discussing at the top of the form. They then list the gaps or areas that could be improved in the first column. In the next column they write down what they want to adjust by either modifying existing objectives or adding a new objective(s). In the next column they should write down what actions are required in order to achieve this objective. In the next column they write down who will be responsible for taking this forward. For example, they may have ideas of what needs to be done but the detailed planning of this is beyond what is possible in this workshop. Thus they may identify a person who will develop this fully. This person may need to discuss it with other staff in the organisation, develop a funding proposal, or get some additional information to do the logistical plan, etc. Please note that we are not imagining that

people will come up with large projects. The focus is on looking at their existing programme — what can be adjusted in it — to make it more gender sensitive. There may even be changes which have no or are low cost. Note that participants should rather work in detail on two or three issues than list many issues and deal with them superficially. As the facilitator you need to make this clear to participants before they go back to small group work. The aim is for participants to identify something that they want to and are able to implement once they leave the training.


- Copies of their own project plans that you have instructed them in advance to bring.
- Flipchart paper.
- Felt-tip pens.
- Something to stick paper onto the wall.
- Copies of Handout for each person.


- Handout: Questionnaire for assessing gender perspectives of programme
- Handout: Plan for implementing changes to promote gender equality

# Questionnaire for assessing gender perspectives of our programme

1. Please list what your programme is trying to achieve.
2. Who is the target group of your intervention?
3. Look at the table below. When developing the programme was information collected about the following issues from the following target groups?
   Please fill in what you know about these factors in relation to what your programme/project is trying to achieve. Note that sometimes you need to collect information from groups outside of your target group because they may influence what you do. However, if any of these categories are not at all relevant please leave the square blank. If there are other groups that need to be considered (e.g. old people) please add them. This will change depending on the programme/ project that is being analysed.

| | Role and responsibility in the household | Role and responsibility outside the household | Gender norms (the way that society expects people to behave) | Access to and control over resources | Ability to make decisions over their own lives |
|---|---|---|---|---|---|
| Women | | | | | |
| Men | | | | | |
| Youth | | | | | |
| Poor clients | | | | | |
| Marginalised groups | | | | | |
| Service providers/ NGO staff | | | | | |

4. Using the information from point 3 above assess and fill in how these factors affect the project beneficiaries' health and ability to use the services / be involved in the programmes you have on offer.

| | Role and responsibility in the household | Role and responsibility outside the household | Gender norms (the way that society expects people to behave) | Access to and control over resources | Ability to make decisions over their own lives |
|---|---|---|---|---|---|
| Women's health | | | | | |
| Women's health seeking behaviour | | | | | |
| Men's health | | | | | |
| Men's health seeking behaviour | | | | | |
| Youth's health | | | | | |
| Youth's health seeking behaviour | | | | | |
| Poor client's health | | | | | |
| Poor client's health seeking behaviour | | | | | |
| Marginalised groups' health | | | | | |
| Marginalised groups' health seeking behaviour | | | | | |

5. Go through each issue you have identified in point 4 and explain if and how these issues are taken into account in your programme. If they are not taken into account please list what you think the consequences of this are.

## In relation to your programme please answer the following questions which attempt to explore more specifically how your programme may have attempted to overtly address gender-based inequalities.

6. Were beneficiaries, especially disadvantaged groups, involved in the development of your programme?

7. Are there elements in your programme that target women specifically so as to overcome existing inequalities? If so please describe these.

8. Does the programme put effort into changing existing power relationships between men and women? If so in what way?

9. Does your programme build different appropriate skills for men and women, for example skills that encourage girls/women to be more confident and to have higher self esteem and self worth; or skills that will encourage boys/men to communicate with their partners, be responsible for their sexuality and recognize women's rights? If so, how is this done?

10. Is women's autonomy strengthened in your programme? If so, in what way is this done?

11. Do your project interventions require that beneficiaries put in time and effort in order to get benefits? If so, is this different for men and women? Please explain.

## The next set of questions deals with some aspects of how you are doing monitoring in your programme.

12. Does the way that you monitor your programme include input from all people involved, e.g.
    - management ?
    - service providers?
    - all beneficiaries?

13. Is there a planned mechanism for returning information gained from the programme back to the community for whom the programme is intended (e.g. meetings, easily understood newsletter etc.)?

14. Does the data/information you collect include any indicators that will allow you to assess whether you are moving towards greater gender equity? If so what are these indicators?

15. Does the data/information you collect include any indicators that will allow you to assess whether you are moving towards a greater appreciation of human rights? If so what are these indicators?

handout

## The next set of questions relate to issues internal to your own organization that prepare staff to deal with gender and rights issues.

16. Do the staff in your organisation have an understanding of gender relations?

17. Do the staff in your organisation have an understanding of human rights?

18. Are there any methods to assess if men and women beneficiaries are treated differently by the staff in your organisation? If they are treated differently are there any interventions in place to try to address this? If so, please describe these.

19. Are the staff in your organisation effective and sensitive communicators? For example, are they trained to receive the views and experiences of the target group without being judgmental and, at the same time, able to encourage further discussion and impart gender equity and human rights views?

# Plan for implementing changes to promote gender equality

| Gaps Identified | Modification required | What action is needed to achieve this? | Who will take this forward? | How will they do it?* | By when? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*Note: to answer this question remember to think about potential obstacles (e.g. having to convince others of the need for changes, resource requirements etc.) and to factor this into how this person will take this forward and what actions are required to make this implementable.

## Reproductive Health Initiative

The EC/UNFPA Reproductive Health Initiative for Asia is the largest cooperation arrangement between the European Commission and the United Nations Population Fund. It is a six - year programme (1997/ 2002) designed to accelerate the implementation of the ICPD Programme of Action in Asia. Its goal is to create sustainable alternatives to current systems that will contribute effectively to improving the reproductive health status of women, men and youth in seven South and South East Asian countries: Bangladesh, Cambodia, Laos, Nepal, Pakistan, Sri Lanka and Vietnam. The programme consists of 42 projects executed by 19 European NGOs in close partnership with over 60 local NGOs and no profit organizations.

## Italian Association for Women in Development

The Italian Association for Women in Development (AIDOS) is a non-governmental, non profit organisation, established in Rome in 1981 by a group of women development professionals and activists with the intent of carrying out the goals of the UN Decade for women: equality, development and peace. Its mission is to support the concept and the methodology of women's empowerment by reinforcing women's organisations and NGOs in developing countries, enabling them to respond to women's needs and to manage their interventions autonomously.

Since its creation AIDOS has concentrated its work in three areas of intervention, where the contribution of Italian women is particularly relevant:

- women's reproductive health and rights through the creation of health counselling centres for women that follow a holistic, integrated approach, and support to projects aiming at the eradication of female genital mutilation in Africa;
- creation of micro and small enterprises run by women and support to existing enterprises through the establishment of business service centres that provide technical and organisational support;
- capacity building of women's institutions and organisations, mainly through the creation of documentation / information centres and networks.

## Women's Health Project

The Women's Health Project is the Women's Health Research Centre of the School of Public Health, University of the Witwatersrand, Johannesburg, South Africa. It operates as an independently funded non-governmental organisation. It was started in January 1991. Its staff are from disciplines ranging from medicine to social sciences. It aims to support the development and implementation of policies and programmes which promote human rights and are responsive to women's needs and aspirations.

Specific foci of WHP are

- policy analysis and advocacy
- health systems research and evaluation
- community education and mobilisation in relation to quality of care and integration of services, mainstreaming gender in health, and sexual and reproductive rights and health.

WHP works at the national and international levels, both in self-initiated projects and through consultancy.