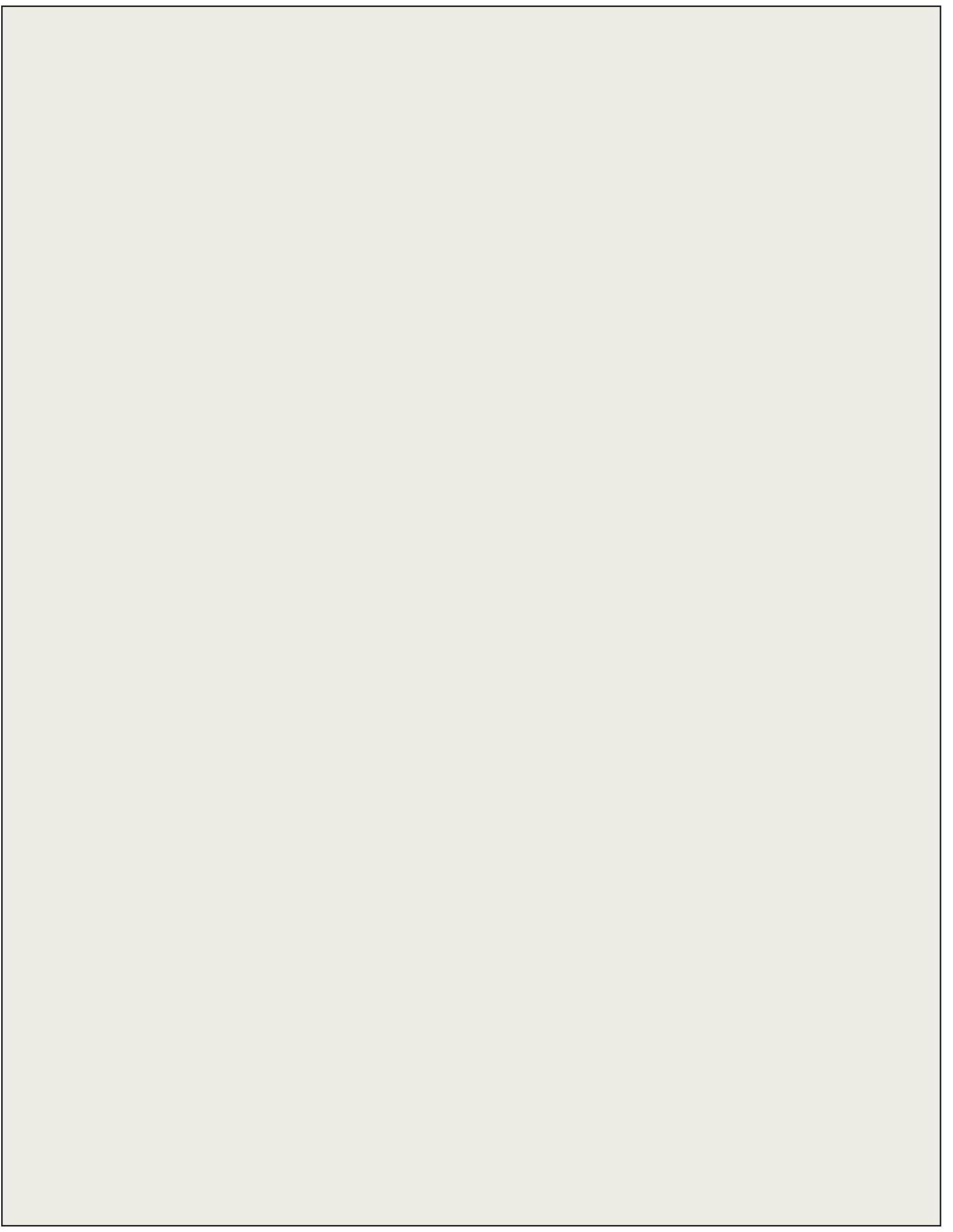


Integrating Poverty and Gender into Health Programmes

A Sourcebook for Health Professionals



Foundational Module on Gender



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ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CVD	Cardiovascular disease
CWCC	Cambodian Women's Crisis Centre
ARI	Acute respiratory infection
DALY	Disability-adjusted life year
DHS	Demographic and Health Survey
GAD	Gender and development
GDP	Gross domestic product
GHI	Global health initiative
GNP	Gross national product
HDI	Human development index
HIS	Health information system
HIV	Human immunodeficiency virus
HMN	Health Metrics Network
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
IMR	Infant mortality rate
LGBT	Lesbian, gay, bi-sexual and transgendered
LBW	Low birth weight
MDG	Millennium Development Goal
MSM	Men who have sex with men
NCD	Noncommunicable disease
NCRFW	National Commission on the Role of Filipino Women
NGO	Nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
PRSP	Poverty reduction strategy paper
STI	Sexually transmitted infection
TB	Tuberculosis
U5MR	Under-5 mortality rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNDP	United Nations Development Programme
VLSS	Viet Nam Living Standards Survey
WHCF	Women's Health Care Foundation
WHO	World Health Organization

Note: In this publication, \$ refers to US dollar.

PREFACE

Over the past two to three decades, our understanding of poverty has broadened from a narrow focus on income and consumption to a multidimensional notion of education, health, social and political participation, personal security and freedom, and environmental quality.¹ Thus, poverty encompasses not just low income, but lack of access to services, resources and skills; vulnerability; insecurity; and voicelessness and powerlessness. Multidimensional poverty is a determinant of health risks, health-seeking behaviour, health care access and health outcomes.

As analyses of health outcomes become more refined, it is increasingly apparent that the impressive gains in health in recent decades are distributed unevenly. Aggregate indicators, whether at the global, regional or national level, often mask striking variations in health outcomes between men and women and rich and poor, and across and within countries.

An estimated 70% of the world's poor are women.² Similarly, in the Western Pacific Region, poverty often wears a woman's face. Indicators of human poverty, including health indicators, often reflect severe gender-based disparities. In this way, gender inequality is a significant determinant of health outcomes in the Region, with women and girls often at a severe societal disadvantage.

Although poverty and gender significantly influence health and socioeconomic development, health professionals are not always adequately prepared to address such issues in their work. This publication aims to improve the awareness, knowledge and skills of health professionals in the Region in relation to poverty and gender concerns.

The modules that comprise this Sourcebook are intended for use in pre-service and in-service training of health professionals. This publication is also expected to be useful to health policy-makers and programme managers as a reference document, or in conjunction with in-service training.

All modules in the series are linked, though each one can be used on a stand-alone basis if required. The series includes two foundational modules, including this one, which set out the conceptual framework for the analysis of poverty and gender issues in health. Each of the other modules is intended for use in conjunction with these two foundational modules. The Sourcebook also contains a module on curricular integration to support health professional educational institutions in integrating poverty and gender concerns into existing curricula.

All modules in the Sourcebook are designed for use through participatory learning methods that involve the learner taking advantage of his or her experience and knowledge. Each module contains facilitators' notes and suggested exercises to assist in this process.

It is hoped that the Sourcebook will prove useful in bringing greater attention to poverty and gender concerns in the design, implementation and monitoring and evaluation of health policies, programmes and interventions.

Introduction



Introduction

Humanity has enjoyed impressive gains in health. From the 1950s to 2002, the global average life expectancy increased from 46.5 years to 65.2 years. This positive trend has been attributed to rapidly declining rates of mortality, especially infant and maternal mortality, as well as that due to infectious diseases among children and young adults. Improved public health measures, coupled with increasing levels of education, better housing and sanitation, and the growing number of couples that choose to have fewer children, have contributed to enhanced health outcomes in developed and developing countries.³

The Western Pacific Region has been at the forefront of many of these gains in health and well-being. Life expectancy in developing countries in the Region is now 70.40 years, compared with an estimated 84.20 years for developed countries. Among other improvements, impressive gains have been made in controlling many infectious diseases, and the under-five mortality rate (U5MR) has fallen from an average of 154 per 1000 live births in 1955–1959 to 48 in 1995–1999 and 39.50 in 2006.⁴

However, this progress has not been uniform across and within populations. The mounting availability of sex-disaggregated data increasingly shows how the health of men and women and boys and girls⁵ differs across the life cycle. For example, the life expectancy for men living in developing countries in the Region is calculated to be 68.20 years, while that for women is 72.70. Simultaneously, our understanding of differential health outcomes in men and boys, as compared with women and girls, has progressed from an approach that focuses on the role of biological sex to one that seeks to understand how gender and biology interact from the individual to the structural level to produce differences in health.⁶ The application of such analysis increasingly reveals differentials between men and women, arising from sex and gender, across health conditions.

The growing concern over differences in the health of men and women in health research, policy and programming has been propelled by the

commitments of governments to realize the equal rights of women contained in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), sustained advocacy at the International Conference on Population and Development (ICPD), and the Fourth World Conference on Women in Beijing, among other events.⁷ More recently, the Millennium Development Goals (MDGs) have articulated the links between improved health outcomes among men and women, on one hand, and efforts to eliminate gender equality and empower women, on the other.

The enhanced commitment to addressing differences in the health of men and women and boys and girls increasingly requires that health professionals at the community, provincial, national and international levels have the knowledge, skills and tools to respond more effectively to the health needs of men and women, as well as to understand the pathways through which the interaction of gender and biological sex might influence health. Awareness of the influence of gender on health is fairly new, and many health professionals have not had access to the related information and training. Using gender analysis and planning can help ensure that gender norms, as well as the gender roles of men and women, are taken into account in designing health programmes, plans and policies. Understanding and accounting for the differences between men's and women's roles, and the relations between them, can increase the success of a programme or policy, potentially leading to better use of scarce resources. Thus, the addition of gender analysis to the tools employed by health professionals and planners can enable them to design and implement more equitable and effective health programmes.

This foundational module on gender and health aims to build the capacity of health professionals to analyse the links between gender and health; to understand the importance of integrating gender into their work; and to use gender analysis and planning methods in designing and implementing health policies, programmes and interventions.

The module is divided into six sections:

- **Section 1** defines WHAT gender is and how it differs from sex. It also introduces the concepts of gender roles and the gender-based division of labour, gender-based access to and control over resources, and gender needs.
- **Section 2** explains WHAT the links are between gender and health.
- **Section 3** discusses WHY health professionals should address gender concerns in health from efficiency, equity and human rights perspectives.
- **Section 4** discusses HOW health professionals can address gender concerns in health policies, programmes and interventions. This section introduces some basic gender analysis methods and tools, and provides examples of how gender can be addressed in health.
- **Section 5** provides notes for facilitators.
- **Section 6** is a collection of tools, resources and references to support health professionals in their work in this field.

1. What is gender?



1. What is gender?

What is sex? What is gender?

In every society, sex is one part of the definition of what is male and what is female. Sex is a biological characteristic determined by chromosomes, genitalia and hormones. However, sex is only one aspect of what defines each of us as female or male. The other criteria are culturally driven and tend to differ between societies, often reflecting religious, political, economic and other influences. These socially constructed aspects of being male or female are referred to as gender.

Gender is learned through socialization and is based on social norms—that is, attitudes and assumptions, behaviours and activities. Throughout life, girls and boys are expected and taught to assume certain roles in their families and communities. Parents, peers, teachers and others reinforce this process. The gender roles assigned to boys and girls and men and women in turn influence the division of labour within society. In addition, unequal power relationships between men and women in society underpin the activities, roles and responsibilities associated with gender. Box 1 provides definitions of several gender-related terms used in this module.

As an organizing principle of social life, gender does not exist in isolation. Instead, it interacts with other dimensions of social exclusion and discrimination, such as class, ethnicity and race, which combine to create distinct forms of power relations within societies.⁸ The interaction between gender and poverty, for example, tends to disadvantage women more than men. Women often earn less than men do, and women appear to be overrepresented among the poor.⁹ Furthermore, groups of men and women within a society might experience gender differently. Box 2 describes the multifaceted nature and characteristics of gender.

Gender norms also tend to marginalize transgendered individuals and people whose sexual identities do not conform to social ideals. In many societies, heterosexuality is considered the norm, implying that individuals express sexual desire only for the opposite sex.¹⁰ In many settings, individuals with alternative sexual identities—that is, lesbian, gay, bisexual and transgendered (LGBT) sexual identities—may face discriminatory attitudes and, at times, violence. For example, transgendered individuals in Cambodia have reported experiencing discrimination and abuse.¹¹

Box 1: Gender-related terms and definitions

Gender: Refers to women's and men's roles and responsibilities that are socially determined. Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organized, not because of our biological differences.

Sex: Genetic/physiological or biological characteristics of a person that indicate whether one is female or male.

Mainstreaming gender: Integration of gender concerns into the analysis, formulation and monitoring of policies, programmes and projects, with the objective of ensuring that these reduce inequalities between women and men.

Gender equality: Absence of discrimination based on a person's sex with respect to opportunities, the allocation of resources or benefits, and in access to services.

Gender equity: Fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognizes that women and men have different needs and power, and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes.

Source: World Health Organization 1998.

Box 2: Characteristics of gender

Relational: Refers not just to women or men in isolation, but to the relations between them and how these are socially constructed.

Hierarchical: The differences between women and men, in most cases, tend to attribute greater importance and value to the characteristics and activities associated with what is masculine. This tends to produce unequal power relationships.

Changes over time: Even though gender is historical, roles and relationships change over time. Therefore, they have potential for modification through health and development interventions.

Context-specific: Gender roles and gender relations vary depending on the context, ethnic group, socioeconomic group, culture, etc., underlining the need to incorporate these perspectives into gender analysis.

Institutional: Gender refers not only to the relations between women and men at the personal and private level, but also to a social system supported by values, legislation, religion, etc.

Source: Pan American Health Organization 1997.

Those from the *hijra* community in India, long recognized as transgendered people, are often stigmatized and harassed.¹² In some areas, discrimination is rooted in the law, while in others, progressive laws protecting against discrimination on the basis of sexual orientation may not be enforced or implemented. For example, Fiji was one of the first countries to enshrine protection against discrimination on the basis of sexual orientation in its 1997 Constitution. However, activists allege this law has not been strongly implemented in practice.¹³

Social movements for LGBT rights from around the world are increasingly drawing attention to gender and sexual orientation as an important source of bias and discrimination. These movements challenge common understandings of gender to move beyond the male/female

dichotomy and to explore the possibility of ‘gender plurality.’¹⁴

Gender roles

Gender roles are learned behaviours conditioned by social norms that dictate which activities, tasks and responsibilities are defined as male and female. That is, social norms influence the roles that men and women and boys and girls play in society. Gender roles tend to vary across communities and can change over time. Gender roles often are influenced by other factors, including age; class; ethnicity; religion; and geographical, economic and political contexts.¹⁵

In a broad sense, these roles can be divided into productive, reproductive and community work (Box 3). The social norms that ascribe gender roles to men and women typically give rise to a clear division between men’s and women’s activities, tasks and responsibilities. This demarcation is known as the gender-based division of labour. In many societies, men are primarily responsible for productive work, while women are assigned reproduction-related tasks. Although the gender-based division of labour may be expressed differently across societies, this pattern also extends from the household to the public sphere. Thus, it tends to be reproduced within larger social institutions. In the public sphere, for example, this division is reflected in the overrepresentation of women in caring professions, such as health care and teaching in some countries. Such phenomena reinforce gender-based divisions in other social structures, thereby creating a recurring cycle.

Productive work is work undertaken to earn income. Such work can include anything from growing produce for sale or fishing to working in a factory or on a construction site. In most societies, men have traditionally done the majority of productive work that is remunerated or paid. Table 1 presents data on the economically active population as a percentage of the working age population (15–64 years old), by sex, for selected countries in the Region. The proportion of men who are counted as being economically active

Box 3: Gender roles and the gender-based division of labour: terms and definitions

Productive work

Involves the production of goods and services for consumption and trade (farming, fishing, employment and self-employment). When people are asked what they do, the response is most often related to productive work, especially work that is paid or generates income.

Reproductive work

Involves the care and maintenance of the household and its members, including bearing and caring for children, food preparation, water and fuel collection, shopping, housekeeping, and family health care. Although reproductive work is crucial to human survival, it is seldom considered “real work” or counted in national accounts and labour statistics. In poor communities, reproductive work is, for the most part manual, labour-intensive and time-consuming. The bulk of this work is assigned to women in most societies.

Community work

Involves the collective organization of social events and services, ceremonies and celebrations, and community improvement activities, as well as participation in groups and organizations, and political activities.

Within community work, a further distinction is often made between community managing roles and community political roles. Women often perform community managing roles as an extension of their reproductive work. These roles include the provision and maintenance of scarce resources for collective consumption, such as water, health care and education. Much of this work is perceived to be voluntary and undertaken during women’s “free” time. These roles are distinct from community political roles, or those concerning politics in the formal and informal spheres. Often performed by men, much of this work is paid directly or indirectly through the associated status and power.

Source: Williams S., Seed J. and Mwau, A. 1994; and International Labour Organization, South-East Asia and Pacific Multidisciplinary Advisory Team 1998.

**Table 1: Economically active population
(as % of working age population)***

	1990		Latest year	
	Female	Male	Female	Male
Cambodia	55.4	82.2	59.1	79.6
China	79.1	88.9	76.2	88.0
Cook Islands	48.0	52.0	61.0	76.0
Lao People’s Democratic Republic	71.2	69.4	85.3	83.4
Kiribati	68.2	84.5	76.1	86.1
Republic of Korea	47.0	74.0	50.1	74.6
Malaysia	47.8	85.3	45.9	80.0
Mongolia	65.1	71.9	62.2	64.8
Papua New Guinea	72.3	75.9	72.7	75.1
Philippines	47.5	81.8	50.2	82.9
Tonga	17.0	64.0	53.0	75.0
Viet Nam	79.4	85.5	77.6	82.6

* working age population refer to ages 15–64
Source: Asian Development Bank 2006.

is higher than the comparable proportion of women for almost all the countries listed. This is thought to reflect a systematic undercounting of some types of economic activities that women are engaged in, because they might be home-based, invisible, unreported or unrecognized by women themselves, as well as by households and labour statistics. However, as the table shows, women’s share in the labour force is increasing in almost every society.

In contrast to productive work, reproductive work consists of all household responsibilities, care giving and nutrition-related work that are required to keep people alive and healthy. These tasks include raising children, taking care of domestic tasks (e.g., cleaning and cooking), feeding household members and animals, caring for the sick and elderly, watering the garden, collecting fuel, and sewing, among many others. In poorer communities, much of reproductive work

Table 2: Percentage of time men and women spent on paid and unpaid activities in Mongolia, 2000

	Urban areas		Rural areas	
	<i>Paid work</i>	<i>Unpaid work</i>	<i>Paid work</i>	<i>Unpaid work</i>
Men	17.8	82.2	5.6	94.4
Women	14.7	85.3	4.7	95.3

Source: National Statistics Office and United Nations Development Programme 2000.

is labour-intensive and time-consuming. Women and girls predominantly carry out these tasks, which are usually unpaid. This is illustrated by the findings of a time-use survey from Mongolia, which reported the share of time men and women spent on paid and unpaid activities in 2000 (Table 2). Similarly, focus group discussions in Cambodia showed that Cambodian society discourages men from performing household tasks. If men engage in such activities, they will try to ensure that their neighbours do not see them.¹⁶

Since women tend to have primary responsibility for reproductive work, which is fragmented and time-consuming, they generally have less leisure time than men do. They also tend to combine their reproductive tasks with their productive ones. However, if they do not do the reproductive work, the productive work cannot be done and communities cannot exist. Unfortunately, reproductive work has traditionally been undervalued and is not considered part of a country's gross domestic product, although it contributes significantly to a country's economic well-being.

Community work refers to the civic organizations and groups that people take part in to govern and provide services for the community. These include school boards, local government councils, and women's and men's groups that organize civic celebrations or fund-raising drives for schools, parks or other public needs. As noted in Box 3, much of the community managing work tends to be voluntary, although it is also necessary for producing public goods. In turn, men are more likely than women to be involved in community political work. The representation of women in economic and political decision-making bodies, which is rising slowly, is still generally lower than

that of men. In the Philippines, for example, 36% of senior executives in the bureaucracy were women in 2005, according to a report. Women's participation in national politics was far lower, comprising 12.5% of senators and 17.0% of Congress members. Below the national level, 17% of provincial, city and municipal legislators were women, while 19% of provincial governors and 15% of city and municipal mayors were women in 2001.¹⁷ The 2004 elections in Malaysia elected three women to full ministerial posts. Increasingly, women are found among the top ranks of the Malaysia Civil Service. In 2004, key posts held by women included that of auditor-general at the National Bank.¹⁸

A woman living in rural China provides some insight into the gender-based division of labour in her community:

Usually I do the planting and weeding for our tobacco and grain crops and watch the baby. I also cook and haul water. I don't need to go out to gather firewood since we burn charcoal that we can buy from a vendor nearby. These light tasks are mine, while he (my husband) takes care of the heavy tasks (such as ploughing and digging). Naturally, since I do the lighter things, I do more than he does.

We (my husband and I) don't really divide up our farm work. He does the harrowing while I do the planting, but we both weed together. We also both gather firewood together. During the tobacco planting season, we both water the crops, apply fertilizer, weed and mulch. Housework of course is my responsibility, cooking, feeding the pig and chickens and so forth. When my baby was small, I used to carry him on my back

into the fields to work. He's older now and is studying in school, but I still have to go home and prepare meals for him.

Of course, men take care of the heavier tasks while women do the lighter chores. Men and women are equal, but I always have more work to do.¹⁹

As the above quotation illustrates, in reality, women and men perform both productive and reproductive tasks, as well as community work. That is, men and women play multiple roles. Women, however, often bear the burden of the work of the three roles. This is sometimes called the “double” or “triple” burden of work. In other words, women are usually responsible for reproductive work, as well as much of the productive work and community work.

While women still might be expected to “stay at home,” a considerable share is involved in the formal labour market. Further, they dominate the informal labour market, where work tends to be more insecure and unprotected. For example, estimates suggest that worldwide 30%–90% of street vendors, 35%–80% of all home-based worker and 80% or more of home workers are women. In the Philippines, 79% of home-based workers were found to be women in 1993.²⁰ In Iloilo, the Philippines, women owned or operated 63% of all street food enterprises.²¹ Women are also more likely to work part-time than men are. Table 3 presents data on employment in the informal economy of selected countries.

In turn, men generally are responsible for the productive work and some community work. While they might assist with some reproductive work, they bear little or no responsibility for it.

Access to and control over resources

Gender norms and gender roles determine the resources that people have access to and/or control over. Such resources include

- economic resources, such as credit, money, equipment, food, health insurance and housing;
- political resources, such as leadership positions and opportunities for communication and negotiations;
- information education and skills resources, such as formal and informal education, opportunities to exchange information and opinions, and information to be able to make decisions;
- time resources, such as hours of the day that can be used as one wants, and flexible paid work hours; and
- internal resources, such as self-esteem, self-confidence and the ability to express one's own interests.

“...In poor and marginalized communities (men and women) in many ways lack the economic freedom to choose how they negotiate their distribution of productive and social reproductive tasks.”²² However, women in most societies have much less power than men in such negotiations and less control over resources.

Table 3: Informal employment in selected countries

	Informal employment as percentage of non-agricultural employment	Women's informal employment as percentage of women's non-agricultural employment	Men's informal employment as percentage of men's non-agricultural employment
India	83	86	83
Indonesia	78	77	78
Philippines	72	73	71
Thailand	51	54	49

Source: International Labour Organization 2002.

“Access” to a resource can mean the entitlement to use a resource. Entitlements might be rooted in social norms, such as the use of common property. Access differs from “control” over a resource, which describes the right to make decisions concerning its allocation and use, such as selling land, without requiring the permission of other family members or the larger community. In many societies, women do have access to resources—often through their husbands, fathers or brothers. However, women often have less control than men over resources. In many societies, for example, land titles are issued in the names of heads of households, who are usually defined as men. Thus, while their wives might have use rights over the land, they do not have the right to sell or mortgage the land.

The access to and control over resources men and women are able to mobilize depends on the broader legal, political and economic context. For example, the prevailing formal legal system, customary law and social practices determine

patterns of land ownership and inheritance. In China, women enjoy equal rights to land under the formal legal system. Moreover, the law states that, if a woman relocates to her husband’s village, her land holdings in her natal village may not be revoked until she is given a new allocation of land in her husband’s village. The law also protects a woman’s rights to land in the case of divorce or the death of her husband. However, patrilocal inheritance practices tend to negate these formal rights in practice, thereby creating gender inequality in the rights to land and discrimination against women in land redistribution.²³

Gender needs

Initiatives that aim to work with men and women to address gender inequalities may respond to the practical or strategic needs of women and men, or both. A practical gender need is pertinent to the current situation. For example, a programme

Box 4: Men and gender inequality: the role of ‘dominant masculinities’

In many societies, men are expected to be strong, successful, sexually experienced and risk-takers. They are financially responsible and make decisions for their households, influencing or determining many of the choices their family members make. These prevailing gender norms concerning the roles and responsibilities of men (and women) in societies often are referred to as dominant masculinities. In many communities, it is not sufficient for men to internalize and conform to these gender norms; men are required to act out these gender norms repeatedly to demonstrate and prove their masculinities.

Yet these dominant masculinities are not equally achievable for all men. For example, men from poor communities and households, and ethnic minorities, or men who have sex with men, among others, might experience a gap between their day-to-day realities and the idealized notions of masculinity prevalent within their society. Similarly, men tend to experience masculinities differently through their life cycle, as their roles, responsibilities and power within society shift. For example, young men might have more difficulty living up to these ideals than older men. Men’s experience of masculinities is influenced by how their gender interacts with their class, race, socioeconomic status, religion, etc. These factors, in turn, shape the relations between men, and between men and women.

Dominant masculinities are increasingly understood to drive gender inequalities. For example, the belief that “real men” are the primary breadwinners in a household works to devalue the financial contribution of women in the household, and might reinforce the belief that women are primarily responsible for reproductive labour. While men are responsible for their choices and actions, the negative impact dominant masculinities have on men, as well as women, must be recognized. Thus, men and their concerns need to be incorporated into continuing and renewed efforts to challenge gender inequalities. An integral aspect of such efforts is to support men as they challenge strict gender norms, roles and responsibilities within society.

Source: Esplen E. 2006.

to increase the immunization rates of children in a region might recognize that, while women and men both care about their children's health, women will most likely take the children to be immunized. As such, the programme carries out the immunizations at flexible times and in locations that are convenient to women. This meets women's practical gender needs by making it easier for them to carry out this socially assigned responsibility.

Meeting practical gender needs is an important part of an effective intervention. However, it might not change existing and unequal gender power relations.

Meeting a strategic gender need might not have immediate results, but it will work towards a sustainable redistribution of roles, responsibilities, resources and power between women and men. Meeting strategic gender needs means making changes that reduce the structural inequities that harm men's and women's health and access to treatment. In the previous example of immunization, meeting strategic gender needs might imply instituting training courses for men in the care of newborns, so men are more involved in child care from the beginning and feel more comfortable in that role. This can increase the

possibility that women and men might share the responsibility of keeping their children healthy, including taking the child to be immunized.

Approaches that meet the practical gender needs of women might not meet the practical needs of men, or vice versa. For example, providing condoms and education on transmission would be a practical gender approach to combating HIV/AIDS. Men with knowledge of the health risks and access to condoms can decrease transmission rates significantly. However, providing condoms and education to women will not meet their practical gender needs because, even though they have condoms as well as the information and economic resources of knowledge, they might not have the power in male-female relationships to insist on the use of condoms. Men might see it as a threat to their masculinity or their sexual pleasure. In this instance, a strategic gender approach that changes the power relationship is needed. Women would need to be able to insist upon the use of condoms, and men would need to listen to and respond to women's preferences. This is not an easy approach and requires time. Changing social expectations and roles is a lengthy and complicated process, but can lead to real and sustainable improvements in the factors influencing health and health-seeking behaviour.²⁴

2. What is the relationship between gender and health?



2. What is the relationship between gender and health?

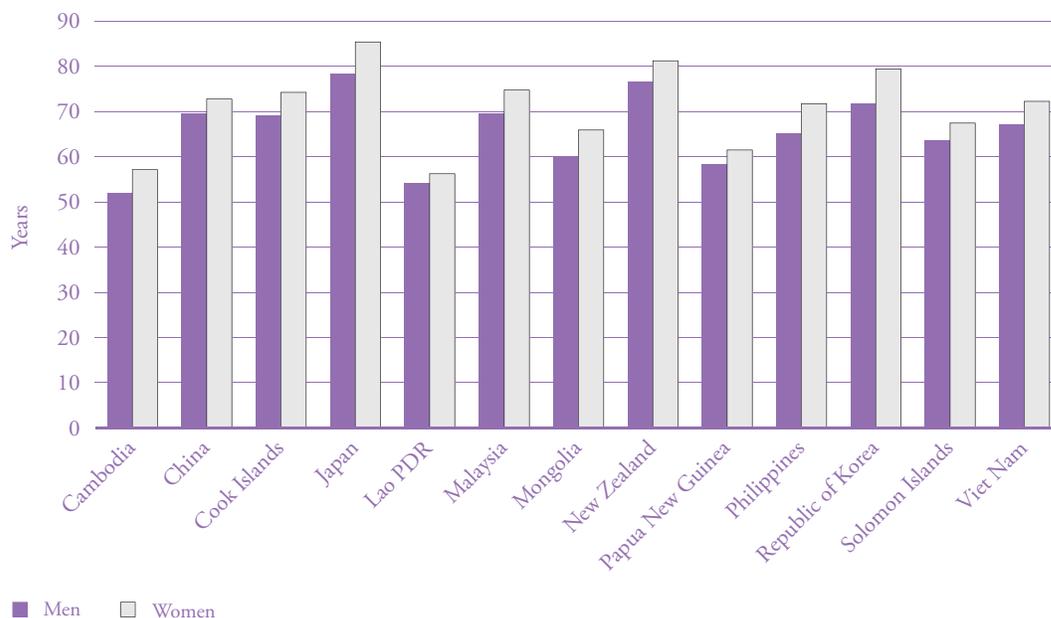
Health is an issue that affects everyone. As defined by the World Health Organization (WHO), health is “a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity.”²⁵ That is, good health is more than not being ill. It depends on how people live, what they do, with whom they interact and the quality of their relationships with other people. If people are tired or working too hard, they might not feel well. If living with people or in a place that makes a person unhappy or stressed, she or he might not feel healthy. Feeling healthy is closely tied to feeling relaxed, productive and useful. Supportive relationships help people feel healthier, as do supportive environments. In the same way, infection or disease make a person feel unhealthy. This is true for women and men.

Important differences between the health of men and women exist, however. This is seen most clearly in the generally longer life expectancy of women compared with men, although this pattern varies across regions. In the Western Pacific Region, women tend to live longer than men (Figure 1). Figure 2 also shows how the male-female gap

in life expectancy varies among countries in the Region. In countries where this gap is smaller (these are often developing countries), studies suggest that the life expectancy of women is shortened by maternal mortality; discrimination against women with regards to nutrition and access to health care; and, in some cases, the neglect or killing of girl babies.²⁶ In some countries in East and South Asia, the general tendency for women to live longer than men is eroded or reversed.²⁷ In Bangladesh, for example, both women and men have a life expectancy of 62.6 years.

Differences in the health of men and women are also observable across health conditions. In the Western Pacific Region, for example, twice as many men as women are reported to have smear-positive tuberculosis (TB) each year.²⁸ When disaggregated by sex, official data likewise suggest that the incidence of malaria is higher among men than women in the Region.²⁹ In contrast, the burden of depression in the Region is as much as 50% higher in women than in men, and maternal illness and death significantly influence women’s experience of health.³⁰

Figure 1: Life expectancy at birth in selected countries in the Region, 2002



Source: World Health Organization 2003.

Differences in the health of men and women are also found within countries, regardless of the level of development. In the Cook Islands, the infant mortality rate was higher among girls (7.1 per 1000 live births) than among boys (6.5). The U5MR in Kiribati was reportedly 80 per 1000 live births among boys and 69 among girls.³¹ Such differentials in health persist even in highly industrialized countries known for having greater equality, such as Sweden. For example, the risk of becoming depressed before reaching 80 years old is 28% for Swedish men and 49% for Swedish women.³² Health differences likewise exist between men and women of the same socioeconomic class, race or ethnicity.³³ The

prevalence of moderate stunting among children from the lowest wealth quintile in Cambodia was found to be lower in boys (24%) than in girls (30%).³⁴ Thus, while differences in the health of men and women are apparent across and within countries, they also tend to differ in direction and magnitude and how they change over time.³⁵

Analysing the differences in the health of men and women

Sex as a determinant of health differences between men and women

In seeking to understand these and other differences in the health of men and women, biological sex and gender must be considered. To begin with, men and women are biologically different. These differences give rise to differing health needs, which health research, policy and health care services might not address adequately and fairly. For example, the leading types of cancer among men and women differ: cancers of the lung, stomach and liver are the leading causes of cancer-related mortality among men, while women are more likely to suffer from breast and lung cancer, and, in developing countries, from stomach, liver and cervical cancers.³⁶ Similarly, women give birth to children and breast-feed them, while men do not.

Gender as a determinant of health differences between men and women

Differences in the health of men and women also arise from the socially constructed category of gender. How gender inequality stratifies the opportunities for good health men and women experience can be traced to differences in men's and women's exposure to the risk factors for ill health, their access to health information, their health seeking and their use of quality health services. Together, these factors lead to inequalities in health outcomes, which might have different social and economic consequences for women than men (this is discussed in more detail in the sections below).³⁷ Box 5 illustrates some of the

Box 5: Sex and gender as health determinants

Exposure and vulnerability:

Sex differences

- preclude certain health risks for males and females (e.g., prostate or ovarian cancer);
- lead to differential exposures (e.g., pregnancy-related conditions); and
- explain differences in risk of certain illnesses (e.g., hormone-related illnesses, such as breast cancer and cardiovascular disease).

Gender roles

- lead to differential exposures (e.g., tobacco-related deaths, traffic accidents, exposure to cooking fires);
- lead to differences in vulnerability (e.g., domestic violence, depression, alcoholism); and
- affect the age of onset of certain diseases.

Outcome and impact:

Sex differences

- affect the severity of certain diseases (e.g., measles, mumps, gonorrhoea); and
- affect the age of onset and duration of certain illnesses (e.g., allergies, autoimmune disorders).

Gender roles

- affect the social impact of diseases (e.g., skin diseases are more likely to affect marriage options for women than men; infertility has a greater stigma for women than men).

Source: World Health Organization 2001.

sex- and gender-related differences between men and women as they relate to health status and the impact of morbidity.

Interaction between sex and gender

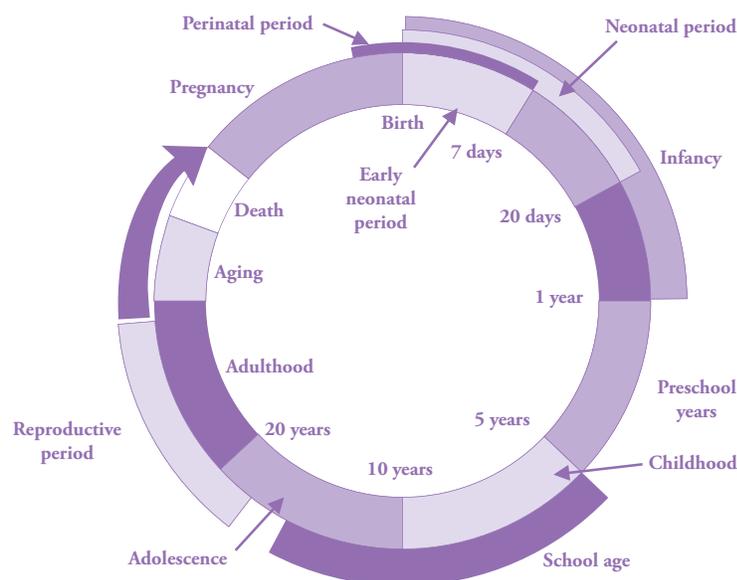
Analysing the health of men and women increasingly reveals differences arising from both sex and gender across health conditions. Although gender and sex are conceptually distinct, clearly demarcating the effect of sex as opposed to gender on the health of men and women might be difficult.³⁸ In practice, gender might amplify, counteract or work independently of biological sex.³⁹ Biological vulnerability interacts with unequal gender relations, as well as with other social and economic variables, to create different patterns of exposure to health risks, and access to and utilization of health information, care and services for men and women.⁴⁰ The differences between men and women for each of these types of issues are explored in greater depth in the discussion below.

Further, gender roles and norms, and the gender-based division of labour, might change as men and women age. How gender distinctly

constructs the roles and responsibilities of younger women and men, as compared to older or elderly men and women, has important implications for health across the life cycle and might influence their quality of life through the ageing process.⁴¹ Similarly, men and women's biological characteristics change over time, such as with puberty in boys and girls and menopause in women. Thus, young men and women tend to face different reproductive health needs, while gender and age discrimination might influence the health of elderly women. The life cycle approach is particularly useful because health is a complex phenomenon that encompasses mortality and morbidity from birth until old age, including reproductive health.⁴² Exposure to the determinants of ill health and periods of morbidity at a younger age often influence health in older age. Figure 2 presents an overview of the human life cycle.

The discussion that follows uses the life cycle approach to explore differences in the health of men and women across the life cycle. The generally poor quality and, in some cases, lack of sex-disaggregated data from countries in the Region constrains this approach, however.⁴³

Figure 2: The human lifecycle



Source: Claeson M., *et al.* Health, nutrition and population. In: World Bank. *PRSP sourcebook*. Washington D.C., 2004.

Differences between men and women in exposure to the determinants of ill health

As is becoming increasingly clear, sex and gender are important determinants of health for men and women. The different biological characteristics of men and women determine many of their health conditions. Biological differences between men and women include anatomical and physiological differences, as well as variations in genetic susceptibilities and immune systems.⁴⁴ For example, women confront health issues related to pregnancy, menopause and their reproductive system more generally, such as cervical cancer. Pregnant women are generally more vulnerable to malarial infection than are non-pregnant women or men, in areas of stable and unstable malaria transmission.⁴⁵ In Papua New Guinea, for example, the prevalence and incidence of malaria are highest in young children and pregnant women.⁴⁶ Women are also more vulnerable than men to anaemia, osteoporosis and sexually transmitted infections (STIs), among other health issues, due to physiological factors. The transmission of HIV from men to women appears to be 24 times more efficient than transmission from women to men.⁴⁷ In turn, men must contend with cancer of the prostate and haemophilia, for

example. These and other biological determinants might act independently of, interact with or be compounded by gender-related determinants of health.

Gender influences the health of men and women through multiple pathways. Gender roles and norms, and the gender-based division of labour, interact with other social determinants of health—such as education, employment status, income, culture, household position, age, and physical and social environments—to shape the possibility of good health for men and women in a society. Sociocultural norms of maleness and femaleness also influence the health of men and women. In some societies, for example, it is considered normal for men to visit sex workers. Since using a condom can be considered “unmanly,” men might be unwilling to do so and might not be well informed about the health risks of not using condoms. Admitting to gaps in their knowledge can also be difficult due to social expectations that men should “know everything.”⁴⁸ In Cambodia, for example, as in many other countries, society traditionally defines the roles of men, women, children and monks, among other categories of people. Young women are expected to be shy, unassertive and submissive, while for men

Box 6: The relative importance of sex or gender: the case of lung cancer

Whether sex and gender work independently or interact to affect the health of men and women continues to be a topic of debate. Take the example of lung cancer. Research increasingly suggests a complex relationship between sex, gender and lung cancer. While research has highlighted many aspects of this complex relationship, much remains unclear. In particular, the relative importance of sex compared with gender, and the manner in which they might combine to increase the risk of lung cancer in men and women, remains blurred.

A recent meta analysis suggests that women are more vulnerable than men to the effects of smoking. The analysis shows that lung cancer develops at lower levels of smoking in women than in men. To double their risk of lung cancer, women must smoke three to five cigarettes per day, while men must smoke six to nine cigarettes per day. The analysis also found that women were more susceptible to aggressive small cell lung cancer, such as adenocarcinoma.

Much of the research seeking to explain greater vulnerability of women to the effects of smoking remains contested. However, the analysis suggests that some of the answers could lie in women's greater tendency to smoke low-tar cigarettes, to inhale deeper and smoke faster than men. Biological factors, specifically women's sex hormones and reproductive status, appear to play an important role as well.

Sources: Payne S. 2005; Mackay J., Mensah G. 2005; Morrow M., Barraclough S. 2003b.

being sexually active, including by purchasing sex, is considered normal.⁴⁹ Harmful traditional practices often affect women disproportionately. This is closely linked to the more pervasive issue of violence against women, which gender-based discrimination might endorse implicitly or explicitly in a society.⁵⁰ Box 6 considers how sex and gender influence women's experience of lung cancer.

Importantly, gendered expectations, roles and behaviours are founded on power relations that shape the access men and women have to decision-making power, influence and resources at the household, community and national levels. These relationships might constrain or enable the ability of men and women to make choices and take actions to create a healthy lifestyle. In addition, gender norms, roles and relations are not static; they change over time and are renegotiated continually.

Nutrition

Gender inequality and poverty often interact in a manner that places girls and women at a greater risk of undernutrition than boys and men.⁵¹ Undernutrition encompasses protein-energy malnutrition, as well as deficiencies in micronutrients such as iron, vitamin A, iodine and zinc, in particular. While undernutrition might affect men and women across all stages of the life cycle, undernutrition *in utero*, infancy and childhood are of particular concern because of the long-term effects on health later in life.

Many studies that document nutritional inequalities between men and women or boys and girls are from countries in South Asia. However, some evidence is available from countries in the Western Pacific Region. A study from the Philippines, for example, reported differences in the diet of boys and girls. Specifically, it reported that boys consumed more protein-rich foods than girls, who were given more vegetables.⁵² A second study from the Philippines found that the intrahousehold allocation of calories favoured boys over girls.⁵³

Similarly, some evidence suggests that the rates of undernutrition in boys as compared with girls vary in the Region. However, a general lack of sex-disaggregated data on undernutrition has hampered efforts to elucidate a clear pattern. Data from 2000 show that the prevalence of moderate stunting in Cambodia was 24% among boys and girls under 5 years old, while severe stunting was higher (21.8%) among girls than boys (18.6%).⁵⁴ The evidence from Viet Nam is mixed. The 1997 Viet Nam Living Standards Survey (VLSS) estimated that the prevalence of undernutrition among boys and girls is the same, with no evidence to suggest systematic gender-based discrimination.⁵⁵ A second study exploring inequalities in undernutrition in Viet Nam using the 1993 and 1998 VLSS found that the risk of stunting was higher among boys than girls, and that the gender gap in stunting appeared to have widened from 1993 to 1998. A meta analysis that combined the results of studies of infant and child mortality and child nutrition utilizing household survey data supported the mixed influence of gender on undernutrition. Analysis of data from 35 studies on child nutrition from countries in Africa, Asia, Europe and Central and South America found that the sex of the child was largely insignificant in determining undernutrition.⁵⁶

Undernutrition in childhood often affects the health of adult men and women, although women appear to be particularly affected. The prevalence of anaemia among women of reproductive age in Viet Nam is estimated to be 30%–45%.⁵⁷ In 1998, the prevalence of anaemia among pregnant and lactating women in the Philippines was 50.7% and 45.6%, respectively.⁵⁸ Undernutrition might be harmful to women's productivity and their own health during pregnancy and child birth, and is also transmitted to the next generation. Children whose mothers were undernourished are born with a low birth weight (LBW) and have a higher risk of illness and shortened life expectancy.⁵⁹ An underweight girl will grow into a stunted adolescent and into a stunted woman, who is more likely to have LBW babies. Recent evidence also suggests a link between intrauterine growth

retardation (leading to LBW) and chronic diseases in adulthood.⁶⁰

Education

Education has been found to influence health significantly. Education, specifically health-related knowledge and awareness, leads to better nutrition and child-feeding practices, improved sanitation, and increased use of maternal and child health services.⁶¹ Table 4 presents the adult literacy rates for selected countries in the Region. The positive influence of education on health is distributed unevenly in the Region, as education levels vary across countries and between men and women within countries. In general, however, women's literacy levels are lower than those for men.

Table 4: Adult literacy rate in selected countries in the Region, 2000–2004*

Country	Adult literacy rate (%)	
	Male	Female
Cambodia	85	64
China	95	87
Fiji	94	91
Lao People's Democratic Republic	77	61
Malaysia	92	85
Mongolia	98	98
Papua New Guinea	63	51
Philippines	93	93
Singapore	97	89
Tonga	99	99
Viet Nam	94	87

*Data refer to the most recent year available during the period indicated in column heading

Source: United Nations Children's Fund 2006.

Disaggregating literacy rates by sex reveals that women are often disadvantaged in education. This arises, at least in part, because girls are kept from school or forced to leave school at an early age more often than boys if money is insufficient for their education or help is needed at home. In some communities, safety concerns might make parents reluctant to allow their daughters to travel

long distances to schools. For example, a study in Cambodia found that girls could not go to secondary schools located at a distance from their homes because of customs prohibiting daughters from travelling far from their homes and because of fears about girls being raped.⁶² Lack of education has ramifications throughout their lives, leading to fewer employment opportunities, higher rates of illiteracy and less access to information, such as basic family health guidelines, that could have significant positive effects on their lives. Evidence increasingly suggests that the positive relationship between education and health is amplified in the case of education for girls. Improved educational outcomes for women have been found to produce better health outcomes for themselves, their children and eventually their grandchildren.⁶³ This makes the elimination of gender-based inequalities in education an even more compelling goal.

Evidence suggests that women with higher levels of education are more likely than those with lower levels of education to seek care during pregnancy and child birth. The positive influence of education on pregnancy appears to extend to improved nutrition and increased spacing between births.⁶⁴ An analysis of data covering Peninsular Malaysia showed a significant association between education, as well as the likelihood of a woman seeking prenatal care and delivering in a clinic or hospital.⁶⁵ The World Bank estimates that, for every 1000 women, an extra year of education will prevent two maternal deaths.⁶⁶

Some studies from the Region have reported a significant positive association between maternal education (as measured by literacy or years of schooling) and child survival.⁶⁷ A study of 63 countries, including China, Lao People's Democratic Republic, Malaysia, Philippines and Viet Nam, substantiated this association. Using household survey-based nationally representative underweight prevalence data, the study reported that 44% of the reduction in the prevalence of child undernutrition from 1970–1995 could be attributed to improvements in women's education.⁶⁸

Gender-based division of labour

The gender-based division of labour found in a society influences the range of health risks men and women might experience. In many countries, women are primarily responsible for the well-being of their families. Thus, women might spend more time than men on productive and reproductive work at home, and fewer hours outside the house. When women work outside the house, they are often engaged in the informal sector or the lower ranks of formal employment.⁶⁹ Men tend to spend more hours than women engaged in productive work outside the house. In many countries, men are often engaged in seasonal work in forestry and fishing. In the case of transgendered individuals, their social marginalization and extreme exclusion from the labour market can force them into a precarious position, with few options other than sex work to survive. In this way, the type of work and employment conditions men and women experience differs, and hence influences their health risks differently.

The nature of their domestic tasks exposes women and girls to distinct health risks. In some communities, women spend more time than men in and around water sources because of their

responsibility for washing clothes and bathing children. Such water-related domestic tasks can increase the exposure of women and girls to waterborne diseases, such as schistosomiasis (Box 7), malaria and worms.

A majority of households in some developing countries burn unprocessed biomass fuels, such as dried animal dung, agricultural waste, wood or charcoal, for heating and cooking daily meals. These fuels often are burnt on open fires or in inefficient stoves. As a result, women and girls, who are usually responsible for cooking and might spend more time indoors than boys and men, are exposed to high levels of indoor air pollution. Young children who remain close to their mothers also might be affected. Evidence from some studies shows that indoor air pollution increases the risk of chronic obstructive pulmonary disease and acute lower respiratory infections in children under 5 years old. Exposure to coal smoke at home has been linked to lung cancer among women in China.⁷⁰ Prolonged exposure to open stoves also increases the risk of burns among women and girls.⁷¹

The gender-based division of labour influences the health of men as well. The workplace hazards men and women experience tend to differ, as

Box 7: Schistosomiasis: exposure and vulnerability

A study was undertaken to investigate the growth patterns of schoolchildren in the Dongting Lake area of Hunan Province, China. Despite long-term control efforts, schistosomiasis remains a serious health issue due to *schistosoma japonicum* (*S. Japonicum*). The study collected data on 427 children aged 10–13 years in five villages.

The study found that the prevalence of *S. Japonicum* was highest in children 12 and 13 years old, reaching 19% in girls and 10% in boys. The higher prevalence rate of *S. Japonicum* in girls than in boys was attributed to gender norms in the area that result in differential rates of contact with water. That is, girls are more likely to be engaged in domestic work, such as the collection of grass in marshlands for animal feeding and harvest of wild vegetables along water embankments. On the other hand, recreational activities in the infected water, such as swimming, might be higher among boys than girls.

Infection of *S. Japonicum* has been shown to result in reduced growth among children in the Philippines and Jiangzi Province, China. The study in the Dongting Lake region of China likewise reported inhibited child growth due to *S. Japonicum*, particularly in girls.

Source: Zhou H. *et al* 2005.

they are often concentrated in different types of work. For example, more men than women earn a living from fishing, which may increase men's chances of developing cataracts and skin cancer from the sun reflecting off the water. Case studies from the Region attribute the higher prevalence of malaria among men to their greater exposure to mosquitos. In many malaria-endemic countries in the Region, men's work tends to take them into the forest at different times, or for a longer duration, than women. A study from Viet Nam reported that regular forest work is a significant activity for men and not for women. While women went into the forest regularly, they went less frequently and for shorter durations than men. This is largely because women returned home to attend to their domestic tasks.⁷² Women, in turn, often are overrepresented among health workers. Thus, they are exposed to used needles, diseases and infection.⁷³

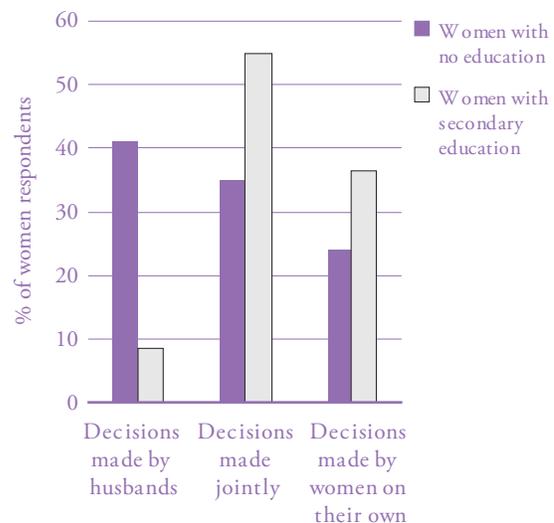
Even when men and women are engaged in the same occupation—such as agriculture, manufacturing or services jobs—they are often assigned different tasks and responsibilities. For example, men might be responsible for ploughing the fields for farming, while women are responsible for weeding. These tasks, and their related health risks, often differ from region to region. In the Cordillera region of the Philippines, for example, women are responsible for planting the rice fields. They suffer from back problems due to hours spent bending over, and suffer fungal infections caused by standing in water for extended periods. On the island of Bali in Indonesia, where men tend the rice fields, they are exposed to those health problems.

In some communities, men migrate in search of work, while in other communities women more commonly migrate. Men often perform activities such as truck driving, seafaring and serving in the military, which require long absences from home. It is not unusual for men to engage in sexual activities while away from home, increasing the chance that they will contract an STI, which they might pass on to their partners when they return home.⁷⁴

Bargaining power

Gender inequality in society is often expressed in the greater bargaining power of men compared to women within the household and society. Evidence from Viet Nam, for example, shows that women's ability to make decisions on how to spend their own income varies with their level of education (Figure 3). In some societies, a single individual—male or female—or a couple does not make decisions concerning health and health care seeking. Instead, such decisions are made in the extended family or community.⁷⁵

Figure 3: Who decides how married women spend their own income in Viet Nam



Source: Mohdeen R. 2002.

The typically unequal bargaining power of women is associated with their lower access to, and control over, household resources, which can constrain the ability of women to protect their health and the health of their family members.⁷⁶ In the Lao People's Democratic Republic, for example, the decision to purchase and use a bednet is considered a man's decision.⁷⁷ Similarly, a study in Diandong County in rural China found that 45%–55% of women respondents required their husbands' permission to go to the market, clinic or natal village.⁷⁸ Another powerful example is the inability of many women to refuse

Box 8: The status of women and child health outcomes

The unequal bargaining power of many women within households has received much attention. The main reason is the increasing evidence of strong positive links between the improved status of women within their households and communities and their own health, as well as that of their children. A study in 1983–1984 in three rural provinces in the Philippines shows that, as the value of a woman's time increases (as measured by an estimated wage), her own nutritional status and that of her preschool children (13–83 months) improves. This is attributed mainly to the improved intrahousehold allocation of calories to women and children.⁷⁹

A recent study that analysed the relationship between women's status and nutritional outcomes among children under 3 years old substantiated this association. The study used Demographic and Health Survey (DHS) data from 36 developing countries in South Asia, Sub-Saharan Africa, Latin American and the Caribbean to assess two measures of women's status as defined by their power relative to men—women's decision-making power relative to that of their male partners and the degree of equality between men and women in their community. The study clearly demonstrated that improvements in these two measures of women's status are correlated significantly with improved nutritional outcomes in children. The authors explained that women with higher status have better nutrition and are better cared for—and, thus, are better able to care for their children—compared to women with lower status.⁸⁰

Sources: Senauer B. 1988; Smith L. *et al* 2003.

sex or insist that their partner use condoms. Box 8 discusses the relationship between women's unequal bargaining power within households and child health outcomes.

Differences between men and women in incidence and prevalence of disease

The cumulative effect of the different exposure of men and women to the risks of ill health arising from gender-based and biological differences leads

to different patterns of morbidity. Table 5 presents the leading diseases for men and women 15 years old and older in 2002. The differences between men and women with respect to the diseases that contribute most to their loss of disability adjusted life years (DALY) are notable.

Communicable diseases

Although impressive gains have been made in controlling communicable diseases, many remain

Table 5: Leading causes of disease burden for men and women 15 years old and above, worldwide, 2002 (DALYs)

Males	%DALYs	Females	%DALYs
1. HIV/AIDS	7.4	Unipolar depressive disorders	8.4
2. Ischaemic heart disease	6.8	HIV/AIDS	7.2
3. Cerebrovascular disease	5.0	Ischaemic heart disease	5.3
4. Unipolar depressive disorders	4.8	Cerebrovascular disease	5.2
5. Road traffic injuries	4.3	Cataracts	3.1
6. Tuberculosis	4.2	Hearing loss, adult onset	2.8
7. Alcohol use disorders	3.4	Chronic obstructive pulmonary disease	2.7
8. Violence	3.3	Tuberculosis	2.6
9. Chronic obstructive pulmonary disease	3.1	Osteoarthritis	2.0
10. Hearing loss, adult onset	2.7	Diabetes mellitus	1.9

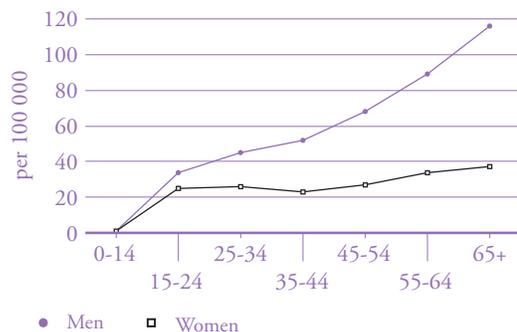
Note: A DALY is a disability-adjusted life year.

Source: World Health Organization 2003a.

major public health issues in countries throughout the Region. Of particular importance for adults in the Region are TB, malaria and HIV/AIDS. Analysis of sex-disaggregated data shows gender differentials in the burden of these diseases. Communicable diseases cause a higher proportion of death and DALY loss among poor women than among poor men, even after maternal conditions are removed.⁸¹

Epidemiological evidence shows differences between men and women in indicators such as prevalence of TB infection, rate of progression from infection to disease, incidence of clinical disease, and mortality due to TB.⁸² In 2004, the Region had an estimated 3.8 million cases of TB.⁸³ More men than women are diagnosed with TB in the Region (Figure 4). The male-female ratio of new smear-positive case notification in 2004 ranged from 2.6 in Viet Nam to 0.9 in Kiribati.⁸⁴ Some studies argue that this reflects a true difference in the incidence of disease.⁸⁵ However, other studies debate the extent to which this male-female difference is explained by true differences in incidence, as compared to differences in social and gender-based factors, such as barriers to access, which might lower rates of diagnosis and reporting for women. Evidence from a population-based survey in 2000, in Bavi District, Viet Nam, found that the prevalence of TB was similar among men and women, despite higher rates of TB reported among men in clinic registers.⁸⁶ Nevertheless, studies have reported that the risk of progressing

Figure 4: Smear-positive notification rates by age and sex, 2004



Source: World Health Organization Regional Office for the Western Pacific 2006.

from infection to active disease is higher in women of reproductive age than in men of the same age. Case fatality rates likewise appear to be higher for women than men.⁸⁷

Based on available sex-disaggregated data, the prevalence of malaria is often reported to be higher among men than women in the Region (Figure 5).⁸⁸ Some case studies lend weight to this finding. A study from Viet Nam reported that significantly more men than women in the study population sought care for malaria at one of four private health clinics.⁸⁹ Estimates from the Philippines show that a larger share of men than women were diagnosed with malaria. In East Sepik, Papua New Guinea, men were found to be 9.7% more likely than women to present with malaria at rural health clinics.⁹⁰ However, a few studies suggest that this trend might not be universal, and the prevalence of malaria might be similar in men and women. For example, the distribution of malaria cases was reported to be the same for men and women in three villages in Attapeu Province, Lao People's Democratic Republic.⁹¹ A survey of communities near forested areas in rural Cambodia found little difference between the slide positivity rates of men and women.⁹²

Differences between men and women have also been reported for other diseases, including

Figure 5: Percentage of male and female malaria cases reported in selected countries in the Region, 2003



Source: World Health Organization and United Nations Children's Fund 2005.

dengue and filariasis. The prevalence of dengue in men as compared to women appears to vary across countries in the Region. A study from Thailand reported that women were hospitalized with dengue haemorrhagic fever twice as often as men, while in Singapore 1.5 times more men than women were admitted to the hospital for the disease.⁹³ A study of dengue in Malaysia reported that, while men had a higher incidence of dengue haemorrhagic fever than women, the case fatality rate was higher among women.⁹⁴ A global review of filariasis observed that lymphoedema occurs 1.5 times more often in women than men.⁹⁵

The combination of female biological characteristics and gender inequality makes women more vulnerable to HIV/AIDS infection. Indeed, women appear to be more susceptible to HIV than men in heterosexual encounters.⁹⁶ In 2003, women accounted for roughly half of the 35.7 million adults infected with HIV globally—up from 41% in 1997.⁹⁷ Younger women are at particular risk of infection, largely because gender norms and cultural beliefs often encourage older men to have sex with much younger women. Estimates suggest that, in 2001, the prevalence of infection in women 15–24 years old was higher than that in men of the same age.⁹⁸ Overall, one third of DALY loss by women 15–44 years old in developing countries results from reproductive health problems.⁹⁹

Differences between men and women in the prevalence of HIV vary across countries in the Region, reflecting the distinct characteristics of the epidemic and gender norms in each country. From 2002 to 2003, the prevalence of HIV among adults 15–49 years old in Cambodia declined from 2.1% to 1.9%. In 2003, the male/female ratio among those infected was 1.14. The prevalence of HIV was highest among female sex workers, and roughly one third of HIV/AIDS cases occurred in women of reproductive age.¹⁰⁰ In the Philippines, where the prevalence of HIV has remained low, men accounted for 64% of HIV cases in 2005.¹⁰¹ In Viet Nam, 2.3 men were infected with HIV for every woman in 2003.¹⁰² As of 2005, men accounted for most of those with AIDS (90.4%)

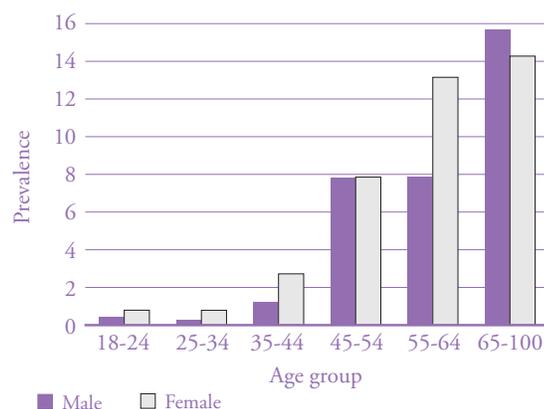
or HIV (92.6%) in Malaysia.¹⁰³ The burden of HIV infection appears to fall equally on men and women in Papua New Guinea.¹⁰⁴ Box 9 discusses how gender norms influence the spread of HIV in men who have sex with men (MSM) in countries in the Region.

Noncommunicable diseases

Ill health and disability from noncommunicable diseases (NCDs) are rising rapidly among adults in the Region. NCDs account for about half of the global burden of disease, with injuries accounting for an additional 13%.¹⁰⁵ In the Region, 85% of the burden of NCDs falls on low- and middle-income countries.¹⁰⁶ However, due to the general lack of sex- disaggregated data on NCDs from developing countries in the Region, little is known about differences between men and women with respect to the burden of NCDs.

Levels of obesity are reportedly rising in developing countries in the Region. In Pacific island communities, for example, obesity is beginning to pose a significant health burden. This appears to be especially true for women—the prevalence of obesity among women has been found to be 84% in Tonga, 63% in Fiji and 56%–74% in Western Samoa.¹⁰⁷ Overall, obesity levels tend to be higher in women than in men, especially poor women and men.¹⁰⁸

Figure 6: Diabetes prevalence, by sex and age group, in Fiji



Source: World Health Organization Global InfoBase 2006.

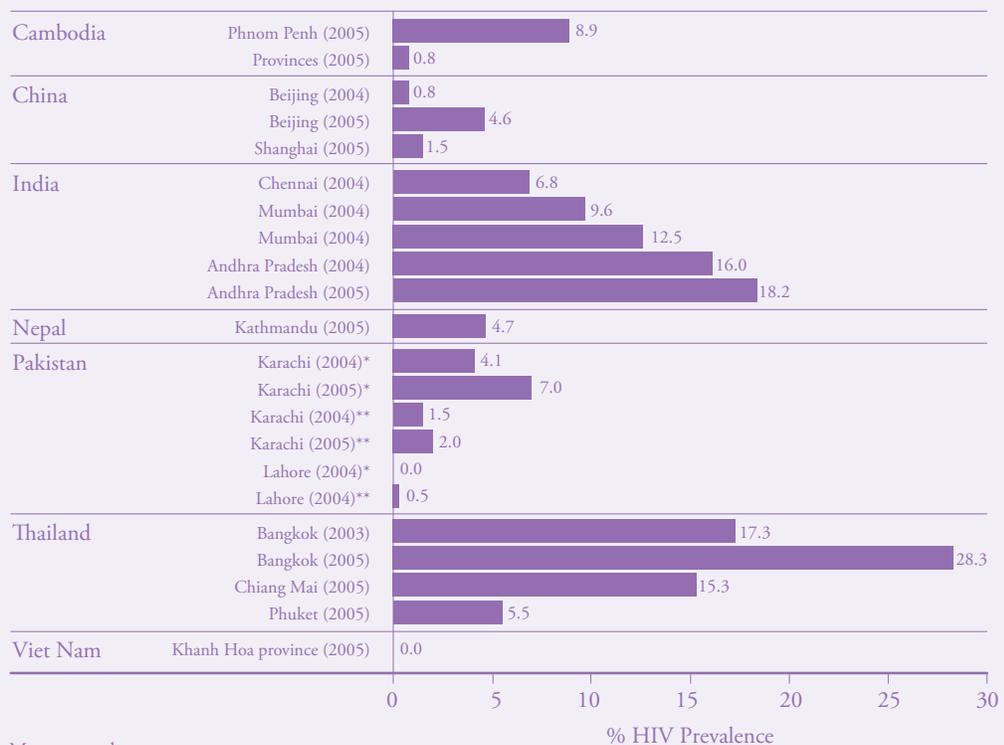
Box 9: The influence of gender norms on the health of men: the case of men who have sex with men and HIV/AIDS

For many men, the social pressure to conform to gender norms or dominant masculinities can be intense, and the consequences of nonconforming behaviour might be harmful. For example, men who have sex with men (MSM) are often vulnerable to sexual violence from other men. The influence of dominant masculinities might be much more pervasive, however. Growing awareness of HIV/AIDS in MSM suggests that dominant gender norms might undermine the health of men and the capacity of the health system to respond to their needs.

In more than 70 countries, homosexuality remains criminalized or highly stigmatized. This might be linked to pervasive notions concerning appropriate sexual behaviour for men (and women). Because MSM do not conform to dominant ideals of masculinity, they often face discrimination and human rights abuses that might deter them from seeking prevention, care and treatment for HIV/AIDS. Estimates suggest that less than 10% of MSM have access to adequate prevention and care services globally. In communities where MSM face discrimination and stigmatization, improving their access to HIV-related information, diagnosis or treatment is difficult. This is because efforts to enhance access to appropriate services might result in MSM being identified, harming their relationships and position within their community.

Moreover, continued denial among governments and service providers means that, even after more than 25 years of confronting the HIV/AIDS epidemic, data on HIV/AIDS among MSM remain scarce. Figure 7 presents estimates of the prevalence of HIV among MSM in selected countries in Asia.

Figure 7: Prevalence of men who have sex with men in selected countries in Asia, 2003–2005



* Men sex workers

** Hijras

Source: Joint United Nations Programme on HIV/AIDS (UNAIDS) 2006f.

Continued on next page

Box 9 (continued)

In 2006, UNAIDS reported “deep seated confusion concerning who MSM are.” As a result, an understanding of the needs and circumstances of MSM is generally lacking, which adds to the challenge of meeting the needs of MSM and effectively preventing the spread of HIV/AIDS. Enhancing the availability of information on HIV/AIDS for MSM, and improving their access to HIV prevention, treatment and care, should go hand in hand with efforts that aim to challenge dominant notions of masculinity and the position of MSM within society.

Source: UNAIDS 2005.

Similarly, the prevalence of diabetes appears to be higher among women than among men. In Luzon, Philippines, women were found to have a higher prevalence of diabetes and impaired glucose tolerance than did men in 2000.¹⁰⁹ Yet this pattern appears to vary across age groups. Figure 7 presents the prevalence of diabetes among men and women of different age groups in Fiji.

Based on the results of a meta analysis of population-based surveys on blindness prevalence in Asia, Africa and industrialized countries, an estimated two thirds of reported blindness occurred in women. Cataract is the major cause of blindness in countries in Asia and Africa, where an estimated 53%–72% of people living with cataract are women. Another key source of blindness is trachoma, which is also more common among women than in men.¹¹⁰

Mental health problems are an important source of disease and disability, accounting for 12.3% of DALYs loss globally in 2000. While little evidence is available on differences between men and women in the overall prevalence of mental health conditions, such differences are seen in the patterns and symptoms of particular disorders over the life cycle. In childhood, boys are more likely to experience conduct disorders, such as aggressive and antisocial behaviours, while girls suffer a higher prevalence of depression and eating disorders. Among adults, the prevalence of depression and anxiety is higher in women than men, who tend to engage more than women in antisocial behaviours and substance use disorders. Rates of suicide are higher for men than women, except in China.¹¹¹

Injuries are a hidden plague, particularly among young men. Remarkably, 70% of the 4.5 million victims of injuries worldwide are men.¹¹² Injuries include deaths caused by road traffic accidents, violence and self-inflicted injuries. The rate of injury and fatality in road traffic accidents is 2.7 times higher among men than women.¹¹³ Increasingly, violence—particularly gender-based violence—is also understood to be an important cause of injury among women. It has been linked to physical health problems (injury, chronic pain syndromes and gastrointestinal disorders) and numerous mental health problems, including anxiety and depression.¹¹⁴ Gender-based violence and rape account for 5% of DALY loss among women in developing countries.¹¹⁵ A nationwide prevalence survey in Samoa observed that, among women 15–49 years old who had ever partnered (i.e., married or lived with a man), 41% had experience physical violence and 20% had experienced sexual violence in their lifetimes. The experience of physical and sexual violence was found to be negatively associated with level of education. That is, 54% of women with primary education had experienced physical or sexual violence during their lifetime. The corresponding rates among women with secondary education (45%) and higher education (35%) were significantly lower.¹¹⁶

As noted, women in the Region generally live longer than men. As such, women are more likely to suffer periods of disease and disability than are men. Women’s generally longer life leads to a variety of menopause and age-related issues, such as arthritis, osteoporosis and Alzheimer’s disease. The health of poor women is compromised further by their heavy work burden and child-bearing, and unequal access to food in earlier life

might undermine their nutritional status. Since many women will outlive their partners, they might be alone and vulnerable in their later years, particularly if they were unable to earn money of their own earlier in life.¹¹⁷

Differences in men and women's access to health care services

In many cases, the reasons for the differences between men and women in the incidence and prevalence of diseases outlined above remain poorly understood. Evidence suggests that the observed differences arise from both biology and gender inequality. Men's and women's different, and at times unequal, access to preventive and curative health services might account for at least some of these differences. In particular, some studies have highlighted how gender norms might influence the access of men and women to health services. Often, gender norms interact with other dimensions of exclusion in society (Box 10) to further shape access. This section explores this issue in greater depth.

Some studies from the Region have observed that access to health services might not be distributed equally between men and women. A survey in 1998 found that an estimated 59.8% of Filipino children with diarrhoea and acute respiratory infection (ARI) in the preceding 2 weeks had been taken to a public, private or traditional health service provider. However, boys were more likely than girls to be taken to such a provider.¹¹⁸ Conversely, data from 2002 show that girls were slightly more likely than boys to be taken to a provider when they were sick with fever, while boys were more likely than girls to receive medical attention when suffering from ARI.¹¹⁹ In Cambodia, 36.1% of boys suffering from fever and 32% of girls with fever were seen by a health service provider in 2000. In Viet Nam, the proportion of children with ARI seen by a provider was 76% for boys and 64.8% for girls in 2002. Of these children, 38.5% of boys and 35.1% of girls were taken to a public facility, while 35.4% of boys and 25.6% of girls were taken to a private facility.¹²⁰ In Papua New Guinea, a study reported that mothers took their boys to the health centre more often, and

Box 10: Gender and poverty: inequalities in health among men and among women

A growing body of evidence shows that the biological and gender-based differences observed in the burden of diseases are punctuated with inequalities in the incidence and prevalence of morbidity among women and men. Such inequalities arise, in part, because gender inequality and biological vulnerability often overlap with, and are reinforced by, discrimination based on low income, race, ethnicity or other forms of social exclusion.

The case of maternal health illustrates how women of different socioeconomic groups experience unequal health outcomes. Reproduction places unique demands on women's bodies. For example, pregnancy-related complications have been estimated to account for 18% of the global burden of disease for women of reproductive age. Ensuring adequate nutrition is often an integral aspect of a healthy pregnancy, yet many women experience periods of protein and micronutrient deficiencies in their reproductive years. Instead of affecting all women equally, undernutrition tends to be concentrated among women from poor households. The results of a survey from more than 50 developing countries show that women from the poorest income quintile are twice as likely as those from the richest quintile to suffer from malnutrition.¹²⁴

Data from countries in the Region illustrate a similar trend. In Cambodia, 21.6% of women in rural areas suffer from chronic energy deficiencies (with a body mass index less than 18.5), compared with 16.1% of women in urban areas. Similarly, the incidence of anaemia is higher among women living in rural areas (71%) than in urban areas (45%) of Mongolia. The prevalence of anaemia in Cambodian women was found to be 62.1% for those with no education, 57.8% for those with primary education and 49.9% for those with secondary education or higher.

Sources: Carr D. 2004; National Institute of Statistics, Directorate General for Health (Cambodia), and ORC Macro 2001; Government of Mongolia 2003; Sen G., George A., Ostlin P. 2002.

travelled further with them than with their girls.¹²¹ Another study found that, while the prevalence of malaria (measured by parasitaemia rates) within communities was equal, men were six times more likely than women to seek care at a health clinic.¹²² Similarly, women appear to have lower access to eye care services than men.¹²³ In India, for example, a study found that only 8% of rural women had sought care for gynaecological illnesses, although 92% had one or more reproductive health problems, including reproductive tract infections, pelvic inflammatory disease, genital prolapse and urinary tract infections.¹²⁵

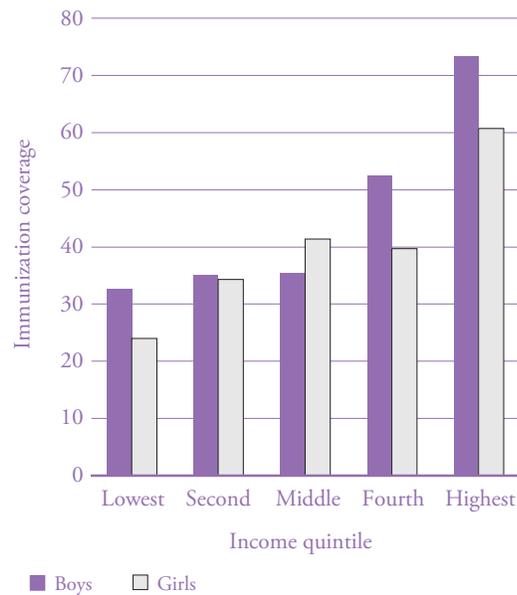
Studies show that some financial and non-financial barriers that delay and prevent men and women, particularly those who are poor and marginalized, from accessing health services might influence access to health care.¹²⁶ A smaller number of studies have explored how gender might determine these barriers to access, thereby resulting in differences in access for men and women. Some barriers also might be more difficult for women than for men to overcome. In some areas, for example, men are more likely than women to consult a health service provider if they are ill. In others, men are culturally pressured not to admit weakness, which might result in a delay in seeking treatment. Such delays in seeking health care might make treatment more expensive, difficult and sometimes impossible. As gender norms are socially constructed and tend to vary across geographical locations, the way gender might shape access to preventive and curative health care is likely to be context-specific, overlapping with poverty and ethnicity, among other indicators of social exclusion.

The following section discusses various types of barriers to access—including geographical, economic, sociocultural, and limited knowledge and awareness—that lead to low demand for and use of services.

Geographical barriers

Limited human and financial resources for health have resulted in generally inadequate coverage of health services. For example, full

Figure 8: Proportion of boys and girls aged 12–23 months who have received full basic immunization coverage (BCG, measles and DPT) by income quintile, Cambodia



Source: Gwatkin D. *et al* 2007a.

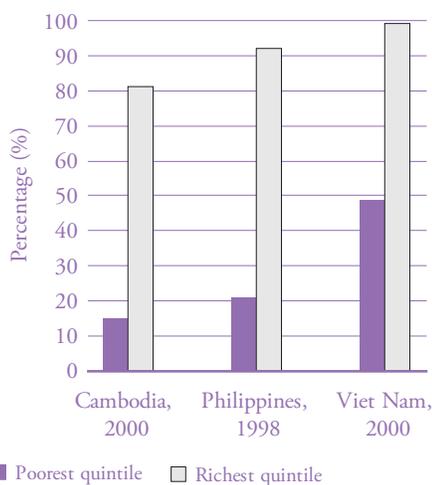
basic immunizations reached 65.9% of boys and 67.6% of girls in Viet Nam in 2002.¹²⁷ Data from the Philippines show that the coverage of full basic immunizations was on average higher for girl children (71.3%) than for boy children (68.4%) aged 12–23 months.¹²⁸ In Cambodia, the proportion of children 12–23 months who received measles vaccinations in 2000 ranged from 45.6% (for children whose mothers had no education) to 71.1% (for those whose mothers had a secondary education or higher). Notably, the coverage of measles vaccinations appeared to be only 35% among poor girl children.¹²⁹ Figure 8 presents the proportion of boys and girls who have received basic immunizations by income quintile in Cambodia in 2000.

Many households, particularly those in rural and remote areas and small island communities, are often forced to travel considerable distances to reach the nearest health facility. In northern Lao People's Democratic Republic, for example, roughly 30% of the population lives at least 16 kilometres from a health centre.¹³⁰

A study of demand for prenatal care among pregnant women in Metro Cebu, the Philippines, found significantly longer travel times for women living in rural areas than for those in urban areas. Travel costs in rural areas were reported to be almost double those in urban areas.¹³¹ Travel time to the nearest aid post (nursing station clinic) in Papua New Guinea was found to range from 67 minutes in Papua/the South Coast to 28 minutes in New Guinea Island.¹³²

Geographical distance, often measured in terms of time travelled, remains a crucial barrier to access in many poor and rural communities in the Region. In emergencies, people often do not have enough time to reach a clinic or hospital, or the facility is too difficult to reach. For women of reproductive age, this means they often do not have access to prenatal care and must give birth at home. If the birth is a healthy one, and especially if a skilled midwife can be in attendance, the mother and child might not need further assistance. However, if difficulties arise, facilities are often too far away to be of use. Figure 9 presents the share of women from the poorest and richest income quintiles receiving delivery assistance from a doctor or nurse/midwife in Cambodia, the Philippines and Viet Nam.

Figure 9: Women receiving delivery assistance from a doctor or nurse/midwife in Cambodia, the Philippines and Viet Nam



Source: Carr D. 2004.

Given the geographical barriers, gender norms might result in lower access for women and girls than for men and boys. For example, distance was found to decrease significantly the likelihood of seeking treatment for malaria in East Sepik, Papua New Guinea. This finding was most pronounced among women.¹³³ In some areas, women's mobility might be constrained relative to men. Women might not have their own source of transportation, and their generally lower access to cash income might prevent them from using public transportation. The normative expectation that women should remain in the private sphere of the home, while men may move freely in the public sphere, might reinforce such constraints. In some areas, women must seek the permission of their partners or fathers to seek health care. In others, a male family member often must accompany them when travelling beyond their community. This increases the cost of seeking care in terms of lost household labour and transportation costs.

In addition, the sociocultural environment might determine what is considered "near" and "far". In some settings, women might be limited to their village, while in others they might be limited to their home compounds. Elsewhere, women might face few mobility restrictions. Therefore, local norms related to male and female mobility determine treatment seeking in some communities in the Region. When faced with constrained mobility, women might seek diagnosis and treatment from nearby, but less-qualified, providers, traditional healers or village pharmacies rather than travelling farther to access better quality primary health care.¹³⁴ In Viet Nam, a study assessing adults with long-term cough found that women were more likely than men to choose less-qualified health service providers. More women than men reported convenience and proximity to home as the reason for their choice of health service provider.¹³⁵

Economic barriers

Where health services are available, the cost of seeking care might delay or prevent men and women from accessing appropriate health services.

The total cost of seeking care can be disaggregated into direct costs (such as fees charged for health care), indirect costs (such as the cost of transportation and food) and opportunity costs (such as time away from work).

Economic barriers to access have come to the fore with the introduction of user fees in many developing countries. This is because user fees have been shown to impede access to health services, especially for the poor.¹³⁶ In general, user fees are associated with reduced use of health services, such as maternal health services.¹³⁷ A study from Kenya assessed the impact of the introduction of user fees in government outpatient health facilities on the use of STI services by men and women. The study observed that the user fee, which amounted to half a day of pay for individuals classified as poor, reduced the use of services by men and women. Women reduced their use significantly more than men.¹³⁸

Some studies have observed that women must purchase supplies, such as bleach to sterilize materials, bed sheets, gauze, gloves and sanitary pads, when admitted to a health facility for delivery.¹³⁹ A Chinese woman living in a rural area underscored the challenges that women may face when dealing with illness:

Of course (when you are sick) you should see a doctor. But if you have no money, how can you talk about going to see a doctor? Money is the important thing. If you have money, you will go to see the doctor, even if there is no way to go but to walk.

*It's a long way to see the doctor. The only way to get there is by molap (small three-wheeled tractor used for hauling), but that requires money too.*¹⁴⁰

Women are thought to be particularly vulnerable because of their generally poorer access to and control over household resources, including financial resources. One study observed that widows and unmarried women with children were especially vulnerable.¹⁴¹ As discussed in

Section 1, men are more likely to be engaged in income-generating productive work than are women, thereby leading to women's limited access to cash income. Thus, women must obtain the cash required to seek health care through their relationships with their male partner, parents or siblings.

Compared to men, women's generally lower level of formal employment has implications for their access to health insurance. For example, a case study in Tianjian, China, found that the Government Insurance Scheme and the Labour Insurance Scheme were less likely to cover women (41.9%) than men (46.3%) in 1998. This is largely because women, in addition to being less likely than men to be employed in the formal sector, were more likely to be laid off and less likely to be reemployed. Additional estimates suggest that up to 70% of women in China are not covered by any health insurance.¹⁴² As a result, 64.8% of women reported that financial difficulties prevented them from accessing hospital services when referred by a doctor, compared with 55.6% of men.¹⁴³

The generally lower intra-household bargaining power of women relative to their male partners might result in the distribution of household resources, including decision-making and influence, favouring male over female household members. Thus, the ability of women to make decisions benefiting their health, as well as that of their children and family generally, might be curtailed. For example, higher household income has been found to increase the likelihood of women receiving antenatal care and skilled assistance during delivery.¹⁴⁴ However, evidence from Indonesia shows that, holding household income constant, a woman's use of prenatal care, including the amount and timing of care, rises as the share of household assets she owns increases. Owning a larger proportion of household assets also increases the probability that a woman will give birth in a hospital, at a private doctor's office or at home with a midwife in attendance.¹⁴⁵

Further, time constraints impose an important opportunity cost on women, relative to men, in

seeking care. The heavy time demands of their multiple productive and reproductive roles often constrain the time women are able to devote to health seeking. Cuts in health service funding can also increase the burden of caregiving on women in the home.

A case study from Mongolia points to the important role that social networks play in achieving improved health outcomes among women. The study found that maternal mortality was higher among women who lacked integrated and well-functioning support systems. This could be important, because social networks might provide supplementary household labour when women seek care and might assist them in seeking care.¹⁴⁶

Sociocultural barriers

Social norms and conventions also might constitute barriers to access to health services for men and women and boys and girls. Social norms are in continual flux as societies evolve and change in response to social, economic and political factors. Within a society, social norms also might differ between socioeconomic or ethnic groups.

Social norms often define what is considered appropriate behaviour for men and women across the life cycle. In some societies where men are understood to be the family decision-makers, they decide when and where health care should be sought. Reproductive health issues might be particularly sensitive to social norms. In Malaysia, the low use of condoms has been linked to the commonly held belief that condoms are associated with extramarital affairs and sex workers.¹⁴⁷ Evidence suggests that some adults in Cambodia continue to deny the possibility of premarital sex, particularly among young women. As a result, young people might be discouraged from discussing or asking questions about sexual matters, and remain relatively uninformed about how their bodies function.¹⁴⁸ In many societies, women remain ignorant about their sexuality and sexual health because they are not “supposed” to know about

such things, while men remain ignorant because they are “supposed” to know without asking.¹⁴⁹ Similarly, men might perceive admitting illness as a sign of weakness, thereby making them dependent on family members.¹⁵⁰

Stigma can be another powerful sociocultural barrier that deters men and women from being tested for HIV and other STIs. Evidence suggests that stigma and discrimination restrict the access of men who have sex with men to information and health services.¹⁵¹ Women might be especially concerned about the ramifications of testing positive for HIV, TB and leprosy, among other diseases, when such a diagnosis is perceived to reduce their likelihood of marriage or increase the chances of their marriage ending in abandonment or divorce.¹⁵² A woman living in India illustrates the life-changing impact of such illnesses:

I was 17 when I finished my schooling. My father who works in a bank and my mother decided to get me married because there was an offer from a family friend. The boy was earning well and the 10 stars in our horoscope matched perfectly. After marriage I had a beautiful baby girl. Soon after the first birthday of our daughter my husband started falling very ill and died, they say due to “meningitis”. He was tested for HIV one week before he died and was found positive. They drew my blood without our counselling and I was terrified when they told me I was also positive. My mother-in-law asked me to leave home saying “I had killed her son”. I left my husband’s house with a small bundle of clothes and my little girl. My in-laws said, “If it was a son we would have taken care of him”. All what is due to me—life insurance, Provident fund, etc. have been snatched away by my in-laws. My parents are worried to take me in because I have a sister to be married. So I stay in a widows’ shelter home, where my little girl is happy playing with other children of HIV positive widows.¹⁵³

Where abortion is legal, access to safe abortions has been identified as a core component of

Table 6: Literacy rates for men and women from ethnic minorities and the total population in Cambodia, Lao People's Democratic Republic and Viet Nam

Literacy rates	Ethnic minorities		Total population	
	Female	Male	Female	Male
Cambodia*	17%**	26%**	55%	63%
Lao People's Democratic Republic	17%	33%	48%	60%
Viet Nam***	—	73%	86%	92%

* Literacy rates for ages 7 years and above

** Literacy rates in the provinces of Mondolkiri and Ratanakiri, which are 67% ethnic minority

*** Literacy rate for ages 10 years and above

— signifies that no data are available.

Sources: Asian Development Bank 2001.

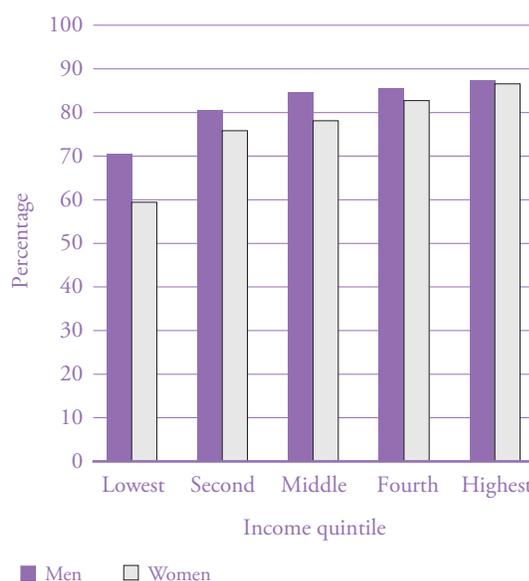
reproductive health services.¹⁵⁴ However, access to safe abortion is uneven across countries in the Region. Even in countries where it is legal, social stigma and the poor quality of services might put women's health at risk by continuing to veil abortion—and women who seek abortions—in silence. The continuing paucity of data and misinformation on abortions in many countries in the Region highlights this risk. In Cambodia, for example, a study reported that misinformation concerning abortion continues, with only 17% of medical providers correctly responding to questions concerning the 1997 abortion law.¹⁵⁵

Silence and stigma also continue to surround domestic violence and rape in many countries in the Region, resulting in under-reporting and neglect of this important health issue. In China, domestic violence reportedly continues to be neglected, and victims of abuse are expected to “silently endure suffering alone.”¹⁵⁶ In Malaysia, the number of reported rape cases has increased steadily. This is estimated to be a fraction of total rape cases, however.¹⁵⁷

Ethnic minorities and other marginalized groups might face distinct barriers when seeking to access health care. In Guizhou Province, China, 56.2% of infant deaths among the majority Han are not seen by a doctor or taken to a hospital. This proportion rose to 69.3% for the minority Miao and 66.6% for the Bouyei.¹⁵⁸ A study in Viet Nam identified limited knowledge of the majority language and the high cost of transportation as

the main causes of lower health service use by ethnic minorities (24%), compared to that by the majority ethnic group (34%).¹⁵⁹ Literacy rates for ethnic minorities tend to be lower than the national average in many countries in the Region. Among ethnic minorities, women tend to be particularly disadvantaged (Table 6).

Other studies explain that health service providers might be unresponsive to, or might not understand, the needs of ethnic minorities.¹⁶⁰ For

Figure 10: Proportion of women and men 15–49 years old who listened to the radio at least once a week, by income quintile, the Philippines, 2003

Source: Gwatkin D. *et al* 2007b.

example, reports suggest that women dwelling in some ethnic minority communities in Viet Nam, like women in communities elsewhere, are expected to place the health of their family members ahead of their own. As a result, they might not seek treatment when they fall ill.¹⁶¹ Among the Akha people, who live in the highlands of Thailand, Myanmar, the Lao People's Democratic Republic and China, men and women traditionally sleep in different parts of a large house. If only one bednet is distributed for the family, social ranking or perceptions of vulnerability to malaria might determine who within the family has access to it.

Low education and knowledge

Limited or no information or knowledge among men and women can decrease their demand for preventive and curative health services. Educational outcomes tend to be distributed unevenly between men and women in the Region. Figure 10 presents the proportion of women and men 15–49 years old who listened to the radio at least once a week, by income quintile, in the Philippines in 2003.

Compared to men, women's typically lower levels of literacy might place many forms of health information, such as print media, beyond

their reach. Meanwhile, restrictions on their mobility might limit women's exposure to new health-related ideas and practices. This might be especially true for women from ethnic minorities, who often live in rural and remote areas and face unique cultural and linguistic barriers. Figure 11 presents the proportion of women and men 15–49 years old who read a newspaper at least once a week, by income quintile, in the Philippines in 2003. Women's lower literacy rates also mean they might be unable to read a prescription, understand a poster on preventive health or find their way through the confusion of modern health systems without difficulty.

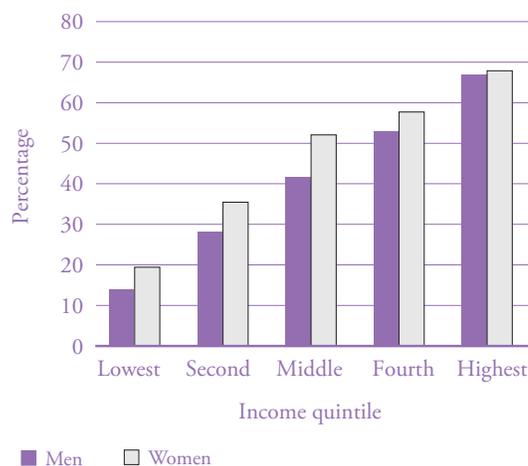
Access to appropriate and adequate information also might determine whether a woman recognizes that she has a gynaecological problem, or a man is able to recognize the signs of potential prostate cancer or sexually transmitted diseases. Again, gender can interact with sex to produce particular disadvantages for women. Studies also show that educated women are more likely than uneducated women to benefit from health promotion programmes, such as immunization, and have a lower incidence of child mortality.

Differences in the quality of health services men and women receive

When men and women and boys and girls are able to access health services, the quality of care they receive might differ. Health facilities for poor and marginalized populations in urban slums, or rural and remote areas, have often been described as being understaffed; lacking equipment, supplies and essential medicines; and being neglected or dilapidated. For example, a study in Viet Nam found that 50% of commune health centres were not working full time as regulated, and that supplies go out of stock multiple times a year in 36% of commune-level facilities.¹⁶² As another example, doctors in rural areas in Mongolia often lack essential supplies, such as transportation and medicines.

Health service providers' perceptions of illness, and how these perceptions might differ with

Figure 11: Proportion of women and men 15–49 years old who read a newspaper at least once a week, by income quintile, the Philippines, 2003



Source: Gwatkin D. *et al* 2007b.

respect to their male and female patients, also influence diagnosis and treatment. For example, medical doctors in some areas have been found to frequently misdiagnose women's illness as psychiatric disorders. This perception of women's illness leads to inappropriate prescriptions of drug therapy.¹⁶³ Other studies have found that health service providers are often unable to respond to expectations and concerns that are specific to women.¹⁶⁴ A study from Viet Nam, for example, found that women who presented with symptoms of TB typically experienced a longer delay and were less likely than men to be diagnosed.¹⁶⁵ Some evidence also highlights the general lack of responsiveness of health service providers to the needs of homosexual men and women.¹⁶⁶

In addition, the health care system might not respond adequately to the distinct biological needs of men and women. Some evidence suggests that NCDs of particular concern to women, such as cervical and breast cancer, might receive less attention from health care practitioners and policy-makers than do other NCDs. In general,

preventive efforts to reduce the risk factors for cervical cancer appear to be lacking, and effective methods of screening and treating cervical cancer are not routinely available in primary health care facilities.¹⁶⁷ Similarly, evidence suggests that women with TB are less likely than men to present with typical symptoms, such as cough, sputum expectoration and haemoptysis. This finding is valuable because an absence of cough and sputum expectoration has been associated significantly with delays in diagnosis and treatment.¹⁶⁸ Evidence from developed countries also suggests that women with coronary heart disease might be diagnosed and treated differently than men (Box 11).

The behaviour of health staff is particularly important for poor women, who might be deterred from seeking care from providers who are perceived to be disrespectful and insensitive to their needs.¹⁶⁹ The concerns typically voiced by women about health services in many societies include lack of privacy and confidentiality, as well as inadequate information about available options and services.¹⁷⁰ A case study from Sri Lanka

Box 11: Coronary heart disease and gender in the United States

Over the past decade, the average rate of coronary heart disease in the United States has been decreasing. Upon closer inspection, however, this trend appears to have benefited men rather than women, whose mortality rates from coronary heart disease have continued to rise. Some studies from the United States suggest that the lower survival rates of women might arise, in part, from women with coronary heart disease often being diagnosed and treated differently than men.

Evidence increasingly shows that women tend to present with symptoms that are more subtle than and differ from the classic symptoms of heart disease—substernal chest pain, pain down the arm, sweating and nausea—or those experienced by men. Instead, women commonly report symptoms such as gastrointestinal irregularities, which health service providers tend to associate with illnesses other than heart disease. This often results in delayed diagnosis or misdiagnosis of heart disease in women. Delayed diagnosis might cause worse damage to the heart muscle, leading to more severe attacks later in life or death.

Even when women are diagnosed accurately with coronary heart disease, evidence suggests that they are less likely than men to receive effective health care. Compared with men, women have been found to wait longer for an electrocardiogram, be less likely to be cared for by a cardiologist, and less likely to receive invasive diagnostic measures and treatments. Evidence also shows that women are less likely than men to receive invasive and established treatments, such as aspirin and heparin. Another study found that the risk of in-hospital complications, including death, was 15%–20% higher for women than for men. This difference arises in part because of greater co-morbidities in women.

Sources: American Heart Association 2003; Batchelor S. 2006; Blomkalns A.L. *et al* 2005.

found that numerous women with symptoms of malaria in the community refused to be examined because the health staff involved in case detection were predominantly male.¹⁷¹ Women with HIV/AIDS have reported being ridiculed, insulted or harassed.¹⁷² Women complain that health care workers get angry with them and treat them with derision and scorn for not taking better care of their health. A woman from rural China illustrates this attitude:

*I went to see a doctor in (the prefectural seat). As soon as I got there, he was scolding me. This makes sick people feel very bad. The attitudes of doctors (toward their patient) are very poor, so we aren't willing to go.*¹⁷³

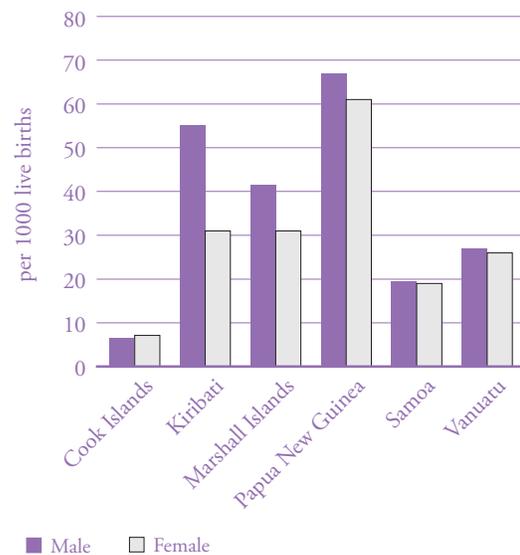
Irregular hours of operation and inadequately trained staff also might deter women from seeking care more than men.

Health promotion initiatives also might address gender-based inequalities inadequately, thereby reducing the effectiveness of such efforts for men and/or women. Some health-promotion initiatives have taken a strategic approach towards women, viewing them as providers of health care in the home. While correctly identifying the typically larger role women play in health care for their children, these efforts tend to ignore the gender norms that might constrain women's ability to make decisions that are good for their own health or that of their children. Oral rehydration therapy, for example, has been proven to be an effective means of reducing childhood diarrhoea. This approach depends on mothers administering the intervention. However, it has been described as ignoring the significant time constraints under which many women operate, as well as the need to increase the role of fathers in the care of their children.¹⁷⁴

Differences in the mortality of men and women

The cumulative effects of the complex interaction between the biological and gender-related

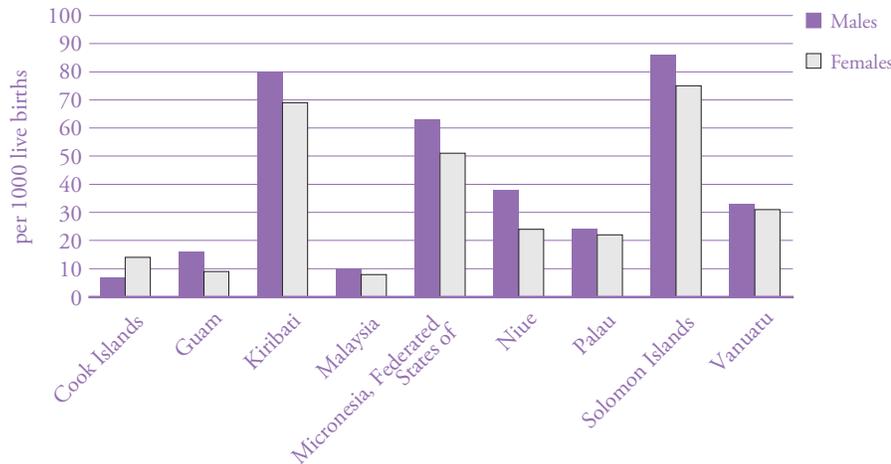
Figure 12: Male and female infant mortality rates for selected countries in the Region, 2002



Source: World Health Organization Regional Office for the Western Pacific 2005a.

determinants of health, the differences in the morbidities of men and women, and gender-based differences in seeking health care and in the quality of care men and women receive are manifested in different mortality rates of men and women. As with the analysis of morbidity, the continued lack of sex-disaggregated data constrains an analysis of differences in the mortality of men and women in the Region.

Worldwide, child mortality is higher among boys than among girls. Based on an analysis of data from the few countries in the Region that produced sex-disaggregated data on infant and child mortality in 2002, mortality appears to be higher among male infants and children than among their female counterparts. This reflects girls' relatively greater biological hardiness. Figure 12 presents the infant mortality rate for male and female infants, while Figure 13 shows the male-female child mortality rate for selected countries in the Region. China, however, is an exception where the risk of dying is estimated to be 33% higher for girls than for boys, reflecting the possibility of gender-based discrimination.¹⁷⁵ The risk of dying is similarly higher for girls than boys in India—the female

Figure 13: Under-5 mortality rate for selected countries in the Region, 2002

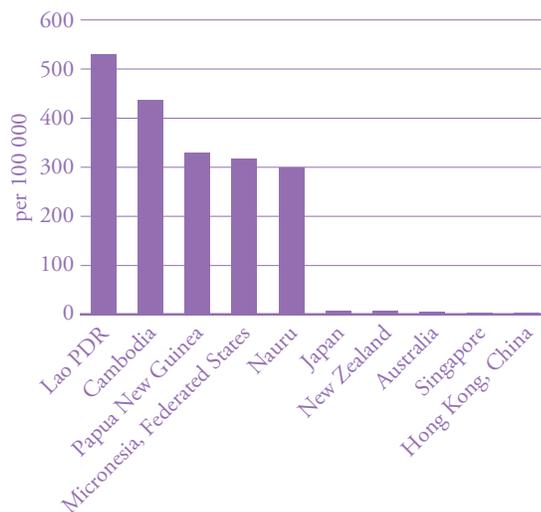
Source: World Health Organization Regional Office for the Western Pacific 2005a.

U5MR is 95 per 1000 live births compared with 87 for boys.¹⁷⁶

Globally, mortality among men is higher than among women, and the gap in adults is higher than in children.¹⁷⁷ This general trend, however, masks differences in the causes of death between men and women across socioeconomic groups. That is, communicable diseases and maternal conditions accounted for an estimated 7.5 percentage points more of total deaths among poor women than among poor men.¹⁷⁸ Excluding maternal conditions, communicable diseases continue to cause more deaths in women than in men. This pattern shifts for the richest 20% of the global population, where communicable diseases cause fewer deaths among women than among men.¹⁷⁹ Maternal mortality and morbidity remain the greatest cause of premature death and disability for women 15–44 years old.¹⁸⁰ Figure 14 presents data from the five countries with the highest and five countries with the lowest rates of maternal mortality in the Region in 2002.

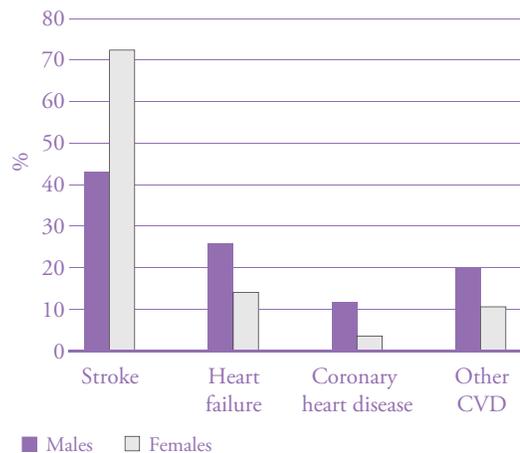
Contrary to the widely held belief that cardiovascular diseases (CVD) are largely male diseases, estimates now suggest that the death rates from CVDs for men and women over 60 years old are similar.¹⁸¹ In contrast, rates of cancer mortality for men are estimated to be 30%–50%

higher than those for women. This discrepancy is largely attributed to the higher rates of lung cancer in men than in women. Violence is one of the top five causes of death in women in developing countries and 5% of the total disease burden, according to the World Bank.¹⁸² In developed countries, violence accounts for more deaths of women 15–44 years old than all infectious diseases combined.¹⁸³

Figure 14: Maternal mortality rate for selected countries in the Region, 2002

Source: World Health Organization Regional Office for the Western Pacific 2005a.

Figure 15: Proportion of specific CVD causes among men and women, Bavi District, Viet Nam, 2000



Source: Hoang V.M., Byass P., Wall S. 2003.

A community-based health survey carried out in Bavi District, Viet Nam, suggests that the burden of NCDs differs between men and women. The study reported that CVDs were the leading cause of death in the study population. Strokes alone accounted for an estimated 56.3% of all CVDs. The incidence of stroke, however, was much higher for women than for men (Figure 15). The death rates from heart failure, coronary heart disease and other CVDs likewise varied between men and women.¹⁸⁴

Differences in the impact of ill health on men and women

The social and economic consequences of ill health and disability are often different for women

and men. For example, studies suggest that men are more likely to default from treatment for TB because of pressure to return to work, and alcohol and drug addiction. For women, the pressure to do housework and the strain of keeping their condition a secret appear to be the main reasons for defaulting from treatment.¹⁸⁵ Because women tend to live longer than men and marry men who are older than they are, the number of widows is growing in many developing countries. Widows are often vulnerable to dependency, isolation, poverty and neglect.¹⁸⁶

In many societies, the gender-based division of labour assigns responsibility for the care of sick individuals to women household members. Studies of caregivers for cancer patients in the Republic of Korea and caregivers in Hunan and Hebei provinces, China, found that more than 65% were women.¹⁸⁷ Female household members, including older women and girls, often handle caregiving activities, tasks and responsibilities in addition to their normal daily activities. Studies have reported that when a household member becomes ill with malaria, the economic burden tends to fall on women, who often assume the majority of tasks normally performed by the sick individual.¹⁸⁸ In Viet Nam, 60% of family members who stop work to care for an individual sick with malaria are women.¹⁸⁹ In addition, women caregivers in China have reported feelings of fatigue and loss of personal time.¹⁹⁰ This is of particular concern because, in many communities, health systems increasingly depend on unremunerated or home-based care, the burden of which often falls disproportionately on women and girls.

3. Why is it important to address differences in the health of men and women?



3. Why is it important to address differences in the health of men and women?

As the earlier parts of this module have sought to show, men and women display important differences in their health. These differences in health arise from the complex interaction between gender-based inequalities and biological differences between men and women. Because of this, men and women might not benefit fully from investments in health. Three main arguments can be made for integrating a gender focus into health interventions is important: efficiency, equity and human rights.

Efficiency

Efficiency means producing the desired result with minimum wasted effort. In health, this term refers to better outcomes for health programmes or interventions, or a higher probability that the desired outcomes will be achieved. Based on the analysis presented in the preceding sections, international, national and local health initiatives might not be responding effectively to the health needs of men and women. Interventions that fail to account for and respond to the biologically specific health needs of men and women might miss the opportunity for concrete improvements to their health outcomes. Instead, such interventions might leave many important health needs unaddressed, or inspire only a partial response. Similarly, ignoring the way in which gender inequality shapes men's and women's health experiences, including access to and use of health services, might result in health interventions missing many women or men, particularly those who are poor. Overall, this suggests that refining health interventions to better address and respond to gender issues in health, as well as the specific biological needs of men and women, can improve efficiency significantly. Addressing gender inequalities can strengthen programme planning and implementation, reducing delay, improving diagnosis, and improving access to services, as well as adherence and treatment outcomes. This would ensure the effectiveness of the chosen strategies.

Equity

Equity in health may be defined as the “absence of systematic disparities in health (or major social

determinants) between groups with different levels of underlying social advantage or disadvantage, such as different positions in the social hierarchy.”¹⁹¹ It refers to the fairness with which resources (and thus health risks and outcomes) are distributed.

Some variation in health status between men and women is unavoidable. However, as is becoming increasingly clear, health systems and health interventions often have failed to respond to the biologically specific health needs of men and women. This omission typically has disadvantaged women relative to men. Moreover, a growing body of evidence highlights how gender inequality influences all aspects of men's and women's health—from the determinants of health to their experience of health services and health outcomes. Because of this, many differences in the health of men and women increasingly are seen to mirror social divisions within society. These divisions trace gender norms and the intersection of gender inequality with other dimensions of social exclusion, such as race, ethnicity and socioeconomic status.

Thus, differences in health arising from gender inequalities are recognized as being unfair and unjust because of the constraints gender norms place on the ability of men and women to influence their health outcomes. Women often have less access to resources and services than men, while notions of masculinity might prevent men from admitting illness. In this way, some differences in the health of men and women reflect the underlying distribution of roles and power in society, rather than individual choices. Therefore, efforts are required—within and beyond the health sector—to address the differences in the burden of morbidity and mortality among men and women arising from gender norms and gender-based inequality.

Human rights

The right to the highest attainable standard of physical and mental health, or the right to health, is rooted in the Universal Declaration of Human Rights. Numerous other human rights treaties

also have endorsed this basic right. Every country in the world is party to at least one human rights treaty that addresses health-related rights.¹⁹² Men and women and boys and girls enjoy the right to health equally. Acknowledging the unique constraints gender discrimination places on the ability of men and women to realize their rights, including the right to health, CEDAW and the Convention on the Rights of the Child specifically articulate the rights of women and children. In Article 1 of CEDAW, discrimination against women is defined as:

*...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 freedom in the political, economic, social, cultural or any other field.*¹⁹³

Signatories agreed to this definition of discrimination, and committed themselves to taking “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 services, including those related to family planning.”¹⁹⁴ In addition, the UN Human Rights Committee has ruled that discrimination on the basis of sexual orientation violates the rights to privacy and non-discrimination.¹⁹⁵ International initiatives have recently applied international human rights law to sexual orientation and gender identity.¹⁹⁶

These principles, in conjunction with other human rights, such as the rights to information and privacy, should guide the interaction of individuals with the

health system. This is reinforced by the inclusiveness of the right to health, which encompasses the right to health services and the right to the underlying determinants of health, such as education and food. However, marginalized populations often are denied multiple human rights.

Member States are responsible for the progressive realization of human rights, including the right to health. Therefore, governments must put in place policies and plans that will make health care available and accessible, and that lead to the realization of other human rights as efficiently as possible. This includes regulating the actions of non-state actors to ensure the right to health is realized.

Box 12: A rights-based approach to health

When evaluating the right to health, four criteria may be used:

Availability: Sexual and reproductive health care is functioning well and adequately available

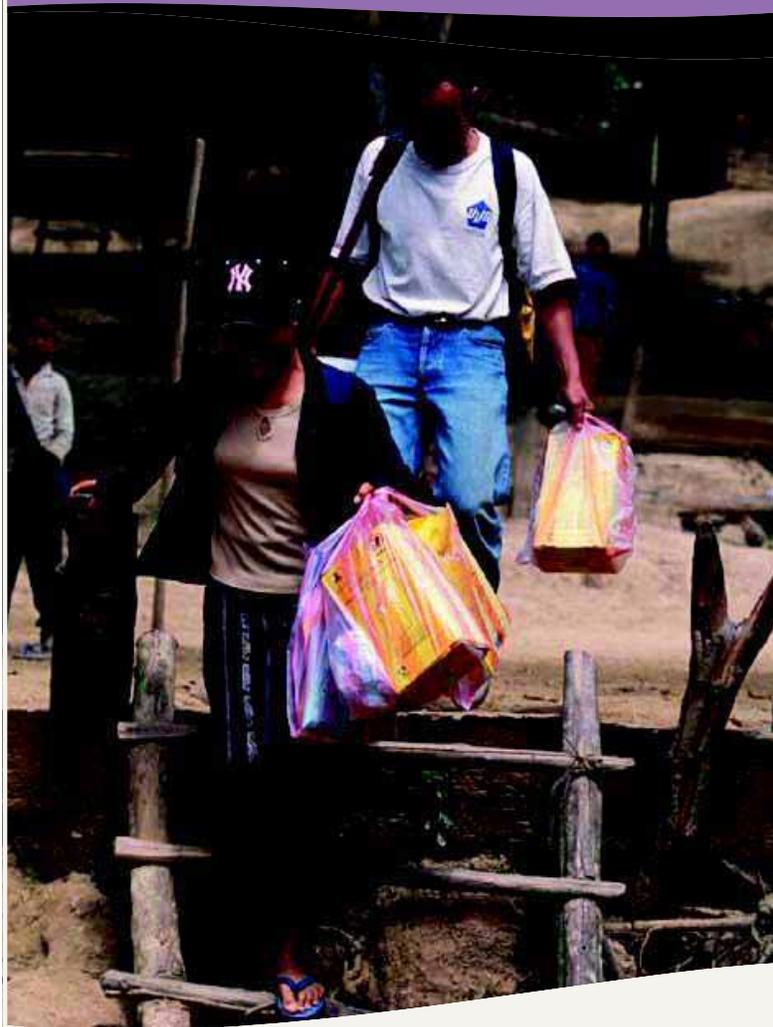
Accessibility: Sexual and reproductive health care is accessible to all, encompassing four dimensions: non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility

Acceptability: Sexual and reproductive health care is respectful, culturally appropriate, and gender-sensitive, and honours the confidentiality of all patients

Quality: Sexual and reproductive health care is scientifically and medically appropriate, and of good quality

Source: World Health Organization 2002a.

4. How can health professionals address gender concerns in health?



4. How can health professionals address gender concerns in health?

As the preceding sections demonstrate, sex- and gender-based factors influence the health of men and women in important ways. These differences often arise from the different, and often unequal, ability of men and women to make decisions to protect and promote their health, as well as to access quality health care.

Responding to gender-based inequalities in health requires health policies, plans and programmes that are informed by an understanding of how gender, and its interaction with biology, influences the health of men and women. That is because factors that are common to men and women might require different types of interventions than factors that are different.¹⁹⁷ This can be achieved through gender analysis and planning.

What is gender analysis?

Gender analysis is a method to identify the relations between men and women, their roles and activities, the resources they have access to and control over, the norms that define their behaviours, and the constraints they might face. Gender analysis can be carried out at different levels—from assessing a specific health issue to analyzing broader health projects or programmes and policies.

With regard to health, gender analysis examines differences in men's and women's roles and relations. It also assesses how these differences determine their exposure to the risk factors of ill health, their access to resources to protect and promote health, the distribution of disease between men compared with women, the responsiveness of the health system to the needs of men and women, and the consequences of ill health for men and women.¹⁹⁸ This is a critical first step in efforts to identify, develop and appropriately implement interventions that recognize and address these differences between men and women.

How to do gender analysis

Gender analysis systematically explores differences in the health of men and women, as well as the

underlying biological and gender-related roots of these differences, and identifies strategies and entry points to address these factors in the given context.¹⁹⁹ This encourages evidence-based decision-making in health.²⁰⁰

Gender analysis systematically poses questions about the differences between men and women in a community with respect to these factors. Some of these factors need to be taken into account when doing a gender analysis of health. Most simply, these include biological factors, gender norms and roles, and access to and control over resources. Additional concepts might be introduced to broaden and deepen a gender analysis. The following are possible questions that might be posed to explore these differences:²⁰¹

Roles and activities:

- Who does what? What productive activities, such as agriculture, do men and women perform? What reproductive activities in the household, such as child care, nursing, cooking, and water and fuel collection, do they perform? Who enjoys recreation, and of what types?
- Who does the work? Women? Men? Boys? Girls? Alone or jointly?

Box 13: Why is gender analysis important?

Gender analysis in health contributes to the understanding of

- differentials in risk factors
- exposures and manifestations of disease;
- differences in the severity and frequency of diseases among men, women, boys and girls; and
- the responses of the culture, society and health system to these problems.

Gender analysis highlights differences in access to

- health care and resources
- information, transport, communication and services
- decision-making processes

Source: World Health Organization, Department of Gender, Women and Health, 2006b.

Box 14: Four frameworks for gender analysis

Over the years, many frameworks have been developed to analyse situations and propose interventions from the perspective of gender. Some commonly used frameworks are outlined below.

Moser's Gender Planning Framework encourages planners to look at all aspects of men and women's activities through its focus on women's triple (productive, reproductive and community organizing) roles. Drawing a distinction between practical and strategic gender needs, the framework allows the user to view short- and long-term goals and outcomes, and to incorporate strategies to meet both. However, as it lacks an overarching concept, it is more a set of tools than a coherent framework.

The *Harvard Analytical Framework* has four interrelated elements:

- The activity profile, which seeks to answer "who does what", taking into account gender; age; and when, where and for how long tasks are performed;
- The access and control profile, which assesses the resources individuals have to carry out the work identified in the activity profiles; and access to and control over resources by gender;
- An analysis of the factors that shape the gender divisions in the above two profiles;
- Project cycle analysis, which examines the proposed project or intervention in terms of the information generated through the first three components.

The framework generates facts outlining who does what, and when and with what resources. However, this might be a static and top-down view. As the framework offers little information on power relations, it is less useful in guiding efforts to transform existing gender relations.

The *Women's Empowerment Framework*, as its name suggests, aims to assess women's empowerment. It is premised on women's equal control over the factors of production and equal participation in development processes. The framework identifies five levels of equality that are arranged hierarchically and denote progressively higher levels of empowerment:

- Welfare: the level of women's welfare as compared with men's with regard to food supply, income and medical care.
- Access: equality in access to factors of production, including public services, which is achieved through legal reform.

Continued on next page

- How long does the work take? Is it seasonal? Monthly, weekly, daily?
- Where is the work carried out? Home, farm, city, factory?
- How strict is the gender-based division of labour?

Resources and constraints:

- What types of resources do men and women have to work with?
- Who uses/owns/controls each of these resources? Who is excluded from use/ownership/control?
- What decisions do men and women make, separately and jointly? In the household? In the community?

- Are constraints to participation in social and economic life different for men and women?

Benefits and incentives:

- Who controls productive activity? Reproductive activity?
- Who benefits from economic activity? Who receives income? Who controls income? What about non-income benefits?
- Do men and women have different incentives for participation in these activities?²⁰²

Biological factors:

- What are the effects of biological differences between the sexes?

Box 14 (continued)

- **Conscientisation:** an understanding of gender roles in society, and the belief that these roles and responsibilities should be fair for men and women.
- **Participation:** the equal participation of men and women in all decision-making processes, including policy-making, planning and administration.
- **Control:** men's and women's equal participation in decision-making processes to achieve equality in the control over the factors of production

The framework identifies empowerment as a core component of development, and enables an associated assessment of interventions. As the approach is political, it aims to change attitudes and gender relations. However, the assumed hierarchy in levels of equity, its omission of the interrelationship between rights and responsibilities, and its relatively static approach have been identified as some of the framework's limitations.

The *Social Relations Framework* was developed by a group of academics at the Institute of Development Studies, Brighton, England, led by Naila Kabeer. This framework is premised on the belief that gender relations are one type of social relations that determine the distribution of resources, claims and responsibilities. Social relations are reinforced and reproduced through institutions (defined as the rules for doing things), which are linked to organizations (the specific structural form of institutions). That is, gender inequality is reproduced in the institutions of the family/kinship, community, state and market, each with its specific organizational form. Five aspects of institutional relations are pertinent for gender analysis:

- **Rules:** how things are done, including those that are formal and informal.
- **Activities:** who does what, who gets what and who can claim what.
- **Resources:** what is used and what is produced, including those that are human, material and intangible.
- **People:** who is in, who is out and who does what within an institution.
- **Power:** who decides and whose interests are served.

At each level, the framework assesses the immediate, underlying and structural causes of gender issues. While potentially detailed and demanding, the framework usefully links micro to macro factors, and illuminates interactions between different forms of inequality, including those based on gender, race and class.

Source: International Labour Organization 1998.

To conduct gender analysis, data disaggregated by sex are needed. Gathering available data from a range of information sources is often useful. National and subnational data on health and gender-related issues sometimes can be sourced from national statistical agencies, government agencies and international organizations. Reports from non-governmental organizations (NGOs), health service-based research and participatory methods also can provide useful data. Some participatory tools and methods can be used to guide the collection of primary data from stakeholders and community members.

Gender analysis requires seeking answers to questions that many respondents might find

difficult and challenging. Some tools, such as questionnaires and matrices, have been developed to assist in asking the questions required for a gender analysis. Specific theories of gender relations usually underpin these tools. Box 13 discusses some of the more common analytical frameworks and tools. The gender analysis matrix developed by WHO, and outlined in Figure 16, includes concepts to examine differences in who gets ill; when, where, why; and the recognition, response and effect of illness on men and women.²⁰³ Additional tools are provided in Section 6.

It is important to remember, however, that these questions and check-lists are intended to serve as a guide to stimulate more questions and reflection.

**Figure 16: Gender analysis matrix of a health problem:
the impact of different characteristics of gender on men and women's health**

Health issue/problem	How biological differences between sexes influence:	How gender norms/values affect men's and women's (boys' and girls');*	How do access to, and control over, resources affect men and women's:
Health vulnerability			
Health-seeking behaviour			
Ability to access health services			
Preventive and treatment options, responses to treatment or rehabilitation			
Experience with health services and health providers			
Outcome of health problem (e.g., recovery disability, death)			
Consequences (economic and social, including attitudinal)			

* Are there any differences in the way in which society responds to this health problem? (e.g., Is there a difference in the way a woman and a man responds when a man/woman experiences this problem?)

Source: World Health Organization, Department of Gender and Women's Health, unpublished draft, 2006b.

The tools and checklists might be adapted to a particular issue or context. Repeating the gender analysis at set intervals can provide interesting insights into how gender norms change.

When to do gender analysis

Ideally, gender analysis takes place from the beginning and continues throughout the project, programme or policy cycle—from formulation to resource mobilization, implementation, and monitoring and evaluating (Figure 17). Even if gender analysis is not carried out during the initial phases of project, programme or policy formulation, it is never too late to begin the process of integrating gender concerns. That is, gender analysis can be

initiated at any stage of a policy, programme or project and provide useful insights. The findings of the gender analysis then can be integrated into each succeeding stage of the project, programme or policy. Gender analysis can help identify and address emerging gender concerns at each stage of the project, programme or policy cycle.

What is gender planning?

Gender planning uses the results of gender analysis in developing health policies, programmes or projects that take into account possible gender-based differences and needs. It also aims to account for impacts on gender relations and on the activities, tasks, responsibilities, roles and

Box 15: Guidelines for gender analysis

“What to ask” includes:

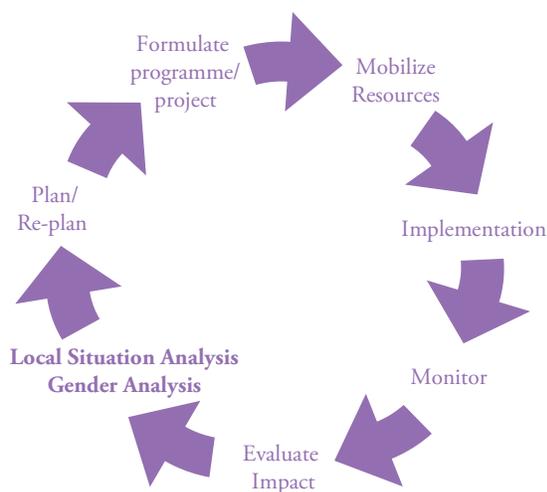
- who is the target, who will benefit and who will lose;
- have women been consulted and involved in the development of the solution;
- does the intervention challenge the existing gender-based division of labour, tasks, responsibilities and opportunities;
- what is the best way to build on the government’s commitment to the advancement of women;
- what is the relationship between the intervention and other action and organizations;
- where do opportunities exist for change;
- what specific ways can be proposed to encourage and enable women to participate despite their traditionally more domestic location and subordinate position; and
- what is the long-term impact on women’s increased ability to take charge of their own lives, and to take collective action to solve problems.

“What to do” includes:

- gaining an understanding of gender relations, the division of labour, and who has access to and control over resources;
- including domestic (reproductive) and community work in the work profile;
- using participatory processes and including a wide range of female and male stakeholders at the governmental level and from civil society—including women’s organizations and gender equality experts;
- identifying barriers to women’s participation and productivity; gaining an understanding of women’s practical needs and strategic interests, and identifying opportunities to support both;
- considering the differential impact of the initiative on women and men, and identifying the consequences to be addressed;
- establishing baseline data, ensuring sex-disaggregated data, setting measurable targets, and identifying expected results and indicators; and
- outlining the expected risks (including backlash), and developing strategies to minimize these risks.

Sources: Canadian International Development Agency 1999 in WHO, Department of Gender, Women and Health 2002d and World Health Organization, Department of Gender, Women and Health, 2002d.

Figure 17: The project, programme or policy cycle



Source: World Health Organization, Department of Gender, Women and Health, 2006c (unpublished draft)

status of men and women in the short- and longer-term. Gender planning involves analysing from a gender perspective questions regarding, among others, the vision, goals and principles; design and planning; resource mobilization; implementation of intervention; and monitoring and evaluation.²⁰⁴ Box 16 outlines possible questions to be asked with regard to a given policy, programme or project.

Gender analysis can help in identifying and prioritising the gender-related issues to be addressed. Once the focus of the policy, programme or project has been identified, its goals need to be articulated. For example, policy, programme or project goals can be formulated in terms of gender equality or gender equity (Box 17).

Box 16: Key questions to ask about the content of the intervention, programme, project or policy

- Do the project's vision, goals or principles explicitly state its equity intentions, including gender equity?
- Does the project/intervention involve stakeholders in its design, monitoring and evaluation? Have steps been taken to ensure both women's and men's participation?
- Does the design and planning take into account differences between women and men in:
 - ♦ roles and responsibilities?
 - ♦ norms and values?
 - ♦ access to and control over resources?
- Does it make a conscious effort to promote gender equity, i.e.:
 - ♦ reduce overt or covert discriminatory practices?
 - ♦ actively promote gender equality?
- Have gender-specific indicators been identified and included in monitoring through the programme cycle?
- Does the design address the influence of gender-biased norms and practices at relevant levels of the political and bureaucratic systems that might obstruct the intervention?

Source: World Health Organization, Department of Gender, Women and Health, 2006c (unpublished draft).

Types of gender-responsive approaches

Depending on the approach each follows, policies, programmes or projects can be designed and implemented to have a range of impacts on gender—from undermining gender equality to ignoring gender to seeking to work within existing gender relations to challenging and transforming gender discrimination. Box 18 outlines various gender-related approaches. Again, applying gender analysis to the implementation of a strategy can help ensure that all aspects of the programme or project are gender sensitive—from resource mobilization to staffing issues. The overall goal is to reduce gender inequalities and transform gender relations that discriminate against women or, more rarely, men.

Another way to categorise gender-responsive programmes or projects is according to their responsiveness to practical or strategic gender needs.

Adopting the typology outlined in Box 18, Figure 18 suggests a possible method for analysing how health programmes and projects address gender. The definitions of key concepts in Figure 18 are

Box 17: What is the difference between gender equality and gender equity?

Gender equality refers to the equal opportunity of men and women to access and control social and economic resources that are valued by society. This does not imply that men and women, or different groups of men and women, be treated the same or be represented in the same numbers. Rather, the aim is to enable men and women to participate fully as equal partners in decisions that affect their lives.

Gender equity integrates a notion of fairness into how men and women are treated. To ensure fairness, gender equity goals and strategies often include measures that aim to address the historic disadvantage of women or men in particular spheres of life. Gender equity aims to realize gender equality.

Sources: United Nations Population Fund (UNFPA) 2006; World Health Organization, Department of Gender, Women and Health, 2006a (unpublished draft).

in Section 5. Figure 19 provides an example of how this tool—the Gender Analysis Matrix—can be applied to a malaria prevention and control programme.

Box 18: A framework to assess gender in policy, programme and project development

The following typology has been developed to assess the extent to which policies, programmes and projects address gender.

Gender-unequal	Privileges men over women. Inequalities are clear and undisguised. Denies women's rights or gives men rights and opportunities that women do not have. <i>Example:</i> A policy that denies a married woman the right to medical insurance in her own name makes her dependent on her husband for access to medical insurance. If her husband is unemployed, she (and her husband) is denied access to medical insurance.
Gender-blind	Ignores gender norms; is blind to differences in the allocation of roles and resources; is not intentionally discriminatory, but reinforces gender discrimination nevertheless. Often ignores the lack of opportunities/discrimination that underpins what appears to be fair practice. <i>Example:</i> Efforts at institutional homecare for people with AIDS that do recognize that women most often perform homecare contributes to women's unequal burden.
Gender-specific	Recognises differences in gender roles, responsibilities and access to resources; and accounts for these when designing interventions. Gender-specific policies or programmes do not try to change the underlying causes of these gender differences. <i>Example:</i> Workplace child care recognises women's primary responsible for children and enables women to work. However, it does not encourage men to share the responsibility for child care.
Gender-transformative	Recognises differences in gender roles, norms and access to resources; and tries to change these to promote gender equality. <i>Example:</i> A health education programme might advocate mutual respect and equal rights in sexual decision-making by women and men as a means of promoting safer sex practices.

Source: World Health Organization, Department of Gender, Women and Health, 2006c (unpublished draft).

What is gender mainstreaming?

To quote the United Nations Office of the Special Adviser on Gender Issues, “gender mainstreaming is a globally accepted strategy for promoting gender equality. Mainstreaming is not an end in itself but a strategy, an approach, a means to achieve the goal of gender equality. Mainstreaming involves ensuring that gender perspectives and attention to the goal of gender equality are central to all activities—policy development, research, advocacy/dialogue, legislation, resource allocation, and planning, implementation and monitoring of programmes and projects.”²⁰⁵

Thus, gender mainstreaming is a strategy to bring about gender equality through an intervention, policy, programme or organization. This

approach requires addressing gender relations within the institutions and organizations that comprise the health sector from the national to local levels. Gender mainstreaming is multifaceted, involving changes in policies, programmes, human resources, and financial and administrative aspects. In many cases, training and education might be necessary to generate political commitment and “buy-in.”

Gender mainstreaming in health initiatives is often required to achieve long-term change in gender relations. Because gender mainstreaming aims to change gender relations, including those within institutions or organizations, an effective monitoring and evaluation system is required to inform strategies for gender mainstreaming and assess changes over time.

Figure 18: Applying gender analysis to health programmes and projects: the Gender Analysis Matrix

Programme or project area	Gender-unequal (privileges men over women) Does programme/ project component privilege men over women?	Gender-blind (Ignores gender norms) Does programme/project ignore gender norms?
Project/ programme formulation: <i>Programme/ project vision, goal, principle</i>		
Project/ programme formulation: <i>Scope of project design and planning</i>		
Programme/project implementation		
Resource mobilization		
Programme/ project monitoring		
Programme/ project evaluation		
Local situation/gender analysis Re-planning		

Source: World Health Organization, Department of Gender, Women and Health, 2006c (unpublished draft).

Figure 19: Applying the Gender Analysis Matrix tool to a malaria prevention and control programme

Programme or project area	Gender-unequal (privileges men over women) Does programme/project component privilege men over women?	Gender-blind (Ignores gender norms) Does programme/project ignore gender norms?
Project/programme formulation: <i>Programme/project vision, goal, principle</i> Does the project vision, goals or principles contain a statement on its equity intentions, including in relation to gender equity?		
Project/programme formulation: <i>Scope of project design and planning</i> Does the project/intervention include scope for stakeholder participation in the design, monitoring and evaluation of the project? Have steps been taken to ensure women's participation equally with men?		

Gender-specific**(Recognizing differences in gender roles, responsibilities and access to resources)**

Does programme/project recognise gender-specific issues and account for them?

Gender-transformative**(Recognizes differences in gender and supports changes to improve equality)**

Does programme/project support change that will promote gender equality?

Gender-specific**(Recognizing differences in gender roles, responsibilities and access to resources)**

Does programme/project recognise gender-specific issues and account for them?

Decrease incidence and negative outcomes of malaria during pregnancy

Develop technology to facilitate use of preventive measures to reduce risk to male farmers

Include women in project planning and advisory committees, as well as in community meetings. If necessary, hold separate community meetings with women and men to allow women's voices to be heard. If consulting with community leaders, ensure discussions with women and men leaders (gender-specific/gender-transformative)

Gender-transformative**(Recognizes differences in gender and supports changes to improve equality)**

Does programme/project support change that will promote gender equality?

Build women's and men's responsibility for malaria prevention and treatment

Include women in project planning and advisory committees, as well as in community meetings. If necessary, hold separate community meetings with women and men to ensure that women's voices can be heard. If consulting with community leaders, ensure discussions with women and men leaders (gender-specific/gender-transformative)

Continued on next page

Figure 19 (continued)

Programme or project area	Gender-unequal (privileges men over women) Does programme/project component privilege men over women?	Gender-blind (Ignores gender norms) Does programme/project ignore gender norms?
Programme/project design Does the programme design and planning account for differences in the roles and responsibilities of women and men? Norms and values?		
Resource mobilization		
Programme/project implementation Is an effort made to promote gender equity, or at least not to worsen women's position in relation to men?	Ensure, for example, that involving women in production of bednets does not add to poor women's already excessive work burden (i.e., avoid gender-unequal)	
Programme/project monitoring Have gender-specific indicators been identified and included in the monitoring system throughout the programme cycle? Input indicators regarding resources devoted to the intervention? Process indicators monitoring the implementation of the interventions?	Women and men community education officers recruited for the programme Proportion of women and men who have participated in community meetings regarding introduction of bednets	
Programme/project evaluation Is gender included in the outcome indicators regarding achievement of the longer-term objectives of the programme? Does the design take steps to address the influence of gender norms and practices at relevant levels of the political and bureaucratic systems that might obstruct the intervention?	Proportion of women and men and girls and boys utilising bednets everyday	
Local situation/ gender analysis re-planning		

Source: Adapted from Klugman, 2001 with extracts from Ravindran, 2001 in World Health Organization, Department of Gender, Women and Health, 2006c (unpublished draft).

Gender-specific**(Recognizing differences in gender roles, responsibilities and access to resources)**

Does programme/project recognise gender-specific issues and account for them?

Explore possibilities of reaching out to men through workplace-based treatment, malaria diagnosis and treatment facilities

Gender-transformative**(Recognizes differences in gender and supports changes to improve equality)**

Does programme/project support change that will promote gender equality?

Reduce or subsidize the cost of nets and insecticides to make them more accessible to women

Use different forms of media, such as newspapers for men and radio for women (depending which they use), with content matching their different vulnerabilities and health-seeking behaviour

Ensure that programme messages on appropriate care for childhood malaria are addressed to fathers and mothers, thereby challenging the stereotype that only mothers are childminders

Encourage local production of nets through women's cooperatives instead importing them

Sufficient funds have been raised to cover costs of transport and honorarium for time of women volunteers whose time is usually not paid for

Workshops have been conducted with members of community decision-making structures to identify potential gender-related barriers and ways to address these

Decline in incidence of malaria amongst pregnant women

Key stakeholders and opinion leaders are given information on the consequences of not addressing gender issues within the programme's context

Box 19: Practical and strategic gender approaches in policies and programmes

Practical gender approach

- Responds to short-term needs.
- Responds to needs that users and suppliers usually can identify easily.
- Responds to biological requirements and specific health conditions.
- Meets gendered health needs through provision of goods and services.
- Tends to involve women and men as subjects of intervention.
- Can improve the health condition of women and men through access to services.
- Usually does not change gender roles and relations.

Strategic gender approach

- Tends to be a long-term strategy, as an integral part of sustainable human development.
- Responds to needs that people do not always identify easily.
- Targets inequities between women and men in responsibilities and power relationships.
- Identifies needs through empowerment processes, such as the creation of awareness, increased self-esteem, education, strengthening organizations, political mobilization, etc.
- Can improve the position of women by increasing their control over resources.
- Improves the balance of power between men and women in the use of health resources through control over internal and external factors that affect the ability to protect health.

Source: Adapted from Moser, 1993.

How to address gender in health policies, programmes and interventions

Approaches to addressing gender in health policies, programmes and interventions are still in their early stages and have not always been rigorously evaluated or standardized. Nor does this section provide an exhaustive list of approaches, since the evidence base for ways to address gender needs to be augmented through more operational research. However, these examples are general approaches that suggest some ways forward. They must be refined based on further analysis and country-specific situations. Other modules of this Sourcebook outline more detailed information on health interventions that address gender with regard to specific diseases and conditions.

The opportunities and constraints for the success of gender-responsive policies, programmes and interventions vary across different contexts and could change over time. Notably, the following seem to be critical factors in ensuring success in addressing gender in health policies, plans and programmes:

- continued management support

- ensured attention to gender issues through systems and procedures that are widely recognized
- leadership by skilled personnel
- allocation of sufficient time and resources²⁰⁶

In many cases, to see tangible results, such efforts must be sustained over the long term, supported by a mix of strategies and alliances across diverse stakeholders.²⁰⁷

Policy-level responses

International initiatives

International commitment to reducing gender-based inequality and promoting human rights for women and men is increasing. The Universal Declaration of Human Rights (1948) and CEDAW (1979) have strengthened efforts to address differences in the health of women and men. These conventions articulate the rights of women and men, including the right to health. The ICPD, held in Cairo in 1994, firmly placed reproductive health within the context of human rights. The ICPD mobilized a broad

commitment to addressing gender inequality and increasing women's empowerment and right to self-determination as core aspects of reproductive health. The Fourth World Conference on Women (1995) in Beijing, and its outcome document the Beijing Platform for Action, declared that women's rights are human rights, in particular recognizing the need to protect women's rights in the private sphere, too. The conference also affirmed the centrality of sexual and reproductive rights for advancing the status of women. Thus, mirroring the outcome of the ICPD, the conference identified gender equality and women's empowerment as the foundations for the realization of human rights for all.

The Millennium Declaration signed in 2000 committed United Nations Member States to a series of time-bound and measurable targets known as the Millennium Development Goals (MDG). The MDGs contain goals and targets pertinent to the issue of gender and health. Of particular importance is Goal 3, which seeks to promote gender equality and empower women.²⁰⁸ The MDGs reflect a multidimensional understanding of development and poverty. Thus, progress towards any of the goals contributes towards the achievement of the other goals. In this manner, gender equality and women's empowerment resonate across each of the goals and numerous targets.

Mission statements of numerous international organizations reinforce this broad international commitment to gender equality. WHO, for example, adopted a gender policy in 2002 that aims to ensure that gender is integrated into all aspects of its work (Box 19). To realize the aims of this policy, WHO also has developed a strategy to integrate gender analysis and actions into all aspects of its work.²⁰⁹

National initiatives

Achieving the MDGs requires a broad and sustained political commitment to gender equality at the national level. To be effective, however, such commitment needs to be translated into clear

policy goals with dedicated financial and human resources. This can improve the likelihood that policy goals are followed up with programmes and projects that address gender inequalities and differences in the health of men and women. A clearly articulated national policy addressing gender in health can create a unifying framework to guide actions at all levels of the health sector. Implementation of such a policy needs to encompass questions of gender as related to specific health issues, as well as broader concerns, such as the principles that guide resource mobilization and allocation of human resources.

Evidence suggests that policies can maximize health gains across the population without reducing existing inequities or improving the health of marginalized or hard-to-reach populations.²¹⁰ Since men and women have a differential burden of ill health and disability, as well as different patterns of seeking health care, universalistic approaches expressed in terms of population averages might not reach men and women equitably. Instead, policies need to be articulated in terms of improving the health of all women and men, particularly those who are have not been reached. This then can guide the equitable allocation of limited human and financial resources.

Some countries have turned to legislation or regulation as ways to improve health outcomes. Laws and regulations are often an effective means of promoting public health objectives. Recent examples of public health initiatives that prioritized enabling legislation include tobacco control.²¹¹ Box 20 discusses this approach with regard to gender-based violence in Cambodia.

Awareness- and capacity-building for policy-makers

Political commitment to gender equality is crucial for successfully addressing gender in health policies, plans and programmes. To mobilize political support, health staff can advocate for gender equality in health. To ensure sustained

political support, advocacy efforts need to be addressed to politicians from across the political spectrum—both within and beyond the health care sector.

Such advocacy can be supported through activities that aim to build the awareness of gender issues among policy-makers. Political statements

regarding gender equality in health need to be followed up by policies and programmes that seek to reduce disparities between the health of men and women. A WHO report analysing a survey of ministries of health in the Region suggests that the knowledge of gender issues among policy-makers might be low.²¹² That is, of the health policies, plans and programmes that ministries

Box 20: WHO gender policy and strategy

The World Health Organization's (WHO) commitment to gender equality is rooted in its Constitution, which states, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." In response to the growing body of evidence that gender is linked to the health of men and women, WHO's gender policy explicitly outlines its commitment to "integrate gender considerations into all facets of its work," as a matter of good public health policy and for meeting the broader United Nations goal of promoting social justice.

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

The gender policy aims to:

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

These objectives are to be realized by incorporating gender analysis into all aspects of the work of WHO. The gender policy notes that this approach requires the continued active participation of all WHO staff and the establishment of effective links across departments and levels of WHO. Responsibility for the successful integration of gender into all areas of WHO work is placed with senior management, who are accountable to the Director-General.

In 2007, WHO introduced its gender mainstreaming strategy, which aims to enhance and expand its capacity to analyse the role of gender and sex in health, and monitor and address systemic and avoidable gender-based inequalities in health, so as to improve the support provided to Member States in formulating and implementing effective gender-responsive health strategies. The strategy comprises the following strategic directions, which are to be introduced gradually and regularly monitored and evaluated:

- building WHO capacity for gender analysis and planning;
- bringing gender into the mainstream of WHO's management, i.e. into country cooperation strategies, medium-term strategic objectives and the programme budget, and their monitoring and evaluation;
- promoting use of sex-disaggregated data and gender analysis, and developing policy positions and advice, norms, standards, tools and guidelines to respond to any unfair, avoidable differences; and
- establishing accountability.

Sources: World Health Organization 2002a and 2007.

of health identified as gender-responsive, slightly more than half were deemed to be gender-responsive upon a more rigorous assessment. Based on these and other findings, the report concludes that current awareness and capacity on gender issues in the Region is weak.

Thus, initiatives to build gender-related awareness and capacity among policy-makers are required to promote more gender-focused policies and programmes that are well formulated and technically sound. Various strategies may be employed to build the capacity of policy-makers. For example, gender training can enhance awareness of gender-related issues and the complex relationship between gender and biology. Training initiatives also can include familiarizing policy-makers with gender mainstreaming tools, such as those outlined in this module. Health staff who already have the technical knowledge and capacity on gender issues in health can lead these initiatives. Otherwise, technical assistance can be sourced from other government agencies, NGOs, academia, community groups or international organizations with expertise in gender and health.

Health sector response

Health financing

The way health services are financed can influence their availability, as well as the extent to which households and individuals—women and men—are protected from the economic costs of seeking care.²¹³ Policies for mobilizing and allocating funds tend to impact men and women differently and differentially influence their access to health services. As Box 21 shows, the principles that guide the mobilization and allocation of financial resources can enable or hamper the extent to which policies, programmes and projects achieve the articulated goals of gender equality.

Urban areas might benefit more from the allocation of funds, leaving many rural and remote areas underfunded. Resources should be allocated to improve benefits to underserved communities, based on population- or needs-based formulas for resource allocation to regions or provinces.²¹⁴ While this might improve access for underserved areas, such an approach is

Box 21: Laws and regulations for public health

Laws addressing gender discrimination and gender-based violence provide a legal framework that criminalizes such actions and provides survivors and victims recourse to justice. However comprehensive, national laws must be followed up by national actions that are systematically enforced to be effective. Efforts are often required to educate women on their rights under the law. Poor women in particular might require assistance in accessing legal services that will enable them to seek justice under the law.

In Cambodia, the Cambodian Women's Crisis Centre (CWCC), with the support of the United Nations Fund for Women (UNIFEM), undertook a comprehensive effort to addressing gender-based violence. The aim of the project was to emphasize the prevention of violence at the community level. To this end, CWCC sought to increase understanding of violence in the community and provided tools to combat violence.

CWCC launched the pilot project in November 1998 in 18 communities around Phnom Penh. Activities included community workshops on the issue of violence against women, relevant laws and the role of local authorities. Communities were encouraged to assist victims of violence, establish support networks for victims and their families, and monitor the incidence of violence against women. This work at the community level was complemented through the gathering of documents on violence against women, relevant laws and regulations, and services available to women, such as health care, shelter, credit and vocational training.

Source: UNIFEM Trust Fund in Support of Actions to Eliminate Violence Against Women (EVAW), Popular Education and Organisation as a Means to Prevent and Deter Violence Against Women in Cambodia (<http://unifem-eseasia.org/projects/cambodia/VAMCAM2.HTM>, accessed 4 March 2006).

essentially gender-neutral, as the formula does not explicitly consider the differential needs and impact of resource allocation on men as compared to women. Complementing the use of a population- or needs-based formula with gender analysis can help integrate gender concerns into the resource allocation pattern.

Countries in the Region often draw upon a mixture of sources to finance health care: general tax revenues, social insurance contributions, private insurance premiums, direct out-of-

pocket payments and community financing.²¹⁵ Donor aid is often a key source of health care financing in many low-income countries. Evidence suggests, however, that various health financing methods might impact men and women differently, depending on the sources of funds. Box 23 discusses a study that assessed discrimination in public health spending in Mexico concerning the right to health, which is a striking example of how the allocation of health financing can discriminate against some groups within society.

Box 22: Gender-responsive budgeting

Gender-responsive budgeting aims to analyse local and national budgets from a gender perspective. While national, local and sector budgets might appear gender-neutral, the impact of government revenue collection and expenditure differs for women and girls as compared to men and boys. Analysis of the distribution, use and generation of public resources is a powerful tool for holding governments accountable to their commitment to gender equality. The analysis might focus on the entire or selected parts of the national or local budgets. Increasingly, gender-responsive budgeting initiatives undertaken locally involve community members in the analysis and monitoring of budgets. The involvement of community members in determining priorities for resource allocation and shaping resource collection is also rising.

Gender-responsive budgeting was initiated in the Philippines in the late 1990s with the issuance of a government directive on the Gender and Development (GAD) budget. The GAD budget is implemented through the General Appropriations Act. This act, which has the force of law, mandates government agencies and local governments to allocate at least 5% of their respective budgets to “programmes, activities and projects that address the needs and hold up the rights of women.” The National Commission on the Role of Filipino Women (NCRFW) acts as the oversight agency for the GAD budget. NCRFW requests every government ministry and local government to formulate a GAD plan and to use at least the 5% GAD budget to implement this plan.

The experience acquired since the introduction of the GAD budget offers many insights into the challenges of implementing gender-responsive budgeting initiatives. Monitoring conducted by NCRFW highlights the need for continuing capacity building among government agencies, particularly senior management staff, on gender equality and other gender-related concepts. In the absence of sufficient capacity, some local governments and government agencies misallocated the GAD budget to inappropriate activities, such as those that promote beautification and fashion, ballroom dancing and etiquette, and others. Some evidence suggests that the vagueness of the gender budgeting directive might have contributed to such outcomes. Frequent changes in staff in government agencies and limited financial support to NCRFW also might have hampered the realization of the GAD budget.

The 5% GAD budget is intended to be used to promote gender mainstreaming in the budget as a whole. As gender is a crosscutting issue within development, the different needs of men and women need to be recognized and reflected in 100% of the budget. Similarly, responsiveness to gender issues needs to be integrated into the entire budget process. To this end, NCRFW has made efforts to create gender-sensitive indicators and to monitor the impact of the GAD budget on women as compared to men.

Sources: International Development Research Centre (IDRC) 2006a; IDRC 2006b; Budlender D. *et al* (eds) 2001; and Magtolis Briones L., Valdez G. 2005.

In many countries, the division of productive and reproductive labour between men and women results in more men being employed in the formal sector than women, while women are more likely to be employed in the informal sector or engaged in reproductive labour than men. This gendered division of labour influences men and women's entitlements to health financing. That is, formal sector work tends to be protected by labour laws that often include mandatory health care insurance financed through general taxation, social insurance contributions or private health insurance schemes. These public or private schemes are rarely extended to informal sector or home-based workers. As a result, the benefits of the various health financing methods might flow disproportionately to men as compared with women. In addition, entitlements to health financing schemes are often in the name of the male household head; women's entitlements are premised on their relationship with the male household head. Thus, if the household dissolves, these entitlements can be lost.

A recent review of literature concludes that taxes and social insurance schemes offer the most equitable form of health financing. The shift from taxation to a greater reliance on direct user fees has been shown to harm the poor's access to health services. Moreover, private for-profit health insurance schemes and private direct fees to private for-profit schemes appear to result in substantial inequalities in access to health services.²¹⁶ The literature review finds gaps in the evidence base on the gendered impact of health financing reform. However, some evidence suggests that the increasing reliance on user fees may have disproportionately affected women relative to men, and that women might receive less health insurance coverage. Thus, it is important to assess through gender analysis the impact a given mixture of health financing options has on the ability of men and women to access health services.

Human resources

The distribution of human resources for health can support or constrain the realization of gender

equality policies. The distribution of health staff should meet the needs of the population generally, such as ensuring adequate staff in rural and remote health facilities. Beyond such general concerns, men and women health staff members need to be allocated in a manner that responds to the needs of men and women patients. In many settings, women cite the absence of a female health professional as an important reason for not seeking treatment. For some, it is an issue of embarrassment; for others, a cultural taboo.

Staffing policies that promote equal opportunity and working environments that are friendly to male and female staff might help improve gender balance in the recruitment, distribution and career development of health staff. This often requires an analysis of the organisational structures and practices of institutions.²¹⁷ This might help raise awareness of these issues and enable the development of strategies to address gender-related inequalities among health workers. Establishing equal opportunity policies can help reduce inequalities in recruitment, contracts and pay. For example, recruitment policies that adjust job descriptions and recruitment strategies, and contracts that include maternity and paternity leave, can contribute to equal opportunity. The legal and political framework also might undermine the goals of equal opportunity policies and might require modification.²¹⁸

Efforts also are required to improve the knowledge and awareness of gender concerns among health staff. Health service providers at different levels—from primary care to tertiary—need to receive such training. Allocation of adequate resources to provide practical training on how to implement norms and protocols is required. In-service training on gender analysis and planning needs to be followed with the development of gender-responsive action, plans and institutional mechanisms to promote gender mainstreaming.

Health information

An important constraint in tackling gender issues in health in developing countries in the Region

is the general lack of data that are disaggregated by sex at the national and subnational levels. Sex-disaggregated data are required to assess differences in men's and women's exposure to the risk factors for ill health, patterns of morbidity and mortality, and changes over time in the distribution of ill health. Sex-disaggregated data also can yield insights into men's and women's access to health services and gender-related factors that might underlie differences in the health of men and women.

However, collecting, analysing and using data that are disaggregated by sex, and other indicators of social exclusion, might not be sufficient. Whether, and how, gender inequality might influence differences in the health of men and women also needs to be considered. Gender-

sensitive indicators enable an assessment of the ways gender roles, gender norms, and differences in access to and control over resources might influence a health concern for men or women.

Once collected, sex-disaggregated data and gender-sensitive indicators need to be considered through gender analysis. Applying gender analysis to these data and indicators can reveal important insights into the health of men and women.

These efforts may be supplemented with appropriate research, including quantitative and qualitative methods to assess unmet needs, perceived quality of health services, and various financial and non-financial barriers that poor men and women might face when accessing health services. Case studies and other qualitative

Box 23: Institutional and geographical distribution in public health spending in Mexico

A study analysed the health budget in Mexico concerning the right to health enshrined in the Mexican Constitution and the International Convention on Economic, Social and Cultural Rights. In particular, the study examined the prohibition of discrimination in access to health services contained within the right to health. The prohibition on discrimination is not subject to the "progressive realization" clause attached to many of the rights outlined in the international convention. Instead, it is an immediate obligation that requires the reallocation of existing financial resources rather than obtaining additional resources.

To this end, the study analysed whether the institutional and geographical allocation of resources was discriminatory with regards access to health services. To examine the possibility of institutional discrimination, the study compared the social security system, which finances health care for citizens with higher income and in formal employment, with decentralized funds for health services for citizens who are poor, not in formal employment and who depend upon health services financed by the Ministry of Health (the unprotected group). These two financing schemes comprise the public health system in Mexico.

This division within the public health system does not, by itself, constitute discrimination. Discrimination arises when the availability of quality health care services to these two groups is unequal. To assess possible inequalities in the availability of services, the study estimated the annual real per capita expenditure for those covered by the social security compared with the unprotected group. The results show that annual real per capita expenditure in 1998 for those covered by social security was more than half of that for the unprotected group. This gap shrank slightly over 1999 and 2000. Overall, however, almost three quarters of public health care finances were allocated to citizens covered by social security.

With regard to geographical discrimination, the study found that the distribution of health resources by geographical region was unequal, and that the poorest regions had the lowest per capital health expenditure. These regions also had the highest concentration of indigenous peoples and the worst health indicators. Based on these results, the study concludes that inequality is institutionalized in public health expenditure in Mexico.

Source: Hofbauer, Lara, Martinez 2002.

analytical methods might provide information that an analysis of data from health information systems otherwise would miss. Box 24 describes how such research revealed important differences in men's and women's experience of TB in Viet Nam. A gender analysis of these data can identify entry points and priority interventions to improve the health of men and women, and to assess how interventions might affect men and women differently.

Initiatives beyond the health sector

Gender inequalities in health arise not just from the health sector alone. Instead, gender interacts with the multiple determinants of health that lie beyond the health sector. Therefore, addressing gender inequalities in health requires actions across sectors. Such cross-sector initiatives need to address inequalities rooted in factors such as socioeconomic status, race and ethnicity, among others, since gender inequality often overlaps with and reinforces other dimensions of exclusion.

Taking the lead on such initiatives, ministries of health might need to encourage cooperation across a wide range of partners. Building partnerships with women's organizations, the gender machinery of government, civil society organizations committed to gender equality, and international organizations can foster an environment that enables efforts towards achieving gender equality goals. Establishing such broad coalitions can mobilize support across diverse stakeholders and various segments in society. This, in turn, can help build and maintain the political commitment for gender equality. Box 25 describes the experience from Bangladesh, which shows how mobilizing broad support among diverse stakeholders is important for ensuring the success of gender equality policies.

At the global level, WHO has set up the Commission on the Social Determinants of Health. The commission aims to draw attention to the impact social determinants—including gender—have on producing and sustaining inequalities in health. The commission will

Box 24: Gender analysis of sex-disaggregated data on TB in Viet Nam

The male-female ratio of new smear-positive tuberculosis (TB) cases in Viet Nam follows the regional pattern, having increased from 1.6:1 in 1990 to 2.1:1 in 1999. Some studies have sought to explain this male-female gap in notification of new smear-positive TB. The results show that the prevalence of long-term cough in men and women is not significantly different within communities. Men and women were found to recognise their symptoms and seek health care at roughly the same time. However, women were shown to be more likely to self-medicate and consult less qualified health providers than men, who were more likely to seek care directly from hospitals. In other words, women took longer to contact a qualified medical provider than men, and a smaller share of women were likely to present for diagnosis than men. The studies also found that the mean expenditure per health action for male TB patients was almost twice that of female TB patients.

Women who presented for diagnosis were found to experience longer delay and were less likely than men to be diagnosed with TB. The studies suggest that this might occur because women were less likely than men to present with typical TB symptoms, such as cough, sputum expectoration and haemoptysis. In turn, the absence of cough and sputum expectoration was found to be significantly associated with provider delay. An estimated 36% of men and 14% of women reported giving sputum samples at hospitals. Of the TB patients who were requested to give sputum samples, female TB patients were less likely than male TB patients to return for the requested follow-up. Conversely, the studies revealed that female TB patients were perceived to be more compliant than male TB patients. The analysis presented in these studies suggests that the male-female gap in Viet Nam might arise at least partially from gender-related barriers to diagnosis and treatment.

Sources: Viet Nam National TB Programme Review 2003 (draft report); Thorson A. *et al* 2000; Long N. *et al* 2002; Long N. *et al* 1999a; and Long N. *et al* 1999b.

recommend strategies to improve the health of men and women by addressing the social determinants of health.²¹⁹ Women and gender equality are also the focus of one of the “knowledge networks” of the commission.

At the national level, multisector planning instruments, such as national socioeconomic development plans or the poverty reduction strategy papers (PRSP), can provide the basis for a cross-sector approach to tackling the social determinants of health. Such instruments offer the opportunity to increase policy coherence and undertake joint planning to address the

gender determinants of health.²²⁰ However, analysis suggests that the PRSP process has not systematically incorporated attention to gender inequality. Instead, the inclusion of gender often appears arbitrary and fragmented.²²¹ Ministries of health, therefore, need to advocate for the inclusion of gender within such multisector planning instruments.

Improving access to health services

Gender-sensitive approaches are required to improve access to health services for men and women, particularly those who are poor or

Box 25: Mobilizing support among diverse stakeholders to ensure sustained political commitment for reproductive health in Bangladesh

In 1996, Bangladesh formulated its first Health and Population Sector Strategy. A 5-year Health and Population Sector programme followed in 1998. The main goal of these initiatives was to “improve the health of women, children and the poor.” To this end, 60% of the national health budget was allocated for an essential package of services delivered through primary health facilities. A core aspect of this package of services was reproductive health care, based on the scope of services defined at the International Conference on Population and Development: safe motherhood, including expansion of emergency obstetric care; family planning; prevention and control of reproductive tract infections and sexually transmitted diseases, including HIV/AIDS; maternal nutrition; menstrual regulation and management of the complications of unsafe abortions; adolescent care; and infertility and neonatal care.

Implementing the health and population strategy and programme required reforms to restructure and strengthen the health system. Given the scope of change involved, the Government and international partners agreed that the involvement of nongovernmental organisations (NGOs) was crucial to assist in building a national consensus for change. Thus, the task forces established to elaborate various aspects of the programme drew members from Government, donors and civil society. The task force on community and stakeholder participation was supported with adequate staff with strong links to civil society organizations and financial resources. This enabled the task force to consult widely with a range of stakeholders, including service users and providers, women, adolescents, indigenous populations, professional organizations, NGOs and the media.

The consultative process assembled these diverse stakeholders for the first time in Bangladesh, thereby consolidating strong support for continued civil society involvement in programme formulation. This was matched by a political commitment from a new Government in 1996. As a result, the focus of the programme shifted from family planning to comprehensive sexual and reproductive health services. Processes for continued consultation with stakeholders were institutionalized into the programme design. In particular, 25 community-based primary stakeholder committees were set up across the country to act as “health watch groups.”

Although the initial phase of programme implementation faced some constraints, significant improvements in health were recorded: maternal mortality decreased from 4.1 to 3.2 per 1000 live births, severe undernutrition decreased from 20.6% to 12.9%, and coverage of antenatal care increased from 26.4% to 47.5%, among other improvements.

Source: Jahan R., Germain A. 2004.

marginalized. To be effective, initiatives to improve access should be informed by an analysis of sex-disaggregated data, generated through the health system or qualitative and quantitative studies. The following discussion suggests how various types of barriers to access to health services might be addressed in a gender-responsive manner.

Addressing geographical barriers

The coverage of health services in many developing countries in the Region remains incomplete, often benefiting non-poor communities more than those that are poor. Among countries in the Pacific, for example, health services might not effectively cover remote and small island communities. Such geographical barriers to access might prevent or delay care-seeking care. If the clinic is too far away, women are less likely to access it than men, because they tend to be less mobile than men.

In many countries in the Region, the network of primary health facilities tends to be more accessible for poor men and women than services lodged in secondary or tertiary level facilities. Thus, prioritising primary health care when allocating resources might improve geographical access to services for poor men and women. To augment this strategy, underserved areas or those where the poor are concentrated (e.g., rural and urban poor, and remote island communities) can be prioritized further in the allocation of resources.

Attention is turning increasingly to the role communities can play in supporting and extending the delivery of health services, such as care for people living with AIDS and prevention and control of NCDs.²²² This is particularly important for women, who typically bear the burden of home-based care for long-term illness among family members. Key aspects of community-based interventions are the mobilization and participation of community members in decisions that affect their health.

Being aware of the needs of the community is an important step toward increasing access for all.

Box 26 describes the experiences of the Women's Health Care Foundation in Manila, Philippines, which has improved women's access to health services in underserved areas.

Addressing economic barriers

Because men and women face different economic barriers to access to services, the mix of financing sources adopted has important implications. For example, evidence from Cambodia suggests that in some areas condoms are available free to women sex workers, while in others they must buy them from health facilities, brothel owners or NGOs.²²³ Where user fees are prevalent, adopting strategies to limit the disproportionately adverse impact user fees have on poor and marginalized groups, which may include women, can ensure the continued accessibility of health services for all.

Gender analysis can uncover economic barriers to access, such as the generally lower ability of women than men to pay for health services. Gender analysis can also help identify ways to address such barriers, such as through exemptions targeting particularly vulnerable groups of women (e.g., widows, adolescents, unmarried mothers or ethnic minority women). Other strategies might include exempting from user fees health services that respond to the priority health needs of men and women. In Ghana, the Government has adopted a policy of free delivery care for all women, financed through the PRSP process. Similarly, the Government of Nepal has a policy that provides cash payments to cover transport costs of women during delivery and free institutional delivery for women residing in the poorest districts.²²⁴

Another way to reduce economic barriers to access is to ensure that particular health services deemed to be important to both women and men are covered in health insurance schemes. The social insurance scheme in Bolivia was designed to extend coverage to maternal and child health services. Evidence suggests that this approach effectively increased the coverage of antenatal and delivery care in public health care

Box 26: Improving accessibility and affordability of health services for women in the Philippines

The Women's Health Care Foundation (WHCF) was established in 1980 to improve women's access to health services beyond maternity and family planning services. WHCF operates three fixed-site clinics in the Metro Manila area, plus an extensive outreach programme designed to provide information, education and services to women and their families in underserved communities near Manila. Placing the health of women within the context of the wider community, WHCF has a strong community outreach programme that includes training of local residents as community health workers to provide health care information to their neighbours, a political advocacy effort that involves lobbying for health care reforms that affect women, and networking with nongovernmental organisations that have similar interests.

The clinic's weekly visits to low-income neighbourhoods are important for local women, who are entitled to free health care in the government-run clinics in the centre of town, but find the cost of getting there beyond their reach. With no household help or child care, leaving home is difficult. However, since clinic sessions are held in the home of a community health worker, neighbours can summon a patient from home when the appointment time comes.

To ensure affordability, client fees are extremely low and a fee schedule based on ability to pay has been implemented. As a result, poor women and students can obtain health services. To minimize costs, WHCF leases inexpensive office space, and local clinics are held in community health workers' homes. Doctors are hired on a part-time basis, while nurses and midwives are trained to perform multiple tasks—from taking medical histories to conducting simple laboratory procedures, such as gram staining and pregnancy tests.

WHCF developed several strategies to increase access to services. The clinics are open from 8:00 a.m. until 6:00 p.m. or beyond, far longer than the government-run clinics. They also open on Sundays, allowing access to women who work full-time during the week. In addition to the community health workers, WHCF recently started to recruit community-based distributors of condoms from among street vendors working in the same areas as sex industry workers. Promotion is done mainly through small street signs and paid notices in telephone directories. Special events are also important: annually on International Women's Day, WHCF provides free Pap smears and breast exams.

Source: Baume E., Juarez M. 2001.

facilities by 50%, especially among the poorest group.²²⁵ Another approach is to extend financial incentives to improve access for specific groups to particular services. Conditional cash transfers, for example, are a means of mobilizing demand for health services among poor families, particularly mothers. These schemes transfer a set amount of money to pre-identified families, or individuals within families, tied to their use of specified services. Evaluations report that conditional cash transfer schemes increased use of antenatal care by 8% during the first trimester of pregnancy in Mexico, and by 15%–20% in Honduras.²²⁶ A more recent analysis suggests that conditional cash transfers might have important implications for gender equality. For example, conditions that demand women perform unpaid community

labour might undermine opportunities for paid employment.²²⁷

Community-based health insurance schemes that generally operate on a much smaller scale have been established in many developing countries. Such schemes spread the financial burden of ill health among households and over predictable periods. The Self-Employed Women's Association (SEWA) has one such scheme that seems to have achieved success in improving coverage among poor women in Gujarat, India (Box 27).

Time may constitute an especially important opportunity cost for women in seeking care. Therefore, selecting the location and hours of a clinic or office is an issue of concern.

Understanding the roles and timing of activities in the community is the first step towards choosing hours that are convenient to all. Women might be unable to spend time away from their families and domestic responsibilities, while men might be earning income outside the home and be unable to miss work. If the clinic is only open in the morning, when women and men are in the field or otherwise engaged in productive or reproductive

work, neither are likely to use the facilities unless absolutely necessary. In some areas, evening office hours might be unsuitable if women are not allowed to leave home after dark.

Addressing sociocultural barriers

Many of the strategies to address gender-based inequalities in health outlined above implicitly

Box 27: Insuring the health of poor women: the case of SEWA

Community-based health insurance (CBHI) schemes have been identified as a promising means of protecting poor individuals and households from the economic costs of ill health. CBHI schemes typically involve prepayment and pooling of resources to cover the costs of ill health. However, some evidence suggests that the system of prepayments may exclude poor members of communities from CBHI. An assessment of a large CBHI in Gujarat, India, shows that even when high rates of coverage are achieved among the poor, other factors must be considered.

The Self-Employed Women's Association (SEWA) is a trade union of informal women workers founded in 1972 in Ahmedabad, Gujarat. The aim of SEWA is twofold: to organize women to achieve full employment (work security, income security, food security and social security), and to make women independently and collectively self-reliant, economically independent and capable of making their own decisions.

In 1992, SEWA launched an integrated health insurance programme, Vimo SEWA, which offers life, hospitalization and asset insurance in an integrated package. Membership, which is voluntary, is open to SEWA union members and non-members. Members pay annual premiums that are passed on to a formal insurance company. The insurance covers hospitalization up to a maximum of Rs2000 (about \$46) per member annually. The member, who must pay for health services upfront, chooses the health provider. Upon submission of medical certificates, bills documenting hospital stay and expenses, the member is reimbursed. Studies have found that this system has provided considerable financial protection for members.

An analysis of the distributional impact of Vimo SEWA found that the rates of coverage among the poor were high in urban and rural areas. This was attributed, in part, to SEWA's focus on the poorest women, i.e. those who work in the informal sector. However, an analysis of the patterns of claim submission showed that members in rural areas who were less poor were significantly more likely to make claims than were the poorest members. This was not the case in urban areas, where the pattern of claims submissions appeared to be equal.

Women constitute about 83% of adult Vimo SEWA members in rural areas and 80% in urban areas. The findings of the study show that men who were members of the scheme were significantly more likely than women members to make claims. The rate of claims was 1.8 times higher by men than by women in rural areas and 1.3 times higher by men than by women in urban areas.

The results of additional qualitative research suggest some reasons for these findings. Even when poor individuals were covered by Vimo SEWA, they reported difficulties in accessing hospitals because of lack of money and distance. In addition, women explained that their household responsibilities made seeking care at hospitals difficult. Filing a claim was also found to demand certain skills, such as literacy, and the capacity to negotiate the official, formal system, which many women members felt they lacked.

Source: Ranson M.K. *et al* 2006.

tackle gender norms and roles that undermine the health of men and women. While these strategies can help, engaging in initiatives that directly challenge gender discrimination in a given context is often necessary. Such efforts can complement strategies to address geographical and economic barriers to access, for example, and can independently offer valuable outcomes, such as tackling gender-based violence. Tackling sociocultural barriers, such as gender norms, needs to be undertaken in manner that is sensitive to all actors and groups in a community and the differences, conflicts or hierarchies between them. Efforts to address sociocultural barriers are, in effect, interventions to change social relations and power dynamics. Individuals or groups that feel threatened by the intervention might react negatively and hinder activities. In addition, these types of interventions often need to be carried out in the long term, as short-term change might not be practical or sustainable.

Participatory methods that engage with and respond to the perceptions, views and needs of all community members are often more effective in creating social change than top-down interventions initiated by organizations or individuals outside the community. However, the voices of all community members must be heard, which requires strategies to ensure the inclusion and equal participation of men and women, as well as those from poor or ethnic minority households. Where women are especially disempowered, they may be enabled to speak in focus group discussions held separately from those held with the men. Similarly, a better approach might be to seek the input of marginalized groups in a forum where powerful members of the community are not present. Box 28 describes a project with sex workers in Calcutta that used participatory methods that enabled sex workers to identify project strategies and challenge gender norms within society.

While community-based initiatives might be effective in extending the reach of health services, the benefits of this approach are not automatic. Effort is required to ensure that the women's interests—whether as users of

Box 28: Transforming gender norms in India: the experience of sex workers in Calcutta

Gender discrimination increases women's vulnerability to HIV/AIDS infections. With HIV/AIDS infection rates rising in India, many Indian women remain largely unable to contemplate being assertive in their sexual relationships with men and to negotiate safer sex. A movement among sex workers in Sonagachi has transformed gender relations, enabling women to negotiate safer sex with their clients as well as better treatment from society in general, including the police.

The STD/HIV Intervention Project established a sexually transmitted diseases (STD) clinic for sex workers in 1992 to promote disease control and condom distribution. The project was structured to ensure broad participation from the sex workers. Sex workers set project strategies—25% of managerial positions were reserved for sex workers—and sex workers were in many key positions in the project. Sex workers acted as peer educators, clinic assistants and clinic attendants. The broader project goal was to enhance the capacity of sex workers to question cultural stereotypes and gender norms in society.

Employing a variety of participatory methods, sex workers identified their vulnerability to poverty and social deprivation. This set the foundation for changing attitudes and behaviour among sex workers and society more generally. For example, the peer educators gained respect from the community, thereby challenging the notion that they were “fallen women”; alliances were formed with long-term clients to promote safer sexual practices, including the elimination of violence in the area; training sessions were held with the police; and a union of sex workers was established to promote and enforce the rights of sex workers.

The project entered into negotiations with groups of mostly men, including pimps, brothel owners, clients and the police, and enlisted their support to improve the rights of sex workers. This represents a direct challenge to dominant gender relations in India.

Source: Nath M.B. 2000.

services or as caregivers—are articulated in the planning and implementation of community-based interventions. Dividing men and women into separate groups might enable women to participate more freely than they would as part of a mixed-sex group.

Group discussions that include methods such as brainstorming, role playing, discussion sessions and individual reflection are also useful in eliciting or identifying, as well as addressing, sociocultural barriers.²²⁸ Additional participatory methods also might be employed to enable individuals to generate their own information and understanding of a given situation. Box 29 describes a project in Rio de Janeiro, Brazil, that used some of these strategies to effect change among young men in the *favelas* (low-income neighbourhoods) that challenged dominant gender norms. Box 30

discusses an initiative in Chiang Mai, Thailand, that relied upon peer educators to educate and facilitate discussion among young male and female factor workers with the aim of challenging gender norms impinging upon behaviour to protect against the spread of HIV and STI.

Improving quality of health services

Training and awareness building at all levels are required to improve the gender responsiveness of the health system. Understanding how health service providers view the needs of men versus women, and how gender stereotypes might influence the quality of care provided, are important. This approach can elucidate differences in the standards of care that providers might use when diagnosing and treating men as compared with women. In Viet Nam, for

Box 29: Working with young men to transform gender relations as a strategy for HIV prevention

Evidence shows that the risk of HIV/STI infection and violence among young men and women is linked with the early socialization processes of boys and girls that promote prevalent gender norms and roles, such as the belief that men have multiple sex partners and maintain control over the behaviour of their female partner. Addressing these and other inequitable gender norms is increasingly identified as a key strategy to prevent HIV.

A project in three *favelas* of Rio de Janeiro, Brazil, worked with young men 14–25 years old to empower them to question and challenge traditional gender norms related to masculinity. Before project implementation, an estimated 70% of participants were sexually experienced, having initiated sexual activities at 13 years of age, on average. Of those who were sexually experienced, one third reported having sex with more than one partner during the previous month. This, in combination with support for inequitable gender norms, pointed to the high prevalence of behaviour that places these young men and their partners at high risk of HIV and sexually transmitted infection (STI).

The project combined interactive group education sessions with a social marketing campaign. The group education sessions with the young men followed a curriculum designed to change their attitudes and behaviours. This included the use of a manual and educational video. An older man facilitated the sessions. A community-wide social marketing campaign reinforced the information shared and topics discussed during the group sessions. The social marketing promoted condom use; a more gender-equitable lifestyle; and the prevention of HIV, STI and violence among the communities.

An evaluation revealed that the combination of the educational sessions and social marketing campaign led to significant changes in attitudes and behaviour. A significantly smaller proportion of participants supported inequitable gender norms. Reports of STI symptoms were found to have decreased, while condom use was reported to have increased. The participants were also found to have communicated better with their partners on a wider range of topics regarding sexuality and safer sex.

Source: Pulerwitz J. *et al* 2006.

example, women who present for TB diagnosis experienced a longer delay and were less likely to be diagnosed with TB than were their male counterparts. In the study sample, almost twice as many men as women reported giving sputum samples.²²⁹ Similarly, it is increasingly evident that health service providers in the United States are less likely to diagnose heart disease in women than in men. When women are diagnosed with heart disease, studies have shown that they are less likely than men to be provided with effective treatment.²³⁰

Gender analysis of differences in treatment practices can help identify suitable actions to

ensure that services are sensitive to the needs of men and women. Improving the coverage of and knowledge about interventions that benefit the health of men and women likewise can make the health systems more responsive. Information on techniques and interventions with demonstrated benefits needs to be made available, especially among hard-to-reach populations.

A significant aspect of the overall quality of health services available to men and women is how health service providers treat them. Health professionals must be sensitive to the patient's feelings and concerns and should not belittle them. Feeling belittled by health workers is a common

Box 30: Using peer education to challenge gender norms among young male and female factory workers in Chiang Mai, Thailand

Countries across the Region are undergoing rapid social change. In some areas, this has resulted in an increasing number of women being engaged in non-traditional forms of employment, such as in electronics and garment factories in Cambodia, People's Republic of China, the Philippines and Viet Nam. In areas where demand for female labour in factories is high and wages and working conditions are perceived to be better than in other sectors, many young women migrate from rural to urban areas to search for factory employment. Women who have migrated to urban areas are often distant from parents and families, and thus traditional social norms. This loosening of social norms can encompass changing notions of acceptable male-female behaviour.

A study of young male and female factory workers in Chiang Mai City, Thailand, reports that social norms in the city associate masculinity with sexual prowess, and that men prefer women who are sexually inexperienced. Young men and women agree that women are responsible for preventing pregnancy. Concerning HIV and sexually transmitted infection (STI) prevention, few men take any precautions unless the woman is perceived to be infected. Meanwhile, fear of being perceived as socially undesirable often prevents young women from adopting appropriate preventive behaviour. In combination, these social norms can place young men and women at high risk of STI and HIV infection.

In response, a peer education programme was set up, which explored the effect of gender roles and social norms on sexual behaviour, attitudes, relationships and communication patterns. The initiative aimed to increase awareness among young (15–25 years old) factory workers who have never married. Eighteen peer leaders were trained to facilitate small groups through a variety of activities, including comic books and romance novels.

An evaluation found improvements in attitudes and awareness regarding behaviours that influence risk, following the peer education. An increased proportion of respondents were able to identify challenges, such as peer pressure and male promiscuity, to adopting risk-reducing behaviour. Following peer education, more participants said that it was acceptable for women to raise the issue of HIV with men (29.9% to 42.3%). Further, more participants felt it was appropriate for women to carry condoms. This suggests that male and female participants developed an awareness of gender norms and how they influence the practice of safe sex.

Source: Cash K. *et al* 1997 in Boender C. *et al* 2004.

complaint from women, making them less willing to seek treatment. For example, an evaluation of the 100% condom use programme in Cambodia suggests that the low quality of care in some government STI clinics might deter female sex workers from seeking care. The evaluation also identifies actions that have improved the quality of services in some STI clinics, such as improving staff attitudes, communication skills and general quality of services provided; decreasing waiting times; and increasing confidentiality. In particular, efforts should be made to increase awareness, sensitivity and skills of health care providers in dealing with marginalized communities, such as ethnic minorities and migrant communities, to ensure that all clients, especially the poor, are treated with dignity and respect.

Health education and communication

Advocacy and health education and communication strategies aim to communicate information strategically to change the perceptions of individuals and positively influence their decision-making. Educating clients and the public and raising awareness about health issues are important steps towards building a healthier population. Providing information on preventative health practices, signs and symptoms of common illnesses, and basic family health care is critical. To ensure effectiveness, gender considerations need to be integrated into the formulation,

implementation and evaluation of health communication initiatives. Box 31 provides an example of a health-promoting programme that is gender sensitive and focused on education.²³¹

Health communication is typically a key aspect of strategies that aim to create social change. Advocacy campaigns can create an environment that is supportive of social change. Social marketing may help change gender norms. As health communication materials are often tailored to specific groups of people, they can encourage behavioural change at the individual level. To be effective, health communication materials need to be developed to pique the interest of the users and meet their needs. For example, HIV- and STI-related health communication strategies need to be developed from a man's perspective; materials that address issues of pleasure, power and security have been found to be particularly effective.²³²

Using a variety of communication methods is essential to ensuring that health messages reach their target audiences. Asking basic questions about where people in the community get information is the first step. Are the illiteracy rates high? In this case, pictures and posters might be effective. Do certain segments of the population, such as women, live in seclusion? Might they have access to the radio, which would make public service announcements a useful tool? What about using social groups, such as women's or men's

Box 31: Building reproductive services for men in Turkey

In 1980, the Ministry of Health of Turkey reported that 450 000 abortions were performed annually, and attributed the country's high maternal death rate to unsafe abortions. One way Turkey is combating this is increasing men's involvement in the health care system without detracting from services for women, through targeted information, counselling and services:

- programmes at hospitals that use couples counselling or group information for men to increase couples' access to family planning information and services at the time of abortion;
- prenatal programme designed to help couples adopt postpartum practices that promote family health; and
- programmes to provide increased access to family planning information and vasectomy services to Turkish State Railway workers and their families.

Source: Pile J. *et al* 1999.

clubs, or community meetings? Understanding where people gain information will help ensure that health-related messages reach the intended audience. Once the sources of information are known, the accuracy and appropriateness of the information provided must be ensured.

Health professionals should keep in mind that economic and cultural realities affect people's willingness and/or ability to carry out certain health practices and treatments advocated by health communication. For example, if water and fuel are scarce, asking women to boil water for all household use is unrealistic. Posters about schistosomiasis showing women wearing shoes on the way to the river in a community where no one wears shoes, for example, are likely to be ineffective. The following quote demonstrates the importance of designing messages that are relevant to the situation in the community:

*They are tired of being told to boil drinking water, wash hands after defecating and give their children a balanced diet. This is an area where water is scarce. To expect people to boil water and carry it with them during their long journeys is not realistic. Further, because of the lack of latrines, people defecate in the abundant bush where water is not available. The message of a balanced diet has apparently been abandoned because the issue is to get enough of whatever food is available.*²³³

Taking the reality of current conditions into account will improve the effectiveness of health communication initiatives substantially.

Monitoring and evaluation

Despite the growing recognition of ongoing and often increasing health inequities, including those that are gender-based, health information systems (HIS) have been weak in yielding the information needed to assess and address these inequities. The challenge is to determine the information required to address health inequities; shape health information systems to meet those requirements;

promote sensitization to equity issues; and develop the skills required to use information for effective planning and policy-making.²³⁴

The Health Metrics Network (HMN) has begun work to construct equity indicators and create mechanisms to link records between data sources.²³⁵ Gender has been identified as one of four priority equity indicators, along with socioeconomic status, racial or ethnic minority status, and geographical location. The HMN is quick to point out, however, that sex-disaggregated data, which many countries are already collecting, are not necessarily equity indicators. Careful consideration of these data through gender analysis can draw attention to equity concerns and enable comparison of data across and between countries from an equity perspective.²³⁶ The HMN works with countries to undertake assessments as a first step towards strengthening national HIS.

Disaggregating data by sex is the first step in conducting gender analysis of health data; without such disaggregated data, identifying and addressing differences in the health of men and women over time remains difficult, if not nearly impossible.

Gender-sensitive indicators

Sex-disaggregated information tells us whether a specific dimension of health differs according to sex. Gender-sensitive indicators are meant to help us understand whether the problem or the sex differential is influenced by gender inequality. Once sex-disaggregated data are available, gender-sensitive indicators can be adopted to enable an examination of whether, and in what way, health-related issues that affect men and women are influenced by

- gender-based division of labour and activities
- gender norms
- men's and women's access to and control over economic, physical and social resources
- men's and women's decision-making power within the household and community

Having asked these questions, existing indicators can be modified or new indicators constructed to capture these and other gender-related concerns. Gender-sensitive indicators are needed in routine data collection in health to identify the existence of a problem—for example, are there differences in male and female health that cannot be random? They can provide insights into whether gender role socialization or discrimination might underlie the problem. Such analysis can help in developing interventions to address the problem. The indicator then can be used to assess whether the intervention has the desired impact.

Box 32 outlines various ways to make indicators gender sensitive. Box 33 describes some general principles to follow when developing gender-sensitive indicators.

To be effective, gender-sensitive indicators need to be incorporated into routine data collection, including monitoring and evaluation. The regular collection of gender-sensitive indicators enables an analysis of health problems among men and women, and how these might change over time. These indicators also point to underlying factors that contribute to differences in the health of

Box 32: Creating gender-sensitive indicators

Gender-sensitive indicators can be created in several ways, including the following:

- New indicators can be created on aspects of men’s and women’s health where gender differentials occur or are likely to occur.
Example: Indicators on social and economic consequences of sexually transmitted infections (STIs) or infertility for women as compared to men. The new indicator can ask not only whether medical help was sought, but also what kind of medical help was sought, since many studies show that women tend to use providers closer to home or those who are less expensive, because of gender-related factors.
- Data can be disaggregated along additional variables, chosen based on a gender analysis of factors likely to affect health.
Examples:
 - ♦ Analysis of maternal mortality rates by place of death (home or health facility?)
 - ♦ Analysis of the cause of death by type of attendance at delivery
- Existing data can be analysed or re-analysed by “gender” factors.
Examples:
 - ♦ Demographic and health surveys provide information on non-use of antenatal care or non-use of contraception, as well as the reasons for non-use, such as lack of permission from the husband, women do not think it is necessary; too expensive, etc.
 - ♦ These surveys also contain data on whether the last pregnancy was “intended” and, separately, on the experience of domestic violence. Cross-tabulating the two can reveal whether they are related.
- Indicators can be modified or new ones created, to be used concurrently with others that are already in use, based on the same sources of information:
Examples:
 - ♦ Indicator: Proportion of pregnant women who are seropositive for syphilis.
Modified indicator: Of pregnant women who are syphilis seropositive, proportion who report that their partners have symptoms.
 - ♦ Indicator: Proportion of women below 19 years old who have had a child or been pregnant.
Modified indicator: Proportion of the above who report the age of the child’s father to be 30 years or more.

Source: Ravindran T.K.S., not dated.

men and women, and reveal issues that are of particular concern to women or men.²³⁷ For example, some gender-related questions might be asked to understand what drives low contraceptive

Box 33: Developing gender-sensitive indicators

These are some general principles to follow when developing gender-sensitive indicators.

Comparison to a norm: Use of gender-sensitive indicators should involve comparison to a norm, for example the situation of men in the same country or the situation of women in another country. In this way, the indicator can focus on questions of gender equality and equity rather than only on the status of women.

Disaggregation: Data should be disaggregated by sex. When possible, national-level indicators should also

- be disaggregated by age;
- be disaggregated by socioeconomic grouping;
- be disaggregated by urban and rural settings;
- be disaggregated by ethnic minorities;
- be disaggregated by national and/or regional origin;
- note the time period;
- note the geographical coverage; and
- note data sources.

Ease of access: Data should be easy to use and understand. Indicators should be phrased in easily understandable language and should be developed at a level relevant to the institutional capabilities or the country concerned.

Scope of availability: Indicators should be available for the whole country.

Reliability: Data should be relatively reliable. No data is absolutely reliable, but reliability checks should be carried out. For example, findings from consensus should be compared to findings from micro-level studies for accuracy.

Measurability: Indicators must be about something measurable. Concepts such as “women’s empowerment” and “women’s equity” might be difficult to define and measure. In this case, proxy indicators, for example, relating to greater choice for women in accessing health care or education might be used instead of the less-precise concepts.

Time-frames: Gender-sensitive indicators should be reliable enough to use as a time series. The time span that the indicator covers should be clearly specified.

International compatibility: Gender-sensitive indicators should be collected using internationally accepted definitions. While definitions are sometimes imprecise, they are usually the best terms available and allow for international comparisons.

Measuring impact: The indicator, where possible, should measure the outcome or impact of a situation rather than the input. For example, female mortality rates are a better measure of women’s health status than access to health facilities.

Participation: The indicator should be used and developed through a participatory process as possible. This will involve setting up interdepartmental government committees and holding focus group meetings with the public to elicit the opinions of women and men whenever possible.

Source: Commonwealth Secretariat in Baume E., Juarez M. and Standing H. 2001.

prevalence in a given population. These questions might include the following:²³⁸

- Do women make decisions on contraception? If so, do they make these decisions alone or in conjunction with their male partner or with other women?
- Do women have the financial resources to purchase contraceptives? Do they have information on where contraceptives are available?
- Are there social norms concerning how many (male) children women should have?
- Are women responsible for productive and reproductive tasks? If so, do they not have the time to access contraceptives?

As Box 33 shows, adopting gender-sensitive indicators requires the disaggregation by sex of data collected through HIS. Routine monitoring and evaluation also should use sex-disaggregated data and other gender-sensitive indicators. As with sex-disaggregated data, analysis of gender-sensitive indicators then can be used to design appropriate health interventions and monitor the impact of these and other interventions on men and women, boys and girls, over time.

An important need is to sensitize health staff involved in the collection, management and analysis of health information to the need for such disaggregation and analysis of data. Such capacity building can include an awareness of the need to collect and present data in a manner that will enable an analysis by other dimensions of social exclusion, such as socioeconomic class, race, ethnicity or location, in addition to sex.²³⁹

Complementing an analysis of sex-disaggregated data from HIS with qualitative data can contribute to an understanding of how to achieve improved health outcomes among men and women. That is, case studies and participatory appraisals, among other research methods, can provide information on people's perceptions, views and actions that an analysis of HIS data might miss.²⁴⁰ These alternative methods can also be an effective means of elucidating information on sensitive topics, such as gender-based violence. Moreover,

participatory methods can ensure that the views of marginalized or minority groups are represented and taken into account.

Monitoring and evaluation of gender mainstreaming

An ongoing monitoring and evaluation system is particularly important for gender mainstreaming, as men's and women's needs and access to resources might change over time. Being able to adapt as necessary and make changes based on unforeseen variables are essential to the long-term success of an initiative. Focusing monitoring and evaluation on the following areas can generate a comprehensive understanding of how the health intervention or programme affects men and women:

- empowerment indicators;
- distribution of beneficiaries by sex;
- participation in decision-making, disaggregated by sex;
- perceptions of beneficiaries of change/impact in their well-being; and
- identification of areas for further work and research.

Even if gender mainstreaming is considered advanced or complete, ongoing monitoring and evaluation of gender concerns should not be abandoned as situations and participants can change.²⁴¹

Addressing gender bias in research

Health research in past decades has often tended to neglect issues that specifically or predominantly relate to women's health. The tendency has been to focus on men patients as normative, instead of looking at the evolution of illnesses in men and women. For example, the research related to heart disease has focused primarily on the disease's progression in men, because it was traditionally seen as a disease of men. Despite data confirming that women are susceptible to heart disease, the research and treatment methods remain skewed toward men. This leads to inadequate information on the progression of certain diseases in women and on women-specific illnesses overall. A notable

Box 34: Gender-sensitive research

Gender-sensitive research focuses on the similarities and differences between:

- women's and men's roles and responsibilities,
- women's and men's positions in society,
- women's and men's access to and use of resources, and
- social codes governing female and male behaviour that affect health and well-being.

Source: World Health Organization 1998.

exception to this trend is contraception, which has traditionally focused predominantly on women and neglected men. Indeed, more research on men could promote their involvement in and responsibility for contraception.

Medical research and clinical trials also generally exclude women subjects. This exclusion is commonly based on the rationale that women's reproductive functions, such as menstruation, might raise confounding variables.²⁴² Women of reproductive age are also excluded specifically because of concern for their fertility or reproductive functions. However, generalizing the results of drug trials carried out exclusively among men to the population as a whole can have negative or unforeseen repercussions on the health of women.

Thus gender bias in research needs to be addressed to ensure that both men and women benefit from health research. Box 34 outlines some principles of gender-sensitive research. Raising questions to reveal gender bias is particularly important during the design phase when the research hypothesis and questions are reshaped and refined.²⁴³ Interviewers also need to be sensitized to gender concerns. Research tools, such as questionnaires, need to be reviewed from a gender perspective. In addition, the variables of analysis need to be chosen with care. For example, the multiple roles women play often need to be taken into consideration.

Overall, addressing gender bias in research requires an increase in the number of women researchers

Box 35: Social influences on smoking prevalence in the Region

Smoking is becoming an increasingly important public health issue in the Region. Male smoking prevalence in the Region is estimated at 62.3%, while the female rate is roughly 4%.²⁴⁴ In fact, some have argued that being born male is the greatest predictor for tobacco use in the Region.²⁴⁵ Some studies from countries in the Region have begun to highlight the influence social norms and gender roles have on the differences in smoking prevalence among men and women.

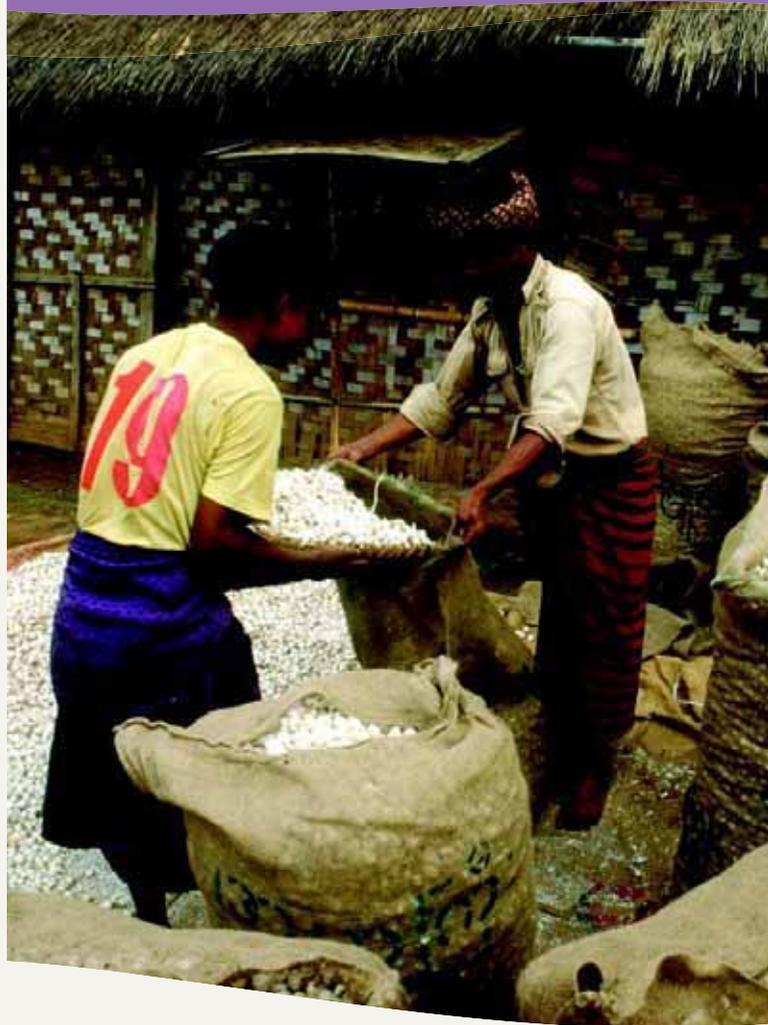
In Viet Nam, an analysis of a national survey found that the main reason women rejected smoking was the belief that "women shouldn't smoke". Among women 15–42 years old in Ho Chi Minh City, 76% attributed the low female smoking prevalence to social disapproval, while 20% noted health concerns as the main cause. Conversely, smoking has been identified as an integral aspect of male social behaviour in Viet Nam. For example, offering cigarettes has become a common courtesy among men. The exchange of cigarettes serves a similarly important social function among men of all ethnic groups in Malaysia.

Sources: Morrow M., Barraclough S. 2003a; and Morrow M. *et al.* 2002 in Morrow M., Barraclough S. 2003b.

appointed to advisory bodies and research funding committees. The success of lobbying efforts to increase funding for breast cancer research in the United States of America, for example, shows what is possible when research efforts are directed more equitably.

Qualitative research has an important role to play in addressing gender bias in health research. This is because qualitative research has the tools to analyse questions concerning the distribution of power between men and women, men's and women's sense of control over decision-making processes, and the influence of social norms more generally. Research on smoking, much of it using qualitative methods, has begun to reveal the different reasons men and women in the Region start smoking. Many of these reasons are rooted in social norms of masculinity and femininity (Box 34).

5. Facilitator's notes



5. Facilitator's notes

These training materials are designed for facilitators to begin working with learners in the health field on the concept of gender, build their awareness of their own perceptions and those of the people and institutions around them, and to understand how gender affects health.

Target audience

The module is part of a series for learners in the health field. Ideally, the group should have no more than 20–24 learners, as the activities are highly participatory and not suitable for large groups. It can be adapted for health workers in the field by changing some of the methodologies.

Role of facilitator

As the facilitator, you are responsible for setting the tone for the course. This will include making sure that participants understand the expected learning outcomes, providing clear instructions for the activities and keeping to the time schedule. You are also responsible for summing up and synthesizing the discussions at the end of the day or the end of a complex session.

You should be aware of the group dynamics and make sure that no one feels left out or discriminated against, and that all have the opportunity to speak and participate equally. While no one should be forced to speak if he or she is uncomfortable, you can use techniques such as pairs and small group activities to encourage interaction and balanced participation. You can also use questions to draw out quieter members of the group. It is important to make everyone feel valued and that his/her experiences are important. You can also state the principles of participatory training, which include equal participation, and tell participants that men usually dominate groups, so you would like to encourage participation that is more balanced.

If someone is dominating the conversation, you can use a “talking stick” or “conch shell” or other object, which is passed around the room to those who wish to speak. Only the person holding the object is allowed to speak. You can also introduce

a rule that no one is allowed to speak twice before everyone has spoken once, or divide people into small groups with the quiet ones in one group and the louder ones in another.

As the facilitator, you can adapt the course format to suit your group. For example, if the participants already have an understanding of poverty, you can skip some of the introductory exercises. If trust is lacking, you can use more of the introductory and energizer activities to bring people together. In addition, some exercises might be more suited to some groups than others, or specific questions might need to be changed to reflect the participants' backgrounds.

Methodologies²⁴⁶

This module is designed for adults, which means it is participatory and involves the learner in the programme taking advantage of her or his experience and knowledge. Studies have shown that adults learn best by being active participants in the learning process as they rely heavily on their own experiences to aid them in determining what information and skills are relevant to their work.

Multiple methods are suggested for different activities to vary the course format and to give participants a variety of ways to acquire the knowledge and skills. As the facilitator, you may adapt the methods to suit your group as you see fit. If you would like to use this module in the field, you might wish to avoid lectures, for example, in favour of more participatory question and answer or large group discussion sessions.

Pairs. Participants group themselves into pairs for activities or discussions. Usually the time given for the activity is short (3–5 minutes). If used more than once, ask the participants to switch partners to give them a chance to get to know more people in the group. Working in pairs helps participants get to know each other better and feel more comfortable in the course, which is important as some discussions might become controversial. It also allows participants time to discuss individually specific points or questions

raised by the facilitator. The outcomes of the pair discussions can then be shared with the larger group in a plenary session. As working in pairs often takes longer than anticipated, be aware that it might cause difficulties with timing.

Small group work. In this case, participants are divided into small groups of five to seven people. This size is small enough for everyone to take part, but large enough to offer a variety of opinions and backgrounds. It is important to have enough space in the room for the groups to talk without disturbing each other; if there is not enough space, using additional rooms if available would help. Give the participants the topic and materials needed for the small group project, tell them how much time they have to complete their work, and ask them to appoint someone to take notes and report back to the larger group. It is helpful to let the groups know how much time they have left at appropriate intervals (at the halfway point and shortly before the end at a minimum). When the time is up, ask the people taking notes in each group to present the main points to the rest of the class. Each presentation should be brief (5 minutes or less). When each presenter finishes, ask other members of the group if they have anything they would like to add. Questions should be noted and saved for the end.

Buzz groups. Buzz groups are informal groups that can be set up spontaneously to quickly discuss more challenging issues or questions. Like pairs, buzz groups can break up a lecture period, re-energize the group and allow more time for individual comments. They should be kept brief (no more than 5 minutes). If possible, the questions should be prepared ahead of time and written on a flipchart for easy consultation.

Brief lectures. Lectures are the most passive form of learning and should be brief and used sparingly. However, they are useful for delivering information in a short amount of time and can be used to break up other course methods. Ideally, they should be followed by exercises to ensure that participants absorb the information. Encouraging participation during the lecture through questions

or buzz groups is also useful to be sure people understand the material. Another technique to highlight the main points of the lecture is to write them on flipcharts, which you can display as you speak.

Brainstorming. With this method, the facilitator poses a question and asks everyone to call out his/her answers and ideas spontaneously. No censoring should take place, either by the participants or by the facilitator. Write all responses on the flipcharts as they are called out, even if they are repeats. The main point is to elicit as many ideas as possible in a short time frame. It encourages participation from everyone and welcomes all points of view. When the time is up, the ideas can be prioritized or grouped under topic headings when appropriate.

Questions. Providing time for questions and discussions, especially at the end of sessions or during a plenary, gives participants the opportunity to clear up any confusion and get further information on any aspect of the topic. Some people will ask questions simply to hear themselves speak, but you must be firm in asking people to keep their comments brief, particularly if the questions are irrelevant. One way to deal with excessive or irrelevant questions without making people feel they are being ignored is to establish a “parking lot”. This is a flipchart where you list any topics or questions that cannot be answered immediately due to time or other limitations. Tell participants about the parking lot at the beginning of the course and have it available and visible at all times. Some topics that are parked may be addressed later in the discussions or may cease to be important. Others can be addressed when time is available or participants show repeated interest in the issues.

Other methods: Icebreakers and energizers²⁴⁷

Icebreakers can be used to help participants get to know each other and relax at the beginning of the course. Energizers can be used at any time and are short activities that are useful for re-energizing a group on a hot afternoon or to break up a long

session. These can be used at the facilitator's discretion. Samples are listed below.

Icebreakers

Greeting. Explain or ask how people in different countries greet each other. Then ask participants to pick a pre-prepared slip from a hat or basket, each with one of the following:

- Place both hands together and bow (India)
- Kiss on both cheeks (France)
- Rub noses (Iceland)
- Hug warmly (Russia)
- Slap on each hand and bump each hip (some parts of southern Africa)
- Ask the participants to move around the room greeting each other in the way indicated on the slip.

Wallpaper. Ask participants to draw a picture of themselves doing something they enjoy doing. After 10 or 15 minutes, ask each one to show and explain their picture. Afterwards each person signs their picture and puts it up on the wall. As some people feel very anxious about drawing, only do this with a group of people who will be able to do it without anxiety.

Who am I? Write the names of famous people or roles onto squares of paper. Without letting the participant see the paper, pin or tape a square onto the back of each participant. When each person has a square attached, ask everyone to walk around the room asking questions with yes or no answers to try to guess what is written on their back, such as "Am I a woman? Am I young? Do I live in Asia? Do I sing?". Participants can ask only one question of each person they meet. After 10–15 minutes, ask them to come together and say who they think they are. Examples of names/roles could be the following. Be sure to include female and male examples of both wherever possible:

- Famous singer/actor
- Well-known author
- Mother
- Father
- Basket weaver
- Rice planter

- Construction worker, etc.

Beautiful Bee. "I'm Bee and I'm beautiful".... Each person says his or her name and a positive word to describe himself or herself (no negative words allowed) and goes on to introduce the preceding members of the group: "I'm Lynne and I'm lovely...this is Sue and she's super...William and he's wonderful...Cathy and she's courageous". A variation on this is for people to say their name and one thing about themselves (not necessarily starting with the same letter): "I'm Cathy. I have three children". In the same way, they introduce the preceding members: "I am Thandi and I like working in groups. This is Cathy. She has three children." And so on.

What I like to do. This is useful near the beginning to help get to know each other in a fun way. Each person briefly shows in mime something that he or she likes to do. The second person does the previous person's action and then his/her own. The third person does the first, second and third actions, until the last person does the actions for the whole group. This can be made more fun by also including a sound (not words) to go with the mime.

Energizers

Stand in a circle. Each person takes a turn making a sound and gesturing to show how he or she is feeling. This is a good one to do at the start of a day for people to express their feelings.

Untangling. Ask the group to stand in a circle and close their eyes, until you tell them to open them again. Move slowly towards each other stretching out your hands until each person is holding someone else's hand in each of his/her hands. Check to make sure that everyone is holding only one hand in each hand. Then ask everyone to open their eyes. You will find the group in a tangled knot. Holding hands, with eyes open, try to untangle yourselves until you are standing in a circle holding hands again.

All change. Arrange the chairs or mats so there is enough room for everyone except one person

to sit down. The person without a seat calls out to all people who have a certain characteristic, e.g. “everyone wearing blue” or “people with an E in their name”. Those people stand up and run around to find another seat. The person who is the caller also tries to find a seat. One person will not be able to sit, and she or he will go to the centre and become the caller. If the person calls, “all change”, everyone has to stand up and run to another seat.

While this game can be used just to get people moving, it also can be used to build awareness and provide information on a topic. You could ask for people who are parents, grandparents, daughters, brothers, heads of household, etc.

Be aware that some people might not feel comfortable sharing certain topics in public. Also, be aware that some people might not be able to run. In this case, it might be best to choose another energizer.

Word and deed. The first person in the circle does one action, while describing another. For example, she says “I’m cooking”, while pretending to type. The second person then acts out the thing the first person says she was doing, while saying she’s doing something else: “I’m scratching my nose”, while pretending to cook. This then continues around the circle. It can be hilarious, but it is not for people who want to remain dignified at all costs.

Tropical rainforest. With the group standing in a circle, the facilitator starts rubbing her hands together. The next person copies, then the next, continuing around the circle. When the movement gets back to the facilitator, she changes to snapping her fingers, and one-by-one everyone copies her. Then she starts slapping her hands on her thighs. Next she stamps her feet. Then she begins the whole process again in reverse until everyone is silent again. It sounds like a rainstorm in a forest, starting quietly, building up and then gradually dying away again. It is important that each person copies the actions of the person to the right, not the facilitator. It is also important

that the facilitator wait until everyone is doing the action before changing to the next one.

Materials

Flipcharts. Flipcharts are large sheets of paper, usually bound together at the top and placed on a stand. These allow plenty of space to write and can be seen at the back of the room. Flipcharts should be prepared ahead of time with key points for a brief lecture, questions for buzz groups or pairs, etc. Having extra flipcharts available that can be used for brainstorming, parking lots, plenary reports and other additional points is useful.

Markers. Make sure you have plenty of dark coloured markers available, so they can be seen from the back and replaced quickly if they dry up.

Flipchart stands. It is important to have something to hold the flipcharts upright at a height that can be seen by everyone and easily reached for writing.

Masking tape. Select a tape that does not leave marks on the wall. It will be used for taping up important flipchart pages for future reference, such as questions for a small group session, the parking lot or course rules.

Handouts. Included in the course are handouts for the participants that should be photocopied and given out as indicated in the notes. These include substantive material on the topic, case studies, resources and exercises.

Suggested evaluation format

Please rate the following components from 1 to 5, with 1 representing the lowest level of satisfaction and 5 representing the highest. Please circle your answer.

- How well do you feel you learned the concepts covered in this session?
1 2 3 4 5
- How useful were the tools presented?
1 2 3 4 5

3. How useful were the group exercises?
1 2 3 4 5
4. How successful were the methodologies used to explain the concepts?
1 2 3 4 5
5. How well did the facilitator handle the subject?
1 2 3 4 5
6. How was the length of the workshop?
Too long Too short Just right

Please answer the following questions:

7. Which sections were most useful?
8. Are there some sections you would eliminate?
9. Are there some sections that need to be improved? What recommendations do you have for this?
10. Do you think that the poverty approach is appropriate for your specific work?
11. Do you foresee limitations or great difficulties in including it in your work?
12. What strategy and what concrete activities do you suggest for achieving the inclusion of a gender-responsive approach in your daily work?
13. How could the World Health Organization support you in including a gender-responsive approach?
14. Would you recommend this course to a colleague? Why? Why not?
15. Any additional comments.

Expected learning outcomes

Upon completion of the module, participants will be able to:

1. Demonstrate an understanding of the concept of gender and how it differs from sex, including gender roles, access to and control over resources, and gender needs.
2. Demonstrate an understanding of WHAT the links are between gender and health.
3. Explain WHY it is important for health professionals to address gender concerns in health
4. Indicate HOW health professionals and health systems can address gender concerns in health.
5. Demonstrate familiarity with some tools, resources and references available to support health professionals in dealing with gender in health

Lesson plans

Session 1: Introduction; analyzing the difference between sex and gender

Objectives

- Introduce learners and help learners start thinking about male/female relations early in the course.
- Review expectations and ground rules for the activity, address any concerns and help learners feel comfortable with the course goals.
- Explore the differences between sex and gender.

Time required: 2.5 hours

Methods

- Icebreaker
- Brief lecture
- Brainstorming
- Plenary
- Small groups

Materials

- Any materials needed for chosen introductory activity
- Handout: The gender game
- What is sex? What is gender? Relevant pages from Module text

- Prepared flipcharts

Activity 1: Introductions (time: 15 minutes)

Process

1. Welcome participants and introduce yourself.
2. Explain that in the coming activity, they will be working on the concept of gender, why it is so important to the field of health, and how to incorporate it into their work.
3. Explain the introductory activity you have chosen and ask the participants to complete it, so they can get to know each other better.

Activity 2: Expectations and rules (time: 30 minutes)²⁴⁸

Materials: Flipchart, markers, text from Introduction of Module

Process

1. Using a flipchart, ask learners the following questions and write down their responses:
 - a. What do you hope to get out of the training?
 - b. What do you hope will NOT happen or fear might happen?
 - c. What contributions do you bring to the course? Any special experience of being discriminated against because of race, gender or some other characteristic? Any special skills, such as ability to listen well? Any special talents, such as willingness to learn and change?
2. Go through the lists, explaining what expectations, if any, might not be met and why. This also might be a good time to establish a parking lot (see introduction to facilitator's notes).
3. Pass out copies of the Introduction and go through the goals for the course (it is important not to give it out until the expectations have been listed; otherwise it will influence the discussion). Explain how much flexibility there can and cannot be in terms of content.
4. Explain that the activity will be participatory

in nature because you know that they all have a range of experiences and knowledge to bring to the learning process. Let them know that you will expect and encourage equal participation by everyone.

5. Explain to the learners the need for having a set of rules for behaviour.
6. Ask the group for suggestions for rules the group should adhere to, and make it clear that the group should agree upon the rules. You can add rules if no one suggests them. Samples of common "ground rules" are:
 - a. Everyone should be on time.
 - b. No smoking in the classroom.
 - c. Do not interrupt while others are speaking.
 - d. Everyone should try to listen as well as speak.
 - e. Maintain confidentiality of what is shared—no gossiping.
 - f. Show respect to others and their experiences.
 - g. Do not make personal attacks.
7. Write the agreed ground rules on the flipchart.

Activity 3: To be a man or woman (time: 10 minutes)²⁴⁹

Materials: Flipchart and markers

Process:

1. Draw a vertical line down the middle of a flipchart. At the top of one column, write "women" and at the top of the other write "men".
2. Using the brainstorming technique, ask learners to call out answers to the questions: "What are the characteristics of women?" and then "What are the characteristics of men?" The pace should be fast.
3. Write down all answers as they are given.
4. If no one mentions child birth or lactation, ask a question to ensure they are included.
5. After the lists are finished, cross out "women" and replace it with "men" and cross out "men" on top of the other column and replace it with "women."

6. Ask participants, “Which characteristics on these lists would now not be possible in any society?”
7. You should only have to underline characteristics like “child-bearing”, “breast-feeding”, etc.
8. Then ask, “What do these characteristics that are left have in common?” Answers should include change over time, differences between cultures, differences within cultures, learned behaviour, historical. Point out that these are typical characteristics of gender.
 - c. Gender roles vary greatly in different societies, cultures and historical periods.
 - d. Age, race and class are also major factors that determine our gender roles.
 - e. Women in every country experience power and oppression differently.
6. Pass out copies of What is sex? What is gender? from module text for participants to read on their own.

Session 2: Determinant of the differences in the health of men and women

Objective: To understand that the inter-relationship between biological, psychological and social factors generates specific health needs for women and men

Time required: 2 hours

Methods:

- Brief lecture
- Small groups
- Buzz groups
- Plenary discussion

Materials:

- Flipcharts and markers
- Module text on “What are the links between gender and health and why is it important to address gender in health policies, plans and programmes”
- For the power walk:
- Suggested roles and questions
- Pieces of paper with assigned roles
- Large space (ideally in open air)
- Handout: Exploring the relationship between gender and health. Optional: This handout can be copied and distributed to participants for additional reading.

Activity 1: Gender as a determinant of health
(time: 25 minutes)

Process:

1. Ask learners to have read module text on “What are the links between gender and

Activity 4: The gender game (time: 30 minutes)²⁵⁰

Materials:

Pens, paper, handout: “The gender game, What is sex? What is gender?” from the module text

Process:

1. Based on the previous exercise, ask the members of the group if they now understand the difference between sex and gender.
2. If they are confused, emphasize the following points:
 - a. Sex refers to the biological differences between men and women.
 - b. Gender refers to the roles that men and women play. Social and cultural influences determine these roles and promote certain types of relationships between the genders in various situations.
3. Pass out blank sheets of paper to all the learners and ask them to write the numbers 1 to 10 in a list on the paper.
4. Read out the numbered statements on the handout: The gender game. Ask participants to write ‘G’ for those statements that refer to gender and an ‘S’ for the ones that refer to sex.
5. Pass out copies of the handout to everyone and discuss the answers with the whole group. Focus on these questions and key ideas:
 - a. Did any of the statements surprise you?
 - b. Do the statements indicate that gender is

- health?” before the start of this lesson.
- Summarize the main points from the reading, highlighting main points on the flipchart.
 - Ask if anyone has any questions.

Activity 2: The Power Walk (time: 40 minutes)²⁵¹

Process

- Each learner is randomly assigned a role to assume, the identity of which is not to be shared with others. Participants begin by assembling themselves as if they are about to begin a race—i.e., in a horizontal line facing forward. The facilitator begins by reading out the questions one at a time from the provided list. Participants must silently think about whether or not they can answer yes or no to the given question in their assumed identity. “Yes” indicates that they take a large step forward. “No” indicates that they remain in the same place. An uncertain answer should be taken as a “no.” Participants who feel their “characters” could partially answer “yes” to the given question should take a small step forward. Each question is equivalent to one step.
- At the end of the questions, ask participants to remain in their places while each one reveals his or her identity to the others. Participants will be asked to discuss how they felt during the activity, how they felt about those around them and what they think the exercise reveals. Review some of the questions and compare responses. Those in the front are those that perceive their characters to have the most power with respect to the questions posed. Looking at the distribution of characters across the “power line” will reveal the differential possibilities available to “characters” within a health setting and allow for a more visual representation of the interaction of the social determinants of health and how this relates to gender and health.
 - The facilitator sums up by noting the following:
 - It is not only the existence of health services (regardless of their quality) that ensures proper and effective access to, and use of, them. Who you are, and the conditions of your life, affects how you can interact with the health system and how the health system treats you.
- Further, certain conditions of your life might mean that you have less social support for coping with disease and illness, or less power to make decisions regarding your body. These are all aspects that are uncovered when we pay attention to gender.
- Use the handout: Exploring the relationship between gender and health to conclude, highlighting the factors that affect health, and where gender fits into this bigger picture.

Activity 3: Origin of differences in health/illness profiles (time: 50 minutes)²⁵²

Process:

- Pass out copies of the handout: Origin of differences in health/illness profiles.
- Read the two upper boxes aloud and highlight that differences in health profiles between the sexes are based on an interaction between biological determinants and gender constructions.
- Ask the learners to form small groups again. Have one person in each group take notes.
- Ask them to read the bottom box and write down examples for each of the situations: sex specific, higher prevalence in one or the other sex, etc. Tell them they have 15 minutes. Walk through the room and make sure they understand the assignment. Alert them when they only have 5 minutes left.
- Bring them back together into a plenary to report their responses, asking the first group to list their responses to Category 1, the second group to Category 2, and the third group to Category 3. Before moving from one category to the next, ask if anyone from the other groups would like to add something to that category. If any significant examples are missed, add and discuss them as necessary (above is a sample list)

Table 7: Sample list of responses for Activity 3

Category	Women	Men
Sex specific	Pregnancy (in adolescence); cervical cancer; menopause; maternal mortality; prolapse of the uterus; abortion (which can have consequences, such as anaemia, infections of the reproductive tract, prolapse of the uterus and urinary incontinence).	Prostate cancer; haemophilia
Higher prevalence in one or other sex	Anaemia due to iron deficiency (linked to women's loss of iron during menstruation, pregnancy and lactation and exacerbated by cultural practices that privilege men in intra-household distribution of iron-rich food); osteoporosis (eight times more likely in women than in men, associated not only with biological factors but also with lifestyles); diabetes, hypertension and obesity (conditions which are more frequent in women than in men and also in lower-income groups); depression (two to three times more frequent in women than in men in all phases of life, related to personality types and experiences connected with types of socialization and differential opportunities for men and women); malaria in women pregnant for the first time; sexual violence (in childhood, adolescence and adulthood); excessive mortality due to cancer as adults (associated less with the lethal nature of cancers in women than with limited access to medical technologies for early detection and treatment of cancers in their initial stages); varicose veins, urinary incontinence, arthritis, autoimmune disorders.	Cirrhosis (associated with alcohol abuse); schizophrenia; lung cancer (associated with tobacco consumption); excessive mortality from violence, homicide and accidents (evident from the first year of life, associated with stereotyped masculine attitudes and behaviours such as aggression, risk-taking, excessive consumption of alcohol); silicosis (associated with mining work); hernias; colour-blindness (20 times more likely in men than women); coronary artery diseases (which are the biggest killers of men during the years they are engaged in the labour force); greater incidence of dyslexia, hyperactivity and stuttering.
Differences in characteristics for men and women	<ul style="list-style-type: none"> i. Sexually transmitted infections (STI) are more easily transmitted to women and have more severe consequences in women, such as sterility and even death in cases of pelvic inflammation. ii. Nutritional deficiencies can cause maternal deaths in child birth. iii. Alcoholism and tobacco consumption have different health consequences for women, particularly during pregnancy. iv. Sexual violence for women can cause unwanted pregnancy and STI. v. Malaria during pregnancy is an important cause of maternal mortality, spontaneous abortion and stillbirths; particularly during pregnancy, malaria contributes significantly to the development of chronic anaemia. vi. Death with weapons (suicide or homicide) is more characteristic of men. vii. Women tend to be victims of violent crimes perpetrated by intimate partners more often than men. viii. In our societies, the repercussions of sexual impotence are more negative when it involves a man than does sexual frigidity when it involves a woman. This is due to the great importance given male sexual prowess in many societies. Being unable to perform sexually implies not being a "real man." ix. Lack of access to quality water supply affects women more than men because in many societies women are the main users of water, and they and their children must fetch and carry it. 	

Continued on next page

Sample list (continued)

Generate differences in response by individual/family/ institution depending on whether the person is male or female	<ul style="list-style-type: none"> i. Cardiovascular problems: the notion persists that these are typically men's diseases; as a result, symptoms are not recognized in women. Data indicate that cardiovascular diseases are one of the main causes of death among women over 49 years old. ii. Disfigurement for Leishmaniasis, schistosomiasis, leprosy, onchocerciasis generates greater rejection by society if the sufferer is female, given the connection between physical beauty and women's worth. However, enlargement of the scrotum and testes by filariasis is more socially harmful to men than enlargement of the breasts for the same reason to women. iii. Ratio of 1 to 300 for masculine/feminine sterilization, even though vasectomy is simpler, more economical and less invasive than sterilization for women. iv. Schistosomiasis rates will be higher for women or men depending on the gender division of labour in the region. v. Domestic violence toward women is judged differently from public violence against strangers, and there is a greater degree of social tolerance for violence towards women from their male partners than there is for other types of social violence. This tolerance is reflected in legislation on family violence in almost every country. vi. The exclusion of women from clinical studies of pathologies affecting both sexes means that therapies based on these studies may not be reliable for application to women and may be hazardous for the female population. The consideration of the male body as the standard for clinical studies acts to limit the number of studies that focus on women's health and obfuscates the impact of certain medications or treatments at different stages of their life cycle. vii. Cataracts and skin cancers are more prevalent in men in coastal fishing areas from the sun reflecting off the water. viii. Low priority has been assigned to research of pathologies and treatments exclusively or primarily affecting women. ix. Focus of family planning services on women has excluded men, with the result that men have limited access to such services. In addition, given the gender relations within a family, decisions about contraception need to include men. Otherwise, women might be prevented from using them by their partners/husbands. x. Differences by sex in the quality of care in health services: research in Australia, Canada, Sweden, and the United States, as well as some countries in Latin America, shows that the quality of care received differs between men and women and is inequitable for women (waiting time, over-medication, humiliating treatment).
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6. After Category 3, but before Category 4, point out that the last category (Category 4) is clearly gender-based, meaning that important structural barriers to access to the resources and benefits of the health system derive from the roles that men and women play in society and the relations that arise from the value assigned to these roles.
7. Ask the last group to report their responses to Category 4.
8. Then, ask learners to quickly form buzz groups of three and undertake the following task:
 - a. What situations/conditions/problems in the categories are affected by gender?
 - b. Begin the analysis from the perspective that all health issues have a gender dimension, and challenge participants to look for the gender implications in each. Give them 10 minutes.
 - i. An example might be: Although maternal mortality results from women's biological capacity to give birth, the value society in general and the health sector in particular places on women clearly influences the deaths of women during child birth from preventable causes.
 - ii. The higher prevalence of diabetes

- among women is derived from biology. However, because of women's nurturing role, they are more likely to ensure that diabetic men in their families are fed correctly. Research indicates that women who have diabetes are less likely to feel comfortable with providing themselves with special food and adequate medical attention.
- iii. School-aged boys might be diagnosed as hyperactive more often than their female counterparts because of developmental differences between the sexes and the way these differences are addressed by the school system.
 - c. Bring the groups back together into a plenary and ask for volunteers to give their responses. Be sure to clarify any points as responses are given.
 - d. Summarize the discussion by noting:
 - i. Even though most of these are biologically specific to one sex or the other and appear to be "gender neutral", meaning they have no social or gender connotation, they do so in terms of how and when they are reported and treated by the health system, as well as how persons presenting the symptoms of disease are treated by society.
 - ii. Differences and disadvantages in the field of health are demonstrated not only in the way health and disease are distributed in a population, but also in the way health is promoted, disease is prevented and controlled, patients are cared for, and in the models adopted for structuring health and social security systems.
 - iii. Without fully appreciating the implications and impact of gender roles and relations, health practitioners will fail in their treatment of certain groups and individuals, and health planners

will inadequately serve the total population.

Session 3: Gender roles and needs and policy approaches

Time required: 3 hours

Objectives

- Identify the daily tasks of men and women in low-income households in different regions of the world.
- Raise awareness of men and women's workloads.
- Understand the concepts used for analysing gender in policies and programmes
 - a. gender-unequal,
 - b. gender-blind,
 - c. gender-specific,
 - d. gender-transformative.
- Be able to use a gender analysis checklist as a tool to assess their programme/project

Methods

- Small groups
- Plenary
- Brief lecture

Materials

- Flipcharts and markers
- Handout: The 24-hour day
- Handout: Mr. Moyo goes to the doctor
- Gender roles and needs (see Section I of Module).
- Refer to the text on assessing gender in policies and programmes, which includes the concepts gender-unequal, gender-blind, gender-specific and gender-transformative
- Handout: Examples of approaches to gender in policies and programmes
- Handout 1: Key questions to ask about the content of the intervention, programme or project
- Handout 2: Basic Questions – Does my programme consider gender?

Activity 1: Analysing gender roles: The 24-hour day
(time: 1.5 hours)

Process

1. Ask the learners to form small groups and choose one low-income social group of which they have personal knowledge, e.g., fishers, landless labourers or an urban shantytown community.
 - a. Ideally, both urban and rural groups will be chosen. Encourage this if possible.
2. Ask the groups to imagine a day in the lives of a wife and husband from each social group in a particular season of their choice.
 - a. Remind them to think of activities, such as breast-feeding, knitting and community meetings, which might not be considered work.
 - b. If gender is a new concept, some might be surprised at the amount of work women do and might distort the information. Be aware of this phenomenon and try to clarify it during the plenary discussion.
3. Using the 24-hour day chart as a model, as on Handout: The 24-hour day, ask the groups to list the tasks performed by women and men in a household over 24 hours. If you have enough flipcharts, ask the groups to write their responses on flipchart pages to post on the wall.
4. Put the pages or flipcharts on the wall and ask learners to walk around and look at them.
5. Bring everyone together for a plenary discussion to bring out common points from the charts. Despite the differences in daily lives, some common points that should emerge are:
 - a. Women and men do very different things during the day.
 - b. Women usually work longer hours.
 - c. Women have more varied tasks, sometimes doing more than one thing at once.
 - d. Women usually do the work for the family.
 - e. Men's work is usually outside the home.
 - f. Men have more leisure time.
 - g. Women get less sleep.
 - h. Men are more involved in decision-making.
 - i. In some societies, traditional roles of men and women were more balanced in terms of workload, but changes have decreased men's traditional activities and increased women's.
6. Give out Handout: Mr. Moyo goes to the doctor. Ask learners to read it and ask for questions or comments. These activities begin to analyse gender roles, but they deliberately ignore differences due to age, class, season, historical period, effects of war, etc. It can be used to show differences, e.g., between work boys and girls do versus men and women, but do not let it get too complicated at this early stage.
7. Give out copies of the "gender roles" and "gender needs" from Section I. and ask learners to read them. Discuss the roles and needs as outlined in the text. Clarify any questions that come up. Sometimes participants want to know why men's gender needs are not part of the exercise. Explain that men's gender needs are usually seen as overall human needs and are already taken into account. The purpose of the gender discussion is to improve the balance between men's and women's needs.

Activity 2: Useful concepts to assess gender in policies and programmes (time: 45 minutes)

1. Introduce the session highlighting the following:
 - Gender and policy analysts have developed a useful framework to assess and address gender in policy and programme development.
 - These include approaches that range from ignoring gender, to trying to work within the limits imposed by gender discrimination, to challenging it.
 - Over time, a common language has developed for describing these approaches. These are (a) gender-unequal, (b) gender-blind, (c) gender-specific, and (d) gender-transformative. These terms are further explained in the activity.

2. Discuss the examples of interventions presented in Handout: Examples of approaches to gender in policies and programmes, and have the participants characterise the examples into one of the four types of approaches.
3. Now ask the group to select one example from the each category, and discuss ways one could change this to gender-transformative. When you come to the gender-transformative category, discuss ideas on how to sustain this positive situation. [Optional: Depending on time and the mood of the group, you could do this in small groups, pairs or as a group activity—if you work with the whole group, draw the table on the flipchart.]
4. Clarify any questions that might arise, referring to the characteristics of each approach outlined Table 8:

Activity 3: Checklist tools to refer to in assessing gender (45 minutes)

Go through Handout 1: Key questions to ask about the content of the intervention, programme or project.

Refer to Handout 2: Basic Questions – Does my programme consider gender?

Option 1:

- Ask learners to do this on their own, focusing on the area (programme/project/

department) most relevant to their work.

- Discuss findings, looking to see if any are common to the group, examples of gender-unequal, gender-blind, gender-specific, or gender-transformative. Take a few examples and look at ways to make these gender-transformative.
- Suggest they do this with their colleagues/team/management as well.

Option 2: Working on the checklist after the group.

If time is short, ask learners to complete this after the workshop, and suggest they do this with their colleagues/team/management as well.

Session 4: Gender analysis in a health project or programme

Objective:

To understand and use the gender analysis matrix in programmes/projects

Time required: 2 hours

Materials

- Handout 1: Gender analysis matrix in programme/project
- Handout 2: Explanations of concepts used in the gender analysis matrix in programme/project
- Handout 3: Applying the gender analysis

Table 8: Approaches for addressing gender in policies, programmes and projects

Concept	Characteristics
Gender-unequal	Privileges men over women. Inequalities are clear and undisguised. Deny women's rights or give men rights and opportunities that women do not have.
Gender-blind	Ignores gender norms; is blind to differences in the allocation of roles and resources; is not intentionally discriminatory, but reinforces gender discrimination nevertheless. Often ignores the lack of opportunities/discrimination that underpin what appears to be fair practice.
Gender-specific	Recognises differences in gender roles, responsibilities and access to resources, and takes account of these when designing interventions. Gender-specific policies or programmes do not try to change the underlying causes for these gender differences.
Gender-transformative	Recognises differences in gender roles, norms and access to resources, and actively tries to change these to promote gender equality.

matrix tool to malaria prevention and intervention

- Handout 4: Applying the gender analysis matrix tool within a malaria service-delivery context

Activity 1: Introducing and applying the gender analysis matrix (time: 2 hours)

1. Introduce the matrix:
 - Distribute all the handouts.
 - Refer participants to Handout 1: Gender analysis matrix in programme/project; and Handout 2: Explanations of concepts used in the gender analysis matrix in programme/project.
 - Notes that the matrix categorises programmatic areas and some of the gender issues presented in the previous sections. The combination will help to implement gender-sensitive programmes and projects. The features of the matrix are: on the x axis, the concepts/aspects related to a programme/project; and on the y axis, gender-related considerations.
2. Apply the matrix
 - In the whole group, read through Handout 3: Applying the gender analysis matrix tool to malaria prevention and intervention and handout 4: Applying the gender analysis matrix tool within a malaria service-delivery context, noting that each takes a different angle—with a focus on prevention and intervention, on the one hand, and service delivery, on the other.
3. Learn to use the matrix
 - Select two health issues relevant to the group, and divide into 2–4 groups. If the learners are from the same programme, use their programme area as their topic for the exercise. If the groups are large, repeat the same topic in each group. Ask the group members to select whether they are going to deal with an intervention or service-delivery context, and to work through the matrix, as it would likely apply to their work situation. Ask learners to write up their analysis to present to the group.
4. Use the findings of the matrix
 - Do a group brainstorm/discussion on:
 - ♦ the usefulness of the gender analysis, and
 - ♦ using the findings—ways the gender analysis can be used.
 - To supplement the contributions from the group, the facilitator may mention that gender analysis findings are useful as they provide an opportunity to raise awareness among key stakeholders; provide evidence for effective advocacy work—to secure support from policy-makers, management and political leadership to argue for additional resources to integrate gender interventions into programmes and services; show the strengths and weaknesses in a programme in terms of addressing gender issues; stimulate further research and assist in refining research questions; assist in uncovering exactly where weaknesses lie in a programme/services
 - The facilitator may suggest the following as ways to use finding from gender analysis in a programme/project:
 - ♦ Make a summary of the analysed information and the ideal targets for effective gender integration.
 - ♦ Meet with the programme/project team and review the results. Evaluate whether any aspects of the cycle need to be revised to be gender-transformative.
 - ♦ Decide together how the team will implement the changes.
 - ♦ Present gender analysis findings to the key stakeholders in the community, including government

officials and other NGOs, especially those serving on various boards and task forces of the programme or project. This is because most health interventions affect the community. The composition of these bodies should include adequate representation of men and women. During these various presentations, further recommendations and suggestions could be made.

- ♦ Translate recommendations and suggestions into a programme or project for a gender-responsive plan and go through the programme/project cycle again.

Session 5: Closing and evaluation²⁵³

Time required: 45 minutes

Materials: Evaluation instrument

Process

1. Give a few closing remarks and ask if anyone has any last issues he or she would like to have clarified.
2. Explain the importance of the evaluations for improving the course and pass out a copy to each learner.
3. When they have finished and turned in their evaluations, conduct a brief oral evaluation. Ask the learners what was most useful and least useful, and any particular comments

they would like to make in general?

4. Thank the learners and share any personal thoughts on the course.

Note: A complete evaluation is impossible immediately following a workshop. Only with time is it possible to assess the real impact of the course. However, the questionnaire is useful in getting feedback from participants on their satisfaction with the goals and elements of the course to make any adjustments necessary to increase the course's immediate effectiveness.

Ideally, longer-term follow-up should be undertaken to study the following:

- whether there are any changes in the learners in terms of their attitudes, skills, knowledge and behaviour;
- whether the institutions within which the activities take place and with which the learners are later associated make changes in their structure and operational procedures to be more gender-sensitive; and
- whether there is any external impact in terms of more efficient use of resources due to gender-aware planning and increased gender equality due to more equitable division of social and economic resources.

This last criterion is extremely difficult to measure and is the long-term goal of gender training around the world. However, it is important to keep all of these goals in sight and mark any progress or lack of progress when possible.

Handouts

Session 1, Activity 4, Handout: The gender game

1. Women give birth to babies; men don't. (S)
2. Little girls are gentle; boys are tough. (G)
3. In one case, when a child brought up as a girl learned that he was actually a boy, his school marks improved dramatically. (G)
4. Among Indian agricultural workers, women are paid 40% to 60% of the male wage. (G)
5. Women can breast-feed babies; men can bottle-feed babies. (S)
6. Most building site workers in Britain are men. (G)
7. In ancient Egypt, men stayed at home and did weaving. Women handled family business. Women inherited property, and men did not. (G)
8. Men's voices break at puberty; women's do not. (S)
9. One study of 224 cultures found that men did all the cooking in five and women built all the houses in 36. (G)

According to United Nations statistics, women do 67% of the world's work, yet their earnings for it amount to only 10% of the world's income. (G)

Session 2, Activity 2: Suggested roles and questions for the Power Walk

Orphan girl (10 years old)	Poor rural grandmother looking after 4 grandchildren
Orphan boy (10 years old)	Woman living in rural Asia/Africa (aged 18–44 years)
Male sex worker	Illiterate woman (50 years old)
Female sex worker	Illiterate man (50 years old)
Minister of Health	Professional man with one child (35 years old)
Female Community Health Worker	Professional woman with one child (35 years old)
70-year-old woman living in a refugee camp	Teenage boy
20-year-old survivor of rape	15-year-old girl, married to someone three times her age
20-year-old male survivor of a traffic accident	HIV-positive woman
Gay man (18–44 years old)	Poor agricultural labourer (male)
Lesbian woman (18–44 years old)	Poor agricultural labourer (female)
A male doctor	A female doctor

Roles/characters to be selected (add or change as appropriate)

Questions/statements for Power Walk:

- I know where to find the nearest health facility.
- I feel respected by local health care workers.
- I have a say in the way health services are organized and delivered in my community.
- I can consult health services when and if I need to.
- I have access to household resources if I need to pay for health care.
- I can talk openly to local health care workers about my health problems.
- I can talk openly to my family about my health problems.
- Health programs in my area understand what my life is about.
- I understand how to take medication given to me by my doctor. [Note: If participants feel that they would not even have access to medication, they should remain in the same place.]
- I am allowed to be treated by a male health care worker.

Session 2, Activity 2, Handout: Exploring the relationship between gender and health.

Social determinants of health include education, employment status and income, culture, household position, age, and physical and social environments. Many of the determinants of health may be the same for women and men, but it is through their interaction with gender that we can witness these differential effects. The underlying social relations of gender have important impacts on the ways women and men receive treatment, perceive illness and health, and set health priorities. In other words, men from marginalized groups (i.e., the elderly, the poor and the displaced) are also subject to barriers, although their sex provides them with a certain level of “protection” compared to women.

A gender perspective goes beyond merely noting the sex differences; it acknowledges the diversity between women and men. Gender analysis assists in drawing together the social, cultural and economic factors that influence health. Gender sensitivity in daily public health practice begins with the recognition that women and men react differently to health care services due to their differing experiences across the life cycle, which, in turn, affect experiences of health, illness and treatment.

In applying a gender approach to health, we can move beyond describing women and women’s health in isolation and analyse the differences between women and men. A gender approach to health also allows for the consideration of all factors that affect women’s health through their multiple roles (i.e., not only as wives and mothers) and across the life cycle, as well as the roles and responsibilities of men and the inequalities between women and men by examining men’s roles and perspectives.

One frequently asked question is why women’s health receives such emphasis when looking at gender issues in health? The simple answer is that gender inequalities create a disproportionate burden on women due to the lower status attributed to women in many societies. As such, much of the work done on gender inequalities in health tends to focus on women. However, we also know that social norms can undermine men’s health—and this becomes clearer when we look at intersections of sex with ethnicity, age, socioeconomic status and health.

Including gender in public health helps to build understanding of how differences in power/status/roles between women and men affect:

- exposure to risk and protective factors
- access to and use of resources (information, education, technology and services)
- health outcomes (prevalence, incidence, case fatality, and social and economic consequences of ill health/disease)
- the response of health systems and services
- the roles of formal/informal health care providers (male or female)
- the right to protect oneself and have control over health

Session 2, Activity 3 Handout: Origin of male/female differences in health profiles ²⁵⁴**Biological differences**

- a. Anatomical/physiological
- b. Anatomical, physiological and genetic susceptibilities
- c. Anatomical, physiological and genetic resistances, immunities.

Social differences

- a. Roles and responsibilities
- b. Access and control
- c. Cultural influences and expectations
- d. Subjective identity

Health situations, conditions and/or problems

1. Sex-specific
2. Higher prevalence in one or other sex
3. Different characteristics for men and women
4. Generate difference response by individuals/family/institutions depending on whether the person is male or female

*Session 3, Activity 1, Handout 1: The 24-hour day*²⁵⁵

	Women		Men
4:00		4:00	
5:00		5:00	
6:00		6:00	
7:00		7:00	
8:00		8:00	
9:00		9:00	
10:00		10:00	
11:00		11:00	
12:00		12:00	
13:00		13:00	
14:00		14:00	
15:00		15:00	
16:00		16:00	
17:00		17:00	
18:00		18:00	
19:00		19:00	
20:00		20:00	
21:00		21:00	
22:00		22:00	
23:00		23:00	
24:00		24:00	
1:00		1:00	
2:00		2:00	
3:00		3:00	

Session 3, Activity 1, Handout: Mr. Moyo goes to the doctor²⁵⁶

“What is your job?” asked the doctor.

“I am a farmer,” replied Mr. Moyo.

“Have you any children?” the doctor asked.

“God has not been good to me. Of 15 born, only 9 alive,” Mr. Moyo answered.

“Does your wife work?”

“No, she stays at home.”

“I see. How does she spend her day?”

“Well, she gets up at 4:00 in the morning, fetches water and wood, makes the fire, cooks breakfast and cleans the homestead. Then she goes to the river and washes clothes. Once a week, she walks to the grinding mill. After that, she goes to the township with the two smallest children, where she sells tomatoes by the roadside while she knits. She buys what she wants from the shops. Then she cooks the midday meal.”

“You come home at midday?”

“No, no, she brings the meal to me about 3 kilometres away.”

“And after that?”

“She stays in the field to do the weeding and then goes to the vegetable garden to water.”

“What do you do?”

“I must go and discuss business and drink with the men in the village.”

“And after that?”

“I go home for supper, which my wife has prepared.”

“Does she go to bed after supper?”

“No, I do. She has things to do around the house until 9 or 10 p.m.”

“But I thought you said your wife doesn’t work.”

“Of course she doesn’t work. I told you she stays at home.”

Session 3, Activity 2, Handout: Examples of approaches to gender in policies and programmes

- A policy that denies a married woman the right to medical insurance in her own name makes her dependent on her husband for access to medical insurance. If her husband is unemployed, she (and her husband) is denied access to medical insurance.
- A practice where service providers require a man's consent before a woman can be sterilized is also gender-unequal as it gives men power over women and denies women the right to self-determination.
- Senior management recruitment policy in a department of health requires managers to have a PhD.
- Community-based AIDS care programme says that the health care system cannot take responsibility for caring for people with AIDS, thus requiring the institution of home-based care, without finding ways to involve men in home-based care. As a result, however unintentionally, the programme puts the burden of care on women.
- Occupational health policy protects women from working in places that are hazardous to their reproductive health. However, such a policy might in fact be gender-unequal if it does not take into account damage to male reproductive functions from similar or other workplace exposures and fails to offer them protection as well.
- Water supply policy establishes a mechanism to provide taps close to villages, shortening the distance women have to walk to fetch water.
- Workplace provides a child care facility for women with babies. This acknowledges women's role as primary carers and makes it easier for mothers to work. It does not necessarily encourage men to share in child care responsibilities. A redistributive policy would provide a child care facility for men as well as women with babies.
- Land policy removes restrictions on women's right to inherit land.
- Health communication programme encourages mutual respect among women and men and equal rights in sexual decision-making as a means of promoting safer sex practices.

*Session 3, Activity 3, Handout 1: Key questions to ask about the content of the intervention, programme or project*²⁵⁷

Does the project vision, goals or principles include an explicit statement about its equity intentions, including in relation to gender equity?

Does the project/intervention include scope for stakeholder participation in the design, monitoring and evaluation of the project? Have steps been taken to ensure equal participation by women and men?

Does the programme design and planning take into account differences between women and men in:

- roles and responsibilities?
- norms and values?
- access to and control over resources?

Is a conscious effort made to promote gender equity?

- no overt (open) or covert (hidden) discriminatory practices
- actively promotes gender equality

Have gender-specific indicators been identified and included in the monitoring system through the programme cycle?

Does the design take steps to address the influence of gender norms and practices at relevant levels of the political and bureaucratic systems that might obstruct the intervention?

*Session 3, Activity 3, Handout 2: Basic questions: Does my programme consider gender?*²⁵⁸

This quick checklist is intended to identify how well programmes/projects/ departments are integrating gender.

Question	Yes	No
Does my project or programme demonstrate a clear understanding of the difference between sex and gender?		
Does my project or programme include sex as an important variable/inclusion criteria for the target population?		
Does my target population intentionally include women and men?		
Does my project or programme take into consideration the life conditions of women and men in the target population?		
Has my project or programme piloted methods/tools on both sexes?		
Does my project or programme consider family or household dynamics and anticipate different consequences and opportunities for individual members of the household (e.g., intra-household allocation of resources)?		
Does my project or programme include men and women team members who have equal say in the direction of activities?		
Is the evidence generated by or informing my project or programme collected and reported by sex?		
Is a male norm adopted as the “standard” in my project or programme (i.e., symptoms, mobility, rights, etc.)?		
Do the principles of my project or programme exclude one sex but assume that the conclusions are to be applicable to both sexes?		
Do aspects of my project or programme exclude one sex in areas that are traditionally considered relevant only for the other sex (e.g., reproductive health issues in programmes for men or paid work in programmes for women)		
Does my project or programme treat women and men as homogeneous groups when outputs could have differential outcomes on subgroups of women and men (e.g., poor women versus rich women, employed men versus unemployed men, etc.)?		
Does my project or programme, through its materials, depict men as actors and women as being acted upon?		
Does the language of my project or programme exclude one sex or favour one over the other?		

Scoring: Questions 1–8 should yield “yes” answers, while questions 9–14 should yield “no” answers. If the opposite results are found for your project or programme, it might need to be revised accordingly.

*Session 4, Activity 1, Handout 1: Gender analysis matrix for programmes/projects*²⁵⁹

Programme or project area	Gender-unequal (privileges men over women) Does programme/project component privilege men over women?	Gender-blind (Ignores gender norms) Does programme/project ignore gender norms?	Gender-specific (Recognizing differences in gender roles, responsibilities and access to resources) Does programme/project recognise gender-specific issues and account for them?	Gender-transformative (Recognizes differences in gender and supports changes to improve equality) Does programme/project support change that will promote gender equality?
Project/ programme formulation: <i>Programme/ project vision, goal, principle</i>				
Project/ programme formulation: <i>Scope of project design and planning</i>				
Programme/project implementation				
Resource mobilization				
Programme/ project monitoring				

*Session 4, Activity 1 Handout 2: Explanations of concepts used in the gender analysis matrix in programme/project*²⁶⁰

In addressing gender differences and discrimination in a health intervention, important gender issues can be raised at each phase of the programme/project. Even when a programme is ongoing, gender analysis will help you to re-plan and integrate new and emerging gender considerations based on feedback from monitoring and evaluation. The table below shows key issues that could be examined for gender at different phases.

Gender dimensions at each phase of the programme/ project	Explanation
Local situation analysis/gender analysis	<p>Local situation analysis</p> <p>The term <i>local situation analysis</i> relates to activities that help to define the health needs and problems of the programme's target group. This is done to capture the true picture of the health needs and problems and forms a starting point to develop targeted interventions. A <i>gender analysis</i> should be part of the assessment of the local context. This is achieved by integrating gender-specific needs, which help to pinpoint gender issues that need to be addressed. Such information is useful for planning, re-planning, implementation, and monitoring and evaluation.</p>
Project or programme formulation	<p>Programme/project vision, goals and principles</p> <p>When developing or reviewing the goals/vision of the programme/ project, ensure that:</p> <ul style="list-style-type: none"> • an explicit statement is included on its intentions to address gender issues that are gender-specific and gender-transformative; • the intentions should relate to the programme/project vision, goals or principles with concrete actions identified.
Scope of programme/project design and planning	<p>Scope</p> <ul style="list-style-type: none"> • The scope should include stakeholder participation in the design, monitoring, and evaluation of the project and the mechanisms envisioned to ensure the equal participation of women. • The scope should reflect the ways sex and/or gender differences will be taken into account in the programme—regarding norms, values, roles and behaviours, biological differences between men and women, and access to and control over resources. • There should be clear steps to address discriminatory features at relevant levels of the political and bureaucratic systems.

Continued on next page

Session 4, Activity 1 Handout 2 (continued)

Gender dimensions at each phase of the programme/ project	Explanation
Resource mobilization	<p>Resources</p> <ul style="list-style-type: none"> Resources include people, materials and money including time. An understanding is needed of available and unavailable resources to carry out the work on gender. This requires political and management support to access resources. Community support and mobilisation is also important: Finding people who can support the work in any way is important. For example, if the activities on gender require substantial input from the community, as in malaria, HIV and TB programmes, community support and commitment can facilitate resource mobilisation for the programme or project. Stakeholders should be brought on board to understand and support the gender initiatives in the programme. Such consultation and dialogue can raise awareness about the importance of including gender work, and elicit additional financial support to carry out gender-related activities.
Programme or project implementation	<p>Implementation</p> <p>The inclusion of gender issues is easier during the implementation phase if the gender analysis findings are clear and specific.</p> <p>The programme design must actively promote gender equality, and must be appropriate and adequate, given the nature of the program.</p>
Programme or project monitoring	<p>Monitoring</p> <p>Monitoring provides continual feedback on whether gender integration in a health problem or condition is on course or requires redefining. Specific instruments or forms need to be developed to collect the relevant information. Indicators for monitoring must reflect the project's gender-related impact.</p>
Programme or project evaluation	<p>Evaluation</p> <p>Evaluation provides an opportunity to look back at all the work that has been done over a certain period to determine the effectiveness of the programme or project.</p> <p>The evaluation needs to include problems and successes of the gender aspects uncovered in the gender analysis, with recommendations on how to improve them.</p> <p>(The indicators for evaluation system similarly should include input and process indicators, and outcome indicators. All such indicators must be appropriate and adequate to the task of reflecting the project's gender-related impact.)</p>
Re-planning	<p>Improve practice and planning</p> <p>Information collected from evaluation could be used to improve the health intervention and should shape planning. Decisions should include gender-related activities to strengthen the effectiveness of the programme.</p>

Session 4, Activity 1 Handout 3: Applying the gender analysis matrix tool to malaria prevention and intervention ²⁶¹

Programme or project area	Gender-unequal (privileges men over women) Does programme/project component privilege men over women?	Gender-blind (Ignores gender norms) Does programme/project ignore gender norms?
Project/programme formulation: <i>Programme/project vision, goal, principle</i> Does the project vision, goals or principles contain a statement on its equity intentions, including in relation to gender equity?		
Project/programme formulation: <i>Scope of project design and planning</i> Does the project/intervention include scope for stakeholder participation in the design, monitoring and evaluation of the project? Have steps been taken to ensure women's participation equally with men?		
Programme/project design Does the programme design and planning account for differences in the roles and responsibilities of women and men? Norms and values?		
Programme/project implementation Is an effort made to promote gender equity, or at least not to worsen women's position in relation to men?	Ensure, for example, that involving women in production of bednets does not add to poor women's already excessive work burden (i.e., avoid gender-unequal)	
Programme/project monitoring Have gender-specific indicators been identified and included in the monitoring system throughout the programme cycle? Input indicators regarding resources devoted to the intervention? Process indicators monitoring the implementation of the interventions?	Women and men community education officers recruited for the programme Proportion of women and men who have participated in community meetings regarding introduction of bednets	
Programme/project evaluation Is gender included in the outcome indicators regarding achievement of the longer-term objectives of the programme? Does the design take steps to address the influence of gender norms and practices at relevant levels of the political and bureaucratic systems that might obstruct the intervention?	Proportion of women and men and girls and boys utilising bednets everyday	

Gender-specific (Recognizing differences in gender roles, responsibilities and access to resources)

Does programme/project recognise gender-specific issues and account for them?

Decrease incidence and negative outcomes of malaria during pregnancy

Develop technology to facilitate use of preventive measures to reduce risk to male farmers

Include women in project planning and advisory committees, as well as in community meetings. If necessary, hold separate community meetings with women and men to allow women's voices to be heard. If consulting with community leaders, ensure discussions with women and men leaders (gender-specific/gender-transformative)

Explore possibilities of reaching out to men through workplace-based treatment, malaria diagnosis and treatment facilities

Reduce or subsidize the cost of nets and insecticides to make them more accessible to women

Use different forms of media, such as newspapers for men and radio for women (depending which they use), with content matching their different vulnerabilities and health-seeking behaviour

Decline in incidence of malaria amongst pregnant women

Gender-transformative (Recognizes differences in gender and supports changes to improve equality)

Does programme/project support change that will promote gender equality?

Build women's and men's responsibility for malaria prevention and treatment

Include women in project planning and advisory committees, as well as in community meetings. If necessary, hold separate community meetings with women and men to ensure that women's voices can be heard. If consulting with community leaders, ensure discussions with women and men leaders (gender-specific/gender-transformative)

Ensure that programme messages on appropriate care for childhood malaria are addressed to fathers and mothers, thereby challenging the stereotype that only mothers are childminders

Encourage local production of nets through women's cooperatives instead importing them

Sufficient funds have been raised to cover costs of transport and honorarium for time of women volunteers whose time is usually not paid for

Workshops have been conducted with members of community decision-making structures to identify potential gender-related barriers and ways to address these

Key stakeholders and opinion leaders are given information on the consequences of not addressing gender issues within the programme's context

Session 4, Activity 1 Handout 4: Applying the gender analysis matrix tool within a malaria service-delivery context²⁶²

Programme or project area	Gender-unequal (privileges men over women) Does programme/project component privilege men over women?	Gender-blind (Ignores gender norms) Does programme/project ignore gender norms?
<p>Project/programme formulation: <i>Programme/project vision, goal, principle</i></p> <p>Does the project vision, goals or principles include an explicit statement on its equity intentions, including in relation to gender equity? Are these gender-specific or gender-redistributive?</p>		
<p>Project/programme formulation: <i>Scope of project design and planning</i></p>		Ensure that women can access women providers (in contexts where this affects utilization of services).
<p>Programme/project design</p> <p>Does the programme design and planning take into account differences between women and men in:</p> <ul style="list-style-type: none"> • roles and responsibilities? • norms and values? • access to and control over resources? <p>Does the design take steps to address the influence of gender norms and practices at relevant levels of the political and bureaucratic systems that might obstruct the intervention?</p> <p>Does it include strategies that are:</p> <ul style="list-style-type: none"> • gender-specific? • gender-transformative? 		
<p>Resource mobilization</p>	No information available.	No information available.
<p>Programme/project implementation</p> <p>Does the project/intervention include scope for stakeholder participation in the monitoring, evaluation and modification (to the extent possible) of the service? Have steps been taken to ensure the equal participation of women and men?</p> <p>Is a conscious effort made to promote gender equity, and at least not to worsen women's position in relation to men?</p>	Do not take women's time for granted in community-based activities for malaria prevention, such as maintaining and re-impregnating bednets with insecticide. (avoiding gender-unequal impact).	Compensate women for the time they spend on community-based malaria prevention activities.
<p>Programme/project monitoring</p> <p>Have gender-specific indicators been identified and included in the monitoring system for programme performance?</p>	Women and men community education officers recruited for the programme	When introducing user charges, plan for mechanisms to ensure that women and low-income groups are not excluded from treatment and care (avoiding gender-blind impact).
	Proportion of women and men who have participated in community meetings regarding introduction of bednets	
<p>Programme/project evaluation</p>	To be explored.	To be explored.
<p>Local situation/ gender analysis re-planning</p>	No information available.	No information available.

As many of the above interventions are generic, they would be as beneficial for improving other health interventions as for malaria.

Gender-specific (Recognizing differences in gender roles, responsibilities and access to resources)

Does programme/project recognise gender-specific issues and account for them?

Identify and address community-based obstacles to treatment experienced by men and women, boys and girls.

Explore mobile testing units for men working away from home.

Return malaria test results on the same day to save women a second visit.

Design health communication strategies that address notions of masculinity that might deter men from seeking health services until symptoms are severe.

Design community-based pre-payment schemes for malaria treatment with lower premiums for women in reproductive age groups.

Advocate for the inclusion of malaria services at the primary care level to be available beyond antenatal services, so that men have greater access.

No information available.

Set up routine feedback mechanisms that would represent men's and women's views on the content and mode of delivery of the service

Ensure that health service records collect, use and analyse information that is disaggregated by sex.

Use indicators such as participation of women and men in community health committees; increase in service use by previously marginalized groups; or increase in men's involvement in ensuring pregnant women access malaria services.

Use qualitative indicators such as men's and women's perspectives on service availability, costs and quality.

Same as for monitoring.

No information available.

Gender-transformative (Recognizes differences in gender and supports changes to improve equality)

Does programme/project support change that will promote gender equality?

Ensure men's participation in malaria prevention programmes.

No information available

Conduct workshops with providers on gender issues in malaria prevention and treatment.

No information available.

Include women and men from the community in clinic review meetings at regular intervals, and design meetings to ensure that both participate actively and effectively

No information available.

No information available.

6. Tools, resources and references



6. Tools, resources and references

Resources

Gender mainstreaming

Gender has been identified as a key issue for all programming and activities carried out by the World Health Organization (WHO). To this end, WHO issued a Gender Policy in 2002 (<http://www.who.int/entity/gender/documents/engpolicy.pdf>). A gender strategy was approved in 2007.

The Department of Gender and Women's Health, WHO (<http://www.who.int/gender/en/>) has some useful resources, including policy recommendations for mainstreaming gender into HIV/AIDS programming (http://www.who.int/entity/gender/hiv_aids/en/Integrating%5B258KB%5D.pdf)

Health service providers are increasingly drawing upon a rights-based approach to mainstream gender in health programming. For example, see **Realising Rights** (<http://www.realising-rights.org/>), a research consortium that aims to improve sexual and reproductive health in poor and vulnerable populations.

The **Centre for Health and Gender Equity** seeks to advance gender equity and social justice in international population and health policy. The Centre's website (<http://www.genderhealth.org/>) offers resources and information on current events concerning gender and health.

The **Gender and Health Equity Network** (<http://www.ids.ac.uk/ghen/>) is a network of international and national institutions aiming to develop and implement policies to improve gender and health equity. The network offers access to case studies on gender inequalities in health from China, India, Mozambique and Sweden, as well as various resources on mainstreaming gender into health systems.

The Department for International Development of the United Kingdom and the Gender and Health Group of the Liverpool School of Tropical Medicine have developed **Guidelines for the Analysis of Gender and Health** (1999), with step by step information on gender analysis and planning, as well as case studies on gender and health.

Gender, diseases and other health issues

The Department of Gender, Women and Health at WHO produces information sheets on various health topics (http://www.who.int/gender/other_health/en/). The department has prioritised gender-based violence, which continues to be a major health programme and human rights violation for millions of women around the world (<http://www.who.int/gender/violence/en/>). The department has also prioritised HIV/AIDS and gender (http://www.who.int/gender/hiv_aids/en/). Among other initiatives, the department has drafted information sheets on the intersection of HIV/AIDS and gender violence.

UNIFEM also maintains a portal on gender and HIV/AIDS: <http://www.genderandaids.org/>

ID21 (<http://www.id21.org/index.html>) communicates development research on health, including gender and health.

The **Health Resource Guide** hosted by Eldis offers access to a wide variety of resources, including a section devoted to gender and health (<http://www.eldis.org/health/gender/index.htm>).

The HIV and AIDS Resource Guide on Eldis includes a portal with a range of resources on gender, HIV and AIDS (<http://www.eldis.org/hivaids/gender/index.htm>)

While not specific to gender and health, the World Bank's Health, Nutrition and Population website offers useful information on various health issues, including reproductive health and maternal health (<http://www.worldbank.org/html/extdr/thematic.htm>).

The Commission on Social Determinants of Health Knowledge Network on Women and Gender Equity aims to focus on mechanisms, processes and actions that effectively reduce gender-based inequalities in health. To this end, various resources will be produced and made available at: http://www.who.int/social_determinants/knowledge_networks/gender/en/index.html.

Gender and access to health services

The Department of Gender, Women and Health's at WHO, in collaboration with the Department of HIV/AIDS and Joint United Nations Programme on HIV/AIDS, has produced a policy statement on ensuring equitable access for men and women to antiretroviral treatment, which can be located at: <http://www.who.int/entity/gender/violence/en/equitableaccess.pdf>. The department has also produced a publication that reviews selected tools for a gender analysis in health (<http://www.who.int/gender/documents/en/Gender.analysis.pdf>).

The Health Systems Resource Guide on Eldis (<http://www.eldis.org/healthsystems/gender/index.htm>) encompasses a range of resources on health systems and gender.

Tools

Key health indicators ²⁶³

- Rate of contraceptive use:
 - ♦ Number of adult women (generally between 15 and 49 years old) using some type of contraceptive, divided by the total number of women in this age group, times 100.
Source: Fertility surveys.
- Percentage of births attended by suitably qualified health workers:
 - ♦ Number of births attended by qualified health worker divided by total births recorded in vital statistics, times 100.
Source: Statistics from health system records and vital statistics.
- Proportion of cases of HIV among adults:
 - ♦ Cumulative total of recorded HIV cases, by sex and from a given age limit upwards (for example, 15 years), divided by the total population of this sex and age band, times 100.
Source: Health services and demographic projections by sex and age.
- Proportion of HIV cases among pregnant women 15–24 years old:
 - ♦ Number of HIV cases among pregnant women aged 15–24 recorded in a given period (for example, the year), divided by the total number of pregnant women attended to in the same period, times 100.
Source: Health services.

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Key health indicators (continued)

- Population with access to health services, by sex:
Source: Household surveys, specific health surveys, statistics from records on health system contributors and beneficiaries, population projections.
- Life expectancy at birth, by sex:
 - ♦ The average number of years that a newborn child would live if all the years of life of the cohort to which that child belonged were divided equally between its members. It is generally calculated by national offices of statistics.
Source: Demographic statistics.
- Infant mortality rate:
 - ♦ Number of deaths among infants under 12 months old out of every thousand live births. This is generally calculated by national offices of statistics.
Source: Demographic statistics.
- Under-5 mortality rate:
 - ♦ Number of death among children under 5 years old per 1000 population under 5 years old. This is generally calculated by national offices of statistics.
Source: Demographic statistics.
- Rate of mortality deriving from maternity:
 - ♦ Number of deaths among mothers for every thousand live births, resulting from complications during pregnancy, delivery or puerperium. This is generally calculated by national offices of statistics.
Source: Demographic statistics.
- Population size:
 - ♦ Population of all ages, by sex.
Source: Population censuses and demographic projections for the periods between censuses.
- Population aged 0–4 years, 5–14 years, 15–49 years and over 50 years, by sex:
Source: Population censuses and demographic projections for the periods between censuses.
- Population by urban/rural distribution:
Source: Population censuses and demographic projections for the periods between censuses.
- Rate of growth in the population aged 15–24 years, by sex:
Source: Demographic projections.
- Overall fertility rate:
 - ♦ The average number of children that would be born by the end of child-bearing age to each woman in a hypothetical cohort who, during the reproductive stage (15–49 years old), had the same fertility rate by age as the population being studied, and was not subject to mortality from the time of birth until the end of child-bearing age. This is generally calculated by national offices of statistics.
Source: Demographic statistics.
- Fertility rate among women aged 15–19 years:
 - ♦ Number of births to mothers under 20 years old, divided by the total number of women 14–19 years old, times 100.
Source: Vital statistics, birth records.

Additional gender-sensitive indicators ²⁶⁴

- Percentage of government expenditure devoted to women's health needs in both productive and non-productive areas;
- Percentage of budget support allocated for gender priorities;
- Percentage of female health personnel at the different levels of the health system;
- Percentage of female health personnel in managerial and professional posts;
- Salary/wage differentials of women/men by class of workers;
- Number of visits to and number of bed-nights spent in hospital by women and men and number of hospital beds as percentage of population;
- Proportion of girls and boys immunized against specific diseases;
- Percentage of women's and men's income spent on food;
- Access to sanitation and clean water by sex;
- Percentage of women's, men's, girl's and boy's injuries by type of incident or accident; and
- Proportion of male involvement in contraceptive use.

Checklists for gender-sensitive planning

Project design

Gender roles and power

- How is men's/women's (and boys'/girls') labour distributed by time over the day, week and season, and by type of role (reproductive, productive, community)?
- How much role conflict exists for each sex?
- How does this conflict manifest itself?
- How will the project affect this labour schedule and how can it best use the schedule to its advantage?
- Will the project increase women's workload, especially care-giving responsibilities?
- Is alleviation of women's workload a prerequisite for their full participation in the project's activities?

Decision-making

- In which spheres do women/men have direct/indirect decision-making power, both in the household and in the wider community?
- Who has ultimate decision-making authority?
- Who controls household economic resources? Which ones?
- To what extent are women included in local organizations (number of members, numbers in decision-making roles, level of participation)?
- Will the project increase women's/girl's decision-making power within their households, including resource expenditure, sexual relations, marital partner choice and age at first marriage, when and how they will bear and raise children and when and how household health needs are met?
- Will it increase their decision-making power in the wider community?
- Will it challenge their decision-making authority or that of others?

Access

- Which population, health and nutrition resources do women/men have access to?
- Which are they barred from?
- What different constraints do men and women face in accessing resources (for example, social stigma, provider assumptions, community norms, cost and time)?
- Will the project improve women's and men's access to services and resources?

Continued on next page

Checklists for gender-sensitive planning (continued)

- Will women's access to services be restricted by lack of access to material resources (for example, fees for services or transportation)?

Control

- Which benefits do women/men get from the use of resources, including their own bodies, health, energy and money?
- Which benefits do women/men control?
- Will the project improve women's control over benefits and resources, including their own bodies, health, energy and money?
- Or is it likely to threaten their control over them?

Definition of key population

- Is the project clear that women are not a homogenous group but are divided along age, class, caste, religious and ethnic lines?
- Is it clear that the project will benefit poorer, more marginalized women and families?
- Are different sorts of women/men/children included?
- How and to what degree are women and men involved in the population, health and nutrition sector? If only men or only women play a role, should the other sex be involved?
- Why or why not?
- What are the proportion, position and specific constraints of women-headed households in the community?

Current levels of knowledge about population, health and nutrition issues and services

- What knowledge do women/men have about population, health and nutrition issues, including nutrition, sexuality, reproduction, family planning methods, breast-feeding, safe motherhood and/or maternal mortality, the value of girls, sexually transmitted diseases and infertility?
- What knowledge do women/men have about population, health and nutrition services available in their community?
- What knowledge do women/men have about their reproductive and other health rights?
- Has the project understood the local methods used by women (and men) to safeguard physical and mental well-being?
- What form of traditional healing system exists?
- What different roles do women and men play in the system?
- How will the project tap into and affect these?

Deciding on project priorities

- What are women's/men's gender-specific health needs in the project area, as defined by the women and men themselves?
- What attempts have been made to gain a detailed knowledge of those needs? Are the areas that the project aims to address priorities for women/men?
- To what extent are women/men involved in setting research priorities in population, health and nutrition planning?
- To what extent are women and men from the key population involved in the research planning, implementation and dissemination of results?
- Why would women/men be interested in getting involved in the project activities?
- Are any women or men likely to oppose the project? For what reasons?

Checklists for gender analysis and planning ²⁶⁵

Checklist to identify and address factors influencing gender disparities and barriers in health and quality of care:

- What specific factors from the economic, social, political, cultural and religious environment have implications for gender and health?
- What are the current gender relationships at the community and household level that have a positive or negative impact on health?
- What are the established gender roles and how do they affect gender differences in incidence and early detection of diseases, health seeking behaviour, use of health services and compliances?
- Do women need permission from their husbands, fathers, mothers-in-law, brothers or others to use health services?
- Which policy and programme initiatives exist to meet the needs of specific groups (children, adolescents, men, women, elderly, displaced, disabled, etc.) in the health sector?

Checklist to incorporate gender concerns into various aspects of health promotion and disease control programmes with special focus on the vulnerable and disadvantaged:²⁶⁶

- Who are the stakeholders?
- What mechanisms exist to involve primary stakeholders in the health sector and in specific health programmes?
- What are the mechanisms to facilitate access to appropriate health care by women and men from vulnerable groups?
- What powerless groups are particularly discriminated against, and how does such discrimination or lack of power affect their health?
- Which disparities can be identified between men and women, boys and girls?
- Which disparities affect differently the health and well-being of men and women, boys and girls?
- Do efforts to improve the inclusion of marginalized groups face resistance?
- Which disparities exist between different social groups and between women and men in those groups?
- Do health programmes address the needs of men, women and adolescents?
- What are the specific issues affecting men, women and adolescents in each of the health programmes?
- Which male/female attitudes and behaviours have a negative effect on girls'/boys' and women's/men's health?
- Have initiatives been developed to increase men's/women's responsibility and involvement in solving health-related problems?
- Which interventions would create opportunities for men/women, boys/girls to change their own high-risk behaviours?
- What mechanisms exist to involve men/women in promoting and protecting their own health as well as that of their partners and their communities?

Checklist for gender analysis and planning in policy ²⁶⁷

- Do differences in the division of labour expose women and men to different kinds of health risks?
- How are any differences between women and men in the use of existing services explained?
- Are there apparent differences in the way women and men are treated or in the quality of care they receive?
- Who controls access to health-related resources and do the criteria for allocation take into account the different roles and needs of women and men?

Checklist for gender issues in health sector reform²⁶⁸

1. Improving the performance of the civil service (i.e., reducing staff, changing pay, appraisal systems).
 - a. What would be the impact on the gender balance and composition of staffing at different levels?
 - b. What effects would human resources policies have on relations between predominantly male health service professions, such as doctors, and those of predominantly females, such as nursing?
2. Decentralization (i.e., devolving management systems/health care provision to local government).
 - a. Does decentralization improve access to health care or further marginalize vulnerable groups?
3. Improving the functioning of national ministries of health (i.e., organizational restructuring to improve human and financial resource management, performance monitoring, prioritizing and defining cost-effective interventions).
 - a. What effects would human resources policies have as described in number (1) above?
 - b. In setting priorities, what criteria are used to determine health needs and cost-effectiveness?
4. Broadening health financing options (i.e., introducing user fees and community financing mechanisms).
 - a. What are the implications of different modes of payment?
 - b. Are poor women affected differently than poor men?
 - c. How does cost recovery affect access to services for both sexes?
5. Introducing managed competition (i.e., promoting competition between health service providers).
 - a. How does managed competition affect equity and access for the most vulnerable?
6. Working with the private sector (i.e., establishing mechanisms for regulation, contracting with, or franchising providers in the private sector).
 - a. Are vulnerable groups more or less likely to be appropriately served by different parts of the private sector?
 - b. Are women's health needs more or less likely to be met in a mixed economy of health care?

Checklist for project implementation and monitoring

Project decision-making

- Are participants (women and men) fully involved in deciding the project/programme priorities and how they will be implemented?
- Is there a community advisory committee and is it holding regular meetings?
- Is participation in advisory committee equal by socioeconomic group and sex?
- Were rules developed in a participatory manner, involving all community members?
- How many women/men are in decision-making positions, by socioeconomic group?
- Do people in leadership positions rotate regularly?

Participation/service utilization rates

- Are data disaggregated by sex, socioeconomic status and age?
- Can women/men, in practice, make productive use of health facilities and services, taking into account their workload, daily and seasonal peaks in activities, financial resources, and lack of mobility and decision-making power?
- How does the project address these constraints?
- What percentage of births in the region are attended by trained personnel?

Continued on next page

Checklist for project implementation and monitoring (continued)

- What are the service utilization rates by socioeconomic groups, sex, age and ethnic background?
- Are these expected, give local demographics? Are the desired populations being reached?
- How often are clients accompanied by their partners/others and how often do they come alone?
- Are there differences in the payments made (cash or in-kind) by socioeconomic grouping of household (for example, is a sliding scale fee system in place)?
- What mechanisms are in place for users of services to provide ongoing feedback?
- What means of redress exist?

Service quality

- Are the benefits from the project/programme attractive for women/for men?
- What are the success rates of clients achieving their reproductive intentions, by socioeconomic group and sex?
- How are the issues/concerns/ needs of clients' partners addressed in counselling?
- Is health education planned to include discussion of the following gender issues:
 - ♦ the equal value of men and women and the need for joint decision-making and shared responsibilities;
 - ♦ women's and men's roles in family planning and reproductive health;
 - ♦ women's rights to good health, quality health services, freedom from violence, joint decisions about household expenditures and so on;
 - ♦ women's human rights and local legal rights, especially those related to health issues; and
 - ♦ the dynamics of men and women's decision-making in the areas of sexuality, contraception, child-bearing, nutrition and other health matters.
- What is done to maintain client confidentiality?

Checklist for project evaluation ²⁶⁹

Process evaluation

- Are data disaggregated by sex, age and social class?
- To what extent were participants' assessments of the project used to measure its success?
- Were appropriate indicators used (or developed) to describe the situation for women and men, so as to inform project development, implementation and monitoring?
- Were women employed and trained by the project, so women and men were able to participate equally in project activities?
- Does the project use the extent to which women's relations with men have improved (for example, cessation of violence, more independent and assertive decision-making, greater knowledge of legal rights, etc.) as an indicator of effectiveness or success?
- Are women and men treated with equivalent respect, both as participants and staff personnel?
- Are staff rewarded for providing better counselling, links with other services, addressing sexual and other health needs beyond family planning? Are the issues of violence and non-consensual sex addressed?
- Have indicators or incentives for steering clients toward certain family planning methods been removed?
- Are staff well-trained on all methods? Is a full range of methods available? Are clients provided with sufficient information for informed decision-making and consent?
- Are women and men treated as different audiences for information, education and communication efforts, and are they being reached with gender-appropriate messages that challenge oppressive gender stereotypes?

Continued on next page

Checklist for project evaluation (continued)

- What gender-related messages are included?
- Is sufficient effort devoted to male needs, participation, methods, services and responsibility?
- What mechanisms have been used to educate male and older female family members on the need for prenatal and postnatal care, the importance of birth spacing, the value of daughters and the benefits of breast-feeding?

Impact on gender equity

- Has the project improved women's access to and control over population, health and nutrition services and infrastructure? How? What new services exist?
- What impact has the project had on relationships between men and women?
- Has the project increased women's ability to carry out their decisions in a sustained way within their households and the wider community?
- Are men more involved in family planning and family life? Are they more supportive and safeguarding of women's and children's health, as well as their own?

Impact on health

- Has the project or activity improved women's and men's health? Their level of knowledge?
- How has the project enhanced women's and men's roles as health care providers? What impact has this had on male and female clients' access to health care advice and services and their perception of the quality of these?
- Have objective measures of quality improved?
- What are the continuation rates, by age, socioeconomic group and sex? To what extent do male and female clients feel they are meeting their health care needs?

Impact on policy

- Has the project strengthened links between research and service evaluation findings on gender issues and the formulation of population, health and nutrition policies?
- Have policies been revised based on those findings?
- What gender-related process and outcome lessons have been disseminated to key decisions-makers at the implementing organization; local, national and regional organizations and governing bodies; and international donor agencies?
- What, if anything, has changed as a result of these efforts?
- Has the project had an impact on the extent to which the implementing agency integrates a gender perspective into its policies and procedures?
- What information has the project given policy-makers to show that taking gender issues into account contributed to its success?

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ENDNOTES

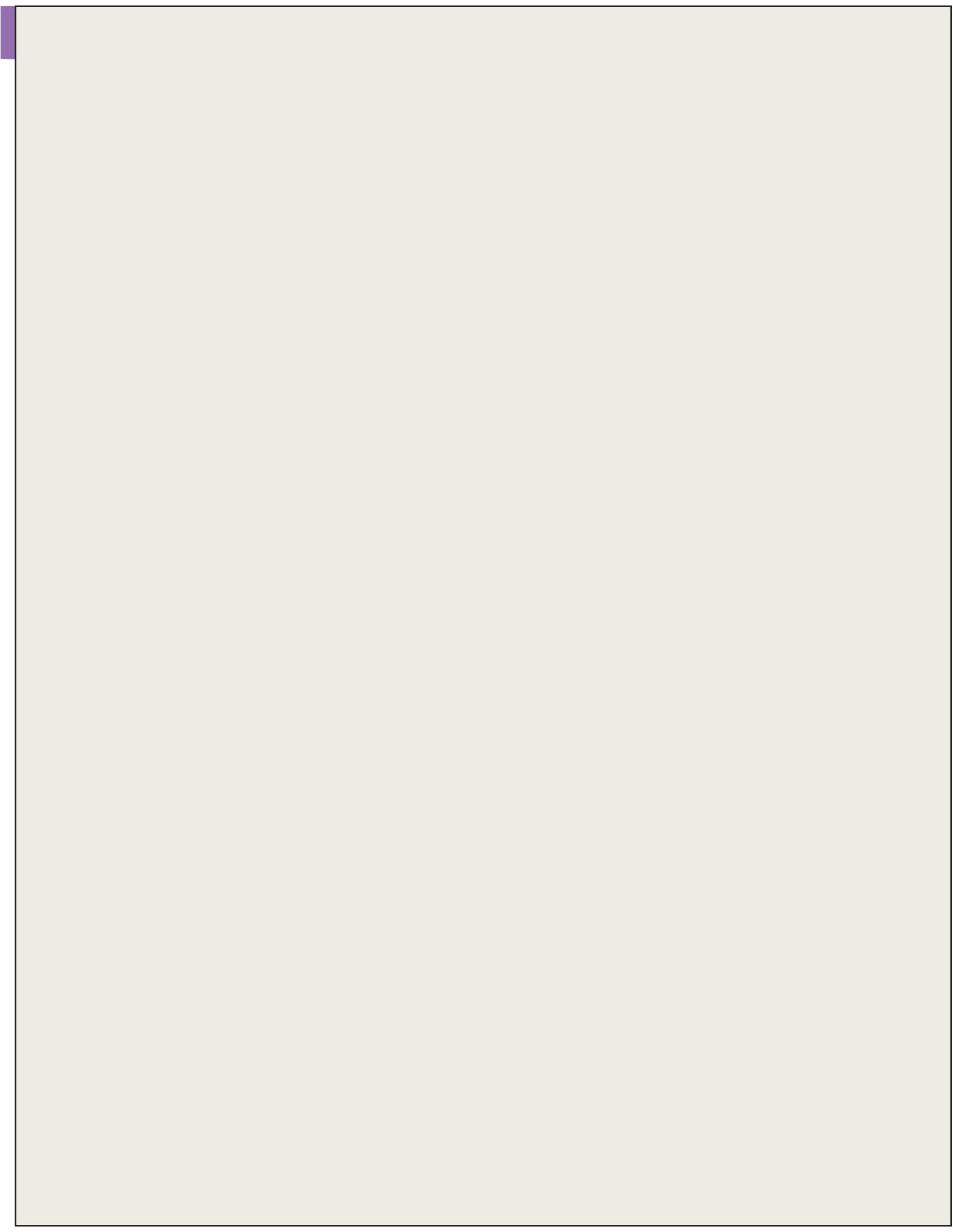
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