Gender mainstreaming for health managers: a practical approach

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Facilitators' guide

CONTENTS

ACKNOWLEDGEMENTS 4

ACRONYMS 6

INTRODUCTION 7
Why do public health managers need a manual on gender mainstreaming? 7
Gender mainstreaming provides tools to reduce the harmful effects of the determinants of health 7
Gender mainstreaming addresses women's specific health needs but is about women and men 7
Gender mainstreaming means a new way of doing business in the health sector 8

WHO'S POSITION ON GENDER MAINSTREAMING, EQUALITY AND HEALTH 9
Tools for integrating gender into public health 10
Sound gender analysis requires high-quality data from multiple sources 10

ORGANIZATION OF THE MANUAL 11
Components of the Manual 11
Progressive approach: from awareness to action in three modules 12
Key to symbols 12

HOW TO USE THE MANUAL 13
Adapting the Manual 13
Facilitator preparation 14
Workshop preparations 16
Checklist for planning and preparing a workshop 17

MORE THAN CAPACITY-BUILDING 18

WORKSHOP AGENDA TEMPLATE 19
Feedback Form 22

CERTIFICATE OF ATTENDANCE 24

INTRODUCTION TO THE WORKSHOP 25
Creating the right atmosphere for learning 25

MODULE 1: AWARENESS – BUILDING BLOCKS TO ADDRESS GENDER INEQUALITY IN HEALTH 29
Overview and objectives 31
Section 1.1: Does gender really matter in health? 31
  Learning activity 1.1: Flash card facts 32
  Materials for learning activity 1.1 – Flash card facts 32
  Handout 1.1 – Flash card facts 32
Section 1.2: Sex and gender are not the same 42
  Learning activity 1.2a: Sex and gender – what is the difference? 44
  Learning activity 1.2b: Unpacking gender 44
Section 1.3: International framework for working on gender equality and health 48
  Learning Activity 1.3a: a global view – international and organizational commitments to gender equality and health... 48
  Learning activity 1.3b: Gender, human rights and health 52
Section 1.4: Gender is a determinant of health 52
  Learning activity 1.4: Power walk 53
  Materials for learning activity 1.4: Power Walk 56
Section 1.5: Equality or equity? 57
  Learning activity 1.5a: Gender equality, equity and health equity 57
  Learning activity 1.5b: Identifying ways to address gender and health inequities 58
Section 1.6: Conclusion of Module 1 59
Annex 1. Module 1 optional learning activities 60
  Optional learning activity 1.2a – Going back in time 60
  Optional learning activity 1.2b – Mind your language 61

MODULE 2: GENDER ANALYSIS OF HEALTH PROBLEMS 63
Module 1 progress check 64
Introduction to Module 2: overview and objectives 65
Section 2.1: What is gender analysis? 65
Learning activity 2.1: Introduction to gender analysis 65
Section 2.2: Introducing WHO Gender Analysis Tools 67
Learning activity 2.2a: Introducing the WHO Gender Analysis Matrix: gender-related considerations 67
Handout 2.2a: Selected biological factors related to selected health conditions for men and women 72
Learning activity 2.2b: The WHO Gender Analysis Matrix: health-related considerations 72
Section 2.3: Using WHO gender analysis tools 74
Learning activity 2.3: Learning to use the Gender Analysis Matrix and Gender Analysis Questions 74
Section 2.4: Conclusion of Module 2 75
Annex 2. Module 2 – optional learning activities 76
Optional learning activity 2.0: Can you tell the difference between sex and gender? 76
Annex 3. Sample Gender Analysis Matrix: HIV 78
Annex 4. Sample Gender Analysis Matrix: Tuberculosis 85
Annex 5. Sample Gender Analysis Matrix: Malaria 89
Annex 6. Selected issues in conducting gender analysis of noncommunicable diseases 96
Annex 7. Selected issues in conducting gender analysis of maternal health 99
Annex 8. Selected issues in conducting gender analysis of children's health (0 – 9 years old) 104

MODULE 3: ACTION – DEVELOPING GENDER-RESPONSIVE ACTIONS 107
Module 2 Progress check 108
Overview and objectives of Module 3 109
Section 3.1: WHO Gender Analysis Tools II – assessing policies and programmes 109
Learning activity 3.1a: The WHO Gender Responsive Assessment Scale: a classification framework for assessing gender in policies and programmes 111
Section 3.2: Integrating gender in health planning and programming 112
Learning activity 3.2: Entry points for integrating gender in health planning and programming 112
Section 3.3: From analysis to the work plan: developing gender-responsive work plans 113
Learning activity 3.3: From analysis to the work plan: developing gender-responsive work plans 113
WHO Gender-responsive log frame 114
Annex 9. Module 3 optional learning activities 116
Optional learning activity 3.0: Understanding access to and control over resources 116
Handout 3.0. Understanding access to and control over resources – Sahara's story 117
Optional learning activity 3.1a: Are these examples gender-responsive? 118
Optional learning activity 3.1b: Case studies with the Gender Responsive Assessment Scale 119
Optional learning activity 3.2b: WHO Gender Assessment Tool: which Gender Responsive Assessment Scale level does my programme fit? 121
Optional learning activity 3.2a: Considering gender in institutional processes 122
Optional learning activity 3.2b: Gender and health communication 122
Optional learning activity 3.2c: Gender and health data 125

CONCLUDING THE WORKSHOP 127
WHO capacity-building feedback 129
"Gender Jeopardy" Questions and Answers for Facilitators 131

GLOSSARY OF TERMS AND TOOLS 134

REFERENCES 138

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ACRONYMS

AFRO	WHO Regional Office for Africa
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
COPD	Chronic Obstructive Pulmonary Disease
CSW	Commission on the Status of Women
ECOSOC	United Nations Economic and Social Council
EURO	WHO Regional Office for Europe
FGM	Female Genital Mutilation
GAD	Gender and Development
GAM	Gender Analysis Matrix
GAQ	Gender Analysis Questions
GAT	Gender Assessment Tool
GRAS	Gender Responsive Assessment Scale
MDG	Millennium Development Goals
MSM	Men who have sex with men
PAHO	Pan American Health Organization
PHC	Primary Health Care
SARS	Severe acute respiratory syndrome
STI	Sexually transmitted infections
UNIFEM	United Nations Development Fund for Women
VAW	Violence Against Women
WAD	Women and Development
WED	Women, Environment and Development
WHA	World Health Assembly
WHO	World Health Organization
WID	Women in Development

INTRODUCTION

Why do public health managers need a manual on gender mainstreaming?
Contemporary public health mandates include addressing a wide range of determinants of health such as sex, gender, poverty and equity[1]. This Manual focuses on gender as a determinant of health for women and men and the particular ways that gender equality contributes to better health outcomes for women and girls. In particular, this Manual addresses how gender norms, roles and relations affect health-related behaviours and outcomes as well as health sector responses. At the same time, it recognizes that gender inequality is a cross-cutting determinant of health that operates in conjunction with other forms of discrimination based on such factors as age, socioeconomic status, ethnicity or place of origin and sexual orientation. The Manual provides a basis for addressing other forms of health-related discrimination.

Gender mainstreaming provides tools to reduce the harmful effects of the determinants of health
Specific strategies are required to address gender-based health inequities. **Gender mainstreaming** is an internationally accepted strategy that aims to institutionalize gender equality across sectors[2]. Given the powerful impact that gender has on the health of women and men, it is imperative that health managers be equipped with the skills to address gender-based health inequities in their work. This Manual responds to a perceived gap in the practical application of gender-mainstreaming strategies for health managers involved in decision-making and agenda-setting with respect to public health policies, programmes and services.

Gender is an important determinant of health with two important dimensions:[3]

1) **Gender inequality** puts the health of millions of women and girls at risk globally. Addressing gender equality helps to counter the historic burden of inequality and deprivation of rights faced by women and girls in households, communities, workplaces and health care settings. Addressing gender equality in health enables the important work to improve the health of women.

2) Addressing **gender norms, roles and relations** enables better understanding of how sociocultural identity construction (male and female), attribution of rights and unequal power relations can affect (among other things) risk and vulnerability, health-seeking behaviour and – ultimately – health outcomes for men and women of different ages and social groups.

Understanding and addressing gender-related causes of ill health and inequity enables appropriate and adequate policies and programmes to be developed in the health sector.

Gender mainstreaming addresses women's specific health needs but is about women and men
Historically, work on gender has focused on women. Although the status of women and conditions for gender equality have improved considerably across high-, medium- and low-income countries, women and girls remain disadvantaged relative to men and boys in various ways. Such disadvantage is internationally recognized as both a violation of human rights and a barrier to broader social development. It is also widely acknowledged that women's lower status is often institutionalized through social, economic and political structures. Institutions tend to marginalize women in training, employment, policy-making, health planning, programme implementation and monitoring. These institutions can also perpetuate images of and ideals for men that are not always congruent with reality, contributing to increased pressure and stress on men who are either unable to or are discouraged from fulfilling certain roles and responsibilities in a changing, globalized world.[3,4]

In response to institutional and systemic forms of discrimination and stereotypes about women and men, the field of gender and gender mainstreaming entered the international policy arena as a way of recognizing that an individual focus on women without long-term visions towards changing attitudes, beliefs and structures that promote inequality will yield limited results. Since the 1990s, increasing attention has been paid to how men can and do contribute to improving gender relations and how gender norms may adversely affect men's health and life opportunities.[2,3,5,6]

Gender norms, roles and relations serve as both protective and risk factors for health among groups of women and men. However, women's disadvantaged social, economic and political status often makes it more difficult to protect and promote their physical and mental health, including their effective use of health information and services.[1,2] Although women live longer than men do in many contexts, these additional years of life are often spent in poor health. Women experience avoidable morbidity and mortality as a direct consequence of gender-based discrimination.[3,7,8]

Men, on the other hand, often delay seeking health care longer than women and may even refuse to comply with treatment. For example, in some regoins, men choose not to undergo treatment for TB, because the treatment requires that they avoid consuming alcohol for its duration.[9,10] This affects their overall health status. Because of their responsibilities to promote and safeguard health, public health actors must be empowered with the skills to identify and address the factors that put women and men at risk.

Gender mainstreaming means a new way of doing business in the health sector

The steps towards achieving health equity goals, such as *health for all*, must begin from the basic acknowledgement that "all" are not the same. Differences and disparities in health between countries and regions are widely recognized and recorded in health statistics and profiles. Public health workers at all levels need to recognize and identify differences within populations in their countries and address these differences systematically and appropriately. This may require various interventions to facilitate the attainment of the highest possible level of health across various groups within the population. It also often means that business-as-usual procedures are not the most effective ones. New ways of thinking and new ways of doing business need to move beyond rhetoric to address global health inequities and the different health needs and challenges facing men and women across the life course.

Gender mainstreaming can help in identifying differences and disparities – and in changing how the health sector operates to achieve its objectives. It does this through two contiguous approaches: programmatic (or operational) gender mainstreaming and institutional gender mainstreaming.[11]

1. Programmatic (or operational) gender mainstreaming

Based on human rights principles of equality, participation and nondiscrimination, programmatic approaches systematically apply gender analysis methods to health problems to better understand how gender norms, roles and relations affect the health of women and men across the life course.

Programmatic gender mainstreaming can do the following:

- address how health problems affect women and men of all ages and groups differently;
- focus on women's empowerment and women-specific conditions to address historical and current wrongs women and girls face;
- examine how gender norms, roles and relations influence male behaviour and health outcomes and how these shape the role of men in promoting gender equality;
- adopt a broad equity approach to look at at issues of age, socioeconomic status, ethnic diversity, autonomy, empowerment, sexuality, etc that may lead to inequities; and
- provide an evidence base to enable appropriate, effective and efficient health planning, policy-making and service delivery.

2. Institutional gender mainstreaming

This aspect looks at how organizations function: policy development and governance, agenda-setting, administrative functions and overall system-related issues. Institutional gender mainstreaming acknowledges that an institution must be equipped with mechanisms to create an *enabling environment* for programmatic approaches to succeed. It also ensures that organizational procedures and mechanisms do not reinforce patterns of gender inequality in staffing, functions or governance.

Institutional gender mainstreaming seeks structural changes, calling for a transformation of the public health agenda so as to include the participation of women and men from all population groups in defining and implementing public health priorities and activities.

Institutional gender mainstreaming addresses the alignment of human and financial resources and organizational policies which include:

- recruitment and staff benefit policies, such as:
  - establishing work-life balance;
  - sex parity and gender balance in staffing;
  - equal opportunities for upward mobility; and
  - mechanisms for the equal participation of male and female staff in decision-making procedures.

Institutional gender mainstreaming also addresses reflecting gender equality dimensions in strategic agendas and policy statements as well as monitoring and evaluation of organizational performance, via:
- developing tools and processes to address gender in planning activities (both institutional and programmatic planning);
- mechanisms of accountability on gender and health via advisory bodies, steering committees, etc.; and
- building staff capacity to implement the gender analysis methods required by programmatic approaches.

This Manual focuses on **programmatic gender mainstreaming** by outlining concrete ways to uncover how biological factors interact with gender norms, roles and relations (or sociocultural factors) to affect the health of women and men and that of their communities. Guidance on **institutional issues** for consideration – especially in health planning and programming is also provided. Although analysis of health equity typically focuses on socioeconomic disparity and responses, applying gender analysis methods to public health programmes, research and policies addresses unnecessary, avoidable and unfair differences in health status[11,12] beginning from the interaction of sex and gender as core determinants of health inequity. This means that the differences between and among groups of women and men (age, ethnicity, socioeconomic status, sexual orientation region of residence, etc.) are incorporated into a systematic gender analysis. This added value of gender analysis therefore enhances operational approaches to health equity.

WHO'S POSITION ON GENDER MAINSTREAMING, EQUALITY AND HEALTH

WHO adopts both a programmatic and institutional approach to gender mainstreaming, including World Health Assembly (WHA) resolutions on staffing that aspire to 60% of women in professional positions within WHO – a percentage that has increased since the first resolution in 1979.[13,14]

With respect to organizational policies to create necessary frameworks for institutional gender mainstreaming, WHO has adopted two important policy documents. In recognition of the role of gender-based differences and inequalities in health, and in accordance with its long-standing concern for health equity and the right to health, the Sixtieth WHA in May 2007 discussed and noted with appreciation a strategy for integrating gender analysis and actions into the work of WHO. The WHO Gender Mainstreaming Strategy[15] aims to progressively mainstream gender throughout WHO as a way to better support Member States in achieving the goals of gender equality and health equity. Four strategic directions are included:

- build WHO's capacity for gender analysis and planning;
- bring gender into the mainstream of WHO's management;
- promote the use of sex-disaggregated data and gender analysis; and
- establish accountability.

The WHO Gender Mainstreaming Strategy mirrors the objectives of the United Nations system-wide policy and strategy on gender equality and the empowerment of women[16] and furthers WHO's commitments to gender equality and health as outlined in the 2002 WHO Gender Policy[17], the objective of which is to:

> *…ensure that all research, policies, programmes, projects and initiatives with WHO involvement address gender issues. This will contribute to increasing the coverage, effectiveness, efficiency and, ultimately, the impact of health interventions for both women and men, while at the same time contributing to achievement of the broader United Nations goal of social justice.*

The Directing Council of the Pan American Health Organization (PAHO), also known as the WHO Regional Office for the Americas, adopted a gender equality policy through Resolution CD46.R16 on 30 September 2005.[18] Building from the 2002 WHO Gender Policy, the PAHO Gender Equality Policy aims to contribute to achieving gender equality in health status and health development through research, policies and programmes. In particular, the Policy states that:

> *PAHO/WHO will integrate – and support the integration by its Member States of – a gender equality perspective in the planning, implementation, monitoring, and evaluation of policies, programmes, projects, and research, in order to achieve […its] objectives.*

In 2003, the WHO Regional Office for Africa (AFRO) adopted a Women's Health Strategy; Resolution AFR/RC53/R4 on women's health: a strategy for the African Region[19] that outlines key interventions required to promote and protect women's health based on a comprehensive exercise of developing gender and women's health country profiles. A subsequent call for action was released during Regional Committee discussions in 2008.[20]

Other WHO regional offices have developed strategic directions based on either the WHO Gender Mainstreaming Strategy or the WHO Gender Policy to guide their work.

This Manual, then, supports efforts towards both institutional and programmatic gender mainstreaming by contributing to the implementation of global and regional gender and health policies. It furthers WHO's efforts to integrate gender considerations* in all aspects of its work and in building country-level capacity to address gender-based health inequalities. It supports the Eleventh General Programme of Work [21], which outlines the Organization's strategic priorities until 2015, as well as the strategy for integrating gender analysis and actions into the work of WHO and numerous other international mandates on gender mainstreaming and health equity. The Manual also supports the WHO Global Competency Model, a framework designed to support WHO staff in having a shared vision and direction as well as promoting positive behaviour.

Tools for integrating gender into public health

> *Gender mainstreaming is essential to realizing the right to health and it puts people at the centre of public health programmes and policies!*

A range of stakeholders across sectors have developed numerous tools, guidelines and frameworks to inform the process of examining the ways in which gender-based differences and inequalities influence the health of women and men (known as gender analysis). These are generically referred to as gender analysis tools.

Usually formulated as questions, gender analysis tools guide one through a systematic process of examining the influence of gender-based differences and inequality on health. [12,22] The reasons behind gender-based differences in health are often difficult to uncover by using traditional health analysis methods. Conducting gender analysis is, in many ways, similar to tending a garden. What appears on the surface neither adequately reflects the complexity of the inter-twining roots beneath nor reflects the stronghold these roots may have in the soil. Gender analysis is a similar process. Things must be examined in a bottom-up manner, understanding the realities of local populations before moving up to national and international levels to understand the root causes of how and why power, rights and access to important health-related resources are distributed unequally among internal groups.

This Manual equips you with practical tools to detect where and why gender inequality has harmful effects on health in order to develop adequate and appropriate interventions. **WHO gender analysis tools** are introduced throughout the Manual, with guidance on how to use them. They are also available on the CD-ROM accompanying this Manual as well as on the website of the Department of Gender, Women and Health (*www.who.int/gender*).

Sound gender analysis requires high-quality data from multiple sources

The use of sound evidence in making decisions is very important in public health work. This also applies to work on gender and health. The Manual includes some of this evidence from various regions – on women's and men's vulnerabilities due to gender norms, roles and relations – but should not be considered a complete and up-to-date summary of gender and health data. Users are required to dig under the surface of their contexts to use local, relevant data that can guide their own process of gender mainstreaming. This means that facilitators and participants alike need to actively engage themselves in searching out good sources of context-specific information. This engagement is part of an institutional approach to gender mainstreaming.

Data to support the development of gender mainstreaming efforts as well as methods to comprehensively evaluate their impacts are lacking. In addition to the challenges of measuring gender norms, roles and relations across countries and programme areas, the struggle to obtain adequate sex- and age- disaggregated data persists.

Despite this evidence gap, gender-based health inequities can – and must – be addressed and alleviated. Existing evidence is sufficient to know that gender inequality is an important determinant of health. However, while data sets and methodologies are strengthened, men, women, girls and boys should not continue to suffer the health consequences of harmful gender norms, roles and relations. They should **not** have to wait indefinitely for the health sector to consider and address the inequalities they face. We can act **now** on the information we have, and this Manual will help get you started in the right direction. The millions of women, girls, boys and men for whom harmful gender norms, roles and relations pose a risk to their health and well-being have been waiting too long for such action.

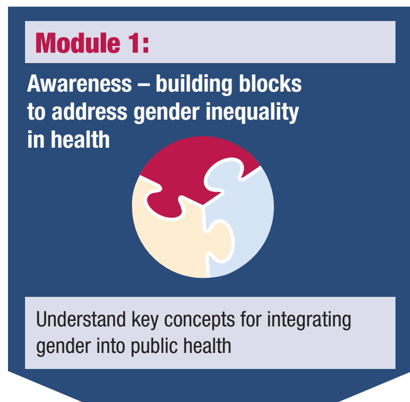
* "Integrating gender considerations" is used interchangeably with "gender mainstreaming".

ORGANIZATION OF THE MANUAL

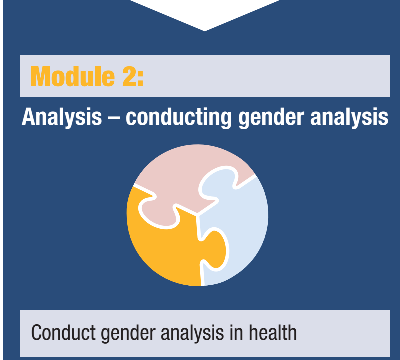
The manual adopts a modular, practical approach and is aimed at public health managers in international, national or community-based institutions. Modules are conceptually organized around answering the questions "What do we know?" and "What can we do?" about gender inequalities in health through global and regional examples, case studies and evidence. These questions are asked about a health condition or problem as well as about organizational mechanisms and structures through which health-related interventions are implemented.

Progressive approach: from awareness to action in three Modules

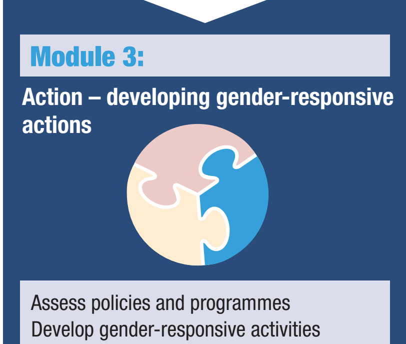
Three consecutive core Modules provide you with understanding and basic skills to integrate gender into public health activities. The Modules progressively introduce tools to conduct gender analysis and assessments and to develop gender-responsive actions. The figure below provides an overview of the three modules and their general content.



Aims to develop a common understanding among participants of key concepts and stimulate participants to get past politically correct discussions of gender and begin to grapple with the reasons why public health professionals should address gender and its links with human rights and other determinants of health.



Applies key concepts from module 1 in a framework to conduct gender analysis of a health problem. This module introduces two core WHO gender analysis tools, the Gender Analysis Matrix (GAM) and Gender Analysis Questions (GAQ). Institutional processes are also discussed and a worksheet for participant practice is provided.



Builds on modules 1 and 2, to introduce additional WHO gender analysis tools to asses existing programmes and policies (Gender Responsive Assessment Scale – GRAS, and Gender Assessment Tool – GAT) as well as a gender and health planning checklist. Ultimately, this module aims to guide users through the process of developing gender-responsive actions for the health sector.

Components of the Manual

The Manual consists of two booklets to guide work across the three modules: the **Participant Notes** and a **Facilitator's Guide**. A complete reference list and a glossary are provided. The accompanying CD-ROM includes electronic versions of WHO gender analysis tools, the entire Manual and other relevant electronic materials that may be of use while applying gender mainstreaming methods in your daily work.

The **Facilitators' Guide** consists of step-by-step guidance to work through the objectives of each Module. Supporting material is provided in the format of PowerPoint slides, handouts, flip-chart content, group work templates, evaluation forms, etc. Each Module has an overview at the beginning stating the **estimated timing for learning activities as well as materials required**. The Facilitators' Guide is divided according to the three main Modules, including a **general introduction** and **conclusion to the workshop**. Each part is further divided into sections that contain at least one related **learning activity**. The aims of each learning activity are outlined, followed by preparations required, notes for facilitators as well as a **suggested process** for conducting the activity.

The **suggested process** refers to learning materials and relevant sections of the Participant Notes to enable facilitators to easily navigate through the materials for both preparation and implementation. Specific points to highlight or summarize various topics, and with the use of PowerPoint slides, are provided; these are not intended to serve as dogmatic scripts for facilitators but to serve as a guide on key messages to be conveyed. Notes are included on the PowerPoint slides for facilitators so that sessions can be run with minimum reading from the Facilitator's Guide during the workshop.

To support smooth transitions between learning activities, a feature called **suggested transition to next section** is included with tips and ideas for facilitators to draw upon.

Materials for learning activities include a range of items such as:
- flip-chart content;
- participant handouts;
- specific activity materials;
- PowerPoint slides (for be transferred to overhead slides or flip charts as necessary); and
- group work templates.

The accompanying CD-ROM includes the PowerPoint slides in electronic, modifiable versions as well as selected learning materials and tools for easy adaptation and use.

Tips for facilitators are included throughout the Modules. These tips have been prepared based on numerous pilot tests and applications of the Manual across WHO regions and at all levels. They are designed to support facilitators in using the Manual. They are not meant to be unduly prescriptive but are suggestions intended to help in running the workshop. If you come across other tips that would be helpful for other facilitators, please contact the Department of Gender, Women and Health for inclusion in future updates of the Manual.

The Participant Notes includes background reading, worksheets and WHO gender analysis tools that mirror each section of the Facilitator's Guide. Facilitators are strongly encouraged to read and refer to the Participant Notes throughout the workshop – and to encourage participants to read them before coming to the workshop. The Participant Notes are the main source of information for participants and are referred to often throughout the workshop.

Key to symbols

Symbol	Meaning	Symbol	Meaning
	Core learning activity		Participant notes
	Flipcharts		Optional learning activities
	Presentations		Tips for the facilitator
	Handouts		Suggested transitions from one section to another
	Group work / activity		Exercises
	WHO gender analysis tools		

HOW TO USE THE MANUAL

The Manual is intended to guide face-to-face capacity-building activities (known as gender training) on gender mainstreaming for public health programme managers. The method is progressive, participatory and based on principles of adult and experiential learning.

Typically, the Manual is used in **three- to four-day workshops** to accommodate the range of activities included and allow enough time for participant involvement and sharing of experiences that contribute to achieving the objectives of each section. The Modules do not have to run during the same training event. However, adjustments need to be made if long delays are planned between Modules to include adequate review of previously covered materials.

The Modules also allow for a great deal of flexibility in **adapting** the content. Selected learning activities can be used for different purposes. For example, if you are required to prepare an awareness raising briefing on the links between gender equality and health, activities can be selected from Modules 1 and 2 and may be sufficient for the objective and target audience at hand. Symbols indicate in each Module the activities considered to be **core learning activities** to transfer skills on gender mainstreaming and health. Facilitators are strongly recommended to include all core learning activities.

Optional learning activities are provided in annexes to each Module that allow facilitators to choose from a range of activities and methods, including learning activities that may be more appropriate to specific target audiences, such as managerial, administrative or communications staff. Optional learning activities can also be used to complement multiple learning activities across Modules; this is indicated so that facilitators can choose the best time and place within their workshop for these activities. The following considerations are important if optional learning activities are used:

- Optional learning activities can be used in evening sessions, as "homework" or referred to for participants to look at after the workshop.
- Including optional learning activities will have time implications that require advance planning.
- Optional learning activities can be conducted with specific participants in parallel sessions to allow for more in-depth discussion on certain areas, such as developing human resource plans. If this is done, the following should be considered.
  - Use a co-facilitator.
  - Make sure to bring the group back together to share the various activities, with short summary presentations as necessary.

Additional Modules and/or activities will be developed to complement areas that are not covered in the three core Modules. For updates and information, please visit *http://www.who.int/gender*.

Adapting the Manual

The Manual has been developed as a resource and may require adaptation to different contexts. Prepare your Modules before the workshop. Use and adapt the material according to your facilitation style, the group (professional and geographical background) and the resources available.

The Modules are global in nature, and the examples and evidence included tend to be global. When possible, regional or country-specific examples and data have been included. Facilitators are encouraged to use data that are most relevant for the group. Use global and other comparative data or strategies provided in the Manual when necessary to provide some contrast and let participants know how similar issues are represented in other parts of the world where appropriate.

It is strongly recommended to always use sex-disaggregated data. When sex-disaggregated data are not available, this should be stated and discussion generated with participants about the obstacles that non-disaggregated data poses to gender analysis. Always link the material to local examples and issues.

Training techniques such as icebreakers, buzz groups, group discussions, case studies and games are used throughout the Manual. These can all be modified to the training technique that may be better suited to your audience. Other training techniques to consider in experiential, adult learning include: brainstorming (through balloons, free writing or listing, etc); statement ranking; sentence completion; questionnaires or case studies; creative work (such as drawing, mapping, role playing, etc.) and debates. Adapt training techniques to your group and comfort in facilitation.

Facilitator preparation

Gender training is a complex task, as it aims to raise awareness, change behaviour, build skills and knowledge of participants related to gender – which touches on personal and political issues. [4,23,25] Facilitators must be professionally and personally equipped to accompany participants in a process of consciousness-raising and active engagement with new skills, navigating through sometimes difficult waters when faced with scepticism or resistance to addressing gender as a determinant of health.

Facilitators may find the following tips useful:

- Be familiar with the local context, concepts and applications of gender and health before facilitating a group with this Manual. If gender training is relatively new for you, take some time to think about how you feel about and understand the concepts. Be prepared for your own views to be challenged and to deal with participant reactions that may be antagonistic. **Learning about gender is a process**, and you will discover things along the way from participants and yourself as you begin to reflect deeper on the issues at hand. Ask for support if you need it!

- The broader development and social science literature may define gender and gender analysis differently. The definitions presented here are those used by WHO and have been adapted to public health contexts as necessary. Facilitators are encouraged to use these definitions; if not, make necessary adjustments to audiovisual materials and the Participant Notes to avoid confusing participants.

- **Co-facilitation** (or shared between three or four facilitators for different sections) has proven to be effective regardless of group size. This allows for increased diversity in delivery for participants, diverse facilitator experiences and allows for better coverage of group work and overall logistics preparations.

- Look for **regional or national examples** of gender mainstreaming from the countries or districts of the participants attending the workshop. This acknowledges existing work being carried out in countries and does not assume that this workshop is the starting point of gender work in the given context.

- Do not read the presentations word for word; summarize the key points. This requires reading and **having a sense of ownership of the material** before the workshop begins.

- Talking points on several of the slides are provided to guide you through the sessions if needed. These points may also be useful for clarifying concepts during discussions.

- Let participants read the material to the rest of the group, when necessary, and **ensure participation by both men and women** during discussions.

- Give participants an opportunity to read the material on their own and ask questions. **Refer to the Participant Notes** and remind them of additional reading throughout the worshop.

- In addition to changing the mode of presentation, the key to avoiding boredom and maximizing learning is to **apply theory with examples and to encourage discussion, drawing on participants' experience**.

- Counterbalance the intense nature of the workshop with energizers, breaks and fun activities. See below text box for suggested energizers.

- Gender work is often challenging. It is closely linked to participants' own values, beliefs and culture. Be aware of and sensitive to this when engaging in discussions on contentious or charged topics such as religion or cultural traditions. **Avoid judgement at all costs and enable open dialogue on ways to mitigate harmful health impacts of gender norms, roles and relations**.

- Remember, the focus of this workshop is on improving public health policies, programmes and service delivery. The Manual has been designed as a resource to **encourage critical, analytical thinking and action**. Even though some participants may have personal gender biases, the tools can help to uncover gender issues in the context of health in an accessible and non-threatening manner.

Suggested energizers – for use throughout the Modules when needed

When facilitators notice that participant energy is lagging, or after a long session, energizers are good tools to bring participants back into focus. Here are a few examples of energizers that can be used; facilitators may need to adapt or use those that are culturally appropriate. It can also be fun to ask participants (in advance) to share energizers from their cultures with the group – an especially effective technique to involve participants, promote sharing of cultural songs or dances. Energizers should not take more than 5-10 minutes.

1. **Get the malaria mosquito!** Have everyone stand up. Participants pretend that they are being attacked by a swarm of malaria mosquitoes. Ask them to try to kill the mosquitoes by clapping their hands together. Start with a swarm above their heads, moving down to in front of them, to their left and right, and finally at their feet. An alternative is to ask them to protect their neighbour and kill the malaria mosquitoes in the same direction around their neighbour.

2. **Body gender**. Have everyone stand up and form small groups with their neighbours. Assign each group a "gender term" that has been used in the training, making sure to select short ones. Examples include sex, gender, equality, norms and roles. Each group must quickly decide together how to spell out the assigned term with their bodies (in line formation, with movement, etc.) and then demonstrate this for the larger group. If facilitators would also like to use this as a way of recalling terms, groups could be asked to define their term after their "spelling" demonstration.

3. **Affirming commitments to gender equality**. Write the phrase "Gender equality is good for health" on a flip chart or somewhere visible where everyone can see it. Ask everyone to stand in a circle – away from their workshop materials. One by one, each person counts. 1, 2, 3, 4 The fifth person will say the first word of the phrase (gender). The counting restarts from 6, and the tenth person will say the second word of the phrase (equality). Counting restarts from 7 and the 15th person says "is", and so on. If someone loses count or forgets to replace a number with a word in the phrase, the group must start over again with the word gender. Continue until the phrase is complete.

Note: these energizers were modified from other materials. For further examples of energizers that can be used, facilitators can consult the Oxfam gender training manual [23] , trainingfairy.com [24] or the wide range of adult learning materials available on-line and in-print.

- The course outline is a guideline that has been based on progressive learning competencies; use and adapt it to group needs. Timing depends on the size, level of existing gender knowledge in the group and logistics such as travel, tea breaks and catering arrangements. Factor all these variables into your planning. The Modules can be run in a flexible manner – if you are short of time, shorten activities, modify the mode of delivery or select only those highlighted as core learning activities.

- A complete reference list is provided at the end of both the Facilitators' Guide and the Participant Notes. The Participant Notes should be sent to participants in advance for preparation. It is advisable to provide them with the materials at least on the first day of the training for background reading and activity completion.

- Modify the PowerPoint slides as necessary, including photos, images and data that will be most relevant and stimulating for the group of participants.

- Incorporate progressive evaluations of participant understanding between Modules. This helps to ensure that objectives are met and provides facilitators with crucial input on areas that may need to be revised.

Workshop preparations

The preparations and arrangements detailed below are suggested to ensure that the workshop runs smoothly. If implementation is shorter or longer than three days, facilitators need to make necessary adjustments.

General preparatory procedures

1. Prepare materials (as outlined at the beginning of each Module) in advance.
2. Photocopy, reproduce or distribute materials for participants (see materials for distribution below).
3. Select a few energizers to be used periodically throughout the workshop when needed.
4. Prepare flip charts for the Modules.
5. Prepare name tags for participants.
6. Ensure enough blank flip charts, markers of different colours, adhesive tape, coloured index cards and other supplies are available.
7. Prepare necessary materials for evaluation.

Room arrangements

1. A U-shaped seating arrangement is preferable – with enough space for people to move around and view the presentations and flip charts. The activities involve some degree of both facilitator and participant movement, and the set-up of the room should allow for such interactivity.
2. Audiovisual equipment should be arranged and tested.
3. Equipment for hanging flip charts, projecting presentations should be available and tested.
4. Flip-chart paper and various coloured markers should be available and set up.
5. Laptops or other methods of recording (such as flip charts) for group work in Modules 2 and 3 are recommended with appropriate templates readily available.
6. Space for group work in Modules 2 and 3 should be arranged. Groups can work in the same room if the room is large enough and the noise does not carry too much from one group to another. A typical training session with 20-25 participants will have four working groups. Ideally, break-out rooms are best for the group work to allow the groups to discuss without interrupting others.

Materials for distribution

Folders are recommended for the participants – and ideally should be sent in advance to participants for their review and preparation. Suggested content for the participants' folders include:

- programme or agenda of the training session;
- list of participants;
- Participant Notes;
- handouts for each participant as indicated in the relevant Modules;
- copies of the PowerPoint slides used during the Modules; and
- note pads.

In addition to the general preparations above, here is a suggested **checklist for planning and preparing a workshop**, noting that each Module includes an overview of detailed preparations required for specific activities.

Checklist for planning and preparing a workshop
Planning ahead
☐ Develop **List of Participants**, considering functions, roles and expected follow up actions with respect to gender mainstreaming in health sector activities.
☐ Determine **workshop objectives with respect to Module 3** (planning activities). For example, will participants work within existing policies and programmes (e.g., an existing national health strategy) or will the exercises be forward-looking to future development of activities (e.g., country X has plans to develop a gender and/or women's health policy)? *This may mean you also need to acquire and review these materials, incorporating them throughout the materials either as examples or part of the group work in Modules 2 and 3.*
☐ Draft **agenda** (see Agenda template)
☐ Procure local information, data, reports, etc necessary for **activity adaptation** (see Modules for further information).
☐ Draft and send **invitation letters**.
☐ Arrange **travel, accommodations, venue, food** for a successful workshop.
Opening the workshop
☐ Determine **opening ceremonies** and what formalities are required for the context. Contact dignitaries well in advance to ensure availability and make sure to follow up as the workshop dates come closer.
Module 1
☐ Ensure an **open space for the Power Walk**, with a back up location in case of bad weather.
☐ **Adapt activities** (e.g., Flash Card Facts, Power Walk) to local context as necessary.
Module 2
☐ **Ensure space (or break out rooms)** for two to four groups.
☐ Based on the type and number of participants, **divide the group for conducting gender analysis of a health problem**.
☐ **Select topics for group work** based on context and mix of participants for "voting".
☐ **Prepare group work material** electronically or on flip-chart paper. For example, group work templates can be downloaded into laptops for group work.
☐ Select **optional learning activities** as appropriate.
Module 3
☐ **Ensure space (or break out rooms)** for two to four groups.
☐ If using parallel sessions (see Module 3 optional learning activities), ensure enough space and time in advance.
☐ **Prepare group work material** electronically or on flip-chart paper. For example, group work templates can be downloaded into laptops for group work.
☐ **Photocopy Module 2 group work outputs** for use in Module 3 group activities.
☐ **Adapt or develop GRAS examples** to local context as necessary.
☐ **Select and/or solicit country work plans / policies / programmes for use** in group activities.
☐ Select **optional learning activities** as appropriate.
Concluding the workshop
☐ **Test, modify or adapt Gender Jeopardy**.
☐ **Adapt Certificate template** and determine who will sign, ensuring to secure necessary authorizations and permissions in advance. Note that certificate preparation and printing should only begin once a list of participants is finalized.
☐ **Prepare photocopies of all group work** (Modules 2 and 3) for distribution.
Evaluation [2]
☐ Prepare Progress Check flip charts or handouts as indicated in Modules 1 and 2.
☐ **Identify an "evaluation officer"** or someone in the group that could report back on the previous Module's content during Progress Checks as appropriate.
☐ **Photocopy participant evaluation forms** (see Concluding the workshop) and distribute at the beginning or mid-way through Module 3 to give participants time to complete them.
☐ **Develop pre and post test questionnaires** as necessary. Ensure that these are simple, that there are clear ways of grading them, and that time is included in the conclusion session to conduct and discuss.

2 Note that monitoring and evaluating gender mainstreaming skills building and transfer is an important component of capacity building that enables follow-up on concrete actions after this hands-on workshop. Facilitators should check *http://www.who.int/gender* for forthcoming tools to monitor and evaluate application of skills developed from the use of this manual.

MORE THAN CAPACITY-BUILDING

Gender training has multiple objectives with respect to awareness-raising, behavioural change and development of new knowledge and skills on gender. [23,24,26] The health sector has paid less attention to gender than other sectors until recently, as the focus has tended to be on physiological factors of health and illness or on sex-specific conditions affecting women or men. This means that capacity in the health sector to address gender as a determinant of health may be disparate across contexts. It is important to use gender training opportunities as a means to **foster dialogue and develop a network with local partners on ways to reduce the harmful health effects (or enhance any positive health effects) of gender norms, roles and relations**.

Such a dialogue is achieved through acknowledging, from the outset, that scepticism on gender and health exist – often from partners that hold much decision-making power. Activities in the Manual are designed to challenge sceptics and supporters alike to develop **practical ways to address gender inequalities in health** – and ultimately, improve the health of women and men of all ages and social groups.

One very practical, concrete step to achieve gender training objectives is to recognize that the work of **gender mainstreaming is not an individual task**. Collective action and learning are crucial to address gender equality in health. Due to contextual particularities and the nature of gender norms, roles and relations, what works in one setting may not work in another – but the lessons learned from different experiences can benefit everyone. **Network building** should not be underestimated as a means to ensure the sustainable development of capacity on gender mainstreaming. When the implementation of this Manual is planned, it should be remembered that convening public health managers with a responsibility to integrate gender into their public health activities in capacity-building workshops has a **dual purpose** of **strengthening their capacity to use and apply gender analysis tools** and **creating a network for sharing experiences and collaborating within and between countries**. This is reflected in the template agenda through the inclusion of sessions for inter- or intra- country presentations. Such mechanisms for sharing in the workshop agendas may increase the time needed for activities and discussion; however, the strengthened networks and lessons learned that result are valuable towards progressively mainstreaming gender in public health activities in community, national, regional and international efforts.

You will be asked to think outside the box throughout this Manual: to rethink the way you view your programmes and policies. You will be asked to look for hidden answers to hard questions, to dig them out and to find their roots. This requires an open mind to see the world in a different context than the norm and an insatiable curiosity to ask "*Why does this happen?*" for phenomena that you may have never questioned before.

WORKSHOP AGENDA TEMPLATE

An outline is provided for a three- to four-day workshop. Facilitators need to make necessary adjustments to suit local contexts, formalities, group size and selection of optional activities. Note that days and times are provisional and include core activities only.

Tentative times and activities	Planning remarks
Days before the workshop	
Planning meetings Preparing the folders and room Facilitators' briefing	Refer to the introduction of the Facilitators' Guide for more information.
Day 1 – Day 2	
08:30 – 09:00 Opening remarks and welcome Workshop objectives, agenda Overview	Module 1 includes the setting of workshop objectives, participant introductions and general ground rules. Each region or country will need to adjust the scheduling according to contextual protocol for opening ceremonies. See Introduction to the workshop for more details.
09:00 – 10:30 Module 1: Does gender really matter in health?	Sections to be covered: • 1.1: Does gender really matter in health? – Learning activity 1.1: Flash card facts • 1.2: Sex and gender are not the same – Learning activity 1.2a: Sex and gender – what is the difference? *Please note that the activities estimated in each time slot will depend on the size and level of the group.*
10:30 – 11:15 **Break**	
11:15 – 11:45 Country presentations	This session can be useful in either a country or intercountry workshop to foster sharing of experiences. Country focal points provide brief presentations with respect to the following questions. 1. What are your main activities in gender mainstreaming? 2. What are the main supporting factors for successful gender mainstreaming in public health? 3. What are the main challenges for successful gender mainstreaming in public health? 4. How have you overcome or addressed these challenges? 5. What do you and your team require to successfully mainstream gender into your activities over the next five years? 6. What can WHO or the health ministry do to support gender mainstreaming in health?
11:45 – 12:45 Module 1: Unpacking gender	Sections to be covered: • 1.2: Sex and gender are not the same – Learning activity 1.2b: Unpacking gender
12:45 – 14:00 **Lunch**	
14:00 – 14:30 Country presentations	As needed; same process as above with additional, selected participants.
14:30 – 15:30 Module 1: Gender equality and health	Sections to be covered: • 1.3: International framework for working on gender equality and health – Learning activity 1.3a: A global view – international and organizational commitments to gender equality and health – Learning activity 1.3b: Gender, human rights and health
15:30 – 15:45 **Break**	
15:45 – 17:30 Module 1: Gender is a determinant of health	Sections to be covered: • Section 1.4: Gender is a determinant of health – Learning activity 1.4: Power walk • Section 1.5: Equality or equity? – Learning activity 1.5a: Gender equality, equity and health equity – Learning activity 1.5b: Identifying wasy to address gender and health inequities • Section 1.6: Conclusion to Module 1 *Please note that the power walk works best after lunch or a break – you may need to adjust the agenda if country presentations are included to accommodate this.*

Tentative times and activities	Planning remarks
Day 2 – Day 3	
08:30 – 09:00 Progress check on Module 1	
09:00 – 10:30 Module 2: Gender Analysis	Sections to be covered: • Section 2.1: What is gender analysis? • Section 2.2: Introducing WHO gender analysis tools – WHO Gender Analysis Questions – WHO Gender Analysis Matrix: ◦ Gender-related considerations *Please note that the activities to introduce the tools may vary – either in plenary, buzz groups, etc.*
10:30 – 10:45 **Break**	
10:45 – 11:30 Country presentations	As needed; see previous explanations.
11:30 – 12:45 Module 2: WHO Gender Analysis Tools	Sections to be covered: • Section 2.2: Introducing WHO gender analysis tools? – WHO Gender Analysis Questions – WHO Gender Analysis Matrix: ◦ Health-related considerations *Please note that the activities to introduce the tools may vary – either in plenary, buzz groups, etc.*
12:45 – 14:00 **Lunch**	
14:00 – 14:30 Country presentations	As needed
14:30 – 16:00 Module 2: Using WHO Gender Analysis Tools	Sections to be covered: • Section 2.3. Using WHO gender analysis tools – Learning activity 2.3a: Group work *The time for the group work should consider the number of participants, range of expertise on the selected topics and number of groups (for reporting back). It has been found that a minimum of 1 hour is needed for a thorough "mock" gender analysis of a health problem (entire Gender Analysis Matrix completed).*
16:00 – 16:15 **Break**	
16:15 – 17:15 Module 2: Group reports	Sections to be covered: • Section 2.3. Using WHO gender analysis tools – Learning activity 2.3a: Group work – reporting-back session *The time for the reporting back is usually underestimated, but this is really when participants have a chance to discuss and reflect on their "first" gender analysis. Allocate at least one hour for this activity – or 15 minutes per group presentation.*
17:15 – 17:30 Conclusion to Module 2	

Tentative times and activities	Planning remarks
Day 3 – Day 4	
08:30 – 09:00 Progress check on Module 2	
09:00 – 10:30 Module 3: Policy and programme assessments	Sections to be covered: • Section 3.1: WHO gender analysis tools II: assessing policies and programmes. – Learning activity 3.1a: WHO Gender Responsive Assessment Scale and the WHO Gender Assessment Tool
10:30 – 10:45 **Break**	
10:45 – 12:45 Module 3: Gender planning	Sections to be covered: • Section 3.2: Integrating gender into health planning and programming – Learning activity 3.2: WHO Gender and health planning and programming checklist
12:45 – 14:00 **Lunch**	
14:00 – 14:30 Country presentations	As needed
14:30–16:00 Module 3: Developing gender responsive workplans	Sections to be covered: • Section 3.3: From analysis to the work plan: developing gender responsive work plans – Group work – Reporting back (See notes about group work timing in Module 2)
16:00 – 16:15 **Break**	
16:15 – 16:45 Module 3: Group reports	Sections to be covered: • Section 3.3: From analysis to the work plan: developing gender responsive work plans – Reporting back – continued
16:45 – 17:30 Wrap-up of the workshop, jeopardy, recommendations Distribution of certificates (as appropriate)	There are several ways to conclude the workshop: slides are provided, a jeopardy quiz is provided (time intensive but worthwhile as it is a fun review of core concepts) and worksheets are provided in the Participant Manual that incite reflection on the next steps for participants. In some regional and country workshops, this time has also been used to have a round-table discussion on recommendations to implement skills developed in the workshop, broad evaluation of the tools (especially if a regional or country adaptation is envisaged) or other discussions on capacity-building, gender and health. This session has proven very dynamic when used and can give both WHO and other partners a tentative agenda for follow-up actions to support countries. Certificates for participants are always a welcome end to the workshop!

Feedback form

WHO is committed to mainstreaming gender into its work at all levels and to supporting Member States and country partners to do the same. WHO is also aware of the need to update approaches and information on gender and health to keep abreast of changing trends across contexts, especially from the users of its materials.

We are very appreciative of feedback on these materials. We are interested in learning how you used the materials and tools; their user-friendliness and adaptability to different contextual realities. A feedback form on ways to improve them and to identify gaps or missing information is included here for your use.

Please take a moment to fill out the below form, and return it with the attention line as "capacity-building feedback" via one of the options listed below.

By regular mail to:

Department of Gender, Women and Health
World Health Organization
20, Avenue Appia
CH-1211 Geneva 27
Switzerland

By e-mail to:
genderandhealth@who.int

By fax to:
+41 22 791 1585

Capacity-building feedback on the *WHO gender mainstreaming manual: a practical approach (Facilitators' Guide)*

	Yes	No	Not quite	Comments
The Facilitators' Guide provides adequate guidance and support to run capacity-building activities on gender mainstreaming in health.				
The materials are user-friendly and comprehensive.				
The progressive organization of the Modules is logical and easy to follow.				
The materials are easily adaptable to local contexts.				
The accompanying CD-ROM includes materials to support the implementation of gender-mainstreaming capacity-building activities.				
The materials included in the Participant Notes are a good supporting resource to facilitators when developing capacity-building activities on gender and health.				

2. Gaps and omissions

Please indicate which areas or materials should be included, expanded upon or excluded in upcoming updates of the Manual (both Facilitators' Guide and Participant Notes):

3. User perspectives

a. I have used these materials in the following context(s):

b. I plan to use these materials in the following context(s):

4. Additional comments

☐ Would you like to be a part of WHO's gender, women and health mailing list? Check here if yes and include the information requested below when sending your form back to us.

Note that this is optional for those that would like to provide anonymous feedback.

Name	
Institution	
Address	
E-mail	
Telephone	
Fax	
Web site	

CERTIFICATE OF ATTENDANCE

The below template can be used to generate a certificate of attendance for participants. Note that this template exists in modifiable format on the accompanying CD ROM for easy preparation and printing.

Certificate of Attendance

This is to certify that:

"FIRSTNAME" "LASTNAME"

participated in the Gender Mainstreaming for Health Managers workshop
organized by

"ORGANIZATION NAME AND PARTNERS"
at "LOCATION AND DATE"

"SIGNING AUTHORITY" "DATE"

INTRODUCTION TO THE WORKSHOP

Creating the right atmosphere for learning

Activity: Introductions

Materials to be prepared and used: PowerPoint slides (0.00–0.07) and/or flip charts (0.00–0.03)

Proposed running time: 15 minutes

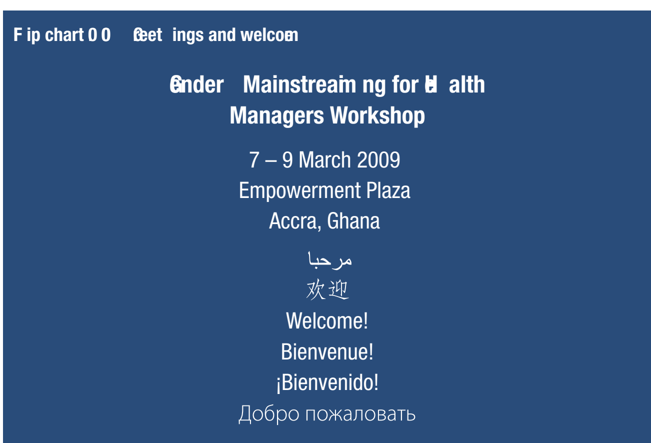
Aims

Participants will:
- get to know other participants and facilitators
- share expectations with the group
- understand the progressive structure of the Modules and overall workshop objectives
- establish ground rules to maximize learning and sharing throughout the workshop
- receive information relating to workshop logistics (as necessary).

Notes

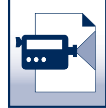
Before the workshop, take some time to set up the room, adapt and display flip chart 0-.00 for participants to see when they enter the room.

Optional: Include welcome greetings in multiple languages – especially local languages. Invite participants as they enter the room to write greetings in the language of their choice on the flip chart as they enter the room.



Suggested process

Step 1: Welcome everyone. Introduce yourself and other facilitators. Ask participants to introduce themselves to the group, using or adapting information from **slide 0.01** (*Introductions*) as a guide. Record participant expectations on an empty flip chart; hang the flip chart somewhere visible throughout the workshop for quick reference and to ensure that relevant topics are incorporated in various Module discussions.



Step 2: Present the outline of the Modules and workshop using slides **0.02 – 0.03**.
- Using **slide 0.02** (*A workshop designed to help you in your daily public health work*), highlight that the manual contains **three consecutive Modules that aim to increase awareness and build skills to conduct gender analysis and develop gender-responsive actions**.
  - Outline the **methods of the workshop**: participatory, interactive and draws upon participant experience and group work on regional or national gender and health priorities.

- Use **slide 0.03** (*Progressive learning activities*) to highlight the progressive nature of the Modules, indicating that **WHO gender analysis tools** are presented throughout. In particular:
  - **Module 1** provides an introduction to key concepts for integrating gender into public health work. This Module ensures that everyone is on the same page about certain concepts – and what they mean for working in the health sector.
  - **Module 2** builds on the key concepts towards using WHO gender analysis tools (*Gender Analysis Matrix and Gender Analysis Questions*) aimed at conducting gender analysis of a health problem.
  - **Module 3** combines the knowledge and skills from Modules 1 and 2 to apply remaining WHO gender analysis tools (*Gender Responsive Assessment Scale, Gender Assessment Tool, Gender and health planning checklist*) to assess policies and programmes and develop gender-responsive actions.
- When possible, highlight where participant expectations (from step 1) and workshop objectives converge, identifying additional expectations you feel you can incorporate; and noting those that fall outside the parameters of the programme.
- Hang **flip chart 0.01** (*Outline of workshop modules*) on the wall to refer to throughout the workshop (as necessary).

F ip chart 0.01 Ot line of worshop m dules

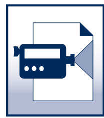
Module 1: Awareness – building blocks to address gender inequality in health
Understand key concepts for integrating gender into public health
Sex, gender, gender equality: what are they? Why are they important for health?

Module 2: Analysis – conducting gender analysis
Learn how to conduct a gender analysis in health
Gender Analysis Matrix
Gender Analysis Questions

Module 3: Action – developing gender-responsive actions
Learn to assess policies and programmes and develop gender-responsive activities
Gender Responsive Assessment Scale
Gender Assessment Tool
Gender and health planning and programming checklist

Conclusions

- Refer to, or introduce, the **Participant Notes** and encourage participants to read them throughout the workshop if they have not already done so.
- *Optional*: Many issues will arise that you may not be able to cover during any given section of the Modules or workshop. To address this, pin a blank flip chart on a separate space and use it to highlight important issues that will be covered later. This can be called the "parking lot".



Step 3: Use **slide 0.04** (*Ground rules*) to introduce suggested ground rules (adapt as necessary). Ask participants for additional ground rules; including them on a flipchart as necessary. You may need to remind participants of the ground rules throughout the workshop (such as phone interruptions and being on time) to ensure a smooth workshop. Make sure you follow them too!

Tips for facilitators

The introduction to the workshop may need to be altered depending on the format and opening ceremony formalities of the workshop you are organizing. Adapt it as necessary – ensuring that you record participant expectations, establish ground rules and provide an overview of the three Modules so that participants know what to expect.

Additional points to keep in mind and/or share with the group include:

- Gender is not something that exists "out there" to "other people" – or only to women from poor, marginalized communities.
- Gender norms, roles and relations are a part of the daily lives of everyone and affect us all – facilitators and participants alike.
- Learning about gender can be challenging because it may require challenging our own beliefs, traditions and behaviour. This can be tough and requires an open attitude from everyone involved.

Step 4: Go over the workshop agenda, logistics, housekeeping announcements, etc.

MODULE 1:

AWARENESS – BUILDING BLOCKS TO ADDRESS GENDER INEQUALITY IN HEALTH

Proposed running times

Section and learning activity	Materials to be prepared and used	Suggested time
1.1: Does gender really matter in health? Learning activity 1.1: Flash card facts	Prepared flash card facts Markers Slides 1.3 – 1.4 Participant Notes, section 1.1 *For health, gender matters!*	60 minutes
1.2: Sex and gender are not the same Learning activity 1.2a: Sex and gender – what is the difference?	Slides 1.5 – 1.6 Participant Notes, section 1.2 *Summary points on sex, gender and health*	15 minutes
1.2: Sex and gender are not the same Learning activity 1.2b: Unpacking gender Optional: • Listing activities: gender norms, gender roles, gender relations Optional learning activity 1.2a: Going back in time Optional learning activity 1.2b: Mind your language!	Slides 1.7 – 1.17 Participant Notes, section 1.2 *Summary points on sex, gender and health* Blank index cards (estimate three per person)	60 – 120 minutes (depending on whether optional learning activities are included)
1.3: International framework for working on gender equality and health Learning activity 1.3a: A global view – international and organizational commitments to gender equality and health	Slides 1.18 – 1.25 Participant Notes, Introduction and subsections 1.3a and b *A brief history of gender equality, health and development efforts* *Gender mainstreaming*	30 minutes
1.3: International framework for working on gender equality and health Learning activity 1.3b: Gender, human rights and health	Slides 1.26 – 1.28 Participant Notes, subsections 1.3c and d *Gender, human rights and health* *What is the CEDAW and why is it important for gender equality and health equity?*	30 minutes
1.4: Gender is a determinant of health Learning activity 1.4: Power walk	Power walk roles, cut and prepared "in a hat" for random selection Power walk statements Questions for observers A large space (ideally in the open air) Slides 1.29–1.30 Flip chart 1.4 (Power walk characters) Participant Notes, subsections 1.4a and b *Gender and other determinants of health* *Empowerment – part 1*	60 minutes
1.5 Equality or equity? Learning activity 1.5a: Gender equality, equity and health equity	Slides 1.31 – 1.33 Participant Notes, section 1.5 *Gender equality and gender equity: Overview*	45 minutes
1.5 Gender equality, equity and health Learning activity 1.5b: Getting started on making equitable changes to health programmes	Slides 1.35 – 1.36 Participant Notes, section 1.5 *Gender equality and gender equity: Overview*	45 minutes
1.6: Conclusion of Module 1	Slide 1.36 Evaluation forms/ Progress check	15 minutes
Total estimated time for Module 1		**6 hours** (core) **7 hours** (if all optional learning activities used)

Overview and objectives

Module 1 outlines key concepts that form an important foundation for subsequent Modules. In particular, Module 1 aims to develop a common understanding among participants, to get past politically correct discussions of gender and begin to grapple with the reasons why public health professionals should address it, its links with human rights and other determinants of health.

Module 1 learning objectives:

- Understand the role of gender and gender inequality as a determinant of health.
- Be comfortable with core concepts of gender mainstreaming:
  - difference between sex and gender
  - gender mainstreaming
  - empowerment
  - difference between equality and equity.

Using **Slides 1.1 and 1.2**, or transferring their content to a flip chart, present the learning objectives and outline of Module 1.

Hang **Flip chart 1.1: Module 1 – overview and objectives** on the wall, ideally placed alongside flip chart 0.02 (Outline of workshop modules).

F ip chart 1 1

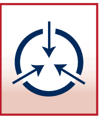
Module 1 – overview and objectives

Module 1 outlines key concepts that form an important foundation to work through subsequent modules.

By the end of this module, participants will:

- understand the role of gender and gender inequality as a determinant of health;
- be comfortable with core concepts of gender mainstreaming:
  - difference between sex and gender
  - gender mainstreaming
  - empowerment
  - difference between equality and equity.

SECTION 1.1: DOES GENDER REALLY MATTER IN HEALTH?



Learning activity 1.1: Flash card facts

Aims of the learning activity

- Trigger quick reflections on the importance of addressing gender in health based on selected global and regional data
- Introduce the distinction between sex and gender

Preparations

- Prepare "question" and "answer" flash cards using provided materials or create your own. Mark and keep them aside separately for easy identification and distribution.

Notes

- This activity works best in groups of two. If more than 20 people are participating, consider groups of four to reduce reporting back time per group.

- You may want to develop additional regional- or country-specific flash card facts. Some questions are generic, with regional- or country-specific answers. This is one way to **adapt the materials** and use comparisons with other contexts on similar issues with participants. Remember that the objective of this activity is to establish the role of gender and gender inequality in health so as to do away with lingering scepticism from participants.

- This learning activity can also be delivered via plenary discussions by placing selected flash card facts on slides or flip charts and asking participants to discuss them. This can be a good addition to existing workshops or meetings at which time for concentrated gender and health activities may be limited.

- All references used in this section can be found in the Participant Notes, section 1.1 (*For health, gender matters!*). Flash card facts references are included in the materials for Module 1.

Suggested process

Step 1:

- Distribute "questions" and "answers" randomly to participants and/or groups.
- Invite participants or groups to find their match by getting up and moving around the room.

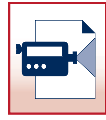
Step 2: Show **Slide 1.3** and instruct participants to discuss with their partner or group:

a) Did they know this fact before? Were they surprised by the fact?
b) How can they explain the fact?
c) What can be done in the health sector to address this fact?

Step 3: Ask participants to remain in groups to present their flash card fact to the group and provide a brief summary of their discussion. Depending on the size of the group and the overall timing, you may need to limit participants to one or two interesting points to share with the group.

Step 4: Wrap up this learning activity by asking participants what conclusions can be drawn from the flash card facts.

After the group discussion, highlight the following points using **Slide 1.4:**



- **Biological differences between men and women are not enough** to explain differences in disease patterns.
- The flash card facts show some but not all of the ways in which **life conditions, chances and norms can affect health outcomes for both women and men**. As public health workers, we need to pay attention to them.
- Non-reproductive health conditions can affect women and men differently. In other words, **health differences exist beyond sexual and reproductive health**.
- Several of the differences in health outcomes presented on the flash card facts can be either **mitigated or prevented** altogether. The workshop seeks to address both the causes of these differences and what health workers can do about them.
- The flash card facts bring us to an important conclusion: biological *and* social factors are important in health – in other words, **sex** *and* **gender matter for the health of men and women**.

Step 5: conclude with the following:

- Ask participants to keep their flash card fact in mind as they go through the modules. Facilitators should also take note of key points made during this discussion to refer to throughout the workshop – and to link future learning activities and examples back to the flash card facts.
- Refer to **Participant Notes, section 1.1** (*For health, gender matters!*) for further reading.
- **Handout 1.1** contains all flash card facts with explanatory notes. Facilitators can make copies of this for participants after the exercise if desired and draw on the explanatory notes for assistance in group discussions. If you develop your own flash card facts, you may want to prepare a similar handout.

Tips for facilitators

- This is a warm-up exercise designed to immediately engage participants with the subject matter, especially those who are sceptical about the relevance of gender to health. The aim of this learning activity is **not** to discuss technical health issues for each condition.
- Tips to keep this learning activity focused on its aims and avoid lengthy technical health discussions include the following:
  - Physicians or public health specialists may want to immediately dive into a discussion or debate on the flash card fact presented. Record discussion points on a flip chart for easy referral throughout the workshop. Encourage participants to remember their points and to raise them in later discussions.
  - Remind participants that the Modules are **not** disease-specific but designed to build skills at identifying the gender dimensions of health to improve health outcomes.
  - If facilitators know the areas of expertise of participants, they may want to choose flash card facts outside that particular area. This will allow the group to brainstorm about the gendered elements of any given disease or health problem without engaging in lengthy technical debates in this warm-up exercise.
  - Give priority to regional over country data for the flash card facts. However, if country data are available, facilitators should have these handy for reference and in case participants ask questions.

Suggested transition to next section

- The flash card facts, together with the discussion about why those facts exist, have helped to show the role that gender plays in health and why it is important to work on gender in health.
- The flash card facts also reveal that **both sex and gender matter in health. But what do these terms mean?**

Materials for learning activity 1.1 – Flash card facts

Health areas or conditions covered in available flash card facts, with indication of specific country information presented, include:

1. Indoor air pollution [27]
2. Road traffic injuries (Pakistan, Saudi Arabia) [28 – 32]
3. Access to health care services (Bangladesh, India, Indonesia, Nepal, Sri Lanka, Thailand) [33]
4. HIV (new cases) [34]
5. Smoking-cessation programmes [35,36]
6. Violence [37]
7. Lung cancer [38]
8. Life expectancy [3,8]
9. Malaria [39 – 41]
10. 2004 tsunami (India, Indonesia, Sri Lanka) [42]
11. Effects of conflicts [43,44]
12. Mental health – general (Islamic Republic of Iran) [45]
13. Blindness [46 – 48]
14. Depression (Islamic Republic of Iran, Pakistan) [49,50]
15. Male involvement in maternal and child health (Scandinavia) [51]

Flash card 1

Q: Can household responsibilities, such as food preparation, pose a risk to health?

✂ .... ✂ .... ✂ .... ✂ .... ✂ .... ✂ ....

A: Yes. The fact that women tend to be in charge of cooking in most contexts puts them at higher risk of respiratory illness than men as a result of their household responsibilities.

Fuel for life: household energy and health. Geneva, World Health Organization, 2006 (*http://www.who.int/indoorair/publications/fuelforlife/en*, accessed 23 November 2009).

Flash card 2

Q: Do more men than women die from road traffic injuries?

✂ .... ✂ .... ✂ .... ✂ .... ✂ .... ✂ ....

A: Yes. Almost three times as many men die from road traffic injuries as women. This is true especially for men younger than 25 years. In fact, a study in Pakistan found 22.4 road crashes per 1000 male population versus 6.9 per 1000 female population. In Tehran, a hospital-based study of road traffic victims found the male-to-female ratio for road crash victims was 4.2:1, while a survey of road traffic victims treated in a hospital in Saudi Arabia showed a male-to-female ratio of 9:1.

Ghaffara A, Hyderc AA, Masudb TI. The burden of road traffic injuries in developing countries: the 1st national injury survey of Pakistan. *Journal of the Royal Institute of Public Health*, 2004, 118:211–217.

Moutaery KA, Akhdar F. Implications of road accidents in Saudi Arabia. *Pan Arab Journal of Neurosurgery*, 1998, 2:2 (*http://www.panarabneurosurgery.org.sa/journal/oct1998/ImplicationOfRoadAccidents.htm*, accessed 23 November 2009).

Roudsari BS, Sharzei K, Zargar M. Sex and age distribution in transport-related injuries in Tehran. *Accident Analysis and Prevention*, 2004, 36:391–398.

Toroyan T, Peden M, eds. *Youth and road safety*. Geneva, World Health Organization, 2007 (*http://www.who.int/violence_injury_prevention/publications/road_traffic/youth_roadsafety/en*, accessed 23 November 2009).

Gender and road traffic injuries. Geneva, World Health Organization, 2002 (*http://www.who.int/gender/other_health/en*, accessed 23 November 2009).

Flash card 3

Q: Do boys and girls have the same access to high-quality health care?

✂ .... ✂ .... ✂ .... ✂ .... ✂ .... ✂ ....

A: Not always. Boys and girls do not always have the same access to high-quality health care. For example, surveys conducted in Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand found that, even when girls were vaccinated at comparable rates to boys, they were often not taken to a health provider or care facility for illness episodes.

Women of South-East Asia: a health profile. Delhi, WHO Regional Office for South-East Asia, 2000 (*http://www.searo.who.int/en/Section13/Section390/Section1376_5513.htm*, accessed 23 November 2009).

Flash card 4

Q: Are women and men equally represented among new cases of HIV?

✂ .... ✂ .... ✂ .... ✂ .... ✂ .... ✂ ....

A: No. HIV trends over the past decade have shown significant increases in the numbers of women living with HIV. Globally, the percentage of women among people living with HIV has remained stable at 50% for several years. However, women's share of infections is increasing in several countries.

2008 AIDS epidemic update. Geneva, Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization, 2008 (*http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/Epi/UpdArchive/2007/default.asp*, accessed 23 November 2009).

Flash card 5

Q: Do smoking-cessation programmes have the same effects on men and women?

✂ .... ✂ .... ✂ .... ✂ .... ✂ .... ✂ ....

A: No. While smoking rates among men tend to be 10 times higher than among women, the rapid rise in tobacco use among younger females in low- and medium-income countries is a worrying trend. Women generally have fewer successful smoking-cessation attempts and more relapses than men, and nicotine replacement therapy may be less effective among women.

WHO report on the global tobacco epidemic 2008: the MPower package. Geneva, World Health Organization, 2008 (*http://www.who.int/tobacco/mpower/en*, accessed 23 November 2009).

Sifting the evidence: gender and tobacco control policy. Geneva, World Health Organization, 2007 (*http://www.who.int/tobacco/mpower/en*, accessed 23 November 2009).

Flash card 6

Q: Do men and women experience violence in the same places, by the same types of perpetrators?

✂ .... ✂ .... ✂ .... ✂ .... ✂ .... ✂ ....

A: No. Women experience physical, sexual and psychological violence in their homes, often from intimate partners, in conflict settings and in communities, often by people they know. Sometimes they die from these situations; sometimes they remain in unsafe settings. Men who experience violence, in contrast, often experience violence at the hands of strangers and tend to die as a result of homicide by unknown perpetrators.

García-Moreno C et al. *WHO Multi-country Study on Women's Health and Domestic Violence against Women: initial results on prevalence, health outcomes and women's responses*. Geneva, World Health Organization, 2005 (*http://www.who.int/gender/violence/who_multicounty_study/en*, accessed 23 November 2009).

Flash card 7

Q: Do males and females differ in mortality related to lung cancer?

✂ .... ✂ .... ✂ .... ✂ .... ✂ .... ✂ ....

A: Yes. More men than women die of lung cancer. GLOBOCAN 2000 data reveal gender differences in lung cancer incidence, prevalence and mortality, with about 10 female deaths and 31 male deaths per 100 000 population being attributed to lung cancer, more than a threefold difference!

Payne S. *Gender in lung cancer and smoking research*. Gender and Health Research Series. Geneva, World Health Organization, 2005 (*http://www.who.int/gender/documents/LungCancerlast2.pdf*, accessed 23 November 2009).

Flash card 8

Q: Do women generally live longer than men?

✂ .... ✂ .... ✂ .... ✂ .... ✂ .... ✂ ....

A: Yes. In most countries women do live longer than men but have higher levels of disability or illness.

Sen G, George A, Östlin P. *Unequal, unfair, ineffective and inefficient: gender inequity in health. Why it exists and how we can change it. Final report to the WHO Commission on Social Determinants of Health*. Geneva, World Health Organization, 2007 (*http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf*, accessed 23 November 2009).

Gender, health and ageing. Geneva, World Health Organization, 2003 (*http://www.who.int/gender/documents/en/Gender_Aging.pdf*, accessed 23 November 2009).

Flash card 9

Q : Are adult women and men equally vulnerable to malaria infection?

✂ .... ✂ .... ✂ .... ✂ .... ✂ .... ✂ ....

A: Mostly. Available evidence suggests that, if adult men and women were equally exposed, they would be equally vulnerable to infection. An exception to the rule is pregnant women, who are at greater risk of severe malaria in most endemic areas. Of the 247 million cases of malaria reported in 2006, the majority are among children in Africa.
In general, high-risk groups include infants and young children (from six months to five years of age), pregnant women, non-immune people (such as travellers, labourers and populations moving from low-transmission to high-transmission areas) and people living with HIV.

Tolhurst R, Nyonator FK. Looking within the household: gender roles and responses to malaria in Ghana. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 2006, 100: 321–326.

World malaria report 2008. Geneva, World Health Organization, 2008 (*http://apps.who.int/malaria/wmr2008*, accessed 23 November 2009).

Gender, health and malaria. Geneva, World Health Organization, 2007 (*http://www.rollbackmalaria.org/globaladvocacy/docs/WHOinfosheet.pdf*, accessed 23 November 2009).

Flash card 10

Q: Did the 2004 tsunami affect men and women in the same way?

✂ ✂ ✂ ✂ ✂ ✂

A: No. A review of deaths from the 2004 tsunami in locations in India, Indonesia and Sri Lanka showed that many more women than men died as a direct result of the tsunami.

The tsunami's impact on women. London, Oxfam, 2005 (*http://www.oxfam.org.uk/resources/policy/conflict_disasters/downloads/bn_tsunami_women.pdf*, accessed 23 November 2009).

Flash card 11

Q: Do armed conflicts affect men and women in similar ways?

✂ ✂ ✂ ✂ ✂ ✂

A: No. Although men and boys are often more likely than women to be recruited into or to join armed forces – exposing them to the possible risks to health this role brings – civilian women and girls also bear the brunt of conflicts today. Women and girls may be combatants or associated with fighting forces, and the impact on their well-being may differ from that of their male counterparts depending on their roles. Further, women and girls are more likely than men and boys to experience sexual violence in conflicts, which has additional implications for their physical and mental health and social well-being.

Shoemaker J. Women and wars within states: internal conflict, women's rights and international security. *Civil Wars*, 2001, 4(3):1–34.

García Moreno C, Reis C. Overview on women's health in crises, *Health in Emergencies*, 2004, 20:2 (*http://www.who.int/hac/network/newsletter/Final_HiE_n20_%20Jan_2005_finalpdf.pdf*, accessed 23 November 2009).

Flash card 12

Q: Do natural emergencies affect the mental health of population groups in the same way?

✂ ✂ ✂ ✂ ✂ ✂

A: No. A population-based study of survivors of the Bam (Islamic Republic of Iran) earthquake found that those suffering from the most severe mental distress were older, less educated, divorced, widowed and unemployed groups - especially women in these groups.

Montazeri A et al. Psychological distress among Bam earthquake survivors in Iran: a population-based study. *BMC Public Health*, 2005, 5(4) (*http://www.biomedcentral.com/content/pdf/1471-2458-5-4.pdf*, accessed 23 November 2009).

Flash card 13

Q: Does blindness prevalence differ between men and women?

✂ ✂ ✂ ✂ ✂ ✂

A: Yes. Trachoma infection rates are higher among girls and women, as are repeat infections that can lead to blindness. Available studies indicate that females have a significantly higher risk of being visually impaired than males in every region of the world and at all ages. Nevertheless, women often do not have equal access to surgery for eye diseases due to inability to travel to a surgical facility unaccompanied, differences in the perceived value of surgery for women and lack of access to health information.

Fuad D, Mousa A, Courtright P. Sociodemographic characteristics associated with blindness in a Nile Delta governorate of Egypt. *British Journal of Ophthalmology*, 2003, 88:614–618.

Khandekar R et al. The prevalence and causes of blindness in the Sultanate of Oman: the Oman Eye Study (OES). *British Journal of Ophthalmology*, 2002, 86:957–962.

Preventing chronic diseases: a vital investment. WHO global report. Geneva, World Health Organization, 2005 (*http://www.who.int/chp/chronic_disease_report/en*, accessed 23 November 2009).

Flash card 14

Q: Do men and women differ in the prevalence of depression?

✂ ✂ ✂ ✂ ✂ ✂

A: Yes. In the Islamic Republic of Iran, the prevalence of mental disorders was 1.7 times higher among women than among men: 29% versus 15%. A population-based study in Rawalpindi, Pakistan estimated that 24% of women and 10% of men had depressive disorders.

Noorbala AA et al. Mental health survey of the adult population in Iran. *British Journal of Psychiatry*, 2004, 184:70–73.

Mumford DB et al. Stress and psychiatric disorder in urban Rawalpindi community. *British Journal of Psychiatry*, 2000, 177:557–562.

Flash card 15

Q: Does male involvement influence maternal and child health outcomes?

✂ ✂ ✂ ✂ ✂ ✂

A: Yes. Male involvement improves physical and psychosocial maternal and child health outcomes. It also leads to positive social outcomes for men themselves. Studies in Scandinavia have shown that men's involvement in maternal and child health programmes can reduce maternal and child morbidity and mortality, such as:

- fewer low-birth-weight infants in low-income families
- improved cognitive outcomes for preterm and low-birth-weight babies
- shortened labour time and rate of epidural use
- obstetric emergencies may be alleviated.

Fatherhood and health outcomes in Europe. Copenhagen, WHO Regional Office for Europe, 2007 (*http://www.euro.who.int/GEM/publications/20070506_10*, accessed 23 November 2009).

Handout 1.1 – Flash card facts

Below are the flash card facts discussed in Module 1; some explanatory factors have been included. Keep these handy with you throughout the workshop – and compare with your own discussions.

Flash card 1

Q: Can household responsibilities, such as food preparation, pose a risk to health?

A: Yes. The fact that women tend to be in charge of cooking in most contexts puts them at higher risk of respiratory illness than men as a result of their household responsibilities.

Why?

Acrid smoke deposits are responsible for 511 000 of the 1.3 million deaths due to chronic obstructive pulmonary disease (COPD) among women worldwide per year versus 173 000 of the total of 1.4 million deaths from COPD among men. Inefficient household energy practices may significantly affect the health of pregnant women such as pelvic organ prolapse during pregnancy due to heavy loads carried during fuel collection and low birth weight – even stillbirth – as a result of exposure of the developing embryo to harmful pollutants.

Fuel for life: household energy and health. Geneva, World Health Organization, 2006 (*http://www.who.int/indoorair/publications/fuelforlife/en*, accessed 23 November 2009).

Flash card 2

Q: Do more men than women die from road traffic injuries?

A: Yes. Almost three times as many men die from road traffic injuries as women. This is true especially for men younger than 25 years. In fact, a study in Pakistan found 22.4 road crashes per 1000 male population versus 6.9 per 1000 female population. In Tehran, a hospital-based study of road traffic victims found the male-to-female ratio for road crash victims was 4.2:1, while a survey of road traffic victims treated in a hospital in Saudi Arabia showed a male-to-female ratio of 9:1.

Why?

Higher risk from road traffic injuries and fatality is associated to a significant extent with greater exposure to driving, in addition to patterns of high-risk behaviour among men when driving. Gender role socialization and the association of masculinity with risk-taking behaviour and a disregard of pain and injury may be factors leading to hazardous actions by men. Men may spend substantially more time in moving vehicles than women and may be more likely to own cars than women in some contexts. Men are also more likely to be employed as drivers and mechanics.

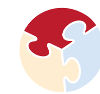
Ghaffara A, Hyderc AA, Masudb TI. The burden of road traffic injuries in developing countries: the 1st national injury survey of Pakistan. *Journal of the Royal Institute of Public Health*, 2004, 118: 211–217.

Moutaery KA, Akhdar F. Implications of road accidents in Saudi Arabia. *Pan Arab Journal of Neurosurgery*, 1998, 2:2 (*http://www.panarabneurosurgery.org.sa/journal/oct1998/ImplicationOfRoadAccidents.htm*, accessed 23 November 2009).

Roudsari BS, Sharzei K, Zargar M. Sex and age distribution in transport-related injuries in Tehran. *Accident Analysis and Prevention*, 2004, 36:391–398.

Toroyan T, Peden M, eds. *Youth and road safety*. Geneva, World Health Organization, 2007 (*http://www.who.int/violence_injury_prevention/publications/road_traffic/youth_roadsafety/en*, accessed 23 November 2009).

Gender and road traffic injuries. Geneva, World Health Organization, 2002 (*http://www.who.int/gender/other_health/en*, accessed 23 November 2009).



Flash card 3

Q: Do boys and girls have the same access to high-quality health care?

A: Not always. Boys and girls do not always have the same access to high-quality health care. For example, surveys conducted in Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand found that, even when girls were vaccinated at comparable rates to boys, they were often not taken to a health provider or care facility for illness episodes.

Why?

While there may be varied explanations across contexts, especially in low-income contexts, social norms such as son preference and lower social status for girls often affect the prioritization of their health.

Women of South-East Asia: a health profile. Delhi, WHO Regional Office for South-East Asia, 2000 (*http://www.searo.who.int/en/Section13/Section390/Section1376_5513.htm*, accessed 23 November 2009).

Flash card 4

Q: Are women and men equally represented among new cases of HIV?

A: No. HIV trends over the past decade have shown significant increases in the numbers of women living with HIV. Globally, the percentage of women among people living with HIV has remained stable at 50% for several years. However, women's share of infections is increasing in several countries.

Why?

While the numbers of men living with HIV continue to be of international concern, women are more susceptible to infection during heterosexual intercourse due to a greater area of mucous membrane exposed during sex. In many cases worldwide, men are allowed multiple partners, which increases infection among spouses. Further, violence and gender inequality create a greater vulnerability to infection.

2008 AIDS epidemic update. Geneva, Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization, 2008 (*http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/Epi/UpdArchive/2007/default.asp*, accessed 23 November 2009).

Flash card 5

Q: Do smoking-cessation programmes have the same effects on men and women?

A: No. While smoking rates among men tend to be 10 times higher than among women, the rapid rise in tobacco use among younger females in low- and medium-income countries is a worrying trend. Women generally have fewer successful smoking-cessation attempts and more relapses than men, and nicotine replacement therapy may be less effective among women.

Why?

Current evidence is inconclusive as to why smoking-cessation interventions appear to be less effective among women. However, some explanatory factors include:

- sex differences in the metabolism of nicotine;
- decreased confidence among women to quit smoking; and
- psychosocial stressors such as single parenting, concerns about body image, low levels of education, caring burdens and poverty.

WHO report on the global tobacco epidemic 2008: the MPower package. Geneva, World Health Organization, 2008 (*http://www.who.int/tobacco/mpower/en*, accessed 23 November 2009).

Sifting the evidence: gender and tobacco control policy. Geneva, World Health Organization, 2007 (*http://www.who.int/tobacco/mpower/en*, accessed 23 November 2009).

Flash card 6

Q: Do men and women experience violence in the same places and by the same types of perpetrators?

A: No. Women experience physical, sexual and psychological violence in their homes, often from intimate partners, in conflict settings and in communities, often by people they know. Sometimes they die from these situations; sometimes they remain in unsafe settings. Men who experience violence, in contrast, often experience violence at the hands of strangers and tend to die as a result of homicide by unknown perpetrators.

Why?

Normalized, unequal gender relations between women and men and an accepted lower social status of women contribute to the numerous cases of interpersonal violence experienced by women. Gender norms that normalize male violence – towards women or other men – further serve to encourage male violence as an accepted problem-solving technique and exercise of control over others.

García-Moreno C et al. *WHO Multi-country Study on Women's Health and Domestic Violence against Women: initial results on prevalence, health outcomes and women's responses*. Geneva, World Health Organization, 2005 (*http://www.who.int/gender/violence/who_multicounty_study/en*, accessed 23 November 2009).

Flash card 7

Q: Do males and females differ in mortality related to lung cancer?

A: Yes. More men than women die of lung cancer. GLOBOCAN 2000 data reveal gender differences in lung cancer incidence, prevalence and mortality, with about 10 female deaths and 31 male deaths per 100 000 population being attributed to lung cancer, more than a threefold difference!

Why?

For many years the marketing of tobacco was aimed at men, and lung cancer was predominantly a male disease. Smoking in several cultures is seen as a rite of passage for young men and has historically been male centred. As smoking habits have changed over time, the disparity between men and women is smaller than in the first half of the 20th century.

Payne S. *Gender in lung cancer and smoking research*. Gender and Health Research Series. Geneva, World Health Organization, 2005 (*http://www.who.int/gender/documents/LungCancerlast2.pdf*, accessed 23 November 2009).

Flash card 8

Q: Do women generally live longer than men?

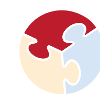
A: Yes. In most countries women do live longer than men but have higher levels of disability or illness.

Why?

There is no clear answer as to why *men die quicker but women get sicker*. Men's shorter life spans may be due to increased exposure to certain risk factors such as tobacco or alcohol use, road crashes, homicide, suicide or cardiovascular disease. Hormonal differences have also been postulated as a protective factor among women.

Sen G, George A, Östlin P. Unequal, unfair, ineffective and inefficient: gender inequity in health. Why it exists and how we can change it. Final report to the WHO Commission on Social Determinants of Health. Geneva, World Health Organization, 2007 (http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf, accessed 23 November 2009).

Gender, health and ageing. Geneva, World Health Organization, 2003 (*http://www.who.int/gender/documents/en/Gender_Aging.pdf*, accessed 23 November 2009).



Flash card 9

Q: Are adult women and men equally vulnerable to malaria infection?

A: Mostly. Available evidence suggests that, if adult men and women were equally exposed, they would be equally vulnerable to infection. An exception to the rule is pregnant women, who are at greater risk of severe malaria in most endemic areas.

Of the 247 million cases of malaria reported in 2006, the majority are among children in Africa. In general, high-risk groups include infants and young children (from six months to five years of age), pregnant women, non-immune people (such as travellers, labourers and populations moving from low-transmission to high-transmission areas) and people living with HIV.

Why?

In some settings, men are at a greater risk of contracting malaria than women if they work in mines, fields or forests at peak biting times or migrate to endemic areas for employment purposes. Women who often do household chores before dawn may be exposed to mosquitoes in early hours. In other societies, the activities of men and women during peak biting times may result in equal risks of infection. A study in Myanmar on activities that enhance human–vector contact revealed that the ways that women and men spend their time during peak biting periods – both for leisure and for work – placed them at equal risk of contracting malaria through exposure to mosquitoes.

Tolhurst R, Nyonator FK. Looking within the household: gender roles and responses to malaria in Ghana. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 2006, 100: 321–326.

World malaria report 2008. Geneva, World Health Organization, 2008 (*http://apps.who.int/malaria/wmr2008*, accessed 23 November 2009).

Gender, health and malaria. Geneva, World Health Organization, 2007 (*http://www.rollbackmalaria.org/globaladvocacy/docs/WHOinfosheet.pdf*, accessed 23 November 2009).

Flash card 10

Q: Did the 2004 tsunami affect men and women in the same way?

A: No. A review of deaths from the 2004 tsunami in locations in India, Indonesia and Sri Lanka showed that many more women than men died as a direct result of the tsunami.

Why?

The different societal roles of and norms relating to women and men determined their response and ability to survive. In some communities, men had learned to swim and to climb trees, whereas women had not, so when the tsunami struck, men were able to climb above the water or stay afloat. More men swept up by the tsunami were probably able to survive than women and children because they had the strength to hold on to something stable or stay afloat in the powerful waves. More women, as primary caretakers of children, focused on saving their children and were unable to save their own lives as a result.

The tsunami's impact on women. London, Oxfam, 2005 (*http://www.oxfam.org.uk/resources/policy/conflict_disasters/downloads/bn_tsunami_women.pdf*, accessed 23 November 2009).

Flash card 11

Q: Do armed conflicts affect men and women in similar ways?

A: No. Although men and boys are often more likely than women to be recruited into or to join armed forces – exposing them to the possible risks to health this role brings – civilian women and girls often bear the brunt of conflicts today. Women and girls may be combatants or associated with fighting forces, and the impact on their well-being may differ from that of their male counterparts depending on their roles. Further, women and girls are more likely than men and boys to experience sexual violence in conflicts, which has additional implications for their physical and mental health and social well-being.

Why?
Of the millions of people displaced by armed conflict worldwide, at least 65% are estimated to be women and girls, who face daily deprivation and insecurity. Many face the threat of violence, including sexual violence, when they engage in daily tasks such as fetching water or gathering firewood. They lack access to health services that address the physical and mental consequences of conflict and displacement and may die in childbirth because basic reproductive health services are often not available. Violence against women – including sexual violence – is increasingly documented, particularly in crises associated with armed conflict. In these circumstances, women submit to sexual abuse by gate-keepers in order to obtain food and other basic life necessities. Rape is used to brutalize and humiliate civilians, as a weapon of war and political power and as a tactic in campaigns of ethnic cleansing. The violence and the inequality that women also face in crises do not exist in a vacuum. They are the direct result and reflection of the violence, discrimination and marginalization women face in times of relative peace.

Shoemaker J. Women and wars within states: internal conflict, women's rights and international security. *Civil Wars*, 2001, 4(3):1–34.

García Moreno C, Reis C. Overview on women's health in crises, *Health in Emergencies*, 2004, 20:2 (*http://www.who.int/hac/network/newsletter/Final_HiE_n20_%20Jan_2005_finalpdf.pdf*, accessed 23 November 2009).

Flash card 12

Q: Do natural emergencies affect the mental health of population groups in the same way?

A: No. A population-based study of survivors of the Bam (Islamic Republic of Iran) earthquake found that those suffering from the most severe mental distress were older, less educated, divorced, widowed and unemployed groups – especially women in these groups.

Why?
Women's particular vulnerability to depression after emergencies may be due to their responsibilities for caring for children, sick people, older people and injured family members, with severe shortages of resources and support. Their vulnerability increases with the loss of male family support due to death, disruption of the social structure and other conflict factors.

Montazeri A et al. Psychological distress among Bam earthquake survivors in Iran: a population-based study. *BMC Public Health*, 2005, 5(4) (*http://www.biomedcentral.com/content/pdf/1471-2458-5-4.pdf*, accessed 23 November 2009).

Flash card 13

Q: Does blindness prevalence differ between men and women?

A: Yes. Trachoma infection rates are higher among girls and women, as are repeat infections that can lead to blindness. Available studies indicate that females have a significantly higher risk of being visually impaired than males in every region of the world and at all ages. Nevertheless, women often do not have equal access to surgery for eye diseases due to inability to travel to a surgical facility unaccompanied, differences in the perceived value of surgery for women and lack of access to health information.

Why?
As primary caregivers, young girls and mothers are more exposed to the infectious agent present in the eye secretions of infants. Delays in access and utilization of blindness prevention services are attributed to several gender variables such as lack of disposable income, gender inequality in decision-making and lack of priority given to their health concerns.

Fuad D, Mousa A, Courtright P. Sociodemographic characteristics associated with blindness in a Nile Delta governorate of Egypt. *British Journal of Ophthalmology*, 2003, 88:614–618.

Khandekar R et al. The prevalence and causes of blindness in the Sultanate of Oman: the Oman Eye Study (OES). *British Journal of Ophthalmology*, 2002, 86:957–962.

Preventing chronic diseases: a vital investment. WHO global report. Geneva, World Health Organization, 2005 (*http://www.who.int/chp/chronic_disease_report/en*, accessed 23 November 2009).

Flash card 14

Q: Do men and women differ in the prevalence of depression?

A: Yes. In the Islamic Republic of Iran, the prevalence of mental disorders was 1.7 times higher among women than among men: 29% versus 15%. A population-based study in Rawalpindi, Pakistan estimated that 24% of women and 10% of men had depressive disorders.

Why?

Biological factors may contribute to the higher prevalence of depressive disorders among women. However, studies in the WHO Eastern Mediterranean Region have found that social factors, such as physical abuse by a spouse, illiteracy, financial insecurity, lack of access to family planning and lack of autonomy also contribute significantly to vulnerability to depressive disorders, and these social factors tend to be more common among women.

Noorbala AA et al. Mental health survey of the adult population in Iran. *British Journal of Psychiatry*, 2004, 184:70–73.

Mumford DB et al. Stress and psychiatric disorder in urban Rawalpindi community. *British Journal of Psychiatry*, 2000, 177:557–562.

Flash card 15

Q: Does male involvement influence maternal and child health outcomes?

A: Yes. Male involvement improves physical and psychosocial maternal and child health outcomes. It also leads to positive social outcomes for men themselves. Studies in Scandinavia have shown that men's involvement in maternal and child health programmes can reduce maternal and child morbidity and mortality, such as:

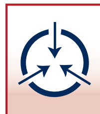
- fewer low-birth-weight infants in low-income families
- improved cognitive outcomes for preterm and low-birth-weight babies
- shortened labour time and rate of epidural use
- obstetric emergencies may be alleviated.

Why?

Although current literature is limited to Europe, data indicate that the relationship between men's various roles as husbands or partners, fathers and breadwinners influence their health and behaviour. Fathers who are equally involved in all aspects of domestic life – including their children's lives – are more likely to engage in less risky behaviour and demonstrate better health outcomes. The psychosocial support offered to female partners during pregnancy and childbirth has also been shown to decrease pain and stress levels – leading to better overall maternal health outcomes.

Fatherhood and health outcomes in Europe. Copenhagen, WHO Regional Office for Europe, 2007 (*http://www.euro.who.int/GEM/publications/20070506_10*, accessed 23 November 2009).

SECTION 1.2: SEX AND GENDER ARE NOT THE SAME



Learning activity 1.2a: Sex and gender – what is the difference?

Aims of the learning activity

- Describe the difference between sex and gender
- Understand why the distinction between sex and gender is important in public health work

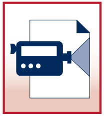
Notes

- This learning activity flows directly from the flash card facts. If the flash card fact discussions have made apparent the distinction between sex and gender, facilitators can skip through the slides in this learning activity, simply referring participants to the additional reading and relevant slides for their reference.

- Facilitators may also simply use **Slide 1.6** as an overview and quiz on the different uses of sex and gender. Again, this depends on the level of participant understanding and the extent of preceding discussions that clarify these concepts.

- Refer to the **Participant Notes, section 1.2** (*Summary points on sex, gender and health*) for both background reading and related references used in this section.

- See Annex 2 for **optional learning activity 2.0** for use as necessary.



Suggested process

Step 1: based on the flash card facts, ask participants to distinguish sex from gender. After a few call-outs, reveal **Slide 1.5** and ask participants for one or two examples of the distinction to ensure group understanding.

- **Note**: facilitators may want to recall the explanatory notes for the flash card facts on road traffic injuries and blindness (if used) to further explain the examples provided in the last bullet point of the slide.

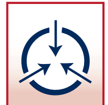
Make use of the suggested talking points as necessary:
- **Sex and gender are not the same**, but they cannot be discussed independently of one another. In other words, you cannot talk about gender without talking about sex. For example:
  - The fact that women can bear children refers to sex. But the fact that most women spend more time than men caring for children refers to gender. (**Note**: this example refers mostly to two-parent, heterosexual households and the internal division of child care responsibilities. Facilitators may need to adapt this example depending on the context of implementation.) In this example, the fact that women spend more time caring for very young children may seem a "natural" outcome of the biological fact that women, and not men, give birth and can breastfeed. But nurturing roles are not "natural", as both women and men can have nurturing and affectionate qualities through processes of socialization. In other words, women do not have a biological predisposition towards caring.
  - Following from the above example, **both categories are always relevant**.
- Mention that people of **indeterminate sex** at birth function under gender norms, roles and relations that are more complex than those of other people.

Step 2: introduce and show **Slide 1.6** by asking participants how they have seen the word gender used (and confused) with sex. Add additional examples on a flip chart if necessary.
- In the form of a group call-out, ask the group to indicate which statements on Slide 1.6 should be "sex" and which should be "gender". See slide notes for additional tips on answers as necessary. (Note: the slide is animated to reveal the answers upon clicking.)
  - Emphasize that gender is often used as a politically correct way of saying sex and the two are sometimes used interchangeably. However, in the health sector, the distinction must be clear, as we cannot ignore biology any more than we can ignore the sociocultural factors that influence health.

Step 3: summarize by referring to **Participant Notes, section 1.2** (*Summary points on sex, gender and health*) and state that:
- **Sex** refers to the things that most people agree are the result of biological differences. It is usually **difficult to change** – unless through surgical intervention.
- **Gender** refers to the things that might reasonably vary from society to society, depending on that society's notion of masculine and feminine norms. It **can be changed but requires long-term strategies**.
- Both sex and gender have implications for health outcomes – and the flash card facts give us a taste of how those implications may play out in real life.

Suggested transition to next section

Now that we understand the differences between sex and gender, how do we learn the "rules" of gender?
To understand this, let us unpack the concept of gender to understand how we learn to be men or women.



Learning activity 1.2b: Unpacking gender

Aims of the learning activity

- Understand social processes that shape and construct gender norms, roles and relations.
- Make initial connections between gender norms, roles and relations and health.

Notes

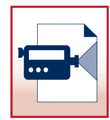
- This learning activity sets the foundation for Modules 2 and 3. Listing activities can referred to in Module 2 to show participants how gender norms, roles and relations influence health behaviour or outcomes. This means that facilitators need to take time between Modules 1 and 2 to go over the examples provided in Module 1 and ensure links are made to the discussions planned for Module 2. Both Modules provide tips to do so.

- Co-facilitators should ensure that approximately three blank index cards per participant and markers are distributed for use throughout this activity. In preparation for this activity, ensure space on a wall in the room marked with three headings: gender norms, gender roles and gender relations. Participant-filled index cards will be taped under each one during the exercise to help stimulate the discussion. If time is a concern, the listing activities can be done as a group call out with facilitators recording examples on flip charts for discussion.

- See Annex 1 for **optional learning activities 1.2a and b**.

Suggested process

Step 1: explain the concepts outlined in **Slides 1.7 and 1.8**, using the following talking points as needed (these points are included on the slides themselves for ease of reference).



Slide 1.7: Gender is …

The concept of gender has five basic elements. Gender is:
- about women and men (relational);
- often privileging male power or characteristics – or those of a particular group in society (hierarchical);
- based on historical traditions and practices that evolve and change (historical);
- not only about women and men but about the multiple identities women and men have (age, ethnicity, sexual orientation, etc.) and different in all contexts due cultural traditions and practices (contextually specific); and
- an influential factor in society and can perpetuate gender-related beliefs through infrastructure such as laws, religion, policies, etc (institutionally structured).

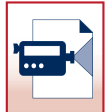
Slide 1.8: Gender is socially constructed
- Gender draws its meaning from the broader sociocultural, economic and political context.
- Highlight that **the socialization process** is important because the things we learn from our environments (social, physical and otherwise) from very young ages are an important source of gender learning. In other words, boys and girls learn about acceptable and unacceptable gender norms, roles and relations through the socialization process.
- Referring to the figure on **Slide 1.8** (note that the figure can also be reproduced on a flip chart for easy reference throughout Modules 1 and 2), explain that the following slides will address each of these terms. The figure shows the overall process of unpacking gender – by demonstrating that socialization is a key trigger for the learning and establishment of gender norms, roles and relations, all of which are closely linked, influencing one another. These can be understood as **components of gender** and can lead to stereotypes and result in social patterns such as the gender-based division of labour. These Modules address all three components of gender.
- Remind participants that these processes are not linear, and changes in the gender-based division of labour can provoke changes in gender roles. For example, the changing role of women in the paid workforce has contributed to changes in norms and domestic roles for women and men in many contexts.

Step 2a: using **Slides 1.9 – 1.10** on **gender norms**, ensure that the following is understood:
- Laws or regulations do not always *explicitly* prescribe **gender norms** in stating how men and women are supposed to be - or beliefs about men and women. But they can be **upheld by rules (or laws)** – for example, laws that set out inheritance rights based on father-to-son lineage or based on the norm that men are heads of household uphold gender norms that contribute to women's lower status. This refers back to one of the five elements of gender: in particular, that gender is institutionally structured.
- Gender norms are passed from generation to generation through the process of socialization.
- **Gender norms change over time and look different in different cultures and populations** due to development, globalization, legislation and other sociocultural, economic and political structures.
  – Religious or cultural traditions often contribute to defining expected behaviour of males and females.
  – Many men and women consider these traditions - or the gender norms based on them - to be the "natural order of things".
  – Resistance to addressing gender may occur if these factors are not considered and the right actors involved appropriately. Addressing gender requires cultural sensitivity and a diversity of approaches to counter traditional beliefs or practices that may be harmful to health. This is why any modification to these norms may be **contested if not addressed properly and requires short-, medium- and long-term strategies**.

Step 2b: activity for listing gender norms

- Ask participants to write down or call out an example of a gender norm from their contexts. Do not allow more than five minutes for reflection before you or the co-facilitator collects the index cards. The time limit is suggested so that initial reactions are captured.

- **Some of the examples may actually be gender roles**. Co-facilitators should identify these and, if any found, set them aside for the following activity.
- Read out one or two examples and refer back to how the example reflects the definition of a gender norm on Slide 1.9 and how it may relate to traditions or something perceived to be natural by or for women or men (Slide 1.10).
- While the co-facilitator hangs the index cards on the wall (under the heading "gender norms" in accordance with the earlier explanation), explain to the group that these gender norms will remain on the wall for the rest of the workshop and that they will be revisited in Module 2 to uncover how these norms can influence health outcomes. Ask them to begin thinking about how gender norms can influence health to contribute to Module 2 discussions.
- Conclude the discussion by showing **Slide 1.11**, reminding participants that the point of the discussion is **not to pass judgement on existing gender norms – or the cultures and traditions from which they may arise**. Instead, the exercise is designed to get us thinking about how norms may affect health – and whether this is harmful or not.
  – One way of doing so is to recall that gender norms that lead to the **mistreatment of one group or sex over the other, or a difference in power and opportunities, can lead to inequality**.
  – **Inequality influences health** – the norms listed will be **revisited in Module 2 in learning how to perform gender analysis of a health problem**.



Step 3a: introduce the concept of **gender roles** with the help of **Slide 1.12**.
Emphasize the following:

- Gender roles are closely related to gender norms.
- The distinction is that gender roles refer to **what women and men can and should do – and what they are responsible for in households, communities and the workplace**.
- Like gender norms, **broader sociocultural, economic and political factors shape gender roles, which can change over time**.
- Refer to one of the norms from the previous activity – making a connection with how gender norms can lead to expected gender roles for women or men.

Step 3b: activity for listing gender roles

- As with gender norms, ask participants to write down or call out an example of a gender role from their contexts. Follow the same process as suggested for gender norms, refer to Slide 1.12 and hang the index cards under the heading "gender roles".

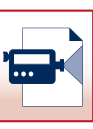
Step 4a: showing **Slide 1.13**, introduce the concept of **gender relations**.
Emphasize the following:

- Gender norms and roles contribute to the establishment of gender relations.
- Gender relations are about the **social relations between and among women and men**. In other words, they set out how women and men should interact with each other – and among themselves.
- They **can determine hierarchies between groups of men or women based on gender norms and roles** – for example, in many households, older men are often those with decision-making authority, and other women and men in the household therefore interact with older men in different ways.
- Sometimes, gender relations – or the unwritten rules about how women and men interact – can **contribute to unequal power relations**.
- Some examples of gender relations are seen in the workplace – which is discussed later in this section.

Step 4b: activity for listing gender relations

- As with the discussion on gender norms and roles, ask participants to write down or call out an example of gender relations from their contexts. Follow the same process as suggested for gender norms, refer to Slide 1.13 and hang the index cards under the heading "gender relations".

- Summarize the discussion on gender norms, roles and relations by showing **Slide 1.14**. Conclude by emphasizing the following:
  – **Gender norms, roles and relations affect everyone** – both women and men, regardless of level of education or culture. But they affect groups of women and men differently.
  – **It is important to look at all three components of gender to better understand sociocultural patterns that can influence women and men's lives**.
    ▪ Looking only at gender norms can *limit analysis to beliefs* but may not look at how such beliefs have different implications for roles – or where and what women and men are doing that may increase their health risks and vulnerabilities.
    ▪ Some focus simply on an analysis of gender roles, that often pits women against men – which, as shown later on in the Modules, is not the objective of a gender analysis. *Analysis of roles alone can also lead to overemphasizing activities that women and men perform but with less attention to the relations between them or the values placed upon them*.
  – Gender norms, roles and relations **can increase exposure to risk factors or vulnerability to certain health conditions through stereotypes, discrimination and the gender-based division of labour**.
  – Use **optional learning activity 1.2a** as necessary.



Step 5: showing **Slide 1.15**, introduce the concept of **gender stereotypes**. Emphasize the following:
- Gender norms, roles and relations can lead to gender stereotypes.
- Stereotypes often lead to discrimination – which has important impacts on health.
- Solicit examples from the group of gender stereotypes and how these may affect health. Note how these examples refer back to the norms, roles and relations discussed in the previous activities – adding that the health effects may not seem obvious. Examples include the following:
  – Women are responsible for child care due to their biological roles. As a result, men are often excluded from prenatal and antenatal care, counselling and services.
  – Men are often assumed to be perpetrators of violence. As a result, they are often excluded in interventions dealing with reducing interpersonal violence.
- Conclude by stating that **gender stereotypes are usually negative** – as they are **based on assumptions about a group according to predetermined roles and norms**. They should be understood as assumptions and not truth.

Step 6: using **Slide 1.16**, briefly discuss the **gender-based division of labour** using the following talking points as necessary:
- Concretely, this term means that gender norms, roles, relations – and sometimes stereotypes –help to determine the fields in which women and men work.
- Clarify that "gender-based division of labour" refers to **formal market and informal labour activities**. This means it refers to jobs **outside the home and the tasks men and women perform in the community and household – paid or unpaid**.
- Ask a few participants to call out examples of the gender-based division of labour. Note how these examples refer back to the norms, roles, relations and stereotypes discussed in the previous activities – adding that the health effects can be either at an outcome level or in terms of exposure to risk factors. Examples include the following:
  – Many women in low- and medium-income countries are exposed to indoor air pollution at higher rates than men due to their labour related to food preparation.
  – Men tend to work on construction sites more often than women due to the heavy physical demands. This may make them more susceptible to work-related injuries.
  – At the same time, women are increasingly entering into traditionally male-dominated working environments with high levels of machine-related accidents and unhealthy working conditions – notably in export-processing zones. These are often high-stress, low-paying jobs that might lead to cardiovascular disease, mental disorders or repetitive stress injuries. Women may be increasingly at risk for miscarriage and other pregnancy-related problems in such settings.

Step 7: showing **Slide 1.17**, highlight the following:
- **Different roles do not cause inequality**; it is the value (stemming from norms or beliefs) placed on these roles that leads to inequality.
- Most societies ascribe a higher value to masculine norms and roles. This has led to inequalities disadvantaging women and girls and can lead to gender stereotypes.
- **Gender norms, roles and stereotypes affect groups of women and men differently. Refer to the examples on the slide**.

Step 8: conclude the discussion on gender as being socially constructed with the following:

- People are **born female or male but are taught what appropriate behaviour and roles are expected of them, including how they should relate to other people**.
- Due to the different value ascribed to these norms and roles, women and men may be treated **unequally**.
- Inequality leads to discriminatory practices that can affect health.
- Societies uphold and protect gender norms, roles and associated behaviour, considering them to be the "**natural order of things**" (by both men and women).
- **Unlike sex, gender norms, roles and relations can change**.
- Refer to **Participant Notes, section 1.2** (*Summary points on sex, gender and health*).
- Use **optional learning activity 1.2b** as necessary.

Tips for facilitators

- Having participants brainstorm on gender norms, roles and relations from their own communities and contexts is a powerful way of ensuring that these concepts are understood and internalized. Make sure you have some examples from your own context to help the discussion along.

- There may be confusion about or even opposition to saying that "gender norms can be changed". It is important to unpack such statements by emphasizing that integrating gender into public health programmes and policies is not about changing cultural traditions for arbitrary reasons – nor is it about changing women and men. Rather, it is about **changing behaviour and practices that harm health**. In other words, when public health actors discuss changing gender norms, they **refer to the harmful gender norms, roles and relations** that increase health risks for groups of women and men. Counter sceptical attitudes through open dialogue and by soliciting concrete examples from participants.

Suggested transition to next section

So far, we have seen that gender matters in health (from the flash card facts), and now we have gone over what exactly gender means – and its distinction from sex. Let's now look at gender in the context of public health and what international commitments exist to which we must respond.

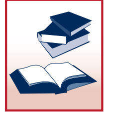
SECTION 1.3: INTERNATIONAL FRAMEWORK FOR WORKING ON GENDER EQUALITY AND HEALTH

Learning Activity 1.3a: a global view – international and organizational commitments to gender equality and health

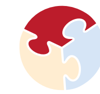
Aims of the learning activity

- Introduce the international framework for gender equality and health
- Understand the meaning of gender mainstreaming and clarify how women and men are involved as target groups
- Be aware of WHO's work on gender, women and health (to be included as necessary, depending on audience)

Notes

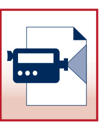


- This is a short PowerPoint presentation with talking points below and on each slide. As this is a presentation and not an activity per se, the facilitator should encourage participation by posing questions and allowing for short discussions between the slides. **Refer to Participant Notes, introduction and subsections 1.3a and b** (*A brief history of gender equality, health and development efforts; Gender mainstreaming*) for additional reading and related references used in this section.
- Gender mainstreaming is sometimes referred to as **integrating gender perspectives**. The notion of integration, or mainstreaming, can be seen in other programmes. The terms should be considered synonymous.
- Depending on the audience's existing knowledge and awareness of international agreements and commitments on gender equality, facilitators may summarize this section – using only the slides that are necessary.
- When and if regional or national commitments to gender equality and health can be highlighted, facilitators should include such information to enhance relevance for participants.



Suggested process

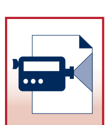
Step 1: showing **Slide 1.18**, recall the flash card facts and use the questions on the slide to outline that not only do both **sex and gender matter in health** but that **health is more than the absence of disease**. Remind participants that the WHO Constitution also reflects this understanding of health. Highlight the following:



- There have been dramatic advances in health technology, with scientific and medical developments continually contributing to improved health outcomes.
- Nevertheless, **social factors are increasingly producing significant insight into the patterns of health and illness among populations**.
- **Gender is one of these factors**. As the flash card facts showed, being female or male significantly influences health status and access to and use of health services. Unless these differences are taken into account, the delivery of health services will have **limited impact and benefit**. The final question of the flash card fact discussion ("What can the health sector do about it?") began the discussion of how the health sector can respond.
- Use **Slide 1.19** to display a quote from the Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health[3] and transition to the next slides on the international framework for working on gender equality and health.

Step 2: using **Slide 1.20**, highlight the below - drawing from information in the Participant Notes (as necessary):

- **The United Nations Decades for Women** have drawn global attention to gender equality and how this affects many aspects of development, including health.
- The commitment to gender equality and women's health issues dates back to **1946**, when a **resolution of the United Nations Economic and Social Council (ECOSOC) created the Commission on the Status of Women (CSW)**.
- Later, in **1979**, United Nations Member States ratified the **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**.
- The movement picked up steam and earned increased international attention during the 1990s, through United Nations sponsored meetings such as the International Conference on Population and Development (Cairo, 1994), the World Summit for Social Development (Copenhagen, 1995), the Fourth World Conference on Women (Beijing, 1995), ECOSOC resolutions (1996 and 1997) and - from 2000 onwards - the Millennium Declaration and United Nations Security Council Resolution 1325 on Women, Peace and Security.
  - Note that a platform and a convention differ in authority. A convention acts as a treaty with guidelines and legal stipulations not necessarily enforced in a platform.



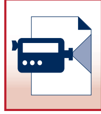
- **The Beijing Platform for Action** includes specific actions and recommendations aimed at **empowering women to promote and safeguard their own health** through various avenues. It is a pivotal component of the international framework for working on gender equality and health.
  - It has separate chapters dedicated to **women's health** and **violence against women**, outlined as one of the key manifestations of gender inequality with negative effects on women's health and well-being. There is also a chapter on **women and armed conflict**.
  - The Platform also underlined the importance of **gender mainstreaming** as a means to achieving its goals. This set the stage for many national governments to develop national plans of action that continue to be relevant today.
    - Ask participants whether they know if their countries have developed a **Beijing platform for action at the national level** or any of the other national mechanisms (MDG plan, CEDAW report, etc) by which they can advance the field of gender and health. Remind them that this means that **the government of that country has signed on to gender mainstreaming and that therefore there is a national obligation to address gender inequality.**
    - Encourage them to locate national colleagues working on gender mainstreaming from other sectors (if they have not already done so) to advance the health chapters of these commitments as well as the gender mainstreaming agenda. This will also provide them with much needed support as they carry this work forward.
- Many regions and countries adapt documents that support United Nations resolutions and conferences but bolster them with local initiatives and documents. There are many examples of this such as the African Union Solemn Declaration on Gender Equality in Africa [52] and the African Charter on Human and People's Rights. [53]
  Note to facilitators: advance preparation is necessary to include and address regional and country-level commitments and obligations on gender equality, gender mainstreaming or health equity.
- **The Millennium Development Goals** (MDG) place health, gender equality and determinants of health at the centre of the development agenda.
  - **Three of the eight goals and nine of the 17 targets relate directly to physical health outcomes**. Other goals represent determinants of health.

Recall for Facilitators

MDG are **8 internationally agreed upon, time-bound goals**:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development.

- **Commitment to gender equality and women's empowerment is both a goal and a condition for achieving all MDG** and recognizes the influence gender plays in development – and by extension, health.
- Encourage participants to become actively involved in the MDG process and promote gender and health issues across all goals.
- **Transition to the next slide** by reminding participants that Goal 3 is both a goal and condition – which means it is considered a cross-cutting issue. Thus, it must be mainstreamed throughout.



Step 2: ask whether anyone can define gender mainstreaming. Using **Slide 1.21**, highlight the following:

- Gender mainstreaming – the term about which we hear so much – was **highlighted in the Beijing Platform for Action and then endorsed and institutionalized for all United Nations agencies and programmes in two consecutive ECOSOC resolutions**. This means that:
- Whatever we do – in whatever sector – we must think about what it will mean for women and men.
- We do not just "add gender on" at the end of a project or what we refer to as *gender salt* as an afterthought to objectives that are not followed through or adequately incorporated from the onset. Addressing gender inequality requires doing it throughout the stages of a programme or development.
- Not only have you thought about what it means for women and men and ensured that all actions of the programme reflect their concerns – but it means thinking about how women and men will benefit from your programme efforts, and thinking about this right from the beginning.
- Emphasize that gender mainstreaming focuses on both how we do business and what we achieve towards gender equality.
- Transition to the next slide by asking "But what does this really mean? How are we supposed to actually do this in our daily work?"
- Use **Slide 1.22** to highlight key points:
  - Gender mainstreaming is about putting away the "gender salt" or adding gender in name only or as an afterthought. No more gender words without gender actions!
  - Gender mainstreaming in health is about **changing organizational structures, behaviour, attitudes and practices** that harm women or men's overall health status.
  - Gender mainstreaming calls for transforming the public health agenda that includes the **participation of women and men in defining and implementing public health priorities and activities**. This will ensure that their needs are subsequently met.
  - As we saw in the international framework, work on gender equality began to address women's inequality; as a result, gender mainstreaming has often been understood to be for and about women. In fact, it is for and about **women and men towards achieving equality.** Gender mainstreaming can include specific projects that empower women as much as it can engage men and boys to address harmful male behaviour and promote their health.
  - Gender mainstreaming addresses both **programme** and **process** issues.
  - Gender mainstreaming is a **long-term process, and its results will be progressive**. This does not mean that short-term efforts cannot be made: in fact, this is often why there are women-only efforts as a way of balancing out gender gaps.
  - Sum up by stating that **gender mainstreaming is not a complicated process but requires time, resources and commitment**. By thinking about, including and planning for women and men in all health activities, the health sector will significantly contribute to international, regional and national commitments on gender equality – and more importantly, to reducing the impact of harmful gender norms, roles and relations on health.

- **Transition to the next slide** by picking up on the point about programme and process issues. Use **Slide 1.23** to outline that both approaches are needed in public health. Emphasize that this workshop addresses both types – but with more focus on programmatic mainstreaming.
  - **Examples** of programmatic outcomes are found in the broad work done on gender and HIV, while examples of institutional (or operational) outcomes include organizational policies on recruitment (such as sex parity) and increased financial allocations for work on gender equality.
- **See Participant Notes, Introduction and subsections 1.3a and b** (*A brief history of gender equality, health and development efforts; Gender mainstreaming*).

Step 3: optional – overview of work on gender, women and health in WHO: using **Slide 1.24**, outline the evolution of work on gender, women and health in WHO.

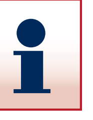
- Note that this overview is based on WHO headquarters only, and the process may have been different in regional offices. Facilitators may want to simply point out that each regional office has specific priority areas on gender and women's health but that all offices work together towards implementing the WHO Gender Mainstreaming Strategy.
- Note that the work on gender, women and health issues in WHO began in a more concerted manner after the Beijing conference. This mirrors the creation of gender architecture in countries.

- Use **Slide 1.25** to outline the four strategic directions of the WHO Gender Mainstreaming Strategy as needed. These four areas mark important areas of work and reflect both programmatic and institutional mainstreaming. Programmatic issues are covered under strategic directions 1 and 2 (building capacity; strengthening evidence) and institutional issues are covered under strategic directions 3 and 4 (changing management structures and procedures – including planning, and ensuring that accountability for gender mainstreaming is at the highest decision-making levels of the Organization).

Module 1: Awareness

Step 4: sum up with the following points:

- By participating in this programme, participants have begun the process of gender mainstreaming.
- Remind participants that gender mainstreaming is our collective duty – it is not the responsibility of one department or unit. It is also not the sole responsibility of women. Remind participants that WHO is responsible for the health of both women and men and that the time is urgently upon us to pay attention to this responsibility by looking at more than biomedical or reproductive health functions. Remind them of the flash card facts.



Tips for facilitators

- In this section, establishing the conceptual framework for the Modules and the work on gender and health more broadly is important. **Facilitators are encouraged to read the additional reading** for Module 1. This will help to prepare for potential questions.
- The term *gender mainstreaming* may pose some challenges, as participants may have heard this in the context of "politically correct" dialogues and may be cynical or interpret it as an activity in which only women need to work. The facilitator should ensure that participants understand that **gender mainstreaming is an important process that has the potential to transform how actors in the health sector currently operate**. Explain **that gender mainstreaming is about putting women and men at the centre of planning, programming and policy-making as both actors and beneficiaries**. For the health sector, this is even more important, as the optimal health status of both women and men is the ultimate objective.
- The question often arises of why gender issues in health lead to a focus on women's health. It is best to address this up front by seeking the opinions of the group and by highlighting that **gender inequality yields a disproportionate burden on women and girls**. This is due to the low status attributed to women in many societies – and continues to pose serious challenges to their health.

Suggested transition to next section

Sex, gender and the components of gender are core concepts in gender mainstreaming. But what about human rights? Let's look at the intersections between gender mainstreaming and broader human rights objectives.

Learning activity 1.3b: Gender, human rights and health

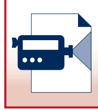
Aims of the learning activity

- Understand the connections between gender, human rights and health.

Suggested process

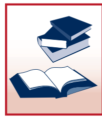
Step 1: transition from the discussion on gender mainstreaming to human rights by asking: "Is working on gender the same as working on human rights?".

- Begin the dialogue with **Slide 1.26**, stating that achieving gender equality and health equity are part of the broader human rights agenda. In going over the bullet points on the slide, emphasize that **equality and non-discrimination are human rights principles**. In other words, human rights cannot be realized without due attention to gender equality.



Step 2: using **Slide 1.27**, introduce the concept of "the right to health".

- Clarify that **the right to health does not mean the right to be healthy**. It refers to a wide range of factors that support populations to lead healthy lives (known as an inclusive right). This includes political, social, economic mechanisms, institutions, as well as equitable access to things such as, adequate heath services, education, water and sanitation, etc. The health sector, especially health ministries, can fulfil commitments to the right to health through a wide range of activities such as building hospitals, training health professionals, ensuring decent living and working conditions and implementing a legal and policy framework that enables the equitable provision of quality health services, essential medicines, etc.



- Note that human rights language, due to its legal origins, can be confusing for some. Try to use simple terms and refer to **Participant Notes, subsections 1.3c and d** (*Gender, human rights and health; What is the CEDAW and why is it important for gender equality and health equity?*) for further reading and all related references used in this section.
- Show **Slide 1.28**, listing some human rights. Lead a brief discussion using the below questions. Make connections between the two questions when possible.
  - How is health affected by the denial of this right?
  - How do gender norms, roles and relations affect the ability to enjoy this right? (Or: How are women and men affected differently by the denial of this right?)

Step 3: conclude by reminding participants that the point of this short activity is not to cover all aspects of human rights but to demonstrate links and encourage harmonization in efforts to address these two determinants of health.

Suggested transition to next section

How does all this help us to understand how gender is a determinant of health? Let's do a fun activity outdoors to bring everything together.

SECTION 1.4: GENDER IS A DETERMINANT OF HEALTH

Learning activity 1.4: Power Walk

Aims of the learning activity

- Understand the interactions of gender with other determinants of health.
- Identify key health stakeholders and patterns of health inequalities.

Notes

- It is essential to review the list of "characters" and "statements" of the Power Walk to ensure maximum impact for participants. Use local contexts and realities to do so. Suggestions are included but should not be considered exhaustive.
- Add local population groups; modify, add or delete statements most relevant to context and that will reveal interaction between gender and other determinants of health and highlight local, vulnerable populations.

Summary of learning activity

This exercise, adapted from training activities on human-rights based approaches, is a role play that allows participants to experience the ways that gender and other determinants of health interact. Participants take steps forwards or stay put, similar to what happens in a board game or a race. At the end of the role play, the position of each "player" is analysed to unearth the interactions of gender and other determinants of health.

The idea is to include a range of characters (with a good sex balance) representing experiences, vulnerabilities and privileges with respect to specific health behaviours and interactions with the health system.

The exercise is preferably carried out in an open and fairly large space to allow for movement and can take a fair amount of time to finish.

It can also serve as an energiser in that it gets participants moving around.

There are about 40 pre-prepared roles that include male and female characters to reflect differential experiences and 2-3 observer positions to choose from or adapt to local populations.

Suggested process

Step 1: distribute roles

- Randomly assign roles to participants. Ideally, at least eight assorted characters are needed to depict a range of vulnerabilities and privileges. A maximum of 12–15 is recommended, and some characters can be duplicated if necessary for differences in experience to be revealed, depending on the time available. **Remind participants not to share their "identities" with others**.
- **Observers (if used)**: assign two or three people to be observers and place them in strategic places to take notes on participant reactions (depending on the number of participants). They will then be asked to report their observations to the group at the end of the activity. Note that observers should be used if the group is too large or if some participants have done the activity before.

Step 2: Power Walk start-up

- Assemble participants (role players) as if they are about to begin a race: in a horizontal line facing forward. Explain rules of the Power Walk as reflected in the Overview below.
- Agree on the size of steps considered "normal" for the exercise and with respect to the space available.

Overview of rules

- Read out statements from the list provided (or adapted) one at a time.
- Participants must silently think about whether they can answer yes or no to the given statement in their assumed identity. "Yes" indicates that they take a step forward. "No" indicates that they remain in the same place. An uncertain answer should be taken as a "no". Participants who feel that their "characters" could partly answer yes to the given statement should take a small step forward. Each statement is equivalent to one step.
- After the last statement, participants should remain in their places and reveal his or her identity to the group. Take note of who is where in the final formation, as this will be used in Module 2.
- Participants should stay in their formation until the facilitator ends the power walk.

Step 3: Power Walk feedback session

- Projecting **Slide 1.29**, lead a discussion on the outcomes of the Power Walk and its connections with health interventions.

Notes:

- if you will be remaining in formation for the feedback session, you may want to print out these questions for distribution or simply ask them to generate discussion;
- characters may end up in placements you may not expect. Be prepared to discuss these with the group as they may reflect contextual or individual interpretations that can assist in understanding the impact of gender in the given context.
- Select a couple of characters from the **front cluster** to describe their experience and what it felt like to be in those positions. After the group on the "front row" has spoken, tell them that **these characters often have the most decision-making (and other) power and are often the partners of WHO or the health ministry**. Note these characters on Flip chart 1.4 – and discuss how women and men are represented in this group.
- Follow a similar process of discussion with characters from the **middle cluster**. Usually **these are community organizations and workers (health and otherwise)** – sometimes even including nurses and other health professionals. Note these characters on the prepared **Flip chart 1.4** – and discuss how women and men are represented in this group.
  - Remind participants **that these are also important partners for WHO or health ministries** to engage with when we want to reach the people at the back. **We also want them to be able to say yes more often to the Power Walk statements. Ask participants what strategies could help to accomplish this**.
- Use the same process for characters from the **back cluster**. Note these characters on the prepared **Flip chart 1.4** – and discuss how women and men are represented in this group.
  - Ask how they felt as they watched others moving forward. If no one else points it out, say that the people at the back are usually the **direct beneficiaries of the programmes and policies we develop** in collaboration with WHO or health ministries – and usually the most difficult to reach. These are **the women and men whose health we are supposed to promote and protect**. Why are they at the back?
- Ask participants to now look at how women and men are distributed throughout the Power Walk outcome. Are all the women at the back? All the men at the front? What does this mean in terms of gender? When no sex was specified for a character, ask participants which sex they assumed their characters where (e.g., land owner) and make necessary linkages with gender stereotypes, norms and roles as appropriate.
  - After allowing some discussion, point out that the **Power Walk confirms that gender norms, roles and relations can affect men and women in different ways**. It also shows that **gender interacts with other determinants of health**. Use examples within the Power Walk to demonstrate how education, profession, income, age, sex and gender can influence the ability of Power Walk characters to move forward or not.
- **If observers are used**: ask observers to report on their observations throughout the process of the power walk. They could be asked to discuss along the same questions as on Slide 1.29.

Note that facilitators (or co-facilitators) should include all participants on the below flip chart for future reference. Some may prefer to reproduce the actual formation of the power walk outcome instead of listing characters by clustering. This can also be an effective recall mechanism and demonstrates that some characters fall between categories.

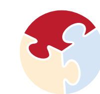
F ip chart 1.4

Power walk characters

Font cluster: (list characters)

Middle cluster: (list characters)

B ck cluster: (list characters)



Step 4: transition into a brief discussion of empowerment, using **Slide 1.30** and asking why some characters at the back may not have been able to take a step forward. Introduce the definition of empowerment, emphasizing the following:

- The characters in the back cluster often have lower levels of empowerment, which sometimes explains why they have difficulty moving forward.
- Make the links between empowerment, reducing unequal power relations, addressing unequal gender norms, roles and relations – and ultimately gender mainstreaming. In other words, **gender mainstreaming cannot be achieved without attention to empowerment**.
- Ask participants whether they felt empowerment was an obstacle to moving forward. Time permitting, record these on a flip chart for later use – or ask participants to reflect on this for discussions in Modules 2 and 3.

Note: Modules 2 and 3 revisit empowerment, as it is an important element for analysis as well as developing health sector responses. The purpose of introducing the concept in Module 1 is not to cover the concept in its entirety but to introduce it for further discussions in the other modules.

Step 4: Power Walk conclusions

Ask what the outcome of the Power Walk says about how we should develop health programmes and policies. Ask what capacity the various people need to participate effectively or to listen to others in the process of health programming or policy-making. Agree on the different groups to consult and involve when developing health programmes or policies. Use the below summary as needed.

Summary points on Power Walk implications

- Due to the heterogeneity of communities, it is important to make deliberate efforts to include characters representing marginalised groups, especially the young and groups from different cultural or ethnic backgrounds.
- Sex, age, ethnicity, sexual orientation and place of residence are all important determinants of health. When they interact with gender they often compound inequalities and reduce the ability of certain characters (both women and men) to take a step forward in the Power Walk – or to safeguard their own health.
- Certain life conditions may mean that you have less social support for coping with disease and illness or less power to take decisions over your own body. These life conditions become apparent when we pay attention to gender.
- The front and middle clusters often represent characters that have more decision-making power in the community and in the health system than those in the back.
- For optimal health outcomes, health equity and promotion of gender equality, there is a need to work with key characters that are represented in all three sections.
- Often, characters represented in the front and middle clusters are gate keepers while those in the back clusters are from marginalised groups.
- The back clusters must be consulted for their needs to be understood and incorporated into plans, programmes and policies.

Refer to **Participant Notes, subsections 1.4a and b** (*Genderand other determinants of health; Empowerment – Part 1*) for additional reading.

Transition to next section

As the power walk demonstrates, not all characters have equal chances to protect their health and maintain good health status. We will now look in more detail at the concepts of equality and equity to understand how to address these imbalances.

Materials for learning activity 1.4: Power Walk

Orphan girl (10 years old)	Orphan boy (10 years old)
Male sex worker	Female sex worker
Staff member at WHO (or other UN agency)	NGO or community worker
Single father	Single mother
Minister of Health	Female community health worker
Journalist for a national or local newspaper	Teenage boy
Illiterate woman (age 50 years)	Illiterate man (age 50 years)
70-year-old woman living in a refugee camp	Rural grandmother looking after four grandchildren
Woman living with a mental health condition	Man living with a mental health condition
Primary school teacher	Dispenser or pharmacist
Religious leader	20-year-old survivor of rape (female)
15-year-old girl married to someone three times her age	20-year-old survivor of a road traffic accident (male)
Woman living with HIV	Man living with HIV
Police officer (male or female)	Indigenous man or woman
Gay man	Lesbian
Community nurse	District director of health
Domestic workers (male or female)	Traditional healer
Village / community leader	Farmer (male or female)
Visually impaired young man	Visually impaired young woman
Male doctor	Female doctor
Land owner	Migrant or seasonal workers (male or female)

Power Walk Statements

1. I know where to find the nearest health facility.
2. I feel respected by local health care workers.
3. I have a say in health decisions in my community.
4. I can consult health services when and if I need to.
5. I have access to family/household resources if I need to pay for health care.
6. I can talk openly to local health care workers about my health problems.
7. I can talk openly to my family about my health problems.
8. I know my rights.
9. 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.]
10. I am allowed to be treated by a health care worker of the opposite sex.
11. I get to meet government officials.
12. I can read and understand health information posters at the health facility.
13. If I need medicines, I know where to get them.
14. I have access to micro-credit or other forms of earning money.
15. My opinion is important within my own ethnic group.
16. I have access to clean and safe drinking water.
17. I eat at least two full meals a day.
18. I can buy condoms.
19. I can negotiate condom use with my sexual partner(s).
20. I can refuse sex with my partner or spouse.
21. I have completed secondary school.
22. I can pay for treatment in a private hospital if necessary.
23. My opinion is considered important by municipal or district health officials where I live.
24. I am not in danger of being sexually harassed or abused.
25. I do not feel judged by health care workers.

SECTION 1.5: EQUALITY OR EQUITY?

Learning activity 1.5a: Gender equality, equity and health equity

Aims of the learning activity

- Understand the distinction between gender equality and gender equity.
- Define health equity.
- Apply Module 1 concepts on gender equality and health equity in a group activity.

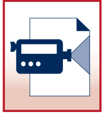
Notes

- The differences between equality and equity are often difficult to understand for new gender learners. Minimize the use of jargon.
- Many gender training manuals include a discussion of or the distinction between equality and equity. Facilitators may want to draw from several guides that address this to make the links with health equity, for example: the PAHO gender, health and development guide; [4] *Training manual for gender mainstreaming in health* from the Medical Women's International Association; [54] and a trainer's manual for *Working with men on gender, sexuality, violence and health* from SAHAJ (Society for Health Alternatives), SAHAYOG and Tathapi. [55]
- See the **Participant Notes, section 1.5** (*Gender equality and gender equity: overview*) for further information and all related references used in this section – including a story that could be used in the session.

Suggested process

Step 1: ask if anyone can define **gender equality** before revealing the first half of **Slide 1.31**, highlighting the following:

- What gender equality is **not about**:
  - making women and men the same;
  - giving one sex more authority over the other; or
  - making the incidence, prevalence, morbidity or mortality of disease the same for women and men.



- What gender equality is about:
  - being valued equally, regardless of sex; and
  - taking steps to ensure that women and men **have the same chances and opportunities in life**: this is also known as **formal equality** or making sure that formal structures allow for equal access and participation for groups of women and men.
- Revealing the second half of **Slide 1.31**, highlight that **gender equity** is about going beyond equality of opportunity to **recognize that women and men have different needs, preferences and interests**. This may mean that different treatment is needed to ensure equality of opportunity. This is often referred to as **substantive equality** and requires that the realities of women's and men's lives be considered in setting goals around equality and equity. Ask participants what this reminds them of. Recall the definition of gender mainstreaming and the importance of reflecting women's and men's lives, needs and realities as a precondition for achieving gender equality.
- Summarize the distinction between gender equality and gender equity by emphasizing that, **although the concepts are used interchangeably, they refer to different strategies – and that both strategies are needed to contribute to health equity**.

Step 2: transition to the **definition of health equity** and read the definition on **Slide 1.32**. Make the connections between gender equality, gender equity and health equity by emphasizing the following:

- **Equality of opportunity** (gender equality) is needed to ensure that women have the same chances as men to access social, economic and political resources.
- **Recognizing different needs and abilities related to social, economic and political resources** (gender equity) is a fundamental aspect of addressing inequality between women and men.
- **Avoidable health differences** can only be reduced when both equality of opportunity and needs recognition among groups of women and men are addressed.
- **Show Slide 1.33** – cartoon test. Use this as a way of clarifying the concepts of gender equality, gender equity and health equity as necessary. Solicit examples from the group as needed to ensure that the concepts are understood.
  - The test **creates equality of opportunity for all "students" but does not actually consider their different needs** so that they can actually take and pass the test. In other words, the test is not equitable.
  - Although the test is a fun way of looking at these concepts, it reminds us that if we establish health facilities, much like this "tree test", without considering whether, how and under what conditions all groups of women and men can actually reach them – we may end up like this professor, with very few "students" that pass the test.
  - Refer to **Participant Notes, section 1.5** (*Gender equality and gender equity: overview*) for summary reading on gender equality and health equity. As necessary, facilitators may want to read or use the **fox and stork story** from the Participant Notes in the session.

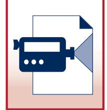
Learning activity 1.5b: Identifying ways to address gender and health inequities

Aims of the learning activity

- Brainstorm on ways the health sector can modify existing programmes to address gender and health inequities, by applying the concepts learned throughout Module 1.

Notes

- This activity is a short "teaser" for what is to come: that is, it is intended to get health planners and managers in the room already thinking of how work on gender applies directly to their work. Facilitators should adapt and modify the case study as needed to stimulate discussion based on local health programmes and gender norms, roles and relations.



Step 1: use **Slide 1.34** on immunization or develop a similar case example for the given context. After participants have read the case study, ask them to turn to their neighbour (buzz groups) and discuss the questions included on the slide. This can also be done in plenary.

- Facilitators may wish to go over each of the questions and highlight some of the "forgotten" gender issues:
  - Women are primarily responsible for the health of children, and yet the communication strategies may miss women altogether. For example, campaign information is only on written posters. This means that illiterate people, most of whom are women, cannot access the information.
    - The posters are available in the health facility. This implies that women (or men) need to actually go to the health facility to be aware that the campaign exists. Women and men who live far from health facilities may never see the posters. Women with reduced social mobility are excluded altogether – even though they are usually responsible for the health of children.

- The posters are made available in the community, but it is unclear whether these are in places in which both men and women can be – and whether there is any attempt to ensure that women, being primarily responsible for child care, can access the information.

– Although the campaign states that it is free of charge, it is delivered in health facilities and not in the community. This implies indirect costs such as transportation and potential time off work. All of these may be differently available to men and women in the household in terms of bringing children to the health care facility.
  - The fact that the campaign is facility based may also mean that rural populations will not have access and could mean that women who depend on being accompanied for attending health services may not be able to take their children.

Step 2: wrap up the discussion by highlighting the need to contextualize such analysis of health interventions and the responses required. Remind participants that addressing the harmful ways that gender norms, roles and relations affect health requires understanding certain practices in societies. **Local populations must be consulted** to understand what different needs, realities and practices may exist. Remind participants of the Power Walk – and that all the characters are important stakeholders in health. This means that we must find ways to engage with them all.

Step 3: using **Slide 1.35**, sum up this session with the following points:
- **Achieving gender equality, gender equity and health equity is not a one-off goal**. They must be constantly promoted and actively sustained!
- Remind participants that **adding gender salt after the fact is not acceptable** – and that there should be no gender words without gender actions!

SECTION 1.6: CONCLUSION OF MODULE 1

Step 1: congratulate and thank participants for their participation in Module 1. Acknowledge that Module 1 is intense and concept-heavy but that it sets the framework for the rest of the workshop. Use the following points as necessary:
- This Module has provided the first step in exploring how gender affects public health work and what can be done about it. The basic concepts of gender and health need to be clearly understood to effectively apply them, in various health actions.
- In this Module we have shown that gender is not only about women or that women's health is not only affected by reproductive health interventions. We have also shown that men's health is affected by gender norms.

Step 2: Recap the key messages from Module 1 using **Slide 1.36**.
- Time permitting, you can make use of the "quick quiz" questions on the screen to incite participant recall of the core concepts. If treats are on hand, give them out to the ones that answer most quickly … and accurately of course!

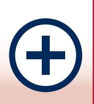
Step 3: Remind participants to review additional reading in the Participant and to consult the references if they would like further information.

Step 4: Distribute evaluation forms and/or the progress check (see below) as necessary. Facilitators should note that the progress check can be either distributed to participants or conducted at the start of the subsequent module (on a flip chart) as a way of testing participant comprehension before moving forward. Details on using the progress check can be found at the beginning of Module 2.

Module 1: Progress check

I know or understand …	Not at all	Somewhat	Well
1. Why gender matters in public health.			
2. The difference between sex and gender.			
3. What gender norms, roles and relations are.			
4. What the difference between gender equality and gender equity is.			
5. What gender mainstreaming is.			

Give yourselves a round of applause!



ANNEX 1. MODULE 1 OPTIONAL LEARNING ACTIVITIES

Optional learning activity 1.2a – Going back in time

Aims of the learning activity

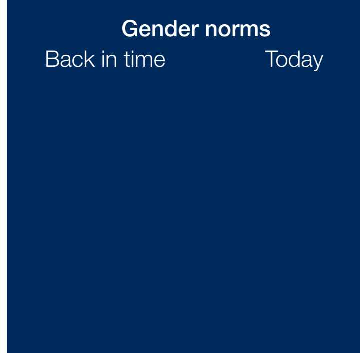
- Stimulate understanding of gender norms, roles and relations and how they can evolve over time.
- Reiterate awareness of the fact that gender plays a part in the lives of all participants and not only women or the beneficiaries of health programmes, policies and services.

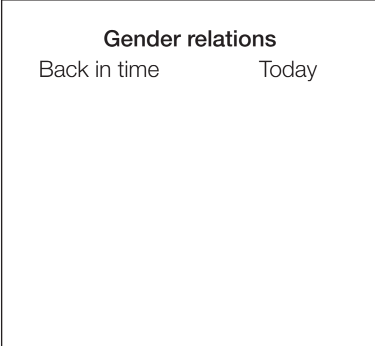
Notes

- This learning activity can be used to complement **learning activity 1.2** or as part of **the progress check in Module 2**.
- Estimated time: 30 minutes

Suggested process

Step 1: Distribute coloured index cards (six in total using different colours – two per colour) and markers. Hang three blank flip charts on the wall, labelled and divided as demonstrated below.





Step 2: Recall, as necessary, the five elements of gender, highlighting the fact that gender is historical. Note that if this activity is done in Module 2 (or at any time when there is a delay after Section 1.2), facilitators may need to quickly review what gender norms, roles and relations are to stimulate participant recall.

Step 3: Ask participants to take a couple of minutes to reflect on what was considered to be "normal" with respect to gender norms, roles or relations in the lives of their grandparents or parents. They should write one example for each component (norm, role or relation) on a differently coloured card.

Step 4: Now ask how these examples differ from their own lives and those of their sister or brother of a similar age. Write down current examples of a gender norm, role or relation on a coloured card (matching the colour of those from the previous step). The same process can be done with respect to the next generation or children of participants.

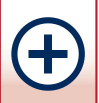
Step 5: Ask participants to post their cards with past and present gender norms, roles and relations on the designated flip chart. Select a few and call them out to the group demonstrating how the norm, role or relation in question has evolved from one generation to the next. Invite participants to comment on the examples, time permitting.

Step 6: Wrap up the activity by drawing on the examples provided to reiterate the definitions of gender norms, roles and relations and to emphasise the notion of change within gender.

Tips for facilitators

- Facilitators should limit discussions of the examples provided by participants and recall the ground rules as necessary to avoid judgement of the examples provided, as this may exclude some participants.
- Time permitting and depending on how this optional learning activity is used, select a few examples to explore the influences on health.

Optional learning activity 1.2b – Mind your language



Aims of the learning activity

- Stimulate participant reflection on how language can uphold gender stereotypes.

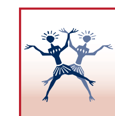
Notes

- This learning activity can be used to complement **learning activity 1.2** or as part of the **progress check in Module 2**.
- Using common statements or messages from the local context to stimulate the discussion may be preferable.
- This optional activity deals with language only – a complementary learning activity is included in Module 3 that includes broader aspects of health communication.
- Estimated time: 45–60 minutes.

Suggested process

Step 1: Using either a slide or flip chart, explain that gender-inclusive language refers to **language that is not discriminatory and does not reflect or uphold gender stereotypes or harmful gender norms, roles and relations**.

Step 2: Projecting the box below on either a slide or a flip chart, divide participants into groups to conduct an activity entitled "mind your language!".



Mind your language! Do these statements uphold gender stereotypes?

a. One small step for man, one giant step for mankind.
b. All doctors and their wives are cordially invited to dinner.
c. The midwife training course is two weeks long.
d. The project will improve the livelihoods of fishermen and their families.
e. Applications are invited for the position of housemaid.
f. The government's manpower planning policy includes adequate training opportunities for both men and women.
g. The consultant shall submit his report within three months.
h. We invite nominations for the positions of Chairman and Vice-Chairman of this regional consultation.

- Divide participants into six to eight groups (or however many phrases you choose to use) by whatever means is quickest (such as clustering participants seated next to one another). Assign one, two or all phrases to groups (as time permits).

- Participants should discuss the phrases provided and respond to the question: "Do these statements uphold gender stereotypes?". Once they have assessed this, they should (where necessary) revise the phrases accordingly.

- Facilitators should prepare one blank flip chart per statement for use during the group reporting back and distribute them around the room.

Step 3: Distribute differently coloured index cards to each participant, selecting one colour for "yes" and one colour for "no". During reporting back, have groups write down their reconstructed phrases on the flip chart that corresponds to their assigned phrase. Allow groups a few moments to share with the others highlights of their discussions and the rationale behind their revisions. Do not have group discussion at this point.

Step 4: After all groups have reported back and revisions to all phrases have been presented, put the phrases to a vote by going over each option and having participants vote by showing index cards for their preference. Call on participants that were not involved in the reformulation to explain "no" votes and to revise further as necessary.

Step 5: Wrap up by highlighting that language, as found in proverbs, laws or policies – written documents that shape norms, roles and relations for women and men – is an important way of communicating ideas about women and men and how society views them. Remind participants to mind their language!

MODULE 2:

ANALYSIS – CONDUCTING GENDER ANALYSIS

Proposed running times

Section and learning activity	Materials to be prepared and used	Suggested implementation time
Module 1 Progress check Optional learning activity 2.0: Can you tell the difference between sex and gender? Introduction to Module 2	Module 1 progress check Module 1 slides and Participant Notes, Module 1 (for reference) Slides 2.1 – 2.2	35-60 minutes (depending on whether the optional learning activity is used)
Section 2.1 Learning activity 2.1: Introduction to gender analysis	Slides 2.3 – 2.8 Participant Notes, Section 2.1 • *2.1a. What is gender analysis in health and why is it important?* • *2.1b. The added value of gender analysis in health*	15 minutes
Section 2.2 Learning activity 2.2a: The WHO Gender Analysis Matrix: gender-related considerations	Slides 2.9 – 2.24 Handout 2.2a: Biological factors of selected health conditions for men and women Power Walk flip charts and notes (Module 1) Participant Notes, Section 2.2 *a. WHO Gender Analysis Matrix (GAM)* *b. Health effects of gender norms, roles and relations* *c. What are health-related resources?* *d. Gender-based discrimination in health* *e. Empowerment - part 2: Assessing empowerment is part of gender analysis* Flip charts 2.2a and b Blank flip charts and markers Completed index cards from Module 1 (Learning activity 1.2)	80 minutes
Section 2.2 Learning activity 2.2b: The WHO Gender Analysis Matrix: health-related considerations	Slides 2.25 – 2.34 Participant Notes, Section 2.2 f. Health-related considerations in the Gender Analysis Matrix (GAM) g. WHO Gender Analysis Questions (GAQ)	110 minutes
Section 2.3 Learning to use the Gender Analysis Matrix	Slides 2.35 – 2.36 Participant Notes, Section 2.2 – for reference during group work WHO Gender Analysis Matrix template on PowerPoint, loaded into group work computers or on flip charts Annexes 3-8 Participant Notes, Section 2.3 *a. WHO gender analysis tips* *b. Sources of information for gender analysis* *c. Gender analysis recap*	120 minutes
Concluding Module 2	Slide 2.37	10 minutes
Total estimated running time – excluding lunch and other breaks		**6 hours (core)** **7 hours and 25 minutes** (if optional learning activities used)

Module 2: Analysis

MODULE 1 PROGRESS CHECK

Aims of the progress check

- Ensure common understanding of the concepts in Module 1 as a progressive evaluation before moving to subsequent Modules.

Notes

- The progress check requires advance planning and can be delivered in different formats (either a flip chart or distribution of a handout – see below).
- Keep Module 1 materials on hand for easy reference.
- **Annex 1** includes **optional learning activities (1.2a and 1.2b)** that can be used to revisit certain concepts from Module 1 (if they are not used in Module 1).
- **Annex 2** includes an **optional learning activity (2.0)** that can be used to strengthen the understanding of the difference between sex and gender as appropriate.

Suggested process

Step 1: place the flip chart in a corner of the room and have participants fill out the flip chart confidentially as they enter the room for Module 2. Alternatively, ask participants to complete distributed handouts. Tally the checkmarks found across the three columns.

I know or understand ...	Not at all	Somewhat	Well
1. Why gender matters in public health.			
2. The difference between sex and gender.			
3. What gender norms, roles and relations are.			
4. What the difference between gender equality and gender equity is.			
5. What gender mainstreaming is.			

Step 2: review of Module 1

- Share the results of the progress check with participants.
- Revisit definitions and concepts as necessary with participants using materials from Module 1.
- Some concepts may be woven into activities in Module 2. For example, clarifications on the difference between sex can be revisited in Section 2.2 when introducing the WHO Gender Analysis Matrix.

Step 3: making the bridge to Module 2

- Emphasize the following key messages from Module 1:
  - **Sex and gender are not the same**.
  - **Gender is an important determinant of health** that can influence health needs and experiences, access to and use of health services, participation in health decision-making and the achievement of optimal health status.
  - **Gender norms, roles and relations are hierarchical** and often **privilege one group over another**, leading to **unequal power relations between the sexes**, which often affect health behaviours and outcomes.
  - **Gender equality and gender equity are not the same, but both are needed to achieve health equity**.
  - **Gender mainstreaming is about women and men** and aims to **achieve gender equality**. It also aims to **bring about new ways of doing business** in the health sector.

Tips for facilitators

- The progress check should avoid repeating jargon. Revisit the facilitator's talking points in Module 1 for ways to unpack core concepts and definitions.
- Facilitators may wish to ask specific participants or partners involved to conduct this session as a wrap-up to the day before. Make sure that the person selected will be comfortable in answering questions on the concepts in Module 1.
- Try to limit the progress check to 30 minutes.
- If most participants have not understood the main concepts from Module 1 (and therefore the objectives were not met), the facilitator will need to go over the materials as appropriate. This may have time implications for subsequent modules.

Suggested transition to next section

Now that we are comfortable with the main concepts and some examples of how gender affects health, let's look at how we can use them to conduct a gender analysis.

INTRODUCTION TO MODULE 2: OVERVIEW AND OBJECTIVES

Module 2 applies key concepts from Module 1 in a framework to conduct gender analysis of a health problem. This module introduces two core WHO gender analysis tools, the Gender Analysis Matrix (GAM) and Gender Analysis Questions (GAQ).

Module 2 learning objectives:
- Outline the principles of gender analysis
- Understand health and gender related considerations for conducting gender analysis
- Be familiar with WHO gender analysis tools for gender analysis of a health problem.

Using **Slides 2.1 and 2.2**, introduce the learning objectives and outline of Module 2.

Hang **Flip chart 2.1: Module 2 – overview and objectives** on the wall, ideally placed alongside Flip charts 0.02 (*Outline of workshop modules*) and 1.1 (*Module 1 – overview and objectives*).

F ip chart 2 1

Module 2 – overview and objectives
Module 2 applies key concepts from Module 1 in a framework to conduct gender analysis of a health problem.

By the end of this Module, participants will:
- Outline the principles of gender analysis
- Understand the health and gender related considerations for conducting gender analysis
- Be familiar with WHO gender analysis tools for gender analysis of a health problem.

Module 2: Analysis

SECTION 2.1: WHAT IS GENDER ANALYSIS?

Learning activity 2.1: Introduction to gender analysis

Aims of the learning activity
- Understand what gender analysis is in relation to health.

Suggested process

Step 1: introduce gender analysis using **Slide 2.3.** Emphasize the following:
- Gender analysis is essential for gender mainstreaming;
- Gender analysis may differ according to the context (health, education, etc.), but the **core elements remain the same; and**
- Gender analysis methods can be applied to institutional functions such as human resource planning and budget development.

Transition to the next slide by asking "How does this relate to health?".

Step 2: using **Slide 2.4**, begin a brief discussion on gender analysis in health. Emphasize that when gender analysis is applied to health it refers to **examining how gender inequality affects health and well-being**. In particular, gender analysis in health:
- examines the interaction of biological and sociocultural factors and their influence on health behaviours, outcomes and services;
- highlights how gender inequality disadvantages the health of women and girls; and
- uncovers health risks and problems among men and boys as a result of gender norms, roles and relations.

Step 3: highlight the guiding principles of gender analysis by showing **Slide 2.5**. Emphasize the following as necessary:
- **Sex is not gender, and women and men are different**.
  - Sex and gender are distinct units of analysis and variables. This means that **there should be no confusion between biological and sociocultural factors**.

- **Policies and programmes do not affect men and women identically**.
  - **Because women and men are not the same** – at any stage of their lives, policies and programmes that ignore these differences are less likely to recognize the diverse needs and realities of men and women. Remember the definition of gender equity from Module 1? If differences cannot be recognized and addressed, goals of equity are unlikely to be reached.
- **Diverse types of evidence are needed to understand how gender operates as a determinant of health**.
  - Gender analysis must be **evidence-based** or informed by data and information gathered from research, consultations with diverse groups of women and men and standard health surveillance and monitoring activities. **This sometimes means that we need to look for information where evidence may not be available**, and that increased efforts are needed to have **data disaggregated by variables that are necessary to perform gender analysis**.
  - **Key and critical questions** uncover where women, men, boys and girls are differentially placed, affected and involved in given situations; why these differences occur; whether they are harmful to health; and how they can be prevented or improved.
    - This process of critical questioning can be likened to the Socratic method – or is analogous to Russian matryoshka (babushka) dolls that, when opened up, lead to another doll (or question). **In gender analysis, one good question leads to another towards uncovering the root causes of gender-based health inequities**.
- **Sustained commitment is necessary.**
  - Gender analysis, as the first step in gender mainstreaming, requires sustained commitment and efforts to attain results in the short, medium and long term.
- Facilitators may choose to hang **Flip chart 2.2** on the wall to remind participants of these guiding principles.

They can also be found in the **Participant Notes, subsection 2.1a** (*What is gender analysis and why is it important?*). Refer participants to these materials as necessary.

F ip chart 2 2

Gi ding principles of gender analysis

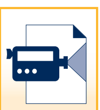
Sex is not gender.

Women and men are different.

Policies and programmes do not affect men and women in the same ways.

Diverse types of evidence are needed to understand how gender operates as a determinant of health.

Sustained commitment is necessary.



Step 4: using **Slides 2.6 and 2.7**, remind participants of the following:

- Tools and frameworks of gender analysis help to understand how gender norms, roles, relations – and inequality – affect the health of women and men. These tools can help you to:
  - **develop appropriate responses** that meet the needs of women and men from different groups; and
  - identify and address practical and strategic gender needs.

- Transition into a brief discussion on **practical and strategic gender needs** by referring to the definition on **slide 2.6**. Emphasize the following:
  - **Practical gender needs** refer to necessities such as adequate living conditions, water provision, health care and employment. Meeting women's practical gender needs, for example, is essential to improving women's status in society.
    - Examples of practical gender needs include the provision of health care, food, shelter or income.
  - **Strategic gender needs** are those that address women's unequal status and position to men in society. Today, strategic gender needs would also include those that apply to men from marginalized groups. Addressing strategic gender needs challenges predominant gender systems such as the gender-based division of labour.
    - Examples of strategic needs include engaging men in domestic responsibilities such as child care and ensuring that women have control over their own bodies through laws and in practices such as consent for health interventions.

Refer to **Participant Notes, subsection 2.1a** (*What is gender analysis and why is it important in health?*) for a summary of practical and strategic gender needs.

- Using **Slide 2.8**, remind participants that **gender analysis alone does not identify and address practical and strategic gender needs in health**. Addressing gender inequality in health **begins** with analysis but must be followed by the development of activities and other actions about which you will learn more in Module 3.
- Recall Module 1 and the concept of *gender salt*: adding gender on top of existing programmes without actually integrating it. Remind them that there should be **no gender words without gender actions** – and carrying out proper analysis is one way of ensuring this.

Step 5: conclude this section by referring to the **Participant Notes, subsection 2.1b** (*The added value of gender analysis in health*) for brief case studies of ways that gender analysis methods contribute to the evidence base for sound health decision-making, planning and programming. Facilitators may want to use these case studies or develop their own, to discuss the benefits and uses of gender analysis in health. These can also be used at the end of Module 2 or in Module 3.

Suggested transition to next section

Two complementary tools have been developed to guide the process of performing gender analysis in health. These are the WHO Gender Analysis Questions (GAQ) and the WHO Gender Analysis Matrix (GAM). The GAQ are used to complete the GAM.

SECTION 2.2: INTRODUCING WHO GENDER ANALYSIS TOOLS

Learning activity 2.2a: Introducing the WHO Gender Analysis Matrix: gender-related considerations

Aims of the learning activity

- Introduce gender-related considerations of the GAM and related GAQ
- Discuss and clarify the distinction between access to and control over resources
- Discuss the concept of gender-based discrimination as a barrier to good health

Module 2: Analysis

Notes

- Section 2.2 (both learning activities 2.2a and 2.2b) can be long and intense. Consider taking a break or doing energizers at appropriate times throughout.
- The objective of both learning activities is to prepare participants for the group activity in Section 2.3. Facilitators must strike a balance between introducing tools in user-friendly ways and leaving enough time for hands-on practice.
- Use and develop case studies and/or other interactive activities to convey links between the GAM and GAQ. When possible, this is provided (more so in learning activity 2.2b). Facilitators should review the entire section for ideas of how to engage participants interactively, drawing on various facilitation skills and techniques such as role-playing or case studies.
- **See Annex 3** for **optional learning activity 3.0** as necessary when discussing the distinction between access to and control over resources.

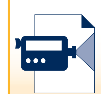
Summary of the learning activity

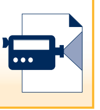
Participants are introduced to the WHO Gender Analysis Matrix (GAM) and, in particular, the gender-related considerations (biological factors; sociocultural factors; access to and control over resources). WHO Gender Analysis Questions (GAQ) are introduced throughout the explanation of the GAM – with the full list included in the Participant Notes. For the gender-related considerations, flashbacks to concepts from Module 1 are incorporated. This learning activity should be relatively quick if the core concepts of sex and gender are well understood.

This learning activity is followed by another that introduces the health-related considerations of the GAM.

Suggested process

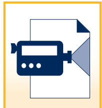
Step 1: introduce the GAM by showing **Slide 2.9**. Explain to the group that this is the main gender analysis tool WHO uses for analysing gender and health problems. Refer to **Participant Notes, subsection 2.2a** (*The WHO Gender Analysis Matrix*) for a copy of the GAM participants can refer to. Highlight the following:





- The GAM comprises **two interacting axes: gender-related and health-related considerations**.
- With respect to the health-related considerations, the GAM is organized as follows:
  - **The first three rows cover the perspective of the user of health services** or the demand side of health care.

- – **The last two rows address the health sector response** or the supply side of health care. Understanding both perspectives is critical to develop better health sector responses.
  - – The **final row** addresses issues that affect **both the users and providers of health services**. We know that **illness affects more than the ill person, and health services and responses must address this**; these issues often become invisible in health sector planning and activities. Including them in the GAM highlights them.
- The GAM is **a way of organizing information for a gender analysis in health**. A matrix format is suggested to do this, but **users should feel free to use any format as long as all components are covered**.
- Finally, remind participants that many other gender analysis tools exist for various sectors. Refer to the reference list for further resources.



Step 2: using **Slide 2.10**, highlight the three gender-related considerations of the horizontal GAM axis. Emphasize the following (as necessary):

- The **interaction between these three considerations** refers to core concepts covered in Module 1.
- **These three factors influence the health-related considerations those listed on the vertical GAM axis**. Mention examples of risk and vulnerability, health-seeking behaviour and experiences in health care settings if necessary.

Notes: steps 3 – 9 guide the facilitator through the explanation of **Slide 2.10** and set up the use of the GAM.

Step 3: unpacking biological factors

- Using **Slides 2.11** and **2.12**, lead a discussion on biological factors and how they affect health. Note that men and women are biologically different, and many of the health issues they confront are related to these differences. Revisit the definition of sex with **Slide 2.11**, highlighting the following as necessary:
- **Sex-specific conditions** – or **conditions related to biological factors alone** – can be thought of in two categories:
  - – Reproductive and/or conditions related to physiological and/or hormonal changes such as pregnancy or menopause or sex-specific organs, such as cervical or prostate cancer.
  - – Genetic or hereditary conditions (or those transferred from parent to child through chromosomes) such as colour blindness or haemophilia. Colour blindness and haemophilia tend to be more prevalent among males.
- Remind participants that, in the beginning of Module 2, you discussed the critical questioning aspect of gender analysis. Introduce the WHO Gender Analysis Questions (GAQ) as a resource to assist this process. In particular, project selected GAQ related to biological factors on **Slide 2.12**, highlighting that **questions that are normally asked (such as the questions at the top level) will not tell you much about gender differences unless specifics about men and women are included**.
  - – Note that critical questions about biological factors related to health conditions go beyond disease burden to include health and social outcomes.
  - – Remind participants that these examples could be explored further – these are simply examples of GAQ that can be used.
- Conduct a group brainstorm using blank flip charts (or other ways to record the group discussion) and ask participants to identify how biological factors – or sex – may affect men or women differently for specific conditions. Facilitators may choose to use the GAQ outlined on slide 2.12 to guide the discussion as necessary. Write contributions on blank flip charts. Use any of the following as examples:
  - – Anaemia [56]
  - – sexually transmitted infections (STI) [57]
  - – osteoporosis [58, 59]
  - – HIV. [60, 61]

Other examples could include cervical, breast or prostate cancer. Choose examples that you are familiar with to ensure your ability to fill in gaps as needed. Refer to and reproduce (as necessary) Handout 2.2a – making necessary revisions according to the conditions selected.

Sample flip chart

Biological factors

Anaemia

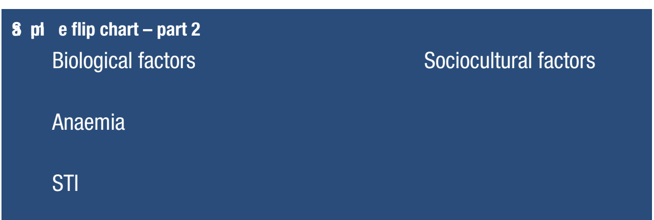
STI

Transition to next step in this learning activity
Summarize the discussion on biological factors by stating that, although certain conditions are only attributable to them, most of the time we need to ask what other factors contribute to the problem. This was also the case in the flash card facts.

Step 4: unpacking sociocultural factors

- Using **Slides 2.13–2.14**, lead a discussion on sociocultural factors, the second gender-related consideration in the GAM. Ask the group to recall the meaning of gender before showing **Slide 2.13**. Emphasize the following:
  - **Sociocultural factors relate to gender norms, roles and relations** that may result in gender inequality, as explained in Module 1.
  - Understanding **sociocultural factors is an important part of gender analysis**.
- As necessary, recall the five elements of gender using **Slide 2.14**.
- Introduce **GAQ that correspond to sociocultural factors** using **Slide 2.15**. Remind participants that, similar to biological factors, questions that are normally asked (such as the questions at the top level) will not tell you much about gender differences unless specifics about men and women are included.

  - Note that critical questions about sociocultural factors of health conditions are not only limited to exposure to illness but should also be asked about how women and men react to illness
  - Remind participants that these examples could be explored further – these are simply examples of GAQ that can be used.
- Go back to the flip chart or notes from the brainstorming activity on biological factors. Using the same conditions, ask participants to now identify ways that **sociocultural factors – or gender** – may affect males or females differently. If you have used the GAQ from slide 2.12 for the brainstorming around biological factors, use the same top level questions here (in other words, change slide 2.15 as needed) to guide the group discussion
  - Refer, when possible, to the examples from the listing activities in Module 1 (index cards) and select examples of gender norms, roles and relations, asking whether they are relevant for these health conditions and what the impact could be.



- Summarize by emphasizing the health effects of gender norms, roles and relations, drawing on the previous discussion, the flash card facts, listing activities and **Participant Notes, subsection 2.2b** (*Health effects of gender norms, roles and relations*).

Step 5a: unpacking access to and control over resources.

- **Using Slide 2.16**, introduce the final gender-related consideration of the GAM: access to and control over resources. Highlight the following:
  - Distinguish between access and control by emphasizing that control does not mean owning a resource. **Access is the availability of a resource (the resource exists and can be used), whereas control implies the ability to make decisions on how and when a resource can be used and by whom**.
  - Use **optional learning activity 3.0** (see Annex 3) as needed.
  - Accessibility or availability has several different dimensions that must be considered. Using the definitions on **Slide 2.16**, outline three **types of access** important to consider in gender analysis (including **geographical or physical, financial and social accessibility)**.
- Transition to the next slide by indicating that there are many important **health-related resources besides money** and that the three types of access can also refer to health-related resources.
  - Before revealing the content of **Slide 2.17**, ask participants to call out examples of health-related resources. After a few minutes, reveal the range of health-related resources on Slide 2.17, **noting that health-related resources can be regrouped into economic, social, political and "other" categories**. Take some time to discuss the connections between each of the resources and health as necessary. Conclude with the following:
    - Gender norms, roles and relations often produce **differential access to and control over resources between and among groups of women and men**.
    - Refer to **Participant Notes, subsection 2.2c** (*What are health-related resources?*) for a summary table of health-related resources.

- Introduce **GAQ that correspond to access to and control over resources** using **Slide 2.18**. Remind participants that, similar to biological and sociocultural factors, questions that are normally asked will not tell you anything about gender differences unless specifics about men and women are included. In other words, key questions lead to more questions to get to the bottom of things. Highlight expanded questions to reinforce the point of continual critical questioning in gender analysis.
  - Remind participants that these examples could be explored further – these are simply examples of GAQ that can be used.

Step 5b: revisiting the Power Walk: character analysis

Analysis of the Power Walk characters

1. Show **Slide 2.19; recall the Power Walk activity** from Module 1. Ask participants to put themselves back into the shoes of their character. (Note: if you have taken photos during the Power Walk on Module 1 and have the time and facilities, replace the existing photos with some from your own workshop. Participants will be surprised – and it will help to stimulate recall!)
2. Refer to or make visible flip charts from the Power Walk in Module 1 that reveal where characters ended up. Remind participants that characters ended up in different positions largely depending on their access to and control over resources.
3. Divide participants into groups (3 – 4 depending on the total number of participants) and ask them to choose one or two characters from among them. The selected characters should have ended up in different clusters (i.e., avoid two characters from the back group if possible) to demonstrate a range of responses.

- Display **Slide 2.20** and encourage groups to reflect on two of the characters for the selected statements:
  - **They should first determine a few key health-related resources the character would have needed to say "yes" to the statement**.
  - **Second, consider whether or not the character has access to and/or control over the selected health-related resources**.
  - Refer groups to the listing of health-related resources in the **Participant Notes, subsection 2.2c** to guide the discussion.
  - Give the group **15 minutes to brainstorm and then invite them to briefly present the differences between their characters** to the larger group.
- Discuss briefly the responses and what (if anything) can be done about changing them so that characters can move forward. Ensure that the discussion touches on other cross-cutting issues (or determinants of health) such as social class, ethnicity and age.
- Remind participants that the character analysis is based on interpretations of how the character would respond. In real life, they would need to have more information about the people, their circumstances and opportunities to better understand how access to and control over key health-related resources affects their health.

Transition to the next step in this activity

- Summarize the character analysis by recapping that **biological and sociocultural factors can influence access to and control over key health-related resources**.
- Remind participants that characters in the back cluster face various barriers to taking a step forward and may require additional assistance to overcome them. **One of these barriers is gender-based discrimination, and one strategy to overcome it is empowerment**.

Step 6: Gender-based discrimination

- Define gender-based discrimination using **Slides 2.21–2.22**. Highlight that Modules 1 and 2 already refered to gender-based discrimination – or **stereotypes based on gender norms, roles or relations that lead to discrimination**.
  - Ask participants to suggest examples of gender-based discrimination (such as practices, attitudes, policies and laws), and encourage them to give examples of discrimination of both men and women **in relation to health**. After a few examples, **show Slide 2.22** with a few health-related examples to supplement the discussion.
  - Refer to **Participant Notes, subsection 2.2d** (*Gender-based discrimination in health*). Encourage them to note other examples included in the space provided.
- Sum up the discussion on gender-based discrimination with the following points:
  - Gender-based discrimination is often **based on traditional beliefs about groups of women and men**.
  - Gender-based discrimination can be **direct or indirect**; in other words, either through overt prejudicial treatment (direct discrimination) or through "neutral" laws and policies that often result in unequal treatment between groups (indirect discrimination).
  - Gender-based discrimination may not always be intentional – as it often results from normalized beliefs and practices. This does not, however, make it excusable!

– **Normalized beliefs and traditions** are often passed from generation to generation (as the process of socialization) without any question as to their validity or fairness.
– The **limited access to and control over resources many women face** is often the result of gender-based discrimination.
– Health programmes and policies must respond to instances of gender-based discrimination when they pose potential or real **harm to the health of men or women at any age and of any social group**.
– Public health workers must understand how gender-based discrimination may influence health to be able to **develop sound responses**. They also need to know some of the strategies that may be useful to incorporate in their programmes.

Tips for facilitators

The examples provided on slide 2.22 may yield lengthy discussions, as some may be considered controversial. The facilitator may want to change the examples to make them locally relevant – and to prepare some material on each example so that this can be used to facilitate discussions and respond to potential questions.

Recall from Module 1

Empowerment …

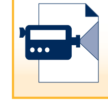
… is a process that helps people to gain and/or strengthen control of their lives;

… focuses on putting power in the hands of women and men of all groups; and

… is an important gender-mainstreaming strategy.

Step 7: Empowerment

- Remind participants of the discussion on empowerment at the end of the Power Walk (Module, 1 section 1.4), using Module 1 flip charts as appropriate. Recall examples of characters who were empowered to take steps forward and the reasons why. These are often related to access to resources such as education, information or money – all important determinants of health.
- Using **Slide 2.23**, emphasize that **Module 1 Power Walk discussions defined empowerment in practical terms**.



Recall key elements of empowerment from Module 1 on the slide as necessary. Highlight the following:
– Empowerment is a **way to address aspects of gender-based discrimination**.
– The aim of empowerment is to **achieve a more equal society in bottom-up ways**.
– Empowerment is an important concept in exploring gender-based discrimination and equality because it **aims to address unequal power relations and to increase individual and group capacity**.

- Conclude the discussion on empowerment by outlining some key empowering actions, indicating that practice in developing empowering strategies will come in Module 3, when participants begin to develop action plans for gender mainstreaming. Refer them to **Participant Notes, subsection 2.2e** (*Empowerment – Part 2: assessing empowerment is part of gender analysis*) for further reading.

Suggested transition to the next activity

Show the GAM, repeated on **Slide 2.24**. Indicate that participants are now familiar with the gender-related considerations and some of the corresponding GAQ that can be used to conduct a gender analysis of a health problem. Refer to the vertical axis, indicating that these elements are probably better known among an audience of public health specialists. These health-related considerations interact with the three gender-related considerations.

Take a break, do an energizer, play a game!

Handout 2.2a: Selected biological factors related to selected health conditions for men and women

Anaemia

- Iron deficiency linked to loss of iron during menstruation and pregnancy contributes to higher anaemia among women.
- Haemophilia is more common among men for genetic reasons.

Source: de Benoist B et al., eds. Worldwide prevalence of anaemia 1993–2005. In: WHO Global Database on Anaemia [online database]. Geneva, World Health Organization, 2010 (*http://www.who.int/vmnis/anaemia/en*, accessed 23 November 2009).

Sexually transmitted infections (STI)

- STI are asymptomatic for longer periods among women. This may mean that STI are more likely to be diagnosed earlier among men due to the presence of physical symptoms.
- A man with a STI such as gonorrhoea is more likely to seek health care earlier because the symptoms (such as pain on urination) appear within a few days after infection.
- The non-specific and asymptomatic nature of the symptoms of STI in women often results in their seeking health care late, which can increase complications.
- A painless syphilitic ulcer on the genitalia of a man is more likely to be noticed than a similar ulcer on the female genitalia. This may influence health-seeking behaviour.
- See also HIV example below for further biological factors related to STI.

Source: Sexually transmitted infections. Geneva, World Health Organization, 2007
(Fact Sheet No. 110; *http://www.who.int/mediacentre/factsheets/fs110/en/index.html*, accessed 23 November 2009).

Osteoporosis

- Osteoporosis is three times more common among women than among men: partly because women have a lower peak bone mass and partly because of the hormonal changes that occur at menopause and the effect of pregnancy, which can alter the calcium composition in a woman's body in the absence of appropriate diet and/or calcium supplements.
- Lifestyle factors such as diet, amount of sun exposure (influencing vitamin D levels) and degree of weight-bearing exercise (which reinforces bone strength) may also contribute to a higher prevalence among women.

Sources:
Karasik D, Ferrari SL. Contribution of gender-specific genetic factors to osteoporosis risk. *Annals of Human Genetics*, 2008, 72:696–714.

Oelzner P et al. Significance of risk factors for osteoporosis is dependent on gender and menopause in rheumatoid arthritis. *Rheumatology International*, 2008, 28:1143–1150.

HIV

- Women are more vulnerable to infection transmitted through unprotected sex with men.
- Higher vulnerability for women relates to:
  - the larger mucous membrane exposed during intercourse;
  - the length of time infected semen can remain in the vaginal tract (or greater exposure to infectious fluids such as semen);
  - the changes that occur in the vaginal mucosa as a result of the reproductive cycle or age; and
  - increased friction during intercourse, which may lead to tearing of the vaginal mucosa.

Sources:
Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women's needs. Geneva, World Health Organization, 2009 (*http://www.who.int/gender/documents/gender_hiv/en/index.html*, accessed 23 November 2009).

Gender and HIV/AIDS. Geneva, World Health Organization, 2003 (*http://www.who.int/gender/documents/en/HIV_AIDS.pdf*, accessed 23 November 2009).

Learning activity 2.2b: The WHO Gender Analysis Matrix: health-related considerations

Aims of the learning activity

- Introduce health-related considerations of the GAM and related GAQ

Notes

- Facilitators and co-facilitators should circulate among groups to ensure that discussions are on track and in case participants have questions.
- When participants are reporting back, start from the top of the health-related considerations so that you can follow in order with the relevant, explanatory slides as necessary.
- All sources used for this learning activity can be found in the **Participant Notes, subsection 2.2f** (*Health-related considerations in the Gender Analysis Matrix [GAM]*).

Summary of the learning activity

This learning activity leads into the group activity of conducting a gender analysis (section 2.3). The objective is to complete the explanation of the GAM by going over the health-related considerations and to introduce relevant GAQ. This learning activity is based on group work and facilitator input so that participants become familiar with components of the GAM and increase their comfort with using it both in section 2.3 and after the workshop is complete. **Use of the GAM and GAQ represents a core skill to be developed in the workshop**.

Suggested process

Step 1: projecting **Slide 2.24**, refer to the vertical axis of the GAM. Invite participants to unpack these health-related considerations based on their experiences and resources within the **Participant Notes, subsection 2.2f** (*Health-related considerations in the Gender Analysis Matrix [GAM]*).

Group work instructions

- Divide participants into **six groups** by whatever means is quickest (such as clustering participants seated next to one another); assign one health-related consideration per group.
- Refer to **Slides 2.25 – 2.32** and **Participant Notes, subsection 2.2f** (*Health-related considerations in the Gender Analysis Matrix [GAM]*) and request participants to discuss their assigned health-related consideration in terms of:
  - **Definition**
  - **Interaction with one of the three gender-related considerations** – using the health conditions discussed in learning activity 2.2a. Note that you can invite participants to discuss any health condition they prefer, but this may increase the time needed for the activity as groups need to agree on health topic. For the purposes of continuity from the previous learning activity, it is suggested to choose from among the health conditions discussed earlier.
    - **For example**: group A on risk and vulnerability will discuss how access to and control over resources affects risk and vulnerability related to STI for women and men of different ages. Group B on access and use of health services will discuss how biological factors may influence this health-related consideration, and so on for the other health-related considerations.
- Each group will have approximately **15 minutes** for the activity and should select a rapporteur and a presenter. Provide groups with flip-chart paper and markers as necessary.
- **Reporting back**: in the same order as on the GAM, each group will present its health-related consideration (definition) and how it interacts with the gender-related consideration selected.
- Facilitators can project the related slides for each health-related consideration as necessary to introduce the relevant GAQ (see complementary facilitator input below).

Complementary facilitator input during when the group is reporting back: as groups present the health-related considerations, facilitators can project the following slides as needed. Note that this information is in the **Participant Notes, subsection 2.2f** (*Health-related considerations in the Gender Analysis Matrix [GAM]*) and is therefore included on slides (with relevant talking points) in case they are needed or facilitators decide to present the vertical axis of the GAM in an alternative manner.

- **Risk factors and vulnerability (Slides 2.25 – 2.27)**
- **Access and use of health services (Slide 2.28)**
- **Health-seeking behaviour (Slide 2.29)**
- **Treatment options (Slide 2.30)**
- **Experiences in health care settings (Slide 2.31)**
- **Health and social outcomes and consequences (Slide 2.32)**

Step 2: Use **Slide 2.33** to wrap up the discussion by reminding participants that health-related considerations are explained in detail in **Slides 2.25 – 2.32** and in the **Participant Notes, subsection 2.2f** (*Health-related considerations in the Gender Analysis Matrix [GAM]*).

Step 3: recall that the process of gender analysis uses critical questions to uncover root causes of gender-based health inequities and remind participants of the GAQ introduced during discussions on the gender-related considerations of the GAM. Showing **Slide 3.34, highlight the top-level GAQ that can be used when unpacking the health-related considerations of the GAM**.

- Note, in particular, that **some questions apply to more than one health-related consideration** (such as questions on health-seeking behaviour, treatment options and experiences in health care settings). Emphasize that the **GAQ are a tool to help uncover gender- and health- related considerations and that linking specific GAQ to GAM components is less important than ensuring that the information is included in a gender analysis of a health problem**.

Step 4: Refer to the complete GAQ list in the **Participant Notes, subsection 2.2h** (*WHO Gender Analysis Questions*). Walk participants through the GAQ by highlighting the **eight top-level questions**. Some top-level questions have been introduced throughout the activity introducing the GAM.

- **Second-level GAQ** were also introduced in discussions on gender-related considerations. These are the exploded questions or further critical questioning. These questions are included beneath the top level questions. Draw participant attention to the fact that even these second-level questions can be "exploded" further.
- The second column of the GAQ chart helps to indicate which health-related considerations of the GAM can be unpacked using top- and second-level questions.

Suggested transition to next section

Now that participants have been introduced to WHO gender analysis tools (GAM and the GAQ), it is time to do their own gender analysis of a health problem.

SECTION 2.3: USING WHO GENDER ANALYSIS TOOLS

Learning activity 2.3: Learning to use the Gender Analysis Matrix and Gender Analysis Questions

Aim of the learning activity

- Acquire hands-on practice using WHO gender analysis tools (GAM and GAQ) to analyse a health problem.

Suggested process

Step 1: show **Slide 2.35** and go over the tips on using the GAQ and GAM. Refer to **Participant Notes, subsections 2.3a and b** (*WHO gender analysis tips; Sources of information for gender analysis*). Discuss briefly what kinds of sources of information are required to complete the GAM and corresponding GAQ. If there are no further questions, it is time for the group to get busy with their first gender analysis of a health problem.

Step 2: Group work using the GAM and GAQ

Formation of the groups

- Divide the participants into two – four groups. Mix men and women in each group.
- It is useful to have a programmatic or subject specialist linked to the topic chosen in the group – or to provide ample data or information on the topic to be discussed.
- Get to know participants' competencies before the activity; ensure that appropriate topics are chosen and that the topic specialists are evenly distributed in the groups. The activity can still function without experts; participants just need to draw on their own public health knowledge, conventional wisdom and supplemental documentation (provided by facilitator).

Selection of topics

- It is recommended to choose only three to four topics, as the feedback session is time-consuming and the discussion and interaction generated important for participants. Do not shorten time for reporting back.
- Select a health topic that is of concern to participants – either due to country priority or one that all (regardless of specialty) can discuss. This should be done in advance. Facilitators may want to **incorporate local policy and programme priority health areas** – that can then carry through into Module 3 learning activities (see Module 3 for facilitator notes).

Such **adaptations** require advance participation by facilitators - ensure you review policies and programmes and discuss with local partners current needs for gender mainstreaming in health sector activities (e.g, development or review of national health sector strategies, WHO Country Cooperation Strategies, UNDAF, national HIV/AIDS policies, etc.) that may be relevant for use in the workshop.

– For example: Country X has a national health strategy that is approaching its mid term review. Identified priority areas include cardiovascular disease, HIV/AIDS, mental health and tuberculosis. The group conducts gender analysis in Module 2 on these four priority areas. In Module 3, examples from the national health strategy are used throughout the GRAS introduction (Section 3.1) or used as a group activity to practise using the GRAS and GAT. Finally, in Section 3.3, use the existing policy or programme as a framework within which to develop or revise activities across the four priority areas of the strategy. Such adaptations can enhance practicality of workshop activities for participants.

- Groups can either all work on the same topic or double up on one topic (two groups working on the same topic) depending on the composition, size and availability of experts in the group. In very small groups, participants can work in pairs.
- If time is short and participants are many, you may need to divide the GAM along health-related considerations. For example, one group discusses risk factors and vulnerability and another experiences in health care settings. If this option is selected, **ensure a mix between the supply and demand side rows of the GAM**. If both aspects are not covered, the planning activities in Module 3 will be more difficult to complete.

Instructions for the groups

- Instruct the group that they will be performing a mock gender analysis. Project **Slide 2.36** with guidance for the group work. If the groups will be in separate rooms, ensure that they have the slides with them so that they can follow the instructions.
- Give groups about **one hour to complete the activity**, recommending they leave 15 minutes for preparing the presentation. Check in on them regularly, join their discussions when necessary and ensure that you are available to answer any questions.

Module 2: Analysis

Step 3: group feedback session

This is a vibrant, interactive session during which groups present their completed GAM. Facilitators should invite comments and questions from the broader group and also provide feedback and pose questions to the presenting group as necessary and appropriate. Highlight, when possible, the relative emptiness of the column related to biological factors (as appropriate) and make linkages to the Flash Card Fact conclusions and the need to look at **both** sex and gender. Get feedback on the process and challenges and discuss adaptations and usefulness of the WHO gender analysis tools to guide participants in using these tools in the future.

Step 4: wrap up group presentations by congratulating the group on their gender analysis of a health problem. **Acknowledge that the group activity is a mock exercise in gender analysis because they may not have had all of the data, expert input or stakeholder involvement as in the real world**. Emphasize, however, that the process of conducing a gender analysis of a health problem – by **examining interacting gender- and health-related considerations (as in the GAM) through a process of critical questioning (as in the GAQ) is just as important as the outcome**.

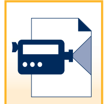
Sample GAMs / Annexes 3 – 5
- Gender and HIV
- Gender and tuberculosis
- Gender and malaria

- **Distribute sample matrices** (Annexes 1 – 3) as necessary and appropriate for the context – explaining that these matrices have been developed by groups from prior workshops. Highlight that **the process after the workshop was to consult data and literature, subject experts and other partners to compile information on gender and a given health problem**. Facilitators should check for additional sample matrices for use in workshops at *http://www.who.int/gender*, where updates will be posted.

- Some programme areas, such as **maternal health, child health or noncommunicable diseases**, may be selected for group work. Although these do not focus on any one specific condition, **Annexes 6 – 8** include relevant gender issues for consideration in these programme areas. These annexes can be used either as supporting documents for group work or as reference resources.

Section 2.4: Conclusion of Module 2

Step 1: congratulate participants on their hard work – they have performed their first gender analysis! They have seen through this exercise that it is not always easy or obvious, that team members do not always agree and that many times we would have missed things had we not asked the right questions about gender norms, roles and relations for women, men and their implications for health.



Step 2: conclude Module 2 with **Slide 2.37**. Highlight the following:

- You have been introduced to different **tools that can help you conduct gender analysis of a health problem**.
- Gender analysis **uncovers the interaction of gender-related considerations** (biological, sociocultural factors and access to and control over resources) and **health-related considerations** (risk factors and vulnerability, access and use of health services, health-seeking behaviour, treatment options, experiences in health care settings and health and social outcomes and consequences).
  - These have been organized in the **GAM**, and **GAQ** are provided to support its completion.
- Gender analysis findings can:
  - provide an opportunity to raise awareness on potential harm due to gender norms, roles or relations;
  - be used for advocacy work;
  - stimulate further research and assist in refining research questions; and
  - assist in planning and implementing health sector activities.
- Time permitting, use the quick quiz questions on the screen to incite participants to recall core concepts. If treats are on hand, give them to the ones that answer most quickly … and accurately!

Tell the group that they will be transforming their findings into action in Module 3.

Step 3: refer to the **Participant Notes, subsection 2.3c** (*Gender analysis recap*) for some concluding thoughts on gender analysis.

Step 4: remind participants to:

- Review additional reading in the Participant Notes.
- Consult references for further information.

Step 5: distribute evaluation forms and/or a progress check (see below). Facilitators should note that the progress check can be either distributed to participants or conducted at the start of the subsequent module (on a flip chart) as a way of testing participant comprehension before moving forward.

Module 2 progress check

I know or understand …	Not at all	Somewhat	Well
1. What a gender analysis is and its benefits in public health work.			
2. What gender-related considerations are in gender analysis of a health problem.			
3. What health-related considerations are in a gender analysis of a health problem.			
4. What gender-based discrimination is and why it is important to address when working in health.			
5. What the WHO gender analysis tools are and feel comfortable using them in my work.			

Thank the group – give everyone a round of applause!

ANNEX 2. MODULE 2 OPTIONAL LEARNING ACTIVITIES

Optional learning activity 2.0: Can you tell the difference between sex and gender?

Aims of the learning activity

- Reiterate the distinction between sex and gender.

Notes

- This optional learning activity can be used to complement the **Progress Check of Module 2** or **Module 1, section 1.2** (*Sex and gender are not the same*).

Suggested process

Step 1: using a flip chart, the facilitator draws a table similar to the one included below.

Step 2: ask participants to call out, without too much reflection, "typical" characteristics of women and men. If they are stuck, give them examples from their gender norm listing activity from Module 1 or use some from the prepared table of statements below (note that the table indicates sex or gender for facilitators). Record participant ideas for each sex on the flip chart.

Step 3: once there is a decent list of characteristics, select a few from each sex; for each one, ask whether it is a characteristic that belongs to that sex only. If the answer is no, put an "X" by it. When the answer is yes, circle the characteristic. When you have gone through a few, ask what the difference between the circles and the crosses are. You should find that the crosses are the characteristics that refer to gender (and therefore changeable and attributable to either sex) and the circles are those that refer to sex (and therefore difficult to change and usually attributable to only one sex, often determined by biology). Recall the definitions of sex and gender using slides from Module 1 as necessary.

Statements for use in the optional activity as necessary

Statement	Sex or gender
1. Women give birth; men do not.	Sex
2. Women are more loving and caring than men.	Gender
3. The most important role of the man in a family is to be a breadwinner and head of the household.	Gender
4. Men think and act more rationally than women.	Gender
5. Women can menstruate; men cannot.	Sex
6. Women make poor managers.	Gender
7. Most men are taller than most women.	Sex
8. Women develop breasts that are usually capable of lactation; men do not.	Sex
9. According to United Nations statistics, women do 67% of the world's work, but their earnings for it amount to only 10% of the world's income.	Gender
10. Studies show that girls perform better in girls-only classroom situations.	Gender
11. Women do not consider having sexual relations as important as men do.	Gender
12. Only men can provide sperm for reproduction.	Sex
13. In a study of 224 cultures, there were five in which men did all the cooking and 36 in which women built all the houses.	Gender
14. Women are the weaker sex.	Gender
15. Men do not cry.	Gender

ANNEX 3. SAMPLE GENDER ANALYSIS MATRIX: HIV

Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Risk factors and vulnerability	Both men and women are at risk for HIV. Men who have sex with men (MSM) are at increased risk because the virus is readily transmitted through unprotected anal intercourse. Women are at greater risk than men of acquiring HIV through **heterosexual contact** due to:[1] • larger surface area of the mucous membrane exposed during intercourse; • the introduction of an infectious fluid (semen); and • the fragility of the vaginal mucosal membrane (especially among women younger than 18 years).	Vulnerability to HIV may be higher in settings where there is more **poverty and migration. For women and girls**, poverty may increase vulnerability to HIV infection and force them to exchange unprotected sex for food, money, school fees or other basic needs. Gender norms about **sexuality, masculinity and peer pressure** may promote unprotected intercourse and contribute to acceptance of **promiscuity** and multiple partners for some young men and to a lack of voice for women in terms of if, when, where and with whom they have sex. • In many parts of the world, the prevalence of HIV infection is higher along major trucking routes and highways. Truck drivers, mostly male, are considered a most-at-risk population. **MSM** may be reluctant to get tested due to **stigma and discrimination**, which is often caused by attitudes against homosexuality and/or bisexuality. Such attitudes reflect an emphasis on heterosexual sex as a norm. As a result, infected men may continue to have unprotected sexual relations and unknowingly pass on the disease to their partners (male or female). Gender norms relating to sexuality and masculinity tend to privilege **heterosexual relations.** [3-5] **Adolescents, especially girls**, are particulary vulnerable to HIV. The exact reasons depend on the region:[1-2] • In some places, adolescent girls either engage in premarital sex or marry early. Young girls may be married to older men and lack the power to negotiate safer sex. • In many settings, adolescent girls lack access to information and services for HIV prevention because of social norms that dictate that young women should not be sexually active. • Peer pressure may play a role in some settings, influencing young girls and boys to engage in unprotected sex with multiple partners. • Older men in some areas sometimes seek to have sex with young girls in the belief that their young partners are more likely to be virgins or otherwise free of HIV. The false belief that sex with a virgin cures HIV infection or AIDS may also lead older men to have unprotected intercourse with a girl or young woman.	Gender norms about interpersonal relationships between women and men may decrease women's access to and control over essential resources (such as condom negotiation skills, legal recourse for experiences with violence and information on preventing HIV infection) that could increase risk factor exposure and vulnerability to HIV infection.[2] • See also the intersection between "risk factors and vulnerability" and "sociocultural factors". Discrimination and stigma against MSM and norms related to masculinity may prevent men from seeking information and services related to HIV prevention. Poverty and economic resources, including paid employment, may affect exposure to risk factors and vulnerability differently for women and men. • For more information, see the intersection between "risk factors and vulnerability" and "sociocultural factors".

Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Risk factors and vulnerability		In some Asian and African countries, **married women** account for a large proportion of people newly infected with HIV even though their only risk factor is having unprotected sex with their husbands. Social norms may encourage the belief that men are entitled to have unprotected sex with their wives. This indicates that gender norms about intimate partner relations, such as marriage, may increase women's vulnerability to HIV infections in several ways: • Married women or women in long-term relationships often do not perceive the risk of HIV infection and therefore may not take necessary preventive actions, thereby increasing vulnerability. • If married women or women in long-term relationships do perceive a risk within their relationships, they may not have the **power to negotiate safe sex or they may be reluctant to raise the issue of HIV risk with their partner for fear of disrupting a relationship of trust or risking a violent reaction by their partner**. • **Wives or regular partners of migrant men and of men in the trucking industry** are often unaware of or unable to address their partner's risk behaviour. • Many women cannot refuse sex (protected or not) with their partners even when they know there is a risk of acquiring HIV. In many societies, rape within marriage is not recognized as a criminal offence. **Violence against Women (VAW)** is both a cause and a consequence of the HIV epidemic. Women experience increased vulnerability to both HIV infection and violence due to various sociocultural norms. • Women who experience physical violence and sexual coercion are often afraid to negotiate condom use with their partners. A study in South Africa[5] showed that women who reported forced sex were less likely to have used condoms and, in turn, were more likely to be HIV infected compared with women who used condoms. • In some settings, women face violent reactions from partners or community members after disclosing their HIV-positive status. The **way HIV symptoms unfold may place intimate partners of a person living with HIV at risk**: during the years between initial infection and symptom visibility, the person and/or his or her sexual partner or partners may not know that the person is living with HIV.	

Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Access and use of health services	**Women's ability to bear children** may increase their access to and use of health services for HIV treatment. In some settings, women are more likely to be tested for HIV in the context of pre- or antenatal care. As a result, pregnant women may be diagnosed and access HIV-related services more often than men.[2]	Men's role in the paid, formal economy may increase their access to and use of HIV services. In some settings, men may have better access to HIV services, including testing, due to **formal employment benefit packages** that may allow greater access to private services. Men often prefer the anonymity offered by private services, which may also be of higher quality than public services in some settings. Norms related to female roles, sexual relations and marriage can prevent women – especially young women – from accessing HIV information and services.[6]	HIV treatment requires facilities at **primary, secondary and tertiary levels**. Yet primary health care (PHC) services in resource-poor settings are not always equipped to provide the full range of HIV services, especially treatment and care requiring follow-up or complicated tests. This affects both women's and men's ability to access and use effective HIV treatment. **Indirect costs** associated with HIV services disproportionately affect women: • Community services such as home-based care, support networks, legal or social support often complement health services delivered through PHC centres for HIV treatment. Gender norms, roles and relations often dictate that women provide these complementary services, free of charge. • People receiving antiretroviral therapy must drink lots of water and eat three balanced and nutritious meals per day. Poor households have reduced access to resources such as clean water and nutritious food; when the household sets priorities, male roles of authority and breadwinning often take precedence. • There are financial costs associated with obtaining water, food and fuel to cook meals. Time may also be at a premium, especially for women who bear the responsibility for fetching water, gathering fuel, obtaining food and preparing meals. **Poverty** or lack of access to and control over financial resources may hinder women's and men's ability to access and use health services for HIV treatment. This is expressed in the following ways in different settings: • People living with HIV require expensive treatment, including lifelong drug therapy. Several countries are making antiretroviral therapy available free of charge or cover part of the associated cost for individuals from certain vulnerable groups. However, few people living with HIV have their medication paid for in full, and **even the subsidized costs can be prohibitive for poor people**. • User fees for antiretroviral drugs, diagnostic tests (such as CD4 counts) and treatment of opportunistic infections are greater than what many women and men can afford. However, women are confronted with additional challenges related to economic resources, including the lack of control over family expenditure, the higher prevalence of poverty among female-headed households and the fact that the treatment needs of men in the family (especially those of the breadwinner) may be given a higher priority.

Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Access and use of health services			Gender norms often hinder women from accessing health services in a timely fashion (whether HIV related or not).[2] These play out differently in each setting: • Some women need permission from their partners and family members to seek health care. • Some women are prevented from accessing services due to child care and household responsibilities. • Some women cannot attend health care facilities without being accompanied, the presence of a female doctor or their partner's consent for certain types of treatment and examinations.
Health-seeking behaviour	Due to the lack of visible symptoms in early stages of the condition, men and women may only be compelled to seek health care long after getting infected.	Fear of **stigma and discriminatory consequences** may affect HIV-related health-seeking behaviour for women and men differently: • Regardless of sexual orientation, **men may be reluctant to be tested or treated** for HIV due to the fear of being stigmatized by peers and the community for having sex with other men. Many countries consider sexual relations between men to be a criminal offence. • Women may avoid seeking testing or treatment for HIV, even in the context of preventing the mother-to-child transmission of HIV, out of fear that their partners and their community will reject, abandon or act violently towards them and/or blame them for bringing HIV into the family.[7]	In some settings, women may delay health-seeking behaviour to give priority to the treatment needs of men in the family or children's nutritional needs. This is often exemplified in situations of **poverty**. For example, in a rural clinic in Zambia, 3 of the 40 people receiving antiretroviral therapy were women. A woman asked, *"How would I feel if there is no food in the house to feed the children because the money has been spent on medication that is only for me?"*[8] The **poverty and employment status** of women and men may affect health-seeking behaviour. • For more information, see "access and use of health services" and "access to and control over resources". Social norms relating to **women's social mobility** and/or stigma for both women and men can affect HIV-related health seeking behavior. For more information, see "access and use of health services" and "access to and control over resources".
Treatment options	In general, antiretroviral therapy for HIV as well as treatment for opportunistic infections due to HIV infection is the same for women and men.	Different roles and needs of men and women tend to affect HIV treatment compliance: • Instructions for taking medicine may need to be adapted for people who are illiterate; this affects both men and women, but more women are illiterate in many settings.	**Poverty or lack of access to adequate socioeconomic resources affects women's and men's compliance with HIV treatment**. • For more information, see the column "access and control over resources" in the rows "access and use of health services" and "health-seeking behavior".

Factors that influence health outcomes: *Health-related considerations*	Factors that influence health outcomes: *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Treatment options	There may be additional considerations related to the **type and dosage** of antiretroviral drugs used **for women and girls due to their reproductive systems**:[7] • Certain first-line antiretroviral drugs are contraindicated for pregnant women. • Treatment options for certain reproductive tract infections are different for women than for men. • The full implications of women's treatment for viral load and CD4 count are not yet known.[9] Clinical trial data on HIV treatment among women are limited, and most studies that included women have not been geared to detect sex differences in viral and immune success rates.[7]	• Advice for taking medicines may need to take into account differences in daily routines, working environments, budgets and the need for social care. Men may require treatment support in terms of opportunities, time and spaces at workplaces, whereas women may need household- or community-based treatment support, including care for children, other family members that test positive or for older household members.[7] • Some gender norms relating to communication and problem-solving patterns may affect how and how often men and women seek support for HIV treatment. Norms for masculinity that tend to downplay help-seeking may discourage men and boys from revealing their HIV status and/or asking for support. Women and girls, in contrast, may be encouraged to share and seek help. These norms may influence their willingness to participate in HIV groups and other support networks that provide emotional, mental and practical help for treatment preparation and adherence.[7] • Women may require counselling on the fear of and/or potential side effects of antiretroviral drugs. For example, in some settings, pregnant women fear that antiretroviral drugs will harm the fetus and therefore refuse to take them.	People receiving antiretroviral drugs must eat three balanced and nutritious meals per day. In Zambia, a single mother of five spoke about how food was an issue in her home: "*On most occasions we go without food as women, we eat last and there usually is not enough to go around. So how can we go on the medication? We need food to go with it. I tried to take the medication on a stomach full of water and I vomited everything.*"[8] • Women (especially older women) and girls are more often caregivers than men and boys. In a household with people living with HIV of both sexes, this may lead to women actively taking less time for their own health and passively getting less care than men.[2,10] • Receiving antiretroviral therapy does not necessarily lead to completion for many women. Some women report sharing their medicines with children or friends or selling it on the black market to get money to buy food; other women indicate that their male partners force them to give him their dose of antiretroviral drugs or steal it, even if he has never been tested for HIV.[10]
Experiences in health care settings		Women and men face different types of stigma and discrimination in health care settings – whether due to individual practice, legislation or institutional policies.[11] • Homophobia and anti-bisexualism among health care professionals may negatively affect women's and men's willingness to seek information and services for HIV prevention – whether they have intercourse with the same, opposite sex or both. In addition, norms related to masculinity may highlight heterosexuality as the only way of proving manhood, thereby encouraging men who have sex with men to also have sex with women.[12] • Health care providers, family members and the community may stigmatize women living with HIV and treat them as being promiscuous because of assumptions about how they became infected. • Women living with HIV who desire children may be coerced into accepting sterilization because providers or family members believe that they should not be having children.[2]	Access to information may affect people's experiences. In some settings, women are told about their HIV status only after health care personnel inform their husband or male in-law.[12]

Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Experiences in health care settings		• Some studies reveal that women's feelings of stigmatization depend on the specialty of the physician. [9] The timing of being diagnosed as being HIV-positive can cause emotional stress among both men and women. Women who have never considered an infection may be traumatized when being informed at an antenatal clinic, especially if tested without consent. [12]	
Health and social outcomes and consequences	Men and women differ in the physio-logical manifestations of HIV and AIDS. For example, women with AIDS may experience vaginal thrush and require screening for cervical cancer; pregnant women with HIV are more susceptible to malaria. [13] In sub-Saharan Africa, young women 15 – 24 years old account for 75% of infections in their age group and up to 90% in South Africa. [1,14] The ways HIV is transmitted can put an entire family at risk because: • HIV infections are transmitted sexually between partners. • HIV can be transmitted from mothers to children.	As HIV infection is a chronic and debilitating condition, entire families (and especially women) are significantly burdened by the **need to care for infected individuals**. In many countries in sub-Saharan Africa, older women often care for grandchildren who have been orphaned because their parents died from HIV/AIDS. Boys and girls are likely to undergo **emotional stress** when their parents reveal their HIV-positive status, fall sick or die. In many countries, especially in sub-Saharan Africa, an **increasing number of orphans** whose parents died from HIV/AIDS live in child-headed households. This pressures girls to leave school to take over family roles and puts them at risk for abusive relationships. [2,12] HIV-related communication problems, **stigma and social exclusion** negatively affect the men and women themselves and their entire core and extended family. However, women more often then men experience physical assault, abandonment by spouse or family, violent threats and property being taken away. [1,2] The consequences of living with or supporting someone living with HIV may have a greater **economic impact** on women as they are more likely to lose their job in the formal sector if they are seropositive. [2]	Undergoing HIV treatment has different economic effects on men and women. In most settings, men have **access to assets**, such as land, property or cattle, that can be used to pay for treatment and ancillary costs, whereas many women do not. Second, men usually control household spending. As a result, women may not have the means to pay for HIV treatment on their own or without their partner's permission. [6,11,14] **Lack of education and economic security** for women and girls may force women to adopt survival strategies (such as survival sex) to cope with their own illness or that of those for whom they care – that could also increase their chances of contracting and transmitting HIV. [7]

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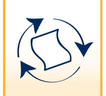
ANNEX 4. HANDOUT – SAMPLE GENDER ANALYSIS MATRIX: TUBERCULOSIS

Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Risk factors and vulnerability	Men and women are at risk. However, **sex, age and existing health conditions** seem to make a difference:[1,2] • After 15 years of age, TB cases commonly increase among men in most parts of the world. This may differ depending on the context, especially in sub-Saharan Africa, where the prevalence of HIV is high among young women. Women in their early reproductive years have **higher rates of progression from infection to disease and higher case-fatality rates** than men of the same age.[3,4]	Gender norms and roles may increase women's and girls' **exposure to indoor air pollution**, a risk factor for TB, due to open, often unsafe fires in closed kitchen areas.[5-7] Women's and girls' roles as **household caregivers** may increase their risk of infection when caring for a family member with TB infection. Certain **occupational factors** such as crowded or poorly ventilated working environments, travelling or commuting in closed vehicles – which are more common among men – may increase risk and vulnerability for men. **Male gender norms** may increase the risk and vulnerability for men and boys:[7,8] • Substance abuse, such as smoking, alcohol consumption and injecting drug use, in combination with TB poses a higher risk of progressing from infection to disease for men than women. • TB incidence in prisons is quite high in some settings – a population group that is largely male.	Combined, **poverty and gender inequality** may lead to different exposure to TB bacilli for women and men:[6,9] • Gender norms about **social mobility and access to education and information** may mean that some women have more difficulty than men in accessing health education and communication programmes. • Gender norms related to **son preference** may mean that women eat less nutritious food; this may be exacerbated in low-income households in which resources are often kept for those earning income. When such food patterns occur, it may disproportionately expose women to malnutrition, potentially increasing vulnerability to TB.
Access to and use of health services	**Pregnancy** and the use of prenatal and antenatal health services may facilitate access to TB detection and treatment services for certain women.[10] Tuberculin-positive women of reproductive age tend to progress faster to active TB than tuberculin-positive men of the same age.[10]	Research findings suggest that there are **gender-based barriers to diagnosis and treatment** that active case-finding might address. This might be attributed to patient or provider delay:[2,10,11] • Patient delay is the time between the onset of symptoms and the first contact with a health care provider: – In some cultures, women with chest symptoms are reluctant to seek treatment because of embarrassment and/or fear of stigma. – Data from Bangladesh, Thailand and Vietnam indicate that women perceive the stigma of TB to be worse for them than for men.	**Poverty** reduces the access to and use of high-quality TB services for both women and men. However, **poverty and gender inequality** combined often have a greater effect among women on access to and use of health services. **Ethnicity, combined with gender**, may also contribute to differential access to and use of health services. For example, many ethnic or religious minorities in eastern Europe have reduced access to health care – which can be exacerbated for women.[7] Gender norms, roles and relations may affect **access to diagnostic health services** via detection methods. The choice of detection method seems to lead to different case numbers between men and women and may affect access to therapeutic responses:[8,11,12] • Gender norms that limit unaccompanied hospital visits or being treated by male physicians may restrict women's access to and use of health services. • More men than women are found to be positive for acid-fast tubercle bacilli on microscope examination after sputum submission. This may be due to gender norms of femininity that emphasize hiding body fluids, which may result in fewer women submitting sputum samples.



Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Access and use of health services		• Provider delay is the time from the first contact with a provider until diagnosis: – A study from Vietnam revealed that provider delay averaged 3.8 weeks for men but 5.4 weeks for women. Potential explanations for this difference include the following: ▪ More women than men sought family approval before providing a sputum sample. ▪ More men than women present with characteristic symptoms. ▪ More men than women with symptoms of prolonged cough underwent sputum testing. ▪ There appear to be more false-negative results for women than for men (low sputum positivity among women may be due to the decreased quantity and quality of sputum production).	
Health-seeking behaviour	Fewer women than men report any of the typical TB symptoms of cough, sputum production and haemoptysis. [12] This means that women's symptoms may serve less as a trigger for health-seeking behaviour.	Fear of stigma and social exclusion may cause delays in seeking health care. Gender norms, roles and relations can further influence these delays: [8,2,9,10] • Women in all settings may hesitate to search for help due to embarrassment related to exposure of otherwise hidden body parts, especially if the observer in the DOTS treatment is likely to be a man. • In some contexts, women and girls may hesitate to seek help, as **stigma** for them may translate into reduced marriage opportunities and increased chances of abandonment, divorce, rejection by their husband and harassment by relatives. Men may hesitate to seek help due to stigma that may bring them a reputation of weakness and reduce employment opportunities. For further information on patient delay, see "access and use of heath services" and "sociocultural factors".	Gender norms, roles and relations can often limit women's movement and access to key household resources necessary for seeking health services. **User fees** for treatment can affect men and women in different ways, especially in low-income households. Preference may be given to treating the breadwinner. **Lack of access to education** (formal or informal) as well as barriers to health education campaigns may limit women's ability to recognize non-classical TB symptoms (breathlessness and chest pain). Men's health-seeking behaviour and adherence to treatment may be **delayed or precluded** by potential loss of income. [13]
Treatment options	Biological differences relate to **pregnancy**, especially in case of undetected TB or late onset of TB treatment: [8] • Untreated TB during pregnancy poses a threat to the mother and the fetus. • A late diagnosis of pulmonary TB increases the risk of **obstetric morbidity** and brings about a higher risk of **miscarriage, eclampsia and intrapartum complications**.	Gender norms, roles and relations may affect treatment adherence, as household responsibilities may deter women from completing treatment and fear of losing paid income may deter men. [13,14]	See "health-seeking behaviour" and "access to and control over resources".

Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Experiences in health care settings		People with TB, male or female, often experience stigma, especially if they are HIV positive. This stigma may be experienced differentially due to gender norms. [10,15]	For both men and women, the total out-of-pocket expenditure associated with TB treatment poses a financial burden. • See "access to and use of health services" for more information.
Health and social outcomes and consequences	Genitourinary TB is more likely to cause **infertility** in a woman than a man. [8] Men are more likely than women to progress more rapidly from infection to disease and to die from TB than women. [4,10] Pulmonary TB in mothers increases the risks of **miscarriage, eclampsia, intrapartum complications and poor pregnancy outcomes** such as female and male neonates' risk of prematurity, low birth weight and perinatal deaths. The mother herself has increased risk of obstetric morbidity. [8,15] Treatment failure increases the risk of the person with TB of developing **drug resistance** and of passing on TB and/or drug resistance to his or her household and social network. Men more often than women do not complete their TB treatment and therefore may be more prone to drug-resistant forms of TB. See also "risk factors" and "biological factors".	Both males and females with TB and their immediate and wider social network may be affected directly and indirectly at any stage of infection and treatment: • Household exposure to TB may directly affect the health status of family members, especially boys and girls living at home and women taking care of people with TB and/or fulfilling domestic duties. • Lack of income or support from people with TB may directly affect family members. Due to gender norms related to masculinity, the former function of a man as a main income provider may be transferred to a younger male relative and/or a female relative – with other consequences for these individuals and household survival. Besides physical symptoms, females and males with TB are usually burdened by distress brought on by stigmatization, isolation and coping with a chronic condition. This may lead to suicide attempts or family abandonment. [2] See additional outcomes or consequences in "health-seeking behaviour" and "sociocultural factors".	**Employment and income-related stresses** of coping with TB may have different effects on men and women. Men may feel stress, as they may consider themselves failing in their duty to provide their relatives with income, while women may regard themselves as poor caregivers when they take care of their own heath needs. [8,9]

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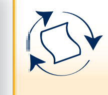
ANNEX 5. HANDOUT – SAMPLE GENDER ANALYSIS MATRIX: MALARIA[1]



Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Risk factors and vulnerability	**Pregnant women** and **young children** have the highest risk of severe malaria symptoms.[2] Risks and vulnerability for pregnant women include: • Malaria is four times more likely to strike pregnant women than other adults and is more common among pregnant women than in the general population. Immunosuppression and loss of acquired immunity to malaria during pregnancy are possible causes of this.[3] • Anaemia during pregnancy determines a higher risk to severe symptoms of malaria. • Women with both HIV and malaria are especially vulnerable to severe anaemia and adverse birth out-comes.[6] • Adolescent girls in some regions are particularly vulnerable to malaria, due to young people's lack of acquired immunity to malaria, and the lack of malaria immunity acquired during one's first pregnancy.[6,7] **People living with HIV** are more likely to catch malaria because of their immune deficiency. Globally, the percentage of women among people living with HIV has remained stable at 50% for several years. However, among young people in Africa, prevalence tends to be notably higher among females than among males.[9]	**Sleeping patterns** (outdoors or indoors): men may be more likely to sleep out-doors than women, where they are less likely to use insecticide-treated bed nets. In addition, gender norms determine that boys are more likely to stay outdoors at night than girls, which increases their exposure to mosquito bites.[2] **Dress codes** determined by gender norms may affect skin exposure. Men who work in forests while shirtless and in shorts are more likely to be bitten by mosquitoes and suffer malaria than women who wear clothing completely covering their bodies.[2] Due to the gender-based division of labour, patterns of **occupational exposure** differ between women and men: • Men may be more likely to engage in manual labour in forests, mines or fields or to travel to higher-risk areas to work.[6] • In Southeast Asia, for example, high-risk groups are those who work in forestry, agriculture and mining.[8] • Women's outdoor activities, such as cooking, washing clothes or fetching water from areas with a high presence of mosquitoes during peak biting time, can put women at risk.[6] In cases where a household only has one bed net, priority may be given to men, seen as breadwinners of the family, or to those seen as vulnerable, such as young children. If young children traditionally sleep with their mothers, both women and children may be protected by joint use of bed nets.[14] A study in Nigeria, found that, if the household head was male, the household was more likely to own an insecticide-treated net. The gender reasons for this are unclear.[15] In polygamous families, the "favourite" wife may receive protection, as she sleeps under the net in the same bed with her husband. The remaining wives and other family members may not receive this protection.	**Vulnerable groups** such as migrant workers, women and children who are displaced or under **emergency situations** may face more constraints on accessing resources. Food aid may be distributed to household heads, primarily men, and therefore marginalize women. This may lead to lower nutritional status among some women and greater risk of infection, including malaria. • Women may be at increased risk of sexual, domestic and other forms of **gender-based violence in post-conflict or post-disaster situations**. This can increase women's isolation, restricted mobility, and lack of access to information and relief services.[4,5] **Gender-based divisions of labour** may lead to different patterns of exposure. In some settings, men work in outdoor activities and have to walk long distances. They may thus not have time to access information on preventing malaria. Women, due to work and care burdens, may not have time to access information on preventing malaria. Women often have less **education and literacy** than men and thus less access to information materials on malaria risk factors, prevention and symptoms. In Kenya, evidence indicates that men are more likely than women to adhere to the belief that malaria is contracted from eating mangoes or raw food. The reasons for this are unclear.[16] Beliefs such as these may influence prevention efforts of public health professionals. **A lack of control over finances** can mean that women are unable to give priority to preventive measures. • A study in Benin found that women were more likely than men to give priority to purchasing and using bed nets but could only do so when they had control over income.[6] In many contexts, men and boys have priority for receiving food within the household. Women have lower average nutritional status than men, which can lead to a greater risk of infection, including malaria.[2]

1 This matrix was adapted from "The Gender Analysis Matrix for malaria – an example" in *A guide to gender and malaria resources*[1] as the purpose was to build from the workshop associated output. Thus, all statements without clear citations are adapted from the guide.

Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Risk factors and vulnerability	The immunosuppression associated with **anaemia** is, in theory, a risk factor for malaria in all groups. Males have been found to have a greater risk of anaemia in infancy,[10, 11, 12,] while women are at generally higher risk of iron-deficiency anaemia than men.[13]	Community-based prevention programmes are often less effective in areas where social norms **prevent women from attending community events**.	Gender norms can prevent women from establishing a large **social network**. This may lead to less access to information on malaria and its prevention.[2] A study in Bangladesh found that lower socioeconomic groups tended to list neighbours and relatives as their source of information on malaria, especially women.[17]
Access and use of health services	**Pregnant women** may have difficulty walking long distances to access care. **Disabled** men and women and older men and women may also have difficulty in this regard.	Gender roles stipulating women's responsibility for **child care** may lead to an inability to use services when children are in need of care at home. Indeed, the prevalence of malaria is often reported to be higher among men than women.[2,8,20-22] **Distance from health services** may have gendered implications for care-seeking. Men in Papua New Guinea, for example, were more likely than women to be deterred by distance and the need to walk to health facilities.[6] In addition, typical occupations for men may be located far from care. On the other hand, sociocul-tural beliefs or religious barriers may dictate women's restricted mobility and affect the utilization of health services. The **national or local security** situation may affect women and men differently. Men may fear shooting or kidnapping, and women may face the additional fear of sexual violence. This can affect mobility and thus access to health services.	Men, in many contexts, have the means to seek health care and **control decision-making and finances**. Thus, they may be more able than women to seek and pay for treatment or to do so quickly. Women may be forced to delay seeking treatment or seek lower-quality, less expensive services for themselves or their children in situations in which men do not provide the resources to obtain standard treatment:[18,19] • A study in India found that, in a situation in which an entire community had little access to adequate formal health services, men were still in a better position to access treatment because of their **greater control over monetary resources and decision-making power**. Men were better cared for and were able to rest more than women after contracting malaria. In addition, women were blamed by their husbands and marital families for refraining from household duties when sick and for using household money for their care.[23] Women tend to have less access to education, finances, transport, time and information than men. For example, women may need to be accompanied by a male relative when leaving the house to seek health care, or women may not have control over the household's means of transport. **Inadequate resources** within the household to meet the health care needs of the family can result in priorities being set for care. For example, household resources may preferentially be allocated to the health care needs of boys, men, young children or mothers carrying male fetuses. In some settings, only men are allowed in social centres, which may increase their access to health-related information. The benefits of health information may not reach women in such cases. Due to the caregiving and childbearing roles attributed to women, the **lack of social support** may imply that they do not have time to access the health sector for themselves.

Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Health-seeking behaviour	Malaria may be **asymptomatic** during pregnancy, causing women to not seek health services. Pregnant women may not differentiate signs of malaria from those of pregnancy. Pregnancy complications may hinder women from attending clinics. **Menstruation and childbirth** may delay treatment-seeking, as women may face mobility constraints due to social customs on moving about the community during menstruation and pregnancy.	Many men and boys **endure discomfort** longer than do women and girls, which may delay reporting. Women, as **primary caregivers of children**, may be more likely to recognize illness and seek care for their children than men. Gender norms may also lead mothers to give priority to the health of their children and other family members above their own. Gender norms and social constraints on women's behaviour may prevent women from seeking care from male health workers. Women have more chores and often less time to seek health services for themselves. Women who go out at night or alone to seek treatment may be vulnerable to sexual violence or the fear of it.	Boys and men usually have more **access to education** and are more literate and thus more likely to have knowledge about illness symptoms, the availability of free medication and the importance of prompt treatment.[17,18] • Men and boys may have more access to transport or be more mobile as a result of gender norms encouraging males to travel and move about more freely than females. Women are marginalized in **formal employment** and therefore receive lower incomes. This may lead to less access to resources that could finance health care. Likewise, women usually control fewer financial resources to pay for care. Women may need to ask men of the household for permission to spend money on health care, and this may delay or prevent care-seeking.[18,19] **Traditional healers** often offer lower-cost services than allopathic practitioners and may therefore be frequented by the poor, both women and men. However, the fact that women often have less access to resources than men may lead women to attend traditional healers more often. A study in Bangladesh found that women were less likely to seek treatment for fever and care from an allopathic practitioner.[17] A husband or other household members may limit women's mobility and autonomy concerning their health care. Decision-making processes in the household, such as to seek allopathic health care or traditional healing, may be dominated by men or mothers-in-law. **Information** for pregnant woman is available at antenatal care centres. However, less information is available at these centres for men and for non-pregnant women. • People with **less education** may not have much knowledge about malaria. This often leads to poor perception or fear of certain interventions. Women tend to receive less education than men and may thus be more vulnerable in this regard.
Treatment options	Traditional exclusion of women from **vaccine trials** could result in vaccines with unforeseen side effects in women. Antimalarial testing protocol focuses on healthy men. Thus, important side effects or interactions in women may remain unknown.	Due to gender roles giving women primary responsibility for **childrearing**, women may visit health centres often because their children are ill. This may increase women's own interactions with health services and result in more prompt care or more preventive care for themselves.	Men may largely control resources to buy nets, medication and transport to health centres. A lack of adequate funds may force poor individuals to visit traditional, unofficial or village-level healers. Women may be most vulnerable to the lack of funds, leading to decreased accessibility to formal or standard care.

Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Treatment options	In some areas, participating in clinical trials may be a source of otherwise unavailable health care free of charge. In these cases, excluding women from trials prevents women's access to free health services. **Pregnant women** have better access to antenatal care and therefore the access to malaria management offered in antenatal care. Antimalarial drugs have shown lower efficacy among **people living with HIV** than other people. Among young people in Africa, the HIV prevalence tends to be notably higher among females than males, [9] and MSM are a high-risk group in many regions. [24]	Traditions, such as the idea that pregnant women should not eat anything bitter, including some antimalarial medications, [2,25] or fever among females seen as related to the supernatural, may lead to poor health seeking or rejection of certain treatments.	Women may have more difficulty paying for a full course of treatment for themselves or their children due to **lack of control over finances**. **Environmental factors**: a study in Côte d'Ivoire found that the presence or absence of irrigation in several farming communities affected the types of crops residents grow and the control women and men exercise over family food stock. Women in irrigated villages had an increased workload, more control over the family food supplies and less access to disposable income. This affected the treatments sought and the speed with which treatments were sought. In communities using irrigation in their farming, women's reduced disposable income meant that men tended to have greater control over malaria treatment-seeking for children. [26] **When health care is too expensive for families or communities**, medication meant for a single person may be shared among two or more people, treatments may not be completed, male children and heads of households may receive priority for access to household finances for treatment. Women are usually responsible for maintaining insecticide-treated bed nets, but **lack of control over money** may hamper this, as they may not have the funds to buy insecticide for re-treatment. [6] Women may lack **decision-making power** to access preventive treatment.
Experiences in health care		**Health care staff** may not be sensitive to the effects of gender inequality on disease, such as women's relative lack of education, leading to poor knowledge about disease; women's lack of time due to a high household labour burden; or women's lack of decision-making power. For example, health workers may blame women for delaying treatment-seeking without acknowledging or addressing women's lack of decision-making power at home. [2]	Facilities may not be adequate to diagnose malaria (personnel, equipment, testing materials and availability of drugs), a factor that may **equally affect men and women**. Men are generally more often able to buy better health services (when they are available). People who are uninformed, poor or illiterate may find using health services to be an alienating or fearful process. Women tend to be more likely to fall into these categories than men. [6,27]

Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Experiences in health care		Health care providers may not have adequate time or motivation to deal with miscommunication problems. Minority ethnic groups in particular may face language and cultural barriers if they do not speak the region's official language. Among minority ethnic groups, women's lower levels of education and relative lack of mobility compared with men can lead to less ability in the region's official language, less interaction and familiarity with the majority culture. In some areas, women may receive incomplete or inferior treatment from health care providers due to gender based discrimination. This may be the case in settings in which health services have inadequate resources to meet everyone's needs and men are therefore given priority. Unmarried or adolescent pregnant women may be particularly likely to face stigma or abandon treatment from providers due to discrimination, even if this is unintentional. Some health providers may dismiss malaria symptoms as merely pregnancy complaints and therefore inadequately investigate the symptoms. In the United Republic of Tanzania, some evidence indicates that malaria treatment practices differ by the sex of the clinician. [28]	
Health and social outcomes and consequences	Outcomes and consequences related to pregnancy include the following: • Complications of pregnancy, anaemia and premature labour. • Malaria during pregnancy can impair the growth and survival of the foetus. [2] • Pregnancy may complicate the course of disease, with risks for both woman and child, regardless of the child's sex.	When one or several family members contract malaria, women may be overburdened by the responsibility of caring for sick people. Those who are more inclined to abandon treatment, due to a lack of resources to buy medication or to giving priority to other people's treatment above their own, may face the following consequences: • Illness lasts longer. • The risk of death or developing disabilities increases.	Lack of resources leads to non-compliance with drug regimens, which could lead to resistance, lower dosing, sharing pills and finishing treatment early. Other consequences: • Women may be taken advantage of (sexually) because they cannot pay for treatment. • Men are more likely to get proper treatment and recover faster because they have more resources at their disposal. • A worsening economic situation and lack of access to money reduces productivity, which leads to more poverty, a longer illness cycle and negative socioeconomic effects for families.

Factors that influence health outcomes: *Health-related considerations*	**Factors that influence health outcomes:** *Gender-related considerations*		
	Biological factors	**Sociocultural factors**	**Access to and control over resources**
Health and social outcomes and consequences	• More maternal death and morbidity. • Severe symptoms in pregnant women progress faster.	**Time constraints** for women cause delays in accessing health services and hence slower recovery. If the outcome is the death or illness of a male head of household, there is a lack of breadwinner and carer. Women may then be subject to **cultural practices** such as wife inheritance. If the outcome is the death or disability of a woman, children and family may be left without a household carer or the family may lose the secondary income women bring to the family. **Loss of a mother or father** significantly affects children and the extended family. If there is conflict within the household regarding a child's health care, women can risk being blamed for poor health outcomes if they decide to go against the wishes of more powerful members of the family.[19]	Women may be less likely to complete treatment due to **resource and other constraints** or may be burdened with the care of other family members who do not complete treatment.

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ANNEX 6. HANDOUT – SELECTED ISSUES IN CONDUCTING GENDER ANALYSIS OF NONCOMMUNICABLE DISEASES

The below information, organized by the health-related considerations of the GAM, include gender and health issues relevant to noncommunicable diseases. The list is not exhaustive but serves as a guide for group work activities of key issues to consider.

Risk factors and vulnerability

- **Age-related disability** may be more prevalent among women, as the oldest age groups are more represented by women than men. [1,2]
- Women may be at higher risk of developing lung cancer than men at similar rates of exposure to tobacco smoke. [3] However, the evidence is not definitive.
- As more women than men tend to live in **poverty,** women may be more likely to struggle to fund ongoing treatment for chronic conditions common in old age. In several contexts, women tend to earn less, work for fewer years and work less often in a full-time capacity than men, especially when caring for small children. Where it exists, retirement income is based on earnings during working years; older women may be disadvantaged due to lower wages throughout their working lives. [1,4] Men and boys may be given priority for receiving nutritious food in the household, exposing women and girls to malnutrition. Conversely, this may expose men and boys to overnutrition and consequent related risks of noncommunicable diseases. Both **undernutrition** and **overnutrition** increase the risk of and vulnerability to non-communicable diseases. [5] Malnourished women can also give birth to low-birth-weight babies. Low birth weight increases the potential for chronic disease risk factors in the child. [6] In addition, parents, especially mothers, of low-birth-weight infants may face a high child-care burden. Low-birth-weight babies can also lead to greater maternal stress and lower maternal well-being. [7,8] Maternal obesity and/or overnutrition negatively affect the health of babies, including hyperlipidaemia. [9] In some cultures, being overweight may fit standards of female beauty – pushing women towards overnutrition and leading to detrimental health effects for women and their offspring.
- **Alcohol use** is often culturally sanctioned for men and restricted for women. This may be why men generally report more alcohol consumption than women in many low and middle-income countries. [1] Alcohol intake is a risk factor for several noncommunicable diseases.
- Gender norms in many societies encourage **tobacco consumption** (either through smoking or chewing tobacco) among men but prohibit it among women. This can lead to greater risk of non-communicable diseases (such as various types of cancer and heart disease) among men. Women who smoke may try to hide their habit and therefore smoke with others in small spaces, with high exposure to second-hand smoke; may inhale faster or more deeply, which may lead to increased health risks. Women are also more likely to smoke low-tar or low-nicotine cigarettes, a practice with variable effects on health. [1,6,8] Women and men may also use different types of chewing and smokeless tobacco. [10] These can lead to oral cancer. The level of risk associated with each type of smokeless tobacco is unclear. Women's and men's anatomy puts them at risk for sex-specific cancers, such as cervical cancer among women and prostate cancer among men.

Access and use of health services

- Women may not be permitted to receive services from male health providers. [1]
- Women's mobility may restrict their ability to access services. [1]
- In some settings, women's health receives less attention and resources within the household than men's health. In these settings, women and girls may be more likely to face preventable complications due to delays in seeking health care. Women may also suffer more serious effects of disease because of lack of treatment. [5,12]
- Women may be more likely than men to lack resources to pay for transport, while men may be more likely to migrate away from remote areas for school or work. When health centres are located far away, those who have difficulty paying for transport or live in remote areas without good roads and infrastructure may have limited or no access to health services.
- A lack of control over resources may lead women to become coerced into bartering sex for health and relief services and the commodities necessary for survival, especially in post-conflict or post-disaster situations. [11]

Health-seeking behaviour

- Women's role as mothers and family caretakers may encourage them to give priority to the health of other family members above their own.
- Norms of masculinity may delay men in reporting pain or discomfort and may lead men to delay seeking health care. [12]
- Women's lack of decision-making power within the home may mean they do not have full autonomy to decide when or how promptly to seek care for their symptoms. [1,6]
- Women are more likely to work in the informal sector or in unpaid labour. They are thus less likely to have access to a steady income and benefits such as health and social insurance. [1] Women's relative lack of access to resources may lead them to forego prompt seeking of health care or routine physical examinations due to costs.
- Women in many settings have higher levels of illiteracy and lower levels of education than men, due to gender norms and roles that may not give priority to their formal education – especially in resource-poor contexts. [13] Lack of education or low literacy can result in reduced access to health information, awareness of available health services or knowledge about when services should be utilized. Without adequate information on the necessity of seeking care early, health-seeking may be delayed.
- Gender norms may restrict women from complaining about illness and seeking care promptly, since men, as recognized breadwinners, are given priority for household spending (even for health care) in some settings. Girls and older men may also face reduced care-seeking for this reason. [10] Chronic conditions require long-term care and may therefore be particularly expensive to treat. Thus, girls, women and older men may be particularly unlikely to receive household resources in the event of chronic diseases.

Treatment options

- **Antenatal care** may be the only opportunity for detecting women's diabetes or high blood pressure. In communities in which regular physical examinations or prompt health care seeking are not commonplace, pregnant women may be more likely to identify and control disease risk factors than others because of their contact with the health care system.
- Women are less likely than men to benefit from the modern management of noncommunicable diseases. [14]
- **Research and drug trials**, especially in the past, have tended to include no or few women. This may have been because of fear of potential affects on the fetuses of women of childbearing age. At present, however, the reasons for women's underrepresentation are unclear. [13] This underrepresentation has led to women receiving treatments that have been tested and proven effective mainly on men, [15,16] and may have restricted scientific progress on treatments specific to women. [1]
- Decision-making power to allocate household finances towards health care and to decide which type of care to seek (such as allopathic care versus a traditional or local health centre versus a larger health facility) may reside with men or senior members of the household. Thus, women may not have the autonomy to decide their type of care and the speed with which to seek care. [1,6]

Experiences in health care settings

- Studies show that health care workers **underdiagnosed or undertreated lung cancer, kidney failure and heart disease** among women, partly because lung cancer and heart disease were thought to be typically male conditions. [17]
- General practitioners may be less likely to refer women than men to specialist psychiatric services for mental health problems. Young females and older men may be less likely than young males and older women, respectively, to receive treatment for mental health problems. [18,19]

Health and social outcomes and consequences

- When male norms prevent men from seeking treatment for symptoms early, [13] chronic conditions or severe symptoms and/or complications may develop.
- If the outcome is the death or disability of a woman, the children and family may be left without a household carer or the family may lose the secondary income brought to the family by women.
- If the outcome is the death of a man or head of household, women may be subject to cultural practices such as wife inheritance, and the household may lose its primary source of income putting them at risk of economic insecurity.
- Globally, more females than males face a lack of education and literacy, [10] which may lead to poor access to health information.

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ANNEX 7. HANDOUT – SELECTED ISSUES IN CONDUCTING GENDER ANALYSIS OF MATERNAL HEALTH

Risk factors and vulnerability

- **Women's anatomy and physiology** may contribute to poor pregnancy outcomes.* Examples include the following:
  - Women have greater risk than men of contracting HIV infection and sexually transmitted infections (STI) from unprotected heterosexual intercourse, and
  - Women have higher risk of iron-deficiency anaemia than men. [1]
- Immunosuppression during pregnancy leads to a high risk of malaria or severe malaria infection, especially if the woman is pregnant for the first time. [2] Malaria in pregnancy can lead to maternal death, low birth weight or neonatal death. [3]
- Childbirth may occur in an area with poor hygiene and/or with unskilled birth attendants. Unhygienic substances such as cow dung may be used for umbilical cord care. [4,5] Mortality decreases when a skilled attendant is present at childbirth, [4] and proper hygiene in cord care can reduce neonatal infection.
- Infants' underdeveloped immune systems make them vulnerable to exposure to environmental hazards such as unsafe drinking-water and infectious disease. Children and infants are particularly susceptible to the harmful effects of ultraviolet radiation. [6,7] Male infants have a higher risk of mortality than female infants. [8]

- ***Lack of women's decision-making power can negatively affect maternal health.***
  - Women's **lower social status** in several settings contributes to limited power to negotiate with sexual partners about condom use, age and time of marriage, timing and spacing of pregnancies. Unwanted, early pregnancies or STI may result. Unwanted pregnancy has been linked with low birth weight and preterm birth. [9,10] Early pregnancy increases the risk of maternal mortality and obstetric fistula. Child marriage can put girls at risk of intimate partner violence, social isolation and lower education levels. [4,11,12]
  - Transactional or "survival" sex may decrease the negotiation power of low-income girls for the use of contraception or condoms, which could lead to unintended pregnancy, HIV infection or other STI. Transactional sex with older men is a common practice among adolescent girls in several contexts. Receiving gifts or money in exchange for sex is much more common among girls than boys. [11,13,14]
  - Unequal household decision-making power may restrict women's autonomy in reproductive health matters. This could lead to high fertility rates, unwanted pregnancy, forced termination of pregnancy, lack of prompt health care seeking or inadequate birth spacing. [12]
  - Sex-selective abortions take place due to a strong preference for sons in some contexts. Abortion-related complications may lead to disability or death, especially if the abortion is conducted under unsafe conditions.

- ***Gender norms, roles and relations that assign greater value and power to men increase women's risk of gender-based violence, which can contribute to poor maternal health.*** [8,15]
  - Sexual violence is related to increased risk for poor pregnancy outcomes, STI and chronic pelvic pain. It is also associated with decreased use of antenatal care and cervical screening. [12]
  - Forced sexual initiation of girls is a problem in many settings and can lead to early pregnancy (which can result in poor pregnancy outcomes), poor mental health, HIV infection and STI. [12]
  - Women's experience of intimate partner violence may increase or even begin in pregnancy. Violence can lead to poor health outcomes for the woman, fetus, child or even to homicide of pregnant women. [12]
  - Suicide in pregnancy is associated with adolescents and may be related to unwanted pregnancy in settings in which access to contraception or abortion is limited or unavailable. In some settings, pregnant women may commit suicide to preserve family honour. Suicide in pregnancy has also been linked with poverty and abuse. [12]

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* Poor pregnancy outcomes refers to conditions such as maternal death, postpartum haemorrhage, eclampsia, sepsis, obstructed labour, miscarriage, infant mortality, neonatal infection, low birth weight, mother-to-child transmission of HIV or sexually transmitted infections, obstetric fistula, infertility, uterine prolapse and perineal or lower abdominal pain.

- ***Other gender norms, roles and relations can also affect maternal health*.**
  - In many settings, men are given a greater share of household food because of their higher status, leading to poor nutrition among women. [16] Malnutrition can increase pregnancy complications.
  - Women have a higher risk than men of developing eating disorders in several contexts. [17,18] This may be because women face social pressure to maintain more stringent standards of physical beauty (including body shape) than men. Perceived pressure from the mass media to maintain idealized standards of shape, beauty and attractiveness has been linked with the incidence of eating disorders among women. [19-22] Anorexia and bulimia can lead to miscarriage and retard intrauterine growth. [12]
  - In settings with high fertility rates, women's multiple pregnancies over the life course place them at repeated risk of maternal morbidity and mortality. [8]
  - In some settings, girls' sexual debut tends to be several years earlier than that of boys. This can lead to early pregnancy, which increases the risk of obstetric fistula or maternal mortality.
  - Gender norms stipulating that girls should remain modest, chaste or innocent about sexual matters may limit adolescent girls' access to information on sexuality, contraception, pregnancy and related services.
  - FGM is considered necessary for girls in preparing for marriage in some settings. FGM can damage the vagina, trigger anaemia from continuous bleeding or lead to chronic reproductive tract infections, scarring, vaginal obstruction during childbirth, perineal and vaginal tears, which in turn may lead to postpartum haemorrhage and postpartum infection of the perineum. Performing vaginal examinations is also more difficult for women who have undergone FGM. [12]
  - Engaging men in their partners' pregnancy can decrease infant and maternal mortality by increasing the likelihood of prompt care in the event of complications. [23]

Access to and use of health services

- Pregnant women in rural settings required to walk long distances to access a health facility are disadvantaged by restricted physical capacity for strenuous exercise.
- Pregnant women may have more access than other women and men to HIV screening, and even antiretroviral therapy, through programmes for preventing the mother-to-child transmission of HIV.
- Government policies, based on social or religious mores, may render safe access to abortion [12] or access to family planning illegal. Women may thus resort to unsafe procedures, which could lead to death or disability.
- Women may be unable to access available health services if services do not offer sufficient privacy and confidentiality. [12] For example, an adolescent girl may fear that her doctor will inform her parents about her pregnancy and abortion, a woman who has had an abortion may fear that her community will discover this and stigmatize her or a private space for physical examination may not be provided.

Health-seeking behaviour

- Women may not be taken to a health centre or may not have access to household resources for health care, as family priorities may focus on household breadwinners, which are more likely to be male in many settings. [24]
- In some settings, the idea that only weak women go to a hospital to give birth may be common. [16] This may lead to underutilization of health services for labour and delivery.
- Young, unmarried women in some settings may be labeled promiscuous if they seek reproductive health services or counselling for family planning. [16] This may reduce care-seeking.
- Embarrassment or modesty related to discussing sexual health problems, such as vaginal discharge or genital discomfort, may prevent or delay care-seeking, especially when female health care providers are not available.

Treatment options

- A lack of accurate health information, possibly due to low education and literacy, may lead to fears that contraception can lead to infertility. [25] This could lead to greater reliance on traditional methods of fertility regulation, which may be less reliable in preventing pregnancy than modern contraception methods. In many low- and medium-income countries, women have higher rates of illiteracy and lower levels of education than men. [11,26]

Experiences in health care settings

- Women's interaction with health care providers may be unsatisfactory for various gender-related reasons:
  - Women seeking treatment for complications of unsafe abortion may be treated rudely by health care personnel or, in countries where abortion is illegal, reported to the police. [12]
  - Health care personnel may stigmatize and disrespect single mothers and pregnant adolescents. Judgmental personnel may prevent adolescents from accessing contraception or sexual and reproductive information or services.
  - Pregnant adolescents may have low negotiation skills and low status due to their age, sex, and context-specific gender norms. Pressure to engage in harmful practices, such as excessive use of Caesarean section, episiotomies or forced positions for childbirth, may result.*

Health and social outcomes and consequences

- The mothers of baby girls may be "penalized" (with mental health implications) because of social and family preference for male children. [12] In contrast, the mothers of baby boys may enjoy enhanced status and self-esteem.
- Gender roles may overburden women with household tasks; this can affect maternal health by leading to fatigue, strain or loss of time due to care-taking responsibilities.
- In some settings, infertility, which can result from inadequate sexual and reproductive health care, is more likely to lead to shame, social ostracism or divorce among women than among men. [27]
- Obstetric fistula, often the result of the physical stress girls face in childbirth, can lead to social ostracism, divorce and poor mental health. Women with obstetric fistula have an increased risk of suicide. [12]
- In some contexts, unmarried or adolescent daughters who become pregnant may be killed under the pretext of preserving family honour.
- Emotional support from fathers has been linked to greater ability among pregnant women to quit smoking, benefiting maternal and fetal health. [23]
- Pregnancy and postpartum rituals may enhance the emotional well-being of pregnant women. [12] For example, the traditional Chinese practice of a woman resting at home for one month following the birth of a baby may be associated with lower incidence of postnatal depression. [28,29] However, traditional pregnancy and postpartum rituals in some settings may be harmful. [4]
- Women with high reproductive or maternal morbidity may be unable to work. Impoverishment may result– especially if these women are the sole breadwinners in the household.
- Pregnancy and childbearing often cut short an adolescent's education and threaten her future economic prospects.
- Unmet need for family planning may lead to unwanted pregnancy and deepening poverty as families cope with raising children with limited financial means to care for them.

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* Public health professionals participating in a gender-mainstreaming workshop conducted by WHO raised this point. This may be an area for future research.

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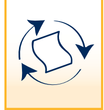

ANNEX 8 HANDOUT – SELECTED ISSUES IN CONDUCTING GENDER ANALYSIS OF CHILD HEALTH (0 – 9 YEARS OLD)

Risk factors and vulnerability

- **Male infants are at higher risk of mortality** than female infants. [1]
- Inadequate engagement of fathers* may negatively affect children's well-being. Some argue that the father's presence during labour and delivery leads to a stronger father–child bond. A study in the United States of America found that fathers' involvement in raising children was associated with a decreased likelihood of children's early sexual activity. However, in many settings, fathers may not be meaningfully engaged in pregnancy, child care and parenting. [2,3]
- **Violence against girls** increases vulnerability to several conditions:
  - Girls have a high rate of coercive sexual initiation, sometimes as young as at age 9 or 10, with data showing coercive sexual initiation among those reporting first sex at younger ages. [4] Sexual and gender-based violence increases risk of STI, depression, suicide, substance abuse in adulthood and several chronic conditions later in life. [1,4-8]
  - Girls in many settings are more likely to experience childhood sexual abuse than boys . [4,9] In various populations, the incidence of child sexual abuse falls between 2% and 62% for females and 3% and 16% for males. [10]
  - **FGM** is a harmful traditional practice used for controlling girls' sexuality and marriage preparation in some settings leading to scarring, urinary tract problems, uncontrolled bleeding, painful sexual intercourse as well as problems with pregnancy and delivery later in life. [5]
- **Male circumcision** of neonates results in complications in less than 1 in 500 cases. However, if complications do occur, haemorrhage or infection can develop; amputation may even be required. [11,12] Male circumcision significantly reduces the risk of transmitting HIV from heterosexual intercourse. [13] Various studies [12] have found several additional benefits of male circumcision, such as reduced risk of other STI, urinary tract infections and penile cancer.
- Orphans (male or female) may be particularly vulnerable to poverty and ill health, due to a lack of parental, financial and emotional support. Son preference may lead to greater vulnerability of abandonment and orphanhood among girls.

Access and use of health services

- **Sexual violence** against girls is more common than violence against boys. Perpetrators of child sex abuse may be parents, relatives, teachers, religious leaders, neighbours or family friends; [4] restricting access to health care. Sexual violence against boys, while less prevalent, is also common and brings with it several physical and psychosocial stressors with which boys must cope, often with fewer resources (due to different forms of stigma rooted in gender norms vis à vis sexual violence and boys) for accessing health care services at the immediate time of need.

Health-seeking behaviour

- Son preference may lead to giving priority to using household resources for food and health care for boys, particularly in situations of poverty. [9,14]
  - **Malnutrition** and **inadequate health care seeking among girls** may result. In addition, within the household, men may have more decision-making power in the household than women. [15] This may affect the type and speed of care sought for children.

Treatment options

- **Female-headed households** tend to face greater poverty than male-headed households, and women are more likely than men to work in the informal sector without access to insurance and benefits. [1] **Traditional medicine** is often less expensive than formal health care services. [14] Thus, people with **low income** [16] or **without health insurance** may be more likely to visit traditional healers, both for themselves and their children. In addition, even in male-headed households, when men refuse to provide household resources to women for children's health care, women may be forced to use traditional medicine. [15,17] Female-headed households may also have low health-related knowledge, as women tend to have less education and lower literacy rates than men. [18]

Health and social outcomes and consequences

- Son preference often leads to **sex-selective abortions**, resulting in the death of female fetuses. Sex-selective abortions can also lead to a skewed male-female ratio. [1,19]

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* Here, fathers means both biological fathers and other men who have taken on the role of a father.

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MODULE 3:
ACTION – DEVELOPING GENDER-RESPONSIVE ACTIONS

Proposed running times

Section and learning activity	Materials to be prepared and used	Suggested implementation time
Progress check Optional learning activity 3.0: Understanding access to and control over resources Introduction to Module 3	Module 2 Progress check: flip chart or worksheet Module 2 slides and additional reading (for reference) Handout 3.0: Explaining access to and control over resources – Sahara's story (optional) Slides 3.1 and 3.2	35-60 minutes (depending on whether the optional learning activity is used)
Section 3.1 Learning activity 3.1a: The Gender Responsive Assessment Scale Optional learning activities: 3.1a: Are these examples gender-responsive? 3.1b: Gender Responsive Assessment Scale – case studies 3.1c: Gender Assessment Tool – revisiting principles of gender analysis to apply the Gender Responsive Assessment Scale	Slides 3.3 – 3.14 Participant Notes, Section 3.1: a. *Gender-responsive: What is all the fuss about?* b. *WHO Gender Responsive Assessment Scale criteria: a tool for assessing programmes and policies* c. *Are these examples gender-responsive? (optional)* d. *WHO Gender Responsive Assessment Scale: summary points* e. *Using the WHO Gender Responsive Assessment Scale – various case studies (optional)* f. *Policy approaches to women's health: where do they fit in the Gender Responsive Assessment Scale?* g. *WHO Gender Assessment Tool: which Gender Responsive Assessment Scale level does my programme fit?* h. *Using the WHO Gender Assessment Tool – family planning in Jordan (optional)*	45-255 minutes (depending on whether optional learning activities are used)
Section 3.2 Learning activity 3.2: Entry points for integrating gender into health planning and programming Optional learning activities: 3.2a: Considering gender in institutional processes 3.2b: Gender and health communication 3.2c: Gender and health data	Slides 3.15 – 3.23 Participant Notes, Section 3.2: a. *WHO Gender and health planning and programming checklist* b. *Gender and reproductive health policy, Turkey* c. *Gender in HIV prevention, care and support programmes, Côte d'Ivoire.* d. *Considering gender norms, roles and relations in institutional processes (optional)* e. *Gender and health communications (optional)* f. *Sex disaggregated data and gender-sensitive indicators: basic ingredients for health planning and programming (optional)* g. *Personal reflections on integrating gender into the programming process*	45-210 minutes (depending on whether optional learning activities are used)
Section 3.3 Learning activity 3.3: From analysis to the work plan: developing gender-responsive work plans	Slides 3.24 – 3.26 Participant Notes, Section 3.3: a. *Empowerment – part 3: a way to address strategic gender needs* b. *Developing gender-responsive work plans* c. *WHO Gender responsive log frame* *Photocopies of Module 2 group work* Module 3 group work template	120 minutes
Total estimated running time		**About 4 hours** (no optional activities) **About 11 hours** (**all** optional activities with **all** participants)

MODULE 2 PROGRESS CHECK

Aims of the progress check

- Ensure understanding of concepts and skills introduced in Module 2 as a progressive evaluation before moving to Module 3.

Notes

- This learning activity requires advance planning and differs depending on delivery (either a flip chart or distribution of handout – see below).
- Have the materials for Modules 1 and 2 on hand for easy reference.
- See **Annex 9** for **optional learning activity** 3.0 for use as required.

Suggested process

Step 1: place the flip chart in a corner of the room and have participants fill out the flip chart confidentially as they enter the room for Module 2. Alternatively, ask participants to complete distributed handouts. Tally the checkmarks in the columns.

I know or understand …	Not at all	Somewhat	Well
1. What a gender analysis is and what its benefits are in public health work.			
2. What gender-related considerations are in gender analysis of a health problem.			
3. What health-related considerations are in a gender analysis of a health problem.			
4. What gender-based discrimination is and why it is important to address this when working in health.			
5. What the WHO gender analysis tools are and feel comfortable in using them in my work.			

Step 2: review of Module 2

- Share the results of the progress check with participants.
- Revisit definitions and concepts with participants using materials from Module 2.
- Some concepts may be woven into activities in Module 3. For example:
  - If participants have questions on the benefits of gender analysis, facilitators can revisit these concepts in section 3.1, when introducing the GRAS.
  - If participants have questions about gender-related considerations (which may also indicate uncertainty about gender norms, roles and relations) or WHO gender analysis tools, facilitators can integrate flashbacks to Modules 1 and 2 in section 3.2 on integrating gender in health planning and programming, as the key questions used here are similar to the GAQ and refer to underlying sociocultural factors.

Step 3: Making the bridge to Module 3

- Wrap up by emphasizing:
  - ***Module 1*** demonstrated that gender norms and roles:
    - **are hierarchical**; and
    - often **privilege one group over another**, leading to **unequal relations between groups of women and men**.
  - ***Module 2*** introduced tools and methods to uncover how gender norms, roles and relations influence health for men and women by examining the interaction between gender-related considerations (biological factors, sociocultural factors and access to and control over resources) and health-related considerations (such as health risk and vulnerability).
    - The GAM and GAQ were introduced to guide this process.
  - ***Module 3*** will build on these skills by applying them to health planning and programming issues.

Tips for facilitators

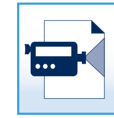
- The progress check should avoid repeating jargon. Revisit facilitator talking points in Module 2 for ways to unpack core concepts and definitions.
- Facilitators may wish to ask specific participants or partners involved to conduct this session as a wrap-up to the day before. Make sure that the person selected will be capable of and comfortable in answering questions on the concepts in Module 2.
- Try to limit the progress check to 30 minutes.

- If most participants have not understood the main concepts from Module 2 (and therefore the objectives were not met), the facilitator will need to go over the materials as appropriate. This may have time implications for Module 3 and, ultimately, implications for reaching workshop objectives.
- Many participants are confused between access to and control over resources (one of the gender-related considerations in the GAM). See Annex 9 for **optional learning activity 3.0** as needed.

Overview and objectives of Module 3

Building on modules 1 and 2, this module introduces practical tools for conducting gender assessments of existing programmes and policies (WHO Gender Responsive Assessment Scale [GRAS] and WHO Gender Assessment Tool [GAT]) and a gender and health planning and programming checklist. Ultimately, this module aims to guide users through the process of developing gender-responsive actions for the health sector.

By the end of this Module, participants will be able to:
- apply gender assessment methods to a new or existing programme;
- understand methods and strategic entry points for integrating key gender issues important for programming; and
- develop gender-responsive plans and activities.



Using **Slides 3.1** and **3.2**, introduce the objectives and outline of Module 3.

Hang **Flip chart 3.1: Module 3 – overview and objectives** on the wall, ideally placed alongside Flip charts 0.02 (Outline of workshop modules), 1.01 and 2.02 (Modules 1 and 2 overview and objectives).

F ip chart 3 1

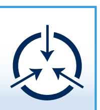
Module 3 – overview and objectives

Module 2 guides users through the process of developing gender-responsive actions for the health sector.

By the end of this Module, participants will:
- Apply gender assessment methods to a new or existing programme
- Understand methods and strategic entry points for integrating key gender issues important for programming and project development
- Develop gender-responsive plans and activities

Module 3: Action

SECTION 3.1: WHO GENDER ANALYSIS TOOLS II – ASSESSING POLICIES AND PROGRAMMES



Learning activity 3.1a: The WHO Gender Responsive Assessment Scale: a classification framework for assessing gender in policies and programmes

Aims of the learning activity
- Learn to analyse gender-responsiveness in policies, programmes and projects using the GRAS.

Notes
- The examples provided on the accompanying slides come from varying contexts. Facilitators may prefer to use local or regional examples. All learning activities in Module 3 can be **adapted to local policy and programme examples** – and linked to one another. For example, if existing policies or programmes will serve as a backdrop for work plan/activity development in Section 3.3 (see Section 3.3 for more details), facilitators may wish to include a group activity on applying the GRAS and GAT to assess the policy or programme in question. This will serve as an introduction to identifying key areas that may need corrective actions proposed for prioritization in Section 3.3 group work activity. Such adaptations require advance participation by facilitators – ensure you review policies and programmes (e.g, national health sector strategies, WHO Country Cooperation Strategies, UNDAF, national HIV/AIDS policies, etc.) that may be relevant for use in the workshop.
  - Continuing from Module 2 group work explanation: Country X has a national health strategy that is approaching its mid term review. Identified priority areas include cardiovascular disease, HIV/AIDS, mental health and tuberculosis. The group conducts gender analysis in Module 2 on these four priority areas. In Module 3, examples from the national health strategy are used throughout the GRAS introduction (Section 3.1, slides 3.7, 3.11-3.13) or used as a group activity to practise using the GRAS and GAT. In Section 3.2, examples are also used on relevant slides.

For example, use indicators from the existing national health strategy in plenary discussions when introducing the critical questions related to the M&E stages. Finally, in Section 3.3, use the existing policy or programme as a framework within which to develop or revise activities across the four priority areas of the strategy. Each section includes a reminder of these types of adaptations that can enhance practicality of workshop activities for participants.

- **See Annex 9** for **optional learning activities 3.1a and 3.1b** for ways to practise using the GRAS.
- The GRAS is based on various tools gender advocates have been using across sectors to assess programmes and policies. [6,12,24,62,63] Facilitators may want to collapse the Scale to have only 2 or 3 levels (those to avoid, those that are okay and those that should be implemented). If this is done, **it is important to maintain the integrity of the different criteria included in the GRAS levels, as they refer to different intentions and assumptions about gender norms, roles and relations that may have implications for corrective actions**. Notes are included throughout to guide facilitators.

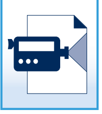
Suggested process

Step 1: introduce the session by giving a brief overview of the term gender-responsive:

- Ask participants what they think this term means.
- Reveal **Slide 3.3**. Explain that, ultimately, we need to aim for gender-responsive strategies as they actually *do* something about harmful gender norms, roles and relations.
- **Recall the definition of gender mainstreaming**, highlighting the fact that achieving gender equality is a process. Assessing policies and programmes is an important step in determining where and how they can be strengthened to address gender.

Step 2: using **Slide 3.4**, introduce the GRAS as a way to assess the gender responsiveness of an entire health intervention, programme, policy - or their components. Explain that the **GRAS includes five levels – but only three are desirable**.

- Refer participants to the GRAS in their **Participant Notes, subsections 3.1a and b** (*Gender-responsive: what is all the fuss about? and WHO Gender Responsive Assessment Scale criteria: a tool for assessing programmes and policies*).
- Ask them to keep the page open to subsection 3.1b for easy reference to the GRAS criteria.



Step 3: using **Slides 3.5 and 3.6**, lead a group discussion on the first two GRAS levels (gender-unequal and gender-blind) using the criteria provided on the slides.

- **Slide 3.7** includes examples that fit the first two GRAS levels. Ask participants to explain why these examples are either gender-unequal or gender-blind. Refer them to the criteria set out in the GRAS explanations in the **Participant Notes, subsection 3.1b**.
  - Conclude **that gender-unequal and gender-blind practices usually occur when no gender analysis has been done - or that a gender analysis has been conducted but nothing has been done with these results. Remind them of the definition of gender-responsive, and that action after analysis is a requirement.** These two levels, therefore, should be avoided.
  - Remind participants that, since many decisions are made without conducting or adequately using the results of a gender analysis, if programmes are gender-unequal or gender-blind this may not always mean that the people in charge do not care about gender inequality. This is important to avoid isolating participants – and to maintain the continuity from Module 2 on the importance of gender analysis.
  - Note that **some find it easier to regroup these two levels into one category**. If this is done, be sure to include all criteria from both levels and **emphasize that gender-unequal reinforces unequal gender norms, roles and relations, whereas gender-blind ignores them**. This distinction is important, as the former is an example of how **institutional structures** sustain existing (and often unequal) gender norms, roles and relations, whereas the latter is based on the **assumption that gender norms are "natural"** (and therefore devoid of unequal power relations and opportunities for men and women). See **Module 1, section 1.2 for links with the five elements of gender and unpacking gender norms, roles and relations**.

Step 4: using **Slide 3.8**, introduce GRAS level 3 (gender-sensitive). Emphasize the following:

- Gender sensitivity is the turning point from undesired (levels 1 and 2) to desired (levels 4 and 5) policy types.
- Only when a policy or programme is gender-sensitive can it be expected to move up the scale of gender responsiveness.
- Note that **some may be tempted to ignore this level**, as it is less action oriented (compared with levels 4 and 5). If the GRAS is modified, remember to emphasize **that gender sensitivity (or awareness, as the group went through in Module 1) is a critical step in ensuring that gender is systematically addressed throughout programmes and policies (gender mainstreaming)**. Without awareness, or sensitivity, many policies remain gender-blind – or may be too easily classified as gender-specific because they address one sex or the other without necessarily addressing the broader gender norms, roles and relations that influence health.

Step 6: using Slides 3.9 and 3.10, discuss the final GRAS levels. Highlight the following:

- **Gender-specific (Slide 3.9)**: remind participants that **gender mainstreaming can focus exclusively on women or girls** to address burdens of gender inequality. **Gender-specific programmes and policies may focus on one sex or the other** with the aim of addressing specific gender norms, roles or relations. Gender analysis would reveal such a target group, by sex, age or other factor.
  - Gender-specific programmes and policies tend to address **practical gender needs** discussed in Modules 1 and 2.
- **Gender-transformative (Slide 3.10)**: recall that gender analysis may reveal that **unfair gender norms, roles or relations are root causes of negative health outcomes and behaviour**. This may mean that a gender-transformative approach should be privileged because it will directly address them.
  - Gender-transformative programmes and policies tend to address **strategic gender needs** discussed in Modules 1 and 2.
- Using **Slide 3.11**, discuss some examples of the final three GRAS levels. Highlight the following:
  - Starting with gender analysis means that you are already on the right path and are gender-sensitive.
  - All three of these levels constitute different degrees of gender responsiveness.
  - Gender sensitivity is not enough; actually doing something with the results of a gender analysis is the true test of being gender responsive. Recall the phrase "no more gender words without gender actions!"

Step 7: using **Slides 3.12 and 3.13**, have a group call-out on the gender assessment of the policy and programmes excerpts included. Refer to the criteria in the **Participant Notes, subsection 3.1b** for assistance. The notes section of the slides provide answers and additional tips for facilitators.

Tips for facilitators

- When discussing the examples provided on the slides, facilitators will note that each example sometimes has more than one classification. This is okay as long as participants are discussing the examples provided based on their contexts and using the criteria set out in the GRAS (see, in particular, example 2 on Slide 3.12).
- Remind participants that true assessment requires much more information than is provided on the slides.
- Remember to consult the **annexes** for **optional learning activities**.

Step 8: conclude the session with **Slide 3.14**. Refer to the graphic depiction and summary points on the slide to highlight the following:

- The GRAS includes five levels, two of which should be avoided, one that represents basic awareness and two levels for optimal policy and programme options.
- Refer back to the concept of gender salt and **"No more gender words without gender actions!"**. The GRAS helps to ensure that gender salt is not added onto existing programmes as an after-thought.
- Information generated from gender analysis is needed to develop gender-responsive actions. Gender analysis reveals practical or strategic gender needs; gender-specific and gender-transformative health sector responses can then be developed accordingly.
- Gender mainstreaming is a process to achieve gender equality:
  - **Fully implementing gender-transformative strategies is an important goal of gender mainstreaming – and is best conceived of as gradual and long term**, although gender transformation can also happen in the shorter term.
  - These often need to be complemented by short- and medium-term strategies – which may need to be **gender-specific**.
- **Gender-transformative strategies may be the most effective** in addressing the harmful effects of gender on health outcomes for men and women. But they are **often the most challenging to achieve** as they involve direct renegotiation of gender norms, roles and relations. Refer to the **Participant Notes, section 3.1** (all subsections) for further reading and worksheets.
  - Introduce and highlight, in particular, **subsection 3.1g** (*WHO Gender Assessment Tool: which Gender Responsive Assessment Scale level does my programme fit?*), which provides a quick checklist participants can use when determining the GRAS level of their own work.

Take a break or do an energizer!

Suggested transition to next section

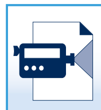
The GRAS exercises are illustrative only; true gender assessments of a programme or policy requires all policy details and may require interviews with those who were involved in its design and delivery. Participants can use the GAT included in the Participant Notes to do so. Once a programme or policy is assessed, it is time to examine how to take corrective action. This action can also apply to developing new policies or programmes.

SECTION 3.2: INTEGRATING GENDER IN HEALTH PLANNING AND PROGRAMMING

Learning activity 3.2: Entry points for integrating gender in health planning and programming

Aims of the learning activity
- Identify strategic entry points for integrating gender in health planning and programming
- Become familiar with the WHO Gender and Health Planning and Programming Checklist

Notes
- All learning activities in Module 3 can be **adapted to local policy and programme examples** – and linked to one another. If facilitators have done so for Section 3.1, they should continue this contextualisation in Section 3.2. In particular, examples can be drawn from existing policies or programmes and included as relevant on slides 3.16-3.23. For example, use policy objectives or monitoring indicators from the existing national health strategy in plenary discussions when introducing the critical questions related to the M&E stages.
- If the group with which you are working is a mix of programme, managerial, administrative and/or communication staff, see **Annex 9** for **optional learning activities 3.2a, b and c** that target these audiences. It should be noted, however, that these optional activities do not cover the breadth of information that may be needed to address these functions. Facilitators may need to complement with other gender training materials.
  - The group can be kept together when discussing the tips on integrating gender into health planning and programming, but facilitators may also want to divide the group and conduct parallel sessions using these optional learning activities.
  - All optional learning activities are best integrated after step 3 (below) has been concluded with all participants.

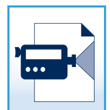


Suggested process

Step 1: introduce basic planning or programming steps on **Slide 3.15**:
- Emphasize that the **gender can be integrated into any of the steps**.
- **Gender analysis** (as conducted in Module 2 group work) should inform health planning and programming towards developing gender-responsive actions.

Step 2: Refer to **Participant Notes, subsection 3.2a** (*WHO Gender and health planning and programming checklist*) for use when integrating gender into various planning and programming stages. Participants should keep these pages open during the discussion for easy reference.

As necessary, use **Slides 3.16 – 3.23** to highlight some ways to integrate gender into the planning and programming steps – referring to the Participant Notes for the full checklist. Suggested talking points are included on the slides when necessary.



- **Note that some of the guiding questions are similar to those in the GAT, and that any guiding question may lead to another – similar to the GAQ**. This reinforces gender analysis methods (or critical questioning), introduced in Module 2.
- Highlight that some questions are repeated, notably those on **stakeholder involvement, the equal participation of women and men and ensuring that the programme does not reinforce or uphold harmful gender norms, roles and relations**. This reinforces the systematic approach to ensuring core principles guide each programming stage.

Step 3: refer to the stages of composing a team and preparing a budget. Remind participants of the **different approaches to gender mainstreaming**: programmatic and institutional. Recall that this means that, to truly mainstream gender and reduce gender-based health inequities, attention needs to be focused on both the content of programmes and how programmes are staffed, financed and run.

Conduct **optional learning activities** as appropriate.

Step 4: conclude by referring to **Participant Notes, subsections 3.2a** (*WHO Gender and health planning and programming checklist*) and **3.2b and c** for two examples of how gender can be addressed in health planning and programming (*Gender and health planning case studies*).

If no optional activities are conducted, refer participants to additional reading in **Participant Notes, subsections 3.2d – f**, that provides information and tips related to institutional processes, health communications and statistics.

Encourage them to complete **Section 3.2g** individually or with colleagues to get started on enhancing attention to gender in their current work.

Suggested transition to next section

- Now that we are familiar with WHO gender analysis tools for health planning and programming, let's put our new skills to the test by developing gender-responsive plans and activities.

SECTION 3.3: FROM ANALYSIS TO A WORK PLAN: DEVELOPING GENDER-RESPONSIVE WORK PLANS

Learning activity 3.3: From analysis to the work plan: developing gender-responsive work plans

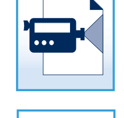
Aim of the learning activity

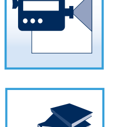
- Develop a gender-responsive work plan or activities.

Notes

- If the group you are working with is a mix of programme, managerial, administrative and/or communication staff, see **Annex 9** for **optional learning activities 3.2a, b and c**.
- All learning activities in Module 3 can be **adapted to local policy and programme examples** – and linked to one another. Whether or not facilitators have done so in Sections 3.1 and 3.2, you can still use existing policies or programmes as a backdrop for work plan/activity development.
  - Enhance actual policy or programming issues processes by working within the framework of an existing policy or programme to revise activities based on the group gender analysis from Module 2. This is especially useful during reviews of health sector plans (generic or programme focussed). If the context in question is drafting new policies or programmes on specific areas that were selected for the gender analysis activity in Module 2, encourage the group to propose activities that will be presented to the larger policy/programme drafting group following the workshop. This enhances the practicality of workshop outputs and enables participants to directly see the applicability of gender analysis skills to their own work – an aspect that has been demonstrated to effect transfer of skills post-training.

Suggested process





Step 1: remind participants of the use of gender analysis findings from Module 2 using **Slide 3.24**.

- Recall from Modules 1 and 2 that empowerment is a strategy towards putting power in the hands of women and men to take decisions over their own health. Refer to the Participant Notes and slides from Modules 1 and 2 as necessary.
- Refer to the **Participant Notes, subsection 3.3b** (*Empowerment, Part 3: a way to address strategic gender needs*) for a recap of gender analysis and examples of empowering strategies used in the health sector.

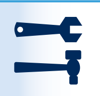
Step 2: using the same groups as in Module 2, reconvene groups to develop a gender-responsive work plan. See notes above about using an existing policy and programme environment of the context in question as much as possible to enhance practical activities for participants. If this option is chosen, introduce the policy or programme at some point in Module 3 (or 2 as relevant) – including distributing copies to participants as necessary.

Using Slides 3.25 and 3.26 and/or referring to the **Participant Notes, subsections 3.3b and c** (*Developing gender-responsive work plans, WHO Gender-responsive log frame*), outline the instructions for the group activity.

- Provide the same guidance as in Module 2 with respect to a rapporteur and leaving 15 minutes for preparing a presentation.
- Distribute **photocopies of the Module 2 group work**.
- Suggest that the participants refer to the **Participant Notes, Sections 3.1 and 3.2** for easy reference to the GRAS and the gender and health planning and programming checklist.
- Upload onto computers for groups, prepare on flip charts or distribute handouts of the WHO Gender-responsive log frame. Facilitators can modify and adjust to the needs of the group in terms of categorization of activities (by GRAS level, whether practical or strategic gender needs are addressed, etc.).

WHO Gender-responsive log frame

Priority gender and health issue	Activity	Type and timeline	Indicators of success	Stakeholders or partners	Gender-specific or gender-transformative



Instructions for the group activity to develop gender-responsive work plans

Refer to Participant Notes subsection 3.3b for easy reference during the activity.

Using the GAM from Module 2, select a **priority gender and health issue** to be addressed. Enter this in the first column of the logframe using active, clear and focused language. If you are modifiying an existing policy or programme, revise objectives as necessary to address the priority gender and health issue identified. Remember to phrase the priority gender and health issue in ways that demonstrate a commitment to addressing gender. Avoid gender-blind statements!

For example, *Adolescent girls and boys have different barriers to accessing sexual health services* is preferable (as a priority gender and health issue) to *Sexual health services*.

When **priority gender and health issues are selected**, ensure they are **realistic and relevant to your public health work**.

Develop one or two **activities** that will address the selected issue. Include as much detail as possible to ensure that gender-responsive elements are clear and transparent. If you are working with existing policies or programmes, include new - or propose new - activities that will ensure the achievement of the revised objectives to respond to the identified priority gender and health issue.

Continuing on the above example, *scale up sexual health* services would be a gender-blind activity. If the issue is that adolescent girls and boys have different barriers to such services, outline in detail how the proposed activities will address them.

Activities should be developed using the following parameters to ensure practical planning in the activity:
- **realistic**
- **within your sphere of influence**
- **high impact: they should address several gender dimensions**
- **do not require a significant influx of new resources**.

Once the activities have been developed, categorize them by **type** (policy, research, advocacy or programming) and develop an expected **timeline (short [0 – 2 years], medium [3 – 5 years] or long [6 or more years] term).**

Once the activities have been fleshed out (with an expected budget, time permitting), propose **gender-sensitive indicators** to monitor success of the proposed activity.

Identify the range of **stakeholders or partners** that need to be involved to ensure success. Do not forget to pay attention to which stakeholders will ensure that activities are implemented in gender-responsive ways. The type of activity developed often determines the types of partners or stakeholders to engage.

Finally, classify the activity as **gender-specific** or **gender-transformative** with an explanation for why.

Repeat with additional priority issues and activities as time permits.

Share work plans and activities in the larger group, presenting a rationale for why priority gender and health issues were selected and activities developed using the above parameters. If you are working with existing policies or programmes, propose ways to ensure these input into national processes – either via mid term reviews or other mechanisms.

Tips for facilitators

- Rotate around groups frequently to see how they are doing and to answer questions. Remind them that there is not one way to do the process, and that the beauty of gender mainstreaming and gender analysis is that they can be adapted to many contexts as long as the main elements and main questions are kept present throughout the process.
- Encourage them to be creative – and simple. Remind them that a gender-responsive intervention does not necessarily have to be something revolutionary to make a difference. Small changes such as including community health nurses in national health plans, for example, may yield extensive and lasting results.

Step 3: group feedback session
- This is a vibrant, interactive session, when groups present completed work plans.
- Ask participants to do a mock evaluation of one another's work plans in terms of their gender responsiveness. Now that they have gone over all the concepts, they should be able to pick up on gaps, provide suggestions and pose critical questions using GRAS criteria and other concepts learned in the workshop.
- Provide inputs on work plans, recognizing that the exercise is time-bound.
- Revisit concepts used throughout the workshop when discussing group work, both to highlight good practices the groups have used and to point out areas where they could have been applied.

CONCLUSION OF MODULE 3

Using Slide 3.27, conclude the module and use the quick quiz questions on the screen to incite participant recall of the core concepts. If treats are on hand, give them to the participants who answer the most quickly … and accurately of course!

Participants should now be able to keep the gender salt away for good. Ask them to do a cheer with you: No more gender words without gender actions!

ANNEX 9. MODULE 3 OPTIONAL LEARNING ACTIVITIES

Optional learning activity 3.0: Understanding access to and control over resources

Aims of the learning activity

- Clarify the distinction between access to and control over resources.
- Complement the **progress check of Module 3 or learning activity 2.2a, Module 2**.

Notes

- This learning activity can be delivered in the following ways:
  - **buzz groups**
  - **role play.**
- Facilitators should alter the case study (name, household dynamics etc.) and select the delivery method best suited to their context.
- A handout is prepared including the case study and discussion questions for duplication and distribution.
- Estimated time: 45 minutes.

Suggested process

Step 1: **If buzz groups are used**, take some time afterwards for a plenary discussion on group conclusions.

If role play is used, select participants to develop and act out the case study. Use the questions provided to generate a group discussion.

Questions and Answers for the group activity

1. Does Sahara have access to the car and driver (or transportation – a health-related resource)?

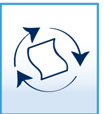
Yes, Sahara has access to the car and driver **in that it is available for her use**. She has the ability to use the resource, but there are conditions on when, how and for what purposes.

2. Does Sahara have control over this resource?

No, Sahara does not have control over this resource. She cannot decide independently when to use the car, for what reasons and under what conditions. This means that Sahara cannot independently make decisions about the use of the car, even for health reasons.

Step 2: wrap up by reiterating the distinction between access to and control over resources. Revisit the core concepts from Module 2 (section 2.2) as necessary.

Handout 3.0. Understanding access to and control over resources – Sahara's story



Sahara is a young woman who, after participating in a school health campaign on breast cancer, performs monthly breast self-examinations. Now married, she lives in a joint household with many other sisters-in-law who are older than her. As the youngest sister-in-law and newest member of the household, Sahara has yet to develop relationships with her husband's family, who could potentially be a source of social support for her in the transition to married life, joint living and a new place of residence.

During a monthly breast self-examination, Sahara noticed swelling in her breast and detected a lump in her underarm area. She remembered that these were signs to look out for from the school health campaign and decided that she should go to the health clinic for a clinical breast examination to rule out breast cancer or pursue treatment options. The household has a car and driver, a rare luxury in her small township. Sahara does not have a driver's permit, as women from her community are not allowed to drive.

To use the car, Sahara must explain the reasons to the eldest sister-in-law, who will then ask her mother-in-law for permission on Sahara's behalf and raise any issues about Sahara's health - including stigmatizing questions about the causes of breast lumps and what this may or not imply about Sahara's character. If her mother-in-law approves, she will go to see Sahara's husband to determine whether he is aware of Sahara's health issues (combined with any commentary of what it may mean with respect to cultural interpretations of breast issues), that Sahara wants to use the car and whether he is available to drive her to the clinic. The mother-in-law finally consults the head of the household, Sahara's father-in-law, to inform him that Sahara needs to use the car – maybe even the driver – to seek his approval. As it would be considered inappropriate for Sahara to go to the health clinic in the car alone with the male driver, a decision will be made as to who will accompany Sahara. In the meantime, Sahara has been worried about the lump she found.

Breast cancer notes

Breast cancer is the most common type of cancer among women younger than 60 years globally and is the leading cause of death among women 20 – 59 years of age in high-income countries. Although breast cancer is thought to be more common in high-income countries, the incidence is increasing in low- and middle-income countries, where a combined burden of breast and cervical cancer takes a toll on women's health.

Although breast self-examinations do not reduce breast cancer mortality, increasing breast awareness among women through such a practice can lead to early detection. Studies have shown that women who report practising breast self-examination tend to have their tumours diagnosed at an earlier stage than those who do not practise breast self-examination. Early detection can enhance treatment effectiveness. Although breast self-examination may lead to early diagnosis, the practice does not constitute a reliable screening modality and should not be considered as a replacement for clinical breast examinations or mammography.

Annual clinical breast examinations (administered by trained health workers) and/or mammography are recommended for women older than 50 years as important screening components of cancer prevention strategies. The choice of method depends on the economic setting of the health system in question, although mammography is the preferred screening method. While the evidence on clinical breast examination is less conclusive, sufficient evidence indicates that screening by mammography reduces mortality from breast cancer among women aged 50 – 69 years.

Discussion questions

1. Does Sahara have access to the car and driver (or transportation – a health-related resource)?
2. Does Sahara have control over this resource?
3. How do gender norms, roles and relations in Sahara's household affect her access to and control over other health-related resources?

References

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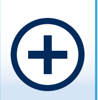
4. Thomas DB et al. Randomized trial of breast self-examination in Shanghai: final results. *Journal of the National Cancer Institute*, 2002, 94:1445–1457.
5. *Women and health: today's evidence, tomorrow's agenda*. Geneva, World Health Organization, 2009 (*http://www.who.int/gender/women_health_report/en/index.html*, accessed 15 January 2010).



Optional learning activity 3.1a: Are these examples gender-responsive?

Aims of the learning activity

- Further develop skills at detecting gender-responsive initiatives.
- Complement **learning activity 3.1a** as necessary.

Notes

- Facilitators may want to include or develop context-specific examples as necessary.
- This learning activity can be delivered in one of the following ways:
  - **buzz groups**
  - **role play**
  - **participant reading and discussion.**
- Suggested responses for facilitators (based on questions included in Participant Notes) are provided.
- Estimated time: 45–60 minutes (depending on the mode of delivery).

Suggested process

Step 1: select the mode of delivery.

If buzz groups used, divide participants into groups and refer to the **Participant Notes, subsection 3.1c** (*Are these examples gender responsive?*). Have the groups report back one or two points on their classification – and how they would modify – their assigned examples.

If role play is used, allow time for the participants to prepare based on either the examples provided or those prepared for the context in question. After the scenario has been acted out, facilitate discussion on whether they are gender-responsive or not.

If participant reading and discussion are used, select two participants per case study to facilitate the learning activity. One participant reads the example while the other facilitates the discussion based on the question. Provide them with flip charts and other material they may need.

Step 2: as necessary, recall:

- the five elements of gender from Module 1, as example 1 shows how policies can uphold unequal gender norms, roles and relations; and
- the definition of gender mainstreaming, as example 2 highlights the important processes of the involvement and participation of women and men and how this enables effective, needs-based health programmes.

Step 3: sum up by reminding participants of the definition of gender-responsive (see Slide 3.3).

Some responses to Exercises 1 and 2 (Participant Notes, subsection 3.1c)

Exercise 1

Is this employment policy gender-responsive? No.

Which GRAS level is this employment policy? Gender-unequal or gender-blind.

Why? Gender-unequal: the policy privileges men's access to health insurance over women's through employment-based benefits.

Gender-blind: the policy assumes that men are the income earners for the family and that men are involved in paid employment. It follows, then, that their families (wife and children) are protected under their benefits. The assumption follows that women do not engage in paid employment and are not responsible for providing social benefits for family members such as dependent benefits, including health insurance coverage.

This is an example of a policy that should be avoided, as it ignores gender norms, roles and relations and (however unintentionally) reinforces unequal power relations between women and men that, in the end, decrease access to health services through limited health insurance coverage.

Exercise 2

Is this campaign gender-responsive? Yes.

Which GRAS level best describes development of this media campaign? Gender-transformative.

Why? The development of the media campaign:

- acknowledges different norms and roles for women and men;
- incorporates women's and men's specific needs;
- demonstrates intent to address the causes of gender-based health inequities; and
- addresses harmful gender norms, roles and relations as well as power relationships between men and women.

Optional learning activity 3.1b: Case studies with the Gender Responsive Assessment Scale

Aims of the learning activity

- Further develop skills at using GRAS classification criteria.
- Complement l**earning activity 3.1a** as necessary.

Notes

- Facilitators may want to include or develop context-specific examples as necessary.
- This learning activity can be delivered in one of the following ways:
  - **buzz groups**
  - **participant reading and discussion**
  - **Module 3 preparatory or post-workshop assignment**
- Answers for the GRAS classification are provided below for distribution or discussion.
- Estimated time: 45–60 minutes (depending on the mode of delivery).

Suggested process

Step 1: **If buzz groups are used**, divide participants into groups and refer to the **Participant Notes, subsection 3.1e** (*Using the WHO Gender Responsive Assessment Scale – various case studies*). Groups should read the case studies and then determine which GRAS levels are applicable and why. Conduct a short report-back session for all groups.

If participant reading and discussion are used, have participants silently read the case study. Reproduce the GRAS checklist from the Participant Notes (or below) on blank flip charts and use these in small-group or plenary discussions to assess the case study. Discussions could be carried out in pairs or small buzz groups.

Step 2: using **Slide 3.14**, recall the key messages about the levels and uses of the GRAS (as necessary). Sum up by reminding participants that **case studies on the GRAS are illustrative only and that a true gender assessment of a programme or policy requires all policy details and may require interviews with the people who were involved in its design and delivery**. Different GRAS levels may apply to different aspects of the programme. The point is not to give a pass or fail – rather to identify areas where corrective action can be taken to reduce gender-based health inequities.

Case study 1: *Seguro Popular*, Mexico

GRAS level	Your assessment	Comments
Gender-unequal		
Gender-blind		
Gender-sensitive	✓	The plan considers gender norms, roles and relations.
Gender-specific	✓	Although the plan addresses households, its specific focus on the maternal health of low-income women considers their broader gender contexts. The inclusion of attention to issues such as gender-based violence that women face makes this clear.
Gender-transformative		

Case study 2: Yari Dosti, India

GRAS level	Your assessment	Comments
Gender-unequal		
Gender-blind		
Gender-sensitive	✓	The programme acknowledges the influence of gender norms, roles and relations on men's and women's sexual and reproductive health.
Gender-specific		
Gender-transformative	✓	Although the programme's participants were all men, this programme addresses underlying causes of gender differences: attitudes that perpetuate inequality between men and women. The programme's goal was to transform men's attitudes to achieve better relations between men and women. Yari Dosti intended to benefit both men and women by addressing harmful gender norms, roles and relations.

Case study 3: Women's reproductive health, China

GRAS level	Your assessment	Comments
Gender-unequal		
Gender-blind		
Gender-sensitive	✓	The programme acknowledges gender norms, roles and relations.
Gender-specific	✓	The focus on women is in the context of gender norms, roles and relations.
Gender-transformative	✓	The project also addresses decision-making processes as causes of gender-based health inequities, undertakes ways to transform the effects of harmful gender norms, roles and relations and includes strategies to foster progressive changes in power relationships between women and men.

Case study 4: Stepping Stones, South Africa

GRAS level	Your assessment	Comments
Gender-unequal		
Gender-blind		
Gender-sensitive	✓	The programme recognizes that gender issues affect the incidence of HIV: for example, women are less often able to make decisions regarding sexual behaviour. This acknowledges gender norms, roles and relations – and their potential effects on health outcomes and behaviour.
Gender-specific		
Gender-transformative	✓	Stepping Stones aims to transform harmful aspects of gender relations by building equitable interpersonal relationships.

Optional learning activity 3.2b: WHO Gender Assessment Tool: which Gender Responsive Assessment Scale level fits my programme?

Aims of the learning activity

- Introduce the WHO Gender Assessment Tool (GAT), a complementary tool to use with the GRAS.
- Practice using the GAT based on a case study.
- Complement **learning activity 3.1** as necessary.

Notes

- Facilitators may want to include or develop a context-specific case study as necessary.
- Estimated time: 45–90 minutes (depending on the mode of delivery).

Suggested process

Step 1: referring to the GAT in the **Participant Notes, subsection 3.1g** (*WHO Gender Assessment Tool: which Gender Responsive Assessment Scale level fits my programme?*), recall the critical questioning methods of gender analysis and introduce the GAT. Highlight the following:

- The GAT is not exhaustive – but can give users a quick idea of how their programme or policy is doing with respect to levels of gender responsiveness in accordance with the GRAS. The GAT can help to identify areas of weakness and strength with respect to gender responsiveness and may also indicate that some further gender analysis may be needed to undertake necessary modifications.

Step 2: Go through a few of the questions, pointing out the scoring hints. Explain scoring hints as necessary by referring to the concepts raised in Modules 1 and 2.

Step 3: Introduce case study activity to practice using the GAT. The case study can be used in the following ways:

- **buzz groups;**
- **participant reading and discussion; and**
- **Module 3 preparatory or post-workshop assignment**.

If buzz groups are used, divide participants into groups and refer to the **Participant Notes, subsection 3.1h** (*Using the WHO Gender Assessment Tool – family planning in Jordan*). Groups should read the case study and apply the GAT. Conduct a short report-back session for all groups.

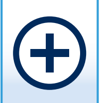
If participant reading and discussion are used, have participants read the case study (silently or aloud). Apply the GAT to the case study using either the Participant Notes or photocopies of the GAT.

Step 4: referring to the definition of gender-responsive (see **Slide 3.3**) and the GRAS criteria (see the **Participant Notes, subsection 3.1b**), determine whether the intervention is gender-responsive. If so, which GRAS level does it fit?
The facilitator responses are given below. Note that the GAT will classify according to gender responsivity and not specific levels (i.e., distinctions between gender sensitive, specific or transformative). Discuss differences with the group.

WHO Gender Assessment Tool case study: family planning, Jordan

GRAS level	Your assessment	Comments
Gender-unequal		
Gender-blind		
Gender-sensitive	✓	The campaign acknowledges gender norms, roles and relations – and their potential effects on health outcomes and behaviour.
Gender-specific	✓	The focus on men within gender norms and roles (and considering gender relations within the household and community with respect to decision-making related to family planning) demonstrates a gender-specific approach.
Gender-transformative	✓	Attention to household decision-making could spark changes in gender relations.

Step 5: sum up by recalling the importance of using critical questions as in the GAT to help to determine gender responsiveness. Remind participants that assessment requires examining much more information than is provided in the brief case study.



Optional learning activity 3.2a: Considering gender in institutional processes

Aims of the learning activity

- Build gender skills related to the managerial or administrative functions of health planning and programming.
- Complement learning activities **3.2b** and **3.3**.

Notes

- This learning activity can be conducted separately with participants occupying managerial or administrative functions.
  - **If it is used to complement learning activity 3.2b**, a separate or joint group activity could be conducted, allowing time for plenary discussions on general ways to address gender in institutional processes.
  - **If it is used to complement learning activity 3.3**, participants with managerial or administrative work responsibilities could be asked to develop gender-responsive staffing plans or business rules within the context of either an intervention on one of the health conditions used in Module 2 (group activity) or within their organizational context.
- Facilitators may project guiding principles on slides or flip charts.
- Estimated time: 45 – 60 minutes.

Suggested process

Step 1: refer to **Participant Notes, subsection 3.2d** (*Considering gender norms, roles and relations in institutional processes*). Walk through the guiding principles and key questions outlined.

- Recall, as necessary, that critical questioning is a key method of gender analysis and is applicable to analysing health problems (see Module 2 – GAQ), assessing health programmes (see GRAS and GAT) and integrating gender in health planning and programming (see checklist).

Step 2: conduct group or plenary discussions to generate recommendations for each guiding principle. Record the recommendations on a blank flip chart. If participants are from the same division or unit, discussions can be tailored to their specific needs. Provide them with copies so that they can build from workshop activities in their daily work.

Step 3: sum up by reiterating that mainstreaming gender and reducing gender-based health inequities requires paying equal attention to how programmes are staffed, financed and run. These elements are part of institutional mainstreaming and are critical to bringing about the institutional change required to address harmful gender norms, roles and relations.

- As necessary, recall the five elements of gender (Module 1) to reiterate that systemic processes can uphold gender inequality.

Optional learning activity 3.2b: Gender and health communication

Aims of the learning activity

- Raise awareness and build basic gender skills related to health communication.
- Complement one of the following learning activities **3.2a, 3.2b** or **3.3**.

Notes

- This learning activity can be conducted separately with participants involved in communication or to stimulate broader group discussions on the importance of addressing gender in health communication. This could be useful to ensure that teams are in accordance in promoting the programme in question, developing advocacy campaigns or preparing health education and communication materials themselves.
  - **If this is used to complement learning activity 3.2a**, facilitators could replace some of the examples when discussing the GRAS and introduce aspects of health communication in accordance with the process suggested below as necessary and appropriate.
  - **If this is used to complement learning activity 3.2b**, a separate or joint group activity could be conducted, allowing time for plenary discussions on general ways to address gender in health communication.
  - **If this is used to complement learning activity 3.3**, participants with communication-related work responsibilities could be asked to develop gender-responsive communication activities based on one of the health conditions used in Module 2 (group activity).

- This learning activity does not cover all aspects of health communication. Facilitators are encouraged to consult the sources on which this learning activity was developed for further examples and tips for addressing gender in health communication: the *Oxfam gender training manual,* [24] *Integrating gender into HIV/AIDS programmes in the health sector* [61] *and The gender guide for health communication programs (Annex 9, ref 6)*.
- Using existing statements, messages or images from existing health programmes from the local context may be preferable. Facilitators are strongly encouraged to use national or regional examples of health communication messages to conduct this exercise, which requires advance preparation.
- Estimated time: 60 – 90 minutes.

Suggested process

Step 1: recall Module 1 discussions on gender and language, emphasizing that language and images can perpetuate gender stereotypes. As necessary, recall key concepts such as sex, gender, gender-based discrimination and empowerment from Modules 1 and 2.

Step 2: emphasize the following (project on a slide or flip chart):

- Some **policy or programme documents may be written in ways that are gender-blind or gender-unequal** – even when objectives or goals include addressing gender-based health inequities.
- **Speechwriters** may overlook phrases that may uphold gender inequality or emphasize gender stereotypes or harmful gender norms, roles and relations. This may occur in press releases, mass-media communication and high-level speeches with broad outreach that can potentially distribute harmful messages.
- Highlight that **language, images and the types of media used to communicate health messages should be used to challenge gender-based stereotypes that may harm health**.

Step 3: introduce key questions to use when **assessing communication messages, images or interventions from a gender perspective**, using the below flip chart (or transfer to a slide). Note that “materials” can be replaced by “slogan”, “statement”, “message” or “image” for the purpose of the exercise.

- The highlighted questions can be given priority for this exercise based on the provided samples if time is a concern for running this optional activity within the workshop – or in its inclusion in other activities or meetings in which you may be called upon to introduce gender and health communication issues.
- Some questions included in the **gender and health planning and programming-checklist** can also be applied to communication materials.

Module 3: Action

Flip chart – assessing gender in health communication materials

Do these materials reinforce gender stereotypes? Which ones? How? Could this affect programme outcomes or harm the community?

Do these materials challenge gender stereotypes? Which ones? How?
Could this affect programme outcomes or encourage positive social change in the community?

Is the selected medium used accessible and appropriate for women and men (according to context)?

How do these materials represent women and men of different ages and groups? Is this accurate for the given context (Examples: women as victims or marginalized, boys playing sports or men as fighters)?

Where and how do these materials include or omit women or men of certain groups (Examples: health workers mainly depicted as Western / urban women or men and patients mainly depicted as pregnant women from low- and medium-income / rural contexts)?

Do you think that the women and men represented would be happy with these materials? Why or why not?

Do the materials represent positive female role models? Are positive male role models represented?

What could be modified to make these materials gender-responsive?

Step 4: conduct group or plenary discussions (depending on the number of participants) to assess provided or prepared examples.

Communication examples

Example 1: A health sector strategy

HIV infection and AIDS are global crises for mankind that threaten human life and impede socioeconomic development and threaten the national security of the most severely affected countries. Women and men living with HIV pose a serious threat to an inadequately resourced health system, health workers and the broader community. Women who are sex workers and men who have sex with men pose the biggest threat of all.

Facilitator notes for example 1:

- "Mankind" could be replaced with "humanity" to avoid using male pronouns.
- The sentence beginning with "Women and men living with HIV"… is phrased in a way that implicitly blames people living with HIV for creating a burden on society and the health system. Stigma that may result will be differentially experienced by women and men.
- The sentence beginning with "Women are sex workers" points a finger at specific groups of women and men. Although these groups may be at increased risk for HIV, the use of the words "pose the biggest threat" as opposed to "be the most vulnerable" may yield discriminatory interventions towards these groups with different gendered outcomes for each. .

Example 2: Health promotion slogans:
"Mothers who breastfeed have healthy children!"
"Educate a girl, educate a family."

Facilitator notes for example 2:

- The first slogan associates responsibility for healthy babies entirely with mothers. Although breastfeeding is recommended and only women can breastfeed, the implicit message here is that mothers (as an extension of their gender roles) are solely responsible for children's health and well-being. When this example is discussed, brainstorm on ways that the phrase can remove this implicit blame. One way could be to say: "Breastfeeding is good for children's health!".
- The second slogan promotes education for girls in a manner that indicates education is not a means to improve her own life (and health) but an investment to ensure that family well-being is insured. This may not be considered inappropriate in some contexts but it presents girls' right to education in a utilitarian manner. Thus, the slogan says that girls should be educated because they will take care of a family someday – when in many contexts, the level of education of the head of household has been shown to impact the roles of women in the household, educated or not. When this example is discussed, recall Module 1 discussions about human rights as entitlements for everyone regardless of sex, age – or future role. Encourage participants to think of ways to transform this phrase that reflect human rights, girls' education and health. Remind participants that girls should be educated because it is their human right and not simply because gender roles in many contexts include family welfare (which is not to say that the impacts of education of all family members on the health of a household is not an important determinant of health to consider. Rather, it is in the ways in which girls' education is conceived). One way to rephrase this slogan is "Educate a girl, educate a woman, ensure her health" – which acknowledges the cumulative effect of education on women's health without attaching the right to education singularly to a future gender role or expectation.

Step 5: sum up by reminding participants that **paying attention to gender in communication is important using the below points** (facilitators to transfer to a slide or flip chart):

- Health policies or programmes may include objectives to address gender inequality but may be written in gender-blind or gender-unequal ways.
- Communication messages and interventions can reinforce stigmatization that is usually a result of gender-based discrimination or stereotypes. This could include depictions of:
  - men as being aggressive, promiscuous or unemotional;
  - women only in the context of motherhood;
  - heterosexual relations or marriage as the norm; and
  - women as passive bystanders in household or community activities.
- Messages or images that reinforce gender stereotypes could compromise the outcomes of communication interventions aimed at raising awareness and reducing gender-based health inequities.
- Depicting women and men as homogeneous groups masks their diversity and could isolate certain groups that could benefit from the messages.

Step 6: using another slide or flip chart, transition to some **positive ways health communication can be used to challenge gender stereotypes**:

- Health messages in any medium should represent and depict women and men in ways that value them equally.
- Women and men should be represented in both productive and reproductive roles – and across a range of professions.
- Textbooks and training materials for health professionals should be based on the symptoms among both men and women for the same conditions and should encourage gender-responsive communication methods with patients.
- Different types of communication media may be needed to address women and men appropriately.

Step 7: wrap up by reminding participants of the definition of gender mainstreaming from Module 1:

- Jog their memories that the process of achieving gender equality means **considering gender at all stages, even in communication**. This requires involving men and women!
- Finally, refer to the **Participant Notes, subsection 3.2e** (*Gender and health communications*) for an overview of the key messages.

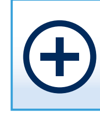
Optional learning activity 3.2c: Gender and health data

Aims of the learning activity

- Raise awareness and build basic gender knowledge related to health data.
- Complement learning activities **3.2b** or **3.3**.

Notes

- This learning activity can be conducted separately with participants responsible for health statistics or monitoring and evaluation activities. It may also be done with the broader group to reinforce Module 2 messages on having the right data to perform gender analysis.
  - **If this is used to complement learning activity 3.2b**, a separate or joint group activity could be conducted, allowing time for plenary discussions on general ways to address gender and health data in various planning and programming stages.
  - **If this is used to complement learning activity 3.3**, participants with data-related work responsibilities could be asked to develop gender-sensitive indicators around one of the health conditions used in Module 2 (group activity). Alternatively, they can be assigned to develop monitoring and evaluation indicators for the activities developed by the group.



- The area of gender and health data is vast; this optional learning activity does not cover all aspects that may be needed for expert audiences. If this is needed, facilitators are encouraged to consult the following guides: *Guidelines for gender-based analysis of health data for decision making (Annex 9, ref. 7), Guidelines for developing a population-based gender and health profile (Annex 9, ref. 8)* or the resources used in the **Participant Notes, subsection 3.2f** (*Sex-disaggregated data and gender-sensitive indicators: basic ingredients for health planning and programming)*.
- Estimated time: 45 – 60 minutes.

Module 3: Action

Suggested process

Step 1: recall the Module 2 discussions on the need to **have good-data** to conduct gender analysis. The same is true for integrating gender in the different planning and programming and steps outlined in Section 3.2.

- Highlight that this discussion will not be exhaustive.
- Ask participants for challenges they face with health data in their contexts and relate this back to the group activity in Module 2.
- Transfer the information below to a slide or flip chart and highlight these as key points to remember on gender and health data.
- Refer to the **Participant Notes, subsection 3.2f** for further information on the aspects raised in this learning activity.

F ip chart or slide: Key points on gender and health data

- **Analysis fram works** must allow for selecting indicators that facilitate gender analysis of health data.
- Generating and analysing **sex-disaggregated health data** is a core requirement of gender analysis. When possible, other forms of stratification are strongly encouraged such as ethnic origin, education level, etc.
- Health indicators should be **gender-sensitive.** They should have relevant disaggregation and capture key gender and health issues for specific groups of men or women.
- Health data are often insufficient to conduct gender analysis. Integrating gender into health planning and programming may require **gender statistics.**

Step 2: draw on the materials provided in the **Participant Notes, subsection 3.2f** to develop slides or flip charts on these four key points – using as much or as little information as suits the profile and needs of the participants. Depending on the audience and the need for discussion on gender and health data, facilitators may want to weave in an interactive discussion or group activity to discuss some of the examples provided in the Participant Notes or to discuss local examples of health indicators.

Step 3: remind participants that **gender mainstreaming needs to be measured for its progress in achieving gender equality as well as the process used to get there**. This goes back to the distinction between programmatic and institutional gender mainstreaming.

- Using the material below (on slides or a flip chart), introduce suggested process indicators that can be used to track progress in gender mainstreaming. Note that these indicators were used during a baseline assessment of the WHO Gender Mainstreaming Strategy *(Annex 9, ref. 9)* of the WHO gender mainstreaming strategy but can be used as a basis for other institutional efforts.
- If participants are developing or implementing a gender and health policy or strategy, conducting a group discussion on their existing indicators as a review may be useful. If no monitoring indicators exist, use this opportunity to develop indicators that can contribute to their current work.

Flip chart or slide: WHO Gender mainstreaming indicators

Strategic direction 1: Building WHO capacity for gender analysis and planning

1. Percentage of all WHO staff members (by sex, WHO category, WHO level and WHO region) who have a basic understanding of gender and health.
2. Percentage of all WHO staff members who at least moderately apply gender analysis and action in their work (disaggregated by sex, WHO category, WHO level and WHO region).
3. Percentage of WHO staff members who report at least some institutional support for integrating gender into their work (disaggregated by sex, WHO category, WHO level and WHO region).

Strategic direction 2: Bringing gender into the mainstream of WHO's management

1. Percentage of planning focal points whose responses reflect strong integration of gender during the **operational planning process** disaggregated by sex, WHO category, WHO level and by whether or not there was collaboration with the gender, women and health network.
2. Number of country cooperation strategies adopted after 2005 of those sampled that strongly integrate gender.
3. Percentage of all professional and administrative long-term and temporary posts by sex and grade level (cumulative)

Strategic direction 3: Promoting the use of sex-disaggregated data and gender analysis

Number of new WHO publications of those sampled that promote and/or use sex-disaggregated data

Strategic direction 4: Establishing accountability

1. Number of speeches by the Director-General and the regional directors of those sampled that include at least one reference to gender.

Step 4: wrap up the session by reiterating the following key tips:

- **Analysis frameworks**: select a framework that goes beyond health status and health outcome data. Include the determinants of health, health system performance and policy frameworks as important areas of analysis to allow good selection of indicators.
- Remember that **sex-disaggregated health data** are not always enough. In addition, when data is collected on one sex only (such as maternal health or types of cancer that only affect men), other forms of stratification are necessary to uncover health inequities.
- Health indicators should be **gender-sensitive**: select or develop gender-sensitive indicators using the criteria in the Participant Notes.

- Health data are often insufficient to conduct gender analysis. Integrating gender into health planning and programming may require **gender statistics**.
- Refer to the **Participant Notes, subsection 3.2f** (*Sex-disaggregated data and gender-sensitive indicators: basic ingredients for health planning and programming*) if this was not already done.

CONCLUDING THE WORKSHOP

Materials to be prepared and used

- Flip charts 0.02 (Outline of workshop modules), 1.01, 2.01 and 3.01 (Module objectives), participant expectations and parking lot
- Gender Jeopardy game* (see electronic resources or accompanying CD)

Proposed running time: 60 – 120 minutes (depending on if Gender Jeopardy played in full or in part).

Aims

- Revisit participant expectations
- Solicit participant recommendations for gender mainstreaming in their own public health work following the workshop
- Test participant knowledge and skills on all three modules
- Distribute certificates

Notes

- The time for concluding the workshop must be factored into the workshop planning – and this is best done immediately following Module 3.
- The participants' follow-up actions (see step 2) can be progressively developed throughout Module 3. Place a blank flip chart on the wall and invite participants to write down, throughout the Module, specific actions they plan to carry out after the workshop, with whom and in what time frame.

Suggested process

Step 1: sum up the workshop by recapping the progressive method of the workshop (awareness, analysis and action), highlighting key messages from each module as necessary:

- Refer to the flip charts with the module and workshop objectives, ensuring that all points have been covered.
- Revisit **participant expectations**, going over the list to ensure that all points have been covered. For the points that have not been covered, refer to either the Participant Notes or other resources that can help address unanswered concerns. This will require advance preparation so that facilitators are not caught off guard if an expectation has not been met.
- Remind participants that the **Participant Notes** serve as a key resource for them in their follow-up actions as well as the accompanying CD.

Step 2: highlight that, now that participants have concluded these modules, they are equipped to avoid using gender salt in their work. Recall the slogan with a flip chart or slide: **No more gender words without gender actions!**

Develop **participants' follow-up actions** to enhance immediate, practical transfer of skills and emphasize the fact that gender mainstreaming does not end when knowledge has increased or attitudes changed. Action is required!

- Ask participants to call out follow-up actions they will undertake after the workshop to mainstream gender in their daily public health work. Record these on a flip chart and transfer to a file or report that can be shared with all participants after the workshop.
- If the flip-chart method has been used (as in the Notes), revisit the flip chart and ask for further additions or comments.
  - Follow-up action could include requests to partners such as WHO for technical assistance, advocacy among senior officials in the country, highlighting things participants will share with colleagues or building on the work plans developed in Module 3, etc.

Step 3: using the prepared PowerPoint file, play a fun game of Gender Jeopardy to recap all modules. Make sure to have someone record scores (or prepare money cards for distribution) and prepare prizes!

- If no access to PowerPoint or related equipment is available, facilitators may want to develop flash cards or other fun ways to test participants on their new knowledge.
- Gender Jeopardy takes at least an hour to play but can be modified, shortened or adapted. It has been found to be a very stimulating way of recalling concepts as well as a fun way to end an intense workshop.
- Facilitators will need help to run the Gender Jeopardy game: one person to help with the logistics of the PowerPoint presentation and one person to help watch the time, identify the teams with the correct answers and record money earned on a flip chart for all to see.

* Note that the Gender Jeopardy used here is modelled after the game used in the UN College training course on Human Rights Based Approaches.

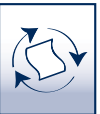
Gender Jeopardy: process and rules

Divide participants into teams or groups. Using the same division as for group work in Modules 2 and 3 is an easy, quick division. Determine a fair way to determine which team will go first.

The master of ceremonies (facilitator) welcomes participants to the game of Gender Jeopardy. She or he explains the following rules.

1. Teams can select from the six categories displayed on the slide. Each category includes five statements or questions on the topic – all worth different amounts of money.
2. Once the teams have selected their category and money level, the master of ceremonies reads the statement or question revealed on the slide. The team that selected the category has the first chance to respond. If they do not respond after one minute, the floor is open to the other teams. The first team to provide the correct answer wins the money and selects the next category in play. Correct answers will be revealed through a double-click, or hitting "enter" on the keyboard.
3. In some instances, a daily double is revealed. This means that the winnings from this category are doubled.
4. If the game is played in its entirety, a final question is provided.
5. Tally up all the money earned and determine the winning team!

Step 4: Collect completed **feedback forms** for the workshop (below), distribute **certificates** (see template) and **thank participants** for their active attention and participation. Note that the below feedback form is on the materials alone and are primarily for revision of the materials. Facilitators should encourage participants to send them directly to WHO or collect and send onwards. If facilitators would like feedback on the running of the workshop itself, a separate form should be developed.



WHO CAPACITY-BUILDING FEEDBACK

WHO is committed to mainstreaming gender throughout its work and to supporting Member States and country partners in doing this. WHO is also aware of the need to update approaches and information on gender and health to keep up with changing trends across contexts.

We are very appreciative of feedback on these materials. Please take a moment to fill out the below form, with the attention line as "capacity-building feedback", and return it via one of the below options:

By regular mail to:
Department of Gender, Women and Health
World Health Organization
20, Avenue Appia
CH-1211 Geneva 27
Switzerland

By e-mail to:
genderandhealth@who.int

By fax to:
+41 22 791 1585

Capacity-building feedback on the WHO gender mainstreaming manual: a practical approach (Participant Feedback)

1. Overall feedback

	Yes	No	Comments
The materials are user-friendly and comprehensive.			
The progressive organization of the modules is logical and easy to follow.			
The materials are easily adaptable to local contexts.			
The accompanying CD-ROM includes relevant, user-friendly materials to support my work in gender mainstreaming.			
The materials included in the Participant Notes are relevant for people who work in public health activities.			

2. Gaps, omissions, etc.

Please indicate which areas or materials should be included, expanded upon or excluded in upcoming updates of the Participant Notes.

3. User perspectives

a. I plan to use these materials in the following context(s):

4. Additional comments

☐ Would you like to be a part of WHO's gender, women and health mailing list? Check here if yes and include the information requested below when sending your form back to us.

Note that this is optional for those that would like to provide anonymous feedback.

Name	
Institution	
Address	
E-mail	
Telephone	
Fax	
Web site	

"GENDER JEOPARDY" QUESTIONS AND ANSWERS FOR FACILITATORS

Description of categories

Gender: Mainly drawn from Module 1, this category features a sampling of key gender concepts. Participants are presented with definitions and must provide the correct corresponding concept.

Gender Mainstreaming: Building from all Modules and additional reading in the Participant Notes, this category consists of concepts and tools introduced relevant for gender mainstreaming. Participants are presented with complete or partial definitions and/or tools introduced and must respond with concepts or tool components as appropriate.

Gender Analysis: Using lessons learned in Module 2, this category features various terms and tools related to gender analysis in health. Participants are given clues on terms, ingredients and tools used from Module 2 and must provide the correct corresponding answer.

Gender "Mix": Drawing from all Modules and additional reading in the Participant Notes, this category includes random definitions, concepts and tools used throughout the workshop. Participants are presented with definitions and must respond with the correct corresponding answer or tool.

Sex, gender or both?: Drawing from all Modules, additional reading in the Participant Notes and participant knowledge of health conditions, this category includes sound bytes of health facts or outcomes. Participants must indicate if these facts or outcomes are a result of sex, gender or both.

International commitments to gender equality and health equity: Building from information shared in Module 1 and additional reading provided in the Participant Notes, this category includes key international commitments and/or instruments important for advancing progress in gender and health. Participants must provide answers to questions on the names of described instruments according to each category.

Description of features

Daily Double: Placed in the $ 800 *Gender Analysis* and $ 600 *Sex, gender or both?* categories, the winnings from these questions are doubled if answered correctly.

Gender Jeopardy Finale: This question will be revealed when there are no more categories to select. If the game is not played in its entirety, the Finale will not be revealed.

Gender	Gender Mainstreaming	Gender Analysis	Gender "Mix"	Sex, gender or both?	International commitments to gender equality and health equity
$200 Biological and physiological characteristics such as reproductive organs, chromosomes, hormones, etc. **Answer**: Sex	**$200** The ultimate goal of gender mainstreaming. **Answer**: Gender equality	**$200** Basic ingredient for gender analysis **Answer**: Sex disaggregated data	**$200** Method to uncover how gender inequality affects health and well-being. **Answer**: Gender analysis in health *Facilitators could accept "gender analysis".*	**$200** Women can bear children. **Answer**: Sex	**$200** What is *Integrating gender analysis and actions into the work of WHO*? **Answer**: The WHO Gender Mainstreaming Strategy
$400 Norms, roles and relationships of and between women and men. **Answer**: Gender	**$400** Two types of policies or programmes to avoid. **Answer**: Gender unequal and gender blind. *Facilitators could prompt participants with the Gender Responsive Assessment Scale as necessary.*	**$400** Money, credit, loans, land, other assets **Answer**: Economic resources *Facilitators could accept either "health related resources" or "resources".*	**$400** Process to help people to gain control over their lives. **Answer**: Empowerment	**$400** Men tend to have higher mortality rates as a result of road traffic injuries. **Answer**: Gender	**$400** This international document, agreed upon in 1995, includes chapters on Women's Health and Violence against Women. **Answer**: The Beijing Platform for Action
$600 Passed from generation to generation through the process of socialization to teach men and women how they should be. **Answer**: Gender norms	**$600** Policies or programmes that address harmful gender norms, roles and relations and promote gender equality. **Answer**: Gender transformative	**$600** A tool to analyse health problems from a gender perspective through the interaction between gender and health related considerations. **Answer**: The WHO Gender Analysis Matrix	**$600** Critical questions to use when conducting a gender analysis of a health problem. **Answer**: WHO Gender Analysis Questions	**$600 (Daily Double)** Sexually transmitted infections are asymptomatic for longer periods in women than in men. **Answer**: Sex	**$600** Which human rights treaty is dedicated to eliminating discrimination against women and girls? **Answer**: The CEDAW *Facilitators could ask for the full name of the CEDAW to make things more challenging.*

Gender	Gender Mainstreaming	Gender Analysis	Gender "Mix"	Sex, gender or both?	International commitments to gender equality and health equity
$800 Refers to what men and women can and should do according to society (in the household, community and workplace). **Answer**: Gender roles	**$800** Needs identified through an analysis of gender inequality and its impact on women and men of different groups. **Answer**: Strategic gender needs	**$800 (Daily Double)** The ability to decide when, how and who can use resources. **Answer**: Control over resources	**$800** Equal chances or opportunities for women and men to access and control social, economic and political resources. **Answer**: Gender equality	**$800** Respiratory disease burden is higher in women, especially in mid and low income countries. **Answer**: Sex and gender.	**$800** True or false? The right to health means the right to be healthy. **Answer**: False
$1000 Process through which girls and boys learn about gender norms, roles and relations – and what it means to be a man or a woman. **Answer**: Socialisation	**$1000** Ensures that organizational procedures and mechanisms do not reinforce patterns of gender inequality. **Answer**: Institutional gender mainstreaming *Facilitators could give a hint of "one of the types or approaches to gender mainstreaming" to help participants if stuck.*	**$1000** Included among the health-related considerations of the WHO Gender Analysis Matrix, these are elements associated with the development of disease or illness but are not sufficient to cause it. Examples include age, tobacco consumption or poverty. **Answer**: Risk factors	**$1000** Needs defined by women (or men) that respond to immediate necessities such as adequate living conditions, water provision, health care and employment. **Answer**: Practical gender needs	**$1000** Women tend to live longer than men in most countries and regions. **Answer**: Sex and gender	**$1000** Millennium Development Goal 3 aims to … **Answer**: Promote gender equality and empower women
Gender Jeopardy Finale	Complete this slogan: No more gender words without … Answer: gender actions!				

Access to and use of health services
Health-related consideration of the WHO Gender Analysis Matrix. Gender norms, roles and relations impact access and use of health services that includes the following components: availability, affordability, accessibility, accommodation and acceptability.

Access to resources
The availability of a resource that includes several components such as geographic or physical accessibility, financial and social accessibility.

Biological factors
Gender-related consideration of the WHO Gender Analysis Matrix. Refers to those factors only related to physiology such as: reproductive and/or conditions related to physiological and/or hormonal changes; genetic or hereditary conditions (or those transferred from parent to child through chromosomes).

Control over resources
The ability to decide when, how and who can use a resource.

Differential exposure to risk factors
Refers to the different ways in which gender norms, roles and relations affect women and men's exposure to risk factors. For example, due to the gender-based division of labour different groups of women and men are exposed to different risks for work-related injuries or illnesses (paid activities) or women's gender roles with respect to food preparation in low and mid income settings (unpaid activities) often exposes them to unsafe cooking fuels more often than men.

Differential vulnerability
Refers to differences in access to and control over resources that may increase vulnerability to illness and disease.

Economic resources
Money, credit, loans, land, other assets.

Empowerment
Empowerment is a multidimensional social process that enables people to gain control over their lives. Strategies for empowerment therefore often challenge existing power allocations and relations to give disadvantaged groups more power. With respect to women's health, empowerment has often meant, for example, increasing education opportunities and access to relevant information to enable women to make informed decisions about their health, improve self-esteem and equip them with communication and negotiation skills. Such skills are known to influence, for example, safer sex practices, treatment adherence and timely health-seeking behaviour.

Experiences in health care settings
Health-related consideration of the WHO Gender Analysis Matrix. Health care provided in a discriminatory, harmful or ineffective manner may discourage women and men from seeking treatment. Health care settings that do not address gender norms, roles and relations in culturally sensitive and appropriate ways may fail to reach the people in greatest need of health services - and lead to unsatisfactory experiences in health care settings.

Gender
Refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed. The concept of gender includes five important elements: relational, hierarchical, historical, contextual and institutional. While most people are born either male or female, they are taught appropriate norms and behaviours – including how they should interact with others of the same or opposite sex within households, communities and work places. When individuals or groups do not "fit" established gender norms they often face stigma, discriminatory practices or social exclusion – all of which adversely affect health.

Gender analysis
Gender analysis identifies, assesses and informs actions to address inequality that come from: 1) different gender norms, roles and relations; 2) unequal power relations between and among groups of men and women, and 3) the interaction of contextual factors with gender such as sexual orientation, ethnicity, education or employment status.

Gender analysis in health
Examines how biological and sociocultural factors interact to influence health behaviour, outcomes and services. It also uncovers how gender inequality affects health and well-being.

Gender based division of labour
Refers to where, how and under what conditions women and men work (for or without pay) based on gender norms and roles.

Gender blind
Level 2 of the WHO Gender Responsive Assessment Scale: Ignores gender norms, roles and relations and very often reinforces gender-based discrimination. By ignoring differences in opportunities and resource allocation for women and men, such policies are often assumed to be "fair" as they claim to treat everyone the same.

Gender equality
Refers to equal chances or opportunities for groups of women and men to access and control social, economic and political resources, including protection under the law (such as health services, education and voting rights). It is also known as equality of opportunity – or formal equality. Gender equality is often used interchangeably with gender equity, but the two refer to different, complementary strategies that are needed to reduce gender-based health inequities.

Gender equality in health
Women and men have equal conditions to realize their full rights and potential to be healthy, contribute to health development and benefit from the results. Achieving gender equality will require specific measures designed to support groups of people with limited access to such goods and resources.

Gender equity
More than formal equality of opportunity, gender equity refers to the different needs, preferences and interests of women and men. This may mean that different treatment is needed to ensure equality of opportunity. This is often referred to as substantive equality (or equality of results) and requires considering the realities of women's and men's lives. Gender equity is often used interchangeably with gender equality, but the two refer to different, complementary strategies that are needed to reduce gender-based health inequities.

Gender equity in health
Refers to a process of being fair to women and men with the objective of reducing unjust and avoidable inequality between women and men in health status, access to health services and their contributions to the health workforce.

Gender mainstreaming
The process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated.

Gender norms
Refer to beliefs about women and men, boys and girls that are passed from generation to generation through the process of socialization. They change over time and differ in different cultures and populations. Gender norms lead to inequality if they reinforce: a) mistreatment of one group or sex over the other; b) differences in power and opportunities.

Gender relations
Refers to social relations between and among women and men that are based on gender norms and roles. Gender relations often create to hierarchies between and among groups of men and women that can lead to unequal power relations, disadvantaging one group over another.

Gender responsive
A policy or programme that considers gender norms, roles and inequality with measures taken to actively reduce their harmful effects.

Gender roles
Refers to what males and females are expected to do (in the household, community and workplace) in a given society.

Gender sensitive
Level 3 of the WHO Gender Responsive Assessment Scale: Indicates gender awareness, although no remedial action is developed.

Gender specific
Level 4 of the WHO Gender Responsive Assessment Scale: Considers women's and men's specific needs and intentionally targets and benefits a specific group of women or men to achieve certain policy or programme goals or meet certain needs. Such policies often make it easier for women and men to fulfil duties that are ascribed to them based on their gender roles, but do not address underlying causes of gender differences.

Gender stereotypes
Images, beliefs, attitudes or assumptions about certain groups of women and men. Stereotypes are usually negative and based on assumed gender norms, roles and relations.

Gender transformative
Level 5 of the WHO Gender Responsive Assessment Scale: Addresses the causes of gender-based health inequities by including ways to transform harmful gender norms, roles and relations. The objective of such programmes is often to promote gender equality and foster progressive changes in power relationships between women and men.

Gender unequal
Level 1 of the WHO Gender Responsive Assessment Scale: Perpetuates gender inequality by reinforcing unbalanced norms, roles and relations and often leads to one sex enjoying more rights or opportunities than the other.

Gender-based discrimination
Any distinction, exclusion or restriction (such as unfair or unequal treatment) made based on gender norms, roles and relations that prevents women and men of different groups and ages from enjoying their human rights. It perpetuates gender inequality by legitimizing stereotypes about men and women of different ages and groups.

Health and social outcomes and consequences
Health-related consideration of the WHO Gender Analysis Matrix. Health and social outcomes and consequences refer to ***what happens*** when a person becomes sick. The consequences of a health problem often cause economic and social changes for both the sick individual and their ***social network***. This social network can include family or household members, friends and broader community members. Health outcomes relate to recovery, disability or death from a health problem. Gender considerations often influence how these outcomes influence a family or individual.

Health equity
The absence of unfair, avoidable or preventable differences in health among populations or groups defined socially, economically, demographically or geographically.

Health seeking behaviour
Health-related consideration of the WHO Gender Analysis Matrix. Health-seeking behaviour is any action carried out by a person who perceives a need for health services with the purpose of addressing a given health problem. This includes seeking help from allopathic and alternative health services. Both sex and gender influence health-seeking behaviour.

Institutional gender mainstreaming (as it relates to public health)
Ensures that organizational procedures and mechanisms do not reinforce patterns of gender inequality. Institutional gender mainstreaming seeks structural changes, calls for a transformation of the public health agenda that includes the participation of women (and other marginalized groups) in defining and implementing public health priorities and activities. It aims at ensuring gender equality dimensions in strategic agendas, policy statements and monitoring and evaluation of organizational performance.

Other health-related resources
Within the categorization of health-related resources, these refer to basic necessities such as time, water, shelter, clothing and food.

Political resources
Decision-making processes and leadership at the institutional, household, community, district or national levels, civic participation; High-quality health care services (formal or informal), medication, health insurance (provided by the state or employer); Economic, social, political, civil and cultural rights.

Practical gender needs
Needs defined by women (or men) that respond to immediate necessities such as adequate living conditions, water provision, health care and employment.

Programmatic gender mainstreaming (as it relates to public health)
The systematic application of gender analysis methods to health problems to better understand how life conditions, opportunities and environments affect the health of women and men and boys and girls.

Risk factors
Health-related consideration of the WHO Gender Analysis Matrix. Elements associated with the development of disease or illness that are not sufficient to cause it. Examples include age, tobacco consumption or poverty.

Sex
The different biological and physiological characteristics of males and females, such as reproductive organs, chromosomes, hormones, etc.

Social resources
Community resources, social support networks, transport and other social services; Education or training (formal or informal), information.

Socialisation process
The process by which girls and boys learn what roles are assigned to them.

Sociocultural factors
Gender-related consideration of the WHO Gender Analysis Matrix. Factors related to gender norms, roles and relations that may result in gender inequality.

Strategic gender needs
Needs identified through an analysis of gender inequality and its impact on women and men of different groups. Addressing strategic gender needs challenges predominant gender systems such as the gender-based division of labour.

Treatment options
Health-related consideration of the WHO Gender Analysis Matrix. Treatment options can range from self-care to alternative (such as local healers) to allopathic treatment delivered in health facilities in the community or at home. Treatment options should address both sex and gender to respond to the health needs and realities of women and men from different groups.

Vulnerability
Health-related consideration of the WHO Gender Analysis Matrix. Refers to the degree to which individuals, communities and systems are susceptible to or have diminished capacity to cope with exposure to risk factors.

WHO Gender and health planning and programming checklist
WHO Gender Analysis tool: check list including tips and critical questions to guide users through mainstreaming gender in different programme and planning stages.

WHO Gender Analysis Matrix
WHO Gender Analysis Tool: a simple tool designed to analyse health problems by crossing gender and health related considerations. The WHO Gender Analysis Matrix is a way of organization information in order to develop programmatic responses.

WHO Gender Analysis Questions
WHO Gender Analysis Tool: a non-exhaustive list of critical questions to guide users in conducting a gender analysis of a health problem. Eight top-level questions are included, with multiple second and third level questions to uncover ways that gender plays a role in health behaviours, outcomes and services. Can be used in conjunction with the WHO Gender Analysis Matrix.

WHO Gender Assessment Tool
WHO Gender Analysis tool: basic check list aimed at rapid assessments of existing programmes and policies. Can be used in conjunction with the WHO Gender Responsive Assessment Scale.

WHO Gender responsive assessment scale
WHO Gender Analysis tool: programme or policy assessment scale including five levels of gender responsiveness. Two levels hinder the achievement of gender equality and health equity, one represents a starting point for gender programming and the two final levels represent characteristics of gender responsive health policies and programmes.

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