

MODULE **4**

**PRACTICAL AND
STRATEGIC GENDER
APPROACHES**



MODULE 4

PRACTICAL AND STRATEGIC GENDER APPROACHES:

OVERVIEW: MODULE FOUR

Objective	<ul style="list-style-type: none"> ● To understand the concepts of practical and strategic gender approaches. ● To begin to apply the gender approaches and the accompanying mechanisms to promote empowerment, to addressing these needs in health.
Core Message	The Practical Gender Approach and the Strategic Gender Approach must be applied in conjunction, in order to ensure that all the health needs of men and women are equitably addressed
Expected Outcome	Participants will be able to distinguish between practical and strategic gender approaches to respond to these needs, and will begin to apply instruments to identify specific needs of men and women in health and development work.
Methodology	Plenary Discussion Lecturette Small Group Work/Plenary Reportback
Materials	OHT No. 7: Practical and Strategic Gender Approaches Flipchart No. 13: Definition of Empowerment Flipchart No. 14: Four Mechanisms of Empowerment Flipchart No. 15: Group Task Handout No. 13: PGAs/SGAs Handout No. 14a: Definition of Empowerment/Mechanisms of the Empowerment Process Handout No. 14b: Empowerment Continuum (adapted from Ronald Labonte) Handout No. 15(a): Promotion of Breast Feeding Handout No. 15(b): Detection and Control of Tuberculosis Handout No. 15(c): Community Based Intervention for Promotion of Mental Health of the Elderly Handout 15(d): Campaign to Stop Tobacco Addiction
Components	Introduction to Module Four 4.1 Practical and Strategic Gender Approaches 4.2 Empowerment Process 4.3 Health Interventions

OVERVIEW: MODULE FOUR (Cont.)

Time	Intro:	5 minutes
	4.1	20 minutes
	4.2	20 minutes
	4.3	50 minutes
	<u>Total:</u>	<u>95 minutes</u>

Preparation	■	Prepare Flipchart Nos. 13 - 15
	■	Photocopy supporting document on the Continuum of Empowerment
	■	Photocopy Handout Nos. 13 - 15

INTRODUCTION TO MODULE FOUR: Review of Modules 1 - 3:

PROCESS

- The difference between "sex" and "gender" was defined, emphasizing that the latter is socially constructed, is modified through time, and differs between social and cultural groups.
- Gender roles and responsibilities are assigned in every society. This has direct implications for the degree to which men and women, respectively, have access to and control over resources needed to protect their health.
- Health profiles of men and women are the product of an interaction between biological and psychosocial factors. Sex disaggregated data is crucial for identifying differences and similarities between the health profiles of men and women.
- The next step is to look at Gender Needs: If men and women are biologically different and have different gender roles, then they also have different gender needs in health. Identifying the health needs that arise out of different roles is critical to achieving equity in health policies, programs and projects.

PRACTICAL AND STRATEGIC GENDER APPROACHES

Method:	Lecture
Materials:	Handout No. 13: PGAs/SGAs OHT No. 7
Time:	<u>20 minutes</u>
Preparation:	Photocopy Handout No. 13

PROCESS

- Facilitator points out that as development practitioners we need to be aware of the following:
 - Whether health needs for men and women are the same or different, gender roles and responsibilities must be considered for development interventions to respond equitably.
 - These gender based needs can be seen as twofold:
 - (1) Those that improve the quality of life and in so doing meet the basic health needs of the people; and
 - (2) Those that address the question of equity and self-determination and in so doing move towards a more equitable distribution of health resources in society.
 - Our ability to respond to these needs satisfactorily is helped in a significant way by distinguishing between two approaches, namely, the practical gender approach (PGA) and the strategic gender approach (SGA).
 - This dual approach is based on the assumption that:
 - (1) The gender division of labor gives rise to an imbalance in the responsibilities for health care and promotion assigned to women and men;
 - (2) The imbalance in power relations between women and men means different access to and control over resources to respond to health problems.

A useful mechanism for ensuring that these assumptions are taken into account is the PRACTICAL GENDER APPROACH AND THE STRATEGIC GENDER APPROACH:

- **A Practical Gender Approach (PGA)** responds to the health needs of women and men within their socially accepted roles in society, without attempting to modify gender inequities. The practical gender approach improves the health condition of women or men because it identifies the roles and responsibilities of each sex and attempts to tailor the response to the present situation of women and men in specific contexts. Although PGAs are a key component to efficient responses, they do not directly address existing gender inequities. In fact, PGAs can even exacerbate existing gender inequities because, while they provide access to resources, they do not seek to increase control over them.
 - **A Strategic Gender Approach (SGA)**, in addition to responding to the concrete health needs of men and women, is aimed at redistributing the roles, responsibilities and power between them, so as to reduce inequities that harm health and health seeking behavior.
- Facilitator provides an example:
- **Practical Gender Approach:** Although both fathers and mothers are concerned about the immunization of their children, it is usually women who take them to the health services for this purpose. Thus, women and men share the need to have children immunized, but when we examine this need in the light of gender roles and responsibilities, women may feel the need for access to services at convenient times more than do men. Thus, we observe gender differences in health needs, caused by a division of labor that delegates the care of children as part of women's reproductive role. A PGA would be sensitive to women's need for accessible health services that offer a flexible schedule. This practical gender approach to the situation makes it easier for women to better fulfill their socially assigned role.
 - **Strategic Gender Approach:** However, in addition to responding to the need to immunize children, the health services could aim toward a redistribution of gender responsibilities and roles, calling upon fathers to assume a share in the care of their children by bringing them to the services to be immunized. A strategic gender approach to such a health need might also include information and training sessions for fathers prior to the birth of children, on how to care for their newborn. As a result, men may become more comfortable in this role and hence more secure about being involved in the raising of their children, enhancing the potential for the responsibility for the health of children to be shared by men and women. This strategic gender approach could then contribute to building a society based on more equitable gender relations.
- It is important to emphasize that PGAs and SGAs are not dichotomous. PGAs are essential to responding efficiently to health needs because they recognize that men and women have different gender roles and responsibilities which imply differential access to and control over resources necessary to protect health. For example, the absence of a Practical Gender Approach in the design of a project that incorporates a clinic could lead to the failure of the project if the hours of opening are

inconvenient to the women because of their domestic chores. However, with a PGA, women's roles and responsibilities would be taken into account, women would be consulted about their needs, and the flexible hours could lead to women having greater control over their available time. This would not necessarily change women's roles, but it would lighten the burden of those roles.

In the case of a project on HIV/AIDS prevention, a *Practical Gender Approach* would call for the use of condoms in order to help stem the tide of the epidemic. In certain cultural circumstances and contexts this might be sufficient. In some countries the reduction of new cases of HIV has been directly correlated to an increased condom use. Hence simply an information campaign and easy access to condoms can meet a gender need for both men and women.

On the other hand, culture dictates in many instances that men resist the use of condoms because they believe that it reduces sexual pleasure, and it is a challenge to their sense of manhood. A man would therefore not take kindly to a suggestion by a woman that he use one. A woman, even though she is aware that the use of a condom could save her life, has little power in the relationship to negotiate condom use. A threat by the man to leave her might be enough for her to not raise the issue at all. In some cultures, men are insulted if a woman suggests its use as he views this as lack of trust on the part of the woman. In other cultures, women are insulted if the man suggests its use, as she infers that he thinks she "sleeps around."

Hence in order for condom use to be successfully negotiated, the roles of men and women and the relations that arise from these roles have to be addressed. Only a Strategic Gender Approach will enable this process, and the WAY in which the project is designed and implemented might be very different for men and women given these different roles, relations and assumptions. Hence, a highly effective PGA for men to protect themselves from infection would ensure them access to condoms; however for women, PGAs in AIDS prevention, such as access to condoms, do not have the same impact because of gender roles that curtail women's ability to negotiate condom use with a male partner. In other words, a PGA might work for men, but is unlikely to work for women. An SGA would work for both, as it would change the gender relations, allowing women to assert their needs and for men to hear and respond to that assertion. However, because an SGA involves fundamental behavioral changes in power relationships, they are slow to take place.

■ Facilitator distributes Handout No. 13 and shows OHT No. 7.

Text of Handout No. 13:

PRACTICAL AND STRATEGIC GENDER APPROACHES	
<p>A. PRACTICAL GENDER APPROACH</p> <ul style="list-style-type: none"> ● Responds to short-term needs. ● Responds to needs that are usually easily identifiable by users and suppliers. ● Responds to biological requirements and specific health conditions. ● Gendered health needs met through provision of health goods and services. ● Tends to involve women and men as subjects of intervention. ● Can improve the health <u>condition</u> of women and men through the access to resources. ● Usually does not change gender roles and relations. 	<p>B. STRATEGIC GENDER APPROACH</p> <ul style="list-style-type: none"> ● Tends to be a long-term strategy, as an integral part of sustainable human development. ● Responds to needs not always easily identifiable by people. ● Targets inequities between women and men in responsibilities and power relationships. ● Needs identified through empowerment processes: the creation of awareness, increased self-esteem, education, strengthening organizations, political mobilization, etc. ● Tends to involve people as active subjects or empowers them for this. ● Can improve the position of women by increasing their control over resources. ● Improves the balance of power between men and women in the use of health resources, through control over internal and external factors that affect the ability to protect health.

Text of OHT No. 7

PRACTICAL GENDER APPROACH	STRATEGIC GENDER APPROACH
● Short term response	● Long term strategy
● Needs more easily identifiable	● Needs less immediately identifiable
● Biological requirements and specific health conditions	● Targets inequities in power relationships
● Provides health goods and services	● Focuses on empowerment processes
● Involves women/men as passive subjects	● Involves people as active participants
● Improves health conditions	● Improves the position of women
● Gender roles and relations remain constant	● Improves balance of power relations

- The facilitator points out:

Practical and Strategic Gender Approaches grow out of what has been generally recognized in the literature on gender and development as practical and strategic gender needs. These concepts came out of the women's movements in conjunction with various disciplines.

PAHO has adapted the concept of gender "needs" for application to health and development. We refer to practical and strategic approaches in order to underscore that in health the key to achieving gender equity is in HOW health projects, programs and policies are designed. However, it is worth emphasizing that since the concept originally grew out of the women's movement, as a result it logically targets needs and approaches identified by women rather than men, because of the continuing imbalance of power relations. Recent years have seen the formation in some countries of men's movements that have determined that gender constructions have also created role identity distortions that have been detrimental to their own health and well-being. We hope that as we are introducing this concept within the health sector, men will also help to identify their health needs and concomitant strategic gender approaches to improve their own health and well-being.

EMPOWERMENT PROCESS

Method:	Lecture
Materials:	Flipchart No. 13: Definition: Empowerment Flipchart No. 14: Four Mechanisms of the Empowerment Process Handout No. 14a: Definition of Empowerment/Mechanisms of the Empowerment Process Handout No. 14b: Empowerment Continuum (adapted from Ronald Labonte)
Time:	<u>20 minutes</u>
Preparation:	Prepare Flipchart Nos. 13 - 14 Make copies of Handout No. 14 (a) -(b)

PROCESS

- Facilitator recapitulates that:

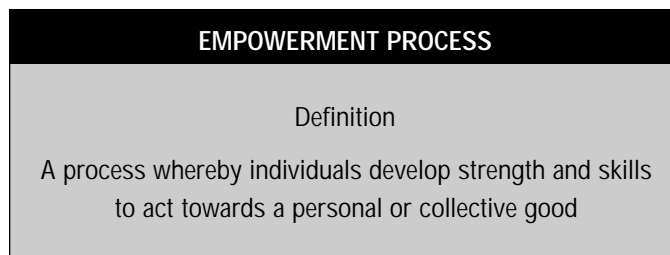
Practical and Strategic Gender Approaches are not dichotomous concepts. In many cases, the two approaches overlap; they are neither static nor universal. The process of change that is implicit in the SGA implies personal and inter-personal conflicts and costs. SGAs are closely related to empowerment processes of individuals and of groups. This internal process that allows a person "the capacity to do or to act" is a critical element in the process of change.

Empowerment is not a new concept in public health, since it has been utilized a great deal in prevention and health promotion. It involves a process within individuals through which they develop the strengths and the skills that allow them to act toward a personal or collective good, either to improve their health in particular or to improve their quality of life (education, credit, work, etc.) in general.

A concept that facilitates the comprehension and implementation of strategic gender approaches is the "Empowerment Continuum" that comes from the health promotion field and was suggested by the Canadian, Ronald Labonte. Labonte utilizes this continuum to refer to the transformative process, not only in women but men, as well as in social classes, whereby the health sector's power over the population is turned into a new relationship of "joint power" shared by both.

Labonte defines Empowerment as: A process whereby individuals develop strength and skills to act toward a personal or collective good.

Flipchart No. 13:



Labonte establishes different moments in the process of reaching this transformation or empowerment. We have adapted this author's suggestions and divide Labonte's continuum into Four Empowerment Mechanisms:

- i) interpersonal encounters;
- ii) support groups;
- iii) community organization; and,
- iv) political action coalitions.

These mechanisms are located along an "Empowerment Continuum," a concept that helps to clarify the use of the multifaceted concept of the strategic gender approach in health. The empowerment process is not a linear process, as we will see later. This continuum is useful in helping us to better understand how our interventions in health can facilitate or impede the empowerment of people.

In the specific case of gender, we can distinguish between men's and women's abilities to improve their health situation through a practical gender approach that makes the necessary resources more accessible to them; and, one which uses a strategic gender approach, which, in addition to responding to a concrete felt health condition or problem, includes elements that move towards greater equity in gender relations by enhancing the degree of control over needed resources to protect health. Increased access to resources is defined by many women as a form of empowerment. But, a clear distinction must be made between people's access to and control over resources; these are crucial concepts in the definition of empowerment.

- Facilitator turns to Flipchart No. 14a of the Four Mechanisms of the Empowerment Process.

Text of Flipchart No.
14/Handout No. 14a:



Talking Points:

The four empowerment mechanisms through which health systems and services can initiate or strengthen a practical and strategic gender approach are:

a. *Interpersonal Encounters:*

Can occur at the level of direct service, where health workers interact directly with users.

Labonte notes that the two pillars that allow services to be empowering are:

- I. That they be offered in a supportive, non-controlling manner;
- II. That they are not the limit of the services and resources offered by the agency.

This type of support respects the autonomy of the individual and seeks to understand the psychosocial and socio-environmental contexts of the problems. The health professional-user relationship is a horizontal one in which dialogue between them enhances a joint search for a solution to a health problem. Such a climate moves constantly towards a greater capacity by the individual to act upon both the symptoms and the roots of his/her distress. The user's relationship with services for managing a health problem at the individual level can facilitate personal empowerment.

e.g., Domestic Violence: A positive response from the health service can promote the development of personal empowerment in a woman as she develops a greater level of self-respect and progresses from a passive victim to an active subject. However, according to Labonte, individual care and crisis management does not have an impact on the structural problem of society's tolerance for violence against women.

b. Support Groups:

Personal empowerment requires opportunities for individuals to overcome their isolation and the "learned helplessness" it creates.

This, according to Labonte, can be accomplished through "group work" in which the individual recognizes that he/she is not the only one suffering from the problem and that, as a result, problems, diseases, etc. are not uniquely about themselves. Group work helps men and woman see their own experiences within a social context. However, the author points out that these groups, although very important for generating empowerment processes, can remain isolated from various forms of action and political organization designed to solve structural problems.

e.g., Domestic Violence: Self-help groups formed by abused women are an important source for promoting self-esteem and personal empowerment, but do not offer sufficient inputs to modify the structural conditions that tolerate violence.

c. Community Organization:

Support groups prompt people to organize around problems or situations that are specific to them.

Community organization, on the other hand, involves the process of organizing people around problems or situations that go beyond the particular interests of those involved. Support groups allay the particular and specific suffering of each of their members; community organizations try to confront the causes of such suffering. Both types of organization are necessary for generating processes of individual and collective change.

Community organization often involves conflict with other interest groups. According to Labonte, conflict, as the predecessor to fruitful negotiation, is a fundamental ingredient for achieving participatory democracy. However, community organization can remain local and parochial without having any effect on the control of resources at the macro level.

e.g., Domestic Violence: Recent decades have seen the emergence of non-governmental community organizations of activist women, offering refuge and comprehensive care to abused women (legal, psychological and physical support), in addition to sensitizing and building awareness of public opinion about the problem.

d. Political Action Coalitions:

The formation of coalitions for political action provides elements for surpassing the limitations of community organizations.

The actions of such coalitions are generally directed toward higher levels of governmental decision-making, and they are called coalitions because action is carried out by a number of groups that unite to exert pressure for achieving a political change or a social reform.

Political Action Coalitions use advocacy as a means to achieve their goal.

Labonte defines advocacy as "taking a position on an issue," in this case, to initiate actions in a deliberate attempt to influence public policy choices. He notes that there are different ways in which health professionals and their agencies can support political action coalitions:

- i) By being a resource to a process, providing information and advising groups on bureaucratic structures and their functions.
- ii) By legitimizing the health concerns of the coalitions. This doesn't mean that the health agency takes the same position on the issue as the coalition, but it does involve taking a position on the health implications of health issues.
- iii) By health professionals themselves taking positions on health issues. An organized, political voice of caring professionals may be crucial in moving towards more equitable and sustainable forms of gender sensitive social organization.

e.g., Domestic Violence: The health sector can legitimize the concerns of women's groups and acknowledge in policy statements that violence against women is a public health issue of growing severity. This way, it is easier for women's groups and other human rights groups to get Domestic Violence "on the agenda" of public and private sector decision-making fora. A case in point is the legitimacy that many governments have accorded to the issues raised by women's NGOs, illustrated by the growing number of NGOs present at intergovernmental fora.

HEALTH INTERVENTIONS

Method:	Group Work
Materials:	Handout No. 15a,b,c,d,: Health Interventions Flipchart No. 15: Group Task
Time:	30 minutes: Group Work 20 minutes: Plenary <u>50 minutes: Total</u>
Preparation:	Photocopy Handout No. 15 (a) - (d) Prepare Flipchart No. 15

PROCESS

- Facilitator distributes Handout No. 15, one health area to each group (Legislation to Promote Breast-Feeding, Program for Detection and Control of Tuberculosis, Design of Community Based Intervention for Promotion of Mental Health of Elderly and Campaign to Stop Tobacco Addiction (Handout Nos. 15a, b, c, d).

Text of Flipchart No. 15:

Group Task: HEALTH INTERVENTIONS

In your groups, read the General Findings pertaining to your topic and the issues to think about.

What practical gender approach (PGA) do you suggest for responding to the particular health needs of women and/or men?

Taking into account the different mechanisms of the empowerment process, how could the intervention selected above incorporate a strategic gender (SGA) approach so that it enhances the possibility of gender equity in health?

- Facilitators can use suggestions for possible responses following the description of findings and issues to think about for each health area.

Note: Facilitator should request each group to select one member who will provide an overview of the General Findings pertaining to the group's health area, by way of introducing the results of the group's discussion. In this way, all workshop participants have information on each health area.

Handout No. 15(a):

PROMOTING BREAST-FEEDING¹

General Findings:

1. Scientific evidence and research have demonstrated the benefits of breast-feeding for child survival, health and nutrition, maternal health, and child-spacing. Breast-feeding currently saves 6 million infant lives each year by preventing diarrhea and acute respiratory infections alone, is responsible for 1/4-1/3 of the observed fertility suppression, and can provide high-quality nutrition at a fraction of the cost of high-risk substitutes.
2. WHO/UNICEF recommend that to ensure optimal maternal/child health and nutrition, the aim should be to enable all women to breast-feed their infants exclusively from birth for at least the first four months of life, and preferably for six months; and to continue breast-feeding, with the addition of adequate complementary foods, for up to two years and beyond.
3. In Latin America and the Caribbean, urban infants are not breast-fed as long as rural infants, and there is a rapid decline during the first three months in both groups. At 12 months of age, nearly half of the rural infants are still being breast-fed, but only 16% of urban infants apparently receive breast milk at this age.
4. Most studies on the subject show that breast-feeding decreases the case-fatality rate in children. In a case-control study in Brazil (Victoria et al., 1987), infants who received no breast milk were 14 times as likely to die of diarrhea as exclusively breast-fed infants.
5. The extent to which hospital personnel and hospital routines foster or discourage breast-feeding practices among new mothers is one of the principal determinants of the rate of initiation of breast-feeding (Winikoff & Baer, 1980; Winikoff & Castle, 1989). Providers should have received adequate training in the practical aspects of lactation management and understand the needs of women who are breast-feeding.
6. The great majority of women in Latin America and the Caribbean have breast-fed their children. However, the recommended practice of exclusive breast-feeding during the first four to six months is rare. In almost all countries the early introduction of liquids such as water, teas, juices and cow's milk is prevalent. For example, in Lima, 80% of children have received water before one month of age (Altobelli, 1991, Brown et al., 1989).
7. Women have positive attitudes towards breast-feeding in the majority of countries but supplement with other liquids almost immediately. Some authors indicate that this supplementing is due to a lack of motivation on the part of the mother to breast-feed, which also is a socially acceptable reason for the introduction of early weaning. However, one of the main reasons women give for supplementing breast milk with other liquids is their perception of not having enough breast milk to feed their children.

¹ Sources: 1) Lactancia Materna en América Latina y el Caribe, Programa de Nutrición de la División de Promoción y Protección de la Salud, Organización Panamericana de la Salud; 2) Breast-feeding: The Technical Basis and Recommendations for Action, World Health Organization.

COMPONENT 4.3

Handout No. 15(a) (cont.):

8. Data appear to show that employment outside the home does not influence the initiation or the continuation of breast-feeding. In many countries the rate of initiation and the duration of breast-feeding among women who work in the formal labor force is not significantly different from that of women who remain at home. Nevertheless, whether paid and working, or unpaid and working, all women have multiple roles which they often perform simultaneously. These multiple roles must be understood in seeking an explanation as to why women do not breast-feed exclusively and on demand for the four to six recommended months.
9. Mother support groups (MSGs) provide individual counselling, information, support and group discussions to enable women to practice breast-feeding and child care well. MSGs attempt to fill the void for a mother when breast-feeding is not the cultural norm and when she lacks family and peer support.
10. The promotion of breast-feeding has been framed as a health issue of importance to the infant and a moral imperative for the mother. However, an understanding of the obstacles women face in breast-feeding exclusively for four to six months must be grounded in the realities of their daily lives, including how decisions are made at the household and couple level. Breast-feeding is not only a "women's issue" but a social issue where other responsible parties include family members, particularly male partners, the social sectors, including education and health, and employers and policy makers.

Issues to Think About

1. Legislation that has been enacted in some countries to ensure that employers uphold women's right to breast-feed have backfired, and in some cases employers are reluctant to hire young married women.
2. WHO and UNICEF recommend that breast-feeding be continued beyond 6 months until two years of age, with the introduction of adequate complementary foods. How feasible is this in the light of gender roles and responsibilities?
3. There is little known about men's attitudes to breast-feeding and their view of the importance of this practice for the health of the child. Why is an understanding of male attitudes important to promoting breast-feeding? What might you expect to find (in attitudes as well as support practices to the lactating wife) in men in general in Latin America and the Caribbean?
4. Why would some women's groups take issue with the way breast-feeding traditionally has been promoted?
5. How might the emphasis society places on slimness and sexual attractiveness for women influence women's decisions as to whether or not to breast-feed?

For Facilitators**How could a breast-feeding promotion campaign incorporate a practical gender approach?**Information Resources:

- Offering information on how women must care for their mental and physical health, including eating properly while breast-feeding to help them to better fulfill their maternal role.
- Informing the male partner that women need additional food at this time, especially when promoting exclusive and prolonged breast-feeding.
- Sensitizing health care workers about the importance of breast-feeding and the need to support the mother as well as the child. Training should discourage practices such as immediate separation from the mother and infant, feeding of glucose water to test the patency of the esophagus and to calm crying babies, and provision of bottle and infant feeding formula.
- Address the needs of women who work in the labor force. To assist these women with breast-feeding, the following special target groups should be considered: child-care workers, occupational health nurses and women's groups. The mass media could be used to publicize existing policies affecting employed breast-feeding mothers and by showing elite professional women breast-feeding.

Material Resources:

- Address the need for private spaces in public places, not only in the formal labor force but also in recreational facilities.

In addition to having a practical gender approach, how could a breast-feeding campaign incorporate a strategic gender approach?

- By involving men in the design of promotional campaigns with messages which provide fathers with a way of becoming active in this process. For example, messages might propose that the father care for the other children and help with domestic chores so the mother can breast-feed. Other mechanisms could be developed so that the broader society shares responsibility for child-care.
- Formulate messages that breast-feeding is not a moral obligation. Promotion programs should include information for women who cannot or will not breast-feed. Because breast-feeding is a woman's choice, information should be made available on safe alternatives. The focus should be on informed decision-making so that women can weigh the importance of breast-feeding within the context of their everyday lives.

Handout No. 15(b)

DETECTION AND CONTROL OF TUBERCULOSIS¹

General Findings:

1. In developing countries, men and women have similar TB notification rates until adolescence, after which males have higher notification rates. Some reasons for this that have been postulated are:
 - a. Women may be less susceptible to TB infection during and after adolescence because hormonally mediated immunological differences protect them.
 - b. Women may exhibit lower delayed type hypersensitivity (DTH) responses than males; males and females may have similar prevalence of infection but the degree of skin reaction in infected women is not large enough to be interpreted as a positive test during and after adolescence (this lower DTH reaction in women has been substantiated). It is not clear why older men have a higher risk of progression from infection to disease in comparison to women of older ages. Cellular immunity may diminish more quickly in men than in women and more men smoke and drink alcohol than women, which can weaken their immune system.
2. Women between the ages of 15 and 40 are almost twice as likely to progress from TB infection to TB disease than men of the same age, and men are more likely to progress from infection to disease after age 40. One of the possible reasons for women's rapid progression during reproductive years may be due to the stress of pregnancy. Some studies show that the risk of progression of infection to disease in women is particularly acute during post partum periods for women. A series of factors may account for this, including rapid hormonal changes, post partum descent of the diaphragm and reexpansion of the lungs, nutritional strain during lactation and insufficient sleep due to the demands of the new child.
3. Women have greater TB case fatality and mortality than men up until age 30. Some studies posit that this may be a consequence of decreased immune and nutritional status that may or may not be a result of complications during pregnancy. There may also be poorer levels of care provision for women, or women may arrive at the health services in more advanced stages of the disease. A study in Bolivia showed that the delay from the onset of symptoms to diagnosis was more than 6 months in the majority of women compared to 1 to 6 months in the majority of men. This diagnostic delay may account for some of the increased case fatality and mortality rates observed in women.
4. Passive vs. active case finding²: men have higher notification rates than women at all ages through passive case finding. Greater numbers of infected women are found than infected men through active case finding.

¹ Sources: Scientific publications based on results of research from 1966 to 1995 which describe relationship between sex, gender and the epidemiology of tuberculosis. We wish to thank PAHO's Regional Program on Communicable Diseases for this material.

² Passive case finding refers to patients presenting to the health services of their own accord, whereas active case finding refers to random sampling conducted in a population to screen for TB, or to an entire population being screened for TB.

Handout No. 15(b) (cont.)

One reason for this may be that women going to health service for pre-natal or post-natal care are not being diagnosed for TB. Additionally, women may not seek care, despite their symptoms. Because men are more involved in the "public" sphere (military duty, formal employment), they are more likely to be screened for TB, whereas women who are more likely to be involved in domestic activities are not candidates for such screening.

5. HIV is strongly associated with TB and this may have a particularly severe impact on young women in developing countries because they are at increased risk for HIV infection at a time when they also appear to be at increased risk for progression to TB. Studies have found that the odds ratio for HIV infection in smear-positive cases for TB is significantly higher in females than males in the 15-34 year age group.
6. The impact of TB on family members is acute. As primary care givers of male family members that are infected, women are exposed to increased risk. While a woman takes care of others when they are ill, when she herself becomes sick there often is little support for her.
7. Worldwide, more disability adjusted life years (DALY) are lost due to TB than to HIV, other STDs or malaria. This burden must be viewed in the light of the added possibility of under-reporting in women.

Issues to Think About:

1. Why might the notification of infection in males during and after adolescence be higher than in females?
2. Why would there be such differences between men and women with respect to active vs. passive case finding? What difference might there be between men and women in terms of access (geographical, economic, cultural, etc.) to health services and, in particular, to TB diagnostic health services?
3. Why would women of reproductive age progress more rapidly from infection to disease than men in the same age cohort? Why would this reverse after 40 years of age?
4. Why would the case of fatality rates for women be greater than for males until age 30?

For Facilitators:

How could a TB detection and control program incorporate a practical gender approach?

Material Resources:

- Active case finding could be done by TB control programs for women attending maternal and child health care clinics.

COMPONENT 4.3

Information/Political Resources:

- Health care workers and young women should be made aware of the elevated risk of progression from TB infection to disease in women's reproductive years, especially following a recent pregnancy.
- Health workers should be trained to detect and treat TB and to encourage young mothers to seek care for symptoms associated with TB.
- Health education efforts should be incorporated into MCH health programs and HIV/AIDS prevention and care.
- Health themes should be incorporated into school curricula and mass media campaigns to educate men and women about their specific risks, needs and opportunities in terms of TB prevention and control.

Material/Time Resources:

- Outreach strategies should be implemented for the detection and treatment of TB cases among women (all women, not only those that are pregnant) that do not come to maternal and child health care clinics.

In addition to having a practical gender approach, how could a TB detection and control program incorporate a strategic gender approach?

Information Resources:

- The school system and other youth organizations should work with young boys and girls to inculcate a value for human nurturing and the practical skills needed to take care of others.
- Together with community based women's groups, explore ways to raise awareness of the problem and support others in their group so that they make use of detection and treatment services.

Handout No. 15(c):

DESIGN OF COMMUNITY BASED INTERVENTION FOR PROMOTION OF MENTAL HEALTH OF ELDERLY¹

General Findings:

1. Over the next three decades, the percent growth in the older population of Latin America will range from 25% in Uruguay to 282% in Costa Rica. The growth rate of the oldest old (persons 85 years and older) is higher than for all other ages in Latin America and the Caribbean.
2. Women live longer, on average, than do men.
3. Education in early life has a major effect on the well-being of the elderly. Illiteracy is almost always higher in older women than in older men.
4. In surveys of elderly persons living in communities, rates for dementia² are much higher in those with little education.
5. Societies have varied reactions to dementia in aging. Some societies are more tolerant than others, which can regard dementia as pathological.
6. Mental health problems can relate to lack of food. The World Bank estimates that 780 million people of all ages worldwide are energy deficient. The elderly, particularly women, are disproportionately poor and therefore more likely than the general population to be malnourished. Lack of food can lead to confusion and forgetfulness.
7. Studies show that the elderly can avoid some mental health problems if they stay active in society. Social changes associated with industrialization often isolate the elderly from their previous roles and increase dependency, resulting in loss of dignity, self-respect and weakening of filial support networks.
8. The burden of caring for the elderly falls predominantly on their children, mainly, their daughters.
9. There is a high prevalence of multiple coexisting physical conditions with age: incontinence, hip fracture, sensory loss. These influence mental health through the loss of self-esteem and independence. These conditions are more prevalent among elderly women than elderly men.

Issues to Think About:

1. Do elderly men and women have sex-specific biological needs that are derived from different immunological, genetic or physiological differences? Could this be associated with women's higher incidence of chronic dis-

¹ Source: *World Mental Health: Problems and Priorities in Low-Income Countries*. Dejarlais, R.; Eisenberg, L.; Good, B.; Kleinman, A. New York: Oxford University Press, 1995.

² Gradual loss of cognitive function resulting from diseases that appear late in life.

Handout No. 15(c) (Cont.)

eases and diseases such as urinary incontinence, diabetes, hypertension, etc.? How might these differences have an impact in the kind of information provided to health care workers and family members caring for the elderly and the elderly men and women themselves?

2. How might gender roles protect or increase the risk for men and women to suffer from these diseases that characterize the aging?
3. Given the importance of education and continued involvement in society to ensure the mental health of elderly men and women, how might a program be structured to respond to or enhance the different opportunities each sex has had for developing their intellectual and social abilities?
4. Given the preponderance of care of the elderly on female family members, what can the state do to promote more equitable distribution of the care of older persons within their families?

For Facilitator:

How could a program for mental health promotion for the elderly incorporate a practical gender approach?

Material Resources/Information Resources:

- Provide health care workers with information and training that will enable them to understand and deal with the developmental needs of elderly men and women, differentiating the needs that both sexes have due the interaction of biological makeup and gender roles.

Material/Internal Resources

- Provide material and emotional support to care givers of the elderly, recognizing that they have gender needs derived from their gender roles. This support should be aimed at those providing care in institutional settings and at those providing home based care to elderly family members.

Material Resources

- Make available community centers where elderly men can come together do conduct activities they enjoy, and women can do the same.

Internal Resources

- Devise programs in which the elderly men and women of the community have opportunities to interact and work with male and female youth, taking account of the learning/unlearning of gendered roles that might be stimulated by same-sex, cross-generational pairing, thus providing an opportunity for young and old men and women to gain self-confidence and a feeling of their own importance for others and for the community.

In addition to having a practical gender approach, how could a program for promotion of the mental health of the elderly incorporate a strategic gender approach?

- In the promotion of mental health for the elderly, one critical aspect is to ensure that earlier in their lives men and women are prepared for their older years. This entails having opportunities available (access) and being able to take advantage of these opportunities (control) to become educated, to participate fully in society, to feel that they are valued members of their communities regardless of their "occupations," and to have the knowledge of the components of healthy lifestyles that will provide greater protection from preventable illnesses that can accompany the aging process.
- Consequently, it becomes critical to empower young women in the direction of improving their education and having an active and satisfying life project beyond their reproductive role (and their reproductive years) that ensures their economic and psychological autonomy.
- For young men, it becomes critical to modify social values that continue to foster masculine dominance, the negation of a nurturing and caring role for men, and the sole importance of income-generating activities as proof of male self-worth.

Handout No. 15(d):

CAMPAIGN TO STOP TOBACCO ADDICTION**General Findings:**

1. According to WHO, tobacco use is estimated to account for 3 million deaths per year, about half a million of which are among women. Slightly more than half of those women live in developed countries. The number of deaths is expected to rise dramatically from 3 to 10 million in the next 20 years. Only if there were to be a substantial fall in smoking prevalence among adolescents would the epidemic of tobacco-related deaths be moderated since the majority of these deaths will occur among youth and young adults of today.
2. The women most likely to smoke in developed countries are those on low incomes with low-status jobs or who are economically inactive. On the other hand, today, affluent and educated young women in Latin America are more likely to take up smoking than their lower income counterparts.
3. Studies from the United Kingdom show that spending on tobacco among low income households with children is higher than among low income households without children. The highest per capita expenditure on tobacco is among one-adult households with children. Qualitative studies of caring highlight the experiences that underlie the association between smoking, poverty and caring for children. Cigarettes were reported by mothers caring for children in low-income households as the way women coped when their children's demands became "too much to cope with." Within a lifestyle devoid of personal spending, cigarettes were the only item that women bought for themselves.
4. Studies in Latin America and in the United States show that girls are smoking for two very different reasons than boys are. Girls use cigarettes to control their weight and appear grown-up, neither of which are reasons boys give for smoking.
5. In Latin America, surveys show wide variations in the prevalence of smoking among women, from 3% in La Paz to 49% in Buenos Aires. Most reports of recent surveys indicate that prevalence among women is increasing, particularly in countries that have higher rates of urbanization.
6. In general, countries in which smoking was first taken up were the first to show a decline in the prevalence of smoking among women in certain age groups. However, recent data in the United States and Canada have shown higher rates of smoking among young women ages 14 to 19 years than among their male counterparts.
7. An Australian study (1995) of 60,000 students from grades 7, 9 and 11 indicates that teenage girls who smoke cigarettes regularly do so because it is a balm for depression and anxiety. A study in Chile found that girls who smoke score lower on measures of self-esteem than those who do not, which is not so for boys where self-esteem is not a factor in boy's initiating and sustaining smoking.
8. For boys, the importance assigned to religion seems to play a key factor in whether or not they take up smoking, with a strong association between importance assigned to religion and not smoking (not the case in girls). For both sexes, the fact that friends smoke is strongly linked to the likelihood of initiating smoking. For girls, the belief that smoking is harmful is a deterrent to taking up smoking, but this is not the case for boys.

Handout 15(d) (Cont.)

9. For biological reasons, the consequences of tobacco use are different for both sexes. In women, smoking has particularly adverse consequences for their own health as well as the health of their children. For example, those who use oral contraceptives are more likely to suffer from cardiovascular problems later in life. Additionally, data collected in the United States indicates that the association between smoking and early menopause has generally been found to be highly significant. The public health implications of this association are derived from the adverse effect of early menopause on morbidity and mortality for several conditions, including the link between menopause and cardiovascular mortality, as well as between menopause and bone fracture.
10. Many women are becoming more aware of the dangers of smoking during pregnancy, but are unaware of the risks of smoking after delivery. Few regular smokers realize that their children are passively smoking. Children whose parents smoke have a tendency to suffer from a series of health problems in the first few years of life, especially respiratory illnesses and infections. There is a condition known as the "Monday morning syndrome," which occurs when children who have been inhaling smoke during the weekend develop otitis and respiratory infections on Sunday evening and have to see a doctor on Monday morning.

Issues to Think About:

1. Tobacco consumption in Latin America appears to be associated with gender relations. In population subgroups in which there is greater subordination of women, tobacco consumption is less than in subgroups in which there is greater gender equity. What do you think might be underlying this finding? How might messages be tailored to counteract this trend in women?
2. A study in Chile finds that knowing that smoking is harmful does not dissuade men from taking up the habit. What do you think might be underlying this finding? How might messages be tailored to counteract this trend in men?
3. If you were to receive a grant to study whether nicotine is more addictive in either sex, for biological reasons only, would you expect to find that it is more addictive in men, in women, or that it is equally addictive for both? Why would this type of study matter for smoking cessation programs?
4. In Canada, a smoking cessation program found dramatic gender differences in the ability of married men and married women to give up smoking. For married men it was much easier than for married women. Why do you think this was the case? How would you tailor a smoking cessation program with this in mind?
5. In the United States, President Clinton announced a series of policies to curb tobacco use in teenagers. Much of this had to do with banning the promotion and advertising of all tobacco products; revision of legislation regarding the sale of tobacco to minors to include stiffer penalties; and legislation banning tobacco sales through vending machines in places where children and teenagers might frequent. Taking gender considerations into account, which of these policies, in your estimation, will have greater effect in curbing smoking in girls? in boys? or will there be no difference? Why?

For Facilitator:

How could a smoking cessation and prevention program incorporate a practical gender approach?

Information/Education Resources:

- Based on sex and age disaggregated data, tailor smoking prevention pamphlets to men and women that provide them with information for each about the risks of smoking. This would include awareness of the different factors that influence smoking initiation in boys and girls, keeping in mind that generally for boys the health consequences do not seem to be a deterring factor.
- Aiming tobacco prevention campaign messages at women that convey independence from addiction as an image of the "woman in control of herself and her future."
- Aiming tobacco prevention campaign messages to men to convey that "real men who care for their family don't smoke."
- Working with church groups to form youth groups, particularly aimed at boys and young men, that coordinate activities such as sports clubs, etc.

Services (Material Resources):

- In smoking cessation programs, form support groups for women who smoke instead of counting on women to be able to get support from family members to stop smoking. For men support from wives and female companions has proven to be an important factor for smoking cessation. However, when trying to quit smoking, women appear to receive less support from family members than men do.

In addition to having a practical gender approach, how could a smoking cessation and prevention program incorporate a strategic gender approach?

Time Resources:

- In countries where the data indicates an association between cigarette smoking in women, isolation and caring for young children, form support groups with women to review how they might work together to care for one another's children. This would provide each with some free time during the week to pursue other interests. Additionally, the women could explore different ways of involving their male partners more in the care taking of their children.

Internal Resources:

- Work with young girls and boys in the primary schools to work on self esteem for both, keeping in mind that girls and boys have different developmental processes and that the content of the discussion sessions should be tailored to meet these variations. For example, work with girls could focus on the acceptance of body image, trying to break the desire for smoking as a weight control measure.
- Together with adolescent boys and girls, design programs to form peer counselors that assist others who have already initiated smoking or who are trying to give up smoking. This work should particularly be centered on youth who are out of school.