HANDOUTS

COMPONENT A.3

H1

WORKSHOP OBJECTIVES

- To examine the difference between sex and gender.
- To discuss the gender approach and its particular relevance to the areas of health and human development.
- To acquire skills and methodologies to enable participants to ensure that their work in health and development is grounded in a gender approach.

COMPONENT A.3

H2

EXPECTED OUTCOME

- Participants understand that the gender approach is essential for health planning and sustainable human development.

DEFINITIONS OF SEX AND GENDER

"Sex" refers to the biological differences between men and women.

"Gender" refers to roles that men and women play and the relations that arise out of these roles. They are socially constructed, not physically determined.

SIX CASE STUDIES

HOUSEHOLD / FAMILY SITUATION A

George and Hazel have lived together for a number of years. George, 52 years old, is a taxi driver and works the night shift; Hazel, 48 years old, works from Monday to Saturday in a factory. In order to increase household income, Hazel also makes yuca bread which she takes to work each morning to sell at lunch time. George's 75 year old mother, Ernestine, lives with them. Hazel has an unmarried son, Vincent, age 28, who lives with them and works in the informal sector selling music cassettes; George has a daughter, Alicia, aged 25, who is married, has small children and lives in the neighborhood.

HOUSEHOLD / FAMILY SITUATION B

Jane is the manager of a private company. She is Chairperson of the Committee of Women Managers in the capital. Her two children live with her; the oldest, Richard, is an 18-year old boy and the younger child, Rachel, is an 11 year old girl. She employs a domestic worker, Teresa, who works Monday to Saturday, from 8 in the morning to 7 at night.

HOUSEHOLD / FAMILY SITUATION C

Sam and Catherine Stevens live with their three children: a 12 year old girl, Marisa, and two boys, Frank and Tom, aged 9 and 7. Catherine is a graphic designer for an advertising company, Sam is a professor in the school of public health. Two nights per week and every other Saturday, Catherine goes to help her elderly parents who, because of their advanced age, are no longer able to do the shopping, clean the house, cook, etc. Sam participates actively in the Public Health Association.

Continued

SIX CASE STUDIES (CONT.)

HOUSEHOLD / FAMILY SITUATION D

Elmer and May, aged 30 and 22, live with their four children in a rural community. The oldest daughter, Jean, is 8 years old, followed by two boys, Jim and Kevin, who are 6 and 3 years, and a 1 year old girl who is being breast-fed. The family lives on subsistence agricultural production which allows them to survive. Elmer and May supplement the family income, Elmer by harvesting produce and May by weaving fine baskets and selling them in the town market one hour away by foot; in addition, May is a health promoter in their community.

HOUSEHOLD / FAMILY SITUATION E

Teresa Martinez, age 38, lives in a poor urban community which has been built on the shores of a river inlet. During the day, she works in a canning factory. With her live her mother, Doña Zaida, age 54, who runs a sewing shop from home; her two sons, Raul, age 17, who is finishing high school and Conchita, age 14, who is also in school. Two years ago, Teresa's sister, Josefina, age 28, came to live with her. Josefina brought along her 10 year old son; Josefina works in the center of town as a street vendor, selling hot meals to passers-by. Teresa's husband, Jorge, is a migrant worker in the banana industry; he returns every two weeks on the weekends.

HOUSEHOLD / FAMILY SITUATION F

John Green is 45 and is the owner of a small dry goods store in a major city in the interior of the country. His wife, Frances, works in a hairdresser shop. Her father Ambrose, lives with them. He is 80 years old. John and Frances have two grown sons ages 27 and 22, respectively. The youngest, Stephen, helps his father in the store. The eldest has married and moved to the capital of the country.

24 HOUR DAY CHART		
HOUR	WOMEN	MEN
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2		
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4		
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24		

COMPONENT 2.1

H6

DEFINITIONS: GENDER ROLES

PRODUCTIVE:
Comprises the work done by both women and men for payment in cash or kind.

REPRODUCTIVE:
Comprises the childbearing/rearing responsibilities and domestic tasks required to guarantee the maintenance and well-being of household members. It includes not only biological reproduction but also the care and maintenance of the persons who comprise the household.

COMMUNITY MANAGEMENT ROLE:
Comprises activities undertaken at the community level to contribute to the development or political organization of the community. It is usually voluntary, unpaid work.

COMPONENT 2.2

H7

DEFINITIONS: ACCESS AND CONTROL

ACCESS
is the ability to USE a resource.

CONTROL
is the ability to DEFINE and make binding decisions about the use of a resource.

FIVE TYPES OF RESOURCES

ECONOMIC RESOURCES

- work
- credit
- money
- etc.

POLITICAL RESOURCES

- position of leadership and mobilization of the actors in decision-making positions
- etc.

INFORMATION / EDUCATION

- inputs to be able to make decisions to modify or change a situation, condition or problem
- formal education
- etc.

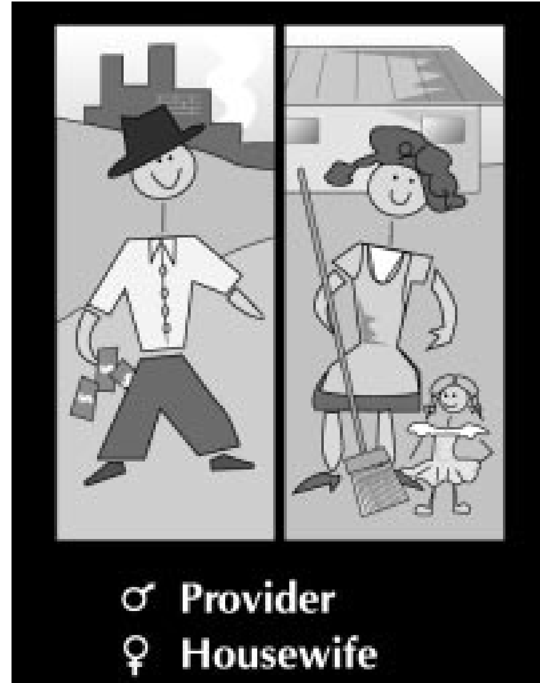
TIME

- ours of the day available for discretionary use
- flexible paid work hours

INTERNAL RESOURCES

- self-esteem
- self-confidence
- the ability to express one's own interests

STEREOTYPES 1, 2 and 3



CASE STUDIES: SCENARIO 2

Situation A, Part 2:

Ernestine, George's mother, fractures her hip. She has an emergency operation. After staying in the hospital, she comes home to convalesce.

Situation B, Part 2:

Richard, the oldest child has a motorcycle accident, needs rehabilitative therapy and rest for two months. Doctors are not sure he will recover completely.

Situation C, Part 2:

Sam is diagnosed with terminal lung cancer.

Situation D, Part 2:

May wakes up with vaginal bleeding and strong pain; she is hospitalized for an obstetric emergency due to spontaneous abortion. The hospital is an hour away by foot from the town where she lives.

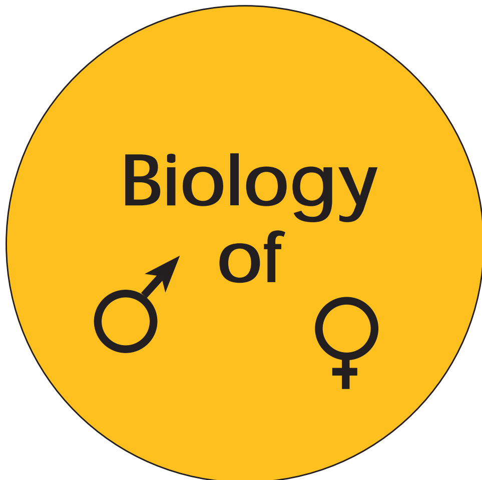
Situation E, Part 2:

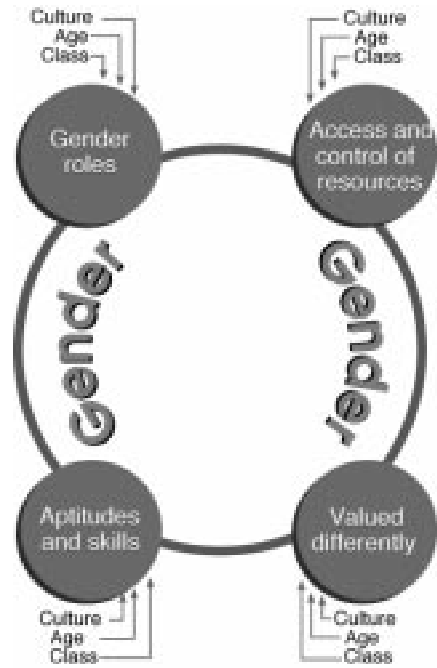
Jorge has an accident at work that cuts off his left hand. He is dismissed with minimal compensation and sent home.

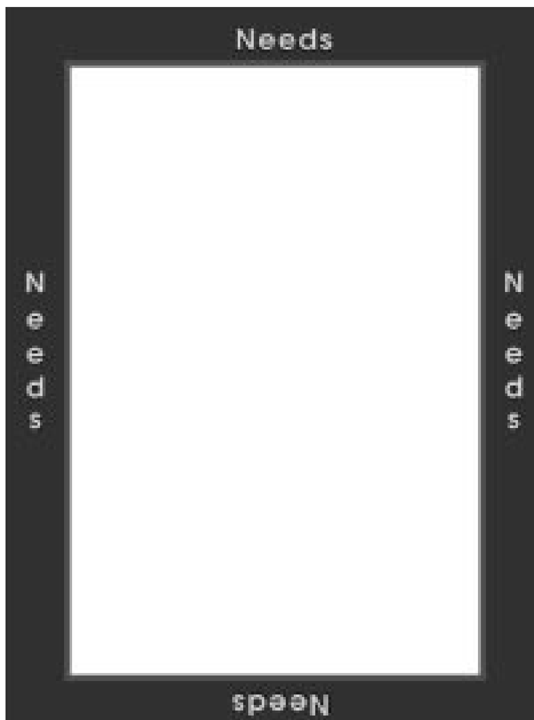
Situation F, Part 2:

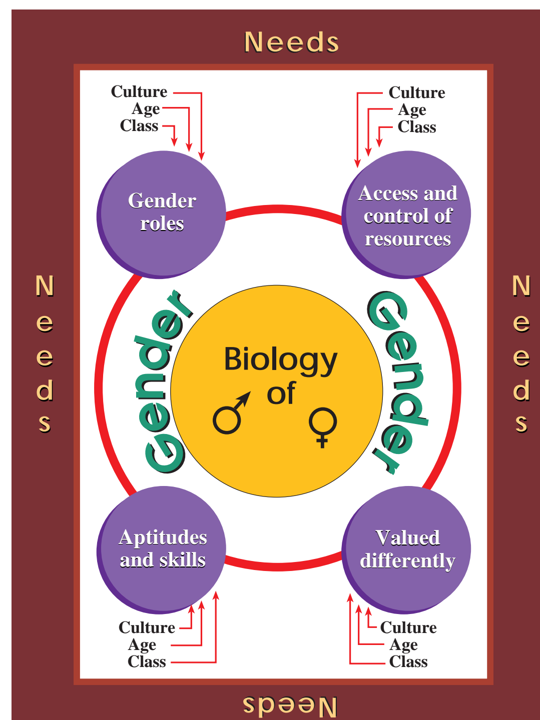
Frances' rheumatoid arthritis in her hands becomes so severe that she can no longer work as a hairdresser.

SOCIAL/BIOLOGICAL

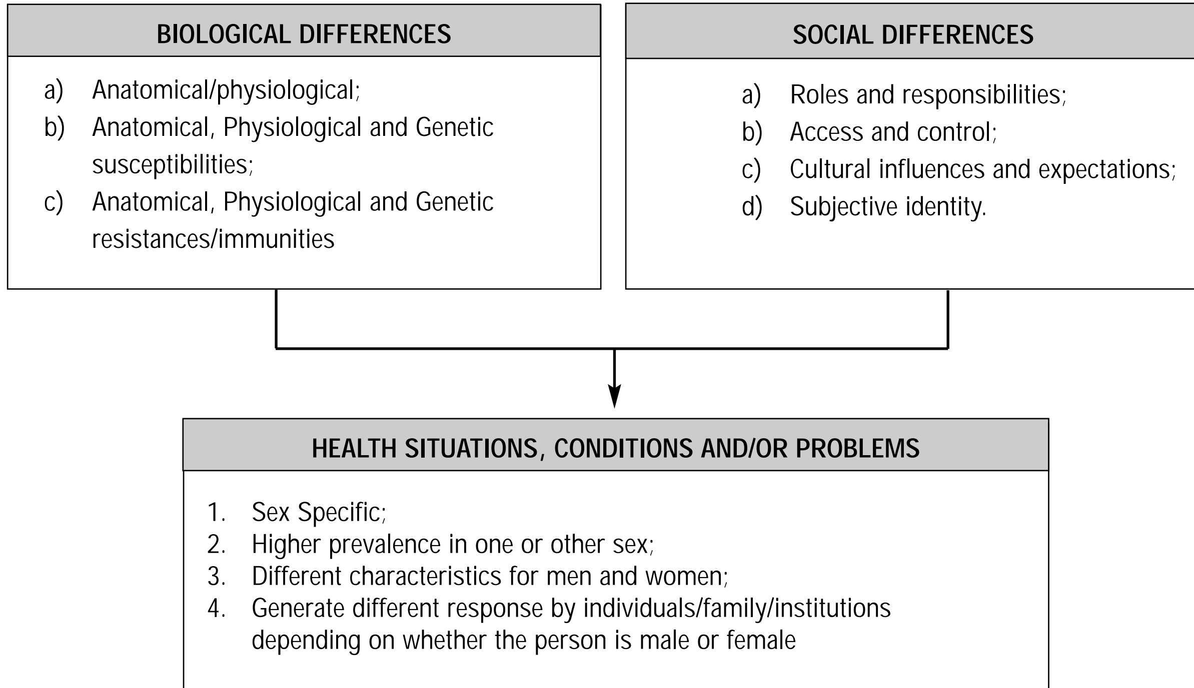








ORIGIN OF MALE/FEMALE DIFFERENCES IN HEALTH PROFILES



PRACTICAL AND STRATEGIC GENDER APPROACHES

A. PRACTICAL GENDER APPROACH

- 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 condition of women and men through the access to resources.
- Usually does not change gender roles and relations.

B. STRATEGIC GENDER APPROACH

- 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.

DEFINITION OF THE EMPOWERMENT PROCESS

A process whereby individuals develop strength and skills to act towards a personal or collective good

MECHANISMS OF THE EMPOWERMENT PROCESS

INTERPERSONAL ENCOUNTERS

- Facilitate self-validation through dialogue

SUPPORT GROUPS

- Facilitate opportunities to overcome isolation ("not only sufferer")

COMMUNITY ORGANIZATION

- Facilitate organization around common problems that go beyond personal interests

POLITICAL ACTION COALITIONS

- Facilitate social movements that go beyond limitations of community organization to achieve political/social change

CONTINUUM OF EMPOWERMENT
Adapted from Ronald Labonte

Empowerment. contrary to popular thinking, does not emanate from the feminist movement. Moreover, it 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.

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.

Continued

LABONTE'S EMPOWERMENT CONTINUUM (CONT.)

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., <u>Domestic Violence:</u> 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., <u>Domestic Violence:</u> 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 sit-

Continued

LABONTE'S EMPOWERMENT CONTINUUM (CONT.)

uations 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.

PROMOTING BREAST-FEEDING[1]

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, Organization Panamericana de la Salud; 2) Breast-feeding: The Technical Basis and Recommendations for Action, World Health Organization.

Continued

PROMOTING BREAST-FEEDING (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?

DETECTION AND CONTROL OF TUBERCULOSIS[1]

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. One rason 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.

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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.

Continued

DETECTION AND CONTROL OF TUBERCULOSIS (CONT.)

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?

DESIGN OF COMMUNITY BASED INTERVENTION FOR PROMOTION OF MENTAL HEALTH OF ELDERLY[1]

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 diseases 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?

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.

Continued

DESIGN OF COMMUNITY BASED INTERVENTION FOR PROMOTION OF MENTAL HEALTH OF ELDERLY (CONT.)

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?

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.

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.

Continued

CAMPAIGN TO STOP TOBACCO ADDICTION (CONT.)

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?

PROGRAMS AND PROJECTS DERIVED FROM MODERNISM

WID APPROACHES

EARLIEST WID APPROACH

Welfare approach →→→→→→→→ Passive beneficiaries

- To help the most vulnerable groups, including women;
- Sees women as passive recipients of development;
- Perspective centered on the family as unit, emphasizing the reproductive role of women;
- Views better child rearing as the principal contribution of women to development;
- Has a practical gender approach.

SECOND WID APPROACH

Anti-poverty approach →→→→→→→→ Gender inequalities reflect poverty, not gender subordination

- Attempts to ensure increased productivity of poor women;
- Women are poor because of economic limitations, not gender structured constraints;
- Recognizes the productive role of women;
- Emphasis on small income-generating projects;
- Has a practical gender approach.

THIRD WID APPROACH, NOW PREDOMINANT

Efficiency approach →→→→→→→→ Women cushion impact of structural adjustment process

- Women seen in terms of their ability to compensate for deterioration of public services;
- Rely on all three roles of women and their supposed free or flexible time;
- Women seen entirely in terms of delivery capacity and ability to extend working day; most popular approach with governments and multilateral agencies;
- Has a practical gender approach.

Continued

PROGRAM AND PROJECT APPROACHES ORIGINATING FROM WOMEN'S GROUPS

Equality approach <-----> Affirmative action to ensure women have active role in development

- Women are the target population of programs and projects;
- By means of legislation, policies are designed to assure the incorporation of women in the paid labor force, in educational institutions and to ensure that their autonomy and rights are respected;
- Projects are designed to reduce inequality between men and women, especially with respect to the division of labor by gender, increasing the political and economic autonomy of women;
- Directed to any of the three roles (reproductive, productive or community);
- Has a strategic gender approach, through top-down state interventions giving political and economic autonomy to women in order to decrease their inequality.

Empowerment approach <-----> Defines empowerment as access to and control of the use of material/ economic resources, political, information/ education and time

- Its origins in Third World women's grassroots organizations; Freire's theory has great influence on awareness of oppressed peoples;
- In health, it proposes a new relationship of "shared power" between the health sector and different groups of a population;
- Seeks to empower women through greater self-reliance: women's subordination seen not only in relation to men at the individual level, but also of predominant development models;
- Tries to serve the particular needs of men and women in their multiple roles, through mobilization from the bottom up as a way to confront different types of oppression;
- Bottom-up mobilization around concrete health needs in a manner that incorporates strategic gender approaches—can be a practical and strategic gender approach.

POLICY DOCUMENTS: EXTRACTS

- Investment in health and education for women produces significantly greater benefit to the society than similar investments in men because of the close correlation between the health, nutritional level and education of women and the health, educational level and productivity of future generations. These correlations are still greater when women have control over how resources are distributed within the home.

- Lack of access to credit, land, information and technology aggravates gender inequity. When women have access to credit, the effect on the well-being of the family and its members is notable. The provision of financial resources to women is related to improvements in the health levels of children.

- Women are more vulnerable than men to micronutrient deficiencies which damage health. Bad health and nutrition diminish productivity and the ability to take advantage of the gains from investments in education. Recent estimates suggest that the combined effects of only three types of deficiencies on morbidity and mortality—vitamin A, iodine and iron—could waste up to 5% of the gross domestic product, and that correcting these deficiencies would cost less than 0.3% of GDP in developing countries.

- Malnutrition of infants is related to poverty and the low educational level of mothers.

- Data from Brazil indicate that when women are given more control over resources, there is a greater impact on the anthropometric measures of their children, a greater level of nutrition in their families, and a greater proportion of the family budget devoted to the health and education of children, than when the man controls the resources.

- There is a critical connection between the provision of public health services and women's access to educational opportunities. A mother who has been taught to seek preventive care and timely treatment for her own illnesses and those of her children, particularly her daughters, will reduce expenditure for health care and in many cases will prevent premature death. Many of these services are cost effective and can be provided in primary health care centers.

CASE STUDY 1: CENTER FOR INTEGRAL COMMUNITY HEALTH

The population of the District of Orange Creek is comprised mainly of migrants who have moved from interior parts of the country. Having set up their settlements around the periphery of a major city, they lack infrastructure and services. Most of the population in the District works in the informal sector of the economy.

Some of the communities in Orange Creek have organized commissions that focus primarily on issues related to property rights; these entities are comprised of men. Women have also organized themselves into mothers' clubs, and the focus of these groups revolves around their children's health.

In an effort to improve health conditions, particularly of women, an NGO secures funding for a project that targets five communities of the District. The selection of those communities is based on their degree of organizational capacity, as evidenced by the formation of two umbrella groups made up of leaders from the five communities: The Pro-Land Commission (PLC), which organizes around issues related to land tenure, and the Intercommunity Coalition of Mothers (ICM), a coalition which draws together women leaders from the different communities to catalyze initiatives of interest to all women that live there.

The NGO that proposed the health project already has been conducting adult literacy programs and supporting, through the ICM, educational programs for children. The ICM, in turn, has been running a children's soup kitchen for the past 4 years, and, after discussions with the NGO, agreed to participate in the health project.

The project proposed the execution of a pilot experience that could be replicated through a District Health Plan in other marginal urban communities of Orange Grove.

The project purpose is:

The health conditions and quality of life of the inhabitants of the district of Orange Grove improved as evidenced by a reduction in diarrheal diseases in children, and in women's morbidity.

Expected results include:

In the five selected communities of the District of Orange Grove:

1. In one year's time, an Integral Health Service Program with a focus on disease prevention and care through prenatal, pediatric and gynecological services is in place and functional for children under 6 and women of reproductive age.

2. The Integral Health Service is promoted through continuous dissemination of health information using printed material and loudspeakers.

3. Ambulatory services attached to the Integral Health Service provide immunization and prenatal care in the target communities and draw 75% of the population of expectant mothers and 95% of children under 6 years of age.

4. Women's organizations strengthened, particularly in the design, development, and management of a District Health Plan, in close coordination with the Municipal government of the area that encompasses all the communities in the Orange Grove District.

Continued

CASE STUDY 1: CENTER FOR INTEGRAL COMMUNITY HEALTH (CONT.)

SALIENT ACHIEVEMENTS OF THE PROJECT:

A1. According to the evaluation by the mothers, the ambulatory services attached to the Integral Health Services were highly effective for reducing infectious diseases in their children.

DIFFICULTIES OF THE PROJECT:

B1. A considerable number of the women that were treated in the ambulatory care services had to be referred to the Integral Services for follow-up. However, the Integral Services had little capacity to respond to these complications.

B2. From the outset of the project, the Integral Health Services faced financial sustainability problems. In an effort to address the financial situation, the focus, which had initially been children under 6 years and women of reproductive age, had to be expanded so as to include the general population. This expansion resulted in an increase in user waiting time, both for getting appointments with doctors and in the time users were kept waiting on the day of their scheduled appointment. It also increased delays in the delivery of laboratory results, and diminished the quality of professional-user interaction.

B3. With respect to community organization networking and negotiations, problems emerged concerning the determination of health priorities. The Pro-Land Commission (PLC) felt that one of the ways of resolving the financial viability of the Integral Health Services was by dropping the gynecological services, a cutback which was put into effect after heated discussions because of the opposition to this reduction by the Intercommunity Coalition of Mothers (ICM).

B4. In addition to this difficulty, the PLC, claiming its track record in negotiating with the authorities, were of the opinion that only their members could participate as community representatives in the formulation of the District Health Plan.

B5. Members of the ICM who wished to engage in these negotiations with the PLC were forced to dedicate more time to this process, time which they did not have because of their need to generate an income and to fulfill tasks involved in maintaining their households. The difficulties inherent in devoting the needed time to ensure that their views were taken into account in formulating the District Health Plan culminated in frustration and exhaustion for the members of the ICM, who gradually ceased to participate in the meetings to design the Health Plan.

NOTE: To facilitate a discussion of this case study, three groups will be analyzed: women of reproductive age in Orange Grove; the ICM; and the PLC. The first two groups are mutually exclusive.

GUIDE TO ANALYZE CASE STUDY

I. PROJECT OBJECTIVES

a. What gender roles did the project target in its objectives and to what purpose?

b. What particular health needs of women and men did the project target in its objectives?

c. What development approach predominated in its objectives: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?

d. In the objectives, did it use a practical gender approach (PGA) or a strategic gender approach (SGA)?

II. IMPLEMENTATION AND IMPACT OF PROJECT

e. What gender roles did the project affect and how?

f. What particular health needs of women and men were affected and how?

g. What development approach actually predominated: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?

h. Did a practical gender approach (PGA) or a strategic gender approach (SGA) predominate in the implementation?

i. What changes occurred during the process of the project's implementation in terms of access to and control over one or more resources (material/economic, political, information/education, time, internal)? Discuss each target group in turn.

j. Referring to Labonte's Continuum of Empowerment, give an example of what elements of that continuum could have been incorporated, either in the project design or during its implementation, to respond more equitably and efficiently to the particular health needs of women and men.

WORKSHEET: CASE STUDY NO. 1

a. PROJECT OBJECTIVES

ROLES	REP.	PROD.	G.M.
Women			
ICM			
PLC			

b. Health Needs

Women	
CIM	
CPT	

c. Development Approaches

Welfare	Anti-Poverty	Efficiency	Equality	Empowerment

d.

PGA? SGA?

Continued

WORKSHEET: CASE STUDY NO. 1 (CONT.)

e. PROJECT REALITY

ROLES	REP.	PROD.	C.M.
Women			
ICM			
PLC			

f. Health Needs

Women
ICM
PLC

g. Development Approaches

Welfare	Anti-Poverty	Efficiency	Equality	Empowerment

h.

PGA? SGA?

i.	ACCESS					CONTROL				
	M/E	P	I/E	T	I	M/E	P	I/E	T	I
Women										
ICM										
PLC										

j.

CASE STUDY NO. 2: IMPROVEMENT OF COMMUNITY HEALTH THROUGH BETTER WATER QUALITY

In a rural agricultural area with small communities distributed along a river, the main impediment to health and development is a simple one: a limited water supply that is apt for human consumption. Health problems that emanate from this situation include enteric diseases, mainly in children, and a number of skin diseases. Household owners living near the river also have problems with water quality, and women must ensure that all water that is consumed is boiled. Women who live in dwellings further away from the river must walk 2 to 3 kilometers to reach this source, and, in addition to the water quality problem, they have the burden of carrying it back home.

It is known that there are underground aquifers in the area that could supply good water, a fact which propels the Department of Environmental Health (DEH) of the district that includes these communities to decide to construct wells, hoping that the wells will solve the problems of quantity, quality and transport. In addition, the DEH decides to construct latrines, taking care not to situate these in places where they might present hazards to the water quality.

On the basis of this description of the situation, the DEH implements the following project:

The project purpose is:

To contribute to the improvement of the quality of life of the target communities, in particular to the health of women and children.

The expected results include:

1. In each target community, at least one water well constructed and functioning, and the population in each instructed in the care of the wells and the hand pumps.

2. In each target community, at least one latrine constructed per 5 people.

3. In each target community, women are instructed in the use and care of the latrines, in personal and family hygiene, in the proper use of water, and in the safe preparation of food.

RESULTS OF THE PROJECT

A1. A well was constructed in each of the target communities.

A2. Eighty percent (80%) of the women of reproductive age in each community instructed in: personal and family hygiene; the proper use of water; the safe preparation foods; and, the care and use of the water wells.

CASE STUDY NO. 2: IMPROVEMENT OF COMMUNITY HEALTH THROUGH BETTER WATER QUALITY (CONT.)

A3. In so far as it was the women who transported and boiled the water and sought the firewood for this latter purpose, the construction of water wells for human consumption in their community was a real relief, as it alleviated the heavy burden that these chores constituted for them. Now the women found themselves with free time that they had not had previously.

A4. Children's continual diarrheal diseases diminished dramatically in only 3 months after having constructed the wells.

A5. Each community selected men to be trained in the care of the wells and the hand pumps.

A6. Shortly after having constructed the latrines, the men of the communities used them for storing their farming tools.

PROJECT DIFFICULTIES

B1. Women's free time was rapidly taken up in assisting the men in preparing their farm production for market. Subsequently, because the men were the ones who engaged in the commercial transactions, women were made responsible for the agricultural work. As a result, women saw themselves once again working very long hours at tasks that were equally demanding as those which they had to perform when they carried and prepared the water.

B2. The women who lived in the communities furthest from the river found another disadvantage to this new situation: the journeys back and forth to get water, a trip that had been undertaken by a group of women, had provided them with opportunities to exchange thoughts, feelings, joys and concerns; when the need to fetch and carry water ceased, so, too, did this only opportunity for daily interaction.

NOTE: The analysis should focus on the men and the women in the communities.

WORKSHEET: CASE STUDY NO. 2

a. PROJECT OBJECTIVES

ROLES	REP.	PROD.	M.M.
Women			
Men			

b. Health Needs

Women

Men

c. Development Approaches

Assistance | Anti-Poverty | Efficiency | Equality | Empowerment

d.

PGA?

SGA?

Continued

WORKSHEET: CASE STUDY NO. 2 (CONT.)

e. PROJECT REALITY

ROLES	REP.	PROD.	C.M.
Women			
Men			

f. Health Needs

Women

Men

g. Development Approaches

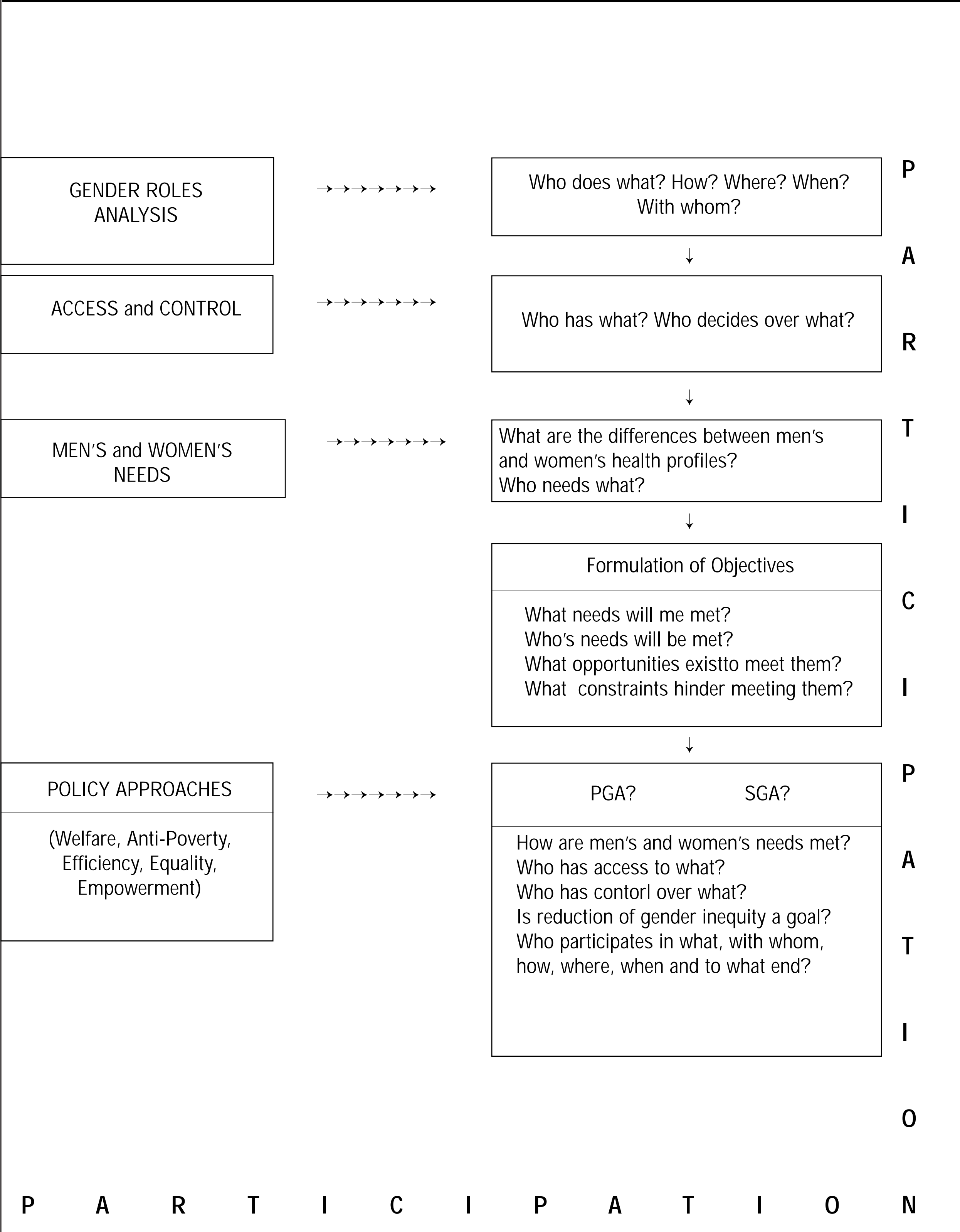
Welfare | Anti-Poverty | Efficiency | Equality | Empowerment

h.

PGA? SGA?

i.	ACCESO					CONTROL				
	M/E	P	I/E	T	I	M/E	P	I/E	T	I
Women										
Men										

j.


STEPS FOR CONDUCTING A GENDER DIAGNOSIS
GENDER ROLES ANALYSIS
Who does what? How? Where? When? With whom?
ACCESS and CONTROL
Who has what? Who decides over what?
MEN'S and WOMEN'S NEEDS
What are the differences between men's and women's health profiles?
Who needs what?
Formulation of Objectives
What needs will me met?
Who's needs will be met?
What opportunities existto meet them?
What constraints hinder meeting them?
POLICY APPROACHES
(Welfare, Anti-Poverty, Efficiency, Equality, Empowerment)
PGA?
SGA?
How are men's and women's needs met?
Who has access to what?
Who has contorl over what?
Is reduction of gender inequity a goal?
Who participates in what, with whom, how, where, when and to what end?
P A R T I C I P A T I O
P A R T I C I P A T I O N

GUIDELINES FOR PROJECT/PROGRAM ANALYSIS

I. Conduct the gender diagnosis, answering the following questions:

- What gender roles did the project target in its objectives and to what purpose?
- What particular health needs of women and men were affected and how?
- What development approach predominates in its objectives: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?
- Do the objectives reflect a practical gender approach (PGA) or a strategic gender approach (SGA) or both?
- Are any assumptions based on stereotypes evident in the project?

II. Identify the information that you would need to carry out an in-depth gender diagnosis.

III. Reformulate one of the project objectives and its indicators so that they reflect a gender approach.

IV. Develop a strategy to put into operation the reformulated objective identifying opportunities and/or obstacles in achieving the objective.