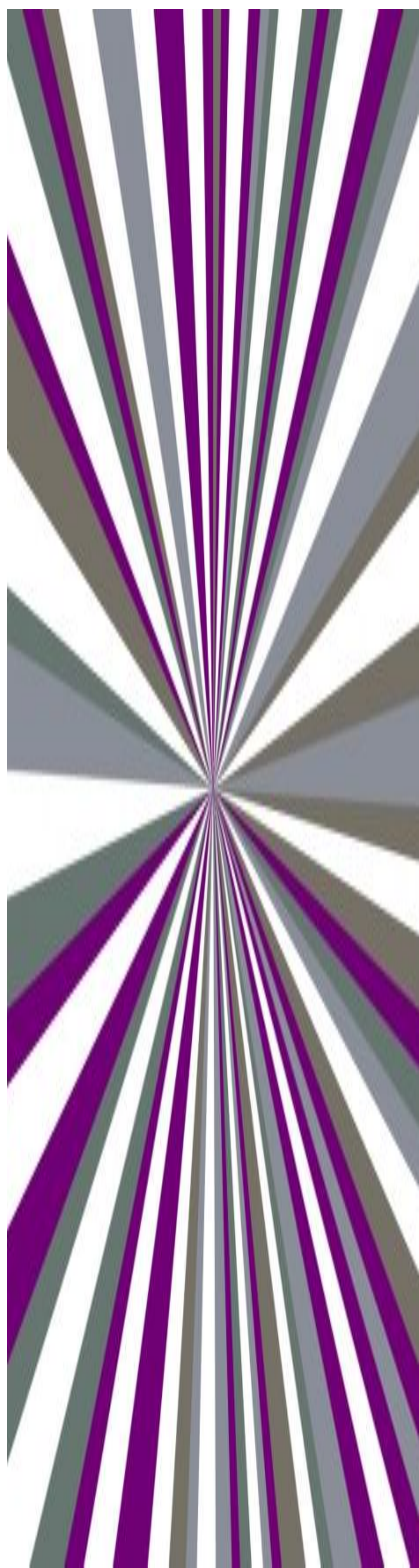
HEALTH SECTOR GENDER TRAINING MANUAL

PARTICIPANTS' NOTE



FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA
MINISTRY OF HEALTH
DECEMBER 2013

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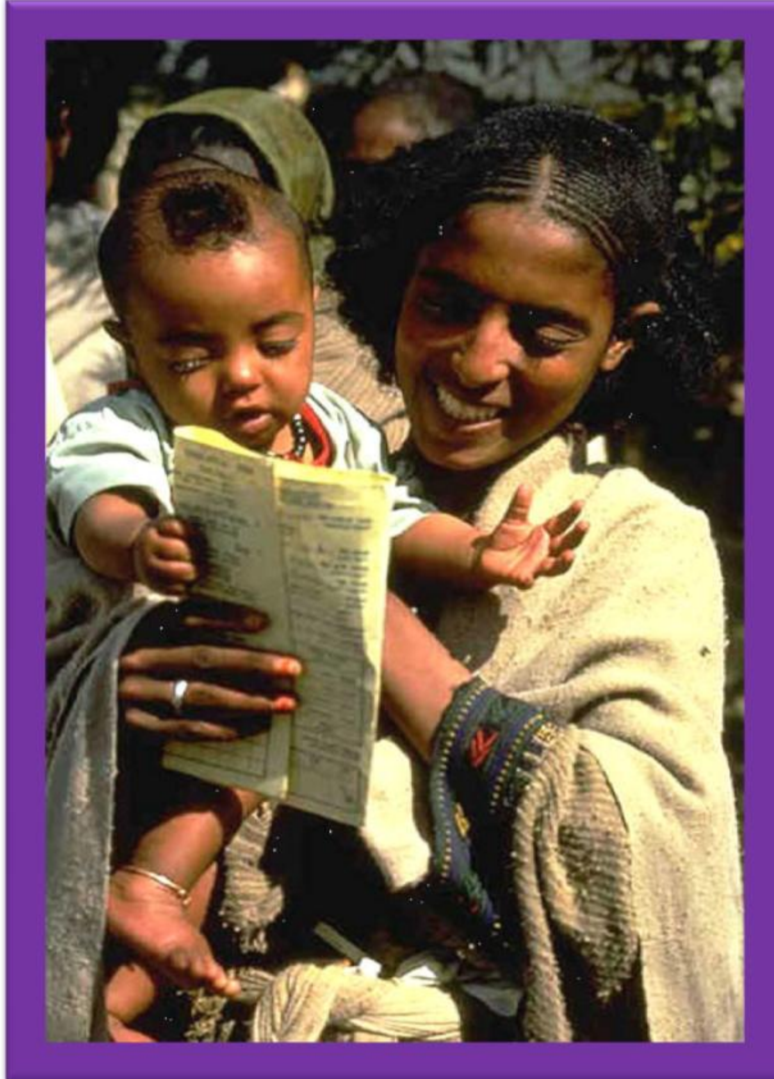

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PARTICIPANTS' NOTE

This participants' note isa detailed handout that accompanies the facilitators'and participants' guide of the gender training manual. The participants' note will be used as a reading and reference material for those interested in cascading the training to lower levels of health workforce. This note contains seven modules and different sessions.

The participants' note builds on various tools and methodologies prepared by other organizations to mainstream gender into overall programs in the health sector. It takes into consideration the sensitivities and challenges that training on gender poses. Both men and women who participate in gender training may not be aware of the values and norms they have been socialized. The training provides an opportunity to assess these.The success of any gender training is whether individuals challenge the status quo as society believes it and as they practice it in their daily lives. Addressing gender is challenging and requires support at all levels. To ensure that the gender training is not abstract and complicated, it utilizes theoretical models for the practical understanding and application based on the participants experience as practitioners and direct actors as one or the other gender.

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LIST OF ACRONYMS

BPFA	Beijing Platform for Action
BSC	Bachelor of Science
CAW	Commission on the Advancement of Women
CEDAW	Convention on Elimination of all forms of Discrimination Against Women
DHS	Demographics Health Survey
ECOSOC	United Nations Economic and Social Council
EDHS	Ethiopia Demographics and Health Survey
FGM	Female Genital Mutilation
FMOH	Federal Ministry of Health
FP	Family Planning
FWCW	Fourth World Conference on Women
GBV	Gender-Based Violence
GPA	Grade Point Average
GTZ	Deutsche GesellschaftfürTechnischeZusammenarbeit
HEW	Health Extension Worker
HRH	Human Resources for Health
HSDP	Health Sector Development Program
HTPs	Harmful Traditional Practices
ICPD	International Conference on Population and Development
IGWG	Interagency Gender Working Group
LLIN	Long-Lasing Insecticide Nets
LMG	Leadership, Management and Governance
MDGs	Millennium Development Goals
MIS	Malaria Indicator Survey
MMR	Maternal Mortality Rate
MoWA	Ministry of Women's Affairs
NAP-GE	National Action Plan on Gender Equality
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
RH	Reproductive Health
SWOT	Strength, weakness, opportunities and threats
TFR	Total Fertility Rate
ToT	Training of Trainers
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United State Agency for International Development
WAO	Women's Affairs Office
WHO	World Health Organization

APPROVAL STATEMENT OF THE MINISTRY

The Federal Ministry of health of Ethiopia has been working towards standardization and institutionalization of in-service (IST) trainings at national level. As part of this initiative the ministry developed a national in-service training directive and implementation guide for the health sector. The directive requires all in-service training materials fulfill the standards set in the implementation Guide to ensure the quality of in-service training materials. Accordingly, the ministry reviews and approves existing training materials based on the IST standardization checklist annexed on the IST implementation guide.

As part of the national IST quality control process, this gender training package for the health sector has been reviewed based on the standardization checklist and approved by the ministry in September 2014.

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PREFACE

In Ethiopia, gender equality is an important aspect of all development sectors. All sectors require the integration of gender—from infrastructure to agriculture, and from health to water. Gender plays a prominent role in determining health and disease patterns, and the response of the health system to these differentials is important. Voicing gender issues should not be limited to women; men have a responsibility and an interest in addressing gender issues: Gender oppression not only affects women and girls but also men and boys since it undermines the wellbeing of the whole family, the household, the community, and the nation at large. Gender does not have to be abstract or difficult to understand. Gender is concrete and visible in the realities men and women face in their daily lives. Gender is not just "women's business," or "*YesotochGoudaye*," which is the literal translation of gender in Amharic. Gender is not just women's business—it is everyone's business.

The Health Sector Development Program (HSDP IV)has placed gender mainstreaming as a subject deserving special attention to achieve improved health outcomes in the country. The program is the leading force in guiding the national health system in Ethiopia. It was designed to cater to the health needs of the majority of the rural poor for the provision of preventive and curative services. Gender mainstreaming is assessing the implications for women and men of any planned action, including legislation, policies, or programs, in any area and at all levels of the health system. This gender manual takes into account this broad definition to ensure that these various dimensions of gender mainstreaming are addressed.

As part of the effort to mainstream gender into all Ministry of Health activities, training will be conducted for health care providers. The training will look at how gender mainstreaming enhances both health care outcomes and health service responsiveness. Such training would facilitate the work of the different directorates at the federal, regional, and *woreda* levels to promote "gender-sensitive" and "gender-responsive" policies and programs, with the goal of creating a "gender transformative" health system in Ethiopia.[1]In order to strengthen and promote national and regional gender mainstreaming efforts by the Federal Ministry of Health, USAID supported the development of this manual.

As a result of the critical role gender plays, all health workforces in the Ethiopian health system can benefit from this training regardless of their position or level within the health system. The manual is designed to make women's and men's concerns and experiences as an integral dimension in the design, implementation, monitoring and evaluation of policies and programs in the health sector. As a result, it is hoped that the inequality between men and women is not perpetuated, but rather, Ethiopian health workers can use a gender lens on all health practices to eventually promote gender equity and transform the health system at all levels.

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INTRODUCTION

During the last two decades, there have been significant strides in understanding and appreciating the role of gender in development. Tangible results for this knowledge continue to be manifested in improvements in the quality of the lives of women. Gender as a legitimate focus for poverty reduction is now accepted. Gender advocates have utilized various strategies to promote the gender agenda. International conventions such as the Convention on the Elimination of Discrimination against Women (CEDAW) the International Conference on Population and Development (ICPD) and the Fourth World Conference on Women (FWCW) have been adopted to bring about gender equity. A majority of countries globally have ratified these conventions. The ICPD has been successful in linking population to gender, providing a program of action within the framework of reproductive health and reproductive rights for women. The FWCW in Beijing reaffirmed the reproductive rights of women and their overall rights to all other aspects of life. However, their implementation has been hindered by customary laws and religious and cultural beliefs that contradict them. Despite these setbacks, what emerged from this movement is a fundamental understanding that the oppression of women negatively affected not only women and girls but also men and boys.

Gender is one of the key determinants for social and economic development in a country, and the empowerment of women is a key focus for all development programs. All sectors should analyze the impact of gender on their policies and programs; however health and social welfare can and should take the lead. The United Nations Millennium Development Goals (MDGs), which guide and measure the progress of poor nations in meeting development goals, includes a specific goal related to gender inequality. More importantly, each goal in the MDGs is directly linked to increasing access to health, education, and other opportunities for women.

Gender equality is a long-term goal because this requires the reversal of beliefs and values supported by religion and custom, which are often handed down from generation to generation. However, change begins with awareness, and awareness can translate into action. The Government of Ethiopia has taken action, placing gender equality as a key component within its development strategies. Gender has been integrated into all line ministries. The Federal Ministry of Health (FMOH) is responsible for mainstreaming gender at various levels of the health system and has established a Gender Directorate, which facilitates the institutionalization of gender to ensure the participation of and access to health services for women. To achieve this objective, the directorate has prepared this manual for health workforce to help them mainstream gender into all activities that is undertaken by the FMOH.

Training on gender presents a challenge and an opportunity. Undoubtedly, it is difficult to change entrenched values and norms through a six day training workshop. However,

at a minimum, it provides opportunities to challenge the status quo, and seek alternative solutions for addressing not only gender but also development as a whole. Gender training is an exercise in which we are asked to question what we have been taught, and examine practices to ensure that they are relevant and appropriate. It is also a mechanism to acquire new knowledge to carry out new practices to promote the equality of men and women. Gender training and the consequent translation of awareness into action can play a significant role in improving the health of communities

Objectives of the Gender Training Manual

Often, there is a tendency to describe gender as the oppression of women by men. Such a simple analysis does not adequately consider how this is played out at the individual, family, household, and state level. Traditional and cultural mechanisms to reinforce and maintain the subordination of women are equally if not more important. The subordinate status of women denies them access to credit, productive inputs, education, training, information, and medical care. As a result, the capacity of women to perform their biological and economic roles is compromised. The distortions in resource allocations from such discrimination carry high costs in development terms; this is why gender will continue to be a critical and cross-cutting piece in current and future development strategies. In operational terms, gender mainstreaming allows policy makers and practitioners not only to focus on the situation of women and their subordinate roles in society, but also gives them the tools to be able to identify those situations, and to address the cause.

In broader terms the gender training for health workforce is designed to raise their gender awareness and equip them with hands-on gender mainstreaming skills**.** In addition to this, the manual isexpected to help participants facilitate the implementation of gender mainstreaming guideline[2].

The gender training manual is expected to provide participants with information and skills to plan, develop, and monitor gender-responsive health programs. This manual addresses the gap that is seen in the practical application of gender mainstreaming for the health workforce in Ethiopia. It is particularly relevant to those who are involved in policies, programs, and setting agendas and priorities in program policies and services in the health sector. The manual looks at particular ways gender equality contributes to better health and how gender norms, roles and relations affect health related behaviors and outcomes. Because gender is a crosscutting issue that addresses health-related discrimination throughout the system, the manual demonstrates the relationship between gender and health.

[2] Gender mainstreaming guideline is a document prepared by the Gender Directorate and endorsed by the FMOH to support gender mainstreaming in the health sector.

Specifically, the training is designed to allow participants to:

- Bring about a change of perspective by confronting their own biases and prejudices regarding gender;
- Explain the concepts of gender in the context of health in Ethiopia;
- Address misconceptions related to gender issues;
- Apply the concept of gender in understanding the overall situation of women in Ethiopia;
- Explain the various levels where gender issues are manifested, and the synergies between those levels in order to design interventions;
- Understand the fundamental principles for the integration of gender and apply the different frameworks and tools which facilitate and accelerate this process;
- Provide information and knowledge on how gender impacts health and health services;

At the end of this gender training, participants will be able to acquire the following core competencies:

- Mainstream gender in the health sector at the program and institutional levels.
- Address gender inequality in programs and projects by applying gender audit, gender analysis and gender budgeting tools.

Justification for theGender Training Manual

The gender directorate of Federal Ministry of Health has initiated the development of this national gender training manual for the health workforce due to absence of standard curriculum for gender in the health sector. The ones that are being used to facilitate various gender-related trainings are not full-fledged and lack the requirements of the standardization guidelines prepared by the FMOH. The request made by federal agencies and hospitals, and regional health bureaus has also been an indication for the need to prepare standardized and hands-on gender training manual for the health workforce.

If health care systems are to respond adequately to problems caused by gender inequality, it is not enough simply to "add in" a gender component late in a given project’s development. Research, interventions, health system reforms, health education, health outreach, and health policies and programs must consider gender from the beginning. Gender is thus not something that can be consigned to "watchdogs" in a single office or unit since no single office could possibly involve itself in all phases of each of an organization’s activities. All health professionals must have knowledge and awareness of the ways gender affects people’s health and the health care they receive so that they can address gender issues wherever appropriate, and make their

work more effective. The process of creating this awareness of—and responsibility for—gender among all health professionals is called "gender mainstreaming".[3]

The manual seeks to help participants mainstream and institutionalize gender equality across the health sector, and to equip Ethiopian health workforce with the skills they need to address gender-based health inequities in their work. Having a national gender training manual with a particular focus on mainstreaming gender into the health sector is important for the following reasons:

- Gender inequality puts the health of millions of girls and women at risk. To reverse the historical burden of this inequality at all levels, gender equality in health results in achieving the important objective of improving health outcomes for communities.
- Without addressing gender norms, roles, and relations, and understanding how the construction of socio-cultural identity and unequal power relations between the genders can affect risk, vulnerability and health service response will be difficult.
- Gender mainstreaming is a new way of doing business—it allows health care professionals to move beyond the rhetoric to address health inequities and the different health needs and challenges affecting men and women.

Gender training has multiple objectives. It raises awareness, promotes behavioral change, and develops new knowledge and skills on gender. The health sector has traditionally focused on the physiological factors of health and illness or on sex-specific determinants affecting men or women rather than on gender. Hence the capacity in the health sector to address gender as a determinant of health may be disparate across contexts. It is important to use gender training opportunities as a means to foster dialogue, reduce harmful practices, and enhance any positive effects of gender roles and relations. Such a dialogue is achieved through acknowledging from the beginning that skepticism on gender and health are prevalent often from individuals that have decision-making power in the health system. Activities in the manual are designed to change skeptics and supporters alike to develop practical ways to address gender inequalities in health and ultimately improve health outcomes. Mainstreaming gender is not an individual task on a very practical level; it is a collective action and learning which is crucial to address gender equality.

Facilitator Qualification and Requirement

Facilitators should fulfill the following criteria.

1. Minimum of first degree in social science or public health fields
2. TOT on Gender training
3. Demonstrated facilitation skills

[3] http://www.who.int/gender/mainstreaming/en/

4. Previous experience in facilitating Gender related trainings
5. Knowledge of Gender situation and context of Ethiopia
6. Ability to speaklocal/regional language

Target Audience of the Manual

All health workforce in the Ethiopian health system can benefit from this training regardless of their position and the levels at which they operate within the health system. This understanding increases the awareness of those trained so that they will feel equipped when confronted by specific situations in specific settings. There is no blueprint for mainstreaming gender, nor are there limitations with regard to what we are able to do once we have a change in perspective, and are able to look at things differently.Hence, the participants of this gender training manual are expected to have necessary qualification and experience to easily grasp the concept and skill of gender mainstreaming. The participants are also expected to develop gender action plans that will help them translate the knowledge and skill gained into practice, and cascade the training in coordination with the gender structures within their organization and beyond.

Organization of the Participants' Note

The manual is intended to guide face-to- face capacity building activities on gender mainstreaming for public health workforces. The method is progressive, participatory, and based on adult and experiential learning. It also utilizes the context of gender in Ethiopia and data to support the theoretical concept of gender. The manual can be used for a six day workshop to accommodate the range of topics, and to provide adequate time for participants to share their experiences. The last day of the workshop will focus on developing an action plan using the concepts and methodologies that participants have learnt. The following are the modules included in the participants' note:

Module 1: Gender Concepts and Terminologies:*Identifies and discusses various gender related concepts and terminologies in order to establish common understanding of concepts before proceeding to the other modules and sessions of the manual. It also shades light on the gender component of the major national and international legislation, policies, and conventions.*

Module 2: Gender as a Social Determinants of Health in Ethiopia: *Provides an analysis of women's biological vulnerabilities and the major socio-cultural, economic, and political factors that impinge on women's health.*

Module 3: Gender Mainstreaming: *Gives an overview of gender mainstreaming concept, principles, stages, tools and methods.*

Module 4: Gender Analysis: *Seeks to strengthen the capacity of health workers to conduct gender analyses so that gender issues are reflected in policies, programs, and activities in the health sector.*

Module 5: Gender Audit: *Provides an overview of how to conduct a gender audit and helps participants understand the purpose, process, steps, and tools required.*

Module 6: Gender Budgeting: *Introduces the concept and approach of gender budgeting into the health system.*

Module 7: Gender and the Health Workforce in Ethiopia: *Discusses the position of women in the health workforce of Ethiopia, the challenges they face, and the opportunities they need.*

MODULE 1

MODULE 1: GENDER CONCEPTS AND TERMINOLOGIES

Session 1: Gender Concepts and Terminologies

Terms	Definitions
Sex	The different biological and physiological characteristics of males and females, such as reproductive organs, chromosomes, hormones, etc.
Gender	Refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men.

The difference between sex and gender are important to the understanding of public health issues. Sex and gender are not the same but they are interrelated. In other words, you cannot talk about gender without talking about sex, and vice versa. People are born female or male but are taught what appropriate behavior and roles are expected of them, including how they should relate to other people.Biology (sex) cannot explain all the different disease patterns between women and men. Many differences in health outcomes between women and men can be attributed to differences in life circumstances and gender can therefore either be mitigated or prevented altogether. Unlike sex, gender can be changed historically, sometimes relatively quickly and often takes long periods of time.Gender is often used as a politically correct way of saying sex. In health, remembering that the two are distinct is important; the health sector cannot ignore the distinct and interacting effects of biological and sociocultural factors that influence health.

Gender-related assumptions

Assumptions	Discussion Points
The health sector is women focused; hence there is no need to address gender specifically.	Compared to other sectors, the health sector activities focus primarily on women. However, gender is not only about women.
Gender is a women's only issue and not a development issue.	Development target of Ethiopia will not be realized unless both women and men are fully involved.
Affirmative action for women compromise quality.	Affirmative action is one way of being fair to women for their past disadvantages. It has to be accompanied with empowerment actions at all

	levels.
Addressing poverty is the main and the only challenge Ethiopia faces. If poverty is eradicated then gender issues will not be relevant.	Poverty exacerbates gender oppression and alleviation of poverty without addressing gender issues will not bring about gender equity.
Gender issues are not relevant to women who are educated and have income.	Education and income decrease women's subordination, but even those who are not poor can suffer from gender oppression.
Laws and legislation will provide guarantees for women to have equality.	Implementation of Laws and Legislation will not succeed without a complementary emphasis on changing the values and norms of a society.
Males are not affected by the subordination of women and in fact benefit from it.	The roles and responsibilities assigned to both sexes can render males victims since they also have to fulfil those roles which may be detrimental to them.
Males are the only ones who perpetuate gender oppression.	Women also participate in perpetuating and reproducing gender oppression through socialization processes.

Terms	Definitions
Gender norms	Refer to beliefs about women and men, boys and girls that are passed from generation to generation through the process of socialization.
Gender roles	Refers to what males and females are expected to do (in the household, community and workplace) in a given society.
Gender relations	Refers to social relations between and among women and men that are based on gender norms and roles.
Gender stereotypes	Images, beliefs, attitudes or assumptions about certain groups of women and men. Stereotypes are usually negative and based on assumed gender norms, roles and relations.

Key points about gender roles, norms and relations:

- The process of socialization influences gender norms, roles and relations.
- Gender norms, roles and relations can produce inequality between and among groups of women and men.
- Examining gender norms, roles and relations helps to better understand the socio-cultural patterns that influence women's and men's lives:
- Gender relations are often based on an unequal division of power, and rights for women and men of different ages and ethnic backgrounds.

- Gender norms, roles and relations lead to stereotypes, discrimination and a division of labor that can influence health and health outcomes.
- Changing gender norms, roles and relations requires short, medium and long-term strategies to reduce harmful effects on health.

Examples of gender norms, roles and relations and how they influence health behavior and outcomes:

- Women are disproportionately responsible for child care due to their biological roles. As a result, men are often excluded from prenatal and antenatal care, counseling and services. Evidence indicates that maternal and child health outcomes – as well as health outcomes for fathers – improve when men are involved in positive, meaningful ways in parenting and in the sexual and reproductive health of their partners.
- Women's gender roles and responsibilities for preparing food in many contexts expose them to indoor air pollution at higher rates than men. As they are also disproportionately responsible for looking after children, the children who remain with them in kitchens are also exposed to such pollution – resulting in severe respiratory disorders, and even mortality, for women and children.
- Gender norms that associate men solely as perpetrators of violence can result in their exclusion or demonization in interventions to reduce interpersonal violence. This ignores the many men who strive to be partners in the fight to end violence against women and can hamper the effectiveness of the health sector in engaging in primary prevention activities related to interpersonal violence.
- Norms that value male authority and privilege increase health risks for women and girls. Examples include violence against women and girls, denial of education and other social resources that improve and protect health and all forms of sexual violence.
- Men tend to work on construction sites more often than women due to the heavy physical demands and the association of physical labor with male gender roles and responsibilities. This may make them more vulnerable to work-related injuries.

Examples of stereotypes:

- Women's biological responsibility for children, often results in the exclusion of men from ante and prenatal care responsibilities.
- Health providers assume that family planning is a woman's responsibility, resulting in limited services for men to protect their own and partner's health.

Terms	Definitions
Access to resources	The availability of a resource that includes several components such as geographic or physical accessibility, financial and social accessibility.

Control over resources	The ability to decide when, how and who can use a resource.

Example of access to and control over resources:

- Lack of access to disposable income can prevent women from using available health care facilities that exist in the community.
- Women and men many have access to the use of condom to protect themselves from STIs but, at the time of sexual relations, women may not have the ability to define or control condom use.
- Gender roles, norms, relations and stereotypes determine expectations for women and men, as well as their control over resources. For example, Women spend most of their productive years caring for children, the ill, elderly and disabled with no or low pay, or in the informal sector. This type of work excludes them from the pensions and benefits provided by formal employers.

Terms	Definitions
Practical gender needs	Needs defined by women (or men) that respond to immediate necessities such as adequate living conditions, water provision, health care and employment. o Tends to be immediate and short-term. o Unique to particular women. o Relate to daily needs, food, housing, income, health, children, etc. o Easily identifiable by women. o Addressing practical needs tends to involve women as beneficiaries and perhaps as participants. o Can be addressed by provision of specific inputs such as food, hand pumps, clinics, etc. o Addressing practical needs can improve women's lives. o Addressing practical needs generally does not alter traditional roles and relationships.
Strategic gender needs	Needs identified through an analysis of gender inequality and its impact on women and men of different groups. Addressing strategic gender needs challenges predominant gender systems such as the gender-based division of labor. o Tends to be long-term. o Common to almost all women. o Relate to disadvantaged positions, subordination, lack of resources and education, vulnerability to poverty and violence, etc.

	o Basis of disadvantage and potential for change not always identifiable by women. o Can be addressed by consciousness-raising, increasing self-confidence, education, strengthening women's organizations, political mobilization, etc. o Addressing strategic interests involves women as agents or enables women to become agents. o Addressing strategic interests can improve the position of women in society. o Addressing strategic interests can empower women and transform relationships.

Terms	Definitions
Gender mainstreaming	The process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated.
Gender equity	Refers to the process of being fair to women and men.
Gender equality	Refers to the state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources.

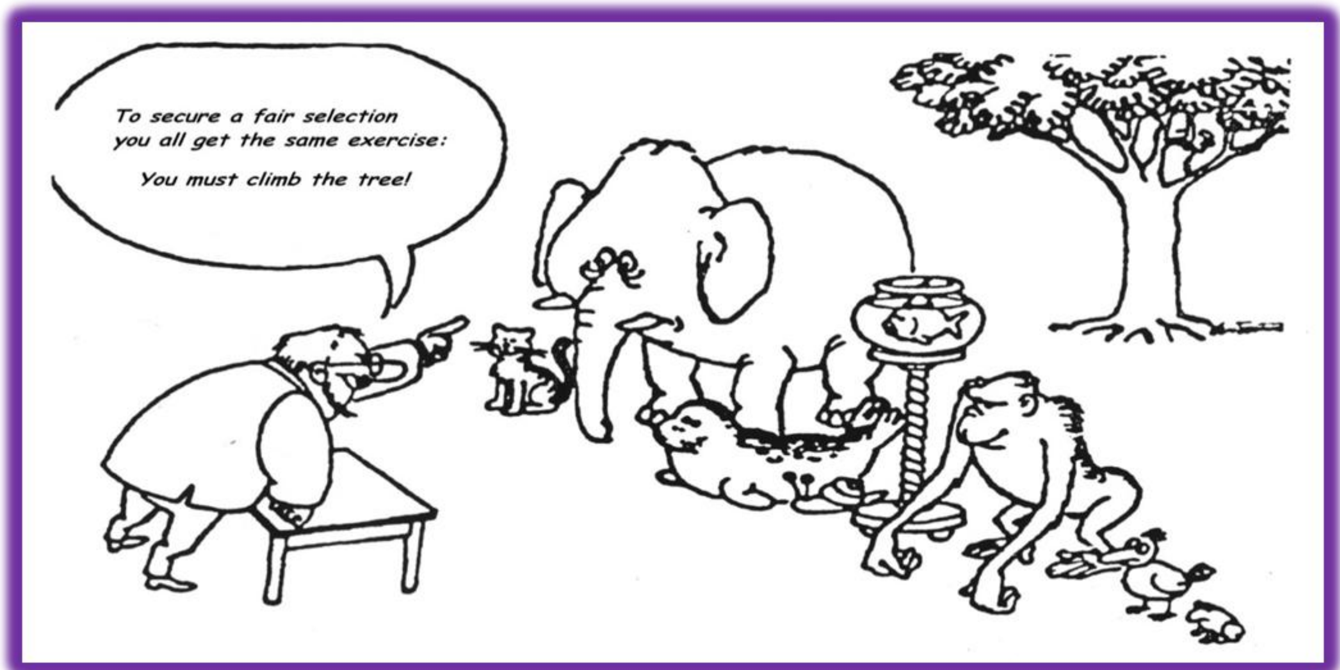
Key points about gender mainstreaming:

- Gender mainstreaming in health means changing organizational structures, behavior, attitudes and practices that harm women's or men's overall health status.
- Gender mainstreaming calls for transforming the public health agenda, including the participation of women and men in defining and implementing public health priorities and activities. This will ensure that their needs are subsequently met.
- Work on gender equality began to address women's inequality; as a result, gender mainstreaming has often been understood to be by, for and about women. In fact, it is by, for and about women and men.
- Gender mainstreaming can include specific projects that empower women to work towards gender equality and can engage with men and boys in addressing harmful behavior and promoting their health.
- Gender mainstreaming addresses both programme issues, such as how certain diseases or health problems may affect women and men differently, and the process

of how institutions are organized to deliver programmes and services in accordance with the principles of gender equality.

- o Gender mainstreaming is a long-term process, and its results will be seen progressively.
- o Gender mainstreaming requires time, commitment, resources, partners and gender analysis skills.

Figure 1: Cartoon and story clarifying the concept of gender equity and equality



Source: Gender mainstreaming in health: a practical guide adapted from WHO manual "gender mainstreaming for health workers". Pan America Health Organization

The story of the fox and the crane

The Fox invited the Crane to dinner. He served the food on a large flat dish. The Crane with her long, narrow beak could not eat.
The Crane invited the Fox to dinner. She served the food in a deep vase, and so the Fox with his short, wide face could not eat.
Both friends had an equal opportunity for nourishment, but each time one of them could not take advantage of this opportunity. What does the story tell us about equality and equity?

Source: Adapted from UNDP-gender in development programme, learning and information pack, gender analysis.

Key points about gender equality and gender equity in health

- ***Gender equality*** in health means that women and men have equal conditions to realize their full rights and potential to be healthy, contribute to health development and benefit from the results.
- ***Gender equality***will require specific measures designed to support groups of women and men with limited access to such goods and resources.
- ***Gender equity*** in health refers to a process of being fair to women and men with the objective of reducing unjust and avoidable inequality between women and men in health status, access to health services and their contributions to the health workforce.
- ***Gender equity*** in health status means that women and men have equal opportunities to enjoy good health, without becoming ill or dying through causes that are unjust and avoidable. It does not mean equal rates of mortality or morbidity for women and men.
- ***Gender equity*** in access/use means differential distribution and access to resources (technological/financial/human) according to need.
- ***Gender equity*** in financing of care means women and men contribute according to their economic capacity, not their need or use of services.
- ***Gender equity*** in participation in health production means just distribution of responsibilities and power. It is also placing value on non-remunerated health work.

Terms	Definitions
Empowerment	Empowerment is a multidimensional social process that enables people to gain control over their lives.

Key points about empowerment:

- With respect to women's health, empowerment has often meant, for example, increasing education opportunities and access to relevant information to enable women to make informed decisions about their health, improve self-esteem and equip them with communication and negotiation skills. Such skills are known to influence actions like safer sex practices, treatment adherence and timely health-seeking behavior.
- Itis an important concept when exploring gender-based discrimination, because it implies transformation –when a disadvantaged person gains more power through confidence, skills-building, and education.

Examples of health-related empowering strategies include:

- Awareness-raising through advocacy or information and education campaigns on priority health topics or taboo subject areas for women and men of different ages.
- Adult education programmes to improve health literacy and health promotion activities.
- Increased education opportunities for young girls.
- Micro-credit and other income-generating activities.

Table 1: Women empowerment at various levels

Levels	Examples of women empowerment actions/programs for positive health outcomes
Individual level: What kind of actions can women as individuals take to empower themselves?	o Ability of women to make decisions over household resources and sexual reproductive rights. o Membership in any association. o Access to health information. o Participate in women's empowerment workshops or meetings. o Self-confidence, earn income
Family/household level: What can the family do to empower women and in the household?	o Assignment of different roles and responsibilities to boys and girls. o Instill self-confidence on girls and boys. o Get family team-building and discussion time.
Community level: What kind of actions can the community take to empower women?	o Sanction proverbs, norms and values that reinforce and perpetrate the subordination of women. o Community tolerance and support for women's leadership. o Ability of women to make decisions within local communities. o Community mobilization/involvement and

	conversations.
State/government level: What is the role of the state or the government to empower women?	o Existence of laws and legislations regarding women's health, empowerment and rights, and their implementation (e.g. property right) o Existence of active women's movements and institutions. o Existence of gender policy. o Use of media and media monitoring strategy from gender perspective

Source:Adapted fromGender Mainstreaming for Health Managers: A Practical Approach, World Health Organization, 2011, page 33

Session 2: National and International Legislation and Policies Related to Gender

The Federal Democratic Republic of Ethiopian demonstrated its commitment to gender issues by creating conducive legal, administrative and policy environment in the country. The most important gender and development measures taken by the government is discussed below.

National Legislations and Policies

Ethiopian Constitution: Constitution of the Federal Democratic People of Ethiopia is committed to building a political community founded on the rule of law and capable of ensuring a lasting peace, guaranteeing a democratic order, and advancing economic and social development of its people. The constitution developed in 1995 further ensures that all fundamental rights granted are to be interpreted in conformity with the principles of the signed international conventions and declarations. Article 35 of the Ethiopian constitution focuses on rights of women stressing on nine key points. The area of focus include: health, employment, customary practices, affirmative action, asset, property and decision-making. The nine areas of the article are summarized in the table presented below.

Article 35 Rights of Women

1. Women shall, in the enjoyment of rights and protections provided for by this Constitution, have equal right with men.
2. Women have equal rights with men in marriage as prescribed by this Constitution.
3. The historical legacy of inequality and discrimination suffered by women in Ethiopia taken into account, women, in order to remedy this legacy, are entitled to affirmative measures. The purpose of such measures shall be to provide special attention to women so as to enable them to compete and participate on the basis of

equality with men in political, social and economic life as well as in public and private institutions.

4. The State shall enforce the right of women to eliminate the influences of harmful customs. Laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited.
5. (a) Women have the right to maternity leave with full pay. The duration of maternity leave shall be determined by law taking into account the nature of the work, the health of the mother and the well-being of the child and family.
   (b) Maternity leave may, in accordance with the provisions of law, include prenatal leave with full pay.
6. Women have the right to full consultation in the formulation of national development policies, the designing and execution of projects, and particularly in the case of projects affecting the interests of women.
7. Women have the right to acquire, administer, control, use and transfer property. In particular, they have equal rights with men with respect to use, transfer, administration and control of land. They shall also enjoy equal treatment in the inheritance of property.
8. Women shall have a right to equality in employment, promotion, pay, and the transfer of pension entitlements.
9. To prevent harm arising from pregnancy and childbirth and in order to safeguard their health, women have the right of access to family planning education, information and capacity.

The Revised Family Code: The revised family code proclamation of Ethiopia emphasize that family is the natural basis of society and shall be protected by the society and the state. It further recognizes that marriage shall be based on the free consent of the spouse, and the need to provide legal basis that guarantees the equality of the spouses during conclusion, duration and dissolution of marriage. The previous law has been amended in such a way that it gives priority for the well-being, upbringing and protection of children in accordance with the constitution and international instruments that Ethiopia ratified.

Changes have been taken place in federal and regional family laws and revised age at marriage, divorce procedures and equality during and after marriage, custody of children and rights to matrimonial properties. These laws have ensured equal rights for women. The revised Family Law of Ethiopia contains most important women and child rights protection issues. The Law raised the marriage age for girls from 15 to 18, making it equals with that of boys and validates marriages concluded by consent. The Family law also gave women right to use and control land.

Penal (Criminal) Code: The penal or criminal code of the Federal Democratic Republic of Ethiopia has been revised in 2005 to ensure safeguards for women and to penalize perpetrators. For the first time harmful traditional practices such as female genital

mutilation, abduction, early marriage, rape, harassments are punishable by law. The revised criminal code increased the number of years of imprisonment of criminals accuses of rape and abduction. However the enforcement of the laws has been very low.

Labor Law: The revised Federal Civil Servants proclamation No. 515/2007 ensured women's constitutional rights to affirmative action concerning recruitment, promotion and deployment. The Ethiopian labor law explicitly stated that there is equal employment opportunity for all citizens of the country irrespective of sex. The labor law also states that the working environment is free of sexual violence.

Policy on Women[4]: The national policy on Ethiopian women was formulated in 1993 to ensure that women participate in and benefit from all political, social and economic spheres on equal basis with men. The policy also seeks to enable them to have access to social services; provide them with the means to decrease their workload; and gradually eradicate traditional practices inflicted on women/girls. In addition to this, the policy establishes women's machineries at different levels to coordinate gender activities and to implement the objectives of national policy on Ethiopian women.

Women's Affairs Departments in different sectors and Women's Affairs Bureaus in the regions have been established with a mandate to mainstream gender in their respective sectors. The Women's Affairs Office, which was established at the Prime Minister's Office, has evolved into a full-fledged Ministry of Women's Affair with its own budget, human and material resources. Currently the national gender machinery is known as the Ministry of Women, Children and Youth Affairs.

A minister, who is a member of the council of ministers, plays a vital role in promoting gender issues. The women's machineries are not only accountable to their respective ministries and regional governments but also have a working relationship with the Ministry of Women, Children and Youth Affairs. The women's affairs departments/ gender directorates and bureaus share their quarterly and annual progress reports, while the ministry provides capacity support to them. The annual forums are held to share experiences and map out future directions for gender activities in Ethiopia.

Ministry of Women's Affairs (MOWA) had selected seven priority areas of the women policy and developed National Action Plan on Gender Equality (NAP-GE). These priority areas are:

1. Poverty and economic empowerment of women and girls
2. Education and training of women and girls
3. Reproductive rights, health and HIV and AIDS
4. Human rights and violence against women and girls

[4] A new policy on women is being drafted but is not available at the time of the preparation of the manual.

5. Empowering women in decision making
6. Women and the environment
7. Institutional mechanisms for the advancement of women

Although no budget estimate has been given for the various activities included in the NAP-GE, the plan has been integrated into the five-year (2005-2010) poverty reduction strategy paper known as A Plan for Accelerated and Sustained Development to EndPoverty (PASDEP)[5]. Gender is currently treated as a development issue under the Growth and Transformation Plan (GTP)[6] that runs from 2010 to 2015.

Education Policy: Education enables individuals and society to contribute in the development process by acquiring knowledge, ability, skills and attitudes. The education policy has various provisions that are related to women and gender.

One of the specific objectives of the education policy is to introduce a system of education that would rectify the misconceptions and misunderstandings regarding the roles and benefits of female education in development. The policy gives special attention to the participation of women in the recruitment, training and assignment of teachers. It also makes sure the design and development of curriculums and books give special attention to gender issues, and the need for financial support to raise the participation women in education.

One of initiatives that have been undertaken through the education policy is the affirmative action plans for female teachers.Currently female teachers are selected with a smaller grade point average (GPA) than male teachers and this has increased the number of female teachers in elementary schools. The affirmative action also has specific strategies to ensure that women get vocational guidance at all institutions of education, have access to the same curricula as men, and are free to choose their field of study.

Reproductive Health Strategy (2006-2015): The national reproductive health strategy builds on a number of notable initiatives undertaken to serve the health needs of all Ethiopians. Included among these are the 1993-health policy, which was followed by formulation of a comprehensive Health Sector Development Program (HSDP) in 1998, and the recent Health Extension Program (HEP). And currently is PASDEP, which gives priority to RH/FP.

The goals identified in the RH strategy are:	Strategies to address key reproductive health outcomes are:

[5] PASDEP is Ethiopia's overall strategy for development from 2005-2010.
[6] GTP is Ethiopia's ambitious five year plan developed to carry forward the important strategic directions pursued in PASDEP.

Addressing cultural practices contributing to the low social and health status of women. E.g. early marriage, FGM, polygamy, wife inheritance, marriage by abduction,	Strengthen the legal frameworks that protect and advance women's reproductive health rights.To ensure the full application of existing laws, and the development of further protection, this strategy encompasses efforts to institutionalize women's rights at the local level, integrate them into regional-level planning activities, and to develop synergistic opportunities with women's groups to ensure that courts and police enforce such protections.
Reduce unwanted pregnancies and enable individuals to achieve their desired family size.	Create acceptance and demand for family planning, with special emphasis on populations rendered vulnerable by geographic dispersion, gender, and wealth.
Reduce maternal and neonatal mortality in Ethiopia.	Empower women, men, families, and communities to recognize pregnancy-related risks, and to take responsibility for developing and implementing appropriate responses to them. Increased knowledge and awareness is essential for reducing delays in seeking healthcare and in reaching a health facility. Communities and individuals must be empowered not onlyto recognize pregnancy-related risks, but they must also have the capacity to react quickly andeffectively once such problems arise.
Reduce HIV infection and improve the quality of life of those living with the disease by optimizing the synergies between RH and HIV and AIDS initiatives.	Exploit opportunities within current RH and HIV and AIDS programs to access populations whose needs would not otherwise be met under existing service delivery arrangements.
Enhance the reproductive health and well-being of the country's diverse populations of young people.	Segment the design and delivery of all youth RH related interventions and policies by gender, age cohort, marital status, and rural/urban residence.
Reduce the risk of developing reproductive organ cancers (ROCs), provide early detection and treatment, and improve the quality of life of those suffering from them.	Understand the magnitude of the problem and identify cost-effective interventions for ROC screening, diagnosis and treatment.

Health Policy: The Ethiopian health policy is developed in 1993 by the transitional government of Ethiopia. It serves as a base for the development of the country's health related strategies.

In general, the policy gives emphasis to the decentralization of the health care system to ensure accessibility of the health services to all segments of the population. Among one of the eight priorities of the policy is giving special attention to the health needs of the family particularly women and children.

The general policy strategy on family health services focuses on addressing women's health needs. These includes: assuring adequate maternal health care and referral facilities for high risk pregnancies; intensifying family planning for the optimal health of the mother, child and family; inculcating principles of appropriate maternal nutrition, optimization of access and utilization; identifying and discouraging harmful traditional practices while encouraging their beneficial aspects; and encouraging paternal involvement in family health.

Environmental Policy: The overall goal of the environmental policy of Ethiopia is to improve and enhance the health and quality of life of all Ethiopians and promote sustainable social and economic development through sound management of resources. One of the policy's guiding principles highlights that every person has the right to live in a healthy environment.

The need to find substitutes for fuel wood whenever capabilities and other conditions allow is in the policy. This will have a direct impact on health of the majority rural women who uses fuel wood as a source of energy. The section under water resources also highlights the need to involve water resource users, particularly women, in planning, design, implementation and follow-up local water policies, programs and projects.

The section on community participation and environment highlights the need to greatly increase the number of women extension agents in the field of natural resource and environmental management. In addition, the policy has a separate section on social and gender issues. This part of the policy focuses on the need for formal and informal training on environmental and resource management.

Cultural Policy: This cultural policy is endorsed by the Council of Ministers of FDRE on October 1997. The policy has been designed in recognition of the positive or negative role that culture can play in the relationship of peoples; with the realization of the fact that culture is itself the mark of the identity of humankind and the foundation of all human rights. The policy believes that it is appropriate to ensure that the cultures of the nations, nationalities and peoples of Ethiopia receive equal recognition, respect, and the chance to develop. The culture policy is closely related to the daily life and psychological states of people, and that it has a decisive role in facilitating development programs to meet their goal.

Among the objectives and the contents of the policy are:

- Abolish traditional harmful practices.
- Ensure women's active participation in all cultural activities and guaranteeing them equal right to the benefit thereof.
- Through the use of art, play an active role in the effort to change the erroneous conception about women which is prevalent in the country and so abolish all sorts of harmful traditional practices they are suffering from.
- Increase women's participation in the activities of the sector and their right to equally share the benefit thereof shall be promoted.

International Conventions and Mandates

Convention for the Elimination of All Forms of Discrimination against Women (CEDAW): The United Nations General Assembly adopted the CEDAW in 1979, and it entered into force on 3 September 1981. It is one of the most important human rights documents for women, since it is legally binding for signatories. CEDAW defines discrimination against women and sets up an agenda for national actions to ensure gender equality. The convention was one of the first instruments of its kind to detail ways to achieve gender equality through ensuring women's equal access to, and equal opportunities in, political and public life. This includes, for example, ensuring the right to vote, to education, health and employment. The convention is unique, since it is the only human rights treaty that establishes the reproductive rights of women. In addition, it states that culture and traditions are influential forces that shape gender roles and family relations. Furthermore, the convention holds states accountable for eliminating all acts of discrimination against women both in public and in private life. The convention contains 30 articles. A summary of the key articles are as follow:

Article 1: Definition of Discrimination. Defines discrimination against women to cover all facets of human rights and fundamental freedoms.
Article 2: Country Duties. Countries must eliminate discriminatory laws, policies, and practices in the national legal framework.
Article 3: Equality. Women are fundamentally equal with men in all spheres of life. Countries must take measures to uphold women's equality in the political, social, economic, and cultural fields.
Article 4: Temporary Special Measures. Countries may implement temporary special measures to accelerate women's equality.
Article 5: Prejudice. Countries agree to modify or eliminate practices based on assumptions about the inferiority or superiority of either sex.
Article 6: Trafficking. Countries agree to take activities to suppress the exploitation of prostitution and trafficking in women.
Article 7: Political and Public Life. Women have an equal right to vote, hold public

office, and participate in civil society.
Article 8: International Work. Women have the right to work at the international level without discrimination.
Article 9: Nationality. Women have equal rights with men to acquire, change, or retain their nationality and that of their children.
Article 10: Education. Women have equal rights with men in education, including equal access to schools, vocational training, and scholarship opportunities.
Article 11: Employment. Women have equal rights in employment, including without discrimination on the basis of marital status or maternity.
Article 12: Health. Women have equal rights to affordable health care services.
Article 13: Economic and social life. Women have equal rights to family benefits, financial credit, and participation in recreational activities.
Article 14: Rural Women. Rural women have the right to adequate living conditions, participation in development planning, and access to health care and education.
Article 15: Equality Before the Law. Women and men are equal before the law. Women have the legal right to enter contracts, own property, and choose their place of residence.
Article 16: Marriage and Family. Women have equal rights with men in matters related to marriage and family relations.

International Conference on Population and Development (ICPD): International Conference on Population and Development (ICPD)was held in Cairo and singed in 1994. Ethiopia ratified the document in 1994. Delegations from 179 states participated in negotiations to finalize a programme of action on population and development for the next 20 years. The conference endorsed a new strategy which emphasizes the numerous linkages between population and development, and focuses on meeting the needs of individual women and men rather than on achieving demographic targets.

Key to this new approach is empowering women and providing them with more choices through expanded access to education and health services and promoting skill development and employment.The programme advocates making family planning universally available by 2015, or sooner, as part of a broadened approach to reproductive health and rights.

The programme of action includes goals with regard to universal education, especially for girls; further reduction of infant, child and maternal mortality levels; access to reproductive and sexual health services including family planning. It also addresses issues relating to population, the environment and consumption patterns; the family; internal and international migration; prevention and control of the HIV and AIDS pandemic; information, education and communication; and technology, research and development. Focus areas of the ICPD is presented in the table below.

Inter-relationships between Population, Sustained Economic Growth and Sustainable Development	o Integrating population and development strategies o Population, sustained economic growth and poverty o Population and environment
Gender Equality, Equity and Empowerment of Women	o Empowerment and status of women o The girl child o Male responsibilities and participation
The Family, Its Roles, Rights, Composition and Structure	o Diversity of family structure and composition o Socio-economic support to the family
Population Growth and Structure	o Fertility, mortality and population growth rates o Children and youth o Elderly people o Indigenous people o Persons with disabilities
Reproductive Rights and Reproductive Health	o Reproductive rights and reproductive health o Family planning o STDs and HIV prevention o Human sexuality and gender relations o Adolescents
Health, Morbidity and Mortality	o Primary health care and the health-care sector o Child survival and health o Women's health and safe motherhood o HIV and AIDS
Population Distribution, Urbanization and Internal Migration	o Population distribution and sustainable development o Large urban agglomerations
Internally displaced persons	o International Migration o International migration and development o Documented migrants o Undocumented migrants o Refugees, asylum-seekers and displaced persons
Population, Development and Education	o Education, population and sustainable development o Population information, education and communication
Technology, Research and Development	o Basic data collection, analysis and dissemination o Reproductive health research o Social and economic research
National Action	o National policies and plans of action o Programme management and human resource development o Resource mobilization and allocation

International Cooperation	○ Partnership with the Non-Governmental Sector ○ Follow-up to the Conference ○ National-level activities ○ Sub-regional and regional activities ○ Activities at the international level

Millennium Development Goals (1990-2015): Over the past decade, UN conferences have provided a platform for transforming the development agenda on different issues. The Millennium Declaration is one such blueprint for development. The Millennium Development Goals aim to significantly reduce the percentage of people living in poverty and improve overall standards of living. The eight goals are visionary, ambitious and provide benchmarks to measure progress towards development.

Although all the goals outlined by the MDGs are relevant for women; Goal 3, 4, and 5 are particularly gender-specific and lie at the core of women's health and development. To bring about positive change through poverty reduction, the cornerstone of the MDGs, women must be made an important target because their poverty is more severe and carries worse consequences. Gender inequity and women's subordination represent major barriers to achieve development objectives. The Millennium Development Goals can provide guidance to both donor agencies and governments and make them aware of these barriers. The summary of the MDG goals are summarized here under.

Goal 1- Eradicate extreme poverty and hunger: by 2015, halve the population of people living on less than a dollar a day and those who suffer from hunger.
Goal 2- Achieve universal primary education: by 2015, ensure that all boys and girls complete primary school.
Goal 3- Promote gender equality and empower women: eliminate gender disparities at all levels by 2015.
Goal 4-Reduce child mortality: by 2015, reduce mortality rate among children under five by two-third.
Goal 5-Improve maternal health: by 2015, reduce maternal mortality ratio by three-quarters.
Goal 6-Combat HIV and AIDS, malaria and other diseases: by 2015, halt and begin to reverse the spread of HIV and AIDS, incidence of malaria and other major diseases.
Goal 7- Ensure environmental sustainability: integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources. By 2015, reduce by half the number of people without access to safe drinking water. By 2020, achieve significant improvements in the lives of at least 100 million slum dwellers.
Goal 8-Develop a global partnership for development: develop further an open trading and financial system that includes a commitment to good governance development and poverty reduction nationally and internationally. Address the least developed countries special needs and the special needs of landlocked. Deal comprehensively with developing countries debt problems.

Beijing Platform for Action (BPFA): The government of the world reaffirmed their commitment in 1995 to "the equal right inherent and human dignity of all women and

men" in the Beijing declaration of Platform for Action. At the United Nation fourth world conference for women in Beijing 1995, both development cooperation members and their partner countries made commitments to gender equality and women's empowerment. The Beijing declaration is based on principles of human rights and social justice. It recognizes that gender equality and women's empowerment are essentials for addressing the central concern of poverty and security, and for achieving sustainable people centered development. The twelve areas of concern of the Beijing Platform for Action are:

1. ***Poverty:***studies have shown that women and especially rural women are more impoverished than their men counterpart. They constitute 70% of the world poor.This is because of absence of economic opportunities due to their lower position in the gender relationship. Example lack of land ownership and inheritance, education etc.
2. ***Education and Training:***Almost 2/3 of all illiterate people in the world are women the majority being from rural areas. Moreover, dropout rates among girls are much higher than among boys due to problems including preference of boys' education at household level.
3. ***Health care***:mortality rates of women are high due to inadequate attention given to reproductive health. Example, in Ethiopia, 8% of every mother dies due to a cause related to pregnancy.
4. ***Violence:***Violence of women could be domestic (at home) or outside (at school, on the road and work place so on.) It includes beating, rape, sexual abuse or harassment causing physical or psychological damage on women .The members of the conference noted that violence is a global problem yet no preventive laws exist to protect women and even if laws exist, there is reluctance from the part of authorities to enforce them.
5. ***War and its effect on women:***Women are affected in many ways during war. Women are left to maintain families when economic and social life is disrupt. Women are also victims of disappearance and rape as a weapon of war. Moreover, 75% of the world's 23 million refugees are women and children…showing devastated position women face.
6. ***Inequality in economic structure and (access to resources):***Though women do produce food and contribute significantly to economic life everywhere, they are excluded from economic decision-making. In most societies, they lack equal access to and control over various means of production (land, capital, technology.) Moreover, their work is underpaid and undervalued.
7. ***Inequality in sharing power and decision making****:* Not enough women participate fully as top level diplomats or leadership position, though there has been noticeable progress over the years. Yet, to attain the goals of equality and development they passed some recommendations in order to create rooms for women at top level.

8. ***Women focused institution***: Though national institutions like ministers (which analyses needs and problems) and women research units have been created in some countries, for the advancement of women, they suffer from the lack of financial and human resources to perform adequately.
9. ***Human rights of women***:Women may have rights guaranteed by law, but do not exercise them because they might not be aware of them and because government bodies fail to promote and protect those rights.
10. ***Women and media:***Although, more women work in the media, few make policy decisions. Still, in most countries, mass media provides a distorted picture of women – their role and contribution to communities and countries.
11. ***Women and environment:***In most developing countries, women are responsible for fetching water and fuel and also management of household consumption. Yet, they are mostly absent from decision-making, environmental policies do not take in to account the close links between women's daily lives and the quality and sustainability of the environment.
12. ***The girl child:***In many societies of the world, girls are often treated as inferior to boys. Girls are subjected to detrimental customary practices as Genital Mutilation (FGM) and early marriage.

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MODULE 2

MODULE 2: GENDER ASA SOCIAL DETERMINANT OFHEALTH IN ETHIOPIA

Gender is one of the broader determinants of health. Gender interacts with a range of other determinants to produce differential health outcomes for women and men. Being female or male significantly influences health behavior, status, access and use of health services. Women and men differ in terms of power, status, biological make-up, socialization and roles in society and these differences must be acknowledged, analyzed and systematically addressed. Unless these differences are taken into account, health services, programmes and policies will have limited benefit because they will not be based on the full range of factors (or determinants) that influence health behavior, risks and outcomes.

Biological factors relate to the differences between men and women and the differentials in health and disease patterns.

Socio-cultural and economic distinctions refers to the relationships men and women have with their families, communities, the state, and the world at large.

Session 1: Situations of Women in Ethiopia

Both men and women play multiple roles. However, the major difference is that men typically play their roles sequentially, focusing on a single productive role. On the other hand, women usually play their roles simultaneously, balancing the demands of each within their limited time constraints. In addition to this,women have triple roles since they engage in productive, reproductive, and community-related work.

Reproductive role: refers to childbearing/rearing responsibilities, and domestic tasks done by women, acquired to guarantee the maintenance and reproduction of the labor force. It includes not only biological reproduction but also the care and maintenance of the workforce (male partner and working children) and the future workforce (infants and school-going children)

Productive role: refers to work done by both men and women for pay in cash or kind. It includes both market production with an exchange-value, and subsistence/home

production with actual use-value, and also potential exchange-value. For women in agricultural production, this includes work as independent farmers, peasant wives and wage workers.

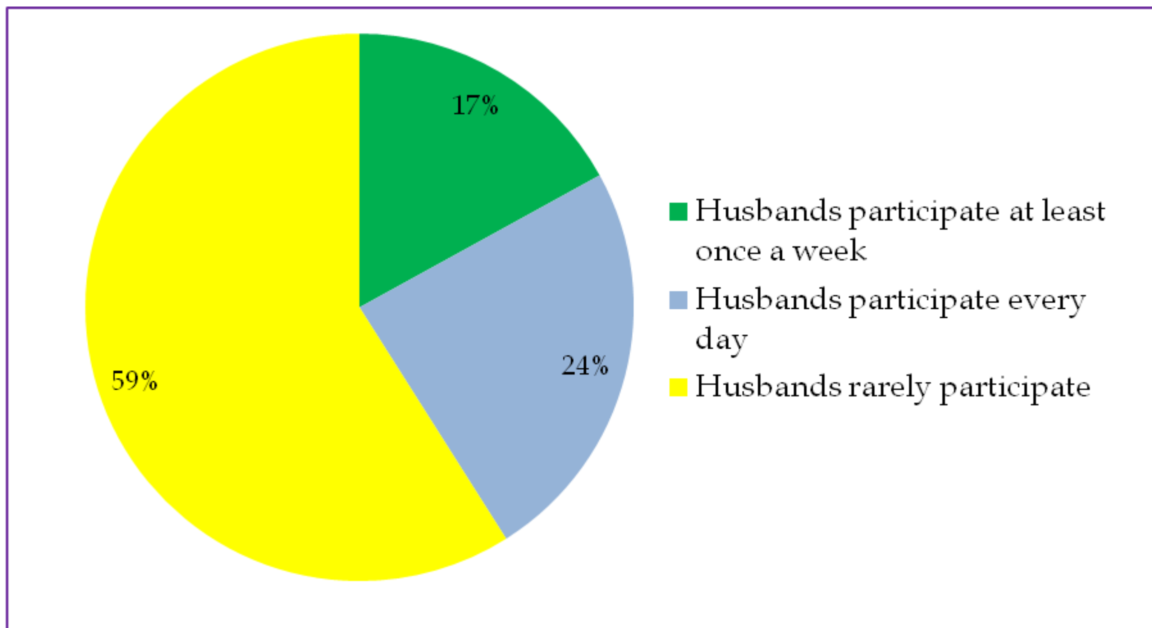
Community managing role: refers to activities undertaken primarily by women at the community level, as an extension of their reproductive role, to ensure the provision and maintenance of scarce resources of collective consumption, such as water, health care and education. This is voluntary unpaid work, undertaken in free time.

Community politics role: refers to activities undertaken primarily by men at the community level, organizing at the formal political level, often within the framework of national politics. This is usually paid work, either directly or indirectly, through status of power.

The gender-based division of labor ascribed in a given socio-economic setting determines the roles that men and women actually perform. Since men and women play different roles, they often face very different cultural, institutional, physical and economic constraints, many of which are rooted in systematic biases and discrimination. The 2011 Ethiopia Demographics and Health Survey (EDHS) key findings indicate the situation of Ethiopian women as follows:

- 26 % or one in four household is headed by women.
- Over half of Ethiopian women have no formal education with only 38 % of literacy rate.
- More than one-third of currently married and employed women who earn cash make independent decisions about how to spend their earnings.
- About half of currently married women participate in three important decisions related to: the woman's own health care; major household purchases; and visits to her family or relatives.
- Access to antenatal care and delivery assistance from a skilled provider increase with women's empowerment.
- Access to antenatal care and delivery assistance from a skilled provider increase withwomen's empowerment.

Figure 2: Response of married women on husbands' participation in household chores



Source: Ethiopia Demographics and Health Survey, 2011

Session 2: The Life-Cycle Approach

Over the years, women's health needs have been addressed through maternal and child health programmes, focusing primarily on the narrow aspects of their lives. With new knowledge and changing perspectives, women's health is now being viewed holistically-as a continuum of care that starts before birth and progresses cumulatively through childhood and adolescence to adulthood and old age. The life-cycle approach to women's health extends beyond women's reproductive role to encompass women's health at every stage and in every aspect of their lives. Through this approach, other health issues affecting women that were previously overlooked, or thought not to exist, have become more apparent.

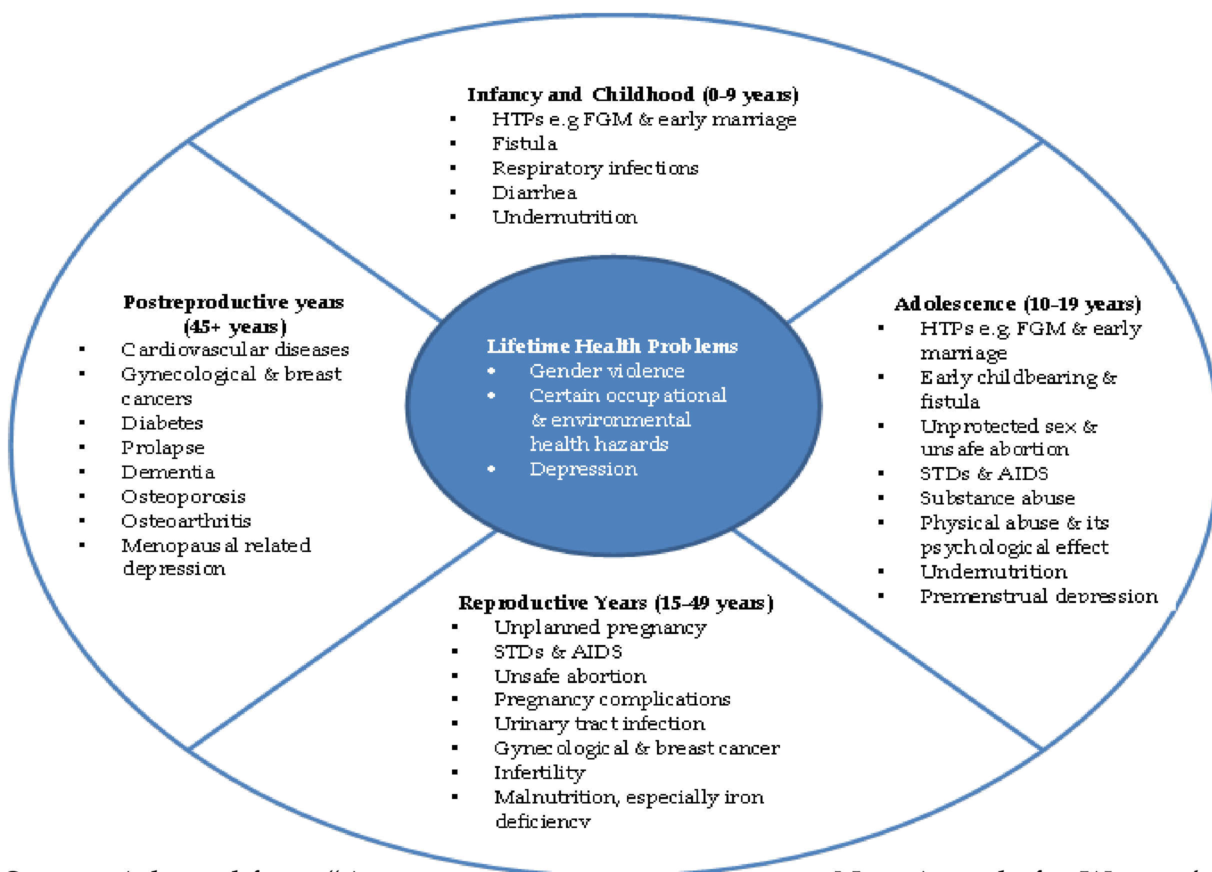
The life-cycle approach helps us understand the different health challenges that women face. It describes both the biological vulnerabilities as well as the socio-cultural and economic aspects which affect the lives of women from infancy to old age. The life cycle approach also helps us understand conceptual framework that looks at the overall vulnerabilities that women have as a result of their gender, identifies and address lifetime health problems which affect women and recognize the experience of women in their daily lives.

What is the life-cycle approach to understanding women's health: The life-cycle approach to women's health captures the different health conditions of women as they move from infancy to old age. The life-cycle chart below summarizes the health and

nutritional problems affecting women during their life-cycle. Based on this chart, it is possible to identify the needs of women in their life-cycle and determine appropriate interventions or actions to help women maintain their health.

The conceptual framework describes the biological vulnerabilities of women and their interaction with social, economic and cultural factors. Many women's lives and their status are influenced by different factors such as work inside and outside home, child care and elder care, reproductive health, and chronic ailments. For example, a major problem affecting women during adolescence is malnutrition. Adolescents grow faster and need protein, iron, and other micronutrients to support the growth and meet the body's increased demand for iron during menstruation.

Figure 3: Health and nutritional problems affecting women during the life cycle



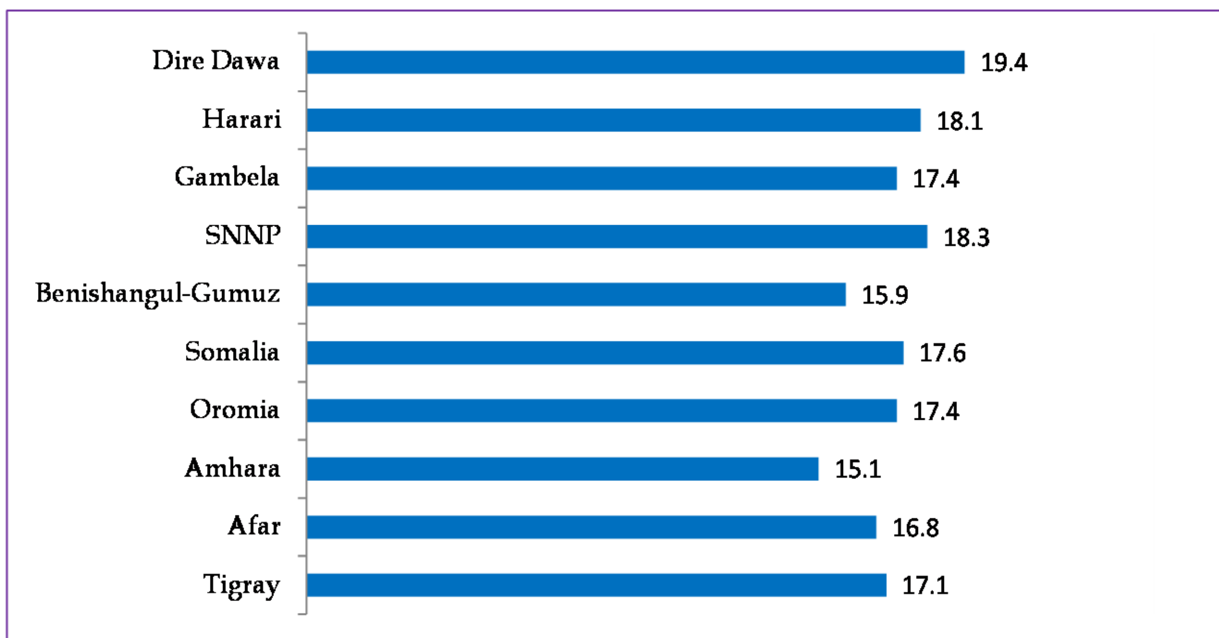
Source: Adapted from "A New Agenda for Women's Health and Nutrition," The World Bank, 1994.

Session 3: What Does The Data Show?

Early Marriage: is a cultural practice that occurs not only in rural and remote areas but also in urban centers like Addis Ababa. The practice contributes to the low socio-economic and health status of women.The average age of first marriage for women in Ethiopia is 16, which is one of the lowest in the world. Men are encouraged to marry much later, at an average age of 23. This age gap between husband and wife also contributes to significant power disparities at the household level.

Confined to domestic duties from an early age, young women often experience significant psychosocial problems related to their lost mobility and inability to pursue educational or vocational opportunities. Almost half of all early marriages end in divorce or separation, with the newly separated woman often migrating to urban areas in search of work. There, many turn to commercial sex, significantly increasing their reproductive and sexual health risks.Reproductive health risks are also high for girls who remain married, as pregnancy-related complications are substantially higher in physically immature women.

Figure 4: Median age at first marriage among women aged 20 - 49 by region



Source: Ethiopian Demographic and Health Survey, 2011.

The most common health related consequences of early marriages are:

- Early pregnancy
- Unwanted pregnancy
- Early child bearing

- Risks to the babies born from them, e.g. low birth weight, prematurity, etc.
- Obstetric complications like prolonged labor, obstructed labor, fistulae, etc.
- Sexually transmitted diseases and infection from HIV/AIDS early in life
- Premature death mainly as a result of obstetric complications
- Physical trauma (genital)
- Vaginismus (being tense during sexual intercourse) which interferes with sexual pleasure
- Vulnerability to HIV infection

Female Genital Mutilation: is a harmful tradition being practiced all over the country. It is the surgical removal of parts of the female external genital for cultural and religious reasons. World Health Organization classified the different types of female genital mutilation as type I, type II, type III and type IV.

- **Type I:** is the excision or removal of the clitoral hood with or without excision of part or the entire clitoris.It is partial or total removal of the clitoris and is considered the simple type. However, to remove the prepuce of the clitoris, which is a very delicate operation especially if done on a child, would require great skill, good light, surgical tools, anesthetized, motionless body, quite aside from a thorough knowledge of anatomy.
- **Type II:** is the excision or removal of the clitoris together with partial or total excision of the labia minora.
- **Type III:**isinfibulation or removal of part or all of the external genital and stitching/narrowing of the vaginal opening leaving a small hole for urine and menstrual flow. The term infibulation is a Latin word meaning pin in or clasp. In some countries it is called "pharaonic circumcision". The procedure entails stitching together of the labia majora after the surface has been scraped to produce a raw surface. The legs of the girl are tied together immediately after operation, and she is immobilized for several weeks until the wound of the vulva has closed, except for a small opening that is created by inserting a splinter of wood or bamboo.
- **Type IV**: is unclassified such as pricking, piercing or incision of the clitoris and/or labia, stretching or the clitoris and/or labia, cauterization by burning of the clitoris and surrounding tissues, scraping of the vaginal orifices or cutting of the vagina, introduction of corrosive substance into the vagina to cause bleeding or herbs into the vaginal opening with the aim of tightening or narrowing the vagina, any other procedures that fall under the definition of female genital mutilation.

The practice results in complications depending on the expertise of the operator and the environment within which the operation takes place.In Ethiopia, mostly old women, traditional birth attendants or other traditional practitioners perform the procedure under unhygienic conditions using a razor blade, knife or other sharp instruments.

FGM is now seen as a health, human rights, women's reproductive rights and developmental issue having the following consequences. The complications are divided into immediate and delayed complications.

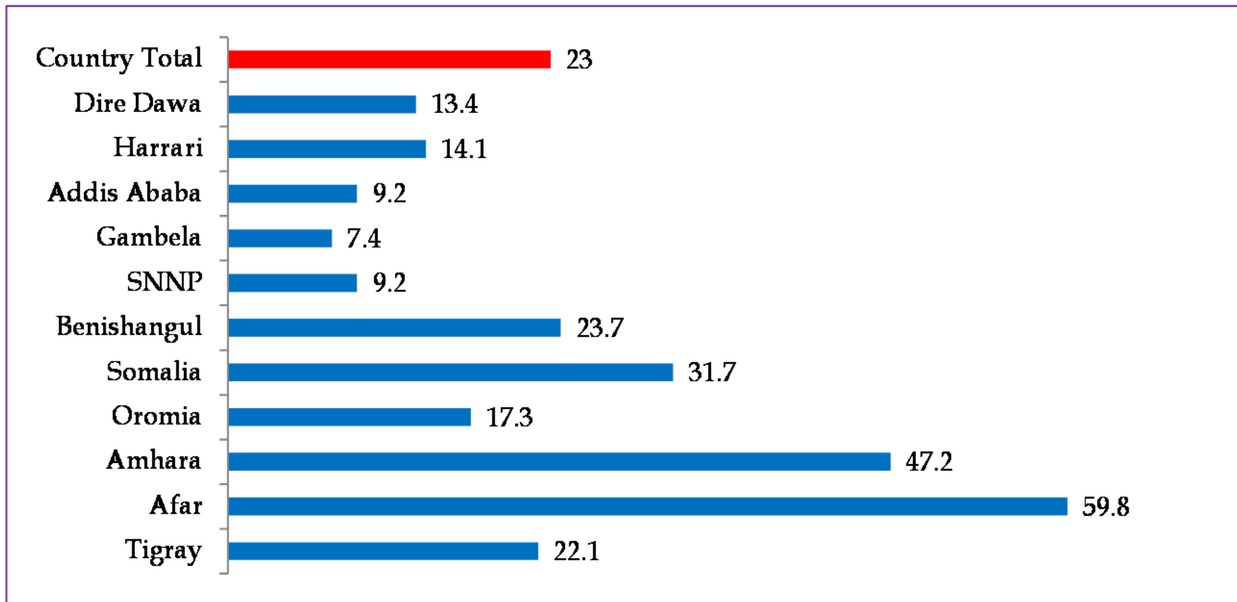
Immediate complications are those which arise soon (in few seconds) or within a few days of the procedure:

- Hemorrhage
- Shock
- Severe pain
- Damage to the nearby urinary structures
- Septicemia
- Tetanus
- Bone fracture following heavy pressure applied to the
- struggling girl
- Death

Late complications are those that occur later on in life:

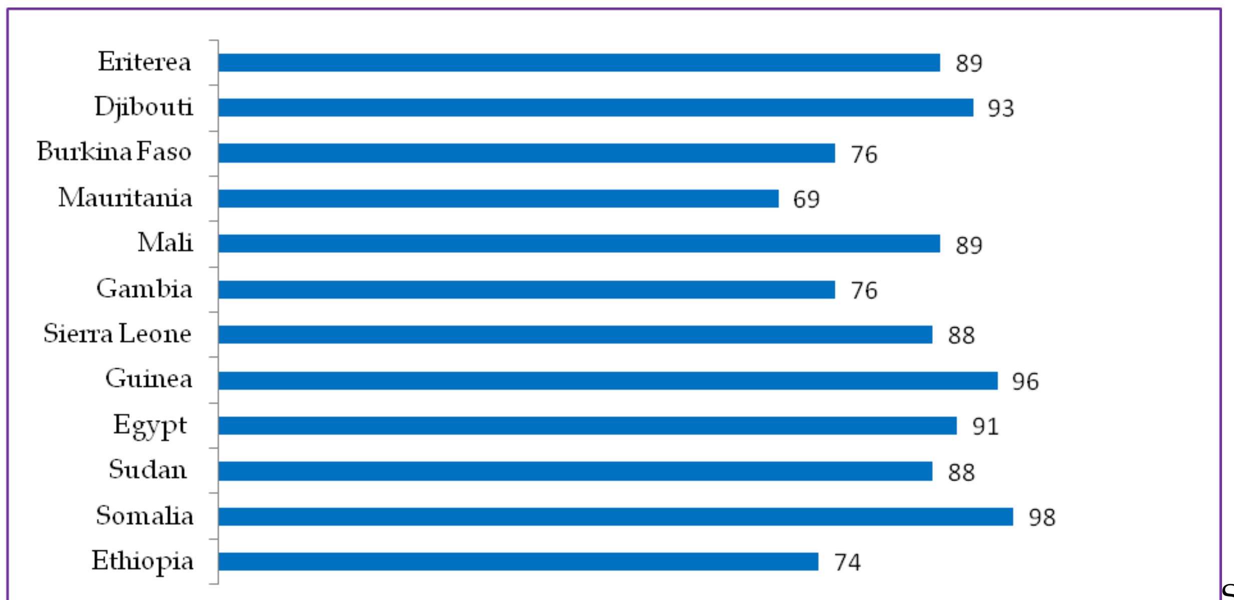
- Heavy scarring (keloid scar)
- Dyspareunia (painful intercourse) or apareunia (not being able to have sexual intercourse)
- Neuromas from cut ends of the nerves
- Haemotocolpos (accumulation of menstrual blood caused by closure of the vaginal opening by scar tissue)
- Recurrent urinary tract infection
- HIV and AIDS
- Obstructed labor and other obstetric complications
- Urinary and rectal fistulae usually following delivery

Figure 5: FGM for children 0-14 years by region by percent



Source: Ethiopian welfare monitoring survey 2011. Central Statistical Agency

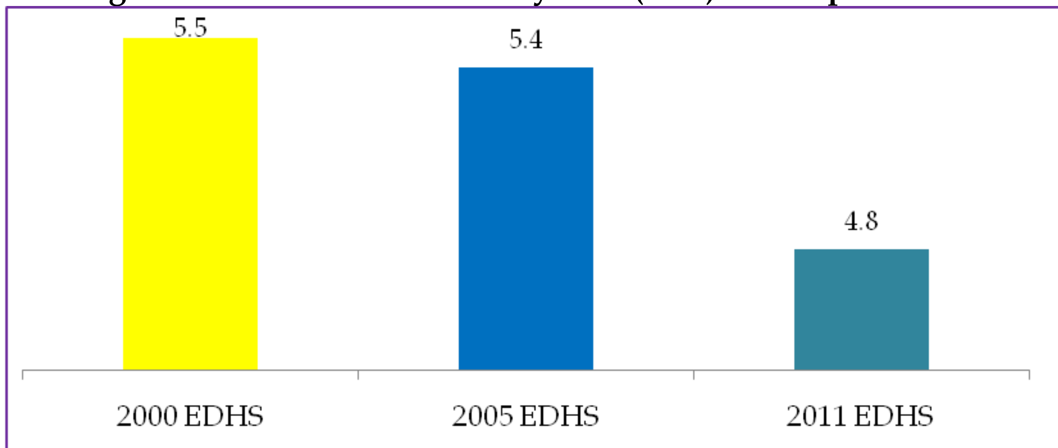
Figure 6: Percentage of girls and women aged 15-49 who have undergone FGM/C, by country



Source: UNICEF (2013). Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change. UNICEF, New York.

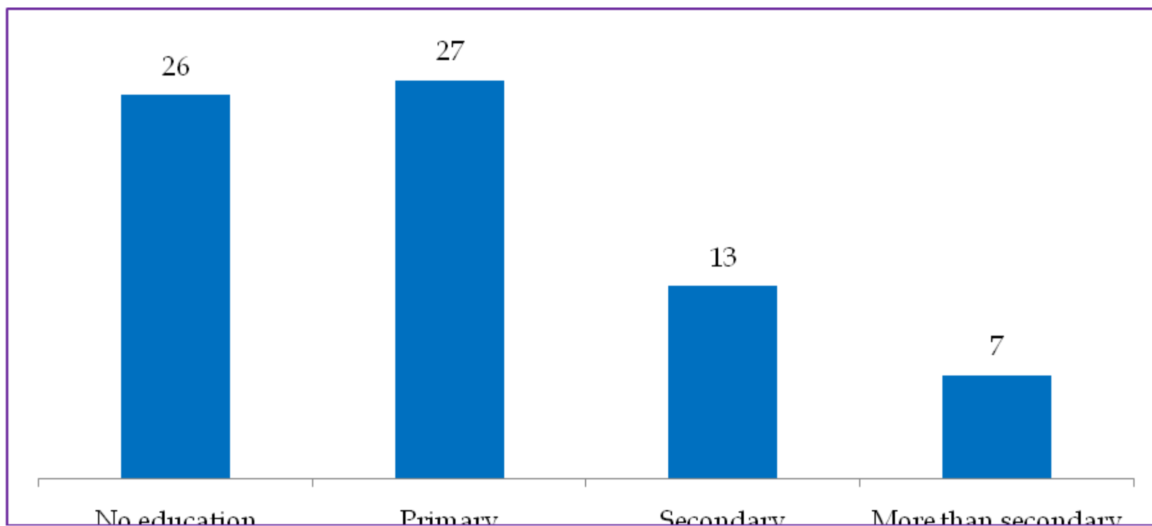
Fertility: is one of the three principal components of population dynamics that determine the size and structure of the population of a country. Information on current and cumulative fertility is essential for monitoring population growth. Birth intervals are important because short intervals are strongly associated with childhood mortality. The age at which childbearing begins can also have a major impact on the health and well-being of both the mother and the child.

Figure 7: Trend in Total Fertility Rate (TFR): births per woman



Note: Age specific fertility rates are per 1000 women; rates for 2005 EDHS is for the three years preceding the survey
Source: Ethiopia Demographics and Health Survey, 2011

Figure 8: Unmet need for family planning by education: percentage of married women age 15-49 with unmet need for family planning



Source: Ethiopia Demographics and Health Survey, 2011

According to EDHS 2011, issues related to fertility are:

- Fertility declinedslightly between2000and2005,from5.5childrenperwomanto5.4, andthendecreasedfurtherto4.8childrenin2011.
- Ruralwomenarehavingabouttwiceasmanychildrenasurbanwomen (5.5 versus 2.6 children on average per woman)
- Women who have no education have over four times as many children as women with more than secondary education (5.8 versus 1.3 children per woman).
- Fertility increases as the wealth of the respondent's household decreases.
- The poorest women have twice as many children as women who live in the wealthiest households (6.0 versus 2.8 children per woman).
- Unmetneed for family planningis almosttwiceashighamongruralwomenasamongurbanwomen(28percentversus15percent).
- Womenwithnoeducation(26percent)orprimaryeducation(27percent)aremuchmorelikelyto haveanunmetneedforfamily planningthanthosewithsecondaryorhighereducation(13and7percent, respectively).
- Unmetneedislowestamongwomeninthewealthiesthouseholds.

Maternal Mortality: The term 'maternal mortality' used in EDHS surveys corresponds to the term 'pregnancy-related mortality'. Maternal mortality rates are key indicators of the health status of a population. InEthiopia they are also national development indicators. Estimation of these mortality rates requires comprehensive and accurate reporting of adult deaths and maternal deaths.

The maternal mortality ratio (MMR) in Ethiopia is very high. There are 676 maternal deaths for every 100,000 births. This compares with an average of 290 per 100,000 births in developing countries, and 14 per 100,000 in developed countries, according to the UN World Health Organization. Even if MDG 5 is committed to improvingmaternal health with a target of reducing MMR by three-quarters over the period 1990-2015, the data over the past five years shows no change.

Table 2: Status of maternal mortality in Ethiopia

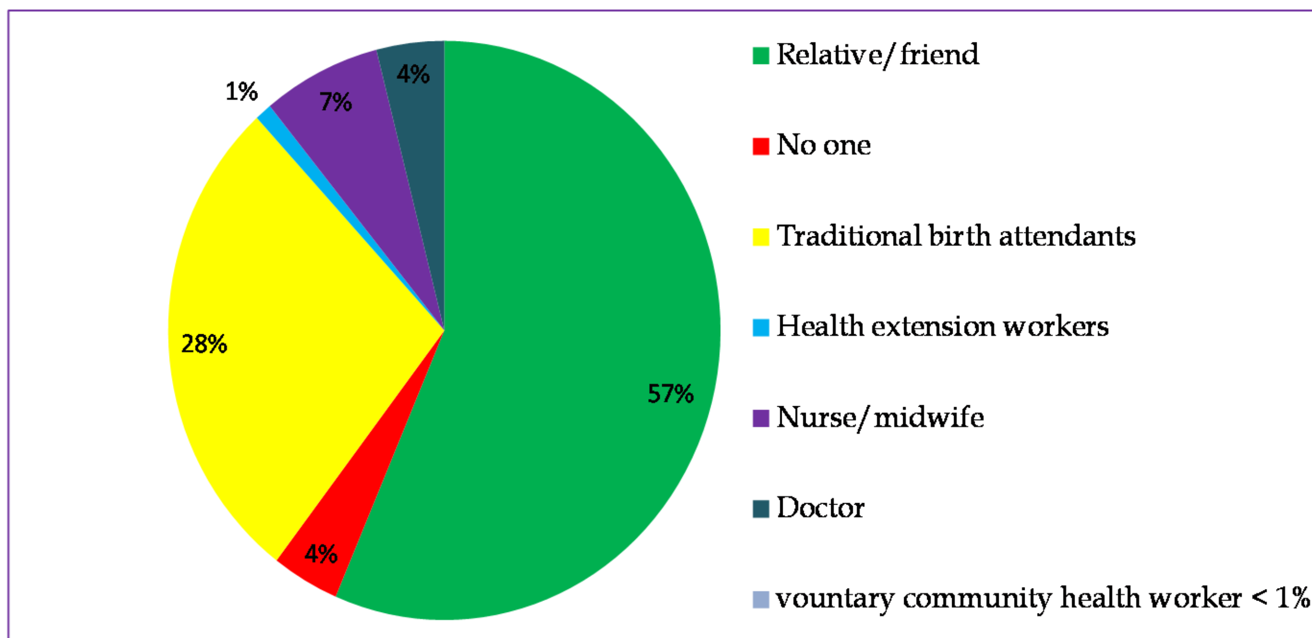
Year	Maternal Mortality Rate
2000	871 maternal deaths per 100,000 live births
2005	673 per 100,000 live births
2011	676 per 100,000 live births

Source: Ethiopia Demographics and Health Survey, 2011

Women need access to quality health services mostly during their reproductive years, when health risks are the greatest. Yet during these years, they face major constraints in accessing health care services. These constraints emerge from a host of reasons. Some of the reasons that have been known to cause women not to use health facilities include:

- Distance of health facilities and associated lack of transportation
- Lack of money
- Workload inside and outside the house
- Belief that childbearing is a natural event and going to the health facility is unnecessary
- Concern that there may not be a female service provider
- Concern about getting permission to go for treatment
- Low priority given to the rights, needs, dignity and privacy of women
- Lack of sensitivity given to women's preferences
- Insufficient priority given to malnutrition among young girl
- Insufficient importance placed on gender attitudes of service providers
- Age of marriage

Figure 9: Assistance during delivery: percent distribution of births in the 5 years before the survey



Note: 10% of births were assisted by a skilled provider (4% Doctor and 7% nurse of midwife). All the figures have been rounded.
Source: Ethiopia Demographics and Health Survey, 2011

The policies and actions taken by the government to reduce maternal mortality include:

- National health policy
- National reproductive policy
- Abortion guidelines
- Emergency obstetric surgery program
- Training of emergency obstetrics care health officers
- Exemption of payment of fees for pregnant women
- Deployment of health extension workers
- Deployment of health development army

Session 4: Gender-Based Violence

Gender-based violence continues to be a significant and serious human rights and public health issue. Although GBV is acknowledged as a fundamental violation of human rights and a constraint to development, it is endemic throughout Ethiopia.

GBV is a violence that involves men and women, in which women and girls are disproportionately affected from all cultures and socio-economic background. Women and girls tend to comprise the majority of GBV victims as it is derived from gender norms, roles, and unequal power relations between women and men.

GBV is specifically targeted against a person because of his or her gender/sex, and it affects women disproportionately. It includes, but not limited to, physical, sexual and psychological harm (such as intimidation, suffering, coercion, and/or deprivation of liberty within the family or within the general community). It includes violence perpetuated by the state.[7]

GBV takes many forms such as rape, domestic violence, sexual violence, emotional and psychological abuse, trafficking for forced labor or prostitution, sexual exploitation, sexual harassment, harmful traditional practices (e.g. female genital mutilation, early marriage, multiple marriage and forced marriage) and discriminatory practices based on gender.

GBV also includes threatening, scolding, men refusing to economically support the family, men denying the existence of children born out of wedlock, refusal to share family property with women after divorce, spending family resources on drink and other personal expenses that result in the economic deprivation of the wife and children, controlling women's fertility (not allowing women to use family planning), restricting women's movement and advancement in education, degrading and neglecting women and girls.

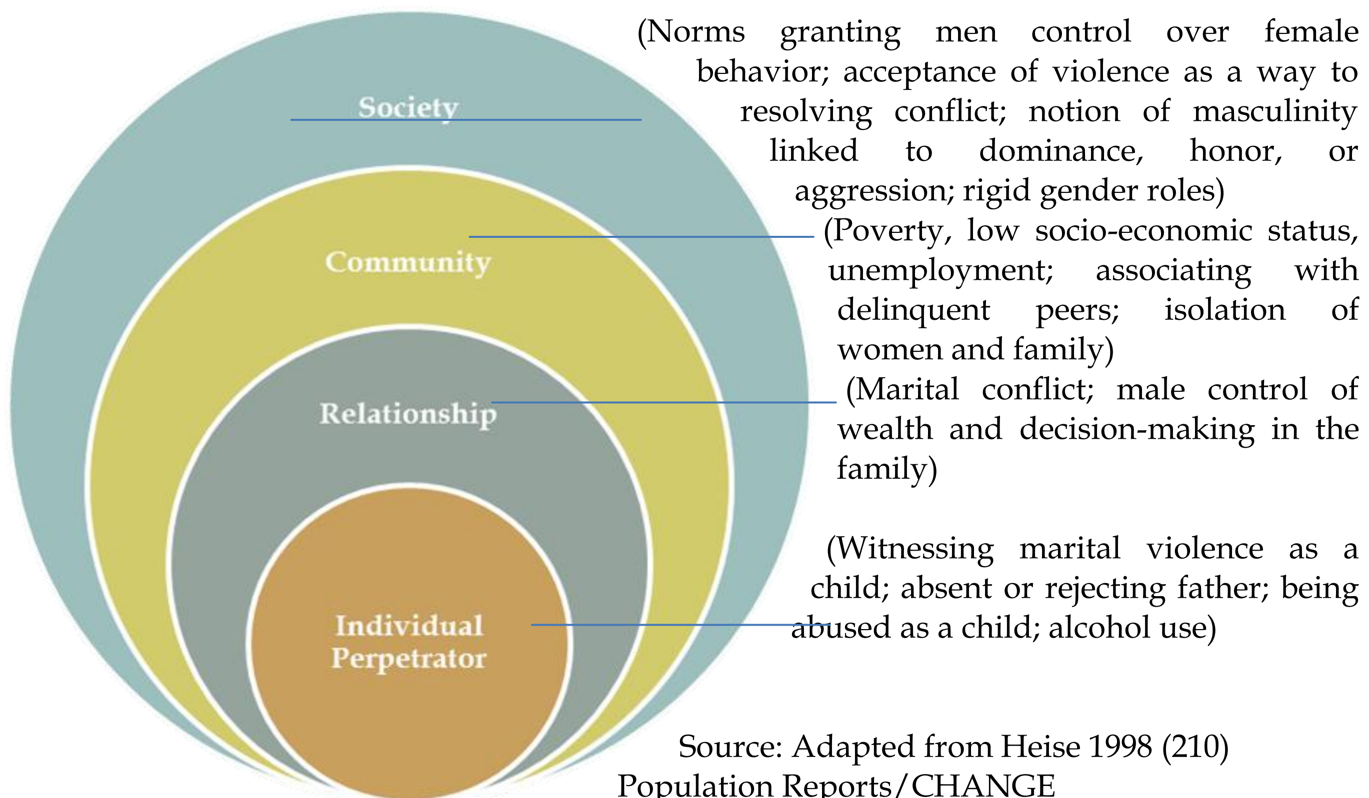
Using an Ecological Framework to Understand Gender-Based Violence

An ecological approach to gender-based violence argues that no one factor alone "causes"violence but rather that a number of factors combine to raise the likelihood that a particular man in a particular setting may act violently toward a woman. In the ecological framework, social and cultural norms-such as those that assert men's inherent superiority over women – combine with individual-level factors – such as whether a man was abused himself as a child – to determine the likelihood of gender-based violence. The more risk factors present, the higher the likelihood of violence.

The 1993 Declaration on the Elimination of Violence against Women, the UN General Assembly defined the issue as "any act of gender-based violence that results in, or is likely sexual or psychological harm or suffering for women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life."

Figure 10: Ecological model of factors associated with GBV

[7] IGWG ibid glossary of terms



Source: Adapted from Heise 1998 (210)
Population Reports/CHANGE

- The innermost circle represents the biological and personal history that affects an individual's behavior in his/her relationships.
- The second circle represents the immediate context in which gender-based violence takes place—frequently the family or other intimate or acquaintance relationship.
- The third circle represents theinstitutions and social structures, both formal and informal, in which relationships are embedded—neighborhood, workplace, social networks, and peer groups.
- The fourth, outermost circle is theeconomic and social environment, including cultural norms.
- A wide range of studies suggest that several factors at each of these levels, while not the sole *cause*, may increase the likelihood of gender-based violence
- The gender perspective on violence against women shows us that the root cause of violence lies in the unequal power relations between women and men, which ensure male dominance over, women, and are a characteristic of human societies throughout the world.

At the *individual level* these factors include the perpetrator being abused as a child or witnessing marital violence in the home, having an absent or rejecting father, and frequent use of alcohol.At the *level of the family and relationship*, cross-cultural studies have cited male control of wealth and decision-making within the family and marital

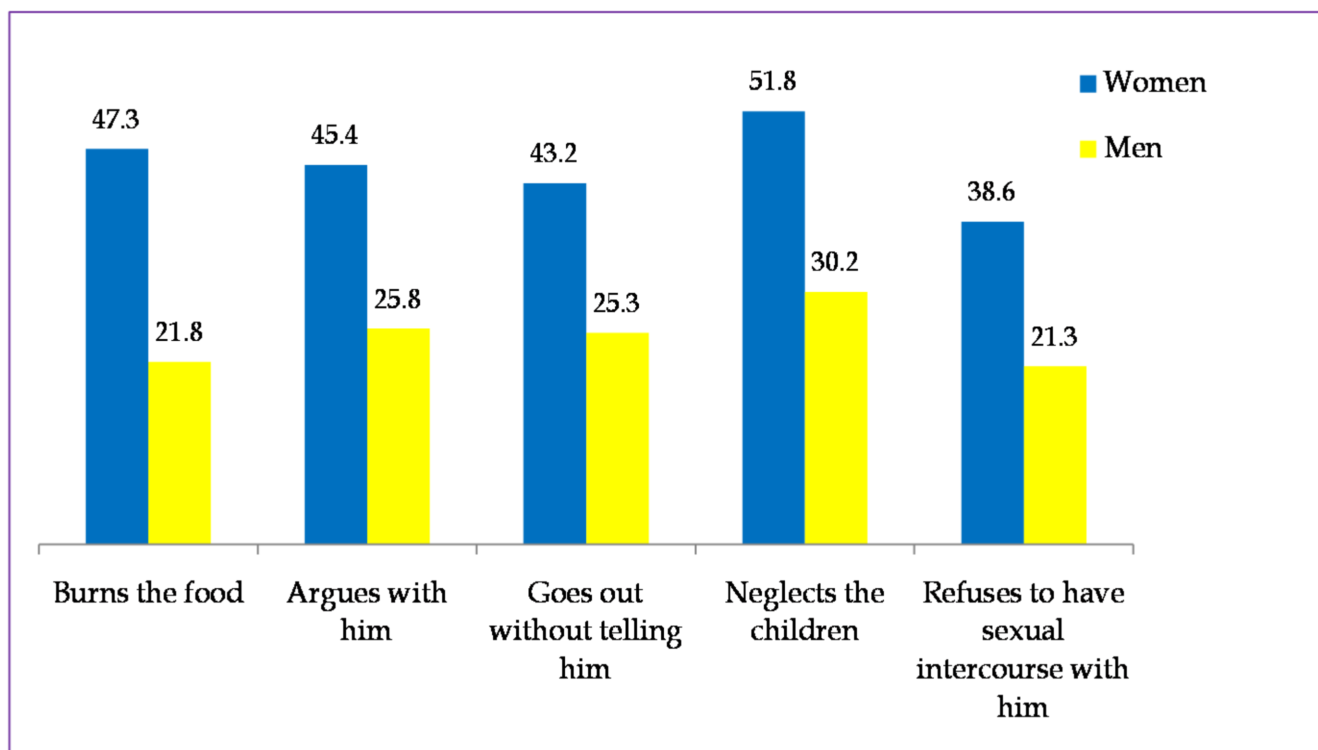
conflict as strong predictors of abuse. At the *community level* women's isolation and lack of social support, together with male peer groups that condone and legitimize men's violence, predict higher rates of violence. At the *societal level* studies around the world have found that violence against women is most common where gender roles are rigidly defined and enforced and where the concept of masculinity is linked to toughness, male honor, or dominance. Other cultural norms associated with abuse include tolerance of physical punishment of women and children, acceptance of violence as a means to settle interpersonal disputes, and the perception that men have "ownership" of women.

Gender-based violence has health effects on women resulting in physical trauma, psychological trauma. According to WHO GBV report of2013, the adverse health outcomes of gender-based violence on women include:

- Partial or permanent disability
- Poor nutrition
- Exacerbation of chronic illness, chronic pain
- Organ damage
- Sexual disorders
- Unprotected sex
- Unwanted pregnancy and abortion
- Bad pregnancy outcomes (low birth weight, neonatal deaths), maternal deaths
- STIs, HIV and AIDS, gynecological problems
- Infertility
- Mental health problems (depression, anxiety and suicide)
- Disability

As indicated in the previous module, Ethiopia has issued a relatively large amount of gender-friendly legislation and policies. These include the constitution, national women's policy, education policy, and other legislative as well as judicial acts. Despite the presence of these important policies and efforts exerted by civil society organizations, women in Ethiopia remain highly vulnerable and continue to suffer from violence and denial of their rights in one form or another. One of the reasons associated with this lack of awareness of women towards policies against GBV which is evident in table and figures presented below.

Figure 11: Attitude of women and men towards wife beating: husband is justified in hitting or beating his wife if she:



Source: Ethiopia Demographics and Health Survey 2011

Table 3: Knowledge of laws in Ethiopia against domestic violence

Percentage of women age 15-49 who know that there is a law in Ethiopia against wife beating	
Background characteristics	**% of women who know that there is a law against wife beating**
Age	
15-19	47.3
20-24	49.7
25-29	48.2
30-34	48.4
35-39	50.2
40-44	53.0

45-49	48.8
Residence	
Urban	61.7
Rural	44.9
Total	48.9

Source: Ethiopian Demographic and Health Survey, 2011

Session 5: Gender and Mental Health

Understandings Mental Health

World Health Organization defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.

A healthy person has a healthy mind and is able to think clearly, solve problems in life, work productively, enjoy good relationships with other people, and make a contribution to the community.It is these aspects of functioning that can be considered as mental health.

Mental health is vital for individuals, families and communities, and is more than just the absence of mental disorder.To be a healthy person we need to have both mental and physical health, and these are related to each other. Mental health provides individuals with the energy for active living, achieving goals and interacting with people in a fair and respectful way.

Mental health disorders include a variety of different conditions ranging from more common problems such as excessive fear and worry (anxiety) or unusually sad mood (depression), to more severe behavioral problems that can involve suspiciousness, violence, agitation and other unusual behaviors (psychosis).

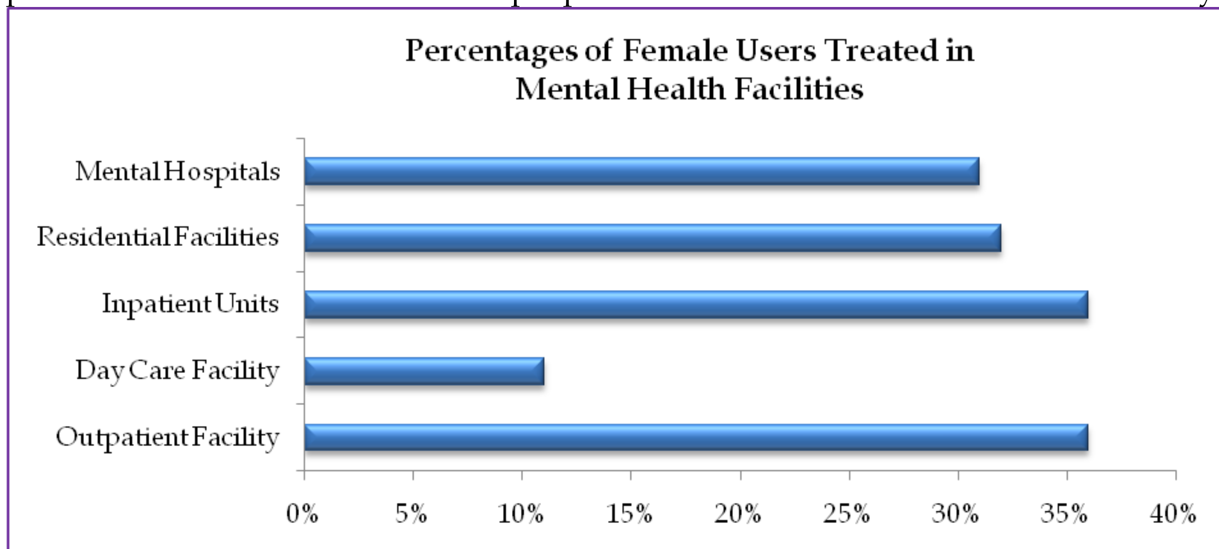
Mental disorders are more than just the experience of stress. Although stressful life events often contribute to the development of mental disorders, stress itself is not considered to be a mental disorder.While seizures, epilepsy, and intellectual disability (mental retardation) are all conditionsthat affect the brain, these are not actually classified as mental disorders.

A mental disorder can be a brief episode or it may be a long-term persistent condition. When a family member has a mental disorder, that family is often socially and economically disadvantaged.

Communities often have many false beliefs about mental disorders, including what theyare, what causes them, and how to respond to a person experiencing a mental disorder. Consequently, many people with mental disorders experience stigma and discriminationthat results in delays in seeking appropriate help for the problem; distress for the affected person and their family; and ongoing social and economic exclusion for the affected person and their family.

In low income countries like Ethiopia, where malnutrition and infectious diseases are common, the prevalence of mental disorders is shockingly high. A study carried out by Shibire and Alem in 2003 indicated that the health problem associated with mental disorder in Ethiopia is as high as 20%.

According to WHO-AIMS report, approximately 1.7% of Ethiopia's health expenditure for 2004 was spent on mental health. The country has 53 psychiatric outpatient facilities, 6 inpatient facilities and one mental hospital. However, majority of users of mental health facilities are males, mental health services are a limited for women, children and people who do not live in the city. For instance, the number of patients in Amanuel mental hospital in 2004 was 1235 of which 31% of patients treated were female and 7% were children or adolescent. In addition, there are few mental health professionals, primary health care providers have little training in mental health and there are no protocols for how to treat and refer people with mental health disorder in the country.



Source: WHO Assessment Instrument for Mental Health Systems Report on Mental Health System in Ethiopia. 2006. Addis Ababa, Ethiopia.

Factors Affecting Mental Health

Multiple social, psychological, and biological factors determine the level of mental health of a person at any point of time. Poor mental disorders are caused by a combination of factors including stressful life events, biological factors, individual psychological factors, and adverse life experiences.

Stressful life events that can contribute to the development of mental disorders includes gender discrimination, family conflicts, unemployment, stressful work conditions, death of a loved one, infertility, sexual or physical violence, and poverty which is associated with low levels of education, poor housing and low income. Poverty can place a person at risk of mental disorders because of the stresses associated with low levels of education, poor housing and low income. Mental disorders are also more difficult to cope with in conditions of poverty.

There are also some biological some biological causes of mental disorders including genetic factors, imbalances in chemicals in the brain, and brain injury. Sometimes people experiencing chronic medical problems such as heart, kidney and liver failure, and diabetes may develop mental health problems such as depression, as living with a chronic illness can be very stressful.

Lastly, there are specific psychological and personality factors that make people vulnerable to mental disorders. This includes poor self-esteem, negative thinking, abuse, emotional neglect, social exclusion, early death of parents or other traumatic experiences, and drug and alcohol abuse.

Gender Differences in Mental Health

Women’s mental health is receiving increased attention from scholars, practitioners, media and the public at large. Medical evidence points to gender-specific vulnerabilities in mental health problems. In fact, twice as many women as men suffer from depression. Migrant women are at an even greater risk because the traditional mechanisms for mitigating stress.

A better way to understand women's health involves looking at a woman's life comprehensively.Throughout their life cycles, women experience tremendous mental health burdens created by gender discrimination, physical and sexual violence, lack of access to appropriate physical and mental health care, nutrition and education, high

rates of illiteracy, the burden of being the family caretaker, and limited opportunities for power and decision making.

WHO also draws link between poverty and women's mental health. It has indicated that women living in poor social and environmental conditions are prime candidates for mental disorders.Women with low education, low income , in insecure job conditions and unpaid labor, difficult family and marital relationships, low quality of housing and dangerous neighborhood are much more likely to suffer from mental disorders than other women.

In some cultures there is a strong preference for male children since maintaining male line in patrilineal society is important, which ensures the continuity of the family. This associated with inheritance such as land ownership and rank in a society has created a preference for male children over female children.

During adulthood, women's work and motherhood are their major roles. It is well known that work is related to mental health in that it increases self-esteem and financial independence. However, the multiple roles that women play in society put them at greater risk for mental problems. Juggling multiple tasks such as household, child-care, food production, etc. increases the risk of mental and behavioral disorders, including depression, worry and anxiety. In fact, twice as many women as men suffer from depression. Migrant women are at an even greater risk because the traditional mechanisms for mitigating stress.

Level of education hasa direct correlation with women's status in the family, ability to gain financial independence, access better health care, and achievement of better mental health. When this opportunity is not available due to various factors, the mental health of women suffers.

Immigration can also bring a sudden loss of role for women, as whatever authority they have had within their households is eroded by their new situation. This has far-reaching effects on self-confidence.

These gender differences have led some to contend that men tend to externalize their suffering through substance abuse and aggressive behavior, resulting in an under-reporting of psychological distress. Women, in turn, more often suffer distress in the form of depression, anxiety, "nerves," and the like.

Interventions for Promoting Women's and Men's Mental Health

Mental health promotion involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles. These include a range of actions to increase the chances of more people experiencing better mental health.

According to WHO, promoting mental health depends largely on inter-sectoral strategies.Fundamental ways to promote mental health include:

- Protection of basic civil, political, socio-economic and cultural rights;
- A national mental health policy;
- Increasing and improving the amount and quality of mental health training for workers at all levels from medical students to health extension workers.

Specific ways to promote mental health include:

- Early childhood interventions (e.g. home visits for pregnant women, pre-school psycho-social activities, combined nutritional and psycho-social help for disadvantaged populations);
- Support to children (e.g. skills building programmes, child and youth development programmes);
- Socio-economic empowerment of women (e.g. improving access to education and microcredit schemes);
- Social support for elderly populations (e.g. befriending initiatives, community and day centers for the aged);
- Programmes targeted at vulnerable groups, including minorities, indigenous people, migrants and people affected by conflicts and disasters (e.g. psycho-social interventions after disasters);
- Mental health promotional activities in schools and universities (e.g. programmes supporting ecological changes in schools, child-friendly schools, and provide guidance and counseling services);
- Mental health interventions at work (e.g. stress prevention programmes);
- Housing policies (e.g. housing improvement);
- Violence prevention programmes (e.g. community policing initiatives); and
- Community development programmes (e.g. 'Communities That Care' initiatives, integrated rural development). housing policies (e.g. housing improvement);
- Violence prevention programmes (e.g. community policing initiatives); and
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MODULE 3

MODULE 3: GENDER MAINSTREAMING

ECOSOC in 1997 defined gender mainstreaming as follows:
"mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making the concerns and experiences of women as well as of men an integral part of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres, so that women and men benefit equally, and inequality is not perpetuated. The ultimate goal of mainstreaming is to achieve gender equality".

Session 1: Understanding Gender Mainstreaming

Gender mainstreaming as a concept was introduced during the United Nations (UN) 3rd world conference on women in Nairobi, 1985. The concept was developed further at the UN 4th world conference on women in Beijing, 1995, which called for international promotion of a policy of gender mainstreaming.

The Beijing Platform for Action (BPFA) in 1995, established gender mainstreaming as a major strategy for development and called for mainstreaming of gender in all critical areas of concern.The UN general assembly,during its 23rd special session in June 2000, underscored and reinforced the importance of gender mainstreaming by following-up the implementation of the BPFA.

Gender mainstreaming has been adopted globally as a strategy to ensure that gender equality is one of the outcomes of all development interventions in social, economic and political spheres, including the health sector. For the health sector, it is an essential strategy since it helps to ensure gender equality and the empowerment of women byidentifying differences and disparities in health inequities and the different health needs and challenges facing men and women across the life course.

In addition, gender mainstreaming definition has two components:**programmatic (operational) gender mainstreaming and institutional gender mainstreaming**. Programmatic (operational) gender mainstreamingsystematically applies gender analysis methods to health problems to better understand how gender norms, roles andrelations affect the health of women and men across the life course.

On the other hand, institutional gender mainstreaminglooks at how organizations function: policy development and governance, agenda-setting,administrative functions and overall system-related issues. Institutional gender mainstreaming acknowledges thatan institution must be equipped with mechanisms to create an enabling environmentfor programmatic approachesto succeed. It also ensures that organizational procedures and mechanisms do not reinforce patterns of gender inequalityin staffing, functions or governance. Itseeks structural changes, calling for a transformation of the public health agendaso as to include the participation of women and men from all population groups in defining and implementing publichealth priorities and activities.Institutional gender mainstreaming addresses the alignment of human and financial resources and organizationalpolicies, which include recruitment and staff benefit policies, such as:establishing work-life balance;sex parity and gender balance in staffing;equal opportunities for upward mobility; andmechanisms for the equal participation of male and female staff in decision-making procedures. Institutional gender mainstreaming also addresses gender equality dimensions in strategic agendas and policy statements as well as monitoring and evaluation of organizational performance, via:

- Developing tools and processes to address gender in planning activities (both institutional and programmatic planning);

- Mechanisms of accountability on gender and health via advisory bodies, steering committees, etc.; and building staff capacity to implement the gender analysis methods required by programmatic approaches

Thus gender mainstreaming is:

- Process or a strategy to work toward the goal of gender equality. It is not a goal in itself.
- An approach to governance that makes men's and women's concerns and experiences an integral part of the design, implementation, monitoring and evaluation of policies and programs in all sectors of society.
- A process that involves changing policies and institutions so that they actively promote gender equality.

The need for gender mainstreaming

Women and men have different roles, rights and responsibilities. Women often have less access to resources and opportunities such as education and training, credit, capital, land and decision making authority. Gender mainstreaming requires a planning process that promotes the well-being and empowerment of both women and men.Gender mainstreaming for the health sector is very significant for the following key reasons:

- It indicates how health problems affect women and men of all ages and groups differently;
- It uses women's empowerment and women-specific conditions to address historic and current wrongs women and girls face;
- It examines how gender norms, roles and relations influence male behavior and health outcomes and how these shape the role of men in promoting gender equality;
- It adopts a broad equity approach to look at issues of age, socioeconomic status, ethnic diversity, autonomy, empowerment, sexuality, etc. that may lead to inequities;
- It provides evidence to enable appropriate, effective and efficient health planning, policy-making and service delivery.
- It is essential for securing human rights and social justice for women as well as men in the health sector.
- It can reveal a need for changes in goals, strategies and actions to ensure that both women and men influence, participate in, and benefit from health systems.
- It can lead to changes in organizations—structures, procedures and cultures—to create organizational environments which are conducive to the promotion of gender equality.

- It calls for transforming the public health agenda, including the participation of women and men in defining and implementing public health priorities and activities. This will ensure that their needs are subsequently met.
- It addresses programme issues, such as how certain diseases or health problems may affect women and men differently, and the process of how institutions are organized to deliver programmes and services in accordance with the principles of gender equality.

Even if gender mainstreaming has been accepted as means to achieve gender equality at global and national levels, resistance and challenge to working on gender – in health and beyond – is still encountered. There are various forms of resistance, misconceptions and challenges to integrating gender into health at all levels. These include:

- Lack of understanding across institutions of what 'gender mainstreaming' means as a concept.
- Inadequate gender-sensitive data systems to inform national policy making and lack of sex-disaggregated data.
- Lack of capacity for gender analysis.
- 'Policy evaporation', where good policies on gender mainstreaming have been lost in translation to programme implementation.
- 'Invisibilization', whereby concrete and positive outcomes of gender mainstreaming are not captured in programme monitoring or evaluation.
- Lack of political and economic commitment to integrating gender into health.
- Thinking that gender is an optional add-on or "something to be done" as an optional programme component.

As gender mainstreaming is a long-term process, it requires time, commitment, resources, partners and gender mainstreaming skills. If public health professionals lack the skills to mainstream gender, public health policies and programmes will continue to fall short, and goals of health equity will remain out of reach. Hence theprerequisites for facilitating a successful gender mainstreaming in the health sector are:

- **Political will:** the political will to mainstream involves the will to question current gender relations and the structures, processes and policies perpetuating inequality. Political will also means getting country's will to mainstream gender equality perspectives into all policies and programs, and indicate that the objectives of policies and programs will effectively promote and lead to gender equality. The government will also have to lay down clear criteria for gender mainstreaming which can help various actors.

- **Gender equality policy framework or separate gender equality policies**
- **Structures and mechanisms to support gender issues and enforce its commitments to gender equality (including gender machinery)**
- **Civil society engagement, along with gender expertise in civil society**
- **Availability of sex-disaggregated data and current research on gender equality**: data on the current situation of women and men, and on current gender relations, are absolutely necessary for mainstreaming. The problem is not only that statistics are not always segregated by sex, but also that data can be gender biased. Good statistics data are relevant for both women and men and that are split up by sex as well as by other background variables.
- **Knowledge of gender relations:**in order to mainstream gender into policies and programs it requires the necessary knowledge of gender relations. Hence, sufficient research in gender studies has to be carried out and made available. Such research would comprise the analysis of current imbalances between the sexes and how future initiatives will affect women and men. Hence mainstreaming requires strong gender studies.
- **Accountability and evaluation frameworks:**
- **Necessary funds and human resources:** financialmeans are an absolute prerequisite for gander mainstreaming, as for any other policy strategy. Mainstreaming implies a reallocation of existing funds
- **Participation of women in political and public life and in decision-making processes:** it isimportant that women enter political and public life and decision-making to ensure that the various values, interests and life experiences of women are taken into account when decisions are made. It is obvious that not every woman is necessarily an advocate for women's issues, but, as a matter of fact, most advocates for balanced gender relations are women. In addition, experience shows that in countries where a greater number of women participate in decision-making, changes are more considerable and take place at quicker rate.

Session 2: Tools and Techniques of Gender Mainstreaming

Before describing the various techniques and tools available, it might be useful to clarify the terms used and the way in which they relate to each other. In this context, techniques and tools are defined as groups or types of means to put the gender mainstreaming strategy into practice, i.e. (re)organize, improve, develop and evaluate policy process in order to incorporate a gender equality perspective. The tools and techniques applied in gender mainstreaming are not new or specially conceived for that purpose. Gender mainstreaming strategies can start from the techniques and tools generally used in the policy process, provided that they are redesigned and adapted to the needs of mainstreaming. Accordingly, gender mainstreaming techniques and tools

are separated into three main sets: analytical, educational, consultative and participatory.

Analytical techniques and tools: there are broad ranges of analytical techniques and tools that can be divided into two categories: those delivering information necessary for the development of policies and those which can be used in the policy process itself. Some examples of analytical techniques and tools are:

- Statistics split up by sex
- Gender analysis and gender audits
- Surveys and forecasts regarding gender relations
- Cost-benefit analyses from a gender perspective
- Research in gender studies, which is one of the most important bases for mainstreaming
- Checklists-setting out objectives, describing actions to be taken
- guidelines and terms of reference – which are not precise but give more freedom to put mainstreaming into practice
- Gender impact assessment is another tool which originates from the environmental sector but has been adapted for the use of mainstreaming. It is a screening of a policy proposal to assess the different effects on women and men and whether their needs are equally taken into account
- Finally, monitoring, comprising regular reporting and meetings, is also a tool to prepare new policies

Educational techniques and tools: contain two main aspects: awareness-raising and transfer of knowledge. Awareness-raising aims at showing how existing values and norms influence our picture of reality perpetuate stereotypes and support the mechanisms (re) producing inequality. It challenges values and norms by explaining how they influence and limit the options taken into consideration and decision-making. In addition, awareness-raising aims at stimulating a general sensitivity to gender issues. Next to awareness-raising, there is a need for training. People have to learn how to detect gender issues and how to develop policies in order take gender into account. Every person involved in gender mainstreaming will have to receive education on the issue of gender equality and mainstreaming. Some of the possible educational techniques and tools are:

- Awareness-raising and training courses – beginning at the highest level of management
- Follow-up action via post-training follow-ups, meeting or mentoring
- Special experts joining a unit for some time ("flying or mobile experts")
- Manuals and handbooks (to be used during and after the training)

- Booklets and leaflets for the general public
- Educational material for use in schools

Consultative and participatory techniques and tools: Gender mainstreaming involves a greater number of people, including external actors, and this requires consultative and participatory techniques and tools. In addition, gender mainstreaming leaves room for involving people who will be affected by policies. Hence, this is a very important tool since it can make gender equality experts and other experts work together. Some of the consultative and participatory techniques and tools include:

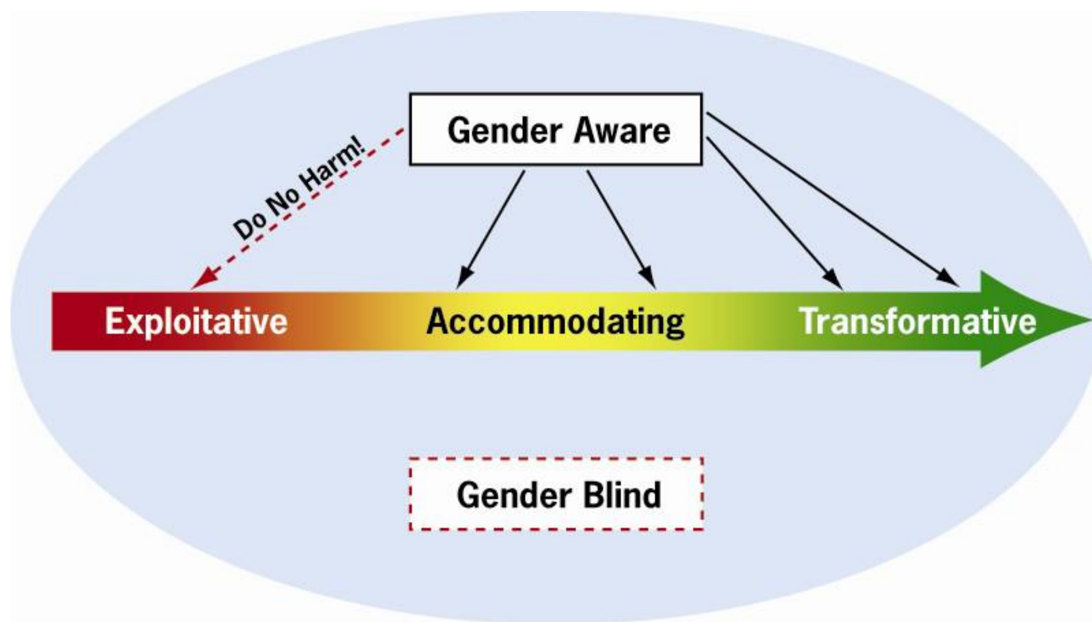
- Think tanks and working or steering groups (interdivisional and interdepartmental collaboration)
- Conferences and seminars that are aimed at informing the public and those concerned by the policies
- Hearingsto help people participate in the policy-making process
- Participation of both sexes in decision-making

Session 3: Gender Integration Processes

Gender Integration Continuum/Scale

Ensuring that existing policies/programs/projects reduce gender-based health inequities requires assessing them for their degree of gender-responsiveness.To guide various projects on how to integrate gender, the Interagency Working Group on Gender(IGWG) has developed a conceptual framework known as the gender integrationcontinuum/scale. This framework categorizes approaches by how they treat gender norms and inequities in the design, implementation, and evaluation of program/policy. Gender continuum concept includes terms such as gender blind, gender aware, Gender exploitative, gender accommodating and gender transformative.

Figure 12: Gender integration continuum/scale



Source: A Manual for Integrating Gender Into Reproductive Health and HIV Programs: From Commitment to Action. 2nd edition. August 2009. USAID and IGWG

Gender blind: refers to the absence of any proactive consideration of the larger gender environment and specific gender roles affecting program/policy beneficiaries. Gender blind programs/policies give no prior consideration for how gender norms and unequal power relations affect the achievement of objectives, or how objectives impact on gender. In contrast, **gender aware** programs/policies deliberately examine and address the anticipated gender-related outcomes during both design and implementation. An important prerequisite for all gender-integrated interventions is to be gender aware.

In the gender integration continuum graphic, the circle depicts a specific program environment. Since programs are expected to take gender into consideration, the term "gender aware" is enclosed in an unbroken line, while the "gender blind" box is defined by a broken, weak line. Awareness of the gender context is often a result of a pre-program/policy gender analysis. "Gender aware" contexts allow program staff to consciously address gender constraints and opportunities, and plan their gender objectives. The gender integration continuum is a tool for designers and implementers to use in planning how to integrate gender into their programs/policies. Under no circumstances should programs take advantage of existing gender inequalities in pursuit of health outcomes ("do no harm!"), which is why, when printed in color, the area surrounding "gender exploitative" is red, and the arrow is broken.

Gender aware programs/policies are expected to be designed with gender accommodating or transformative intentions, or at other points along that end of the continuum. Programs/policies may have multiple components that fall at various points along the continuum, which is why there are multiple arrows in the graphic. The ultimategoal of development programs/policies is to achieve health outcomes while transforming gender norms toward greater equality; therefore, the area around "gender transformative" is green ("proceed forward"), and the arrow extends indefinitely toward greater equality.

Gender exploitative: on the left of the continuum, take advantage of rigid gender norms and existing imbalances in power to achieve the health program objectives. While using a gender exploitative approach may seem expeditious in the short run, it is unlikely to be sustainable and can, in the long run, result in harmful consequences and undermine the program's intended objective. It is an unacceptable approach for integrating gender.

Gender accommodating/sensitive/responsive: in the middle of the continuum, acknowledge the role of gender norms and inequities and seek to develop actions that adjust to and often compensate for them. While such projects do not actively seek to change the norms and inequities, they strive to limit any harmful impact on gender relations. A gender accommodating approach may be considered a missed opportunity because it does not deliberately contribute to increased gender equity, nor does it address the underlying structures and norms that perpetuate gender inequities. However, in situations where gender inequities are deeply entrenched and pervasive in a society,gender accommodating approaches often provide a sensible first step to gender integration. As unequal power dynamics and rigid gender norms are recognized and addressed through programs, a gradual shift toward challenging such inequities may take place.

Gender transformative: at the right end of the continuum, actively strive to examine, question, and change rigid gender norms and imbalance of power as a means of reaching health as well as gender equity objectives. Gender transformative approaches encourage critical awareness among men and women of gender roles and norms; promote the position of women; challenge the distribution of resources and allocation of duties between men and women; and/or address the power relationships between women and others in the community, such as service providers and traditional leaders.

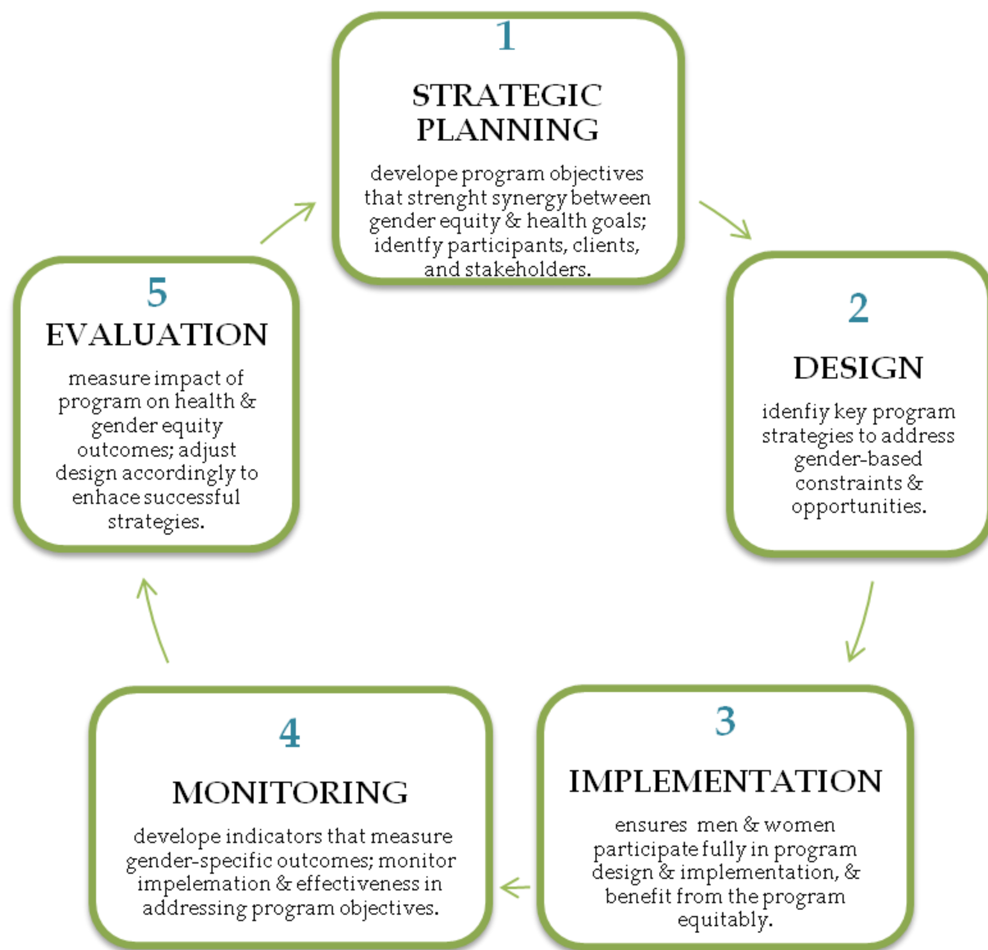
Hence, program/policy planners and managers should follow two gender integration principles in pursuit of health outcomes:

- Under no circumstances should programs/policies adopt an exploitative approach since one of the fundamental principles of development is to “do no harm”.
- The overall objective of gender integration is to move toward gender transformative programs/policies, thus gradually challenging existing gender inequities and promoting positive changes in gender roles, norms, and power dynamics.

Gender Integration Steps throughout Program Cycle

Incorporating a gender perspective in programs involves a series of steps that are sequential. Gender analysis is the foundation of gender integration as it informs gender at each stage of the program cycle. It collects data on gender relations, roles, and identities in relation to the health needs or problems to be addressed by the program. Then analyze information to identify gender-based constraints and opportunities that may affect achievement of health objectives or the relative status of women and men.Hence, a gender-integrated program is flexible, receptive to feedback on progress and problems, and responsive to changes.

Figure 13: Strategic steps for gender integration throughout the program cycle



Source: Adapted from Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action, USAID, August 2009 and Gender Integration Framework, FHI 360, 2012

Steps to gender-integrated programs are:

Step 1- Strategic planning: develop or revise program objectives for their attention to gender constraints and opportunities; restate objectives so that they strengthen the synergy between gender and health goals; identify participants, clients, and stakeholders.

Gender integration in the design of activities begins with the identification of participants and stakeholders, their needs, concerns and interests. To thoroughly assess participants' needs and priorities, gather information from a cross-section of potential participants and interest groups, including men and women of different ages, ethnic groups, and socioeconomic status. Social and economic differences among these groups are likely to affect their capacity to access and use health information and services.

At the beginning of program design, consider developing intermediate results or sub-objectives to specifically address gender-based opportunities and constraints to achieving strategic objectives. For instance: I f women's time is a constraint to seeking antenatal care, consider an intermediate objective that addresses gender-based constraints to access. The objective might be to develop or strengthen satellite services near places women frequent, such as services located close to their places of employment or in mobile units that visit markets and communities.

As time and resources are often limited, program staff—with active involvement of participants and their communities—should examine the feasibility of achieving objectives in light of available financial, human, and technical resources.

Step 2- Design:identify and decide on key program strategies and activities to address gender-based constraints and opportunities. Once the data has been analyzed and has yielded information about gender-based constraints and opportunities, the program team can gain insight into which strategies would achieve the desired program objectives and results. In choosing among different options, the team should consider both feasibility and likely effectiveness for achieving both health and gender equity objectives— choosing a gender accommodating and gender transformative approach (see figure 12).

Step 3-Implementation: implementation strategies are essential opportunities for promoting gender equity and gender equality. It ensures that men, women, girls and boys participate fully in program design and implementation, and that they benefit from the program equitably.

Step 4- Monitoring: develop and monitor indicators that measure gender-specific outcomes; evaluate the effectiveness of program elements designed to address gender issues.

Performance indicators disaggregated by sex are necessary for monitoring progress, health outcomes, and impact of programs on men and women, as well as for assessing if the program is contributing to greater gender equity. One way to formulate gender indicators is in direct relationship to the gender-based constraints and opportunities identified from the gender analysis and project design. Gender indicators measure whether a gender-based constraint has been mitigated or removed, or the impact of taking advantage of a gender-based opportunity. For instance, if women's lack of access to money prevents them from using health services because of users' fees or transport costs, the indicator should measure whether the fees have been removed, transport has been subsidized, or women have been enabled to access services through free mobile clinics. An indicator that measures removal of a gender-based constraint can be

compared to a simultaneous change in health indicators, such as an increase in the use of health services.

Gender indicators are most useful for demonstrating changes in gender relations and impacts when they are developed during activity planning and tracked throughout implementation. Sex-disaggregated data and gender impact indicators provide feedback to implementing agencies and stakeholders on progress, problems, and unanticipated outcomes. They also provide the analytical basis for making informed adjustments to programs during implementation and for the design of future activities. Gender analysis in the planning process helps to define what indicators are required to track differential impacts of activities. Some issues to consider when selecting indicators:

- Are indicators disaggregated by sex, ethnic group, age, and socioeconomic status?
- Are baseline data collected on women and men of different ages, socioeconomic status, and ethnicity?
- Are there specific indicators to measure changes in gender relations, access to services and resources, and power?
- Does the project have a systematized way for collecting and analyzing the information on a regular basis?
- Does the project have policies about what to do when monitoring and evaluation data reveal gender inequities?

Step 5- Evaluation: measure progress and impact of program and policies on health and gender equity. Make recommendations to adjust design and activities based on monitoring and evaluation results; strengthen aspects of the program that contribute to more equitable health and gender outcomes, and rework aspects that do not.

Evaluation involves comparing outcomes at two or more points in time (typically baseline and endline) to ascertain change. In evaluating a gender analysis, some key questions include:

- Has stigma and discrimination against people who do not follow traditional gender norms and behaviors been reduced?
- Has the removal of gender-based constraints contributed to improved health outcomes?
- Are institutions and organizations more supportive of gender equity and less discriminatory?
- Have identified changes contributed to increasing access to healthcare and information, as well as to changes in health seeking behavior and outcomes.

Evaluation can also help to identity what did not work well and why. A second round of gender analysis can reveal important dimensions of gender relations that were overlooked or missed initially. For instance, a program focused on ensuring that key health messages were attuned to the different needs and concerns of men and women might have overlooked the different media and interpersonal contexts through which men and women generally receive information. Therefore, effective messages may never have arrived at their intended audiences. If the program is not achieving its intended results, activities may need to be redesigned in order to more effectively address gender inequalities and to increase the prospects for achieving desired program outcomes.

Module 3 References

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MODULE 4

Gender analysis is a process that assesses the differential impact of proposed and/or existing policies, programs and legislation on women and men.

MODULE 4: GENDER ANALYSIS

Session 1: Understanding Gender Analysis

Gender analysis identifies, assesses and informs actions to address inequality that stems from: gender norms, roles and relations; unequal power relations between and among

men and women; and the interaction of contextual factors with gender, such as ethnicity, education or employment status. It is a methodology for collecting and processing information about gender role, norm, and relation in order to anticipate and avoid any negative impacts of health related interventions may have on women and men.

Gender analysis is one of the core gender mainstreaming tools that generates and processes information needed for health planning and programming. It includes critical questions that dig for information where it is often not easily found.

Gender analysis in health examines the consequences of gender inequality with respect to health and well-being. Gender analysis contributes to understanding health services and disparities among and between groups of women and men in the following areas: risk factors and vulnerability; and patterns of disease, illness and mortality. It also assesses the health effects of policies, legislation/programmes, services and research, specific health conditions and problems, human resource planning, budgeting and operational planning.

Gender analysis in health can highlight differences in access to:

- Health services and other necessary resources for preventing disease and promoting health, such as education, transportation, information, and
- Decision-making processes related to health and the organization of health systems.

Rationale for gender analysis

Gender analysis is important to health and health outcomes since it:

- Contributes to the understanding of differential health risk factors; exposures and manifestation of disease; difference in severity and frequency of disease; responses of the culture, society and health to these problems.
- Highlights difference in access to health care and resources; information, transport, communication and services; decision-making process.

In addition to this, gender analysis helps to increase health sector effectiveness by:

- Ensuring the right to health of different groups of men and women
- Identifying practical and strategic gender needs in health
- Recognizing and reducing the constraints women and men face in protecting and promoting their health

- Considering and addressing how male gender norms, roles and relations may harm the health of men and women
- Reducing inappropriate, ineffective services, programmes or policies that ignore the realities of women's and men's health needs and life conditions
- Identifying and reducing gender bias in the health system
- Developing and implementing gender-responsive policies, laws, programmes and services
- Improving health information, documentation and use

Principles of gender analysis

The guiding principles of gender analysis in health are:

- Women and men are different. Women and men, boys and girls are not the same at any stages of their lives, either by biology, role, responsibilities, opportunities and choices. Considering culture, age and other factors also addresses the range of differences between women and men.
- Policies and programmes do not affect men and women in the same ways. Policies and programmes that are developed without considering these differences ignore the diverse needs and realities of men and women. For instance, the health policy of Ethiopia gives focus to maternal and child health.
- Evidences are needed to understand how gender operates as a determinant of health. Gender analysis must be informed by data gathered from multiple sources, including consultations with diverse groups of women and men. Surveillance, monitoring and health research activities should be based on both quantitative and qualitative methods. Available data must be disaggregated by the variables used in gender analysis. Disaggregation by sex is the bare minimum requirement.
- Gender analysis, as the first step in gender mainstreaming, requires sustained commitment and attention to attain results in the short-, medium- and long-term.
- For better analysis of a health problem/issue, the process should include the participation of members who truly represent the target groups, as well as experts on the topic, and experts from different sectors and disciplines.

Session 2: Gender AnalysisFrameworks and Tools: Gender Analysis Matrix

Gender Analysis Frameworks and Tools

There are different frameworks for undertaking gender analysis. No single framework provides an appropriate way to address all development problems. Hence it is

important to select the most appropriate framework for your specific need, and to follow one particular model or use a combination of methods depending on the situation at hand. Five of the most commonly used gender analysis frameworks are the following:

- The Harvard Analytical Framework (Gender Roles Framework),
- The Moser (Triple Roles) Gender Planning Framework,
- Women's Equality and Empowerment (LONGWE) Framework,
- The Social Relations Approach Framework, and
- Capacities and Vulnerabilities Analysis Framework.

Harvard Analytical Framework/Gender Role Framework: It helps to make an economic case for allocating resources to women and men, and provides planners to design more efficient projects. It is useful for projects that are agriculturally or rurally based, that are adopting a sustainable livelihoods approach to poverty reduction. It is also useful to explore the twin facts of productive and socially reproductive work, especially with groups that have limited experience of analyzing differences between men and women. The framework is designed as a grid (or matrix) for collecting data at the micro level. It uses four interrelated tools: activity profile**,** access and control profile – resources and benefits, influencing factors, project cycle analysis, and gender analysis matrix.

The Moser/ Triple Role/ Gender Planning Framework: It was developed as a planning tradition in its own right. It takes the view that gender planning, unlike other mainstream planning, is both technical and political in nature. There are six tools in the framework that can be used for planning at all levels from project to regional planning. The tools are: gender/triple role identification (productive, reproductive and community role) and gender need assessment (practical and strategic needs).

Women's Equality and Empowerment/LONGWE Framework: It provides a tool for answering the question as to what equality and empowerment means in practice and to what extent a development intervention is supporting empowerment. The Longwe framework assesses the level of women's empowerment in any area of economic and social development. The tools used in this framework are the following:

1. Levels of equality (control, participation, concretization, access and welfare),
2. Level of recognition of women's issues (negative, positive and neutral levels),
3. Disaggregating control of resources and decision-making within a household (intra- household resource allocation and power of decision-making within the household),
4. Balancing of triple roles,

5. Women in Development/Gender and Development Policy Matrix (the WID /GAD policy matrix), and involving women, gender aware organizations and planners in planning.

Social Relations Approach Framework: The framework analyzes existing gender inequalities in the distribution of resources, responsibilities and power and to design policies which enable women to be agents in their own development. Concepts rather than tools are used in this framework in order to focus on the relationships between people, and their relationship to resources and activities, and how they are re-worked through institutions. The essential components of Social Relations Approach are: human well-being, social relations and institutional analysis. Hence, this framework assess the nature of institutional gender policies as to being gender blind, aware, neutral, and redistributive.

Capacities and Vulnerabilities Analysis (CVA) Framework: It was designed specifically for use in humanitarian interventions, and for disaster preparedness. It was developed from a review of thirty case studies of NGO responses to disaster situations around the world. It aims to assist outside agencies to plan interventions in a way that meet the immediate needs of people, build on their strengths, and support their efforts to achieve long- term development.

The core concept of the CVA is that people's existing strengths (capacities) and existing weaknesses (vulnerabilities) determine the effect that a crisis has on them and their response to it. Capacities relate to people's material and physical resources of people, their social/organizational resources and their attitudes. Vulnerabilities are the long-term factors that weaken people's ability to cope with unexpected disaster or prolonged emergencies. They exist prior to disasters and continue after it. In the CVA a distinction is made between vulnerabilities and needs. In the context of a disaster needs are addressed by providing short-term interventions, (for example, food or shelter), whereas vulnerabilities require strategic long-term development. Tool used in this framework are the following: categories of capacities and vulnerabilities (physical/material, social/organizational, motivational/attitudinal), and additional dimension of complex reality (sex-disaggregated data).

Gender Analysis Matrix (GAM)

Among the various gender analysis tools, WHO uses gender analysis matrix (GAM) as a tool to identify, assess and address inequality that stems from gender norms, roles and relations; unequal power relations between men and women; and the interaction of factors such as education or employment status with gender.

The gender analysis matrix (GAM) has two key components that are required to assess factors that influence health outcomes. The first component is gender analysis lenses/gender-related considerations (gender roles and norms;access to and control health services/resources; biological/physiological differences) in the horizontal axis and the second component is health-related considerations (risk factors and vulnerability; access and use of health services; social and economic health outcomes or consequences of health problems) in the vertical axis.

The vertical axis (health-related considerations) of the GAM contains important factors that interact with the horizontal axis (gender-related considerations/gender analysis lenses). The intersection of the horizontal and vertical axes provides a framework for conducting gender analysis in health and helps to recognize differences and disparities as to who gets ill, when, where and why – and what the health sector is doing about this. Below are some brief explanations of the health- related considerations with some pertinent ways in which gender may affect them.

Table 4: Gender analysis matrix

Factors the influence health outcomes: Health-related considerations/issues/ problems	**Factors that influence health outcomes: Gender-related considerations/issues/problems**		
	Biological/physiological factor: How do biological differences between sexes influence men's and women's	**Socio-cultural factors:** How do gender norms/roles/relations affect women's and men's and men's	**Resource factors:** How do access to, and control over resources influence men's and women's
Health risks and vulnerability			
Ability to access and use health services			
Health and social outcomes/ Consequences of health problems (economic and social, including attitudinal)			

Source: Adapted from Gender Mainstreaming in Health: A practical guide, Pan America Health Organization (PAHO), adopted from WHO manual "Gender Mainstreaming for Health Managers: A Practical Approach"

A. Gender Analysis Lenses/Health-Related Considerations in GAM

Biological/Physiological factors: examples of how biological factor affect health behavior and outcomes of men and women

Being male or female has an impact on our health risks, utilization of health services, and overall health outcomes. The biological determinants of health and illness include differential genetic vulnerability to illness, reproductive and hormonal factors, and differences in physiological characteristics during the life-cycle. The following examples illustrate how sex (biological differences between men and women) can affect health:

- Women are more prone/ vulnerable to HIV infection because of anatomical factors (e.g. physiology of genital tract); and complication of pregnancy.
- Anatomical differences between men and women can affect how drugs and or other chemicals act in the body. For example the same drug can cause different reactions and different side effects in women and men, even common drugs like antibiotics. Similarly, women who smoke have higher probability of developing lung cancer than men who smoke the same number of cigarettes.
- During the ageing process, women have finite period of reproductive functioning. Their menopausal transition is associated with mood fluctuations and a decline in sexual interest relating to hormonal change. As they age, men and women suffer from similar types of illnesses but men tend to suffer from acute illnesses for relatively short periods before they die. Women, by contrast, have a longer life, marked by many chronic non-life-threatening disabilities that can greatly affect the quality of their lives. For example, osteoporosis, due to a natural decline in bone density after menopause, affects mainly women.

Socio-cultural factor: examples of how gender norms affect health behavior and outcomes of men and women

Low social status of women can contribute to higher rates of blindness. Available studies consistently indicate that, in every region of the world and at all ages, females have a significantly higher risk of being visually impaired than males. Nevertheless, many women do not have equal access to surgery for eye diseases due to inability to travel to a surgical facility unaccompanied, differences in the perceived value of surgery for women and/or lack of access to health information.

Depriving girls of education opportunities can damage their health. Low levels of education among girls undermine their ability to acquire health information and render them less able to understand health information materials about risk, vulnerability and the signs and symptoms of illness, ultimately impeding their timely access to health services. Lack of education for girls is also a risk factor for early marriage, early childbirth/unintended pregnancy and higher fertility rates, as well as lack of negotiation skills to practice safer sex and effectively access and use family planning services. In some contexts, girls are removed from schools to care for ill family members or engage in commercial sex work to supplement household incomes, exposing them to several, compounded health risks.

Teaching boys to be men according to harmful norms and rites of passage encourages them to put their lives and those of others at risk. Through processes of socialization, many boys are taught they should not cry (to avoid being "girlish") and that violence is an accepted problem-solving technique (for example). Specific rites of passage into adulthood can involve tobacco, alcohol or drug consumption or unsafe sex with multiple partners. The health repercussions of such socialization include delays in seeking health care, substance, alcohol and tobacco use, which can lead to chronic health problems and even death. Other consequences include increased exposure to STI, including HIV.

Socio-cultural factor: examples of how gender roles affect health behavior and outcomes of men and women

Domestic tasks are considered women's work and can jeopardize their health. The risk for schistosomiasis is greater for women generally due to their greater domestic responsibilities, such as washing clothes in rivers infected with parasites. Elevated risk of exposure to unsafe smokes in low- and medium-income countries during food preparation, with the associated elevated risk of chronic obstructive pulmonary disease, is another example of how gender roles can increase women's risk and vulnerability to illness and poor health.

Men's jobs contribute to higher reports of injury among men of working age. The gender-based division of labor tends to define male occupations (or male gender roles in the work place) as truck drivers (with an increased risk of road traffic injuries) and in the construction industry (with an increased risk of occupational injuries due to operating heavy machinery, accidents and falls from heights). These roles contribute to the fact that men are overrepresented in nearly all forms of traumatic injury.

When men take on domestic roles and provide support to female partners during pregnancy and childbirth, it has shown to decrease pain and stress levels – leading to

improved overall maternal and child health outcomes including: fewer low-birth-weight infants among low-income families; improved cognitive outcomes for preterm and low-birth-weight babies; shortened labour time and lower rate of epidural use; and obstetric emergencies may be alleviated.

Socio-cultural factor: examples of how gender-relations affect health behavior and outcomes of men and women

Unequal power relations between women and men contribute to gender-based violence. Women experience physical, sexual and mental violence in their homes, often from intimate partners, in conflict settings and in communities. Sometimes they die from this violence, and at other times, they remain in unsafe settings. Normalized unequal gender relations between women and men contribute to the numerous cases of interpersonal violence experienced by women.

Early and/or forced marriage places young girls at risk for early pregnancy and unsafe, coerced sex which can lead to the transmission of HIV or other STI. Early marriage also removes girls from schools (thereby increasing the range of health effects due to lack of education), reduces their decision-making power within households and may even limit their social support networks, which are often crucial to ensuring informed and timely health-seeking behavior.

Resource factor: examples of how access to and control over resources affect health behavior and outcomes of men and women

Health-related resources can refer to economic, social and political resources. Lack of access to disposable income or to transportation can prevent women from using available health care facilities that exist in the community. Lack of flexible hours of operation is another issue related to access that constraints women and men from accessing health services. Recognizing this, Ethiopia has started the provision of free service for maternal and child health, which is also affirmed by law; practice community health insurance system; and strengthened the use of its traditional ambulance.

On the other hand, women and men may have access to the use of a condom to protect themselves from STIs but, at the time of sexual relations, may not have the ability to define or control condom use.

B. Health-Related Considerations in GAM

Risk factors and vulnerability

Risk can mean a probability, i.e. the risk of getting AIDS from unsafe sexual activity or an infected needle. It can mean a potential danger, i.e. gender norms and roles that undermine pregnant women to seek health care increases the risk of maternal and infant mortality. Or risk can mean consequences, i.e. a boy who has experienced violence in the family could himself be violent person.

Risk factors are elements associated with the development of disease or illness, or the underlying causes of disease and illness. Some risk factors, such as tobacco consumption, are related to several diseases, whereas some diseases, such as cardiovascular disease, are related to several risk factors. Understanding them can lead to interventions that diminish the harmful effects of exposure or eliminate exposure altogether.

Exposure to such risk factors is often linked to gender norms, roles, and relations and therefore differs among and between populations of women and men. For example, women and men are often in different occupations, with variable risks for work-related illnesses or accidents.

Vulnerability refers to factors that put an individual at increased risk. For example although both women and men can be affected negatively by "gender" women's disadvantaged social, economic and political status further undermines their ability to protect and promote their own physical, emotional and mental health, including their effective use of health information and services

Globally, women and men tend to preform different tasks within and outside the household. Women spend more time doing unpaid household work and caring for children, regardless of whether they work outside the home for pay. Pregnant women may experience prolapse of the uterus during pregnancy due to heavy loads carried while gathering fuel. Low-birth-weight infants – even stillbirth – may result from exposure of the developing fetus to harmful pollutants as pregnant women attend to domestic tasks. This means that gender roles may increase omen's vulnerability to certain conditions.

Differences in access to and control over resources may increase vulnerability to illness and disease. For example, in many countries, males have better access than females to nutritious food. Having less access to nutritious food, a lifestyle risk factor, increases the vulnerability of females to infectious diseases and to complications in childbirth. Gender inequality-driven uneven feeding practices between girls and boys also contribute to increased vulnerability to illnesses such as anemia among girls and women.

Ability to access and use health services

Components of access are the following:

- ***Availability*** - existence and sufficiency of needed health services,
- ***Affordability*** - patients' ability to pay for services, including free services and other coverage issues,
- ***Accessibility*** - location of population and services, transport and other related costs to access and use health services such as transport costs,
- ***Accommodation*** - compliance of health services with the time and communication needs of patients, which contributes to the perceived quality of the services received, and
- ***Acceptability*** - fit between services and the community or individual, based on cultural understandings.

Access to quality health care and the use of these services are crucial factors in determining positive health outcomes. Efforts to ensure proper access to and use of quality health services should address all components. For example, restrictions on the physical mobility of women and their decision-making power create obstacles for women with respect to accommodation, accessibility and acceptability. On the other hand, accommodation can refer to the fact that *the* daily tasks (paid or unpaid) of men and women may restrict their ability to effectively access and use health services. The opening hours of health facilities rarely consider the daily tasks and work of men and women – and their resultant access to and use of health services.

Health and social outcomes /Consequences of health problems

Health and social outcomes and consequences refer to what happens to a person with poor health. It relates to disease or illness manifestation and associated recovery, disability or death. Gender considerations often influence how these outcomes influence a family or individual. Health problems or conditions have economic, social and attitudinal consequences that can reach everyone in the social network – placing increased burdens on some more than others. Factors that affect health and social outcomes and consequences include: monetary costs; duration and severity of a health problem; type of care needed, its availability and accessibility; available social networks and stigma.

Table 5: Gender analysis matrix for analyzing HIV and AIDS

Health issue/ Problem	How do biological differences between sexes influence men's and women's:	How do gender norms/roles/relation affect women's and men's and men's:	How do access to, and control over resources influence men's and women's:
Health risks and vulnerability	Women are more prone/ vulnerable to HIV infection because of: • Anatomical factors, e.g. physiology of the genital tract • Complication of pregnancy, with associated possibility of transfusion • Unsafe abortion put women at greater risk of HIV infection	• Women are more prone to HIV infection because of their inability to negotiate condom use • Women, especially young girls, find it difficult to purchase or procure condoms • Women who carry condoms are sometimes perceived to be promiscuous rather than careful; men with condoms are seen as being careful and safe • Young girls with condoms are seen as being sexually active, which is a "negative" perception • Women are more likely to be victims of sexual violence, especially in war-torn areas, which puts them at greater risk of HIV infection • Men are more likely to exhibit HIV risk behaviors, such as multiple partners and intravenous drug use • Masculinity encourages young men to seek sex as conquests and being "macho" • In some communities, there is a belief that having sex with a virgin will not expose to HIV infection. • Peer pressure to have unprotected sex put young girls and boys at risk of HIV and AIDS	• More men than women have access to information on HIV and AIDS. • More women than men experience poverty and more women than men are involved in commercial sex work to access and control resources • Lack of security and breakdown in the social order puts more women than men at risk of sexual violence
Ability to access and use health services		• Adolescent girls may not be allowed to access sexual and reproductive health information from health facilities and health workers, because they are not married and are not allowed to have sex • Lack of privacy in health clinics keep more women away than men since general knowledge of positive HIV status is more devastating for women than men in some societies • In some communities, women need permission from the male head of household to visit clinics • In communities where early marriage is practiced, younger women and girls are not able to seek health care due to health illiteracy and lack of experience • Attitudes that many health providers have toward women clients may impede access to preventive and curative services	• Women have a more difficult time negotiating with their male partners to go for an HIV test than the other way around because of the power differential in the relationship
Health Outcomes /Consequences of health problems (economic and social, including attitudinal)	• Mental health disorder • Death due to the disease	• Women's roles as caregivers put an extra burden on them, and put their health at risk	• A diagnosis of HIV infection in a woman may result in abandonment by her husband and family in many cultures

Source: Adapted from Gender Mainstreaming in Health: A practical guide, Pan America Health Organization (PAHO), adopted from WHO manual "Gender Mainstreaming for Health Managers: A Practical Approach", April 2011

Session 3: Gender-Sensitive Monitoring and Evaluationfor Health Programming

Defining Monitoring and Evaluation

Monitoring and evaluation are indispensable learning and management tools for improving current and future program planning, implementation and decision-making. Monitoring and evaluation structures, systems and processes should be built into public health programs from the design phase and carried out through the lifetime of the project/program. It is therefore necessary to ensure a clear understanding of the basic principles of Monitoring and Evaluation before demonstrating how gender sensitivity can be introduced into such a system.

Monitoring is routine collection and analysis of and reporting on information about the performance of the work in a programme or project, comparison of this with the programme or project plans, and connected discussions about and proposals for any corrective action.Both quantitative and qualitative data areused in monitoring, and information may be collected using a number of sources and researchmethods, including administrative records, surveys, focus group discussions, and participantobservation.

Evaluation is an objective and systematic assessment of processes and outcomes related tothe undertaking and implementation of an activity, project or programme. It is an importantsource of evidence of the achievement of results and the performance of institutions and persons in the process of achieving these results. It helps program and policy formulators to understand the processes by which intended and unintended results are achieved, and the impact of these results on stakeholders.

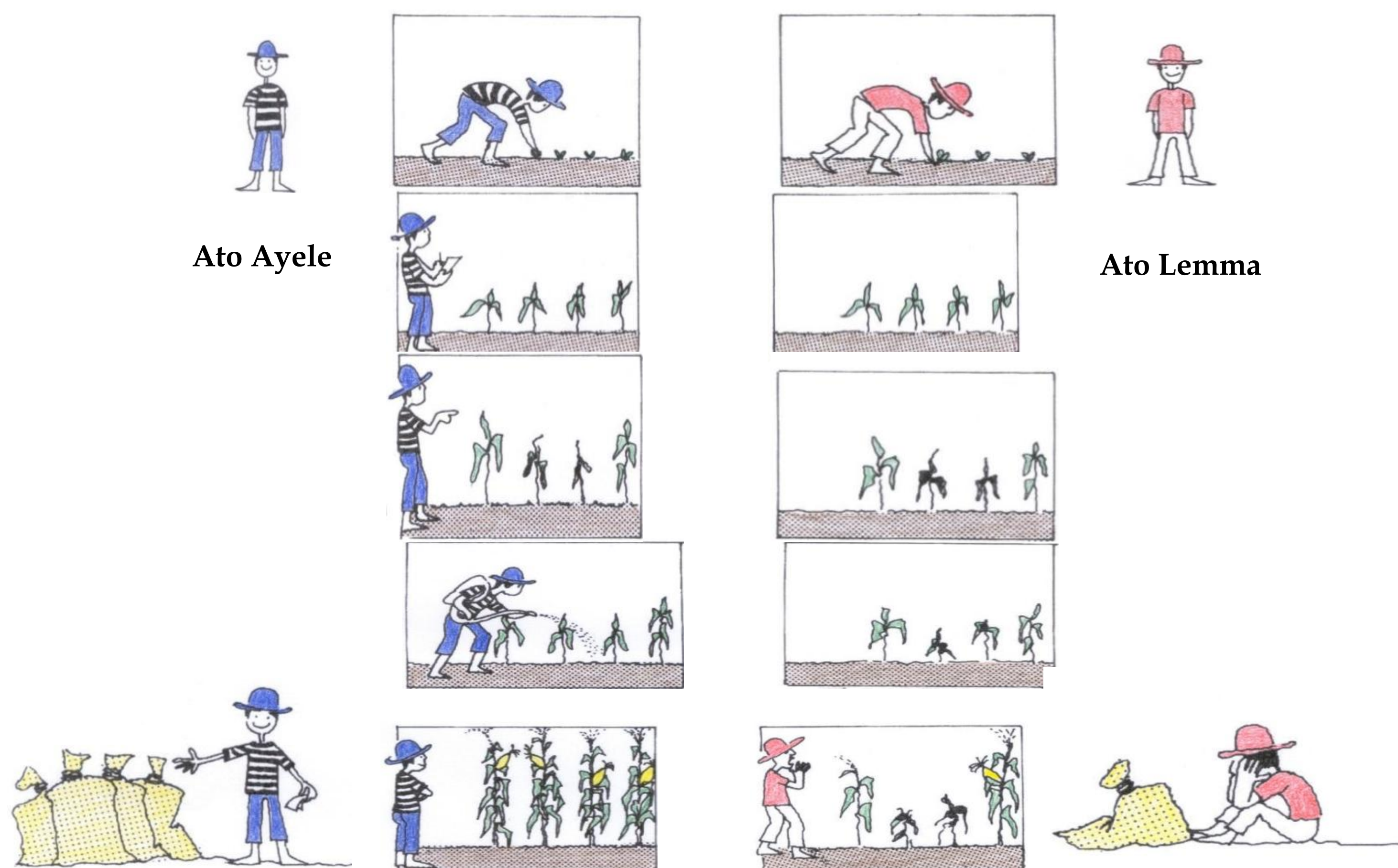
Table 6: Links between monitoring and evaluation

Monitoring	
tly,ona permanent basis.	Takesplacelessfrequently, various stages.
	Assessment
ideinformationforreprogrammingtoimproveoutcomes	Improve effectiveness, imp valueformoney,futurepro
, work plans(operationalimplementation)	Effectiveness,relevance,im
ts,registers,administrativedatabases,fieldobservations	Scientific,rigorousresearch

ystem,fieldobservationreports,progressreports,rapidassessment,programreviewmeetings	Samesources usedformoni basedsurveys,vitalregistra
sspreadacrossimplementationperiod	Episodic,oftenfocusedatth

Source: Monitoring and Evaluation Toolkit: HIV, Tuberculosis, Malaria and Health and Community System Strengthening. The Global Fund, November 2011, 4th edition.

Figure 14: Justification for conducting monitoring and evaluation



Gender-Sensitive Monitoring and Evaluation for the Health Sector

Because women are visible in the health-care system both as caregivers and as clients, there is a widespread misperception that health projects automatically address women's empowerment. Gender gaps in health status, in access and use of health services, and in health outcomes persist, signifying a need to address gender inequality in health sector.

If gender is to be successfully integrated into activities for health and development this requires developing an appropriate framework for assessing progress and the actual impact of these activities. Gender-sensitive monitoring and evaluation provides such a framework. It is used to show the extent towhich a project, programme or policy addressesthe different needs of men and women. It reveals the impact on their lives, their health and their overall social and economic well-being. It can also improve project performance during implementation, through mid-term evaluations, and it can help to develop lessons for future projects. In addition to this, through a gender-sensitive monitoring approach helps to observe to what extent a programmes outputs benefit women and men, how to address health sector specific issues taking into account the different capacities and constraints women and men may face, and proposes corrective paths to address inequalities. Hence, a gender-sensitive/responsive evaluation process:

- Helps the identification of factors that affect the lives of women and men; influencing their roles in society and the balance of power in their relationships. It will therefore point to their differing needs; their structural and biological constraints; and opportunities; as well as the differential outcomes and the impacts that these differences contribute to life experiences in specific programme areas such as maternal mortality, HIV and AIDS, and violence.
- Uses methods to assess the roles of women and men in addressing the issues the programme aims to address and the achievement of the outcomes.
- Measures how the programme's outputs have affected women and men – what are the direct benefits from the interventions; how they improve women's and men's wellbeing; how they empower women and men; to what extent the programme challenged traditional power relations, introduced practices that promote equity, and reduced gender inequalities; to what extent women's and men's needs have been addressed; how addressing gender issues has contributed to dealing with the development or environmental issues at stake.
- Uses gender-sensitive indicators and data categorized by sex, age ethnicity etc.
- Adopts a gender lens throughout the programme process

Gender-sensitive monitoring and evaluation requires a mix of input, output, process, outcome and impact indicators that reveal the extent to which an activity has addressed the different needs of women and men. This information should feed into the program on a continual basis to improve implementation and maximize efficacy and efficiency.

Key activities for an effective gender-sensitive/responsive monitoring and evaluation of projects/programmes/policies include:

- Conducting gender analysis in form of a baseline study to identify the gender related goals.
- Design a logical framework that includes gender-sensitive outputs/outcomes/impacts.

- Identifying and integrating gender-related goals and priorities – even in programmes without explicit gender focus (i.e. infrastructure, etc.)
- Assessing institutional capacity for integrating gender into health-related activities.
- Ensuring all staff are gender aware - provide training if needed.
- Assessing the impact of gender integration in the overall project context - gender impact statement.
- Ensuring a gender balance and approach in all interaction with project/program beneficiaries e.g. interviewers, facilitators, liaison staff.
- Using and collecting sex-disaggregated data during entire programme phase.
- Ensuring baseline studies are gender-sensitive and include sex-disaggregated data.
- Including indicators that measure gender differences in outputs and outcomes.

Sex-disaggregated data is collected, analyzed and reported separately for men and women, boys and girls. This is an important starting point for gender analysis. However one has to go beyond the numbers since looking at data disaggregated by sex alone leaves out some important information. When ethnicity, age and socioeconomic status are added to the data one can easily target programs,projects and policies.

Designing Gender-Sensitive Monitoring and Evaluation

Indicators are defined as "*statistical series, and all other forms of evidence that enable us to assess where we stand and where we are going with respect to values and goals, and to evaluate specific programs and determine their impact*." Indicators are the building blocks of an effective monitoring and evaluation system, but they are highly context specific and uniquely representative of a particular program or project. A gender-sensitive indicator, therefore, can be defined as "*an indicator that captures gender-related changes in society or in the context being dealt over time*".

In order to measure how well a health project or programme has scored in its gender targets and if its results relating to gender equality have been achieved, indicators must be gender-sensitive. Gender-sensitive indicators can measure gender-related changes in society over time. Gender-sensitive indicators are important practical tools because the information produced can be used to advocate for gender equality and advance the agendas of women's empowerment.

In order to make a monitoring and evaluation system gender-sensitive, the following methodologies should be integrated:

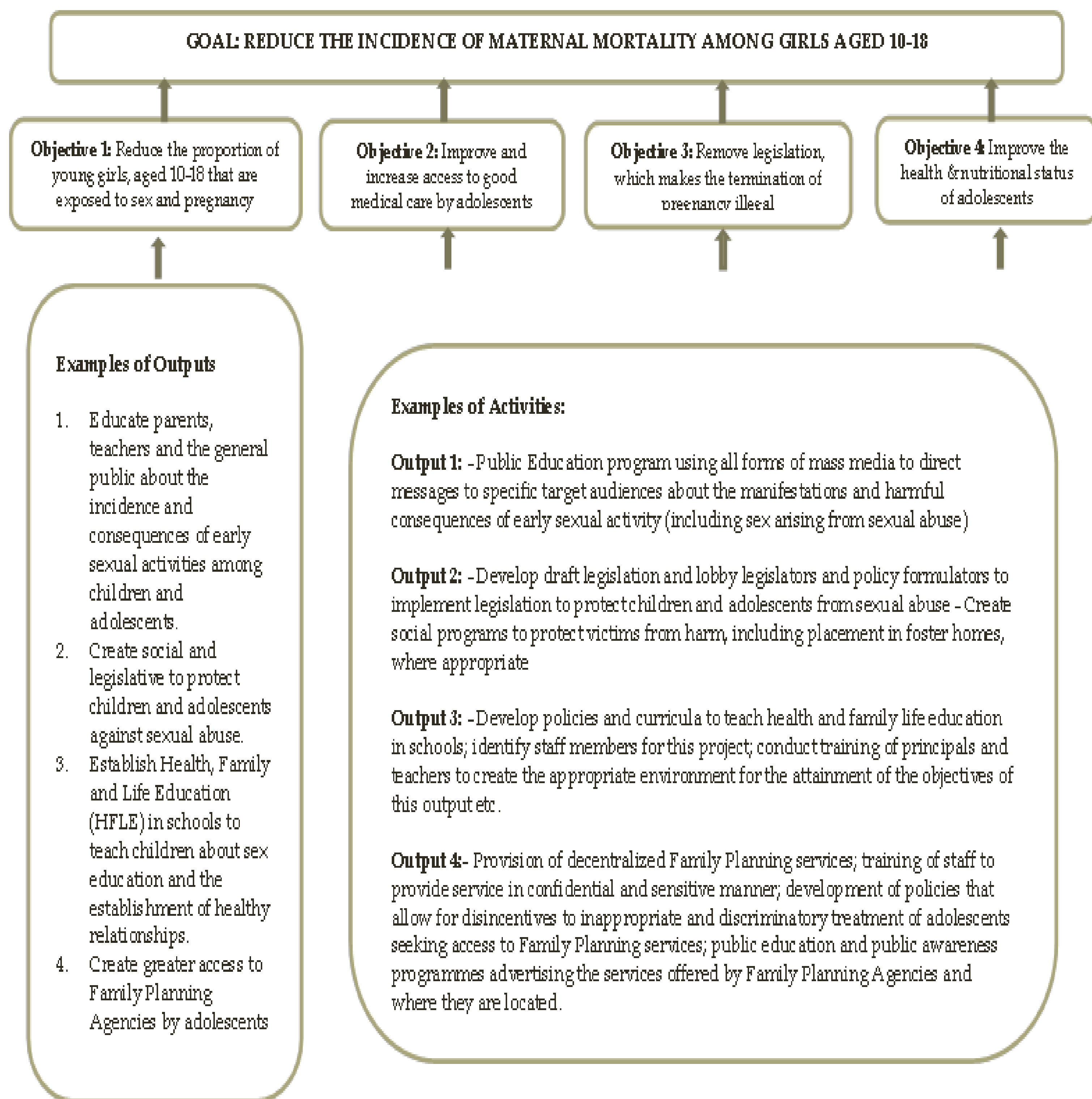
Gender analysis: A gender analysis is necessaryin order to monitor and assess how an intervention affects women, men, gender relations and gender equality thereby determining what the starting point is. Such a study should address not only the policy and normative frameworks of the programme or project, but also carefully discerned power relationships, and identify the structural causes of gender discrimination and

inequalities in employment and occupation. A gender analysis, therefore, has to form part of every baseline study.

Disaggregation of various stakeholder groups: Data should be collected in a disaggregated manner by gender, ethnicity, age etc. Gender-disaggregated data is needed in all types of monitoring, evaluation, auditing, orimpact assessment process. It is important that indicators or other tools for monitoring andevaluation provide disaggregated data by sex because information is not neutral and is likely todiffer between women or men. Data will often need also to be disaggregated along other linessuch as age, urban/rural, ethnic group, disability, etc.

Mixed Methods approach (qualitative and quantitative): Gender issues are so linked to cultural values, social attitudes and perceptions. Therefore,measuring those means using a variety of indicators composed of quantitative and qualitative information. Qualitative analysis is used to understand social processes, why and how a particular situation measured by indicators has taken place and how such a situation could be changed in the future. Qualitative analysis should be used in all stages of the project cycle. Hence it is possible to use appropriate mix of qualitative and quantitative methods to gather and analyze data. This includes, and is not limited to: desk review, interviews, focus groups, surveys, etc.

Figure 15: Gender-sensitive monitoring and evaluation for maternal mortality project



Source: L. Joseph Brown (2006). *Book II: setting up a gender-sensitive monitoring and evaluation system: the process.* UNICEF

Table 7: Maternal Mortality Reduction Project Log frame

Project Description	Performance Indicators	Means of Verification	Assumptions
Goal: • Reduce the incidence of maternalmortality among girls aged 10-18	1. The proportion of pregnant girls aged 10-18 who died while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.	1. Hospital administrative records 2. Census data from country statistical offices 3. Databases of international and regional organizations with comparative advantage in this area e.g. WHO	1. There is a strong capacity and capability for the collection of gender sensitive social statistics, including statistics on maternal mortality
Objective: • Reduce the incidence of young girls,aged 10-18 that become pregnant • Reduce the incidence of sexual abuse among adolescents 10-18 • Reduce the proportion of young girls, aged 10-18 that are sexually active at an early age	1. 50% reduction, over a two-year period, in pregnancy rates among girls aged 10-18, compared to baseline data 2. Increase in the use of birth control methods among sexually active adolescents of consenting age 3. Reduction in reports of incest among adolescent girls 4. Reduction in the reports of rape and sexual assault of adolescent girls 5. Reduction in the incidence of minors who reported having sex 6. Reduction in the incidence of adolescent girls who report having multiple sex partners	1. Data from Reproductive Health Surveys 2. Administrative records of Family Planning Agencies 3. Police records on reports of rape and incest	1. Reduction in reports are not due to poor response, including failure to report on behalf of minors, from duty bearers 2. Police maintain proper administrative records of reported incidents of rape and incest. 3. Gender norms are not so rigid and inflexible as to create resistance to any initiative to deal with the issue
Outputs: • Policy reforms • Legislative reforms • Social Programs • Institutional reforms • Capacity development	1. The development of policy for the introduction of HFLE in schools 2. Age-appropriate curriculum development for HFLE in primary and secondary schools 3. Training of teachers/educators to teach HFLE in schools 4. Drafting and enforcement of legislation that protects children from all forms of violence	1. Ministry of education through administrative reports and interviews with key program and policy formulators 2. Reports of training activities conducted 3. Review of draft	Governments commitment and support to the creation of the legislative and policy environments within which these activities need to take place

Project Description	Performance Indicators	Means of Verification	Assumptions
	and abuse, including rape and sexual abuse, in and out of the home 5. Creation and identification of physical places of protection for children who need to be removed from places of abuse 6. Decentralization of Family Planning Agencies (FPAs) to increase accessibility to adolescents 7. Training of staff members of FPAs to deliver service that is confidential and preserves the dignity of clients	legislation (Justice Department) 4. Review of activities and the reports of the Social Welfare Department in the areas of child welfare and reproductive health 5. Interviews with key social policy formulators in the relevant departments	
Activities/Inputs: **1.** Public Education activities using all forms of mass media, as well as popular communication **2.** Workshops for parents and teachers on the education of children on issues related to HFLE **3.** Legislative committee consisting of lawyers and gender experts to draft legislation and policies **4.** Committee of educators and other stakeholders to draft education policy on the teaching of HFLE in schools and the development of relevant curricula in this area. **5.** Financial resources, budgeted according to the components of the project	1. Number of Public service announcements delivered on radio, television and newspaper 2. Use of theatre, community announcements, flyers 3. Number of workshops conducted in schools within the areas in which the project is being implemented 4. Public consultations around the draft legislation and policies created 5. The introduction of HFLE curriculum, starting with a pilot test in at least two schools	1. Media analysis 2. Surveys 3. Interviews with school children and parents separately to evaluate their response to the new curriculum 4. Mid-term reviews	Social values and norms are not so rigid as to preclude debate on matters relating to sexuality

Source: L. Joseph Brown (2006). *Book II: setting up a gender-sensitive monitoring and evaluation system: the process.* UNICEF.

Table 8: Key questions to consider for monitoring and evaluation of a project/program

Issues	Questions
Setting up the monitoring and evaluation system and deciding what to monitor	○ Does situation analysis/baseline study include analysis of relevant gender concerns? ○ Are project indicators and milestones/targets gender-inclusive? Do they need to be revised/ refined to better capture the project's impact on gender relations? (Think about both qualitative and quantitative indicators.) ○ Does the M&E plan require that all data be sex-disaggregated? ○ Which methods and tools are needed to collect gender-sensitive data? ○ Is data collection (e.g. databases) appropriate to capture gender-related information? ○ Are special budget provisions for gathering gender-responsive information necessary? ○ Are sufficient capacities in place for gathering gender-responsive information and conducting gender analysis? (Is there someone in the team with the necessary expertise? If not, where can it be obtained? What kind of capacity building is needed? Can the regional gender specialist or the Bureau for Gender Equality help?) ○ Has the M&E plan been circulated for comments to the responsible gender specialist or gender focal point?
Gathering and managing information during implementation	○ Is all data collected in a sex-disaggregated manner? ○ Is information collected and analyzed that assess the (possibly) different effects of an intervention on men and women and on gender relations?
Regularly analyzing information and reflecting critically with the partners to improve action	○ Are the effects of the intervention on gender relations and its contribution regularly analyzed as part of regular reflection processes? Is someone specifically assigned to do this? ○ Are observations being discussed with key project partners? Questions in this context are: - How does the intervention affect men and women? If there are differences, why? (Also compare with budget spent on men and women.) - What expected effects does the intervention have on gender-relations? - What unexpected effects does the intervention have on gender-relations? - What are possible long-term effects on gender equality? - Is there sufficient information to know that? - What can be learned from that? - How does the project/program strategy need to be adapted to increase the gender-responsiveness of the intervention?
Communicating and reporting results	○ Are the effects of the intervention on women, men and gender relations part of every progress report? ○ Does the report explicitly address the gender-responsiveness and gender-related performance of the project? ○ Has the project established mechanisms to share knowledge related to gender equality?

Source: ILO (2012). *Guidance note 4: integrating gender equality in monitoring and evaluation of projects.*

Module 4 References

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MODULE 5

MODULE 5: GENDER AUDIT

Session 1: Understanding Gender Audit

Gender audit is an assessment tool for organizations to help them identify staff perceptions of how gender issues are addressed in their programming portfolio and internalorganizational processes.(CAW)

A participatory gender audit is a self-assessment methodology that focuses on improving the organization's performance with respect to gender equality and women's empowerment. Its objective is to help participants learn to assess their work, their functioning, and their collaboration with others, and find ways to improve and contextualize what they are doing. This process can lead to proposals for change, thereby translating learning into action. Unlike a regular evaluation, the participatory gender audit is based on self-assessment and not on external evaluation. (SNV)

A gender audit is a management and planning tool. An audit evaluates the gender-responsiveness of an organization's culture and how well that organization/company is integrating a gender perspective into its work. The audit recommendations can help the organization to become more gender-responsive. (Gender in Education Network (GENIA) Toolkit)

Objectives of conducting a gender audit are:

- Gender Audit enables organizations to systematically take stock of and address the status of gender equality in all aspects of their operations and work. By doing so, organizations will be able to identify gender issues embedded in organizational values, culture, structure and processes: identify gender issues that disadvantage feminine content and work styles.
- Gender Audit helps organizations identify areas of strength and achievement, innovative policies and practices, as well as continuing challenges as a foundation for gender action planning. Through the assessment and planning process, organizations recognize their own potential and are able to make informed decisions for themselves about how best to address the challenges they face, design gender equitable programs

Outputs of a gender audit are:

- A reflection of the status of gender equality within the organization
- A baseline for collective discussions and analysis
- A participatory process that builds organizational ownership for the agency's gender equity initiative.

- A detailed action plan that builds on the strengths of the organization and outline initiatives in the weaker areas of the organization.
- Move towards a gender-friendly organization.

Who conducts gender audit:

A gender unit or astructure can call for the need to conduct gender audit. The gender unit can form a gender task force or advisory group by involving volunteers from the organization and partners. The gender audit can also be performed by external consultant.

When to conduct gender audit:

Gender audit can be performed every 2 to 3 years to assess on the implementation of action points, the progress of the organization with regards to gender mainstreaming, and see if there are still gaps that needs to be addressed.

Gender audit methodology:

Gender audit employs gender audit questionnaire as a major tool and a combination of other tools in order to triangulate staff member responses. Hence, gender audit employs other tools such as desk/document review, and focus group discussions, individual interviews, and SWOT analysis.

Session 2: Gender Audit Tool and Process

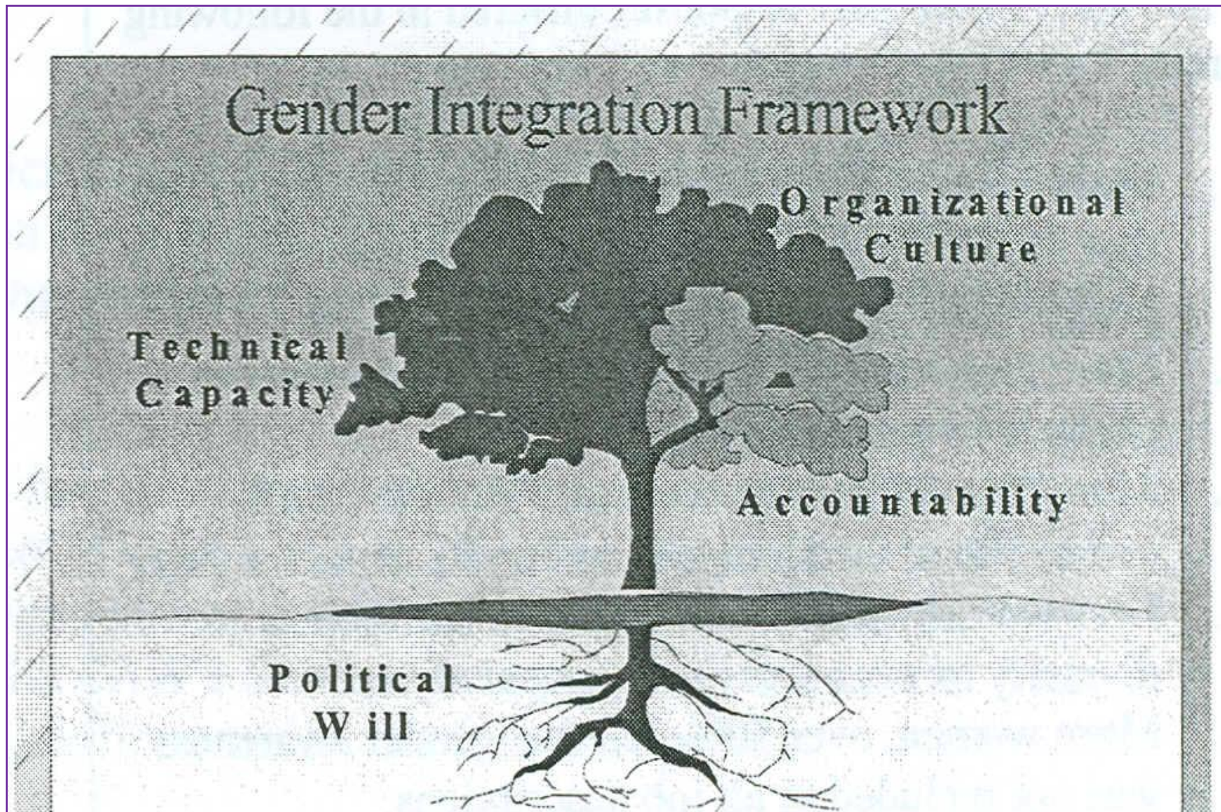
Gender Audit Framework

Integrating gender in an organization's activities and structures has both an external and internal dimension.

- ***Externally***, gender integration fosters the participation of and benefits to women and men in an organization's initiatives or services.
- ***Internally***, gender integration promotes women's leadership and equality in an organization's own policies and structures.

Gender audit framework is an organizational process, similar to a living tree. At the root of the process is political will. An organization with strong political will, like a tree with strong roots, can support the development of three vital branches: technical capacity accountability and a positive organizational culture.

To become institutionalized gender integration builds organizational capacity and ownership in gender-sensitive programming, organizational structures, and



procedures, as the four interdependent parts develop:

Figure 16: Commission on the advancement of women, gender audit framework, 1998

- **Political will** becomes evident when top-level leadership publicity support gender integration, commit staff time and financial resources, and institute needed policies and procedures.
- These conditions lead to a favorable **organizational culture,** which involves progress toward a gender balanced staff and governance structure, as well as equal valuing of women and men in the workplace.
- As organizational culture transforms, **technical capacity** must develop, including staff skills in gender analysis, adoption of systems for gender disaggregated data, and development of gender-sensitive tools and procedures.
- Because gender integration ultimately involves organizational change, systems of **accountability** are also essential. Both incentives and requirements are necessary to encourage and reinforce new behaviors, within individuals and within an organization as a whole.

Gender Audit Questionnaire

The questionnaire focuses on the following five areas of programming and six areas of organizational processes:

I. Programming

1 Policy/program planning and Design
2 Policy/program Implementation
3 Technical Expertise
4 Monitoring and Evaluation
5 Partner Organizations

II. Organization

1 Gender Policies
2 Staffing
3 Human Resources
4 Public Relations
5 Financial Resources
6 Organizational Culture

The gender audit questionnaire is designed to solicit three types of information concerning the status of gender equity in organizations. The three categories of information are the following: (1) to what extent, (2) to what intensity, and (3) with what frequency?

The two areas the questionnaire seeks information on the extent; intensity and frequency of gender equity are programs and organizational processes. There are several dimensions of programming and organizational processes, which are distinguished in the gender audit questionnaire. On the programming side, five (5) dimensions are explored. Three of those dimensions cover the phases of the program process. Those dimensions are (1) policy/program planning and design (2) policy/program implementation and (3) monitoring and evaluation. The other two dimensions focus on (1) technical expertise and (2) partner organization relations. There are 4-7 questions in each sub-section of the programming section of the questionnaire. Table 10 provides an explanation of the kind of information each sub-section of the programming section seeks from questionnaire respondents.

Table 9: Gender audit questionnaire programming sub-section

Programming Dimensions	Types of Information Sought
Policy/program Planning and Design	The extent to which gender-sensitive organizational procedures and methods are used to conceptualize and design policies and programs.
Policy/program Implementation	The extent and intensity of gender-responsive implementation of policies/programs.
Technical Expertise	The extent and frequency of technical gender expertise in the organization.
Monitoring and Evaluation	The extent to which sex-disaggregated data and information is incorporated in the monitoring and evaluation of policies/programs.
Partner Organizations	The extent to which gender equity is integrated in an agency's partner or local NGO affiliate relations.

On the organizational side, six (6) dimensions are explored. As in the programming section there are 4-5 questions in three of the sub-sections, (1) gender policy, 2) staffing, and (3) public relations of the organizational portion of the questionnaire. The other three sub-sections, (1) organizational culture, (2) human resource, and (3) financial resources accordingly have 20, 12 and 4 questions. The six dimensions on the organizational section of the questionnaire and the types of information sought from respondents are listed in Table 11.

Table 10: Gender audit questionnaire organization sub-section

Organizational Dimension	Types of Information Sought
Gender Policy	The nature, quality, extent and intensity of support for the organizations gender policy.
Staffing	The extent of gender balance in organizational staffing patterns.
Human Resources	The level, extent and intensity of gender-sensitive human resource policies, family friendly policies, and gender considerations in hiring and personnel reviews.
Public Relations	The quality and extent of gender sensitivity in the organization's communications and advocacy campaigns.
Financial Resources	The level and extent of organizational resources budgeted to support gender equity efforts.
Organizational Culture	The extent and intensity of gender sensitivity in the organizational norms, structures, systems, processes and relations of power.

Gender Audit Process

Gender audit is a two-stage process that allows for the collection of information to assess the status of gender equality in development. The first stage of the gender audit process is the gender audit questionnaire. The questionnaire can be designed to help organizations assess the range of understanding, attitudes, perceptions and reported behavior among staff in their own organization. The responses to the questionnaire, also serve as a baseline of staff perceptions on the status of gender equity in their organization's programs and processes.

The second stage of the gender audit process is the discussion, analysis and planning phase. This is the point where a focused review of the results of the gender audit questionnaire by staff of the organizations takes place. The review provides the basis for action planning in support of an organization's gender equity initiative.

The output of the gender audit process should be a detailed action plan than builds on the organizational strengths in support of gender equity and outlines initiatives, strategies, processes and guidelines to integrate gender in the weaker areas. The desired outcome of the gender audit process is shared ownership and action to move toward a gender-friendly organization.

Preparing For the Gender Audit

Institutional assessments like the gender audit require a strategy to communicate the initiative's rationale, purpose and intended impact on the staff's day-to-day work as well as the overall organizational mission. For the gender audit process to be effective, it requires consistent and demonstrated political will from senior managers in the organization. An effective and transparent communications strategy allays the fears often found in organizations launching a gender equity initiative.

A communications strategy is a plan, method or series of maneuvers for obtaining a specific goal or result, in this case the understanding of and support for the organization's gender audit. Strategic communications for the gender audit process focus on the needs of the organization's staff and the organization itself. In this case, the primary objective of an internal communications strategy is to promote broad participation in the organization's assessment of gender equity in programs and organizational structure. Inclusions of the following steps for your organization's gender audit communications strategy are recommended:

- **Have senior manager's spell out your organization's gender equity mission**. The organization's senior managers should discuss what it is they are trying to accomplish. If there is an organizational gender policy, it should be reflected in your internal communication goals and regularly shared throughout the organization.

- **Convene a brainstorming meeting.** Your organization's top decision-maker, gender task force or advisory group should hold an initial communications strategy session to clarify where communications ranks in the organization's gender equity initiative and in the plans for carrying out the gender audit. End the meeting by finalizing communications goals. Prepare a final communications plan with an implementation procedure, which clearly identifies the channels and content of communication. Memos, meetings, newsletters, e-mails and other channels of communication should all be mutually reinforcing.

- **Place communications high on your priority list to conduct a gender audit.** You should have a clear understanding of where your communications strategy fits in your overall objectives and priorities for the gender audit, your gender equity initiative and the organization's overall goals. The strategy should cover all phases of the gender audit-beginning with an announcement of the initial launch of the gender audit to regular updates of intermediate progress throughout the implementation stage, and conclude with communications highlighting the final evaluation of the initiative.

- **Commit to being proactive.** An internal communications strategy requires recognition of the need for the strategy and strong personal commitment to flourish. Ensure that everyone in the entire organization is shown the relationship between the elements in their jobs and the information being sought through the gender audit. Creativity and energy go a long way in fashioning a successful internal communications strategy.

Conducting the Gender Audit

The gender audit process, when conducted in a systematic and participatory manner, results in increased organizational understanding, ownership and readiness to act on an agency-wide gender equity initiative.The information from the gender audit questionnaire should come from the responses of staff selected as a representative sample of the organization undergoing the audit. Depending on the size of the organization, the CAW recommends the following sampling strategies. For small to medium organizations or a small country office (less than 100 staff), all staff members should complete the questionnaire.For medium to large organizations, a representative sample of at least 25-30% inclusive of a proportional number of respondents from each unit or department including overseas offices should be taken. Organizations with a large number of non-program staff may wish to administer the program section of the questionnaire exclusively to program staff if here are clear indications that on-program support staff is completely unfamiliar with the organization's overseas program. In this case, non-program staff will only fill out the organization section.

Analysis of the Gender Audit Questionnaire

All evaluation or assessment tools are generally made up of four basic kinds of questions:

- Short answers
- Open ended responses
- Multiple choice questions
- Scaled responses

There are similarities and differences in the way you go about the analysis of the results of each of the four types. At the beginning of the analysis, each requires that you first tally the responses. From this point on, however, the analysis of each of the three types is somewhat different and each will be treated separately below.

Analyzing short answer responses: these are perhaps the simplest to analyze. You often have questions such as, what is your age? Or what is your present position? The only meaningful analysis of information is by computing percentage of individuals who answered the question similarly. Results might indicate that 80% of trainees are between the age of 25 and 30, or that 20% are administrators, 30% are field workers, and 50% are agriculturists. From such results you will be able to determine the diversity of your respondents. Such variability should be monitored closely. The level of diversity has important implication for making decisions about capacity building objectives, policy formulation, training content and methodology design, etc. The benefit of having "hard data" showing percentage and numbers is that this makes it easier to convince your superior that changes should be made.

Analyzing open-ended responses: Often you will ask WHY or WHAT questions. Questions such as: What did you like least about the training activity/or why did you answer a previous question the way you did? are very commonly used. Responses to this type of questions are a bit more difficult to analyze, and more time consuming, especially if you are using a written questionnaire. They are valuable, however, in that they can reveal respondent concerns about which you may not be aware and do not specifically ask about.

In analyzing such responses you should look for TRENDS. Try to restate responses in as few words as possible and tally similar responses. For example if 6 of 20 trainees indicated that the training activity was “too rigid” another 7 described it as “very formal” and 2 more described it as “stuffy,” you do not need much more analysis to convince you that the structure of the training activity might be getting in the way of learning. A change in organization for your next activity is definitely indicated.

Analyzing multiple choice items: Analysis of multiple choice questions is usually done simply by recording numbers and percentages of respondents answering a question

correctly and incorrectly and then using this information to determine what areas seem to be having a problem with.

Analyzing scaled responses: Scaled response questions give respondents a number of scaled options from which they can choose to answer the question. For example:

	Very High	**High**	**In Between**	**Low**	**Very Low**
How would you rate the usefulness of the information presented in today's lesson? ………					
	5	**4**	**3**	**2**	**1**

This type of evaluation question is very much in use, but its ability to provide the evaluator with immediately useful information is limited and a matter of some disagreement among evaluators. Scaled response questions are, however, easy to administer and tally, they give results that are easy to interpret, they allow easy comparisons over time between groups of respondents and questions, and they lend themselves well to statistical analysis and to visual displays of responses (graphs, bar charts, etc.)

Analysis of responses to shot answers and open-ended questions require very little mathematical manipulation. You simply count the number of each response by category and figure percentages. In analyzing responses to this third commonly used question type, usually procedure is to calculate either percentage responses to each category, or average score of the response.

The average score tells you where on the scale the average respondent has indicated her or his opinion. While, helpful, the average score does not tell you the whole story. If the standard deviation of the scores is also computed you will learn more about how the respondents feel.

For example, using the question above on usefulness of information in a lesson, suppose that 20 trainees responded and 5 said very high, 7 said high, 8 said in-between. Notice that each response s assigned a number. 5= very high, running through 1 indicating very low usefulness. To compute the average score in this case you would follow the steps listed below.

Steps in computation of average score
1. Multiply the number of responses to each option by assigned values of each response **2.** Determine totals of number of respondents and scores by adding both column 1 and 3 **3.** Divide total sore by the total number of respondents who answer the question

Computations: Step 1

Option	Number of Respondents		Assigned Value		Score
1	**5**	**X**	**5**	**=**	**25**
2	**7**	**X**	**4**	**=**	**28**
3	**8**	**X**	**3**	**=**	**24**
4	**0**	**X**	**2**	**=**	**0**
5	**0**	**X**	**1**	**=**	**0**

Computations: Step 2

Step 2**:**

totals =20

Step 3:

$$\frac{\textbf{Total Score}}{\textbf{No. Of Respondents}} = \frac{\textbf{77}}{\textbf{20}} = \textbf{Average Score} = \textbf{3.85}$$

Presentation of the Gender Audit Questionnaire Result

After the analysis is done, the result should be presented back to the staff of your organization. It is important for an organization to be aware that the Gender Audit questionnaire provides data for analysis and that the action plan develops out of this analysis. The gender audit is not designed to present an expect plan for an organization to adopt. It is designed to have the action plan emerge from the participatory deliberations of the agency's staff. Consequently, it is important to critically review, summarized and displays the audit results in a user friendly manner. Pie charts and tables have been found very much useful in this regard.

Since the gender audit questionnaire results are to be used in subsequent action planning sessions, the use of newsletter format for presentation of the most salient questionnaire results and as an initial review document for the action planning sessions. The newsletter includes the following set of information:

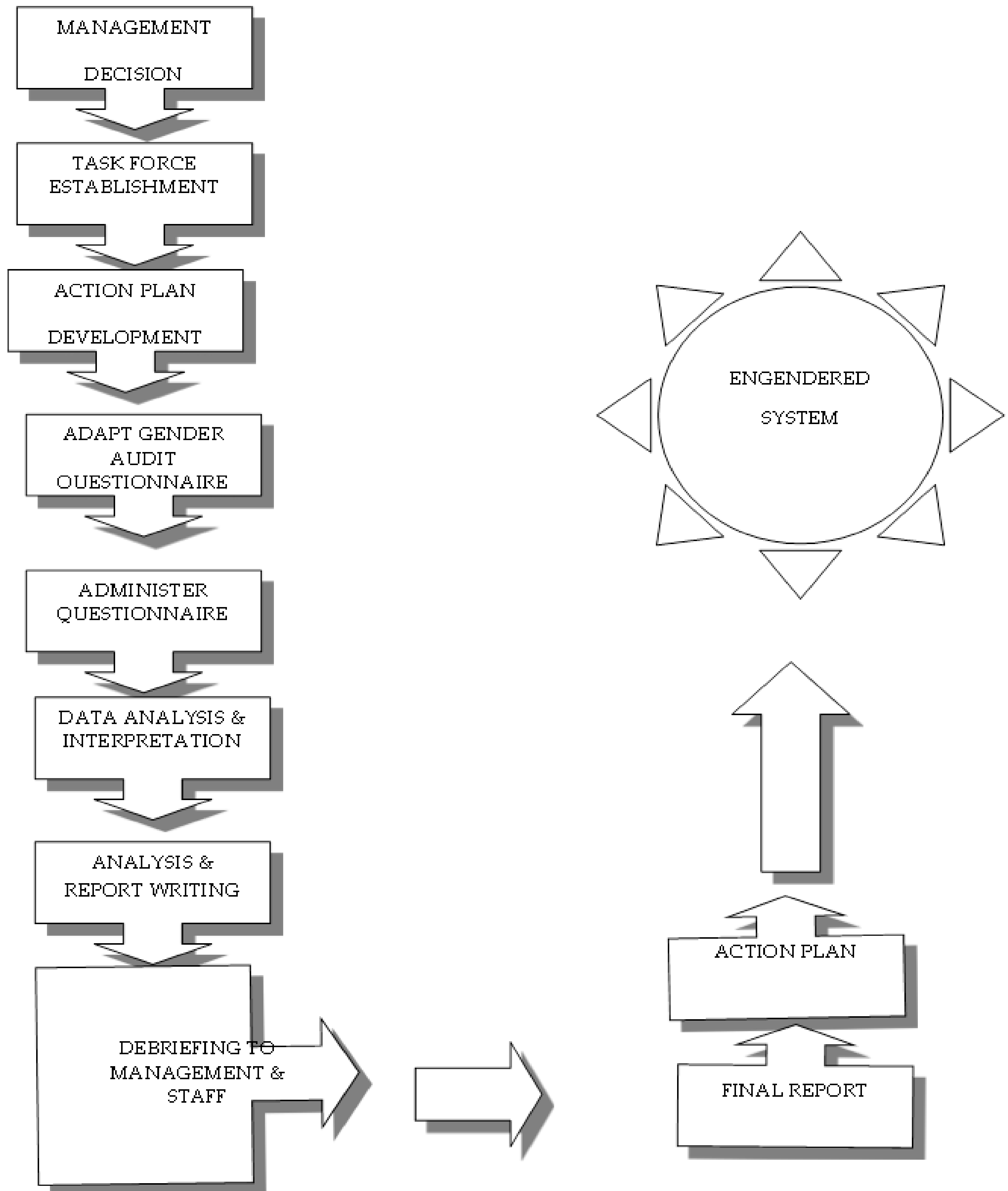
- The number of staff responding to the Gender Audit questionnaire
- The percent of staff respondents in different positions in the organization
- The percent of organizational regions represented by staff
- The percent of male and female staff responding to the questionnaire
- Salient differences in male and female response to questions in the programming and organization section of the questionnaire

Using the Gender Audit Results in Action Planning

The results of the gender audit questionnaire constitute the baseline information for collective organizational discussion and action planning. This process should be a participatory one either through focus group discussions or through the deliberations of a representative gender task force. The discussion and action planning sessions should include the following two steps:

1. A review of the gender audit results, which can be facilitated with the newsletter. This review helps staff in the focus groups or on the Gender Task Force to examine the reflection the questionnaire results paints of the status of gender equity in the organizations programs and organizational processes.
2. A discussion of action steps to address identified weakness and enhanced strengths. This step can be facilitated by a presentation of the action-recommendations staff proposed in the questionnaire. These action recommendations are most useful when they are placed in the four (4) categories of the CAW's gender integration framework. The following are examples of action recommendations under the four categories:

Figure 17: Gender audit steps



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MODULE 6

MODULE 6: GENDER BUDGETING

Session 1: Understanding Gender Budgeting

Budgets are important policy tools available to a government and reflect its political priorities. The numbers and figures compiled in the budget documents might seem gender-neutral. However, empirical findings show that expenditure patterns and the way that government raises revenue have a different impact on women and girls as compared to men and boys. This is often to the disadvantage of women and girls due to the socially determined roles that women and men play in society, the gendered division of labor, different responsibilities and capabilities, the different constraints that women and men face, and difference in access and control of health related resources. In combination, all these normallyleave women in an unequal position in relation to the men in their community, with less economic, social and political power.

Gender-responsive budgeting is an approach designed to mainstream the gender dimension into all stages of the budget cycle of a nation as well as an organization. In general, gender-responsive budgeting seeks to analyze the different impacts of a state's national, localand organizational expenditure and revenue policy on women and girls, and on men and boys, respectively. In addition to the impact analysis, gender-responsive budgeting includes proposals to reprioritize expenditures and revenues, taking into account the different needs and priorities of women and men. Depending on the country or organizational-specific context, other factors of inequality may also be focused on. These include age, religious or ethnic affiliation, or the place of residence (urban/rural, different provinces).

The gender-responsive budgeting process seeks to producegender-responsive budgets. These budgets (which are synonymous with gender-sensitive budgets, gender budgets and women's budgets) are not separate ones for women, but rather government or organizational budgets that are planned, approved, executed, monitored and audited in a gender-sensitive way.

Since men and women generally occupy different social and economic positions, budget typically affects them differently. Ignoring the gender impact of the budget is not neutrality, rather it is blindness. This blindness has a high human and economic cost such as lower productivity, lower development of people capacity and lower levels of well-being. Hence, gender budget analysis helps governments and organizations to decide how /programs need to be adjusted to achieve maximum impact, and where resources need to be reallocated to achieve human development and gender equality.

Gender budget:

- Does not mean separate budget for women or men. Rather, it is about addressing poverty guaranteeing that government resources are used to meet the needs of the poorest women and men, girls and boys.
- Is not about whether an equal amount is spent on women and men, but whether the spending is adequate to women's and men's needs;
- It is about taking a government's commitments to gender equality in treaties, conventions, and declarations and translating them into budgetary commitments;
- Can take into account other categories of inequality such as age, religious or ethnic affiliation, or the place of residence (urban/rural, different provinces), which can then be incorporated into gender-responsive analyses.

Advantages of gender-responsive budgeting

Monitoring of the achievement of policy goals: Gender-responsive budgeting provides a tool for monitoring the extent to which theMillennium Development Goals and other policy goals have been achieved in a gender awaremanner.

Alleviating poverty more effectively: Although the available statistical data on income poverty cannot provide incontrovertible evidence that women are always more affected by income/consumption poverty than men, it is widely acknowledged that women face worse conditions than men with respect to access to health services;that women and men experience poverty differently (and that women experience it moreseverely); and that both face different constraints to overcome poverty. If women's needs are not taken into account onequal terms, there is the risk that poverty reduction policies will fail.

Enhancing economic efficiency: Several studies have shown that there is a positive correlation between diminishing genderinequality and higher growth rates. Women's productivity increases disproportionately if theiraccess to information, credit, extension and health services, inputs and markets is enhanced and if theirtime burden is reduced through, for example, investment in labor-saving infrastructure.

Achieving gender equity/equality: Achieving gender equity requires equality of outcomes for women and men. This implies therecognition of the different needs, preferences and interests that affect the way women andmen benefit from the same policies/programs.

Advancement towards the realization of women's right: Gender-responsive budgeting seeks to measure the gaps between policy commitments withrespect to human rights and women's rights instruments (including CEDAW), the adequacy ofresource allocation, and the outcomes of policies.

Achieving good governance: The process of improving the delivery of goods and services to women, men, girls and boysin a fair, just, and responsible way has to be considered as an integral part of the definition ofgood governance. Good governance requires a participatory approach to the policymakingprocess, so that the different perspectives of different groups of citizens, including women,are represented.

Enhancing accountability and transparency: Gender-responsive budgeting is a powerful tool for highlighting gaps between internationalcommitments (such as those established at the Fourth World Conference on Women inBeijing in 1995, as well as in national policy documents), and the amount of public spendingearmarked for the achievement of gender-responsive budgeting necessitates the availability of sex-disaggregated data plus access to programme information. By tracking how allocated money is spent, gender-responsivebudgeting increases both accountability and transparency.

Achievements of gender-responsive budgeting initiatives

The achievements of gender-responsive budget initiatives include the following:

- Awareness with regard to the gender impacts of budgetary decisions has increased.
- The capacity to analyze budgets from a gender perspective has increased.
- Public expenditures have been reprioritized in favor of women and girls.
- Budget guidelines and formats have been changed.
- Gender issues have been debated in parliament and mentioned in the budget speeches of ministers of finance and other ministries.
- Budget processes have become more transparent.

Session 2: Approach and Tools for Conducting Gender Budgeting

Approaches to Conduct Gender Budgeting

There are many approaches for conducting gender budgets. In 1984, Australia was the first country to analyze the gender-specific distributional impacts of state expenditures and come up with a three-way categorization/classification of budget. The second approach is the South African five-step approach. These two dominant methods can be reconciled into a common analytical framework, which can be used as a basis for either analysis of existing budgets or reporting by sector ministries.

For example, a government initiative might take a particular department or ministry, look at all its programmes and sub programmes –distinguishing between the three categories-and analyze and report on each in terms of the five steps. This is what the Australian gender format did. On the other hand, a civil society initiative would not necessarily start with a government unit and its budget. Instead it might look at a particular gender issue in a society, go through the five steps, and consider which program and sub-programs-possibly from range of ministries –address the gender issue, and which do so in terms of each of the three categories.

The three-way categorization (the Australian approach) divides the budget into three specific types of expenditures. These categories are:

i. Women or gender specific expenditures: are expenditures in the budget that specifically target groups of girls and women addressing a particular gender issue.They are an example of affirmative expenditure.
ii. Equal opportunities expendituresin the public service: these refers to allocations to equal employment opportunities such as programmes that promote equal representation of women in the management and decision-making and equitable pay and conditions of service (e.g. training and mentoring programs for women public servants and the review of job description to remove gender bias).
iii. General or mainstream expenditures: are expenditures that are not gender-specific butare analyzed for their gender impact. This budget category is the biggest and accounts for 99% of the funding (e.g. funding for increased water coverage. Although water coverage does not target women specifically, statistics show that women spend more time collecting water than men, and this has led to poverty). The challenges with analyzing this type of expenditure are lack of sex-disaggregated data or its inadequacy.

Examples for women/gender specific expenditures:	Examples for equal opportunities expenditures in the public service:	Example of general or mainstream expenditures:
o Women's health programs (e.g. reducing maternal mortality, setting up maternity wards) o Drugs for reproductive health o Special education initiatives for girls (e.g. family planning, reproductive health, early childhood and nutrition) o Employment policy initiatives for women o Initiatives to address violence against women o Economic empowerment for women o Scholarships for women o Capacity building for health workers targeting women o Research on women and men health	o Program that promote the equal representation of women in management and decision-making. o Equitable pay and conditions for women public servants. o Review of job descriptions to reflect equal employment opportunity principles and remove gender bias. o Number of men and women in positions with gender knowledge or specialization. o Provision of child-care facilities o Parental and maternal leave provisions	o Includes money for clinics, water and sanitation. o General question that needs to be raised under this category are: • Does the budget, minus the above two types of expenditure, reflect gender equity and equality objectives? o Specific sample questions that needs to be raised under this category are: • Who are the users of health services? • Who benefits from expenditures on tertiary education?

The five-step (the South African) approach involves five steps in conducting a gender budget analysis from a gender perspective and comprises the following stages:

- Step 1: Analysis of the gender situation. This involves identifying gender issues in a sector or society.
- Step 2: Carrying out a policy analysis to establish whether the policy addresses the gendered situation identified in step 1.
- Step 3: Find out whether there are enough resources to implement the policy.
- Step 4: Monitoringwhether the money was spent as planned, what was delivered and to whom.
- Step 5: Assess whether policy implementation has changed the gendered situation identified in step 1.

The Three Steps/Stages of Gender Budgeting

Engendering budget is not a one-time activity; it is a process that helps to identify gender issues in our society and at the same time assist in incorporating gender issues in budgets. It has three major steps: identifying gender issues, engendering policies and engendering budgets.

Step 1: Identifying gender issue: how to identify gender issues

A gender issue is a statistical or social indicator of inequality between males and females due to discrimination or marginalization within society. Such issues can arise out of three areas: access to resources, management of resources, and control of and benefits from resources. For any subject or area, one needs to identify if there is any constraint that is hindering women as well as men from either accessing or benefiting from resources equally. It is from knowing the causes that one can get the solution to that particular problem.

	Gender Issues	**Causes**	**Consequences**	**Solutions/Interventions**
Access to resources				
Management to resources				
Control of resources				
Beneficiary to resources				

Step 2: Engendering policies: how to engender sector policies

This step determine whether the policy designed to address particular problems in a country has explicitly or implicitly tackled gender issues identified in step 1. The policy might also reinforce or remove gender inequalities.

A gender- aware policy appraisal involves the development of an analysis which reflects an understanding of the policy's gendered implications by:

- Identifying the implicit and explicit gender issues and policy objectives
- Identifying the accompanying resource allocation
- Assessing whether the policy will continue or change existing gender inequalities between women and men and patterns of gender relations.

Step 3: Engendering budgets: how to engender budgets

With the background of the situation and policy analysis, the focus of the third step shift s to the budget itself. The main aim here is to determine whether the budget allocations are adequate to implement the gender-responsive policy identified in step 2. If the second step reveals that the policy is gender-sensitive, or may even exacerbate gender inequality, the third step can be used to reveal the extent to which funds are being misallocated. A useful method is to categorize expenditures into three ways:

i. Gender specific expenditures

   Examples of gender specific expenditures in the health sector are:
   - drugs for reproductive health,
   - family planning services both for women and men,
   - research on gender-based violence,
   - capacity building for health workers targeting women,
   - setting up maternity wards, and
   - early childhood nutrition education

ii. Equal opportunities expenditures

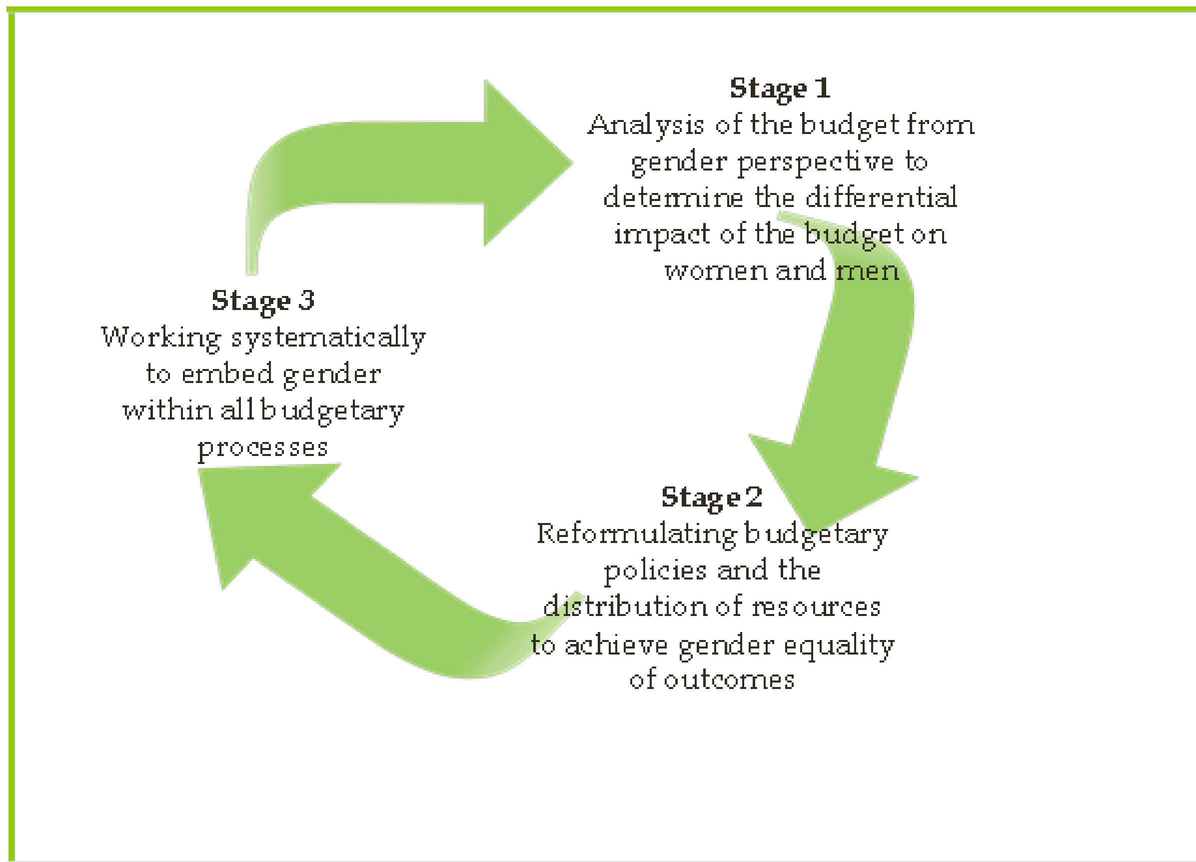
   The equal opportunity issues in public sector employment are analyzed by:
   - Describing employment patterns within particular sector(s) or the public sector as a whole
   - Disaggregating by sex levels of employment/grades, forms of employment (full or part time, permanent or temporary), salaries and benefits.
   - Identifying any special initiatives to promote equal employment opportunities.
   - Determining the number of men and women in positions with gender focus or specialization (gender focal points; police, medical and welfare officials dealing with rape and domestic violence)
   - Disaggregating by sex of the membership of board and committees established under the sector (s)
   - Describing any changes planned in the coming year.

iii. Mainstream expenditures

   The mainstream expenditure can be analyzed by:
   - Investigating the situation of women, men and other marginalized groups
   - Identifying gender issues therein
   - Linking the gender issues to particular mainstream expenditures
   - Determining whether particular gender issues can be addressed in mainstream expenditures

- Discovering whether there are some mainstream expenditures that not addressing any particular gender issues or are likely to reinforce existing gender barriers.

Figure 18: The three stages of gender budgeting



Source: Gender budgeting: practical implementation handbook, 2009

Checklist fora Gender-Sensitive Budget

This checklist is designed for stakeholders who do not have enough time to read the whole guide and who want to make quick decisions regarding whether the budget is gender-sensitive or not. The tool will give an indication of the extent to which a budget is gender-sensitive.

Is there any gender-specific expenditure in the budget: asdiscussed above, gender-specific expenditures are important for promoting affirmative action in the budget. Hence, it is important to look at the budget and determine whether there are such expenditures.

Administrative vs development/service delivery expenditures: gender-sensitive budget should be allocated more service delivery than for administration. Therefore, it is a good practice to ensure that service delivery is given priority in a budget than wages and non-wages. A quick budget analysis would reveal how much is spent on administrative expense and how much on service delivery.

Was the budget process gender-sensitive or participatory: an important aspect for anyone wanting to analyze government budgets is knowledge of the process by which the budgets are drawn up. Key questions to pose here are: was the budget process open to the public before and after enactment to draw inputs from citizens, civil societies and other stakeholders? were there public hearings on the budgets?, etc.

Who benefits from the money allocated: this is another important question about the budget. Because revealing who the intended beneficiaries of resources allocated are can make a difference. Ministries and sectors must show who their target group is. Questions to raise here include: how many and men are being targeted for a particular service delivery? Answer to this question help in evaluating budget performance from gender perspective.

Use of sex-disaggregated data: the use of such data is essential when conducting gender-budget analysis. However, this data is not adequate or available in most countries. Without such kind of data, gender budget analysis becomes a harder task.

How much budget for the gender machinery: ministry of women, gender directorates/ units/focal points are in charge of mainstreaming gender in the development plans and budgets at national and local levels. In most cases, gender ministries and directorates have very small budget, and hence, can hardly implement any gender activities.

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MODULE 7

MODULE 7: GENDER AND THE HEALTH WORKFORCE IN ETHIOPIA

The desired outcomes for all gender-related actions in human resources for health (HRH) are improved service delivery and health for health workers and for the communities they serve. However, gender equality should be a primary goal in all areas of social and economic development. Thus, gender inequalities and discrimination need to be addressed in HRH policy and planning, workforce development and performance support to ensure that women and men have equal opportunity and treatment in employment and occupation, whether it is in the formal or informal health sector.

Gender Discrimination: Any distinction, exclusion or restriction made on the basis of socially constructed gender roles and norms that prevents a person from enjoying full human rights. In the world of work, gender discrimination has been directly or indirectly linked to pregnancy, marital status and family responsibilities and is manifested in occupational segregation, wage discrimination and sexual harassment

In Ethiopia, women generally comprise the majority of workers in the health sector but occupy lower-level cadres, predominate in the informal care economy and experience gender hierarchies in management, which result in differences in pay and promotion. Gender stereotypes, norms, and practices keep women health care workers at the lower-end of the system. Women tend to be concentrated in certain occupations and to be poorly represented in management positions and at senior levels in the system.

Table 11: Distribution of health professionals by gender (2009)

Profession	Gender				Total
	Male		Female		
	Number	%	Number	%	
General Practitioner	907	82.4	194	17.6	1101
Specialist	813	82.4	174	17.6	987
Health Officer	1199	76.1	376	23.9	1575
Pharmacist	443	71.3	178	28.7	621
Pharmacy Technician	1227	62.6	733	37.4	1960
Nurse BSC	982	57.8	718	42.2	1700
Midwives	389	28.8	961	71.2	1350
Clinical Nurse	8140	49.6	8264	50.4	16404
Psychiatry Nurse	37	54.4	31	45.6	68
Anesthetic Nurse	109	62.6	65	37.4	174
Public Health Nurse	615	64.7	336	35.3	951
Other Nurse (Dental, OR, Opthalmic)	193	50.0	193	50.0	386
Physiotherapist	119	79.9	30	20.1	149
Lab Technologist	625	76.2	195	23.8	820
Lab Technicians	1251	64.9	676	35.1	1927
Radiographer	123	76.9	37	23.1	160
X-Ray Technician	113	84.3	21	15.7	134
Environmental Health BSC	512	85.3	88	14.7	600
Environmental Health Diploma	499	78.1	140	21.9	639
Health Assistant	833	56.9	631	43.1	1464
Health Extension Workers*	0	0.0	30578	100.0	30578
Others	1033	72.0	401	28.0	1434
Total (Excluding HEW)	20162	58.3	14442	41.7	34604
Total	20162	30.9	45020	69.1	65182

Source: Report on human resources for health profile study by WHO, 2009, Ethiopia

Gender and HRH Recommendations to Address Gender Discrimination

Gender-aware HRH policy and planning, workforce development and workplace support must all be conceptually and practically integrated to eliminate gender discrimination over the long term and to realize both human rights and efficiencies in HRH at national policy and operational levels.

A. Strengthening HRH Policy and Planning to Promote Gender Equality

Identify gender discrimination in HRH policy and workforce planning: Conduct workforce assessments that routinely gather information on gender discrimination atwork, and women's status relative to men's in policy and law. Assess if policies and lawsindicate which (gender, labor) rights are protected and what opportunities exist to promotegender equality through HRH policy and legislation. Determine if a country is signatory to theCEDAW and the Beijing Platform of Action.

Use sex disaggregated data to inform HRH policy and planning: Design human resources information systems (HRIS) to provide sex-disaggregated data forHRH policy and planning. Document numbers of men and women by (management) cadre,salary scales, promotion or training by gender and use reports to identify any pay,promotionand retention differentials. Reports generated with sex-disaggregated data in an informationsystem that can link workers to jobs and salaries will demonstrate differences in salaries wheremen and women have the same job or difference in the numbers of men and women in tophealth management jobs.

Translate international and regional commitments to gender equality into national equal opportunity policies and laws: Do not codify"breadwinner" wages, bonus and benefits policies that assume that only men are the principalwage-earners in the family. Make job recruitment based on sex illegal. HRH policy and planningshould also promote or reflect antidiscrimination legislation and special or temporary measuresof protection. Equal opportunity laws and policies, targets, affirmative action9 policies andmonitoring and evaluation should be put in place and reinforced by organizational policies andprocedures to provide guarantees of equal treatment for women and men at work.

Eliminate penalties for marriage and motherhood/promote policies that respond to life cycle events: HRH policies and practices should ensure that women are not penalized for marriage andmotherhood. Increase women's attachment to the health workforce through fair careerprogression policies and wage increases that do not penalize women for taking time outof careers for childbirth and family responsibilities. Girls and women are often perceivedto be higher risks for skill investments and are sometimes excluded from educational andtraining opportunities, hiring or promotion. Policies must ensure that women areeducated, hired and promoted regardless of the prospect that they may leave theworkforce for marriage or maternity. Female health workers should not be demoted orlose seniority after maternity leave. Ensure that women who are or who plan to getpregnant enjoy equal opportunity and treatment at work, including measures such as:eliminating retirement plan or health insurance forfeitures for career interruptions;providing minimum paid sick leave days and leaves of absence with a guarantee of anequivalent job upon return; promoting female workers who work part-time; adoptingwork models and policies that are sensitive to life cycle

events and workers who cannotwork at night or travel for extended periods; develop workplace re-entry educationprograms after childbirth; create family-friendly leave legislation or policies, including paidparental leave for both men and women or government-provided child care.

Document and address the unequal distribution of unpaid work: Workforce policy and planning should document and address the unequal distribution ofunpaid care work between women and men in the informal care economy. Make women's(unpaid) work visible in national accounts by calculating its worth in monetary terms.Document how unpaid caregiving between women and men is distributed. Developpolicies, programs and budgets that recognize the value of women's unpaid caregiving andthe support and compensation unpaid workers need. Programs should createstandardized protections and resources for volunteer health workers (e.g., financialincentives, tax credits, cash benefits, child care subsidies, free medical care or healthinsurance contributions and/or pensions to home-based primary caregivers). Developnational educational policies and strategies that valorize caregiving as a social good.Government HIV and AIDS policy and implementers' programs should explicitly promote anequal or more equitable division of responsibilities between women and men andcontinue to strengthen women's capacity to care for those affected by HIV and AIDS.

Ensure workplace safety: HRH policies and programs must assure the safety and security of women at work. Genderdiscrimination has been implicated in the high levels of violence to which health workers areexposed. Address violence and discrimination at the same time by developing nationalworkplace safety and security policies that address gender discrimination. Deployment offemale workers to remote rural areas or areas experiencing conflict should anticipate andprevent the possibility of sexual harassment and assault at work or on the way to work.Workplaces should have zero-tolerance codes of conduct sanctioning violence at work.Make changes in the physical work setting or in housing to improve security; providevehicles to enhance health workers' mobility.

Involve women in HR policy and strategy decision-making processes on an equal basis with men: Make deliberate efforts to ensure that women are invited to or chair meetings where healthworkforce policy and planning take place. Include women in advocacy, leadership, managementand public-speaking training.

B. Increasing Gender Integration in Education, Training and Work

Eliminate stereotypes in education and training: Educational policy-makers and planners should eliminate gender stereotypes in curriculathat may limit the integration of men and women into health professions. Education andtraining for students crossing gender boundaries and entering occupations that have beentraditionally considered female or male should include critical reflection and deliberate attention. Promote

coeducational activities to increase exposure to women's and men's competence. Media recruitment campaigns should target gendered division of labor to promote gender integration of health occupations (e.g., depicting men and women caring for families, girls in conventionally male-identified roles).

Promote equality in educational recruitment: Develop educational recruitment strategies that actively target boys'/men's entry into"female" health occupations and girls'/women's entry into "male" health occupations.Educate advisors and vocational guidance counselors who help boys choose alternatecareer paths. Support men who choose a female-identified occupation. Publicize male rolemodels in the profession. Target older men whoare changing careers for recruitment into nursing and home based care. Avoid usingmasculine stereotypes to attract and compensate men. Provide social support to boys andmen who choose nontraditional health occupations.

Consider cultural factors and expectations: Schools should consider educational and certification requirements that takeinto account cultural factors and expectations of girls and women that may hinder schoolentry, retention or completion of studies or qualification for a health profession (e.g.,expectations that girls leave school for marriage or family caregiving; family preferences tofinancially support boys schooling; sexual harassment by other students or teachers).Girls may need mentoring, tutoring or remedial support to meet math or science entryrequirements of some professional schools, tuition or licensing fee waivers and flexiblescheduling to meet certification qualifications. Schools should also institute codes ofconduct for teachers and students. Eliminate policies and practices that exclude girls andwomen from schooling if they become pregnant.

Ensure that women are equally represented in management and leadership skills training: Female health workers are typically unrepresented in health workforce management(especially upper management). They may be in gender-segregated, temporary or part-timejobs or subject to stereotypes that hold that employment is of secondary importanceto women. Because of this, female health workers may not be considered for promotionor selected for management or leadership training. In-service education programmanagers should therefore look for opportunities to invite promising female employeesfor such training. Strengthen associations as empowerment and leadership mechanisms forfemale health workers.

C. Creating Supportive, Fair and Safe Work Environments

Foster gender-aware human resource management: Promote gender-aware human resource management (HRM) for facility managers and servicesupervisors so that they may effectively support both female and male health workers in fairwork environments. HRM training at all levels should include orientation to forms ofdiscrimination and violence, gender dynamics between supervisor and supervisee

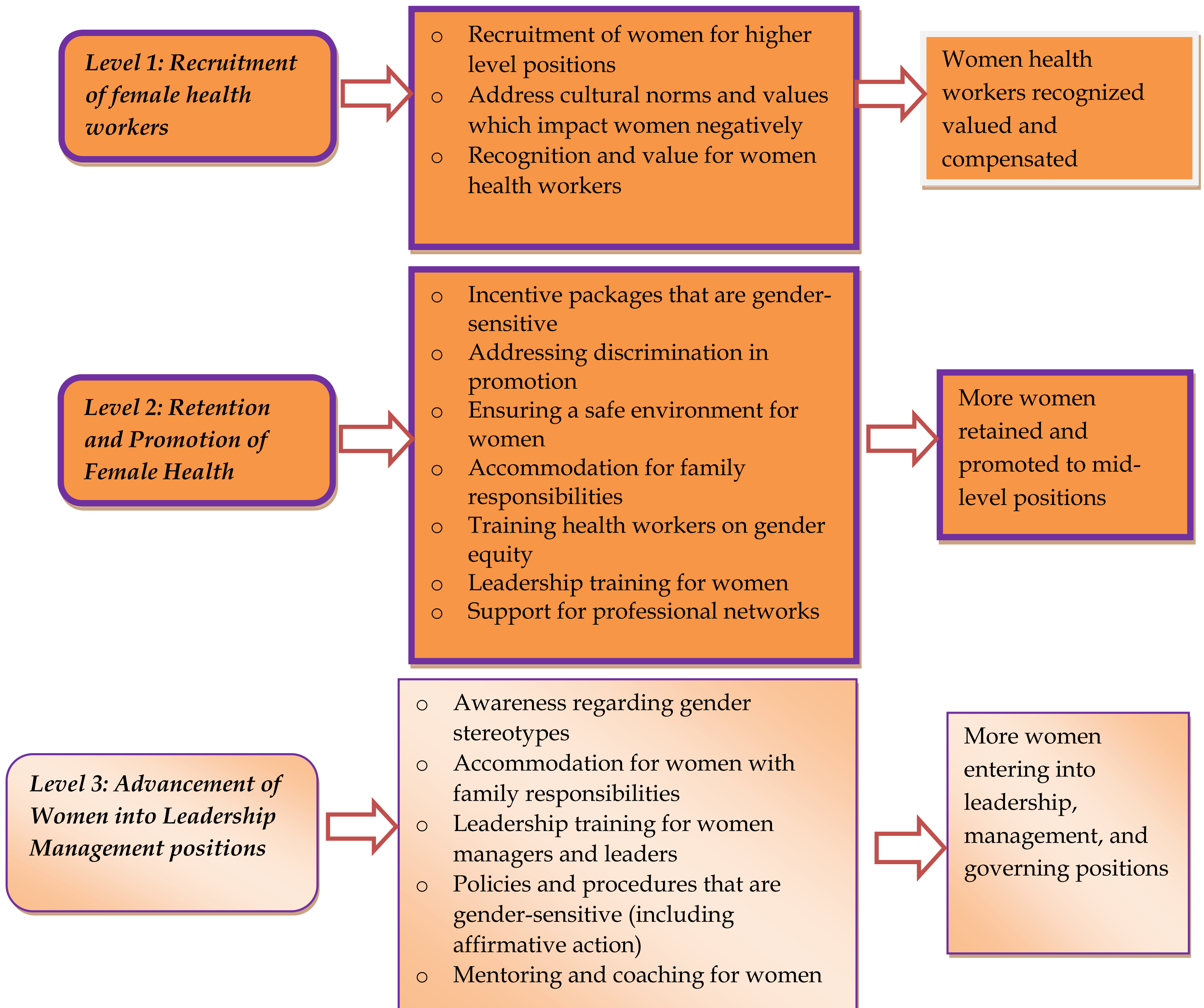
(includingabuse of power and sexual harassment), how to respond constructively to maternity/paternityleave and workers' family responsibilities, equal opportunity policies or labor standards thatprotect workers' rights and how to challenge myths related to women's capabilities anddedication to work. Managers should make deliberate efforts to strengthen female healthworkers' long-term attachment to the workforce by developing or enforcing antidiscriminationmeasures in the workplace, ensuring equal remuneration and opportunity for promotion,flexible scheduling, and parental leave benefits for men and women or on-site child care.

Promote equal opportunity and treatment: Facility managers and supervisors should conduct "gender audits" of workplace policies and practices to identify gender discrimination in hiring, training, promotion, pay and sexual harassment. Develop and enforce equal opportunity employment policies to eliminate discrimination on the basis of marriage, pregnancy and family responsibilities and promote equal remuneration and equal opportunity for career advancement. Recruit men and women into nontraditional jobs and promote equitable task-sharing in similar jobs. Rectify working conditions for nursing and caregiving occupations to attract and retain both men and women. Work with unions to address pay inequalities between predominantly female and male jobs. Create a wage council. Ensure that pay and promotions for men in "female" jobs do not disadvantage women (e.g., men should not be paid more than women for the same work). Employers should monitor for the possibility that women are subject to greater and unfair competition from men for leadership positions even in jobs that are considered "women's work" (i.e., in nursing).

Address workplace violence: Develop and enforce zero-tolerance codes of conduct and implement health personnel trainingon workplace violence and gender discrimination. Communicate regularly with health workersto monitor prevalence of sexual harassment and other forms of violence (including the threat ofviolence) at or around the workplace and the impact of violence on well-being and productivity.
Give incentives and recognition to facilities that create mechanisms to report violence by health workers and to create a fair process to address grievances.

Develop employee assistance programs: Establish gender-aware workplace HIV and AIDS policies and programs that offer voluntarycounseling and testing/prevention of mother-to-child transmission/antiretroviraltherapy, family planning, substance abuse counseling, child care and responseto gender-based violence. These programs should address women's physical, social andeconomic vulnerability to HIV and AIDS, their vulnerability to violence and the need for mento be fully engaged in HIV and AIDS risk reduction.

Figure 19: Gender-based intervention in the health workforce at different levels



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ANNEXES

Annex 1: Glossary of Gender-Related Terminologies and Concepts

Terms	Definitions
Sex	The different biological and physiological characteristics of males and females, such as reproductive organs, chromosomes, hormones, etc.
Gender	Refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed. The concept of gender includes five important elements: relational, hierarchical, historical, contextual and institutional. While most people are born either male or female, they are taught appropriate norms and behaviors – including how they should interact with others of the same or opposite sex within households, communities and work places. When individuals or groups do not "fit" established gender norms they often face stigma, discriminatory practices or social exclusion – all of which adversely affect health.
Gender roles	Refers to what males and females are expected to do (in the household, community and workplace) in a given society.
Socialization process	The process by which girls and boys learn what roles are assigned to them.
Gender norms	Refer to beliefs about women and men, boys and girls that are passed from generation to generation through the process of socialization. They change over time and differ in different cultures and populations. Gender norms lead to inequality if they reinforce: a) mistreatment of one group or sex over the other; b) differences in power and opportunities.
Gender stereotypes	Images, beliefs, attitudes or assumptions about certain groups of women and men. Stereotypes are usually negative and based on assumed gender norms, roles and relations.
Gender relations	Refers to social relations between and among women and men that are based on gender norms and roles. Gender relations often create to hierarchies between and among groups of men and women that can lead to unequal power relations, disadvantaging one group over another.
Gender equity	Refers to the process of being fair to women and men. To ensure fairness, measures must be taken to compensate for historical and social disadvantages that prevent women and men from operating on a level

Terms	Definitions
	playing field. More than formal equality of opportunity, gender equity refers to the different needs, preferences and interests of women and men. This may mean that different treatment is needed to ensure equality of opportunity. This is often referred to as substantive equality (or equality of results) and requires considering the realities of women's and men's lives. Gender equity is often used interchangeably with gender equality, but the two refer to different, complementary strategies that are needed to reduce gender-based health inequities.
Gender equity in health	Refers to a process of being fair to women and men with the objective of reducing unjust and avoidable inequality between women and men in health status, access to health services and their contributions to the health workforce.
Gender Equality	Refers to the state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources. In other words, it refers to equal chances or opportunities for groups of women and men to access and control social, economic and political resources, including protection under the law (such as health services, education and voting rights). It is also known as equality of opportunity – or formal equality. Gender equality is often used interchangeably with gender equity, but the two refer to different, complementary strategies that are needed to reduce gender-based health inequities.
Gender equality in health	Women and men have equal conditions to realize their full rights and potential to be healthy, contribute to health development and benefit from the results. Achieving gender equality will require specific measures designed to support groups of people with limited access to such goods and resources.
Gender mainstreaming	The process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated.
Institutional gender mainstreaming (as it relates to public health)	Ensures that organizational procedures and mechanisms do not reinforce patterns of gender inequality. Institutional gender mainstreaming seeks structural changes, calls for a transformation of the public health agenda that includes the participation of women (and other marginalized groups) in defining and implementing public health priorities and activities. It aims at ensuring gender equality dimensions

Terms	Definitions
	in strategic agendas, policy statements and monitoring and evaluation of organizational performance.
Programmatic gender mainstreaming (as it relates to public health)	The systematic application of gender analysis methods to health problems to better understand how life conditions, opportunities and environments affect the health of women and men and boys and girls.
Social resources	Community resources, social support networks, transport and other social services; education or training (formal or informal), information.
Political resources	Decision-making processes and leadership at the institutional, household, community, district or national levels, civic participation; High-quality health care services (formal or informal), medication, health insurance (provided by the state or employer); economic, social, political, civil and cultural rights.
Economic resources	Money, credit, loans, land, other assets
Other health-related resources	Within the categorization of health-related resources, these refer to basic necessities such as time, water, shelter, clothing and food.
Access to resources	The availability of a resource that includes several components such as geographic or physical accessibility, financial and social accessibility.
Control over resources	The ability to decide when, how and who can use a resource.
Access to and use of health services	Health-related consideration of the WHO Gender Analysis Matrix. Gender norms, roles and relations impact access and use of health services that includes the following components: availability, affordability, accessibility, accommodation and acceptability.
Practical gender needs	Needs defined by women (or men) that respond to immediate necessities such as adequate living conditions, water provision, health care and employment.
Strategic gender needs	Needs identified through an analysis of gender inequality and its impact on women and men of different groups. Addressing strategic gender needs challenges predominant gender systems such as the gender-based division of labor.
Biological factors	Gender-related consideration of the WHO Gender Analysis Matrix. Refers to those factors only related to physiology such as: reproductive and/or conditions related to physiological and/or hormonal changes; genetic or hereditary conditions (or those transferred from parent to child through chromosomes).
Differential exposure to	Refers to the different ways in which gender norms, roles and relations affect women and men's exposure to risk factors. For example, due to

Terms	Definitions
risk factors	the gender-based division of labor different groups of women and men are exposed to different risks for work-related injuries or illnesses (paid activities) or women's gender roles with respect to food preparation in low and mid income settings (unpaid activities) often exposes them to unsafe cooking fuels more often than men.
Vulnerability	Refers to the degree to which individuals, communities and systems are susceptible to or have diminished capacity to cope with exposure to risk factors.
Differential vulnerability	Refers to differences in access to and control over resources that may increase vulnerability to illness and disease.
Risk factors	Elements associated with the development of disease or illness that are not sufficient to cause it. Examples include age, tobacco consumption or poverty.
Health seeking behavior	Health-seeking behavior is any action carried out by a person who perceives a need for health services with the purpose of addressing a given health problem. This includes seeking help from allopathic and alternative health services. Both sex and gender influence health-seeking behavior.
Experiences in health care settings	Health care provided in a discriminatory, harmful or ineffective manner may discourage women and men from seeking treatment. Health care settings that do not address gender norms, roles and relations in culturally sensitive and appropriate ways may fail to reach the people in greatest need of health services - and lead to unsatisfactory experiences in health care settings.
Empowerment	Empowerment is a multidimensional social process that enables people to gain control over their lives. Strategies for empowerment therefore often challenge existing power allocations and relations to give disadvantaged groups more power. With respect to women's health, empowerment has often meant, for example, increasing education opportunities and access to relevant information to enable women to make informed decisions about their health, improve self-esteem and equip them with communication and negotiation skills. Such skills are known to influence, for example, safer sex practices, treatment adherence and timely health-seeking behavior.
Gender analysis	Gender analysis identifies, assesses and informs actions to address inequality that come from: 1) different gender norms, roles and relations; 2) unequal power relations between and among groups of men and women, and 3) the interaction of contextual factors with gender such as ethnicity, education or employment status.
Gender analysis in	Examines how biological and sociocultural factors interact to influence health behavior, outcomes and services. It also uncovers how gender

Terms	Definitions
health	inequality affects health and well-being.
Gender based division of labor	Refers to where, how and under what conditions women and men work (for or without pay) based on gender norms and roles.
Gender blind	Ignores gender norms, roles and relations and very often reinforces gender-based discrimination. By ignoring differences in opportunities and resource allocation for women and men, such policies are often assumed to be "fair" as they claim to treat everyone the same.
Gender responsive	A policy or programme that considers gender norms, roles and inequality with measures taken to actively reduce their harmful effects.
Gender sensitive	Indicates gender awareness, although no remedial action is developed.
Gender-based discrimination	Any distinction, exclusion or restriction (such as unfair or unequal treatment) made based on gender norms, roles and relations that prevents women and men of different groups and ages from enjoying their human rights. It perpetuates gender inequality by legitimizing stereotypes about men and women of different ages and groups.
Health and social outcomes and consequences	Health and social outcomes and consequences refer to *what happens* when a person becomes sick. The consequences of a health problem often cause economic and social changes for both the sick individual and their *social network*. This social network can include family or household members, friends and broader community members. Health outcomes relate to recovery, disability or death from a health problem. Gender considerations often influence how these outcomes influence a family or individual.

Annex 2: Health-Related Resources to be considered during gender analysis

Health-related resources	How it is a health-related resource?
Economic resources	
Money, credit, loans, land, other assets	Enhances ability to afford health services and the means by which to use them effectively (such as transport costs).
Social resources	
Community resources, social support networks, transport and other social services	Coping skills and mechanisms reduce the stress related to the burden of illness. They can also facilitate access to health services through information, resource-sharing, etc.
Education or training (formal or informal) and information	The links between education, health literacy and overall improved health outcomes are notably demonstrated through reduced maternal morbidity and mortality, decreased fertility rates, increased adherence to treatment and better health outcomes among children. Education also leads to higher self-esteem, which influences involvement in community or political networks, comfort to discuss health issues with family or health care workers, etc.
Political resources	
Decision-making processes and leadership at the institutional, household, community, district or national levels, civic participation	Input and influence in shaping local health systems to meet community health needs. This could include, for example, voting rights, suggestion boxes for patients or professional associations to represent health care workers. Political resources also include legal and institutional mechanisms that support the right to health.
High-quality health care services (formal or informal), medication, health insurance (provided by the State or employer)	Available, appropriate, accessible, adequate and affordable health services are necessary to maintain the health of a population.
Economic, social, political, civil and cultural rights	Available legal and institutional mechanisms that support the right to health and the progressive realization of all other human rights.
Other resources	
Basic necessities: time, water, shelter, clothing and food	Basic necessities such as water, clothing, food and shelter are the foundation of good health. Time is an important resource, the availability of which is often underestimated. Women and men require time and the ability to manage that time to engage in preventive and curative strategies.

Annex 3: Gender Audit Questionnaire

I. PROGRAMMING

A. Program Planning and Design

This section focuses on procedures and methods used to conceptualize and design development projects in the field.

1. Is the integration of gender equity in programs/projects mandated in the organization?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

2. Are gender equity goals and objectives included in program/project designs?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

3. For each program/project, is there a needs assessment, including an analysis of gender roles and responsibilities in the targeted community?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

4. Are best practices in gender integration in programming incorporated in subsequent program/project design?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

5. Are gender questions or criterion included in your program/project proposal approval process?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

6. Does the organization use participatory methods to incorporate the views and preferences of both male and female community members in project design?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

B. Program Implementation

This section focuses on how development projects actually operate in the field

1. Does the implementation plan for the organization programs/projects include activities that strengthen skills and provide men with equal access to services and training?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

2. Does the implementation plan for the organization programs/projects include activities that strengthen skills and provide women with equal access to services and training?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

3. Do your project implementation strategies and plans take into account existing gender roles and interests of both male and female participants?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

4. Female beneficiaries of the organization programs/projects value and see the programs/projects as beneficial to their lives.
   [ ] Strongly Agree [ ] Agree [ ] No Opinion
   [ ] Disagree [ ] Strongly Disagree

5. Male beneficiaries of the organization programs/projects value and see the programs/projects as beneficial to their lives.
   [ ] Strongly Agree [ ] Agree [ ] No Opinion
   [ ] Disagree [ ] Strongly Disagree

6. The organization has developed the capacity to identify and handle organizational resistance to addressing gender issues in programs/projects.
   [ ] Strongly Agree [ ] Agree [ ] No Opinion
   [ ] Disagree [ ] Strongly Disagree

C. Technical Expertise

This section focuses on the level of organization's staff expertise in gender analysis and evaluation

1. Is there a person or division responsible for gender in the organization?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

2. Is there assigned staff responsibility for gender integration in different departments/programs?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

3. Does the organization consistently seek technical support from a person or division within the organization who is responsible for gender programming?

   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

4. Does the organization staff have the necessary knowledge, skills and attitude to carry out their work with gender awareness?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

5. Have members of the organization received training in gender planning and analysis?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

6. Program/project planning, monitoring, evaluation and advisory teams in the organization consist of members who are gender- sensitive and include at least one person with specific expertise and skills on gender issues.
   [ ] Always [ ] Frequently [ ] Occasionally
   [ ] Seldom [ ] Never

D. Monitoring and Evaluation

This section focuses on the extent to which gender disaggregated data and information is incorporated in the monitoring and evaluation of the organization's development projects and on program outcomes.

1. Is gender disaggregated data collected for the organization projects and programs?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

2. Is the gender impact of the organization projects and programs monitored and evaluated?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

3. Does the organization have sectoral specific indicators that include a gender dimension?
   [ ] not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

4. Gender disaggregated data provides useful information for program/project evaluation and subsequent program/project design
   [ ] Strongly Agree [ ] Agree [ ] No Opinion
   [ ] Disagree [ ] Strongly Disagree

5. The organization programs/projects contribute to the empowerment of **women** and the changing of unequal gender relations.
   [ ] Strongly Agree [ ] Agree [ ] No Opinion
   [ ] Disagree [ ] Strongly Disagree

6. The organization programs/projects contribute to increased gender equity in the following areas:
   - Material well-being [ ] YES [ ] NO [ ] Don't Know
   - Access to resources [ ] YES [ ] NO [ ] Don't Know
   - Access to training [ ] YES [ ] NO [ ] Don't Know
   - Participation in decision-making [ ] YES [ ] NO [ ] Don't Know
   - Self-respect/legal status [ ] YES [ ] NO [ ] Don't Know
   - Control over benefits [ ] YES [ ] NO [ ] Don't Know
   - Control over resources [ ] YES [ ] NO [ ] Don't Know
   - Participation in the public sector [ ] YES [ ] NO [ ] Don't Know

7. The organization programs/projects collect gender disaggregated data in the following areas:
   - Material well-being [ ] YES [ ] NO [ ] Don't Know
   - Access to resources [ ] YES [ ] NO [ ] Don't Know
   - Access to training [ ] YES [ ] NO [ ] Don't Know
   - Participation in decision-making [ ] YES [ ] NO [ ] Don't Know
   - Self-respect/legal status [ ] YES [ ] NO [ ] Don't Know
   - Control over benefits [ ] YES [ ] NO [ ] Don't Know
   - Control over resources [ ] YES [ ] NO [ ] Don't Know
   - Participation in the public sector [ ] YES [ ] NO [ ] Don't Know
   - Beneficiaries view of the project's benefit to their lives [ ] YES [ ] NO [ ] Don't Know

E. Partner Organizations

This section focuses on the level of gender integration in the organization's relations with partners.

1. Is commitment to gender equity a criterion in the organization selection of partners?
   - [ ] not at all [ ] to a limited extent
   - [ ] to a moderate extent [ ] to a great extent
   - [ ] to the fullest extent [ ] do not know

2. Is commitment to gender equality included in the written agreements outlining the organization relationship with partners?
   - [ ] not at all [ ] to a limited extent
   - [ ] to a moderate extent [ ] to a great extent
   - [ ] to the fullest extent [ ] do not know

3. Does the organization provide training and tools on gender planning, analysis and evaluation to partners?
   - [ ] not at all [ ] to a limited extent
   - [ ] to a moderate extent [ ] to a great extent
   - [ ] to the fullest extent [ ] do not know

4. What are some of the obstacles to incorporating gender analysis in program/project planning, implementation and evaluation in the organization? Please tick all that apply.
   - [ ] organization size
   - [ ] staff size
   - [ ] office culture/environment
   - [ ] local culture
   - [ ] lack of financial resources for gender programming
   - [ ] lack of staff training on gender
   - [ ] lack of gender analysis tools

[ ] lack of support from senior management
[ ] low organizational priority for gender issues
[ ] other, please specify below:

____

II ORGANIZATION

Experience shows that there are usually underlying reasons outside of the strictly programmatic realm which affect the dynamics of programming. Please take a moment to reflect on the following areas.

A. Gender policy

This section focuses on the nature and quality of the organization's gender policy.

1. Does the organization have a written gender policy that affirms a commitment to gender equity?
   [ ] Not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

2. Does the organization gender policy have an operational plan that includes clear allocation of responsibilities and time for monitoring and evaluation
   [ ] Not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

3. Is gender taken into account during strategic planning for organizational activities?
   [ ] Not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

4. Everyone in the organization feels ownership over the gender policy.
   [ ] Strongly Agree [ ] Agree [ ] No opinion
   [ ] Disagree [ ] Strongly Disagree

5. Management takes responsibility for the development and implementation of the gender policy
   [ ] Always [ ] Frequently [ ] Occasionally
   [ ] Seldom [ ] Never

B. Staffing

This section focuses on the gender composition of staff in the organization.

1. Has there been an increase in the representation of women in senior management positions in the past few years at the organization head office?
   [ ] Not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

2. In the program areas, has there been an increase in the representation of women in senior management positions in the past few years?
   [ ] Not at all [ ] to a limited extent
   [ ] to a moderate extent [ ] to a great extent
   [ ] to the fullest extent [ ] do not know

3. Has there been an increase in the representation of women on the organization board in the past few years
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

4. Are there proactive strategies implemented to recruit or promote women into senior management positions?\
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

5. Does management show respect for diversity in work and management styles between women and men in the organization?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

C. Human Resources

This section focuses on human resource policies and the level and extent of gender considerations in hiring and personnel reviews in the organization.

1.Is there a written equal opportunity policy in the organization?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

2. Are there flexible work arrangements in the organization?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

3. Is there a maternity and paternity leave policy in the organization?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

4. Is there a childcare and dependent care leave policy in the organization?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

5. Is gender awareness included in all job descriptions in the organization?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

6. Is gender awareness included in the organization staff performance & development review criteria?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

7. Is there training of staff in gender awareness and sensitization in the organization?

[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

8. Is there training of senior management team in institutionalizing the integration of gender into the management of the organization?

[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

9. The organization promotes teamwork, involving both men and women as equal partners

[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

10. Management is committed to promoting female representation at senior levels of the organization.

[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

11. There has been a gradual increase of gender expertise among staff members in the organization.

[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ]Strongly Disagree

12. Good performance in the field of gender is rewarded in the organization.

[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

D. Advocacy, Lobbying and Communications

This section focuses on the quality and gender sensitivity of the organization communication and advocacy campaigns.

1. Are the organization advocacy and lobbying campaigns/ initiatives planned and informed by a gender perspective?

[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

2. Are the organization advocacy and lobbying policies and plans influenced and advised by women's organizations, networks and gender experts?

[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

3. Is gender incorporated in the organization communications, fund-raising and media strategies?

[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

4. Is a gender perspective reflected in the organization publications, for example books, brochures, newsletters?

[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

E. Financial Resources

This section focuses on the level of the organization resources budgeted for gender equity.

1. Does the organization budget adequate financial resources to support its gender integration work?

[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

2. Are financial resources allocated for the operationalization of the gender policy at all levels?

[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

3. Is staff training in gender issues systematically budgeted for in the organization?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

F. Organizational Culture

This section focuses on the level of gender sensitivity in the culture of the organization.

1. Does the organization encourage a gender-sensitive behavior, for example in terms of language used, jokes and comments made?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

2. Does the organization reinforce gender-sensitive behavior and procedures to prevent and address sexual harassment?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

3. Is staff in the organization committed to the implementation of a gender policy?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

4. Are gender issues taken seriously and discussed openly by men and women in the organization?
[ ] Not at all [ ] to a limited extent

[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

5. Is gender stereotyping (e.g. "those gender blind men", or "those feminists,") addressed and countered by individual staff members in the organization?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

6. There is a gap between how men and women in the organization view gender issues
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

7. The staff in the organization are enthusiastic about the gender work they do.
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

8. Staff in the organization thinks that the promotion of gender equity fits into the image of the organization.
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

9. <u>Women</u> in the organization think that the organization is women friendly.
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

1. <u>Men</u> in the organization think that the organization is women friendly
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

2. The organization has a reputation of integrity and competence on gender issues among the lead organizations in the field of gender and development.
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

12. The organization could do much more than it is currently doing to institutionalize gender equity.
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ]Strongly Disagree

13. The culture of the organization places a higher value on the ways males tend to work and less value on the ways females tend to work.
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

14. Meeting's in the organization tend to be dominated by male staff.
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

15. The working environment in the organization has improved for women over the past two years.
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

16. It is unfair to promote women more than men in the organization field programs/ projects.

[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

17. In the organization males have a much easier time establishing personal and professional networks within the organization than do females.

[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

18. In the organization, what are three characteristics of an ideal worker?

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Annex 4: Supervisory Checklist to Monitor Institutional Gender Mainstreaming

No	Supervision Themes for Respective Units	Yes	No
Policy, Plan, Monitoring and Evaluation Units			
1.	Is gender equity addressed in the health policy, strategic and normative documents?		
2.	Have gender analysis been undertaken for the health sector annual planning?		
3.	Does the planning process include men and women in the target population?		
4.	Has the gender unit been consulted?		
5.	Have gender focal points from partner agencies collaborated?		
6.	Do awareness-raising briefings on gender conducted for decision-makers/planners?		
7.	Is budget allocated for gender mainstreaming activities during planning?		
8.	Are sex- disaggregated data used for the allocation of resources to implement gender-responsive interventions ?		
9.	Are gender issues included in the checklists for supportive supervision?		
10.	Do the M/E tools and formats incorporate gender?		
11.	Is gender considered in researches?		
Gender Unit			
1.	Is there a focal person assigned? Is there a gender officer (trained in gender)?		
2.	Is there adequate budget for facilitating gender mainstreaming?		
3.	Are there stakeholders assisting the unit?		
4.	Are there educational and training opportunities on gender and health, and gender mainstreaming?		
5.	Are there strategies for multi-sectorial linkages and for networking? Including GBV.		
6.	Are there tools developed for training, supervision, implementation and auditing for gender mainstreaming guideline etc.		
7.	Does the performance auditing address the status of gender integration?		
8.	Is there inter-sectorial collaboration to advance gender mainstreaming in the activities of other units within the health system?		
Health Promotion and Disease Prevention Units			
1.	Are all staffs trained on gender mainstreaming on programs?		

No	Supervision Themes for Respective Units	Yes	No
2.	Have the relevant gender issues been identified?		
3.	Have plans been designed to address gender issues in the priority programs?		
4.	Are gender-responsive interventions and indicators selected?		
5.	Are there tools/formats for monitoring and evaluation that includes gender?		
6.	Are gender issues included in the checklists for supportive supervision of programs?		
	Financial Utilization and Mobilization Units		
1.	Are the finance staffs aware of concepts of gender budgeting?		
2.	Is consideration given to gender issues in resource mobilization and gender budget allocation for health?		
3.	Are considerations given to gender gaps in the designs of health care financing schemes and insurances?		
4.	Are the budget and resources allocated to the various areas adequate for them to address gender issues?		
5.	Is there a monitoring and evaluation system in place to track that budgets have being utilized as planned?		
6.	Are there continuous medical supplies and logistics for the provision of gender-responsive health care?		
7.	Is there continuous medical supply for emergency maternal care including contraceptives?		
8.	Is gender a criterion in donor funded programs\projects?		
9.	Are gender issues given consideration in the mobilization proposals/projects?		
	Public Relation and Communication Units		
1.	Are the recognized gender gaps given consideration when designing PR materials?		
2.	Is there a section on gender in the periodic publication of the health sector?		
3.	Is publicity accorded to the gender related activities in the health sector?		
4.	Do the communication strategies of programs incorporate gender?		
	Human Resource		
1.	Is there a sex disaggregated database with the number of staff by education level, position and year of service?		
2.	Is there a format for keeping record of male/female employee's promotion and training experiences?		
3.	Are managers and staff familiar with gender issues in HR according to the Civil Service legislation?		

No	Supervision Themes for Respective Units	Yes	No
4.	Are there enough staffs recruited and deployed for the implementation of gender-responsive interventions?		
	General Service Units		
1.	Are all the general service staffs oriented on gender issues?		
2.	Are there opportunities to supplement the skill and income for general staff?		
3.	Do staff have clearing attires and awareness on the proper utilization?		
	Health Infrastructure Units		
1.	Are gender issues given consideration with respect to infrastructure? (availability of water, electricity and means of communication)		
2.	Are the health infrastructures organized to suit women friendly services? (privacy, indoor toilet in labor and delivery units, adequate and ventilated space)		
	Internal Audit Units		
1.	Are the audit staffs adequately trained on gender issues and auditing approaches?		
2.	Are the auditing tools revised to include auditing of the gender dimensions of health?		
	Medio Legal Units		
1.	Is gender mainstreaming integrated in the priorities of the legal unit?		
2.	Are gender issues included in the training of the staff?		
3.	Does the unit have the capacity to address gender related problems?		
4.	Do the official agreements maintain gender equality in the workplace?		
5.	Do the medical ethics integrate gender equality and equity? (Stigma and discrimination of PLHIV and disabilities…)		
6.	Does the office consider workplace gender related disparities/abuses/harassments as deserving actions?		
	Anti-Corruption Units		
1.	Are the staffs aware on gender related corruptions and misuse of authority?		
2.	Does the office consider workplace gender-based violence related disparities?		

Annex 5: Training Schedule

Days	Agenda	Time
Day One	Registration and Welcome	2:30-3:00
	Creating a conducive learning environment	3:00-5:00
	Tea Break	5:00-5:15
	Module 1: Gender concepts and terminologies Session 1: Gender concepts and terminologies	5:15-6:30
	Lunch Break	6:30-7:30
	Module 1: Gender concepts and terminologies Session 1: Gender concepts and terminologies	7:30-9:00
	Tea Break	9:00-9:15
	Module 1: Gender concepts and terminologies Session 1: Gender concepts and terminologies	9:15-11:15
	Team Review	11:15-11:30
Day Two	Recap	2:30-2:50
	Module 1: Gender concepts and terminologies Session 2: National and international legislations, policies and conventions related to gender	2:50-4:00
	Tea Break	4:00-4:15
	Module 1: Gender concepts and terminologies Session 2: National and international legislations, policies and conventions related to gender	4:15-6:30
	Lunch Break	6:30-7:30
	Module 2: Gender as a social determinant of health in Ethiopia Session 1: Situations of women in Ethiopia	7:30-8:10
	Module 2: Gender as a social determinant of health in Ethiopia Session 2: The life-cycle approach	8:10-9:00
	Tea Break	9:00-9:15
	Module 2: Gender as a social determinant of health in Ethiopia Session 3: What does the data show	9:15-11:15
	Team Review	11:15-11:30

Days	Agenda	Time
Day Three	Recap	2:30-2:50
	Module 2: Gender as a social determinant of health in Ethiopia Session 3: What does the data show	2:50-4:00
	Tea Break	4:00-4:15
	Module 2: Gender as a social determinant of health in Ethiopia Session 3: What does the data show	4:15-5:00
	Module 2: Gender as a social determinant of health in Ethiopia Session 4: Gender-based violence	5:00-6:30
	Lunch Break	6:30-7:30
	Module 2: Gender as a social determinant of health in Ethiopia Session 4: Gender-based violence	7:30-8:30
	Module 2: Gender as a social determinant of health in Ethiopia Session 5: Gender and mental health	8:30-9:00
	Tea Break	9:00-9:15
	Module 2: Gender as a social determinant of health in Ethiopia Session 5: Gender and mental health	9:15-10:15
	Module 3: Gender mainstreaming Session 1: Understanding gender mainstreaming	10:15-11:15
	Team Review	11:15-11:30
Day Four	Recap	2:30-2:50
	Module 3: Gender mainstreaming Session 2: Tools and techniques of gender mainstreaming	2:50-4:00
	Tea Break	4:00-4:15
	Module 3: Gender mainstreaming Session 3: Gender integration process	4:15-6:30
	Lunch Break	6:30-7:30
	Module 4: Gender analysis Session 1: Understanding gender analysis	7:30-9:00
	Tea Break	9:00-9:15
	Module 4: Gender analysis Session 2: Gender analysis frameworks and tools: gender analysis matrix	9:15-11:15
	Team Review	11:15-11:30

Days	Agenda	Time
Day Five	Recap	2:30-2:50
	Module 4: Gender analysis Session 2: Gender analysis frameworks and tools: gender analysis matrix	2:50-4:00
	Tea Break	4:00-4:15
	Module 4: Gender analysis Session 3: Gender-sensitive monitoring and evaluation for health programming	4:15-6:30
	Lunch Break	6:30-7:30
	Module 5: Gender audit Session 1: Understanding gender audit	7:30-8:30
	Module 5: Gender audit Session 2: Gender audit tools and process	8:30-9:00
	Tea Break	9:00-9:15
	Module 5: Gender audit Session 2: Gender audit tools and process	9:15-11:15
	Team Review	11:15-11:30
Day Six	Recap	2:30-2:50
	Module 6: Gender budgeting Session 1: Understanding gender budgeting	2:50-4:00
	Tea Break	4:00-4:15
	Module 6: Gender budgeting Session 2: Approaches and tools for conducting gender budgeting	4:15-6:00
	Lunch Break	6:30-7:30
	Module 7: Gender and the health workforce in Ethiopia	7:30-8:30
	Action planning	8:30-9:00
	Tea Break	9:00-9:15
	Action planning	9:15-10:15
	Course evaluation and closing	10:15-11:15
	Team Review	11:15-11:30

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