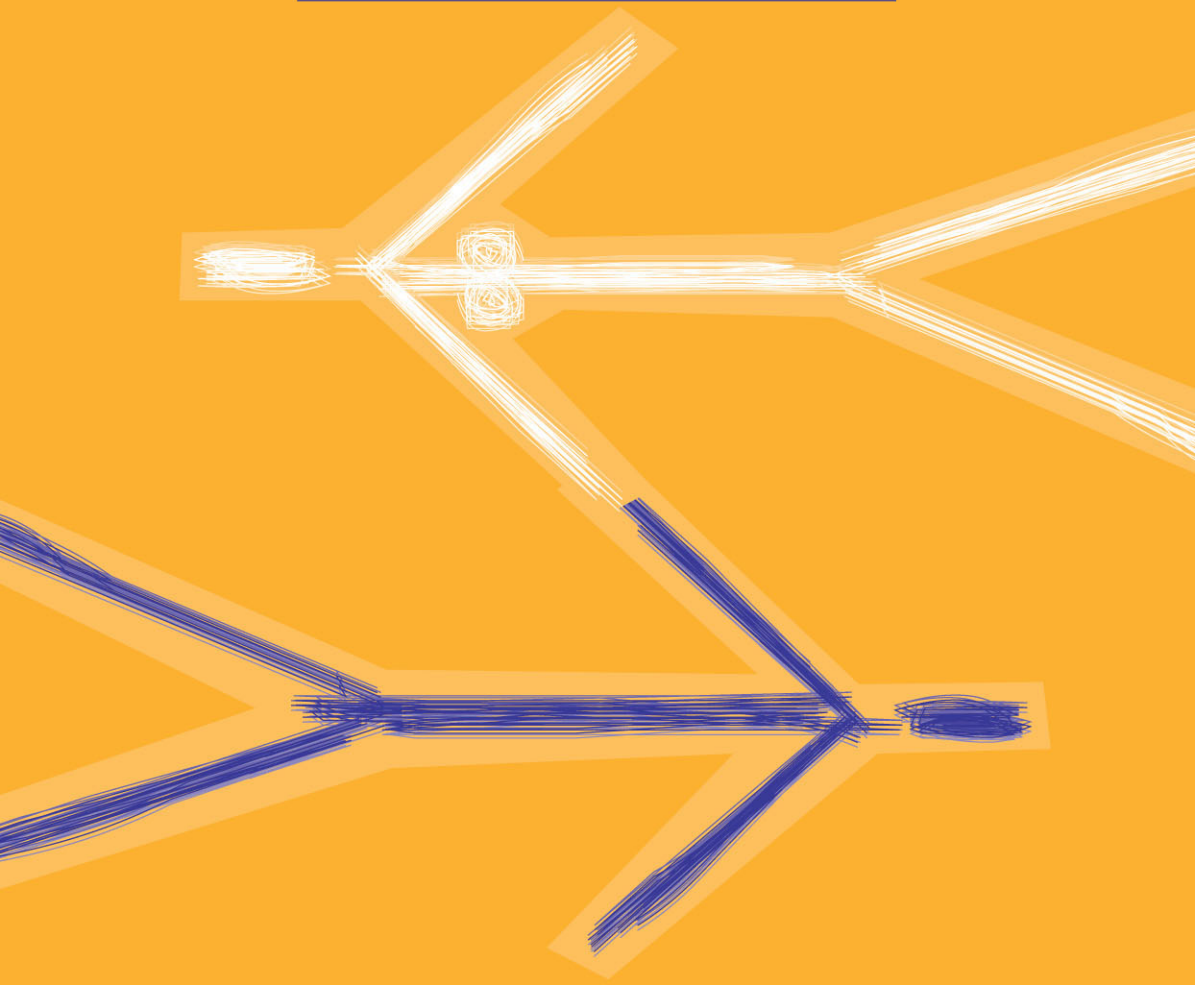
HEALTH AND GENDER

Practical Guide for Practitioners in Co-operation



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(Coordinators)

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Preface

At the beginning of a new century, thanks to the advances in knowledge and technology, human beings are controlling the conditions curbing life into our organism or reducing it with disabilities. Degenerative diseases have become the borderline between welfare and death. But in terms of health, the main advance sprang up last century with the so-called sanitary revolution which brought a decrease in the birth-rate, a decrease in the maternal-infant mortality rate and an increase in life expectancy. This turning point in history, regarding health, comes from the evident improvements in conditioning factors such as an almost generalized access to drinking water sources, water purification, health education, betterment in maternal-infant care, vaccination programs and control over infectious illnesses. However, the reach of these programs have been mainly seen in developed countries, leaving those impoverished areas aside. It is well known that socio-economical factors are decisive in a multilateral consideration about health. Social progress lies in a good health environment, therefore, we can not speak about progress in places where poverty exist. Gender inequities influence the role and the position of women to a large extent, increasing their poverty levels and their morbimortality rates. In the same way, the dimension of gender determines some unhealthy male attitudes which contribute to maintain the subordination of woman.

With respect to this, the answer of the civil society, is the action through NGOs that carry out programs with specific groups. Organizations like Médicos del Mundo, spread out on those least developed countries or areas, try to reduce that increasing morbimortality rates and improve the quality of life through the development of abilities and empowerment. In these areas, the demographic expansion keeps on being one of the most important problems of public health, specially because of a remarkable reduction of natural resources, perinatal deaths and incapacities linked to maternity and risky sexual behaviours, which make that equitable social integration of women more difficult every time. The analysis of this situation make us all concentrate on the basic

health services, and focusing specially on sexual and reproductive health, carrying out programs on mother-fetal health, child health, reproductive health, family planning, prevention of STI (sexually transmitted illnesses), and promotion of empowerment and equity for women. It is considered of great importance, to work at the same time, in items like education, work market, legal affairs and participation in politics. This way we can contibute to the equitable development of women and men, considered as a basic element in social justice.

Clearing up the objectives together, facilitates the learning of the use of the limited resources available in an efficient way. Regarding this, our comprehensive and didactical guide, not only analyzes and develops conceptual tools in gender analysis, but has also given a practical approach, which makes it more attractive for our organization. Our goal is to put it in the hands of all those involved in projects, so they can be part of the whole process, from the planning and the design to the execution and the evaluation. By writing this prologue together, as a woman and a man from the board of directors, emphasize the importance of the reproductive abitlity as a process in which men and women must be partners.

To finish up, we have to add that following our traditional way of working, this guide exists because of the great contributions of volunteers, the operative structure and those experts who brought all the background with them. Thanks to all of them. We hope and wish our guide motivates the creation of future better programs which help improve the life of those who are in need.

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President of the Directive Board of Médicos del Mundo

Nina Parrón
Gender Affairs Member of the Directive Board of Médicos del Mundo

Introduction

This guide is a supporting material for co-operators and practitioners of health services. It mainly aims to bring about a deep reflexion on several topics involved. At the same time it helps the technical team to focus on the importance of making gender a very relevant part of their jobs, so that equality items are included in the field of co-operating developmental health projects. We try to cover all the parts in the making of the project, (from the beginning in their countries of origin, throughout the development, until the moment they come back). That is the reason why it is divided into these parts: "First of all", "Before setting off", "Our fieldwork" and "Coming back". We hope to fulfill and solve many of the concrete questions and doubts about gender the team may have while participating in any sort of sanitary co-operation experience.

The lack of materials and sources in Spanish regarding gender applied to health, sexual and reproductive health, currently denounced by the DNGOs, has given rise to a huge breach that we intend to fill. With this book, we aim to give practical and reflexive solutions, pose concepts and questions and give guidelines on gendering health topics (health services, reproductive health, family planning, sexually transmitted infections, violence, etc). At the same time we design tools to make gender analysis in projects (with samples), set guidelines on cultural differences, on personal and institutional gender identities and collect a good number of informative resources "to go beyond". Though oriented towards action, this guide supports the reflexion processes in co-operators about the intrinsic gender dimension of our work. Gender relations and masculinity (commonly discarded) are analyzed here as part of a more comprehensive guidance where it is necessary to take into account the role of men in an equality gender conception of sexual and reproductive health.

Who is this book oriented to? In general terms, we try to reinforce the work on gender that are performing those participating in sanitary co-operation projects. First of all, we have sorted the co-operators into two big groups: those managing programs and projects, administrating or co-ordinating from

an office and those health specialist who partipate directly in sanitary service to women and men of a concrete community. Since questions and doubts have been dissimilar in both cases, we have to go over them differently. The guide has been published in sequence so steps in the process (before, during or after) can be very easily identified, while thematic, methodological or informative questions on gender and health can be solved. Regarding the content, each chapter can be also taken as an independent whole including concepts, questions, examples, resources and practical exercices. Personal and institutional background in sanitary co-operation have been considered to be a norm in developing the topics. For this reason, we have created a wide multidisciplinary team which have worked hand in hand with the supporting organization. From the beginning, co-operators and practitioner's opinions and experience have been used in the creation of this. The selection and identification of topics, objectives and application of methodology is undoubtedly the result of team work. Indeed, our main purpose was to produce a useful material that could solve typical questions in a sanitary co-operative environment altogether with the cultural travelling involved in co-operative projects.

The editorial committee was made up by August Burns, Irene López, Isabella Rohlfs (CAPS), Beatriz Sierra and Diana Sojo (Médicos del Mundo). We praise the valuable work of the then Gender Group from Médicos del Mundo formed by Hector Alonso, Mariso Baeza, Asun Buil, Ion Gorriti, Ágata Juanicorena, Luz Martínez-Ten, Nina Parrón, Pilar Ramón and Beatriz Sagrado. Cristina de Sierra and Angel Muñoz shared their fieldwork with us and Pedro Campo gave the best of his experience as Project Technician. It would have been impossible to finish our guide without the support of the Spanish Population Gruoup, Health and Reproductive health group led by mercedes Mas de Xaxas, vicepresident of Advocacy International from Population Action International and the Women Institute and the Hewlett Foundation led by Joe Spiedel. We want to thank some other organizations that helped us developing the survey questionnaires to determine the profile, formation and sensitivity of the Spanish health and gender co-operator; thanks also to Action against Hunger, ACSUR Las Segovias (Association for the Co-operation with the South), Spanish Red Cross, Medicus Mundi, Médecins Sans Frontières and International Solidarity. Pilar Ramon and Miriam Cabrera from Médicos del Mundo send, received and made some of this material which will be published next year. Thanks to all the co-operators who in a any way helped us making this guide come true. Thanks to Enric Royo from CIDOB Foundations for his bibliographical revision, Mercedes Solís for performing all the secretarial job in the editorial committee, Aliicia Mele for her patience and support editing and correcting texts and to all our friends and families for their unconditional support.

Madrid December 2001

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Part One First of All

Chapter I

Why Do I Need to Think about Gender if I Am Working in a Health Project?

Gender has to do with life of people, boys and girls, man and women, their right to development and their right to have a decent and a healthy life.

Gender is a proposal that integrates health and development based on people not on things.

Those projects that do not integrate both terms, lose efficiency and impact and cannot get to those in need; sometimes they can even bring unexpected consequences on people's life, on women-men relationships and lives.

Gender fights discrimination against sex, race, social origin, religion or sexual orientation.

1. How Are Men and Women Different? Sex and Gender

Sex is a basic part in human biology: we are born men or women. Men fertilize and women conceive, give birth and feed babies. Starting from this biological and physiological differenciation, we have made up a group of values, attitudes, behavioral rules that make up our identities as men and women, our **gender identity**. Questioning about this can be uncomfortable, because this implies questioning our own ways to see ourselves, our personal and social relationships, our culture and traditions. **Gender comes from a proposal that intends to establish the differences and relationships between men and women.**

Historically, it was natural to consider men to be superior and women to be inferior; a biological and immutable fact that explained and justified the origins of discrimination and inequalities against women just because of being women. Women were considered unable to do things and uncapable of performing some professions; dependent beings uncapable of decision making and autonomy were not thought to be bearers of rights to participate in public life. Women, for instance, have been historically excluded from public health or medicine. The roles of women and men in the family and the society have been described in terms of stereotypes; for example "women can bear pain better", "men are physically stronger", "women are more emotional and men are more rational", etc. Opposite to this, **the term gender appears as an alter-**

native proposal comprising differences between men and women as part of a social and cultural construction that can suffer changes and transformation. These gender inequalities, similarly to other social inequalities, influence greatly in the health of people, becoming an important issue not only in this chapter but all along our project.

Sex

It refers to the biological and physiological difference between women and men. As as result of this, some activities are definitely conceived as masculine and some others as feminine all over the world. Activities which will continue unchanged because of the nature of this biological distinction. Giving birth is an example of this. However, if we try to understand the complexity of the organization we call society, sex is a very limited concept. It is then important to understand and consider the roles derived from this differenciation, but it is completely insufficient to explain the many variations that the context implies.

Gender

It refers to the roles, responsibilities and opportunities associated with being man or woman and with sociocultural men-women and boys-girls relationships. These attributes, opportunities and relations are socially built and are learnt through socialization processes. They vary from one culture to another, and can change in time, among others, because of political action. In all societies there are differences and inequalities between actitvities men and women perform, in the access and control of resources in the and decision making possibilities. All this determines a great difference in the way processes of health and illness in men and women are seen. Health risks for example increase or decrease depending on the individual (Why do men have more car accidents?, Why are women more likely to suffer form depression?).

We learn to be men or women

The characteristics associated with sex are learned from the moment we are born. Each individual has to become a woman or a man through socialization processes in the family, in the school, and in all those groups or institutions where we are educated and taught. We learn how to behave as boys or girls; we are rewarded if so and criticised if we try to change those “boys do not cry” or “girls do not climb up trees” rules.

Gender is part of our individual and social identity

Being a woman or a man is part of our identity, our subjectivity and the conception we have of the world. The characteristics assigned to our sex are strong because we learn them at the beginning of our lives and are components that make up our being, what we are and what others expect from us to do. Daily life is based on gender rules and this influences the way we face health and illness, the roles we assume and the way the health system deals with us (Why do men visit doctors less frequently?, Why are women more willing to take care of ill relatives?).

Gender is linked to other identity attributes: race, social class, age, sexual orientation, etc.

Focusing on a gender dimension does not mean that we leave some other fundamental aspects of our identity apart; race, age, social class, religion or sexual orientation are important factors to be considered. All these have repercussions on the health of people and on the access to health services. Gender has to be considered altogether with those elements, because they are definitely interrelated by all means. In the generic women and men group there are several realities of life: women and men, country people and urban people, black and white, homosexuals and heterosexuals, poor and rich, young and old and a great variety of intermediate possibilities. Gender modifies other attibutes of the personal and social identity. Men and women can share situations of poverty, racial or social discrimination, etc, but gender determines the way and the chances they have to face these problems.

The Feminization of Poverty

In general, economic recessions affect the health systems in all countries, bringing devastating consequences in poor population groups. However, they affect differently men and women coming from the same social class. So, if men experience difficulties in finding a good job and getting money, women are not exempt from this. Social rules discriminate women when looking for a job, getting underpaid occupations. The access to other economic resources like credits, land or technology becomes impossible because of the need to make their jobs compatible with their roles of mothers, taking care of children and others. On the other hand, in many developing countries there is a great rate of monoparental families led by a woman who has to support her family on her own. These difficulties explain the phenomenon known as feminization of poverty, which at the same time increases the vulnerability of physical and mental health in women.

Gender changes and is culturally specific

Gender changes from one generation to another

In our cultural context, for example, there exists a clear difference in gendered roles assumed by men and women all along the 20th century. The massive access of women into the work market creates new gender relationships in our contemporary societies.

Gender changes from a regional context to another

Even in the same country, we can find differences between the city and the country part. There are characteristics that vary from one community to another. As we can remember, gender is culturally specific.

For this reason it is neccesary to be careful with our preconceived ideas about gender and health; the ones in our countries can be different from those existing in the countries or communities where our co-operative work will be done.

Gender changes over time

Just by living, a person will experiment a change in his personality and modifies the vision on gender he has. The society changes and the person will change his values, norms and ways to judge events. Is it not like that in our own lives?

Gender and gender relations are affected by public policies

These can contribute to maintain or make the inequalities bigger, or by contrast and in general terms, promote a more equitable economic and social development.

Sanitary policies are also included here. They can produce some unexpected negative effects on the access that some particular communities might have to those policies (because specific aspects of their health are not prioritized, or even after being identified, are not reachable).

Sanitary policies can be affected at the same time by macro-policies, like structural reorganization which contribute to make gender inequalities worse.

An Extreme Case: the Taliban Regime in Afganistan.

Women were relatively free to work, to dress the way they wanted, to drive or simply to be out in public places until 1996. The current situation of women in Afganistan is so extreme, that speaking of "human rights violation" sounds like euphemism. Men have the right to let their wives and other female relatives live or die. Any desobedience about showing a piece of their bodies in public spheres offending them can mean death. Crowds of men might throw stones or beat them causing women to die. High depression and suicide rates are the consequence of this fast paced transition. Teachers, doctors and other privileged women are being now deprived of the most elementary liberties and are now receiving a infrahuman treatment in the name of muslim fundamentalism. In this case, we are not speaking about tradition or culture, but about alienation; an extreme existing situation even in countries where fundamentalism is the rule. And remember everybody has the right to live honourably, even women living in muslim countries.

Unfavourable Policies

When the realities of women and men are not considered to be an important asset in society, any policy can have some unwanted negative results that affect social equality. For example, policies to fight poverty usually exclude lonely women and widows. Reorganization policies have had devastating effects on the life of the affected communities. Women who were in charge of the feeding, health and education of their families had to face new responsibilities when social services were withdrawn.

Gender makes reference to men and women and gender relations

Gender does not mean woman. Gender refers to the way in which our culture or society places us depending on whether we are men or women. Gender analysis is not based on women, but on the analysis of rules, rights, obligations and relationships that place men and women in a different position in societies.

When we think about the reality of a person, man or woman, the first thing coming to our mind is the environment: the town or city where he/she lives, his/her couple or partner, his/her children, his/her work, his/her interests and the way he/she spends his/her free time. All these aspects of their lives are organized by a set of social relations that determine the way things are done, the requirements to be done, the people participating and the control over

them. Some of these rules are assigned depending on whether you are a man or a woman. This is what we call gender relations. Gender relations are liable to be changed and can have an evolution.

When economic, social or political circumstances are modified by regional or global market conditions or changes in the political context, rights and responsibilies typical of men and women are redefined according to those changes involved.

There are circumstances like war or migration that put the whole responsibility of families and homes in the hands of women. Costums had to be changed to favour the wellbeing of women and the possibility to support their families. Then they had to perform typically male activities and duties and be responsible for the results. Rules were then adapted and permitted women to have a relevant role in public life.

Gender relations are relations of power

Gender relations are relations of power that place women in an inequal subordinated situation. These relations are individually and collectively visible both at home and inside political institutions. At home women may not have access and independent control on economic resources or can be the object of domestic violence. They maybe lack of access and control of contraceptive devices and even her own body. Inside political and health institutions, women's interests and purposes may not be represented and eventually may have problems to be heard. On the contrary, men have a legitimate right to generate and control economic resources because of being born men. They can decide to support their families or not and are considered to be independent to control their rights and power to perform and speak on their behalf.

For this reason, the position of women in gender relations is thought to be considered subordinate. This does not mean all women are ruled and subdued by their husbands or couples. However it is well known that women are in a lower position in comparison to men [1]. Men can also suffer from the gender oppression, can be dominated individually or subdued as part of a group where they are not considered as real men according to the social rules agreed (homosexuals, unmarried men, men without children, patients of AIDS, or monogamous men living in poligamous communities).

Gender and empowerment

Gender relations are considered power relations; for this reason disem-

[1] Lagarde (1996).

powerment in women has been identified as the main obstacle to go towards more equalized gender relations. This is the basic explanation to go towards empowerment.

Beyond concrete life conditions in discriminated communities, this proposal focuses on their capacity to generate changes, to strenghten their economic, social and political situation in such a way that they can make a change in the reality where they have to live in. An improvement in health services would be useless if cultural problems keep on existing, impeding women or men to have access to them. For example, sexual harrasment in the workplace creates a hostile and intimidating environment with terrible consequences on the workers' health. Why do many women tolerate it? Because they are disempowered. In many cultures, including ours, women's bodies and sexuality do not belong to them.

This means there are others deciding for them. That disempowerment to decide on when and how to have sexual relationships, to use or not contraceptives, to wear more comfortable clothes and even to go to the doctor or gynaecologist, leads to dangerous consequences on the sexual and reproductive health that remain unreachable for the health system. The importance of empowerment in health and reproductive health was clearly stated in the El Cairo Conference on Population and Development 1994 (ICPD) [2].

It will be impossible to improve these two items if we do not identify and accept that women are in disadvantage in empowerment relations to make a change. Empowerment implies promoting changes in the position of women in society, in such a way that they become aware on how the empowerment relations affect their lives; so later on they could get self-confident and strong enough to change those inequalities affecting them. To get to this point, it would be necessary to help focusing women's participation in all processes affecting them, including health and illness, to know the way they are being solved.

2. Health, Sex and Gender: How Differences of Sex and Gender Influence Our Health

" Health is a psychosomatic habit
at the service of people's lives and freedom;
it then entails the physical ability to carry
on living and enjoying if possible,
their vital projects with a minimum of effort".

Lain Entralgo, *Antropología médica para clínicos*, 1984

[2] See chapter II, the reference to the El Cairo Conference.

Gender considers health to be something different from not-illness

The World Health Organization defines health as the state of complete physical, mental and social wellbeing and not only the simplistic definition of the absence of illness. This definition reinforce both the positive physical perception of wellbeing and the decisive influence of social and environmental factors. However, the traditional sanitary model, in which most of the professionals in the health sector have been trained, focuses mainly on illnesses, specially mortal ones.

As a result of this approach and the operative difficulties in measuring people's wellbeing, it has been difficult to establish reliable health status indicators; so the ones used until now have limited the knowledge on some other health problems affecting men and women. Mortality indicators report on extreme cases where patients have deceased and pay little attention to relatives affected who also have to face and survive the illness. Next we will see the illness based approach does not care about some clue aspects in women and men's health and contributes to keep myths and false beliefs alive, for example that women are healthier than men.

How do differences in sex and gender influence women and men's health and illness?

It is obvious that women and men are biologically and physically different. Those differences influence on health and illness patterns. And even though medical sciences have traditionally talked about this as the only origin of illnesses, there is evidence to confirm that social and cultural issues play an important role in creating some differencial health and illness patterns.

There are some especific biological and physiological bases which condition the existence of some illnesses and disorders that only men or women can suffer. Cancer of the cervix and the prostate are definitely good examples of those particularized gendered illnesses. However most of the human illnesses and disorders can happen to men and women alike. They can be more frequent and have different symptoms or evolution depending on the gender.

This latest research on the way gendered biological differences influence on the health, illnesses, symptoms and response to treatments, is rather new. For example heart attacks (myocardial infarctions) do not show quite visible symptoms in women. We must then understand that sexual and gender differences can not be considered isolated. They are related (excepting in particular gendered diseases) with the interaction between biological differences and gendered social bases (feminine and masculine).

Let's see how biological and physiological differences influence

Life expectancy

There is evidence of a biological advantage for women, that explains the long life expectancy in relation to the same socioeconomic circumstances in almost all countries. This increase seems to be historically recent and works differently according to the cultural environment. With extremely poor environmental conditions, it inverts. In the United States, for example they found a very close relationship with poverty and life expectancy of the population. The higher the life expentancy, the bigger the difference on the age of women. So, this difference seems to be related to the development and social changes that have reduced reproductive risks in women, specially those in mother mortality cases.

Mortality

Practically all communities show an increase in the mortality rates for men compare to that of women. This is something quite interesting if we take a look at the high number of boys dead during the perinatal period. Even though the natural mechanism used by nature has not been explained, chromosomic differences and lung maturity which is more slowly in boys than in girls, are thought to play an important role. However in some communities a differencial treatment with boys and girls have led to revert this phenomenon. For example, in China the birth rate policy, which allows to have one baby only, has led to an alarming increase in the number of female fetuses abortions and the death of girls, reducing the female population in 80%.

Morbility

If in general women enjoy a longer life expectancy and a lower mortality rate, it is not the same case with morbility; something they experiment throughout their lives with more acute and chronical disorders and the presence of disability and handicap. Problems in women's health persist even excluding reproductive ones. How do we explain this? It seems gender imparities are the answer.

Let's see how gender differences can influence

The high rate of morbility in women does not depend on the biological or physiological differences, but on the access to health care, use or financing of services and appears as a consequence of the differenciation and assesment of social roles of men and women. Personal, social or sanitary resources are

closer to men in all societies. Gender stereotypes also condition the duties assigned to each sex generating higher risks or protection. So, gender can explain to a large extent the different health and illness profiles of women and men at all levels.

On an individual basis

a) Protecting women and men differently throughout all of their lives. As examples of this in youngsters are:

> A prevailing existence of eating disorders in women in cultures where physical beauty (associated to extreme thinness) becomes a leading value in identity.

> The death of young men in car accidents or violent events in cultures where masculinity is associated to taking risks, wearing weapons and practicing violent sports, etc.

b) Conditioning the personal and economic resources and abilities differently. Examples of this are:

> Virginity, passiveness and faithfulness are socially attributed and considered natural in women. These values make it harder to have an open dialogue on sexuality, to have access and to be provided with an affective sexual education. This leads to unplanned or unwanted sexual relationships because of an impossibility to decide on the use of contraceptive methods.

> Male sexuality is based on opposite values and stimulates an early start in sexual relationships, multiple sexual couples and the lack of compromise in the reproductive process causing unplanned pregnancy episodes.

Gender analysis on this examples shows us the varied limitations women and men experience to develop a pleasing, free and responsible sexual life. However, we must remember gender analysis does not exclude biological differences which can cause health problems as a result of unprotected sexual contacts; something that worries women as we will find out in chapter III.

On a social basis

The gendered allocation of duties, responsibilities or differenciated roles, place reproductive work on women; it includes housework, pregnancy, children, adults and senior's care, cooking, collection of water and energy sources, shopping, income management and health problems. As a consequence of a good performance, women could reach a certain place in the community, and sometimes with many health problems. In some women, the devaluation of mothering and reproductive tasks results in low self-esteem.

Those working in the production of goods and services destined to be sold and consumed, generally have worse conditions, have low salaries and less possibilities to be promoted. Production and reproduction tasks performed by women give rise to some health problems. Some examples of this are:

> A prevailing existence of depression in women is not as related with hormonal factors as it is with the dedication and work overload they experience. Besides women's work is not positively valued by their families or communities.
> A high prevalence of working accidents to men goes in relation to the longer time they have to be performing some kind of hard or risky physical activity.

Men do not care about reproductive tasks and concentrate on public or productive ones, causing his family relations to weaken, generating problems for their physical and psychological balance.

On an institutional basis

Being part of a social and cultural system, sanitary institutions and their professionals also reproduce and reinforce unintentionally and unconciously sexist behaviours (sexism is about formulating unjustified hypothesis on the objectives, abilities and social roles of a person based on his or her sex). Good examples or this are:

> The scarce presence of women in decision making in sanitary organizations and the strong imbalance of occupations, salaries and benefits for women and men.
> The late recognition of domestic violence as a public health which has been reported in most of the countries of the world.
> The little importance given to pathologies and treatments for mainly women disorders.
> The low investment on mother mortality in developing countries.
> The exclusion of men from the reproductive health services.
> The discriminatory conduct of medical and pharmacological research which has excluded women from clinical studies of patologies affecting both sexes. As a consequence, the results obtained are based on unreliable information which can be risky for women's health.

It is clear that in both public and private sanitary organizations there is gender inequality. Men are in the most respected managerial and medical positions, even though most of their job is performed by women.

Besides the access to institutional formation remains unreachable. Women have to fulfill their reproductive responsibilities and cannot attend formation courses because they would have to choose between this and their families. Injustice to the sanitary staff (men and women) contribute to keep that same inequality in the service they give to communities.

What other social aspects influence health injustice promoting gender inequalities to arise?

Race, social class (including the salary level, living conditions, education and occupation) are altogether with gender the most important social factors in health.

Several investigations have demonstrated the way health systems may seem discriminating for some groups based on them. These social categories imply a singular expression of non-biological but social relations that undermine power relations and inequeality.

Summary

Gender issues in health influence men and women in a different way, conditioning unequal:

- Needs.
- Risks.
- Perception of health.
- Evolution of illness.
- Type and frequence of attendance to the health system.
- Level of access to basic health resources.
- Control of family, community and institutional health resources.

It is necessary to keep these differences in mind in the planning of health services, if we are interested in solving health and illness problems in diverse population groups. If implications of roles and gender relations are not considered, health planning will be inappropriate and therefore health service workers will fail in their attempt to assist certain groups or individuals. Differences and inequalities in health are visible in the way health and illness are promoted, prevented and controlled.

In the way that patients are treated and in the way that models to structurate health and social security systems are adapted. In fact, if we do not consider biological differences as a relevant matter, we would have to ask how and when ill people are treated by the health system of their community.

3. The Perspective of Gender in the Development and Co-operation in Health: Evolution and Implications

How did they get of this proposal? How did it change from "women in development (WID)" to "gender in development (GID)"?

In the evolution of co-operation policies for development, we find some important changes in the perception of women problems. The WID proposal had its origins in the 70's and set women and their participation in cooperation programs as their main objective. This proposal aimed for women to be benefited from international co-operation plans. Their roles must change and needed to be changed from only passive receptors of wellbeing programs to become active contributors of the economic development. The WID proposal fights for the idea of considering women with a highly productive role in society (paid or not) to be accepted. A role bigger in importance from the existing one in previous co-operation developmental projects. For this reason it is important and necessary not only considering those productive activities from women, but to support them economically. This way, economic and productive conditions in developing countries as well as population living conditions would be improved. Projects of WID proposal are mainly focused on women's wellbeing and try to increase and improve all those money producing activities around them. In the late 70's this women-centered approach was thought to be questionable. Former experience on similar projects demonstrated certain barriers (not neccesarily economical) could not be modified. These barriers in women's lives stopped the increasing control of their own lives. A new approach called GID (Gender in Development) araised in this context and it certainly enjoys worldwide legitimicy.

> It is hard for women to perform their money raising activities properly if there are cultural rules prohibiting them to be seen in public in specific places or at a specific time. Besides housework must be done and they never have the chance to share this in an equalized way.

What Is the GID approach?

This approach wants to incorporate the global context where women and men live. The main problem here is not the integration of women by themselves, but the social structures, processes and relations putting women in an inferior and disadvantaged situation. The problem of inequelities between women and men deals with more than a simple distribution of economic resources; For GID, the solution lies in the redistribution of power in social and

specific gender relations. A process that can generate conflicts and opposition that are not ignored. On the contrary, GID wants them to be visible enough to be incorporated in constructive interaction and diologue among the participating agents. In other words, this is about making a change in the production of social changes looking for gender equality. An objective justified by ethical reasons, and strategies to improve the efficiency of actions to reach developmental goals like poverty erradication and sustainable development. There is now a growing acceptance of this approach among international co-operation organizations which rejected at the beginning by the political, ideological and transforming components involved. From reflection on existing inequalities between men and women, emerged the need for women to acquire a major power to negociate and a major control over their own lives. Empowerment becomes one of the fundamental strategies in GID. Something that can not be given, but self-generated, demands planning actions in development to be done starting in the lowest levels, through open and participative methodologies altogether with local women organizations.

What does the gender in health perspective imply?

This evolution has had a clear influence in the conception of health projects. The approach used in most of women centered cases (women, health and development), has meant some benefits in terms of access to knowledge and control of ways to regulate their fertility and prevention of health problems, reducing risks to health. However, health scientific and technological advances had not guaranteed the end of subordination or the possibility to develop women's abilities to keep their lives and bodies under control. This changed the women-health model for the gender-health model which wants to transform performances in relation to the place women are in society. The following table contrasts the two approaches giving more clear ideas on the way they influence.

Gender perspective is not only a tool used in the study of health-illness processes in men and women added to other influencial factors like social class, income leves, place of living, race, etc. It is a way to reduce inequalities in the access and the use of sanitary resources. It strenghtens women self-esteem letting them making their own decisions about their lives, bodies or sexuality. According to the empowerment approach, developmental and health projects willing to fullfil basic needs, must include objectives and actions making the political and organizational position of women stronger. This way, they can take part in their own lives' decisions, the same way men do. At the same time, in order to construc equalized relations in health, is necessary to refer to the gender relations and include men as a part of them. Women are demanding an

	WID in Health	GID in Health
Perspective	- It considers health risk in women to be the main problem. - It considers the roles of women as educators responsible for the health care of their children, their families and the community.	- It considers health as a way to fulfill basic needs. - Subordination and sex-based division of the work are the causes of inequealities between sexes in the moment they access to health services.
Approach	- Health programs and services considered women as an isolated group. - Maternal health and biological and social reproductive functions of women are basic elements to be considered.	- Analysis of inequalities in the access and control of resources and benefits in health services. - It looks for ways to increase women's abilities to demand for services and widen their choices of health promotion.
Problem	- Insufficient health coverage and quality in services for women. - Low women's knowledge about children, family and community care.	- Health programs and services continue subordination in gender relations and sexist estereotypes. - Socially constructed differences and disavantageous position of women to control their health are not being considered.
Objective	- To improve women's health as an investment in human issues. - To ensure their offspring's health. - To integrate women in the work market. - To increase their efficiency and productivity in biological and social reproductive and productive roles.	- To reduce inequalities in the access and control of resources and benefits of health services. - To develop options and autonomy in women for them to make decisions about their lives, bodies or sexuality.
Solution	- To integrate women in the existing health programs. - To improve their general knowledge and promote their health habits as carer and educators.	- To consider women as people with health rights. - To improve their information on health issues. - To value the social and economical impact of women's reproductive function.
Strategies	- To spread and improve the quality and coverage of health services for women. - To promote formation on health issues to increase women's participation in the community to improve the health of children and community.	- To empower women to promote, protect and take good care of their health. - To look for mechanisms to increase dialogue and negotiation among health institutions and women's groups. - To establish health programs and gender approach services.

organized and systematic response from health programs, for men-women and gender differences to be considered. It is necessary to analyze the ways sexes are interrelated and they way they do with the health system.

Why is the gender perspective important in your job?

In the previous part there is a reflection on the importance of considering the dimension of gender in the work of health. In general terms but with a wider perspective, we can say that in co-operation for development, both women and men are supposed to have the same participation in development, so they both can enjoy its benefits.

The gender perspective lets you understand better the reality of men and women, boys and girls, whose lives are part of co-operation projects. If you are participating in activities that can change the context and content of lives of people, your responsibility is to make sure that these activities are based on real circumstances, limitations and needs of women and men whose lives are being affected with the project.

The gender perspective analyses the impact of development in women and men and is used as a strategy to guide policies and actions towards equality. Regarding health, it is specially important to understand the causes that explain differences and inequalities to effectively determine the success or failure of health programs developed.

Besides these ethic aspects and non-discriminating values that must inspire the work of healt and co-operation proffesionals, there are some other practical arguments explaining the importance of integrating the gender perspective in our work in cooperation to ensure efficiency [3].

What does equity and equality between women and men mean?

Equity between women and men implies the fact of being fair to both of them. To ensure this equity, it is necessry to adopt measures that compensate the historical and social disadvantages that have stopped women and men to enjoy the same opportunities. Equity leads to equality. Equality between men and women means they have the same status and conditions to enjoy human rights. At the same time, they both will be able to contribute to the national, political, economic, social and cultural development and benefit from the results. Equality is therefore, the same valuation of similarities or differences between men and women and the roles they have assumed.

[3] See Family Health International (n.d).

Equality between men and women refers to equality in rights, responsibilities and opportunities.

Equality is not a women's topic only, it involves men the same way.

Equality does not mean men and women must be identical, but to have the same rights, responsibilities and opportunities, regardless their sex.

Gender equality includes quantity and quality aspects. Quantity aspects refer to equal distribution of women and men in all areas of society. Quality ones refer to the need to give the same level of importance to knowledge, experience and values in men or women.

Regarding health, equality implies an identical valoration of women and men's health; This includes: the same responsibility in sexual and reproductie rights, an identical conception of health, same control and access to health services, and attention to women's health, regardless their reproductive cycle etc.

Why do gender stratregies are women-centered?

Developmental organizations have applied policies and gender strategies and carry out projects for women to fight gender inequality. While women are to a large extent, excluded or in disadvantage in comparison to men with respect to social and economic decisions, all efforts must concentrate on women. However, eveytime is more and more common to accept that strategies must concentrate on both women and men and their relations in order to get a real and sustainable change.

Is gender equelity a concern for men?

Gender is frequently overlooked as an important aspect in men's social identity. This is because the tendency is to consider male characteristics and attributes as the norm, and those of women as a variation of the norm. But the lives of men are just as strongly influenced by gender as those of women. Cultural norms and practices about "masculinity" and expectations of men as leaders, husbands, sons and lovers (in other word, their gender) create demands on men and shape their behaviour.

There is a low lever of resources dedicated to research in new contraceptive technologies for men. In most of the countries the leading role of contraception and some collateral and unwanted effects fall on women. In Latin America, women are responsible for contraception in 80% of the couples.

What do men obtain with gender proposals?

Men also have to pay costs as a result of gender relations and the division of the work between women and men. Even though women, children and old people are seriously affected by modern wars, men are expected to be the ones carrying weapons, defendind their nation and community. Men are asked to concentrate on paid occupations, which can limit their abilities to have close relationships with their children. Men's image is devaluated when they can fulfill the expectations as protectors or suppliers for their families, even in poor economic conditions.

The high mortality rate in men caused by accidents and violence is associated with stereotypes and attitudes like agressiveness, lack of fear, bravery and excesive alcohol consumption. It is crucial to promote new and revised images and expectations on men as an important factor to create a more equitable and honourable society where men and women can have some human dignity.

Nowadays, a father's duties vary around the world. Their contribution to their children's care and nurturing, especially when babies, is critical. However, a recent report on 186 different societies found out that only 2% of fathers surveyed, have "regular and strong relations" with their children in childhood.

What is the role of men in gender equality?

Gender equality implies a joint effort from men and women. It must not be (like it is today) particularly based on women's work to fight gender inequalities. More equitable relations need to be based on a redefinition of men and women's rights and responsibilities in the family, workplace and society. And one of the main challenges is to motivate men to participate in this process actively, creating new visions and strategies.

If some stereotypes and prejudice about masculinity associated with physical risks and sexuality were overcome, men's health and their quality of life would improve considerably.

4. Dynamics

Dynamic 1: The concept of gender

Objective: to help participants to understand the definition of gender in a simple and graphic way.

Methodology:

a) Make up groups of three to six people.
b) Give each group a piece of cardboard with a word written on it. Group 1 will receive the one with the word "man" written on top of the cardboard. Group 2 will be given "masculine". Group 3: "woman". Group 4: "feminine" .
c) Ask them to write the words that come to their mind, associated with the word on the paper. For example: those having the word "man" could write "strong", "daring", "manly", "father", etc (15 minutes).
d) Ask them to circle those words which are not strictly related to the biological part of a man or a woman. (10 minutes).
e) Disscuss with them the number of words associated with these concepts that are not directly related to the biological part of people. Pose questions about the origin of these conceptualization: culture? Society?. Those words circled are related to gender. Now you can make a definition of gender.

Dynamic 2: Exchange of gender experiences.

Objectives: to explore gender relations in the workplace of the participants, giving them the chance to speak about them.

Methodology:

a) Make up four groups of three to six people from the same sex.
b) Ask them to write on a piece of paper. (20 minutes).
-Two things they like doing, typical of their sex.
-Two things they hate doing, typical of their sex.
-Two things they like doing, not traditionally performed by their sex.
-Two things they would love doing, not traditionally performed by their sex.
c) Make up two mixed groups and ask them to share experiences and comments on the first discussion. (20 minutes).

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Part Two Before Setting Off

Chapter 11

Legitimacy of the Approach of Gender and Health in International Co-operation

Our co-operation work lies on a list of international policies and strategies that set up agreed objectives and priorities at an international level. Because of this joint action context, we can then speak about global work and dialogue. It is also possible to use them as reference to go over certain practical problems because additional specific orientations and purposes, concrete concepts and guidelines they include sometimes can be meaningful enough to be used. This political and judicial background in current co-operation strategies for development comprises a gender perspective, sexual and reproductive rights, and people's health considered as one of basic human rights.

Health is one of fundamental rights of people which concentrates on human development, crucial in any developmental or social model we can think of. It is an inalienable right that undoubtedly must be guaranteed to all people, men and women, independently from their sex, race, class, sexual orientation, religion, etc. It is then hard to involve some kind of banning or discrimination in this right. It does not sound logical or acceptable that something fundamental for people, directly involved in immediate possibilities of physical, psychological and affective life, might be subjected to judicial privileges or consented discrimination, founded on sex. In spite of this, life is actually quite different and gender as a social and cultural construction determines, to a great extent, the possibilities from people to access and develop a healthy life.

On one level, there are many people both in our teams and in the countries where we work, that think difficulties for men and women in the third world to enjoy a healthy life are only due to poverty, deprivation, under-development, war conflicts or natural catastrophes. For them, gender does not seem to be a leading cause in health of men and women. They only admit that some evident biological characteristics require attention and care, depending mainly on sex. On another level, health has not been a traditionally male domain in comparison with politics or sports which have always been taken as male issues from which women have been constantly excluded. Health seems to be a highly feminine domain, where women are particularly involved, as patients or

workers, sometimes keeping their traditional role of carers in family circles. Besides, have not been women the main priority of international co-operation programs and organisms from the United Nations, since the early programs designed in the 50's? Under this point of view, it seems organisms care about women's interests and want to encourage their participation. As a consequence of this, many people responsible for policies may think integrating gender in health by fashionable plans or international imposition could sound forced and artificial. It is then obvious that power and inequality relations play an important role in health. Is not men's health as important as that of women? It may be thought there is not discrimination in health, because women feel favoured by positive actions linked to their reproductive functions. Yet it is usual to find difficulties in talking about key topics in a gender perspective like sexuality, sexual relationships, AIDS, family planning and birth regulation.

Sexual and reproductive health gender proposals have to face important opposition and lack of understanding coming from different ideologies that are present in theoretical and practical co-operation. However, gender analysis clears up the way inequalities between men and women and social, political, cultural factors, greatly determine (more than we thought) those difficulties experienced by women and men on their way to enjoy a healthty and honourable life, including responsible sexual and reproductive experiences. For this reason, the concepts of gender, gender proposals, sexual and reproductive rights and sustainable human development have acquired a great international legitimicy which is evident in political speeches of co-operation in the last decade. It was in 1994 with the ICPD in Cairo when the conception of sexual and reproductive health was related with empowerment. We invite you to read about some of the main instruments of politics, concepts and guidelines supporting our work in gender and health. It is necessary to remember that all work of gender in cooperation is not only a constitutional mandate with legitimacy agreed through international co-operation, but a need if our purpose keeps on being equalible and sustainable human development, centered on men and women's dignity.

1. International Conference on Population and Development in Cairo (1994)

Since the first decade of the existence of UNIFEM, there has been great improvements in the relations between gender, health and development, but the most important reference point begins with the ICPD convened in Cairo in 1994; it can be said to be one of the most significant worldwide conferences held until today. It radically changed the opinions and perception that thousands of people responsible for adopting policies and managing programs had of the way these policies and population programs should be formulated and applied in the future. It encouraged people to forget and reconsider to aban-

don old demographic approaches to concentrate on how to fulfill the need of couples and individuals. The press, the radio, television and internet advertised the event in an unpreceding way worldwide, contributing to call people's attention on topics related to reproductive health and rights, and women empowerment, increasing understanding of these topics in the first place and clearing up the ideas people had about them.

Many reference models were established in the ICPD. They were aimed to evaluate the progress obtained during two decades (1995 – 2015) in terms of reduction of children and maternal mortality rates, guaranteed access to health programs for people in need, education (specially in girls and women) and empowerment of women. It eventually rescued the role of non-governmental organizations in population issues and firmly established the well known concept of "co-operation" among governments and NGOs. [4] Advances in the Conference in Cairo are visible in the following aspects studied.

From family planning to sexual and reproductive health

A wider and more complete definition of reproductive health was adopted. Reproductive health services should be then identified and included in a context of primary health services; at the same time women and men must be informed on safe, efficient, affordable and acceptable family planning methods. Access to other fertility regulatory methods legally allowed like abortion in countries where it is not prohibited or banned. Two more important aspects of reproductive health were added: AIDS and female genital mutilation (FGM). Reproductive health is related to all reproductive processes, functions and systems involved throughout all stages of life. It takes for granted that people have the ability to procreate and develop a responsible, satisfactory and safe sexual life, choosing the right moment for procreation at will. This is the right of women and men to have access to information and fertility regulation methods, which must be safe, efficient, affordable and acceptable. It is the right for women not to take risks in pregnancy or birth, taking care of the health of the baby all the time.

A relationship between family planning and other reproductive health items was established; besides family planning, prenatal and obstetrical care, infertility treatments, prevention and treatment of AIDS and other sexually transmitted diseases (STD) and gynaechological cancer were included in the definition of health services. The main quantitative goal is to guarantee that reproductive health services will be available for people regardless age, by 2015. Qualitative goals include the improvement of family planning services among other repro-

4 Shankar (2001).

ductive health items. It is also important to say that the international community rejected coercive methods to apply family planning or reproduction.The new definition of reproductive rights is wider and expresses the rights to reach the top in terms of sexual and reproductive health, considering some other purposes of sexual relationships apart from procreation.

People must be familiarized with possible implications and consequences of any way of sexual behavior. In general terms, the ICPD in Cairo pulled down the then existing taboo that make difficult an open dialogue on sexuality in governmental forums.

The implication of men

Men's roles (children care) and responsibilities in sexual and gender relations (contraceptives) were hightlighted in this conference. " We must look for the responsibility of men and promote their active participation in responsible fatherhood, healthy sexual and reproductive behavior – including family planning, prenatal, maternal and children's health, prevention against sexually transmitted diseases, including HIV–, prevention against unwanted or highly risky pregnancy, participation and economic contribution to the family, children education, health and nutrition, recognition and promotion of the idea that children must be loved and considered equitably regardless their sex."

Adolescents

Access to sexual education and complete protection and prevention against unwanted pregnancy have been included as part of adolescents' rights.

Families

They recognize diversity to be part of families and the need for governmental policies to benefit the most vulnerable; This includes for example, those families led and supported by women.

AIDS

The ICPD paid special attention to AIDS. It was agreed to promote and include responsible sexual behavior in education and formation programs, to sell low prices contraceptives and medicines for the prevention and treatment of sexually transmitted diseases.

Abortion

The position of the Conference in México was re-adopted, so abortion must not be considered as a family planning method. The Conference in Cairo supported the fight against abortion in bad conditions as an important health problem. So women must be informed about contraceptive and family planning methods and have access to clean and healthy places in case of abortion in order to avoid complications. The interruption of pregnancy is included in the list of services of reproductive health in countries where it is legal to perform abortions.

Risk-free maternity

The Conference stated risk-free maternity could not be considered isolated. It had to be involved in family planning and health reproductive services. Programs destined to reduce maternal morbility and mortality must provide with information and reproductive health services as well. In order to avoid high-risk pregnancy, maternity and maternal health program must include advice and information on family planning.

Empowerment

The Action Program of ICPD devotes a whole chapter to explain the importance of "gender equality and equity and women empowerment". It considers, for the first time, that the cornerstone of population and developmental programs lies in promoting equality and equity between genders, women empowerment, elimination of any sort of violence against women and the possibility of women to decide on fertility. Women's autonomy and empowerment, improving of their political, social, economic and sanitary conditions, should be the main goal".By the way, this is one of the first conclusions from the proposal of the Platform for Action in Pekin, created in the World Conference on Women in Pekin, convened one year later (1995). From this point of view, a great variety of problems are thought to involve empowerment, intrinsecally related to inequalities, subordination, lack of autonomy in women, and it has been concluded that women empowerment must be included as part of health as well.

Health and Empowerment in the Platform for Action in Pekin

- Health can not be just considered as the lack of illnessess or sicknesses, but a state of complete physical, mental and social wellbeing. Women's health includes their emotional, social and physical wellbeing too and is determined by the social, political and economic context where they live altogether with biological characteristics (...) One of the major obstacles to reach to this high level in health is inequality.
- In health, women and men are not in the same conditions. Frequently, health policies perpetuate sexist stereotypes and do not consider socioeconomic differences between women, or the lack of autonomy with respect to their health among some other things.
- The right of women to have an absolute control of health, including fertility, is fundamental to their empowerment process.
Human rights of women include their ability to decide freely and responsibly about their sexuality, including their RSH, out of coercion, discrimination or violence.
- Sexual and sexist violence, including physical and psychological maltreatment, women and girls trafficking and other ways of sexual exploitation, cause physical and mental traumas or unwanted pregnancy, leading them to use not only public health services but illegal ones.

2. Revision of the International Conference on Population and Development: Cairo+5

Compromises assumed in 1994 were ratified in the revision of Cairo five years later. Most of the countries accepted the importance of their Programs for Action, and decided to set aside enough resources to accelerate their implementation. Issues like adolescents' rights to sexual education and health services, access to sexual and reproductive health and parent's respect to children and adolescents to avoid abuse were discussed in previous meetings. As a result, children and adolencents' rights were considered apart from those of their parents. Countries like Iran, Sudan, Argentina, Nicaragua, Libya, Syria and the Holy See refused to allow governments to decide on the contents of sexual education programs in public schools. In contrast, most of them were in agreement on keeping adolescents in the next century absolutely informed. Sexual and reproductive health services were agreed to be "accesible and confidential". With this respect, more conservative countries considered "parents must know their children's questions and consent their access to SRH services". They all were in agreement "to guarantee active participation of parents, young people, community leaders and organizations to achieve sustainability, coverage and effectiveness of these programs". In order to promote and protect adolescents' rights as far as health programs go, they must be provided with suitable, specif-

ic, friendly and accesible services to meet the need of sexual and reproductive health; this must include education, information, advice and promotion of health. These services must keep adolescent's right to privacy, confidentiality and consentment, respecting their cultural values, regilious beliefs according to international agreements and conventions. Similarly, parents' rights and responsibilities with regards to this were formulated considering adolescents' evolutive ability and their rights to reproduction, education, information and attention.

Regarding abortion, Cairo did not mean any big change. Brazil proposed an advance in two main aspects of implementation: decriminalize women and train the health staff in giving a more humane and effective treatment to reduce maternal morbimortality rates still high. Where abortion has been made legal, it was remarked on the need to train the personnel and take some measures to guarantee the safety of women obtaining abortions. Countries like Argentina, Nicaragua, Libya, Sudan and the Holy See were in disagreement with this. Besides, there were proposals favoring "the provision and movilization of enough resources to satisfy the growing demand of information and services, providing with a wide variety of safe, effective, accesible and acceptable contraceptive methods".

The support and the work of NGOs, the civil society and private enterprises were confirmed to be major bases in the process. South-South Cooperation (SSTF) was included as one of the many supporting organizations and funds participating "to achieve all those goals proposed in Cairo 1994", where women's conditions and empowerment, education and basic health care were underlined as the main focus. Summing up, the process in Cairo+5 was relevant in terms of ratification of those agreements made in 1994, consolidation of development and implementation of Programs for Action. This was evidenced in Latin America where countries, excepting Argentina and Nicaragua, worked together to achieve common agreements based on respect regardless regional differences. Beside this, the work with NGOs is today still considered necessary to reach goals.

3. The European Union

According to international advances on development, policies from the European Union (EU) are in general focused on the erradication of poverty. Besides, they attempt to improve the coherence among the diverse policies designed to improve HIV and AIDS programs, population, water, hygyene, alimentary safety and basic sanitary assistance. The EU is committed to include interventions on health, HIV/ AIDS and population HAP (EC's Health, AIDS and Population Policy), in their global human and social developmental strategy. The EU claimed for the importance of topics referred to the gender perspective in co-operation for development: emergency operations and crisis preven-

tion, relationship between human rights and democratization, macroeconomic analysis and interventions, and sexual and reproductive health and rights [5].

Principal Policy Documents fro the EU on Population, Development and Reproductive Health after ICPD.

1995 *Resolution of the Council about integration of gender approach in co-operation for development.*
- There was a need for all fields in co-operation for development to include the gender perspective and to make empowerment their main objective.

1996 *Resolution of the Council about social and human development.*
- With the attempt to reduce poverty and to highlight the importance of gender, education and health.

1997 *Regulations of the Council about support for policies and population Programs in developing countries.*
- This is the first regulation about population related topics since ICPD,in which they asked for an increase in the economic support destined to population programs according to Programs for Action from the ICPD.

1997 *Regulation of the Council about operations related to HIV/AIDS in developing countries.*
- Supportint programs aimed to help poor people in developing countries in the fight against HIV/AIDS.

1998 *Regulation of the Council on the integration of gender in co-operation in development.*
- It established a commitment to provide technical and economic support in order to develop gender analysis in policies of development in the EU; at the same time, it tried to promote abilities to be included in gender perspective.

1999 *Resolution of the Council about the evaluation of developmental instruments and policies from the European Commission.*
- It committed to make a general, updated, and integrated political declaration about co-operation for development. It was here where the policy of HAP of the Commission was created.

Source: Marie Stopes International (2000)

In the last decade, policies of HAP from the EU have been given a new direction from sanitary infraestructure to the sanitary systems reform and the global approach to health. Specific objectives in this policy refer to human and economic investment in general social development directed to:

5 *Resolution of the Council and the representatives of the members of the European Union about integration of the gender approach in co-operation for development*. December 20, 1995.

- Improve the results of HAP in every country, specially in poor ones.

- Protect the most vulverable people from poverty that results in illnesses, spread of HIV/AIDS and high fetility rates.

- Increase the participation, quality, efficiency, equity and sustainability of sanitary systems.

- Decrease the potentially negative impact of other HAP investments.

In the policies of HAP from EU, the Commission gave special interest to the generation of knowledge and the development of abilities, crucial aspects if internal population changes and women empowerment were the main goals to guarantee the efficiency of developmental policies.

4. The Development Assistance Committee from the OECD

Developmental Objectives in CAD for 2015

Economic Well-being

- To reduce extreme poverty by up to 50%.

Social Development

- Primary education to become universal, eliminating all sorts of gender inequalities in education (2005).
- Universal access to reproductive health services.
- Reduction of 66% on children mortality and 75% on maternal mortality.

Environmental sustainability and regeneration

- National strategy for sustainable development in all countries by 2005.
- Reverse the trend of using up natural resources by 2005.

Qualitative factors

- Participative development, democratization, "good government", human rights.

In the Document on co-operation strategy for the XXI century [6], CAD recognizes the leading role of women equity and empowerment. Participation commitmment is then necessary to achieve the goals working hand in hand with partners. To evaluate progress in this field, the strategy offers measurable goals for combating poverty and improving education, health and ecolog-

6 CAD/OCDE (1996).

ical sustainability. These objectives include aspects related to gender equality: the elimination of imbalances between boys and girls in primary and secondary education by 2005, reduction of maternal mortality rate in 75% before 2015, and access to primary reproductive health services to anyone in need by 2015.

CAD adopted some principles about "gender equality and women empowerment" [7] stating that: "Health, including sexual and reproductive health, is one of the most crucial elements in human well-being". Since the role of women has been highly participative in the sanitary assistance system as doctors or patients, it seems gender problems and women empowerment situations have been already solved. However, inequalities between men and women are evident in the access and the use of sanitary services and in the structure of sanitary and employment institutions. Members of CAD can help local partners to integrate gender equity in the sanitary field through initiatives that promote, for example:

- Planning and sanitary services which include the needs of women and girls throughout their whole lives, not only in relation to maternity and children care.

- Policies and programs enhancing the importance of sexual and reproductive health, women and men's rights and their relationship with equality.

- Strategies that plan activities to involve men and women in children's health, regulations of fertility and risk-free sexual activities. At the same time they must promote rights and responsibilities of men in them.

In conclusion, new strategies in co-operation definitely showed the need to integrate purposes of gender equity into health. It has been stated that women's health is not only a biological problem, but a social, political and economic affair related to inequality, subordination and lack of power in women.

5. From Principles to Practice

According to the ICPD in 1994 and the Conference in Pekin in 1995, all countries and co-operation agencies are obliged to promote gender equality and women empowerment. In spite of this international agreement, organizations do not know exactly how to work together in the operative implications of this purpose.

[7] Ministery of Foreign Affairs/SECIPI - State Secretary for International and Iberoamerican Cooperation.

There are wide variations among countries and organizations about the way gender equality is related to health and specially to sexual and reproductive rights. Actions to be made have not been agreed yet. Some agencies, for example, have written their own international commitments while other have not even considered the idea to do it.

Some agencies see fertility as an objective and not as an indicator of an improvement in the quality of life. Others have adopted strategies through internal and external consultative processes in order to arrive to a consensus while others have developed methodological tools by themselves. And only a few have taken concrete initiatives in emerging areas like violence against women, FGM, abortion and the implication and integration of men into RSH programs.

The Law on International Development Co-operation in Spain established equality between genders as a principle of Spanish co-operation in article number 2c), stating: " the need to promote a global human development, interdependent, participative, sustainable and gender equitable in all nations (...).". In article 7 establishes the importance of: "c) Protection and respect for Human Rights, equality of opportunities, social participation and integration of women and the defense of the most vulnerable population groups (children, focusing on erradication of children's labour, refugees, people displaced, people returning, indigenous groups, minorities)". This principle has to be integrated in the planning instruments, beginning with the Director Plan.

NGOs have included gender equality as a leading factor in their political speech and in many cases in their statutes or strategic documents. In the Code of Conduct, approved by the General Assembly of the State Co-ordinator of DNGO, they asked NGOs to provide the appropriate conditions for women to make decisions and participate in all communities. They were asked to promote their active incorporation in all development and humanitarian assistance programs to guarantee the access and equitable control on resources and benefits.

However, there is always a gap between policies and their practice. All agencies may report a great improvement in the making of policy documents and strategies, while the development and practice of their programs are slightly visible.

Language could have been changed in programs and projects, but their content actually remains the same. Most of agencies have adopted some positive initiatives, but these experiences have not been seriously studied or advertised yet. For this reason, agencies in general terms, lack mechanisms to analyze their own initiatives and learn from their own experiences.

6. Principles of a Good Practice: the Establishment of a Common Performing Framework

In one of the reports by the CAD [8] supported by the analysis of ICPD and Platform for Action in Pekin, a framework is proposed in order to know the clues about equality between women and men. It came from the basic consideration of inequality (in social roles) to be determinants for health. For this reason, it is necessary to talk about equalities if we are interested in the health of population.

Recommendations

- To agree on key concepts.
- To base policies and programs on the commitments of ICPD and the Platform for Action in Pekin, which represent the fundamentals of good practices.
- To analyze and understand the impact of inequality in health of women and men.
- To take measures to correct gender inequalities in the access to sanitary care analyzing the response of the health system.
- To move the attention from demographic objectives (birth rate control), quality of life, and population objectives to individual health rights.
- To promote the access to maternal, children and reproductive health.
- To pay special attention to the needs of women and men throughout their life, to their roles and responsibilities in relation to fertility and children health, ensuring women's health and rights.
- To promote self-esteem, trust and ability in women both users and practitioners in health services.
- To question all the people involved, and to create relationships with women's associations.
- To promote gender equality, by strenghtening local abilities.

Here are three of the basic proposals for a start:

- Inequality is evident in education, access, work load and autonomy and exerts influence over men and women's health.

- Inequality becomes an unequal impossibility to access to health services and a different treatment for women inside the health system.

8 DCD/DAC/WID (99) 2,Working party on Gender Equality, Reference Document. Reaching the Goals in the s-21, Gender Equality and Healthy Volume II, Note submitted by Sweden 8/1/1999.

If equality is going to be promoted, specially in health and sexual and reproductive rights, it is necessary to redirect the health system making sure women have access to sanitary attention, education, employment, rights recognized by the law and participation in political life.

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Chapter III

Essencial Concepts in Intervention in Health with Gender Perspective: Sexual and Reproductive Health

1. What Does Gender Have to Do with Health Services?

If you have this guide in your hand is because you are working as a manager or a co-ordinator in a project or a program, or maybe you are thinking about joining a new one in an underdeveloped country. If so, maybe you have been thinking about what to carry, about the place where you will live, or the place where the program will be developed… Maybe you had to contract people or have visited the community where you will be working. And perhaps, the impact of gender is the last thing on your list now. Even the best programs can fizzle out if topics are not studied properly. As we said, gender involves everything in relation to ideas or expectations generally accepted by women or men; ideas on typical ways of behavior in special situations and intrinsecal abilities and characteristics. We learn these in our environment: family, friends, people we respect like political leaders, religious and cultural institutions, schools, work and mass media. All of them exert some kind of influence over roles, social status, and the economical power of women and men in our society.

As explained in the former chapter, inequalities between men and women can influence the way they take care of their health. In fact, they affect simple decisions like who is receiving medical attention, who is taking medicines, and even if medical care should be asked or not. We can find a good example gender impact when we analyze many aspects of the sexual and reproductive health of men and women as follows. In comparison with illnesses like malaria or diabetes, considered in terms of causes, prevention and treatment, reproductive health illnesses can become complicated because of the existence of social circumstances, religious taboos, or governmental policies. These can involve our abilities as technicians or health professionals to offer programs or services to specific populations.

In order to keep both men and women healthy, they have to get access to sexual and reproductive health services which include family planning, prevention and treatments of sexually transmitted illnesses, including HIV/AIDS. Besides women need to have access to essential obstetrical services, prevention

and treatment in case of risky abortion. As health professionals, we need to detect and take an active attitude towards any kind of sexual violence. However the provide of all these services is controversial. The community where you work could be against family planning, abortion can be illegal and domestic violence or FGM can be accepted practices. It takes more than just opening a clinic and inviting the community to come over. In your own program, gender prejudices of the members of your team could create invisible barriers for those services offered.

Personnel contracted for these projects and programs usually belong to the same benefitted community, and they can have the same problems to accept the cultural norms that you are offering. The success of the program can eventually fail if there are invisible gender prejudices affecting the place of work itself.

Examples of the impact of gender roles in health

Women play an important role in the health of their families. They usually diagnose, cure and give sanitary care. They decide if external medical care is necessary or not. However, families or communities do not always have the power or economic resources to make decisions on the welfare of their members. In most of the cases, men decide if a member of the family requires medical treatment or if there is money available to do it.

Some research have demonstrated that in some cases, the medical and sanitary staff, specially doctors, devote less time to some of their patients, like women, people with low incomes or people from ethnic minorities. They have also found a tendency to diagnose functional or psychosomatic processes in patients with non-specific symptoms when these are women without discarding other pathologies.

Women are not taken into account when making decisions important for the entire community. When women and men are not in similar positions, the development of a program or the identification of real problems can be incomplete, so solutions may not be appropriate in terms of health.

Campaigns in mass media promoting the use of contraceptives without involving some cultural masculine roles that increase the risk, may have very little effect or no impact on the prevention of HIV.

In the field of health, gender perspective serves to analyze the ways gender differences influence in the access to health services. It organizes the way assistance, resources, information and health tech-

nologies must be distributed. A gender approach ensures an equitable distribution of resources to guarantee health and welfare for all community.

A woman who almost died during her last birth may require the use of contraceptives under medical prescription. However, she may be blamed for preventing pregnancy by her community, her religion, her husband, her mother or sister. As a result, and in spite of the existence of a health center and people trained on family planning, this woman will not use those contraceptives unless projects pay attention to gender barriers and prejudices that may affect her health.	A man who is usually away from his family for long periods of time may deny to use contraceptives to protect himself from HIV because of his fears to be considered less masculine by his partners. He returns home after a long time infected with HIV and infects his wife because of fear, shame or ignorance. This situation will not change by providing men with contraceptives. It is necessary to study gender expectations which make men take risks for their own health and that of their couples.

2. Gender and Sexual and Reproductive Health

Regarding all aspects related to the reproductive system, its functions and processes, the International Conference in Cairo, defined SRH as a state of general physical, mental and social well-being. It was inappropriate to consider it only as the absence of illness or pain. This involves the individual possibility to enjoy a satisfactory life out of risk, the decision to procreate, the freedom to do it or not, the frequency and the moment to do it.

Women and men have the right to be informed and to get access to safe, efficient, accesible and acceptable contraceptive methods which are not legally prohibited. They must also receive appropriate health services to guarantee risk-free pregnancy and birth. Sexual health was included as a major item in this Conference; it aims to develop life and personal relationships instead of just informing and giving advice on reproduction and sexually transmitted diseases. Family planning programs and projects do not usually pay attention to this definition of SRH. Services offered are limited to contraception, pregnancy care and prevention and treatment of STD. They do not include aspects in relation to sexuality, gender relations, or human rights either; They do not

speak about cultural or economic factors that influence subordination of women and limit their ability to make decisions related to their life and their sexual and reproductive health.

When gender perspective is included in a gender program, their services and purposes diversify. They aim to change social norms, negative behaviors for health, education, public sensibilization and social marketing. This approach recognizes the importance and the limitations of people working in sanitary assistance for the promotion of health and reproductive rigths.

> Women make up the most of the poor (70% of those living on less than a dollar per day are women). The economic vulnerability of women makes them exchange sexual services for money or protection. It is less probable for them to have this protection or to abandon a relationship which can be risky.

For example, one fourth of maternal deaths are due to unsafe abortions[9]. In order to help women suffering from complications, many programs include postabortion services. These ones can save a thousand lives of women a year. However this will never solve the underlying problem of unwanted pregnancy. The access to good family planning programs is not sufficient to diminish this serious health problem. Finishing with maternal morbility and mortality caused by unsafe abortions, means to modify the basic roles to let women decide on unwanted or unsafe sexual relationships. It means to change social values that permit men not to assume their responsibility in their sexual demand. So, good programs must concentrate on the education of adolescents before they are sexually attractive. They must teach the community the risks of unsafe abortion and the safety obtained when using appropriate contraceptive methods. Programs must inform on safe and legal abortion in those cases where contraception fails and unplanned pregnancies come out.

> Reproductive rights include the individual's right to his corporal integrity and security. They include the right of couples and individuals to decide the number and spacing of children. The rights to information, education and neccesary means to do it; the rights to enjoy the highest quality of sexual and reproductive health; and the rights to make decisions on reproduction free of discrimination, coercion or violence.

Gendered services of reproductive health and family planning

The ways assistance services are designed and offered, play an important role in the access of men and women to SRH. The objective in this case would

9 See defition of "unsafe abortion" from the glossary.

be to provide services with the highest possible quality. To make sure they work, it is necessary to offer reproductive health as part of a universal access sanitary system that provides primary assistance. Being universal implies providing with assistance to women and men regardless of their marital status, income level, residence or sexual orientation. It also implies to provide special services to groups that rarely access to health services like adolescents, widows or women living alone. A good staff is then required. It is necessary to have a group of people who are appropiately trained and motivated and who had experience, resources and a suffiencently complex infrastructure to provide both with information and response to obstetrical complications and diagnosis and treatment of assymptomatic STI. The introduction of new technologies like those used in infertility processes must include only systems that guarantee the protection of women's rights and health as well as their possibility to decide to use them or not. These services must include:

- Information and education about health, sexuality and gender equality, including gender violence problems.
- Follow-up and assistance of pregnancy, delivery and puerpery.
- Access to a wide variaty of contraceptive methods, including barrier and emergency contraceptive methods.
- Prevention and orientation in cases of infertility.
- Advice and orientation on sexual dysfunctions.
- Prevention, diagnosis and treatment of genital infections, STI and other gynaecological disorders.
- Prevention and early diagnosis of cancer in the reproductive apparatus.
- Orientation and treatment in climatery.

The importance of involving men in sexual and reproductive health

In many countries of the world, men's needs in terms of reproductive health are not met. If SRH and family planning services exist, are usually women oriented. The reasons are complex, and professionals are beginning to think about the need to fulfill this need to serve both men and women. Why do we have to involve men in this?

Traditionally family planning programs have been women oriented. They have the whole responsibility to take care of their reproductive health, the control on their fertility, their deliveries and the protection against sexually transmitted infections. Both women and men should share responsibilities in reproductive health.

When men participate actively in decisions-making mechanisms in reproductive health or equity, communication improves, resulting in joint decisions on contraception, number of kids wanted and distribution of duties.

The absence of men in sexual and reproductive health care has brought some consequences for women. For example: some women have been treated for the same sexually transmitted infections several times, because their couples do not have access to medical care or they simply refuse to ask for it.

The role of Men in women's SRH is crucial. First, they often decide if the couple should use protection or not, and if so, when and how. Men also decide on prenatal assistance; they decide when women should ask for emergency obstetrical services. And in cases in which women should be taken to a medical center, they also decide on the means of transportation used. All this has consequences over the survival of mother and child.

> "We all would like to live in a world where women and men could speak freely about their sexual and reproductive health, where contraception and other health services were excellent and easily accessible. Where women would not die because of pregnancy related causes; where all children were desired and all individuals and couples had resources and autonomy to decide their own destiny. However this is not our world and differences and inequalities between women and men keep on causing serious health problems." Family Health International (n.d.)

3. Gender and Family Planning

As we read in previous sections on sexual and reproductive health and rights, the access to family planning is crucial for men and women to keep their own health and well-being and that of their families. However family planning programs are at a large extext determined by gender. For example:

Practically most of reversible family planning methods are for women. The only male methods are condoms and coitus interrupts or withdrawal.

Women have the big responsibility of using family planning methods, including the correct and continuous use, visits to medical centers, costs and side effects of the methods used.

In many communities women need to have permission from their couples to access to family planning methods, even though men have no idea about their results or functioning.

Women are usually pressed by their partners to have many children. These influences do not usually consider their preferences on the number of children they want to have or the consequences over their health.

Men lack enough and adequate information on contraceptive methods, their functioning, their side effects and the ways they can affect fertility.

Men do not have a wide variety of contraceptive methods to choose. Condoms are used in occasional or extra-marital relationships and vasectomy is considered the end of masculinity.

Men are usually excluded from reproductive services including family planning, prenatal assistance and post-abortion care.

It is important to distinguish between contraception and family planning. Family planning is merely considered as the provision of contraceptive methods. It is about providing each family with the necessary means to decide on the number and the spacing of children.

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Family planning programs intend to face the fact that al least one third of pregnancies worldwide in both developed and developing countries are unplanned. In some countries like Kenya or Bolivia, more than 50% of babies are unplanned and undesired. The purpose of family planning is to make all children born desirable. For this reason, family planning programs must provide, besides contraception, with prevention and treatment against infertility and unsafe abortion.

4. Gender and Unsafe Abortion

Abortion is one of the most controversial topics. Besides, in spite of feelings and opinions of individuals, religious leaders or the community where we are working, some women facing an unplanned pregnancy would do anything to interrupt it regardless of the risk for their own life. This fact is real now and has always been like this in different periods in history all over the world. More than 46 of the 210 million pregnancies a year worldwide are interrupted. Abortion rates and frequency do not depend on its legality or safety. It depends on the number of unplanned pregnancies. There are high abortion rates in countries where people wish to have small families but the use of contraceptives is low or

ineffective. On the other hand, these rates decrease if contraceptives use is high and families want to have more children. In many cases, women do not use contraceptives because of social, economic or cultural reasons and not because of personal convictions. In some traditional societies family planning is unacceptable even though this seems to be changing in time.

In some other contexts, women who want to plan the number of children do not have access to family planning and contraception services because these ones may be expensive, the provision may not be reliable or services may be hard or impossible to obtain.

Safe and unsafe abortion

In countries where abortion has been legalized, services in general are accesible and procedures are perfomed at an early stage of pregnancy by prepared and qualified professionals.

In this context, abortion is a very safe procedure and deaths due to abortions are scarce, aproximately 0,04%. In those places where this is ilegal only women in high social status are likely to have less risky abortion procedures, but for many poor women who live in rural areas, these may be more dangerous and they can even risk their own life.

If there is little relationship between legality and incidence of abortions, there is a real corelation between legality and safety.

Even though women survive to most of these operations, unsafe abortion may cause disabilities and even death. More than 90% of deaths due to abortions are produced in countries where this has not been legalized and procedures to perform it are not safe.

Not having access to a safe and legal abortion can cause problems not only for women but for the society. In developing countries where abortion is not a safe practice, two out of three beds in obstetrical services are occupied by women who suffered complications derived from unsafe abortions. Some hospitals spend half of their maternity budget in post-abortion services.

Assistance and advice based on comprehension and not on criticism may be the key solution for women to avoid risks of unsafe abortions. Even though the causes that lead a woman to interrupt her pregnancy are numerous and varied, it is never easy. We must help her think about the options she has, and choose a method that may not lead her to risk her health and life.

If pregnancy has been already interrupted, we must provide her with good medical care, out of criticism and opinions. We must help her making decisions on family planning methods, so future pregnancies are planned and desired.

Why Women Choose Abortion

The woman's decision to have an abortion is never easy. She can ask for it because:
- She does not have the money to support another child.
- She is scared of being rejected or violently attacked if they find out she is pregnant.
- She does not have a partner to support the child.
- She wants to finish her studies and being a mother becomes a problem.
- Pregnancy is the result of a rape.
- Pregnancy may be risky for her life.
- She is infected with HIV and does not want her son/daughter to get
- infected or to live as an orphan.
- She has problems with her couple.

What to do to protect women from an unsafe abortion

Out of the polemics of legalization, there are things that can be done to help women to avoid the dangers of unsafe abortions.

- Provide women with safe and efficient contraceptive methods.

- Make sure prices of contraceptives are affordable or even free for women like adolescents who have no money to pay for it.

- Revise policies in health centers and eliminate all unnecessary obstacles for women to obtain contraceptives. For example, there is no medical reason to ask women for a previous medical examination before taking the pill or injectable contraceptives. A simple exam to discard breast or cervix cancer can be performed six months or after the first year using contraceptives. The demand of escessively frequent (more than once every three years) cervical smear tests is not usually justified and causes resistance from women to come back to the clinic. Besides, these are expensive and take resources that could be used to provide care to women in need.

Many women stop using an efficient contraceptive method to avoid shame and inconvenience coming from constant gynaecological explorations. This way, they are exposed to unplanned pregnancies again.

- Make sure services are adapted to adolescents, a group of people expressing their opinions and judgements can become an obstacle for a young women in need of medical attention. Very frequently, medical personnel make women feel embarrassed and ashamed when asking for contraceptive methods and sometimes they can even refuse to provide them with the service. Male and

female adolescents correspond to that part of population less likely to use protection, to receive information about safe options or to feel comfortable asking for help. It is necessary to train people so they assist them appropriately.

- Postabortion care would be weolcomed, if possible. Probably, a more tolerating and sensitive health center is more attactive for women than hospitals. If this kind of care is not possible in your place of work, try to do it with local authorities so they can provide with complete and adequate postabortion care.

- Offer postabortion family planning services to help women prevent unwanted pregnancy.

- Support if possible, efforts to legalize abortion.

In Guyana, where abortion has been legal since 1995, admissions due to incomplete and septic abortions decrease 42% in the first six months since the law was approved. Before this law came into force, septic abortion was the third most important cause for admissions while incomplete abortion was the 8th.

Postabortion care

The World Health Organization (WHO) included immediate treatment for incomplete abortion is general obstetrical care services. It is supposed to be available in all district hospitals. The treatment of incomplete abortion, if not complicated, can be performed in primary care rooms, or in family planning centers (by breathing in). Key elements in postabortion care include:

- The emergency treatments of incomplete abortions and any serious complications that may risk life of women.

- Postabortion care and family planning services.

- The co-ordination between postabortion emergency service and reproductive health care.

The emergency treatment for postabortion complications include:

- An initial medical examination to confirm the presence of postabortions complications.

- A dialogue with the woman about her problem or complication and the treatment to be used.

- A medical examination (medical history, clinical and gynaecological explorations).

- Attention in specialized centers in case women require treatments different from those available in health centers.

- Provision of emergency services and treatments for any complications occurred during or after the admission.

- Uterine evacuation to remove the pregnancy.

If the health center can not provide postabortion care, it is important to create a good reference system including the means of transportation.

5. Gender and Sexually Transmitted Infections, HIV Included

Many agree that HIV/AIDS is the problem where the influence of gender roles is more visible. Very frequently women lack control of their own sexuality. On the contrary, men make decisions on when, with whom and what protection they use in sexual relationships.

Social expectations about men's masculinity taking risks or having multiple couples, increase the danger of infection for him and his couple.

Once infected, men do not usually go to sexual and reproductive health centers. For them, these are exclusive places for women. This could be due to the fact that most men believe they must be strong and do not need any assistance at all.

Most of couples find it hard to speak about sexual aspects, specially the risk to contract sexually transmitted infections. For this reason many women find it impossible to ask their couples to use a condom, taking the risk of unwanted pregnancies or STI.

Many men do not wear condoms (not even with their most regular sexual partner), knowing they can transmit a sexual infection, because they would have to admit they are having sexual relations with other women. As far as women are concerned, they sometimes refuse to tell their husbands or partners they have a STI, even when they are the transmitters. They fear domestic violence, divorce or death.

Women miss the possibility to enjoy safe or wanted sexual relationships because they are not empowered. They have not good work positions, education or training, and as a consequence their economic power is low; this does not permit them to make their own decisions on their sexuality, health or family welfare.

Women are more vulnerable to infections: Physical differences between men and women

Women are more likely to be infected with STI at once, because semen carries high concentrations of virus and remains in the vaginal canal for relatively long time periods. This increases the possibility to acquire infections. A vagina is more vulnerable to small perforations or injures which can increase the danger for infection. Virus can be transmitted through the extense surface of the vaginal mucous tissue and the cervix.

Researchers estimate the risk factor for HIV infection in unprotected sexual relationships for women, is at least two times higher than that of men. In young women (15–19 years old) can be five to six times higher.

The risk for HIV infection in women and men increase significantly when they suffer another STI, specially those infections causing genital ulcers.

Men are less likely to contract STIs because the penis is less vulnerable to transmission; it is protected by skin (in contrast to the vulva or the vagina which are mucous tissues).

Many STIs do not produce special symptoms in women; they can produce symptoms (like vaginal flux) which can be easily confused with normal processes. For this reason, women do not ask for early treatments while infections spread causing women to suffer worse long term effects.

Untreated STIs can cause more serious complications in women than in men. They can lead to infertiliy, ectopic pregnancy, chronical pelvic pain or cervix cancer.

Men or women can have an asymptomatic STI and transmit it to their partners.

A Personal Experience

In 1998, I got pregnant of my fourth child. My health was suffering diverse disorders; I had persistent vaginal rash and abnormal menstrual periods. Even though I reported this to the doctors in prenatal controls, I was not given a suitable treatment. They collected some blood to do a HIV test without my consent and after the delivery, they did the same test to my baby. Then the doctor told me what they have done and that the results had been positive. When I told my husband about this, he left me that same night, after insulting and accusing me of being unfaithful and a prostitute. Later, I knew he had been previously given the test and informed he was positive; he had not been courageous enough to tell me the truth.

Young men: A key objective in the fight against AIDS

To prevent the propagation of AIDS, we must start with young men or we must take the risk to face devastating long-term effects. Young men (including boys from 15 to 24 years) have sexual relationships with different partners more than any other population group.

Our main purpose is to speak to young people who make up the fourth part of the world population living with AIDS. As a group, they will be empowered for the future, both individually (in their own lives) and socially (leaders responsible for the community where they live).

They have been chosen, because it is easier to influence them while they are young, constructing and developing their attitudes and their sexuality. We attempt to talk to them when they are discovering their bodies and their responsibilities in front of others. It is harder to try to change attitudes and usual behavioural patterns when they are adults. More than 50% of new infected with HIV are young people [10].

What Do We, Women and Girls, Need to Protect Our Lives from AIDS

Ways to protect ourselves from HIV/AIDS that we can control by ourselves.
More power to make decisions at home and in our community.
The chance to be trained to support our families.
Implementation of more rights in accordance to our national law.
The access to education.

6. Gender and Violence

Violence against women is an important problem overlooked in most of the cases. It is one of the many uncomfortable topics to talk about in fund raising campaigns for programs, in our community and with the women who have been through it. The UN define violence against women as "any violent event based on gender that results in physical, mental or sexual harm, including threat, coercion or arbitrary deprival of freedom in individual or social contexts". This includes physical violence, physical mistreatment, children sexual abuse, violence related to dowries, abductions, FGM and other harmful traditional practices, non-marital violence, violence related to sexual explotation, sexual harrasment or intimidation at workplaces or schools, trafficking of women, forced prostitution and permanent violence permitted by the government.

[10] Panos Institute and Joint United Nations programme on HIV/AIDS (2001).

Gender based violence has serious consequences in physical and mental health of women

Women undergoing abuse, will probably suffer from depression, anxiety, psychosomatic symptoms, nutritional problems and sexual dysfunctions. As a consequence:

- Adolescents take more sexual risks.
- STI (including HIV/AIDS) are more frequently transmitted.
- Women can have unplanned pregnancies and deliveries.
- Chronical pelvic pain, painful sexual relationships and sexual dysfunctions appear.

Many cultures have beliefs, norms and social institutions that perpetuate and give legitimacy to violence against women. Specially inside family groups, violence against women is overlooked. Actions that could be punished if they were done to any employee, neighbour or a man you know. Social rules in a culture define the roles and responsibilities of men and women.

In general, the main role of men is to bring incomes home. That of women is to take good care of children, home and feed the family. If a man feels a woman has not been responsible enough, has gone beyond her limits or has questioned her rights, he can react violently.

All over the world, one out of three women has been beaten, forced to have sexual relationships or harassed throughout her life. Very usually, harassers belong to the same family. Gender violence is up to date recognized as a health public problem and a violation of human rights.

Diverse studies from different parts of the world have demostrated violence against women is more frequent in those societies where gender roles are extremely defined and imposed. Where the concept of masculinity is related to strength, masculine honour and domination.

Violence against women is generalized and does not depend on social, economic or educative status. All women are vulnerable. To disobbey to their partners, to answer back, not to have meals ready, to question their partners about food or possible affairs with other women, or to go to places without permission, are enough to trigger violence.

Why do men mistreat women?

Men can justify women mistreatment with alcohol, lost of control and they can even say "she deserved it". However they choose violence as a way to get what they want. Some of the reasons to use violence are that:

- Violence works for them. It ends up an argument where men were not willing to make concessions. The victim learns who is the strongest and will avoid arguing next time not to be mistreated.

- Violence increases power in men: they can become abusive when the feel impotent in some other ways.

- Gender stereotypes continue: If a man thinks he must control what his partner does in order to be a man, maybe he will need to hit her to establish his domination over her. He thinks his woman belongs to him, so if she is having her own ideas about what she wants, he will do what it takes to make her more dependent on him.

- Violence can be learned. If a man has lived in a violent home with a man abusing his wife and children, he is more likely to reproduce it.

Why do women stay with the same men that mistreat them?

Most of women are passive victims; they use their own strategies to protect themselves and their children. Some of them resist physical violence, some others prefer to run away but many stay, justifying the behavior of their partners and trying to please them. The possibility for women to stop mistreatment is harder than we think. Her options are few and limited. These include:

- Fear and threats; specially when a man has promised to kill her and her children if she abandons him.

- No money and nowhere to go. If a woman is not economically independent and besides she is obliged by social rules to stay with her couple no matter what, it is almost impossible for her to find support to leave.

- No protection. It is possible nothing or nobody can stop a man to kill his couple in case she had tried to abandon him.

- Religious and cultural beliefs. A woman can conceive this as an obligation and decide to stay.

- Hope for change. A woman can be hopeful about a possibility to change the situation by pleasing the man in every way.

- Guilty about leaving her children without their father.

What can health professional do about gender violence?

The professional health team can play an important role in all efforts to end up violence against women. They must learn how to question women about violence in order to detect indirect signals and identify cases of domestic violence or sexual abuse. They must help women to develop a personal security plan in order to improve their situation. In order to get to this point, health workers must:

- Respect confidentiality. All converstions must be held in private, without the presence of any other member of the family. This is essential to create confidence and to protect her security.

- Believe her experiences and give them legitimacy. Listen to her and believe her. Recognize her feeling and make her feel she is not alone. Many women have similar experiences.

- Recognize injustice. She is not guilty for any sort of violence against her. Noone deserves to be mistreated.

- Look for signs of abuse when examining a woman. Men usually hit women in not very visible parts of the body. If you find a bruise or an unusual scar, ask her for the story behind it. If a woman comes to you in pain, bleeding, with lesions or broken bones, ask her if she has been hit. Many women will say that has been an accident. Make sure you do not do anything without her permission.

- Write down everything you consider useful when interviewing a woman who has been mistreated. Draw the places where the bruises are. Write the name of the person that mistreated her.

- If she is in danger, help her make up her mind about what to do to be protected.

- Respect her autonomy. When she is prepared, she has the right to decide what to do.

Help her make up her safety plan for the future. What has she done in the past to protect herself? Has it worked ? Does she have a place to go in case she runs away?

Promote the access to the community services. Get to know the existing resources. Is there a place where women can stay after getting out of their homes?

Reproductive Health Programs Trying to Solve this Problem

- Russia: Official employees in Public Health reinforced the objectives of human rights evaluating social norms that accepted domestic violence, underlining the importance of some notions on human and reproductive rights. Practitioners had to intervene to avoid violence. The message is: There is no excuse or justification for domestic violence and the reproductive health care system is the right way to give victims a hand.
- South Africa: the Family Planning Association in South Africa and the AVSC Int, developed a program integrating participative activities on gender, sexual empowerment and intimate relationships in their training courses. The program was created on the basis that 58% of 2000 South african men interviewed thought the term "violation" could not be applied to a husband forcing his wife to have sexual relationships, 48% of men thought the way of dressing of a woman was enough to provoke a rape, and 22% was in agreement with men hitting women.
- Philipines: in Davao the city Council on violence against women started a program to reduce violence in all levels of society. Activities include among others, puppet shows dealing with community dialogue on gender violence, and courses for the police officers of the city, health workers and government employees. In 1997 Davao's City Hall approved the Developments Code for Women, a regulation to promote and protect rights of women and to speak about gender violence, medical and legal support and advice for victims. Besides it created "women units" in police stations of the city.

Responsibles for sexual and reproductive health programs can:

Establish policies and procedures to ask women about abuse.

Establish protocols that clearly indicate the most suitable attention and reference system for victims of abuse.

Promote access to emergency contraception.

Offer places for groups of women organizing support groups and meetings.

Work to educate the community, local authorities on sexual and domestic violence.

Masculinity as a risk factor for men themselves [11]

> "The last one to arrive is a girl", shouts the boy from the 5th grade of primary school, for his friends to run and cross the wet road while a fast car comes closer in a rainy afternoon in Xalapa. Even though he is the last one, he does not become a girl, but besides a broken windscreen, he gets a femur fracture and a concussion.

We understand masculinity as a group of attributes, values, functions and conducts that are essential in men in specific cultures. A trait of behaving in ways considered typical for men. All cultures are ruled by traditional male dominant models which discriminate women and other men not adapted. Over time, this dominant idea on male behavior has some consequences on health. Examples of this situation are a major independence, agressiveness, competence and acquisition of violent and reckless conducts in front of vehicles, addictions, violence and sexuality. Indeed, many causes of mortality in men during their working stage (in comparison with that of women), are based on variations in gender socialization of men. For example. the siniestrality rate increased because men refuse to use caution measures to look stronger. This masculinity can become a risk factor not only for him, but for women, and children, specially through domestic violence, sexual violence, STI transmission, forced pregnancies and careless attitudes in front of the family. Some of these risks of masculinity are:

Accidents

Rashness in men (developed, proved and demonstrated collective in men) begins appearing and developing in men since adolescents.
Homicide, self-inflicted wounds.

Homicide, self inflected wounds

It is true that many deaths can be caused by different ways of violence (narcotraffic, political situations, repression etc). Nevertheless, we have to admit that murder happens among family members, acquaintances or relatives. They can be caused by fights where violence becomes a conflict-resolution mechanism.

[11] Ideas taken from De Keijzer (1991).

Addictions. Alcoholism

Alcohol is a risk factor in traffic accidents, suicides and arrests. Besides its consequences in cirrosis of the liver are more evident after 30. Even though tabaquism is traditionally male in many countries, there is evidence of an increase among women. This explains why lung cancer is more common in men. For example, in Veracruz (Mexico), one out of ten men dies for cirrosis of the liver or alcoholic dependence. The risk is five times higher than that for women.

Suicide committed

When speaking about suicide, this is considered to be essentially a problem for women. And this is absolutely right if we are just speaking about attemps to commit. Studies around the world have proved that women are more likely to attempt to commit suicide than men. However when we speak about suicide committed the percentage inverts. This is related to the difficulty men experience to face pain, sadness, loneliness or defeat. This deals with an inability to ask for help, which means weakness and lost of power.

Suicides per 100.000 inhabitants		
	Men 93 - 98	Women 93 - 98
Canada	21.5	5.4
Sweden	20	8.5
Spain	12.5	3.7
France	30.4	10.8
Slovenia	48	13.9
Estonia	64.3	14.1
Lithuania	73.7	13.7
Russian Federation	72.9	13.7
Colombia	5.5	1.5
Ecuador	6.4	3.2
China	14.3	17.9
El Salvador	15.6	7.7
Nicaragua	4.7	2.2
Source: UNDP (2000)		

Personal care

This is definitely one of the most appealing topics when we relate health with masculine attributes, because there is no idea what personal care is about.

In workshops on this topic, they usually mention the difficulty to ask for help, the inexistence of personal care in terms of medicine and their life style.

What can we do to prevent these risks?

- Enhance the work on masculinity for and with men from their point of view. There are many groups on masculinity in several countries that generate information and developmental projects.

- It is important and necessary to work with men with a gender perspective and incorporate their specific needs in health programs and projects in general.

- To work with young people. The school is a place where gender relations are confronted, learned and practiced. It is a good stage to deactivate sexist education and treatment, and to discover the value of equitable relationships.

- Perform participative diagnosis with different communities to find problems in which men play important roles: alcoholism, domestic violence and problems with the couple or the family.

- Incorporate information, bibliography and evidence that refer to the masculine condition and its relationship with health and sexuality in health centers.

- Organize workshops on masculinity, sexuality, couples and family planning with only men or mixed groups when convenient.

Female genital mutilation (FGM)

This is a traditional practice in some regions in Africa and the Middle East and it is even visible if we work with inmigrants coming from there. Female Genital Mutilation is the term used for removal of all or just part of the external parts of the female genitalia because of cultural or non-therapeutic reasons. This procedure can cause various side effects and suffering in women, specially for her reproductive health. The purpose and the importance given to the procedure varies from one community or from one family to another. This is vital to families in this society as her honor for the family depends on her possibilities to get married. Besides relatives or the same community insist on the practice by convincing parents this is a healthy practice. A good health features consistently as justification for FGM. It is necessary to understand that for many women this is part of their traditions; they will have to take what their mothers

and grandmothers have before with dignity. In cultures where the possibilities for a woman to be honored, congratulated and recognized are scarce, FGM is overvalued in spite of the many side effects it can cause. For health workers from the west, this could be just a cruel and reactionary practice. But we have to remember that many dangerous practices for women have existed for a long time in all cultures. One example was the use of tight corsets that could even break ribs or cause respiratory or digestive disorders. Or the chinese tradition of bandaging the feet of girls. Though widely spread, these practices were recognized to cause problems, and eventually abandoned. It is very important to leave our point of view on FGM aside. Many women that have gone through this procedure may be looking for help desperately and we must be ready to give them a hand. In order to help these women, first we need to know what FGM is about, and what are their sanitary needs.

What is FGM?

a) There are three types:

- The removal of the prepuce (retractable fold of skin, or hood) and/or the tip of the clitoris.
- The removal of the entire clitoris (prepuce and glands) and the removal of the adjacent minor labia.
- Infibulation consists of performing a clitoridectomy (removal of all or part of the labia minora, the labia majora). This is then stitched up allowing a small hole to remain open to allow for urine and menstrual blood to flow through. Experts consider this represents 15% of the performed mutilations.

Generally the procedure is done by a doctor, or a qualified midwife, who are most of the times, have a traditional formation and experience as healers. Mutilation may be carried out using sharpless non-sterilized instruments or cutting instruments like broken glass, earthenware vessels or some other. Very commonly no steps are taken to reduce the pain.

b) Complications and consequences

There are two types of complications caused by FGM: immediate and long-term. Since no anaesthetic is available, the most immediate consequence is pain. The death of the girls undergoing mutilation depends on the ability of the person performing it and the sharp of the instruments used. Many blood vessels can be cut producing bleedings and even death. Infections are also common. Long-term effects coming from FGM, in particular infibulation can include fibrosis of scars, small benign tumours, and the extreme reduction of the opening left after mutilation. Painful miction can be the result of urinary tract infections. A girl recently circumcised can take hours or even days to urinate because of the extreme pain. The infection present in the wound usu-

ally causes chronic reproductory tract infections and chronic pelvic pain. Infibulated women, whose genitals have been tightly closed, have to be cut to allow the baby to emerge. First sexual intercourse can be impossible and very frequently, cutting is necessary before it can take place.A very long childbirth can produce damage to the bladder and the surrounding tissues producing vesicovaginal and rectovaginal-fistulas (communicating bladder and rectum and vagina). Women suffering from these disorders may be excluded by their families and communities. For the baby consequences can be cerebral damage or death.

Testimony

"I was genitally mutilated at the age of ten. I was told by my late grandmother that they were taking me down to the river to perform a certain ceremony, and afterwards I would be given a lot of food to eat. As an innocent child, I was led like a sheep to be slaughtered. Once I entered the secret bush, I was taken to a very dark room and undressed. I was blindfolded and stripped naked. I was then carried by two strong women to the site for the operation. I was forced to lie flat on my back by four strong women, two holding tight to each leg. Another woman sat on my chest to prevent my upper body from moving. A piece of cloth was forced in my mouth to stop me screaming. I was then shaved.
When the operation began, I put up a big fight. The pain was terrible and unbearable. During this fight, I was badly cut and lost blood. All those who took part in the operation were half-drunk with alcohol. Others were dancing and singing, and worst of all, had stripped naked. I was genitally mutilated with a blunt penknife. After the operation, no one was allowed to aid me to walk. The stuff they put on my wound stank and was painful. These were terrible times for me. Each time I wanted to urinate, I was forced to stand upright. The urine would spread over the wound and would cause fresh pain all over again. Sometimes I had to force myself not to urinate for fear of the terrible pain. I was not given any anaesthetic in the operation to reduce my pain, nor any antibiotics to fight against infection. Afterwards, I haemorrhaged and became anaemic. This was attributed to witchcraft. I suffered for a long time from acute vaginal infections." (Hannah Koroma, Sierra Leone)

c) Mental health problems

A girl who had suffered a FGM can be traumatized for years, developing feelings of anxiety or melancholy. Chronical pain and suffering caused by FGM can result in long-term mental problems like depression, frustation and feelings of uselessness. Sexual problems can be the cause of problems with their couples. She can refuse any sexual relationship for fear of the pain.

d) What can you do?

Being a professional coming from a country where FGM does not exist, your role must be prudent. In the past, many western people who openly condemned and criticised the practice were accussed of not understanding and respecting cultural practices. Attitudes like this one can be counter-productive and people can respond by deffending their practices vehemently. Apart from our customs, it is important to work together with local groups, giving them support when necessary and providing sanitary attention to change social norms permanently. We can:

- Find out what other women organizations are doing in the community or the region where you are working. Strong support of women associations have brought FGM to governments and international organizations.
- Find out the legal situation in the country where you are.
- Promote and support the education of communities to keep people informed about risks and problems derived from FGM.
- Promote those programs introducing new harmless rituals for girls and women.

e) How can we offer sanitary assistance to women who have undergone mutilation?

Maybe the most important part of a health worker is to know if FGM is practiced in the community where he/she is working; or if patients include immigrants coming from countries where this is performed. To know that a woman has possibly suffered FGM can help us identify complications related to it more rapidly. We must:

- Provide assistance based on each culture, out of moral judgements.
- If possible, offer the services of a female professional in sanitary health.
- Use the appropriate terminology, like genital cutting. Using the term FGM can be confusing and even insulting.
- Ask direct questions like " how long ago?", " How did it happen?", etc. Usually, questions like " Do you have any problem?" have negative answers; since this is an early age experience they do not feel like sharing their feelings about it.
- Explain the woman why and what you are going to do. It is possible that a woman who has undergone FGM ignores what the normal anatomy of a woman looks like. Probably she does not even know what they have done to her. Use simple words and visual methods to explain.
- Be aware the gynaecological examination can be hard, painful or impossible. Stop if the woman is severely uncomfortable. The examination must then be performed with only one finger.
- Write down everything you have seen and include, if necessary, a

drawing of the genitalia, in order to avoid unnecessary future examinations by other health workers.

The Story of Tostan

In July 1997, forty women from a senegalese village called Malicounda Bambara anounced the press they have decided to stop the traditional practice of FGM. Women have made that decision altogether with their husbands, chiefs and religious leaders after introducing the educative Tostan program in their village. One of them explained the program develops some kind of practices and basic knowledge of life and health and focus especially on women and early stimulation for children. " We started thinking and discussing in class topics we have never talked about before; things that have always been considered "taboo"... The Tostan Program gave us trust we have never had before: the trust to do things if we really wanted to". Over time, women from Malicounda Bambara became more and more interested to discuss problems around FGM. They decided to talk about the negative consequences of FGM with their friends, sisters and husbands. And then they looked for the support of the Iman and chief of the village. They were really surprised to find that many of their partners in the village were against FGM. The Iman explained that the Coran did not ask muslim women to go through this procedure and that he was in agreement to stop the practice of it. In order to spread the word and let women from other villages to know the facts, they played a comedy representing the new things they have just known. As a result, other thirty villages endorsed the program and committed themselves to stop the practice of FGM in their territory.

f) Treatment for complications associated to FGM

As mentioned before, the main complications and long-term consequences coming from FGM include:

- Continuous urinary tract infections.
- Infections of the wounds.
- Continuous vaginal infections.
- Sexual dysfuncions and painful sexual relationships.
- Fistulas.
- Painful and complicated deliveries.

Care for women with complications can include simple healing and curing of wounds and treatments for urinary tract or vaginal infections. However a woman who has undergone infibulation may require more specialized care or surgery and may be even referred to a hospital in case the services offered at the moment are not enough. This can be the only solution to give her the chance to have her life back. Deinfibulation

or surgical opening of infibulated scar [12], can be necessary before the woman has sexual relationships or give birth. This can be done with local anaesthethic during childbirth to make the delivery easier.

How to reinforce the role of men as partners in sexual and reproductive health

The sexual and reproductive behavior of men affect their health and that of their couples

The opinion a man has about family planning and fertility can exert some influence in the attitudes of his couple and her access to services, determining the number and spacing of children. Men's sexual practices poses risks to him (and his partner) to be infected with sexually transmitted infections like HIV. To go over the needs of sexual and reproductive health for women and men, programs managers must understand the diverse factors that affect attitudes and behaviours of men as well as their use of reproductive health services. They also have the right to have access to quality services that fulfill their needs. To fulfill the needs of woman it is necessary to fulfill those of men, who can eventually create barriers or give women an opportunity to look for sanitary attention.

> We have learned men experience a great cultural pressure to become one of those who have control and domain over everything; new sexual conquests become proofs of their masculinity; and men do what it takes in order to make sure they are not considered homosexuals.

Reproductive health services adapted to men can be extremely positive for those offered to women. Some studies on how to increase the access of men to sexual and reproductive health services have shown the existence of some barriers:

a) The information they have about family planning is not precise.
b) Men have less access to information and election of services.
c) Services are usually placed in inappropriate places.
d) Service timetables are not appropriate for men working.
e) Service providers are not frequently friendly and do not provide help.
f) Maternal and child health as well as family planning centers are considered places for women.

[12] If you want some information on how to perform a surgical deinfibulation you can visit www.fgm.org/crashcourse.html.

How can we adapt services to men?

Very frequently, men do not ask for sanitary information or attention because they do not feel welcomed in the existing reproductive health centers. Posters, leaflets, flyers or magazines with images of women and children may discourage men from asking for services.They may think they are not designed to help them too. If the personnel in the center is exclusively composed of women, men can feel unwelcomed and uncomfortable. Like in any other health program, success in the program depends on the adaptation of the services to satisfy the users's requirements. To improve the quality of a men-oriented program, you must:

a) Organize information campaigns for men; include information on contraceptives, sexually transmitted infections and clinical services.
b) Offer specific services for men. Some programs offer special centers and timetables for men.
c) Offer services for diagnosis and treatment of STI and prevention of HIV.
d) Work with the co-operation of couples of men.
e) Promote the use of contraceptives at all time, at least when having extra marital sexual relationships.
f) Adapt yourself to adolescents needs in order to integrate them.
g) Try to include men in the professional team.
h) Ensure an appropriate and regular supply of contraceptives.
i) Provide with information and support to all the personnel to include men as users.
j) Include advice on prevention for men.
k) Offer vasectomy services.

7. What Can You Do for Gender Aspects Not to Affect the Health Programs in a Negative Way?

As we have seen all along this chapter, the success of your program depends not only on the financiation, provision, supply and infrastructure, but on an adequate planning, design and scope.

- Give gender formation to all the team, in particular the sanitar group.

- Ensure confidentiality in all programs.

- Promote communitary discussions on gender influence and organize gender sensibilization activities.

- Include women in the design and development of your program.

- Increase the number of women in the organization and contract paid female employees for technical positions within the benefitted community.

- Provide women technical formation to generate incomes in the future so that they can improve their trading abilities and get involved in decision-making processes.

- Work altogether with schools, religious and professional organizations to improve their knowledge on the influence of gender.

- Design projects involving women with low access to economic resources; give economic value to their work, time and plan new activities based on this.

- Include access to credits as part of an integrated program to address the real needs of low income women.

- Promote community participation as an efficient way to provide some services and minimize men's resistance to participate in programs that benefit women.

- Include sensibilization activities on gender roles that affect sexual and reproductive health in negative ways.

- Go over political questions that create obstacles for the existence of a good reproductive health care system.

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In the following web pages, you will find testimonies, experiences, bibliography and tools for self-formation on reproductive health, family planning, genital mutilation and human rights; most of them in Spanish.

- European NGO's for Sexual and Reproductive Health and Rights, Population and Development: www.eurongos.org
- Federación de Planificación Familiar de España: www.fpfe.org
- Fondo de Población de las Naciones Unidas: www.unfpa.org
- Foro de ONG "Cairo + 5": www.ngoforum.org
- Global Reproductive Health Forum: www.hsph.harvard.edu/Organizations/healthnet
- Flacso. Simposio sobre participación masculina en la salud sexual y reproductiva: www.flacso.cl/bibliomasc.htm
- Health, Empowerment Rights and Accountability: www.iwhc.org/hera/index.htm
- IPPF (Federación Internacional de Planificación Familiar): www.ippf.org
- Organización Mundial de la Salud: www.who.org/
- Qweb Sweden (Red mundial para la promoción de la salud de las mujeres y la igualdad entre los géneros): www.qweb.kvinnoforum.se
- Reproductive Health Online–Reproline: www.reproline.jhu.edu
- Red de Salud de las Mujeres Latinoamericanas y del Caribe: www.redesalud.web.cl
- MDM España: www.medicosdelmundo.org
- Mujeres en Red: www.nodo50.org/mujeresred
- Johns Hopkins University, Center for Comunication Programs: www.jhuccp.org
- Emergency Contraception website: www.opr.princeton.edu/ec
- UNIFEM (Fondo de las Naciones Unidas para las Mujeres): www.unifem.undp.org
- Engender Health (Improving Women's Health Worldwide: www.avsc.org
- Center for Health and Gender Equity: www.genderhealth.org
- The Population Council: www.popcouncil.org
- The International Women's Health Coalition: www.iwhc.org
- Hivafrica: www.hivafrica.org
- Female Genital Mutilation Education and Networking Project: www.fgmnetwork.org
- Maximizing Access and Quality: www.maqweb.org

Chapter IV

Gender Identity, Communication and Cultural Differences.

A. What Are We Going to Find in the Fieldwork?

Maybe the first impression on arriving to a new country is apparently physical: a mere awakening for our senses. But this is only the reflection of the new life we are starting. Accepting "the other reality" which is unusual and different for us takes a big effort. It is hard to assume the ways this conditions and determines the ways other human beings get interrelated, express themselves and make up communities. It takes more than just accepting differences with tolerance. We get committed to listen, accept, respect and value the reality we legitimately want to change. However, that special way human beings see the world from their own point of view makes this harder. It is a biased look limited by their own subjectivity. Our symbolic universe and the experiences lived become "filters" that affect our perception. In general, this guide will give you enough and clear concepts which will be useful when you think about to analyze situations where you are immersed. It will also allow you to share that reflection with the people benefitted by the project where you take part.

This chapter, in particular, is designed to check out our own values, to disqualify some inertia and to "unlearn" some of our own attitudes. Indeed, it proposes a self-analysis and an analysis of the relational frame where we live. For this reason, it may seem: "a bit shocking". At the same time, this guide focuses on the work of words and reviews their ways to make changes easier in personal development processes, promoting the participation of the subjects in the definition of their own changes.All through this chapter, we will analyze:

- Some attitudes that influence positively in human communication: recognition and acceptance.

- The most frequent "filters" that keep us away from listening: preconceived ideas, prejudices and judgements.

- The function of words and factors that interfere.
- Norms in active listening.
- Empathy: the scope of understanding.

1. Learning to Observe, Learning to Listen

> Do not limit ourselves to be simple observers: be part of it.
> *(Buddhist proverb)*

For a long time, women have felt unable to determine and recognize which are our own needs and even find difficulties accepting our rights. We do not take full responsibility for our bodies and lives because we feel they do not belong to us. It seems we have understood perfectly that we have to take care of other people (sons, daughters, husbands/partners, older people…), pushing our own care and well-being into the background. In many cases, this is because we do not know how to do it. There are some causes for this foolish behavior, and probably you will have the chance to study some with the guidelines this book provides. These interpretations are about the methods we use to perpetuate a system of gender relationships, radically unfair, which supply with different values and empowerment to each of their components, keeping the most elemental rights of women undercover. Though this is a generalized situation worldwide, there are different levels and expressions according to the community and culture we are. Possibly, one of the most impressive findings in the work field is that we realize women do not feel legitimate and empowered enough to make decisions and take care of their own reproductive health. We can guess the posible reasons for this, however, the real ones are immersed in women's lives, in their own stories and testimonies. For this, we consider "listening" as a very important component to keep in mind.

> Any intervention or performance directed to change a reality, must include the individual whose life is about to change, empowering him/her to play the most important role.

The individual himself must identify his needs, his obstacles and the resources available. This is the only way to create a respectful, suitable and sustainable performance. From this perspective we can understand the difficulties for women to undertake this responsibilities. They do not see themselves as individuals, they can not find their own resources and do not feel autonomous to make decisions or ask for their rights, and they can even conceive a different life! The result of the work of groups of women in Spain and

Latin America has confirmed that women do not give enough value to their own body. And we can not speak about sexual and reproductive health without resolving this limitation before.

When a woman does not see herself as the owner of her own sexuality, her own body and is not aware of her rights to choose, to make decisions and plans, it is hard for her to be encouraged to accept our indications, suggestions, recommendations and resources. In that case, our role is simply to be present, trying to create spaces for listening that certainly make possible the emergence of a "new woman" holder of rights with a major autonomy. Autonomy taken as "interdependence", as the increase of options and the ability to make decisions…, as well as the necessary strenght to face life differently. So to make things work efficiently, we must provide some renewed gender relations, much more equitable and enriching. New relations based on recognition and respect of diverse identities.

We can have a recess now… We invite you to read attentively the poem by Marcela Lagarde [13] that appears now. Give yourself this short moment to enjoy reading it. It gives the author's own perception on her own body, and suggests some keys for individually or group reflection.

Speaking of Marcela's poem…

- Read the poem very slowly. Does it give you new ideas?
- Which sentences or ideas call you attention in a special way?
- Do you think you respect and love your body? Is this easy for you? Do you feel others respect your body?
- Is it hard for you to ask to be respected? Why?
- How many ways do you think a body can be hurt? Not going to the doctor when you need it? Not taking care of it?
- If we discussed about this in a group, do you think women's perception would be different from that of men?
- Which conditions do you think are necessary in a group to have a good communicative environment?

[13] Marcela Lagarde is an etnologist (Escuela Nacional de Antropología e Historia), master and doctorate in Anthropology (Universidad Nacional Autónoma de México).

Erosymphony to My Body

This is my body and inside I feel
Inside I think, I am within
This is my body, my only house
My only home,
My warm space
Territory to discover
My body is my desire,
My hug, my caress, my inner look
My doubts and my daring.
My body overflows with my affections,
Feelings and learning,
My body is my language,
My sign, my groaning and my oasis of peace.
My body is my laughter and my whisper,
My silence,
My body is my music and my word,
My tear and my wink.
My body is the way I walk and the path
Potions, songs, spells and witchcrafts.
My body is my land and my last home.
My body is for me,
To enjoy life, to enjoy living in this world,
To find other bodies and other lives and be moved.
To walk and leave my footprints.
My body is enjoyment, vertigo, mistery,
Contact, trembling and heartbeat.
My body is ephemeral and delicate,
Strong, painful and joyful.
My body is mistery and wisdom,
Daring and amazing.
My body is hot, pores and cavities, skin and hair,
And textures, moisture and horizon.
My body overcomes fears,
Is sensitive and shakes.
My body irradiates, invites, calls and finds. My body is mine and I love it.
I am my body and I love myself.
I feel, I lie, I walk and enjoy.

Marcela Lagarde

Some attitudes that influence positively in communication

One of the most important attitudes that influence positively human communication is recognition. With this, we get to know people better and they come up with a new personality which has been ignored until now. If we are open to listen to those living around us, sharing our lives, we will rediscover a singular and particular existence, a place full of rights and needs, plenty of possibilities to develop our abitilites and overcome the biggest limits. Marcela Lagarde teaches us something about this: "A good start in our relationship with others is the human equivalence. It is the ethical principle on which the universality of human rights is based; that principle that values each human being equally. Human equivalence is an ethical principle beyond all moral judgement that we need to put before prejudices. **This is about recognize that regardless of the moment, all people are always valuable.**" Another of those important factors in human communication is acceptance. Accepting is not only: "... not me again!" or "she is just like that...". Acceptance is not a synonym for resignation, even though some groups of women think this way. Acceptance means respecting human beings with qualities and faults. **It means to appreciate diversity and difference of ways of being, costums, rythms, points of view, etc.**; It means to respect them even though are not similar to our own feelings, thoughts, opinions and beliefs. **Without a doubt, the best environment to ensure a fluid and honest communication is that where there are no threats, criticism or disapproval for those around us.** To get to this point, it is necessary then to revise the following attitudes:

- Do our best to create a suitable environment for people to feel accepted, with an open attitude to reconcile different ideas and options. Value with honesty divergent opinions thanking for the enrichment of knowledge and experiences resulting from natural and free conversations expressing our own ideas, feelings and attitudes, though seem to be absolutely out of normal.

- We think about the possibility for people to change attitudes is real; for this, we must be out of prejudice and encourage you to promote any positive proposal of change, though your initial instinctive resistence arises.

- Talk about commont issues, and let divergent ones for the last moments. It is necessary to talk more about life experiences than only ideas. Ideas usually separate people while pain or shared holidays joint them.

A proposal to make revisions easier

In communication groups it is very useful to designa person to observe

analytically the most usual attitudes. Impartiality, respect and discretion are the only requirement apart from no special methodological resources or knowledge. If you are going to work with groups, maybe the following questionnaire can help you not only as an indicator that weights up different steps in the process, but also as a guide into personal and group reflection. It is remarkably recommendable to run through it more than once to check the evolution of the group.

In this group, I ...

- Can express affectionate feelings.
- Can express feelings of anger.
- Do not admit ideas different from mine.
- Enjoy allowing others to know me better.
- Am worried about my ridicule things.
- Feel comfortable.
- Try to mix with only one part of the group.
- Pretend to be someone different from who I am.
- Feel insecure about myself.
- Am aware of how people see me.
- Have the impression I am ignored by others.
- Have the impression I am not heard by others.
- Feel nervous.
- Feel I can trust others.
- Observations.

Answer Key: 0: rarely, 3: sometimes, 5: often, 8: generally, 10: always. Materials: Sheet and pencil. Development: Participants must reflect on their roles as part of the group. They will fill in the questionnaire individually and after this they will discuss freely with the rest of the group.

Here is a game: the purpose is to finish as soon as possible. It is not necessary to devote so much time. It is simple. You just have to read the text and answer the following questions.

Short story

A pharmacist had just turn off the lights in his drugstore, when a man appeared asking for money. The owner opened the till. Once the man got the money, he put it in his pocket and left in a hurry. Answer the following questions drawing a circle around the most suitable answer, following this key: C=correct, I=incorrect, ¿? = do not know.

- A man appeared after the man had turned off the lights.
- The thief was a man.
- The man who appeared did not ask for money.
- The owner emptied the till and left.
- Once the man who had asked for money, put it in his pocket, ran away.
- Even though the till had money in, the story does not say how much.
- The thief asked the owner for money.
- A pharmacist had just turned off the lights when a man went into the drugstore.
- The man appeared in the daytime.
- The man who appeared opened the till.

Now, you have to count the answers according to the key you choose, it means: times you responded C, I or ¿?. Read the text again and check if your answer is correct or not. Now think about the bases on which you gave your answers. Are you sure these sentences are based on the text? Do you think you have enough information for your answers or would you like to check it up again?

Some filters that distort communication

This exercise has been done by many groups, some of them formed by different professionals involved in gender violence (police officers, psychia-

trists, doctors, social workers, etc.), and others belonged to women associations. In any case, the number of (¿?) was not higher than three. However, the third is the only sentence we are certain about in the story: **the man who appeared did not ask for money**, and we can therefore answer it is incorrect. You can tell: "But…the pharmacist **is supposed** to be the owner of the drugstore, isn't he?". Of course, we can not think of this man as he was only an employee, after devoting so long and so much money and effort to finish his studies. All this can be conceived as **preconceived ideas.** "**It is clear that** a person that appears in a drugstore about to close, asks for money, puts it in his pocket and leaves in a hurry must be a thief." In this case, we are judging this person in a wrong way. Our experience, fears and the way the story is told, makes us think differently because of our **prejudices.**

The preconceived ideas, prejudices, labels and moral judgements are part of what Marshall Rosenberg called "the communication that distances from life". According to the author, this type of communication "traps" us in a world of preconceived ideas on what is wrong and right, a world made of judgements. It uses a language with a great deal of words, classifications and dichotomies about people and behavior. We use this language when we judge others as well as their behaviors and pay attention to what is wrong or right, normal or not, responsible or irresponsible, cultured or ignorant etc. We have to think about this when getting into a different culture, because according to this, we can realize that our abilities to observe and to listen can be previously contaminated. We do not know with certainty what others need or what is more convenient for them. Now we recognize the value of words… and get ready to listen.

> " When we can not tell our story to anyone: that is death. Death caused by prejudices. Living means living with someone as Ortega said, and when this is impossible because of prejudices, this is death. You die being judged, sentenced and isolated by others." (Maria Zambrano. *Delirio y Destino.*)

2. Words

A word is a gun loaded with future.
(*"Recreando"* a) Gabriel Celaya

" By recognizing that the word was given by our mother, (...) I also recognize that she is also the womb where life started to unify me with life and word. I begin to revive, not only to remember, (...).

Body and word holding hands.

I begin to speak in first person and this is birth.

This, gives birth to myself.

This is my real birth as a woman, a woman who leaves the pain behind and gives birth to love, loving herself and loving others. Speaking in first person. **Creating this new word and being responsible for it**, means **it is me** who had lived, **I** am the main character, **I** am the one who speaks, who tells, **I** am the survivor, **I** am the memory, **I** am the denounce…" (From the book *Rompiendo el silencio* by Marta Elena Montoya Vélez).

In this text, Marta Elena explained (paraphrasing María Zambrano) the way she can give birth to herself through words. Being born by myself means accepting the possibility to change what I do not like, living a new reality and a brand new condition. With a word, I am the main character, I create my story and I become aware of the reality surrounding me. The word lets me speak about my needs, my objectives, lets me gather my resources and form my alliances. The word connects me and others in real and imaginary worlds. **The word is the path between what I am and what I want to be, what I do and what I want to do. The word is loaded with…**

Attitudes frequently interfering with words

- To give advice, offer solutions and recommendations.
- To feel sorry and pity for people.
- To flatter people trying to be excessively nice to them.
- To complain, to blame and recriminate.
- To show disappointment.

3. Listening

We have seen the importance of words in exchange processes of people. Now, appropriate listening is absolutely necessary for the word to be fluid. This kind of listening is by far one of the most incredible resources we can get. However, knowing how to listen is the hardest part of communication.

> " When (…) somebody listens to you out of judgements, without taking responsibilities for you and does not try to change your ways, you really feel great. (…) When they have paid so much attention to me, they have listened, I can see the world in a new way and go on. It is surprising to see something with no apparent solution, found the way through, when there is someone listening to you. And all those things that seemed irremediable turn into a river that flows softly because somebody has listened to your words." (Carl Rogers).

Normally, when speaking with another person, we do not listen to what he/she is saying, because many times we are worried about what we are going to say next, and many others we are just trying to find a solution to the things said,… Listening well means focusing on what we are being said. When people feel listened and understood, they possibly will find the answers to their needs while speaking about them with others.

Guidelines to good listeners

- Develop patience.

a) Give time for the person speaking.
b) Show respect for speech rythms; everybody has one of their own.
c) Respect pauses people make when speaking.

- Pay attention to the text.

a) Pay attention to the tone of voice used by the speaker: it tells us about the mood of people (anguish, happiness, worry, etc).
b) Pay attention to facial expressions: pointing to the mood of people as well.
c) Pay attention to gestures and poses.

Another proposal to consider

Let's take one of the sentences in the former text by Carl Rogers: …**"without taking responsibilities for you and does not try to change your ways…".**

- What do you think this means?

- Have you ever seen yourself preparing your speech while others are speaking?

- In that case, have you ever listened to your own words until the end?

- Have you ever been in an embarrasing situation because of this?

A very healthy exercise is playing "cats chase mice" with yourself, trying to get that part of you making up the answers before questions have been made, or hurries to give solutions or advice before knowing the problem more deeply.

Active listening

In active listening, the listener adopts a position that makes the speaker think he is actually paying attention not only to him, but to what he says, needs or feels.

- Allow others to speak. Interrupt only when you can not understand all the information received, when you have the impression you are lost in the conversation or when you are feeling confused about the content of the speech.

- Allow silences in the conversation. These pauses are really important for the speaker to take time to analyze and reflect about some new contents.

- Express everything that calls your attention from the speech. Here we include contradictions between sentences and facts. In spite of the existence of these, we must not reproach our speaker; very frequently he does not even realize they exist. It is better if we express this simply by making questions.

- Get interested in his feelings and speak about the impression we have about them.

The most important mistakes opposed to "active listening"

- Being ironic, ridiculizing or minimizing the speaker's problems.

- Interrupting the speaker, trying to finish up the sentences he is making.

- Reproaching, critizising and judging what the speaker is saying.

- Offering premature solutions to a problem which has not been deeply expressed; most of the times, without listening to the speaker's solutions and proposals.

- Making too long comments withouth focusing on the problem.

- Making suggesting questions that lead to an answer we expect from our speaker, for example: " So, you are not in agreement, are you?", or "Don't you think that…?"

Empathy

Empathy is perhaps, the most important attitude in listening. In general terms, it encompases all the elements analyzed in this chapter. Some people have defined it as "wearing somebody else's shoes". For Marshal Rosenber empathy is a respectful understanding of what others experiment. It seems simple, but in practice, this is not a very easy attitute, because we need to stay away from prejudices and preconceived ideas.

> " In spite of all similarities, each situation in life is different; like babies, they are born with new unique faces and unpredictable personalities, requiring unpredictable behaviors from us too. It does not take anything from moments in the past, but only our presence and responsibility: they just need us." (Martin Bubber, Israeli philosopher)

However, this is a natural tendence in human beings to give us the responsibility to listen to the person speaking, trying to give back answers, solutions and advice,… We worry about other people's suffering and this moves us, without noticing, we do not provide the neccesary time and space for speakers to express completely and feel understood.

As a conclusion

We have got to the end of this part. Since listening is mainly a practical resource for life, it is hard to write about it. Maybe this material can be useful for you to reflect on several items. Maybe today you are in a country different from yours, developing inteeresting and amazing projects that surely will help people; you are probably packing your bags; or maybe this is just a project you are thinking about. Maybe you feel sensitive and responsible, willing to take care… A last reflection: Be careful about being careful!

- To take care does not mean what you would like others to do to you. It means meeting the needs, expectations and illusions of the people we are going to help.

- We take care when we notice changes in the mood of those around us, when we encourage them and make them feel secure and help them trust in themselves; when we value their achievements…, when we support their projects and ambitions…, when we know and understand their limits (the value of their pros and cons) to be flexible…, and we believe in their possibility to change.

- Taking care means learning how to perceive our own mood changes; when we trust ourselves, when we recognize and value our own achieve-

ments…, when we accept our aspirations and learn to design our own projects…, when we know and understand our limitations (learning the value of our pros and cons) to be flexible with ourselves and when we know that we have the possibility to change what we do not like…

Besides, we must give ourselves a day at the beach, a lovely sunset alone or in company, a week in space with that one we dream of, a little while to do nothing, five minutes to listen to ourselves. In short, we must give ourselves some time…, time without limits of time.

To be cared, we need to know our needs and requirements. We need to know how to express them… we need to know we have the right to receive this care… and must learn how to receive all this care as a gift…we must develop the art of demand and gratitude.

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B. Men Speaking with Men (About Men)

For men, it is very difficult to analyze the way we relate with each other and language is includes as part of our verbal communication; we have been cleared of responsibilities; we live in a patriarchal system that proposes us rationalization instead of communication. Our masculine model considers the lack of emotional expressiveness and scarce communicative skill as positive qualities coming from men's austerity and independence. In contrast communicative fluency is considered feminine and justified as a consequence of social learning that teaches them how to express their emotions. If communication between women and men is difficult, what can we say about communication in men? It usually leads people to suspect about the nature of men as such. When men can speak with that fluency and communication flows creating some kind of more intimate conversation, people may think that they are feminine, homosexual or have a weak personality. As a result of this patriarchal system, just by avoiding men to talk to each other about themselves, men have been put and will be caged in an authentic sort of affective isolation. It prevents men from knowing things about their socialization partners; and this eventually does not let them know the way we live in a dominant masculine model, how near or far we are from that model and its privileges and discriminating consequences. It will be imposible to fight for real (and not only formal) equality of sexes if men do not get involved in this fight. We will find at least a big deal of resistance to change or openly reactionary and belligerent attitudes. This implication with men sharing roles, is questioned by several identities, but specially by the analysis men do to their own masculine identity.

Maybe the major obstacle for masculine communication is that tendence to consider a priori the masculine model uniform. In the first place, because it proposes self-satisfaction. In the second, because this uniformity can lead us to break down our own self-steem. We can meet many men who are more typical and representative of this model with more fidelity and

intensity than ourselves. We can justify our immobility and ambiguity with the necessary social adaptation that let us break down our own world of values and attitudes, but that would not respect human rights and would perpetuate injustice. The ways of masculine communication can be as varied as personal and social situations can be for men. Situations that can be difficult and different according to the vital context they are living in. Since it is really difficult to cover age, culture, etnia, etc at the same time, we have collected the following proposals.

In the family

Communication among men occurs following authority and discipline rules. Until young men reach the age of majority which is difficult to determine now that many of the rituals granting the rights are not taken into account (militar service, access to laboral world, etc). Communication then establishes a basic hierarchical structure from adult to young men. Affection and emotional communication are absolutely part of women's world; and women very frequently become intermediaries to improve affectionate relationships of men in their families. With the majority of age, communication begins to acquire a major continuity and fluency within the strict frame of family relationships related to sucession, maintenance and protection of family assets; women are frequently considered as one of these too.

Men according to the internalized masculine model, prefer "doing" instead of "talking". Communicative levels and contents differ depending on social status and the level of internalization of democratic values. In some families, fathers want to establish more informal relationships with their sons becoming "pals", "mates", or "partners", pushing their daughters into the background. As a result, more confident conversations replace authentic exchange of living experiences and emotional communication.

Where is the origin of masculine incommunication in the family?

The father represents authority and this is reinforced by the distance that causes a rift between him and those who follow him. The image of the father as a lonely hero, can not accept any kind of affectionate approach that shows his real fears and frustations. This is learned within the family; men know emotion and affection are basically reserved for exceptional moments of transition (like birth, illness or death), and evolution (promotions, academic or sport awards, weddings and divorces). It is here, inside each family where trust, expresiveness and the ability to care and be cared must be placed. Listening, talking, asking for and giving must be easier relations where affection would be the norm.

In the world of friends

This is the confirmation of masculinity; there are several rites or proofs to reach the level of young boys, leaving childhood behind. This is the questionning of family rules and values; this is where we, in the role of men, put into practice all that we have learned and that they expect from us. We have to be that way, and if not we would be rejected or discriminated. If verbal communication with friends has no level of intimacy or affection, is easy, fluent and efficient. If these patterns are not followed, we are afraid to be considered homosexual or being out of the typical masculine model. And if we are not men, what are we? With friends, intimacy must include novel stories on conquests of women. Seducing details and some emotions help men to find out the level of affection in the story, and when this comes out, conversations immediately turn somewhere else. A good example of pejorative sentences when telling the most intimate moments is to: "Cry like women", when men get drunk and begin crying or weeping. Holding or hugging friends, and in general physical contact is saved for epic situations so dramatically different such as the death of a beloved person or their own achievements in sports or that of their favorite team. It is then, when gender identity reinforces and modulates our sexual identity acquired in childhood. We have a role to play in life and it goes on once we have acquired a complete autonomy. Luckily, this role is not statically or solidly made so it can be changed, corrected and extended with interactions with other actors.

The world of work

For men, this is the focal point of their masculinity. It represents their independence and autonomy to support the family. Under these principles, communication among men is fluent. Men in similar posts talk about their difficulties to continue being the support for their families. He can be silent to compete or to speak to show support for a cause. In both cases, men communicate through dichotomies: competent-incompetent, competitiveness-conformism, self-satisfaction-support and so on. In vertical hierarchies in companies men speak to restate their own position in the company. Some defend their own merits and others fight for their dignity to be respected. However, both are obedient to the masculine norm to exert power to fight rebelliousness. Difficulties in more intimate verbal communication in the workplace are due to the lack of commitment and trust in their mates. Their purpose in their work has to do with competence and performance, not with reflection or affection. It is very frequent to become friends who avoid giving opinions and perceptions of their jobs, knowing this can be risky.

Masculine interest groups

This involves a voluntary decision to get involved and support any kind of leisure, ideological, political or reflexive collective movement typically masculine. Because this is voluntary, it can be the most suitable way to change dominant masculine models. In sports or culture associations, the level of communicative and methodological demand is low. This relaxing disinhibitory and collective situation makes it easier to work with aspects like respect, tolerance and flexibility. Try to imagine if some famous sports people or writers were mediators. On the contrary, politicians communicate based on political ideologies. It is surprising that in a world like this, where words are used as vehicles and arguments: achievements, excuses, justifications, etc (even as a substitute of action or omission of responsibilities) both communication and contents are completely ineffective. It is inside reflection groups of men like "mythopoetic", "profeminist", "immobilist" or "utilitarian", where verbal communication in men turns more intimate and affectionate. We attempt to analyze in detail therapeutic and purely ideological groups, looking for deconstruction or affirmation of masculinity (trying not to be radical). In this groups, where we as men can see how near or far we are from the dominant masculine model, several emotional responses rise. This is interesting to analyze. Even though communication tends to be more intimate and committed in these groups, the fight for control, power and leadership continue. Let me remind you what we have said about this in our guide: active listening, empathy, our of prejudice, imposition or dominance. These are the basics of communication. It gets more than rethorical to say that men should learn how to communicate with women and other men. But it is necessary to say that feelings keep on being very important and intense whether they are expressed or not. It is better to feel vulnerable than alone. It is better to feel confused than ignored. It is better to feel loved than feared.

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Part Three Our Fieldwork

Chapter V

The Project or the Program

1. What Is a Co-operation Project?

Projects are the most usual ways of action in co-operation for development. Though the objectives of Development NGOs are so different, they all use projects as their fundamental "instruments" to put their policies and vision into practice. NGOs, multilateral organisms and developmental agencies in the North work together with NGOs in developing countries with the same objective: transformation and positive change.

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Main Characteristics of a Project

- A geographical location as well as the population where projects will be applied during a specific period of time.
- Social, economic and cultural contexts where they are developed can be modified considering therefore they are living processes that can be adapted and re-oriented.
- They attempt to change and transform an initial problem or situation.
- They materialize thanks to some activities performed by social agents involved in the situation to be changed.

All **types of social changes and transformations** are complex and slow, and these include co-operation projects: we move in socio-cultural contexts different and far away from ours; we are making changes in the daily life of many people and even entire communities, that can be prejudiced against changes and may have preconceived ideas about our presence. It is natural to find difficulties and both internal and external resistance to our proposals for the change; for this reason we find necessary to anticipate and assess appropriately our influence in private life of people. Our action will attempt to meet all strategic, political and sectorial priorities from our DNGO and our donors, and may be unintentionally supporting those policies perpetuating inequalities; we will manage both public and private funds and will have to demonstrate they are being used in the best way possible, in terms of efficiency, effectiveness and transparency. Due to this

complexity, **planning and identification of the project become essential stages.** Planning must start with three types of analysis:

- Analysis of social, economic and geographical contexts in the project.
- Analysis of power relations within the community.
- Analysis of the actors participating in the community.

In a concrete project, the objectives for a change are translated into those tangible and verifiable results obtained (for example: reduction of maternal mortality rates, increase in the scope of children vaccination plans or decrease in the transmission of HIV). To achieve these goals, some other more profound but less visible chages have to happen to the existing power relations from the community where the project is being developed. Those concrete problems that we identify since the beginning, can be rooted in power relations, motivating us to continue our work. Using medical terminology, that concrete and tangible problem could be identified as a symptom. All communities have power relations determined by local social organization and culture; different factors and social actors get interrelated, creating new relationships that can be based on dependence, synergy or antagonism.

Far from transforming these relations, our objective will be to identify and understand them. These relations make it easy for some of the actors involved and make it difficult for some others, meaning different abilities or limitations that we have to know and assess. By actors, we mean all those individuals or groups, organizations, institutions (including the DNGOs in the North where we work), and public and private donors who can certainly get involved in decisions, support or resistance to the change. Unequal relations between men and women, age, race or ethnic origin, sexual orientation, religion, social class and urban or rural origin of people are all affected by power. Since all power relations are interrelated with each other, they must be identified in the planning of the project, by using participative tools of identification.

Safe Maternity in Baluchistan (Pakistan)

The main objective of this project is to decrease maternal mortality rate in the province. The initial analysis of the project states that: culturally talking, women have not the right to decide when they need or want to go to the doctor. Their husbands and mothers-in-law make the decision for them. Women in general and pregnant ones in particular are not permitted to move freely. They are not allowed to be in company of men coming from different families than theirs, causing problems in the access to helth centers. Finally, these services are not free, and families do not spend on health considering this is not a priority. Women are assisted by traditional midwives who are not well trained increasing maternal morbimortality rates.

To make this project work, it is extremely necessary to consider power relations in the community that relegate women, and specially subordinate the role of pregnant ones in decision-making processes. It will imply working with men and mothers-in-law, looking for them to get involved in the project; other power relations must be considered to reach our goal. Regarding the formal content of projects, they include the information in the following table.

Formal Content of Co-operation Projects
- Analysis of factors and actors implied in the situation to be modified, paying special attention to existing power relations, abilities, weaknesses, opposition and support to the objectives planned. - Clear definition of objectives and results expected to be achieved in the change or transformation. - Identification of activities and necessary actions to reach our goal. - Identification of human, material and financial resources necessary to develop those activities.

When people get involved in a project, they have to keep in mind they are participating in a process of transformation, with objectives previously planned, responding to a particular developmental policy from a DNGO that aims to reach its goals.

Summing up

A co-operation project is a complex process of transformation of unequal power relations in a community; it is determined by policies of DNGOs and initially must work on the correct identification of the existing power relations in the group.

To know a bit more!

There are different methodological tools to facilitate the planning process in projects. The logical framework approach (LFA) is an analytical tool for planning and managing of projects since the beginning to the end, and it has been commonly accepted by DNGOs, multilateral organisms and donors [14].

[14] There are several manuals describing this tool. For example, NORAD (1997).

2. Types of Projects: Emergency and Development Projects

Starting from a simplified classification, co-operation projects can be divided into two types, depending on the situation they aim to change: development and emergency projects.

Development projects

In the current conception of co-operation for development, the main objective is to contribute to equitable and sustainable human development.

Human development

Development centered on people and not on macro-economic indicators; men and women are actors of the social change who develop their potential, and participate actively in the development process.

Equitable development

Development centered on providing benefits to all people independently from their sex, race, ethnic origin, sexual orientation, social or economic status, age and position in social hierarchies. It brings the same resources and let everybody participate equally in decision-making processes of their communities.

Sustainable development

Development with benefits that remain constant over time and does not become harmful for environmental sustainability of future generations.

Concrete changes can be made in three levels:

a) In the life of people (on an individual basis).
b) In the ways of social articulation and participation (community level).
c) In the field of organization and structuring of institutions (policy level).

Most of projects of DNGOs are focused on development and take place in communities where social transformation is actually required. However, DNGOs are being asked to participate in emergency situations in countries with struc-

tural vulnerability, where they may be developing some other development projects [15]

Development Projects	Emergency Projects
- Long-term results. - In social contexts not affected by crisis that might require immediate attention. - Objectives of development in particular fields such as education, community income generation, health, development and training of local institutions, etc.	- Short-term results. - In critical contexts, where people are more vulnerable and their ability to react decrease.. - Specific objectives such as proteccion of people affected by complex problems, displaced people or refugees; fulfilling basic needs in children, men and women (drinking water, food, sanitary assistance…).

Emergency projects or humanitarian aid

Emergencies are usually associated with natural disaster (earthquakes, floodings, draught, etc.) or those caused by men (violence, war, environmental disasters, etc.). These circumstances can disturb the community's "normal" ability to face situations giving a new direction to development projects turning them into emergency ones.

In situations like these, projects must be committed to fulfill the needs of the population and help them recover their former condition of development. We are speaking about the "humanitarian continuum" a community goes through after any crisis:

Emergency–Postemergency–Rehabilitation–Development

Inside emergency projects are "complex emergencies": these ones occur in contexts with severe social crisis with political origins, where a big number of people die or suffer because of war, displacements, hunger or illnesses. They are always caused by men (violence or warlike conflicts) and usually get worse with natural disasters that take place at the same time [16].

[15] See chapter by Menchu Ajamil: "Approaches and Strategies on gender and development" in Villota (1999).

[16] Complex emergencies.

Humanitarian crisis in Afganistan

For more than two decades war has caused an unsustainable situation. As a consequence, there are huge displaced camps all over the country and refugees camps in neighbour countries like Pakistan and Iran. Thousands of deaths, broken families and a country with the highest number of personal mines are the result of war. Health services are terribly poor because of the destruction of the existing infrastructure. People can not live on agriculture anymore not only because of the mines, but because of the strong draught that devastates the country. The situation of women and girls in this country is maybe one of the worst in the world because of the political exclusion imposed by taliban integrists who controlled 90% of the territory. This situation is getting worse with the international coalition against the taliban regime, after the terrorists attacks of september 11, 2001 in the USA.

Emergency projects are sometimes supported by strong mass media campaings calling the attention of international aid (DNGOs, UN and other main donors) and concentrating for a short time in fulfilling the needs of the affected population. Two premises are really important speaking about this:

- The emergency does not "belong" to the international community or DNGOs that responded; actors in this case are commonly called "victims" or "affected".

- It is necessary to respect their human dignity considering they are people with abilitilies and intelligence.

3. Gender in Co-operation Projects

Why is the gender dimension important?

- Because projects have to promote gender equality and social justice.

- Because this way we recognize that gender inequality can be one of the situations that must be modified, making sure projects will benefit both men and women.

- Because projects are not "neutral" performances; they are processes of transformation and can produce unexpected negative consequences in gender relations in the community.

The integration of gender perspective must be present in all stages of the process, but must be an essential in planning and identification; a gender-based analysis of the community must be done and all the development planning must be based on this. To achieve this goal, there are some different tools that will be described in the following chapter. The analysis of gender relations in the identification of a co-operation project allows:

- To examine different social roles, jobs and responsibilities that men, women, young people, boys and girls have in their family, community and place of work.

- To analyze their participation in political and economic processes in their society.

- To identify differences in the control and the access to resources, benefits and decision making processes, health and well-being of men and women.

In the field of health, a gender-based analysis allows:

- To identity different health problems women and men face throughout their lives.

- To analyze generic and biological causes of these problems.

- To confirm the differences between the responses of the community and those of the public health system in front of common or particular illnesses suffered by men and women.

- To confirm the limitations of access of men and women to health, prevention and health promotion services.

In short, a gender-based analysis permits to identify the recognition and access that men and women have to health and human rights universally recognized. The main purpose of sanitary co-operation projects is to promote better health conditions, overcoming, transforming or modifying, if necessary, power relations and power practices (gender ones included), that can negatively affect physical and mental health of men and women and their access to high quality health services. They look for equality access for health, considering this is a natural right for everybody. Projects must also promote gender equality by relating health and well-being with some other issues like equality in the exercise of human rights, decrease in work discrimination against women, creation of new and more equitable divisions of productive work, new models of responsible paternity or the increase of political involvement and participation

of women in decision-making processes. Next we will show two projects with the aim of promoting gender equality.

Associating Economic Empowerment and Reproductive Health in Bangladesh. (Based on a Good Practice by the UNDP)

- The objective of this program was to improve health in families and to advance the economic and social status of women.
- Their strategy was to provide women with the possibility to obtain loans through the creation of 500 local women saving groups mainly focused on the development of agricultural projects and the improvement of the community. 160 community sanitary agents were trained to improve reproductive and family health services; each of them was responsible for about 150 women of reproductive age.
- The results of the project were as follows: 12.750 women were granted credits for creating small businessess; in two years the population accessing SRH services increased from 0,3% to 5,6%. Abortions reduced from 1.113 in 1993 to 307 in 1996.
- Since the reproductive and productive roles of women are intimately related, it was necessary to learn that good practices must involve them both. General institutions like the Agricultural Bank of Bangladesh are important allies that support women saving groups, promoting the creation of new businessess by women. The benefits of these strategic associations are not only for the women themselves, but for their families and the whole communities. Those women who receive appropriate information on SRH, can make decisions about their health and are able to develop more fruitful communication.

Participation of Men in Reproductive Health in Namibia

- The main objective here was to promote discussion and information on SRH among men coming from four different groups (nurses, policemen, members of the Lutheran church and players of football teams) in order to change sexual behaviors and improve SRH of men and women; it also aims to discuss gender roles and responsibilities in their families.
- In this case, the strategy was to answer to all questions men could make about SRH, by involving them into directed practices derived from their actions (education in pairs).
- The results of this project were: 325 men coming from the four groups were trained to become teachers who would work later in pairs. Their formation included not only sexual and reproductive health but also gender inequalities in their own communities.
- Since men had more important roles in the communities, their involvement increased and legitimate the discussions on family planning and gender violence. They identified those inequalities that did not allow men to take shared responsibilities in their homes, and those that never let women take part in decision-making processes as well. They eventually understood negative effects of masculine models on their well-being, SRH and responsible paternity.

Both examples had very different circumstances and objectives, but they both tried to transform a gender reality which was not just: in the first case was the lack of economic empowerment and access to credits for women in Bangladesh; in the second, the men's lack of involvement in sexual and safeguarding reproductive health and in new models of responsibility with their couples. These examples illustrate the importance of working with men and women when integrating the gender dimension in our projects. In fact, there are several different models and approaches to involve gender perspective in our projects.

Possible Hypothesis about Working with Men from a Gender Perspective

- The recognition and response to particular needs of men as a consequence of negative effects of dominant patriarchal model of gender relations, and other power inequalities on their well-being and individual development (masculine violence, repressed psychological affection, irresponsible paternity,...).
- The implication of men in getting more equitable power relations for women, through information, education and sensibilization (implication of men in contraception programs).

However, not all co-operation projects begin with a gender-based analysis. These ones may not consider gender equality as one of their main objectives. In some cases, projects can fail because of the inexistence of this previous examination or as a result of an inadequate analysis. In some others the effects on gender are negative. The only presence of co-operators and their own perception about inequality exert some influence on the way projects are developed.

The Association between Economic Empowerment and Reproductive Health in Bangladesh

The former example about Bangladesh can fail if:
- Men have not been involved and women have overload of work, being responsible for the biggest part of reproductive work, that has not been equitably distributed at home.
- Women participating in the project do not have economic independence managing their small businessess on their own, and their husbands had all control.
- Social transformation and overcoming of models are totally relied upon the access women have to credits; these are their practical but not strategic needs [17].

[17] See the definitions of practical needs and strategies in the glossary.

They can reproduce their own power relations scheme, whether it is equitable or not, causing obviously negative effects on the project. On the contrary, they can obtain positive results if everybody works from an equality perspective.

Gender-based analysis are recommendably used at the beginning of the project, but it can be made during the development as well, as part of an intermediate evaluation.

It is necessary to take into account that co-operators are living in other communities where opportunities and expectations of men and women are different from theirs. Understanding new gender relations models will take time, but at the end, they will be personally thankful and the results of the project can be closer to those previously planned.

They must ask themselves if their projects has included gender variables in their analysis and objectives. To find out, take a look at the following table with some key elements that must be considered.

Gender-based Analysis in Emergencies
Profile of benefitted population including their previous and present contexts. Generic analysis of activities related to production of goods and services, agricultural activity, domestic work, protection of the community and social, political and religious organization before and after the emergency. (Who is the responsible?, What does he do?, when, where and for how long?) Generic analysis of access and control of resources, in relation to those existing before the crisis; considering an analysis of abilities and knowledge of the people benefited from the projects and the external aid offered for the project.

If we really want to meet the needs of men, women, boys and girls in emergency projects, it is deemed necessary to include gender perspective. In crisis scenarios, the existing norms and traditional socioeconomic relations are threatened, mostly in cases of refugees and displaced people.

Women and their daughters are socially vulnerable in emergencies; it is necessary to remember that most of the population of displaced people and refugees is composed of women and girls. Roles and responsibilities are changed and we have to understand the pre-existing power relations and those created during the crisis. The analysis can focus on three aspects shown in the following table [18].

[18] These and other tools are explained in detail in the following chapter.

Does my Project Integrate Gender?

- Is there a gender-based analysis of the situation from the beginning of the project?
- Does my project improve, change or erradicate any negative behavior in men or women? Does it improve their position in society?
- Are specific problems, benefits, and results for men or women recognized? Are power relations included?
- Is at least a gender counselor budgeted in the project?
- Does my project say anything about the sex of the people recruited for work? or does it only refer to the positions offered?
Is the language used to write the text sexist?

An emergency intervention based on a gender perspective in the field of health can not forget that SRH is considered crucial in "primary health assistance". It has great influence in the physical and mental well-being of young people, men and women because it is part of their lives and is not interrupted in times of humanitarian crisis.

However, this element is sometimes forgotten when planning emergency interventions. In populations of refugees and displaced people, an initial response should aim to the following objectives.

Contents of SRH in Emergency Contexts

To identify the organization that coordinates SRH.
To prevent and give help to victims of sexual violence.
To reduce the transmission of HIV, ensuring access to contraceptives and promoting respect for universal precaution guidelines.
To control maternal and neonatal morbimortality by providing safe delivery kits to health centers and midwives in charge; to create a reference system in case of complications.
To include SRH services in primary attention centers.

4. Types of Projects in Relation to Gender Dimension

There has been a remarkable evolution in the way gender equity is involved in development policies; as a result many diverse approaches have been put into practice in projects that have used WID or GID.

Some projects, by contrast had not used the gender dimension while some others have used approaches that focus on women in any way.

Gender "blind" projects

In general, these projects are designed to all populations, ignoring to address the gender dimension. For example, a project to construct and provide basic medical equipments in a hospital in Kosovo, regardless the impact of gender.

Projects with approaches prior to WID

Examples of these are assisting projects aimed at improving the well-being of families, concentrating only on the reproductive roles of women as mothers and wives. Here, women are considered merely passive receptors. Women become the only way to get to children in a project of primary assistance in a refugees camp where maternal-child assistante is provided.

Projects based on the WID approach

These are projects focused on practices to identify and fulfill women's needs. For example, projects of formation and training for women in their traditional roles that aim to improve their situation using their own contribution. They also want to promote the presence and participation of women in the development of the project, for example in projects of integral assistance to women's health, where besides specific medical assistance, they receive training on health and SRH education.

Projects based on the GID approach

These are projects focused on gender. Their strategy is to fufill all practical needs and strategic interests. It aims to promote equality relations between men and women by empowering women. Gender is the core of all interventions and women are the main characters in internal processes of transformation. For example, a SRH project that meets specific needs of men and women, and promotes prevention of domestic violence as well. We can also identify different gender policies that determine the identification strategies and the design of the projects.

Specific policies

They define projects for women where specific needs are identified; they usually suplement the action of other existing projects, but in many cases push gender relations into the background. For example, family planning proj-

ects designed for women, where only they take part; they have access to information on contraception methods, forgetting the role of men in reproduction and ignoring the control or access they have to those methods and information.

Neutral policies

These ones imply projects designed with female "components", it means separate activities for women who take part in bigger projects. For instance, a project of rehabilitation and medical equipping of a health center in an indigenous community in the middle of the jungle in Chiapas. The main objectives are formation and provision of basic equipment for traditional midwives (who see 70% of deliveries in the zone) in order to reduce the maternal-child mortality rates in that community.

Redistributive policies

These ones are designed integrating gender approach. They try to produce changes in gender relations, looking for the integration and active participation of women in the process of development. For this reason, they attempt to mobilize and redistribute resources, responsibilities and power equitably among men and women.Gender is the core and is considered important throughout all stages. For example: A project of prevention of HIV/AIDS focused on people who work in prostitution and their clients, integrating prevention and gender violence.

Attention to practical needs and strategic interests [19]

> Any co-operation project attempts to meet the needs of populations.These ones can be different for men and women; that is why it is necessary to speak about gender needs (those of women and men in particular).

Usually, projects focus their attention to meet specific basic needs, specially in emergency situations. They focus on health, refugees, drinking water, food and protection to affected people. People are considered only to be part of a group, and particular needs, which are not the same for women, men, boys, girls or old people, are not met. It is deemed necessary to include this in emergency projects that usually respond with rapid and global solutions and do not analyze specific aspects of the groups that make up a community. Every group has their own problems and needs in health that we must identify. Meeting

[19] See definitions of gender practical and strategic needs in the glossary.

basic needs is crucial, but development projects can go further. Gender perspective points out the advisability of focusing our attention on strategic needs, as long as they can be crucial to improve long-term living conditions. A project centered on strategic needs and interest of women can change their position they have in society, transforming gender relations. Meeting practical needs does not mean abandoning strategic ones. Projects can promote gender equality by meeting immediate needs and propose transformation and women empowerment.

Projects focused on men

Development projects look for the transformation of the existing gender relations to improve equality between men and women. In the practice, most of the work is focused on women, the improvement of their unequal relations and subordination and very frequently we forget about them. In most of projects designed by institutions, local and international organizations working to improve the position of women in society, men are not actively present; they are considered as one of the problems or the cause for some of them. Lately, many groups are defending and fighting for women trying to promote equality; however, we see it will be impossible to make big changes if men are not involved, if we do not work hand in hand with them; if they are not given responsibilities in the development of our projects.

Evolution of involvement of men in SRH projects

Intervention	Approach	Results	Actors involved
Pre-Cairo Family Planning.	Women only.	More importance to contraceptives. Reduction of fertility.	Contraceptive for women. Absence of men.
ICPD, Cairo Family planning and men.	Supportive responsibility.	Increase the use of contraceptives. Reduction of fertility.	Contraceptives for men and women. Men involved in fertility decisions. Less involvement of gender.
Masculine equality.	"Social" marketing, to fulfill men's needs in SRH.	Focused on specific needs in SRH of men and women.	Men are clients. Response to men's own interests. Less involvement of gender.
Gender equality in SRH	Education on Human Rights.	Promotion of gender equality. Promotion of SRH in men and women. Men involved.	Men are partners. Integration of gender perspective. Work with young men and adolescents. SRR and gender equality.

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Chapter VI

Gender-Based Analysis in Health Projects or Programs: a Methodological Approach

All along this guide, you have noticed the importance of involving gender when you are working in health projects. Now, you have to make sure your project involves the gender perspective in any way. In other words, it must: pay attention to inequalities between men and women, detect different roles and identities given by our society, identify the possible risks for health coming from these roles, and include mechanisms to meet specific needs of women and men. Besides, if you want to go beyond, you have to make sure both women and men are being encouraged to meet their own needs, to give solutions to their own problems and to take their responsibility in the processes they are part of. How do you do this? In this chapter, **we will provide you some tools for you to make a diagnose and a gender-based analysis of your own project.** It is an approach to simplify the process of the analysis, but it is just an example among many existing approaches nowadays [20].

1. What Is Gender-Based Analysis?

Gender-based analysis or gender-based diagnosis is a **basic and practical tool** to introduce the perspective of gender in the actions of development (whether they are policies, programs or projects). In the first place, it takes for granted the idea of men and women participate differently at home, in economy and in society. In the second place, it tries to identify the structures and processes (norms,costums,procedures) that can perpetuate disanvantaging patterns for both sexes. The main **purpose in gender-based analysis** is to evaluate if needs and priorities of men and women are being fulfilled by policies and programs considered; it aims at confirming if some more changes are

[20] Other proposals for gender analysis are available in Williams et al. (1997), PAHO (1997) and Emakunde (1998).

required to make sure women participate and get benefitted and if there are opportunities to reduce or avoid gender inequalities. Even so, gender-based analysis is one of those tools whose existence depends on the objectives or analyses made by people or organizations that put them into practice. It can inform about diverse decision-making processes. All information obtained through this analysis will be used in the planning (with some specific objectives), and can be used as a method to promote empowerment in communities and to increase the access and control of the resources on which they depend. Another of the relevant characteristics to make this type of analysis is that information must be classified by sexes in order to prioritize women's roles and needs apart from those of men.

2. Steps in Making a Gender-based Analysis

Gender-based analysis consists of several stages whose information is progressively obtained.

Steps to Make a Gender-based Analysis
A) Profile of activities and gender roles: Who is the responsible? Who performs the activities? For how long? Where? When? With whom? B) Access and control of resources: Who uses them? Who is the owner? Who decides? Areas: home, community, market, State. C) Needs of men and women: What are the main differences in health profiles of men and women? What do women need? What about men? Which needs are met by the project? Practical or strategical needs? How are they identified? D) Quality of participation: Who participates in the project? How long, where, with whom, how, when and why does he/she participate? How much are participants going to have control over the results of the project? E) Ability of organizations to work under a gender perspective. Have organizations integrated gender perspective into their policies, structure and culture?

Profile of activities and gender roles: analysis of tasks in the daily life of men and women

In general, this is one of the most commonly used tools to make any analysis in development projects, specially in those involving gender. **The profile of activities is the first step**. To start, we need to know what those who are going to be part of the project do: what tasks they do, which are their main responsibilities, the way they organize their daily routine, how much time they

have for this and so on. It is important to remember that the "population" we are going to analize can be "subdivided" into different categories and gender is one of them [21]. All cultures and societies assign different obligations and responsibilities to women and men, through a long list of tasks that make a difference in the daily routines they have.

Why is a profile of activities so important?

Even though it seems obvious, it is so surprising that very few projects start with this profile; this is somehow one of the main causes for failures and basic problems within projects. For example: it is very common to assign the responsibility and control of resources in the project (like wells) to a group of men who are not traditionally in charge of this inside this community. To create a profile of activities allows us to:

a) Visualize what kind of tasks are not recognized as work. In general, it is hard to include some activities that do not generate values or goods in this list (without giving a value); domestic tasks, care of dependent people, or those to improve the neighborhood or community are some of them.

b) Detect different consequences of sexual division of work on the health of men and women. We have to take into account that this separation of tasks and responsibilities can imply different risks for health that must be visible in development projects.

c) Plan the impact that the project may have on the workload of women and men participating, checking their availability and flexibility of time to accomplish the objectives proposed. People who can not perform the tasks assigned, must be included into the program of activities in our projects.

d) Help beneficiaries to identify problems or needs coming from their daily responsibilities and obligations.

e) Get to know the interdependence and reciprocity of work of men and women to organize daily tasks to promote changes in the family or the society they belong to (economic crisis, migration, etc).

How is a profile of activities made?

In order to see better the work of men and women, the gender-based analysis has identified **three main roles or categories of work.**

[21] It is also recommendable to identify other social "subdivisions" like race, economic status, religion, marital status, sexual orientation, etc and the relationships among them.

Types of Roles

- Productive: that refers to production of goods and services destined to be sold and consumed.
- Reproductive: that refers to the maintenance of the house and the care for members of the family, including pregnancy and care of children, adults and old people, the preparation of food, collection of water and sources or energy, shopping, administration of the house and health care.
- Community: that refers to the collective organization of social events and services: ceremonies and celebrations, activities to improve the community, participation of groups and organizations, local political activities, etc. Similarly to reproductive work, this is voluntary and non-paid.

These roles or types of work that men and women play are usually assessed and valued differently. Reproductive work has less value than social work, considering this is work "of women". There are some activities considered reproductive, mainly performed by women, that are given less value or prestige, and in addition they are badly paid; examples of these are nurses or school teachers. In community work, we usually find a strong division of functions between men and women: men usually play leading roles in committees or community organizations and women usually perform organizational and supporting tasks (and if they eventually take leading positions, they focus on the improvement of community services).Community work is specially important for health. Voluntary participation generally from women, promoting health, participating in vaccination programs and cooking in social dining rooms has become indispensable.

There are several tools to make a profile of activities. They all require participation of beneficiaries who make descriptions of the activities they perform every day and later they (beneficiaries or facilitators) organize them according to the categories previously described. It is very important to remark that many of these activities are performed simultaneously (for example: domestic and income generation activities); showing women and men have not much free time and can be overloaded with work according to the responsibilities assumed, risking in some cases their own health.

Who makes a profile of activities?

The profile of activities can me made by the co-ordinators of the projects in the country or region, by local or foreign workers involved, by external assessors or consultants or by the beneficiaries themselves. In all cases it is necessary to recognize that relationships with the people involved will be different. We must be really attentive, so differences coming from social status do not cause any discomfort among people so converstions are respectful enough.

When the profile is made by external agents, differences in culture, attitudes and even body language determine the type of relation that will be established with women and men from that community. Expectations may be unreal, so in this case sincerety is a fundamental support for those relationships.

Access and control over resources

When assigning the roles of women and men in society, they receive certain level of access and control over the resources available to keep those roles. Health resources are included here, as well as all those to promote and protect people's health.

By understanding this, we can be aware of that relative power and notice the unequeal access to that power that people have in one society. Comparing men and women, a big inequality in power is evident; the levels of access and control of resources to solve health problems are absolutely different.

Definitions: Access and Control

- Access: ability to use resources.
- Control: ability to fix ways in which those resources and benefits coming from their use will be used.

The distiction between access and control of one of the resources in particular is important because the ability to use it does not necessarily mean, that we can define the use of that resource.

For example:one woman can have access to the use of contraceptives to protect herself from STI, but in the moment of the sexual relationship, she may not have the ability to decide on their use. It is necessary to examine the way one development activities (programs, policies, projects or any other similar initiave) may be exerting influence on the access and control of women and men to all diverse resources and benefits derived not only from the same activities, but from their daily routines.

Projects often consider income generation activities for groups of women with low control over incomes distribution at home. It is also necessary to consider that frequently men and women are informally given rights to the access to certain resources that a project must not deplete (for example, the use of land or places that belong to the community).

Types of Resources

Economic resources: work, land, credit, cash, equipment, food, transportation, facilities for children care and housework, social security, housing, health and cleaning.
Social resources: self-support nets (urban and rural associations, family ties, long and short term planning, children care, housework, work search, access to health and food), information channels, public services.
Political resources: leading positions and mobilization of people with responsibility; opportunities for communication, negotiation and consensus.
Time: hours of the day or seasons of the year available for discretionary use; flexibility in the number of hours paid at work.
Mobility: ability of an individual to move freely according to norms and costums; limitations to access to certain means of transportation according to norms and costums.
Information and education: formal education, informal education, opportunities to exchange information and opinions.
Internal resources: self-esteem, trust and ability to express own interest (in public or in private).

In the field of health, there are different examples of interaction between the access and control of resources [22].

For a woman

a) For a woman to be aware of possible gynaecological problems she may suffer, she needs to have **access to information/education** that will allow her to identify typical symptoms in this kind of health problems.
b) Even if she finds out she is suffering from these problems, she may not feel comfortable telling the doctors. In this case, the level of development of **internal resources** will give her enough **self-esteem** to do something about it.
c) If this is given, a woman's decision to visit the doctor may not depend on her, but on her husband, parents, in-laws, etc. At that moment, it is important to have **control over economic resources** to pay for medical services, transportation, and the care of children or people depending on the woman.
d) The schedules of health services, the time spent waiting to see the doctor or the time spent travelling, may become big obstacles if she does not **control her free time** that depends on her obligations and reproductive responsibilities.

[22] PAHO (1997).

For a man

a) A man maybe does not have access to information on programs to detect prostate cancer; and even if he is informed, he may decide not to visit the doctor because he feels scared or embarrased.
b) A man can have control over sexual relationships, however, he may not be correctly informed on sexuality or reproduction. The lack of access to information may lead to risky sexual practices for him and his partner and they can be infected with a STI.

How can analyses of access and control of resources of men and women be made?

To improve the knowledge on the levels of access and control of men and women over resources, the gender-based analysis identifies some areas that help us understand the limitations or barriers they experience in their daily tasks.

These areas are their communities, their homes, the market and the environment of the project. We make questions mainly related with norms, costums, rights, responsibilitites, obligations, resources, benefits, activities, roles, tasks, work, and the processes of direction and control (power hierarchies and decision-making) [23].

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Though this information is not easily obtained, it provides us with solid knowledge of scope for action that one specific culture give women or men, the barriers they experiment and the differences between them. Some examples of these questions may be:

a) Who makes decisions at home? what does he/she decide about?
b) Who makes decisions on the distribution of incomes and food?
c) Who decides about when to visit the doctor? Which means of transportation must they use to get to health centers? Or maybe the doctor has to come home?
d) Who buys and sells products in the market? Is there any difference between comercial activities for women and men? Are there specific limitations for their access to credit, transportation of goods and negotiation of prices?
e) Who decides which topics affect the community?
f) Is the government promoting norms that impose barriers to some groups inside the community with respect to one topic in particular?

[23] For further information on this type of analysis, see Kabeer and Subrahmanian (1996).

[24] See chapter I.

Identification of needs of women and men

We know now that men and women are biologically different and we have seen the ways cultures, socioeconomic groups and generations create their own gender caracteristics [24]. Both aspects (biological and social) get interrelated and produce different health profiles. With different profiles, we assume that men and women have different needs in health and they must be identified to be fulfilled equitably and efficiently in our projects. **To reach equality in terms of health, it is important to recognize that people have different needs and to meet these needs, they must be correctly identified.** These needs based on gender can be divided into two groups: those intending to improve the quality of life, by fulfilling basic (and health) needs; and those that refer to equality in society; these one look for the equitable distribution of health resources in that same society. The first ones are called **practical needs of gender** and the second ones, **strategic needs of gender.**

Practical Needs

These one are normally immediate; they refer to those needs coming from daily responsibilities of women and men within their socially accepted roles. Projects meeting practical needs in health, attempt to improve men and women's well-being, because they identify roles and responsibilities attached to each sex, and plan their functions according to these roles. However, these projects try to improve the access to resources but not the control over them. For this reason, they do not show positive effect on gender inequalities.

Strategic Needs

Refer to those needs felt from unequal positions in society; they are related to the redistribution of roles and responsibilities between men and women. In the field of health, they are focused on the reduction of inequalities that deteriorate health, our body's autonomy and the desire to improve our physical and psychological well-being.

Even though this distinction is very useful in our analysis, we have to say sometimes it is not that explicit in practice depending greatly on culture and the context where we are. Some needs can be practical and strategic at the same time, or they may be practical for one culture and strategic for another. For example: the need for education can be a practical need for women in some urban places in Honduras; in contrast, that same need can be strategic for a group of moroccan women in the country. In addition, it is possible, in some cases, to ful-

fill strategic needs by paying attention to practical ones. We have many examples in the diverse projects of popular dining rooms organized in Latin America to face processes of crisis and structural arrangements in the eighties.

Some of the groups of women that perfomed such projects, soon evolved their ideas towards demands involving the rights of women. We can find examples of strategies that use both types of needs in projects of prevention against HIV/AIDS [25]. A project meeting the practical needs, would aim to promote the use of contraceptives as the most effective way for stopping contagion. In some specific cultural contexts, that would be enough. In many countries the reduction of new cases of HIV is directly related to the increase in the use of contraceptives. Good information campaings and good access to contraceptives can fulfill this practical need of both women and men. On the contrary, in some other contexts, culture determines the rejection of men to use contraceptives, based on the idea that they can reduce sexual pleasure and at the same time, their use can challenge manliness and male sexuality. Under these circumstances, a man will never accept suggestions from his partner to use contraceptives. Even though a woman knows that contraceptives can save her life, she does not have much power to negotiate their use. She can forget about this very easily if her partner threatens to end their relationship if she continues with her suggestions. In some cultures, men can feel insulted if a women suggest the use of contraceptives; they may understand this as lack of trust between them. In other contexts women can feel insulted if her partner suggests the use of contraceptives; this suggests the possibility that she is having sexual relationships with other men. In relation to strategic needs, it is important to point out that the concept comes, to a large extent, from the needs of women more than those of men, and focus on them because of a continuous imbalance in the power relations. Lately, we are witnessing the formation of groups of men in many countries (in the north and south) that are showing how gender constructions have created distorsions in their identity and in masculine roles as well, interfering with men's health and well-being.

How can gender needs identified in a project?

We can not do much only by knowing the types of needs. This is not enough to make our gender-based analysis. It is necessary to know the ways they have been identified. We must ask about those who identified those needs, how they did it and this will give us a clear idea on the level of participation of the women and men benefitted from the project. We must know if there are articulation spaces, it means, places and modalities of meetings (accepted by the community) where

[25] PAHO (1993)

their needs can be expressed and discussed. It is necessary to focus on the processes through which the articulation of needs develop and the stages of these processes when beneficiaries get involved. For example, a group of women who has created spaces and processes to discuss their situation can not discuss about their needs the same way than a group recently formed or than in a community where articulation spaces for women do not exist.

Quality of participation of men and women in the project

With gender-based analysis we attempt to identify inequalities and power relations among groups inside the same community that stop or limit a full participation of these groups in processes of development. Full participation in projects is not only related to the development of activities; it has to do with the ability of "participants" to decide on the process and the purpose of the projects. For this reason, it is necessary to include in our reflections, the quality of participation. These ones consist of different types [26].

Quality of Participation of People Benefitted in Projects
They are passive receptors of the assistance, materials or services, without taking part in the supply or the control over continuity.
They perform activities prescribed by others (for example: contributing with work, paid or not).
They are questioned about problems and needs but not about the context, the analysis or possible alternatives.
They are encouraged to organize to meet their own needs, to plan solutions to their problems and to take responsibilities in the processes they are involved.

In a first attempt to analyze the quality of participation in a project, the organization must know the level existing in their own project. In this way, the level of participation is related with the achievement of the objectives proposed, **feasibility and sustainability**. We can not set up very ambitious purposes (like improving the general well-being of one specific population) if participation of beneficiaries in the projects is low (the long-term well-being of a community is questionable if all or one part of them do not have enough control over resources).

The full participation of beneficiaries gives legitimacy to the project avoiding the imposition of solutions coming from external agents. When participation is high, we speak about **empowerment**; It is then when the gender

[26] Based on CCIC (1991).

perspective becomes one of the most important strategies for women to participate in co-operation with their visions and perceptions.

Empowerment can be defined as the process by which individuals develop abilities and faculties to get individual or collective well-being; this is a concept closely related with the objectives of strategic needs of groups with low participation and influence in the project (women included) and with their needs to get more control over the resources used as well. In addition, the collective connotation of empowerment explains why gender analysis focuses on the detection, creation of organizations, spaces and groups with low levels of influence in projects.

Abilities in organizations to work with the gender perspective

We can not forget about the organizations that participate in the planning and the implementation of the projects.They are specially aware of the importance of gender and this can help or limit the introduction of this approach inside developmental actions. Even though it is not very frequently used, the gender perspective is specially important in planning and evaluation processes. Some organizations do not consider gender perspective important to be included and are reluctant to be analyzed; they finally look for explanations and put the blame for their results on external factors. Even so, there exist tools and processes to make the analysis [27]; they are based on some studies of the ways gender relations influence the formation of organizations and also on the fact that these organizations continue making policies, programs and projects that do not pay attention to gender inequalities.

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Chapter VII

Gender-Based Analysis and Management of the Development of a Project

This chapter attempts to show a practical application of the methodology proposed in the former chapter. We will see the ways to integrate the gender dimension into a project of sanitary assistance in South America. The first part shows how to make a gender analysis in one project in particular. Based on this analysis, we can determine whether if the project has the necessary elements to integrate the gender dimension or on the contrary it lacks of some premises that we will identify later. In the second part, there will be some suggestions on actions that must be observed in each stage of the cycle of a project so that this eventually incorporates the gender dimension.

1. Project of Attention and Promotion of Health in the Local Health System of San Juan. (Geographical Area in South America)

This project began in 1995 aiming to support the establishment of the basic conditions of the local health system in the district of San juan. This area (40.000 inhabitants) was chosen to start with the project because it was an isolated rural area, with a relevant high birth rate, an inadequate sanitary infrastructure and human resources and no international co-operator was involved. Later, the main problems and the general principles were established and everything was ready to start. There are three phases in this project.

Phase 1: Coverage of the medical attention, design and implementation of the maternal-child care model (1995-1998)

Its objective was the creation and management of a center of maternal-child care, medical attention, training of the personnel and the creation of an intervention model in the field of maternal-child issues. This phase started

with the rehabilitation and the re-opening of a regional hospital already existing in order to improve the situation of the services in the maternal-child area.

Phase 2: Strenghtening of the local health system in the district of San Juan (1998-1999)

In this phase, the objectives were the creation of a peripheral net of health services in the district (construction of four health centers), the implementation and strenghtening of the rest of the subsystems of the model of attention (subsystems: planning and programming, human resources, medical attention, administration and control, supplies, reference and counterreference, follow-up and evaluation). This second phase, tried to complete the work of the hospital by upgrading four health centers and strenghtening the general net of attention.

Phase 3: Consolidation of the local health system in the district of San Juan (2000-2001)

The main objectives in this phase were the provision of health services increasing their quality and coverage and the improvement of the quality of the training in qualified and non-qualified local human resources; other objectives were the organization, participation and community education to encourage the creation of local health committees, the development of a program providing information, education and communication aimed at all the people in the district, and the implementation of one strategy to promote health in schools. The objectives in this phase tried to consolidate the system started and to promote health to generate more healthy life styles in the population. Because of this, the project looks for the participation of the community through local health committees, and promotes education and information for schools and population in general. The organization that identifies and carries out the project is a NGO of humanitarian action and co-operation for development that wants to help people affected by war, illness, hunger and poverty. The local partner is the Ministry of Health and all the national and regional employees working for them. They focus on work contracts for local people, provision of medical supplies and support for the training of people in the district.

By reading the project in general terms, we can pose many questions in relation to the **general approach** and its relation with the **gender dimension**; we will try to solve them all along the chapter. First questions refer to the approach used according to the population that will be benefited by the project. Is the action designed for the population to be participative of merely observative? Are beneficiaries considered only receptors of health services or

Is the project intending to integrate their conceptions? Is the project interested to know more deeply problems, needs and barriers experimented by beneficiaries in their daily routines? These factors are important to apply gender-based analysis because the stronger the emphasis on the supply of services, the lower the level of incorporation of objectives on social inequalities and the elimination of barriers some groups (like women) can feel. Other important aspects are the ways the project considers women and men from their feminine and masculine identities. Is the project based on assumptions or preconceived ideas of the roles and responsibilities of women and men (at home or in the generation of incomes) or is it based on real information? Are women described only as mothers, from their domestic obligations? Are men described in the project as fathers and partners? From the gender perspective, it is recommendable not to take for granted some assumptions of masculine and feminine identities; In this case, we have to be careful with ideas on health (sexual and reproductive health): responsibilities of women for their children's care and family planning, the necessary resources to promote and protect health, the different concept of health in men and women. Women benefited from this project are mainly women of fertile age (23%), that usually shoulder responsibilities at home, but remain out of the generation of incomes. Talking about men, the information is incomplete and we can not assure that the project considers their involvement or co-responsibilities in general aspects of health or in particular aspects like sexual and reproductive health.

2. Gendered Analysis in the Project

Next, there is an application of the gender-based analysis in this project, developed according to the methodology described in the former chapter. This methodology is divided in **steps** and begins with certain aspects that must be investigated in the men and women who will be benefited, in order to know better gender relations in this society. In each step (profile of activities of men and women, access and control to resources, identification of needs, quality of participation of beneficiaries, analysis of the organizations involved), we will find out if fundamental aspects in the life of people and their social and economic relations have been taken into account. These are things that definitely exert some influence over their general health and well-being, and become fundamental when assessing the relation the population will have with the project.

Profile of activities of men and women

It is impossible to know the way beneficiaries organize their daily routines just by reading the bases of the project: what they do, which are their

main responsibilities, what time do they have for performing those task, etc. We assume that most of users of the hospital will be women considering that the initial objective of the project is to reduce the maternal-child morbimortality rate and the relation or possible involvement of men (as fathers, partners, etc) has not been especified. There is no additional information on the existence of other social subcategories in the population or in the women's population; this would pose some limitations when dealing with the health problems or needs (ethnic origins, different socioeconomic groups, etc). In the case of women users of the hospital and health centers, it would have been very useful to know that subdivision according to their civil status or their responsibilities for their families (for example, percentage of monoparental homes, family women leaders, or non-regulated couples in the family). These aspects determine to a large extent, the limitations of users in the access to health services of the project, because they take the burden of those responsibilities they must assume. These facts can provide initial information on habits in sexual and reproductive health as well.

In general terms, it seems the project takes for granted women (including reproductive responsibilities like their children's care or pregnancy care, and does not include productive responsibilities like the generation of incomes) and men's responsibilities (family leaders generating incomes). Talking about sexual and reproductive health, there is no clear information about patterns of decision-making in couples, and costums and beliefs in women or men. There is no information about SRH for these communities, or the ways employees are dealing with these topics at the hospital, further than just giving information on family planning methods (they give information on the increasing percentages in the use of contraceptive methods in all stages in the project). Unfortunately there is no information to confirm that most of users of planning methods provided by the project are women (giving them all the responsibility) or if there is at least a small percentage of men taking part. The project assumes that the main responsibility for women is that of reprodcution and family planning. According to this, we can guess that the project is providing important services for SRH, but these ones are not necessarily adapted to their needs, their lives or the responsibilities of women we know. We suppose that the project gives less importance to the role of men in SRH of women, in that of their own and in the relationship between them both. We eventually ignore if women benefited have access to those services offered and even if their daily timetables are flexible enough for them to go. Services seem not to be the most appropriate and efficient ones, taking into account the daily responsibilities and the limitations of time and mobility for women participating.The role of health promoters can be very useful in the development of a profile of participative actions in men and women; however there is no much information about them in the project: their activities and duties are taken for granted. They forgot the importance of therole of promoters to get to know

other qualitative aspect in the life of benefited people. By making this profiles, the project could identify many of the problems and needs coming from responsibilities and obligations of benefited women and their partners.

Access and control of resources

This project must have started with some basic observation to understand some necessary resources to promote and protect our own and other's health. As we have seen all along this guide, these resources focus on social and economic aspects and their distribution is not usually equitable. We have no idea if power relations between men and women in this community are unbalanced, and if this affects the access and control over the necessary resources to respond to health problems. For example, we could study some aspects in the daily life of beneficiaries to determine the limitations they feel in their lives and they ways they relate with the promotion and protection of health.

At home

By making the profile of activities, we can get to know the division of responsibilities at home. Questions about this are more qualitative:

a) How and who decides on the family planning method to be used, if it is used, of course?
b) Are there costums, beliefs or norms on the use of certain family planning methods?
c) Who makes decisions at home about the care of children, pregnancy, distribution of food and incomes?
d) Why do women prefer their homes to deliver babies if hospitals work so well?
e) Who makes decisions at home about how and when to go to the doctor? Are there other possibilities to treat illnesses?

In the community

a) Who or which groups exert influence over improvements in the community: drinking water, transportation, electricity, etc.?
b) Are there any costums, beliefs or norms on the way to understand, promote and protect the health of women, men and children in this community?
c) Are there tension and conflicts because of the continuous growth of the population around the hospital with migrations?

In the state

a) What is the tendence of the analysis of the state about attention to health? Has it been paternalist, care-based or participative?
b) Has the state been consistent and coherent in the provision of health services?
c) Has any particular ideology about SRH been promoted in the services offered?

In the market

a) What obstacles do women have in their economic activities? Are these ones similar to those of men? Why?
b) What is the relationship between this and the promotion and protection of oneself and others' health?
c) We know that only 55% of children go to school; so, do you promote any kind of productive activity? How does this influence health?

It is important to analyze the resources contemplated in the project, and for this we can use the classification in the former chapter: economic, social and political resources, time, mobility, information/education and internal resources. An analysis on the types of resources shows which of them are really important in the objectives of the project: how they affect the promotion and protection of health and which strategies and activities the project must develop in relation to the access and control of beneficiaries. The project considers the access to information and education to be really relevant and proposes some activities related (with health promoters, at hospitals, in health centers and schools). Any user of information and education activities has been informed on maternal-child health, sexual and reproductive health and endemic illnesses like malaria or dengue.

The project does not deal with more qualitative aspects of **information and education resources**: it would be ideal if they try to analyze the way receptors of these courses use information and if this has effects on a major demand of services from the hospital and health centers. For example: with information/education, women should be able to make decisions they consider more convenient about their SRH and the health of their children. However, we ignore if they have control over these kinds of decisions or over some aspects of their lives in relation to their health, or on the contrary, if this control is assigned by the community to other people (maybe their partners). Regarding men, this project does not say much if these programs have been aimed at them as partners or fathers, or if they have been suficciently involved in all informative and educative campaigns on family planning, vaccination, etc.

Resources like **time and mobility** seem not to be included in the programs due to the fact they affect users very little. We know that 35% of communities in this zone do not have public transportation representing difficulties for people to get to their health centers. Since a profile of activities is not provided by the project, it is impossible to know if there are limits with respect to flexibility of time and mobility for women and their children to go to hospitals and health centers; it would be necessary to know if women have **economic resources** to pay for medical services, transportation, children or dependent people care, and all medical expenses at home (decision on food, hygiene, etc.). The design of the project would have been benefited from a community analysis that had provided enough information about **social resources** (social nets of help to take care of children, to face food crisis, and to look for information, etc.) that could have remarkable effects to a large extent on the promotion and protection of health. To finish up, the projects must have considered the role of **internal resources** (self-esteem, trust and ability to express their own interests) both for men and women when communicating with doctors, health promoters, midwives or other people in the organization.

Summing up, we can see the project paid special attention to the increase of the access of some important resources to improve certain aspects of health of beneficiaries. However, problems of **control** that in the last resort define the effectiveness of access, quite common in women, have been neglected. As we mentioned in the previous chapter, the ability to use one of the resources does not necessarily mean it will be used. We ignore how often beneficiaries of services in the health project, are really using them.

Identification of needs of women and men

When identifying needs, we would have to assess two fundamental aspects:

- Needs of population identified by the project.

- People who identified those needs and methods used to do it, in order to determine how much beneficiaries have been part of the process of identification.

The initial objective of the project was the reduction of morbimortality and maternal-child rates, developing activities in maternal-child health and increasing the coverage and efficiency of assistence services. In some documents of the project, they refer to this as an important need of the population, however further information was not provided. We have no idea if there are other social subcaterogies besides gender (ethnic origin, place of origin, reli-

gion) that determine the existence of concrete needs. Indeed, the project gives importance to health of women of fertile age and their children (including their specific needs). In spite of this, it would have been recommendable to make a profile of men, women and children in the whole community. The only document that showed an analysis of the general health conditions in the population was "fast diagnosis of health", written in 1996, and it does not give enough detailed information (classifying categories like sex) in order to give conclusions considering the experiences observed.

According to the distinction between gender **practical and strategic needs**, we can say the project identifies a set of practical needs in women of fertile age and those of their children. In fact, those health needs identified, refer to the most immediate ones experimented by mothers and people responsible for children care. They are considered practical by the project, because this focuses mainly on activities to improve the access of people in this group to general health services. In sucessive stages of the project, access to information specially for other social groups like asolescents or children in schools and population in general, is possible with mass media like the radio. Identification of needs is closely related with the detection of problems, obstacles or sources of conflict that beneficiaries can feel in their general or sexual and reproductive health. With this respect, the project must have included a more participative and qualitative-based study that focused on the existence of some problems related to maternal-child health (domestic violence, unwanted pregnancies).

Needs identified with the help of this project would become strategic needs if this were aimed at increasing the access to resources of promotion and protection of maternal-child health and tried to equilize resources of SRH for men and women as well. Here it is necessary to consider important aspects like all those activities and processes of sexual decision-making, family planning and distribution of responsibilities for the health care of children and other dependent people. These activities could have a major impact on gender relations and equity (or inequity) in decision-making processes that affect SRH of women and men in the project.

The documents do not provide enough information to draw conclusions related to an analysis of the ways and processes followed to identify needs. We can not say much about the agents who perfomed the identification or about the processed used to do it. There is no evidence for the existence of groups or organizations (women, fathers, etc recent or not) that could have expressed their own interests to improve their health conditions in this area and services offered at hospitals and health centers. The justification of the project is based on the high motivation of the population about prevention in reproductive health, and the low levels of education and access to resources. And even though the situation may improve by providing resources, this is not enough. They would have required more information on the sources to get to these

premises on motivational aspects of population in order to contrast them with the current services offered by the project.

Quality of participation of beneficiaries in the project

From the beginning, the project has considered community participation as one of the main "strategies of intervention proposed to achieve the objectives". In fact, in the agreement-project there is a structure showing the way it will work. It is composed of the executive council (altogether with the counterparts out of Spain), the co-ordinator of the project, the medical director of the health center and a community committee. This committee was supposed to be "formed by representatives coming from different cultural communities benefited; it is the organization's fundamental base for population to be able to be informed, to know things, to understand and express freely, to contribute creatively and to interact with all the staff in health services. This committee will participate in the planning and performance of activities in the community, and will take part in the development of periodical activities while the project is being performed."

However, these purposes were not evident in the development of the project. When the first stage finished (in february 1996), the "assessment of efficiency conditions" concluded that the level of community participation was really low and that they "had to make bigger efforts." Another evaluation in 1998 (while the second stage was being developed: april 1998-september 1999) argue that "the community was not a favorable place for beneficiaries to participate freely, and as a result, their participation was low." In the same project, they admitted that unfortunately, they have not done very much to get along well with the community. In fact, in one of the reports from the third stage of the project (in 1999) they pointed out that "many meetings were being held with people responsible for health centers in order to encourage their involvement in health activities for the community", however, the population and the groups they were speaking about, were not specified.

In gender-based analysis, we would have to examine two aspects related to community participation:

- The first one is related to the ways the project defines community participation.

- The second one is to try to determine the level of participation of people benefited from the project.

For the gender perspective, the community participation has to do with the involvement of people with their own community (men, women, people

from different socioeconomic status, ethnias, religions) so that they enjoy spaces to express their opinions. With this idea, we could assess the level of participation under a gender perspective. If this is unbalanced, we would have to check the mechanisms available in the project to make it more equitable. In the project we found out that community participation is evaluated in terms of participation with other institutions, specially official ones (schools), social mass media and health promoters within the project.

The final report of the project points out that: "the municipal intendence, the town council, leaders from the catholic church, local health committees as well as representatives of the population benefited have been given the list of improvements introduced by the project." We can then infer many questions to determine the real nature of the project: how do beneficiaries participate in institutions?, are benefited women represented by all groups participating in the project?, what is the own real interest of each of the groups making up this community?, can groups express their opinions with the help of these intitutions?, are not some of them representing other interests like those of the church or the state?

When we contrast the information presented in the project with the table grading the levels of participation from the previous chapter, we can see that people benefited from health services appear as "passive receptors of assistance, material or services, with no participation in the supply or the control over its continuity". In the last phase of the project, local health committees and the work of teachers and students in schools were incorporated. However, it is necessary to remember this stage corresponds to the last year and the percentage of children registered in schools only reaches 55%, pointing out not all of them attend continuously. The work with schools is merely composed of educative and informative campaigns and programs which have not include teachers and students working active in the process. Speaking of participation, the analysis of health committees draws similar conclusions: people did not get involved the way they should. Their participation level can be included in the group of activities performed, but prescribed by others (for example, contribute with work, paid or not). These committees, composed of volunteers, are not created at the request of benefited people, but encouraged by the project. Their main functions are "tasks of maintenance of the centers, communication of dominant illnesses, prevention and assistance mechanisms". There is no evidence of possible enquiry concerning the problems or needs of population by the direction of the project. Regarding their organization, some documents on the composition of the committees show that even though there are less men working there, most of them are in directive positions. It would be interesting to find out if "task of maintenance in health centers" have been performed by women.

Finally, we would have to analyze the role of health promoters as participative agents. We know they work as volunteers too, but information on their

functions and the impact they can cause is scarce. From the perspective of gender we could make questions like: who are they?, when and where do they perform their tasks?, how much influence do they exert in the community?, why have they decided to do this job?.

With respect to the role of women in the project, we know that women reach 90% of the staff working in hospitals, most of health promoters and empiric midwives. It would have been necessary to promote empowerment in women, even if this were the only purpose in health here. They could have included all these aspects during the development of the project, meaning interesting results in the internal feasibility of actions.

As a conclusion, we could add that the **work in community participation (encouraging them to take part) must be focused on people who are actually part of that same community; so they strenghten and develop their organizational methods, with open and flexible objectives for the methods used by the organization**.Real participation develops when the project does not pay too much attention to the definition of results and concentrate on the process itself. This way, the project allows the participation of benefited people who are "encouraged to organize and meet their own needs, to find out solutions for their own problems and to assume responsibilities in the process they are part of.

Ability of organizations to involve gender perspective in their work

All organizations taking part in all stages of the project, also have abilities to involve gender perspective in their work; these ones can limit or make possible the introduction of this approach into developmental actions. In this case, the analysis will fall on the Spanish DNGO, their counterpart, and the Ministry of Health of the receptive country. Some aspects of this analysis would include.

Perceptions and attitudes towards gender in the personnel of the Spanish DNGO and the Ministry of Health. This aspect can be part of workshops organized and aimed at all personnel of institutions involved, where they include discussions on topics like:

a) The way activities are carried out.
b) Attitudes towards local knowledge.
c) Ideas around participation of women.
d) Knowledge on institutional policies.
e) Perception on the needs of employees to improve their work with and for women and gender issues.

The existence of a meaninful gender policy inside institutions and their ability to plan, work and co-operate with other institutions. Perhaps organizations do not have a gender policy; or maybe, even though they have it, they can not put in into practice. Some question to determine such ability can be:

a) How has the gender policy formulated? Which approach does it use? (assistencialist, women-centered including or not gender relations and empowerment…).
b) What is the previous experience of the organization with gender topics?
c)Is the gender policy being completely supported by the direction of the project?
d) Are there enough people formed and prepared to carry on the project with a gender perspective?
e) Are there any experts and distribution of responsibilities on gender topics?
f) Are there instruments for the planning, follow-up and assessment of the role of gender dimension in projects?
g) Are there resources (economic, time, infrastructure, personnel) to put gender dimension into practice?
h) Is this an organization integrated and connected with movements in favour of equality and governmental policies for promotion of women?
i) Can this organization co-ordinate their work with other ones working with gender issues?
j) Does it belong to gender-support nets?

The culture of the organization is the reflex of cultural norms and dominant ideologies. Is this culture favourable to gender issues like the organization and distribution of work, space and time? Besides the impact of the sexual division of work on the population benefited in the projects, the organization should question their own internal distribution of work and their relationship with their members in the privacy of their homes. The strict division between public and private spheres established by our culture admits there should not be related or at least, there should not be implications of what is private over public spheres.

3. Integration of the Gendered Analysis in the Cycle of a Project

Until now, we have seen the ways to apply the gender analysis in a project. We have done this through different steps and questions that reveal all the information regarding the gender dimension that projects may have or may need. The gender dimension is visible in the contents, implications and rele-

vance as long as we analyze each step. It is possible that we still have questions like: What would have we done if we had had all that information from the beginning? How can we incorporate this information in planning, design, development, follow-up or assessment into developmental actions? Next, we study some interesting ideas that might have helped us to involve gender perspective in all stages of the project.

Identification

This is the most important stage if we are really interested in involving the gender dimension in our project. In this phase, we have to look for the information we did not obtained in previous analyses; this way we can make plans to use real information (not assumptions or preconceived ideas) of all beneficiaries: their responsibilities, their activities, their lack of access or control over those activities, main problems and needs they feel, etc. All information obtained must be classified by sex if we look forward to the integration of gender perspective. There is a preliminary analysis of the population involved called "fast health diagnosis in the District of San Juan", made in november 1996; it assessed the most important factors involved in general health conditions (policies, social health services, supply of drinking water, electricity systems, transportation, education, etc.). The only information about the structure of the population classifying women and men separately, are records on maternal mortality rate. The distribution of pupulation in the district is made by families, with no specification about types or existing percentages (monoparental, common-law marriages, timing and duration of marriages, etc.); we know that this information is useful to understand the decisions made in SRH.

The project should provide differenciated information on the situation of women and men and their economic activities (types of activities, property rights, access to credits), distribution of responsibilities and tasks at home and in the community (types of organizations of men, women or mixed, positions of women and men in these organizations; levels of influence on the community and their relationships with local public institutions). This local and national information obtained might be extrapolated to the area of the project to have an ideal of possible critical aspects to keep in mind during the identification stage. For obtaining that general information, it would have been useful to identify and contact local organizations with knowledge or special interest in the gender dimension, women organizations that promote their interests (locally and nationally) and if possible, to look for national professionals with experience in gender. So much nationwide information could have been obtained in order to be used in the project while needs, priorities and especific problems of women and men involved could have been identified through participative methodologies that involve: profiles of activities of men and

women, access and control of resources, identification of needs and quality of participation in the community. The groups to develop this task could have been organized according to the existing social categories in this community besides sex, for example: ethnias, socioeconomic level, etc. In this way, it is easier to identify more specific problems, sources on internal conflict within the community, barriers to open participation and strategies to overcome them.

In relation to health, these participative exercices could be used to explore jointly some basic questions like:

- What do beneficiaries know about promotion and protection of health?
- What do women and men know about SRH?
- What do they think a vision of a good health system could be?
- Which roles could they perform in the project?

The purpose of these question is not only to know the answers; it is a way to give trust and responsibilities to all people benefited by the project since the very beginning.

Formulation

For the application of LFA [28] and its planning, it would be ideal to use participative techniques to get to an agreement about priorities, even though these ones have to fit the type of activities performed by the Spanish DNGO. A project involving the gender dimension must identify problems, objectives, alternatives or possible strategies to reach its objectives, making sure that groups that exert less influence (women included) have their rights to vote and express their opinions. In the project, priorities seemed to be established by the Spanish and their counterparts. There is no evidence of possible consult to get to agreements on those priorities of beneficiaries in the project. It is said that they point out to their own needs, but documents do not provide any information or explanation about this. When the situation between men and women is unbalanced, it is important to consider which activities are specifically women-centered or which measures must be taken to encourage women to visit hospitals and health centers more frequently and to increase their participation. Sometimes it is also recommendable to develop activities exclusively planned for and with men. It would have been positive to involve the health of their wives and their children

[28] On the integration of the gender dimension in LFA, see Comission of European Communities (1993); López and Sierra (2000).

by means of specific activities. When planning activities, it is important neither to overload men and women with more than they can do nor to use them as unpaid workforce, unless they volunteer. It is necessary this plan of activities include mechanisms for the resolution of conflicts that can arise in the community as a result of the project. In this period of formulation, it is deemed necessary to see the level of appropriation of action by the people involved, so the project can be feasible. In this project in particular, this level is considerably low. When the support of the Spanish NGO finishes, the management of the project falls on the Ministry of Health. No other civil groups seem to be interested in the continuity of the health system developed by the project, that must keep the same financiation model or organize in a different way to obtain economic resources from others. With respect to money, it is necessary to assign specific sums to those activities related to the gender dimension.

Indicators

The ones created for the project fundamentally focus on monthly services in hospitals and health centers: coverage of prenatal control, attention in institutional deliveries, coverage of vaccination programs, family planning services. Others indicators were created to analyze abilities in the personnel involved in the project (participation in training courses for midwives and promoters), community participation (formation of local health committees) and health education (radio broadcast, workshops in schools). All of them are quantitative and this is vital, because they can provide basic information about the development of activitities and goals achieved. However, it would have been necessary to implement some qualitative indicators [29] in order to know more precise percentages achieved.

The general objective of this project is to contribute to the social development of the district of San Juan and to improve living conditions of its population by means of a formation of a local health system". The main indicator presented to achieve this objective (decrease of the maternal-child death rate) seems inadequate if we keep in mind that its recognized "complexity" makes everything more difficult; actually the information available points out that this rate has decreased nationwide, and this makes it harder to draw conclusions on

[29] Quantitative indicators are defined as quantity measures like the number of people who own sewing machines in one specific population. On the other hand, qualitatite indicators can be defined as the perceptions or judgements of people on one topic in particular; for example the idea of some people who believe that the sewing machine is a guarantee for their economic independence. These indicators help us know important aspects about quality of life by providing information on levels of satisfaction or insatisfaction perceived from personal or socioeconomic conditions. Qualitative indicators can be subjected to quantification: the number of people satisfied by a development project could be a good qualitative indicator of success of the project.

the impact of the project. Concentrating on the general objective, we can find that the indicators chosen refer to the "formation of a local health system" (meaning their services only), but they do not give us information on how much this proposal contributes to the social development of the district and the improvement of quality of life of the population. Quantitative indicators present limitations when it comes to analyze aspects related to the quality of the assistance, the perception of the population on this assistance, and the impact on social development:

- The number of contraceptives distributed and the freedom women may have to negotiate their use, are not related.

- The number of children vaccinated does not say much if women and men consider this is the most important need for their children's health.

- The number of midwives and promoters trained does not say much about the possible limitations they may have to perform their jobs; it does not give much information on what they and beneficiaries think about their job or the ways to improve it.

- The formation of local health committees does not mean benefits for the community.

The project may include some qualitative indicators for the assessment of issues like these:

- Evaluation of the level of parent's knowledge (mothers/fathers) of their own health and that of their children.

- Opinions of men and women about the meaning of good nutrition and distribution of food (complemented with real data on food distribution, maternal breastfeeding and abuse of alcohol and drugs).

- Access to health assistance: opinions about relationships between men and women and the masculine or feminine personnel in health centers.

- Opinions, visions and ideas of women and men about different options in family planning.

- Safety and violence: help to report and get advice (complemented with quantitative indicators on cases of mistreatment and abuse in women and children, and cases of physical violence in men.

Execution

In this phase, it is important to organize activities adapted to the needs of women (who seem to be the main users) and men attending health centers:

- Consider the calendar, location and duration of activities. Keep in mind the many responsibilities of women (domestic responsibilities, generation of incomes and others) who have very little free time. Taking into account we are speaking about a rural area, try to determine the timing for activities of men and the seasons when work can be harder.

- Consider mobility and flexibility women have at home in order to be able to be out for long periods of time. Are there cultural norms or costums that limit their possibilities to move freely in public places?

- Check if women can speak freely in mixed groups so that meetings and formation must be organized separately. Look for possible difficulties in communication with doctors, in order to find solutions.

The management team of the project must be organized and involve people with knowledge of gender and participative techniques. It is important to make them aware of gender issues by organizing meetings for the personnel of the hospital and co-ordinators from the Spanish DNGO in the country, leaders or influencial posts within the community and of course the beneficiaries. It is necessary to identify and discuss obstacles in communication processes inside the management and execution of the project: language problems, different levels of training and professional experience, different norms, costums, social and cultural roles.

To finish up, the project must provide enough information to the personnel (mainly in hospitals and health centers); information about the profile of actitivities of users and participants (men and women), access and control of resources, and sociocultural factors that influence health and access to services.

Follow-up

In this stage of the project, they could have completed the quantitative analysis of the progress of activities, the investment paid out and the results expected by means of a qualitative analysis of the progress of the intervention, trying to differenciate gender and other social group categories (race, ethnia, socioeconomic level, etc.).

After all, the general objective of the project is a social change, and in order to know better the possibilities for this change, it is deemed necessary to

make a qualitative analysis [30]. This type of analysis could go deeper by introducing qualitative indicators in follow-up reports; as a result we could see and analyze in detail those processes of change generated by the project; and we can find out solutions in cases where change is necessary. Some examples of qualitative indicators for follow-up reports could include:

- Opinions about the role of health promoters in inhabitants of the zone where the project is held.

- Opinions about the role of health committees.

- Has the concepts of promotion and protection of health in beneficiaries changed?

- Opinions about the role and effectiveness of family planning methods offered by the project.

- Opinions about programs of education and formation in health according to participants in these programs.

- Satisfaction in services of mothers.

This project might have used the qualitative analysis ti identify their obstacles when dealing with gender and cultural questions. Follow-up reports confirmed that the number of deliveries assisted in the project does not even reach the figures expected in this district. This analysis would let us know the reasons why women prefer their children to be born at home, in spite of the improvements introduced by the project. The gender analysis and all its components must be integrated in this stage and everything must be registered in their reports: It would be necessary to include an analysis of the impact on access and control of resources and benefits brought by the project, and an analysis on the level of participation of women and men(barriers identified and means to reduce or eliminate them). Some participative techniques for collective revision and critical analysis of improvements in the agents involved must be introduced.

The role of health promoters could have been promoted during this stage: they were supposed to hand in a report on their activities, however, the role and the feedback given by these reports and their efficiency is questionable. They do not exist and no major impact on the project seem to be caused.

[30] Qualitative análisis is used to understand social processes, to analyze why and how a particular situation has been produced and how it can be changed in the future. This analysis can and must be made through all stages of the cycle of a process and must be used altogether with quantitative and qualitative indicators.

Besides it would be vital to analyze the type of information required from promoters, because they are the only ones who can provide qualitative information. To be precise, they could have obtained this inforamtion from qualitative indicators formerly proposed.

Evaluation

An evaluation integrating the gender dimension, would have to analyze first the presence of gender in the main objectives proposed, which seems to be stronger in those objectives attempting to generate changes (improvements) at the social level and quality of life. All changes or social processes affect gender relations in many ways: resources are redistributed, their access and control increase for some and decrease for some others, responsibilities and workload go up or down. The balance between responsibilities for women and men should be evaluated too. This is the case of the project aimed at contributing to social development and increasing quality of life of inhabitants of the District of San Juan. In the evaluation stage, we must assess the impact of medical assistance on gender relations. This impact can be negative if the role of women deteriorated in comparison with their own situation prior to the execution of the project, or if in comparison with the situation of men (mainly in areas like sexual and reproductive health and children's health protection). Maybe the project increased responsibilities in women or maybe not. If the impact has been positive, responsibilities and decision-making must have been equalized.

Some questions to assess the impact on gender relations are: How much has the access to family planning methods improve more equitable sexual relationships? How much freedom have been women given in order to make decisions about their sexual and reproductive health?; Has the increase in the access to preventive health and vaccination of children, made parents more aware of their children's health? Has the participation of partners in assistance services to pregnant women been increased? Regarding the feasibility of the project, the integration of gender dimension means that beneficiaries must get two important things: more control on their own lives and empowerment; and this is visible in a more equitable distribution of responsibilities and a higher level of influence and empowerment in the community. As a result, the intervention can last longer, thanks to the big interest of people willing to continue and keep it going on. For this, it is necessary that the intervention produces the necessary conditions so people not only feel beneficiaries, but owners of the project. This is possible if interests, visions and priorities are taken into account.

The appropriation of beneficiaries assures the continuity and viability moves from external to internal factors. The viability of this project in particu-

lar is assured by a self-financiation system of fees per service without excluding those who can not pay. With the funds raised, they can provide part of the medicines and medical supplies required and give additional fees for part of the staff. When the project comes to an end, the Ministry of Health will be responsible for the economic management. The project does include strategies to grant appropriation for beneficiaries: local committees or civil organizations working as intermediaries in external financiation. Finally, regarding the functioning of the project as such, it would be necessary to analyze how much the gender perspective has been integrated in all stages (planning, formulation, execution and follow-up).

4. As a Conclusion

When the gender dimension has been integrated, women and men can get more knowledge and control over their own lives, responsibilities and obligations, determined by their sex. **The main objective is to promote the existence of spaces where both men and women can reflect on their roles and responsibilities and can identify their own needs to plan solutions for their problems assuming responsibilities in the processes where they are involved, taking part in decision-making processes**. For this reason, we can not integrate gender dimension in a project when we do not know its beneficiaries or their opinions.

With this perspective, it is interesting to observe the evolution of the project and its objectives. The two first phases mainly concentrate on the improvement of the sanitary infrastructure by increasing the coverage and efficiency of their services, improving the equipments or the personnel and the functioning of the intervention system (supplies, reference and counterreference, administration and control). It is only in the last stage when objectives are clearly programmed. Under the point of view of social development, it would have been interesting to revert the process: to start working with the community in order to understand the concept of health in all the different groups (sexual and reproductive health included). Then it must analyze the factors influencing on health and finally plan a long-term sustainable health system.

Finally, we must strenghten the qualitative analysis when we integrate the gender dimension in all the stages of a project aimed at generating processes of social change and improvement of quality of life. To understand social processes and their changes, it is necessary to analyze the factors or social forces producing those changes and this analysis must be visible in all phases of the cycle of the project. Objectives, activities and results must be analyzed in a qualitative way, and have to be supported by qualitative and quantitative indicators to make sure information records are adequately preserved over time.

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Chapter VIII

The Office Taking Us In

Once we are in the field and we are familiar with our project, we must find the ways to integrate the gender-based approach; we have to advance to make the follow-up, and to take a look at the type of organization we work for and other organizations working with it. There are four things we need to analyze with respect to the office taking us in: The type of organization we are[31], the previous experience on health and gender, the nature of the co-operating counterparts and the financiation received or likely to be received in gender and health.

1. The Type of Organization We Are In and Its Counterpart

First of all, we will focus on the office taking us in. What kind of organization is this? Normally, we work for a Spanish or a local DNGO, for a bilateral Agency –from Spain or any other developed country– or for a multilateral development organization. When involving the gender perspective, there are many differences between a Spanish DNGO and a local one. Some local DNGOs from developed countries are much more receptive to work with gender dimension, because they have worked with other DNGOs from different countries, probably with a higher background than those of Spain, for whom gender is a new priority that must be included. Besides, for a long time, co-operation has demanded the local counterparts to develop gender strategies inside their institutions, even when the demanding organizations did not have their own gender policy, or any former experience. For this reason, there are many local DNGOs better prepared to work with gender than the existing ones in Spain.

[31] Some of these questions are also explained in chapter X, especially integration of gender perspective in the organization.

If our organization, is part of the Technical Co-operation Offices (TCO), AECI, or any other bilateral co-operation agency, our approach is going to be absolutely different. Normally, gender relations inside TCOs spread all over the developing world, have inherited the dominant ideology of masculine values, evidenced by the scarce presence of women in positions with high responsibility or decision-making tasks, and by a poor tradition of supporting institutional gender policies. Probably, we will work in a multilateral organization, where institutional speech and some of the practices to institutionalize gender have been assumed; in these organizations, real practices may look like ads to call people's attention instead of a promise of people to assume and interiorize new principles. In any case, we have to pay attention to certain elements that help us identify the ability of organizations to work with gender persperctive [32].

Is there a previous experience with gender-based analysis?

Our analysis must also identify the possibilities of institutional support, previous works performed to use them as examples or we will have to start from zero. Am I the only person working with gender in the organization? Or, are other colleagues willing to incorporate the gender perspective in their daily work? The effectiveness of our work will largely depend on the answers for these two questions. The integration of gender dimension in some specific projects has depended on voluntary work and personal motivation of people involved in similar offices and projects, more than a result of strategies planned and implemented by responsible organizations. For this reason, we have to ask for help to people with prior experience; their support and co-operation will enrich our work and will give us hints to understand gender in our projects. Obviously, it would be ideal to get to an office with people trained in gender topics who promote its integration in the different areas of work of the organization.

Very few Spanish organizations have created and integrated gender policies leading their actions in gender equality and co-operation programs; however, they have structures or gender units [33] in charge of working with gender in women. In fact, the existence of these units or departments has been seriously questioned, because they depend on their design (competence and independence provided and personnel contracted) to be effective and efficient. The experience with these departments has demonstrated that their existence does not necessarily mean big advances in gender relations and activities in institutions, and in other cases, the range of action can even be limited to "women issues".

[32] López and Sierra (2000).

[33] Although AECI have involved groups of people in charge of equality between men and women in Spain, they created a Gender Unit within their formal structure, depending on the Technical Office sinde 1997.

So, in order to be set up in a organization, a good gender strategy must follow these steps:

First of all, get to your place of work and meet the human team with whom you will work; you must introduce yourself and take your time to explain them what involves the incorporation of the gender dimension in their daily work. Everyone has to encourage his/her workmates to get involved in gender inequality; for this reason it is very useful to establish open, permanent and respectful communication. This is a fundamental part in our possibilities to suceed and it depends greatly on our roles as gender experts; our work must be recognized and legitimized by all components in the project. In many societies, like the Spanish one, there is an ideology around "women issues", "feminism" or "being feminist" that plays a relevant role in our workplace even before explaining our purpose to integrate the gender analysis in co-operation. We can not possibly fight against this, but we can change these stereotypes with our attitude and behavior.

Once we have introduced ourselves and explained what the gender approach is, we have to make sure that this is what we want to do; it is important to do research on the topic and make a gender diagnosis focusing on the existing political, economic, social, cultural and legal relationships functioning in the country for both women and men. With this, we will identify inequalities between them and later on, we can determine our objectives depending on their priority. The documents will include statistics of official national institutions, associations, academic research and information in the internet pages of the World Bank, UNDP, UNESCO, etc., including topics like education, health, laboral market, plans of equality and opportunities, etc. Secondly, this information will lead us toward questions of inequality, problems or needs (on inequality between men and women) that we find in our field of work. If we want to provide a high quality work, we must be specially tolerating and receptive at the beginning when we analyze their culture, trying not to pay so much attention to initial problems of ignorance on the topic, sexist behaviors or attitudes of distrust of our work. People's involvement and interest in our project will depend to a large extent on the first impression of us when we join the organization, so they will take us seriously for the rest of the time working with them. The social and cultural information that we gather at the beginning of all the process, will determine if our future approach will be appropriate, positive and favourable for the change regarding gender equality. After arriving to our organization, it will be important not to compare our previous works (regarding gender schemes) with the current one.

In third place, once we have the basic information on the field where you are moving, you can figure out open proposals with the rest of the team,

trying to find priorities. Look for specific allies who help you with punctual actions and support like financial, time and logistic resources, present in their own projects or fields. Next, if possible, look for national and international collaborators developing similar projects based on gender equality (legitimized institutions) that can provide you technical support. Some of them could be the gender units of the UNDP, other international agencies working on the same topics, or the mechanisms of equality in the country where you are.

Finally, we must understand that we will not (and we must not) be working forever with the organization. Our work will be part of a comprehensive collection. To try to solve problems when we eventually leave the project, we recommend to identify a person who had worked with us for some time and knows our objectives; someone we can call to continue all the actions and processes started in a short term. Do not forget to prove their work by writing reports about their performances, and to provide materials (books, documents, videos, etc.), that can be used for reference in the future.

Counterpart organizations

Once we have identified the type of organization and established alliances with important people with experience on gender relations involved in decision-making in organizations, we have to take a look at the office taking us in, as counterpart. We must not forget to establish communication with local organizations and associations in the zone, because they know by far the situation of women, the characteristics of gender relations and the previous experience we can rely on (positive or contradictory).

2. Financing Our Project

Another of the aspects to be considered when working in the field, is the need to get to know the institutions financing co-operation projects for development (nationally and internationally), and to identify those we could contact in order to get economic support. Considering possibilities in international spheres, we could present new projects and apply to announcements trying to get economic support, channeling funds destined to be used in gender health projects. First of all, it is the UN (United Nations) which is one of the first ones to consider gender and health in their international co-operation projects; it has got specialized agencies to solve problems in relation to health and gender in developing countries. So, it is convenient to be informed about the announcements and opportunities provided by the World Health Organization (WHO; www.who.org), known as Organización Mundial de la Salud in Spanish.

The WHO's headquarters are in Norway and its General Director is Mrs. Gro Harlem Brundtland, who is responsible for health problems, specially those involving women; she has worked with humanitarian action and emergencies, sexual and reproductive health, programs of promotion and protection to health, control of contagious illnesses, assistence to refugees and women with HIV, etc.

Among these programs, we have programs like UNAIDS or the Joint United Nations Programme on HIV/AIDS (you can see their web page www.unaids.org). Besides we can turn to the UNFPA (United Nations Population Fund); the agency specialized in the promotion of reproductive health is based in New york and has branches in most of countries receiving help. The UNFPA develops projects and gives advice and information to all organizations interested in the promotion of reproductive health. In the latest years, they have started a program to meet the needs in terms of worlwide political events, called: "International effort to save Afghan women by providing medical attention for reproductive topics". Inside the UN, we can contact the Division for the Advancement of Women (DAW) that integrates, the United Nations Development Fund for Women (UNIFEM) and other organizations like the Commission on the Status of Women (CSW) and the Women Watch Project or Proyecto Observatorio de las Mujeres. All of them work with gender and health.

Finally, it is necessary to point out that in the first semester of year 2001, the UN published a report by the General Secretary which can be fundamental to advance in topics like gender and health, because this provides guidelines to worlwide practices that must be known or avoided to improve health and quality of life of women. The document is called Traditional or customary practices affecting the health of women and girls, and the reference of such report is A/56/316.

Special dates for health and women	
8 March	International Working Women's Day
7 April	World Health Day
10 October	World Mental Health Day
1 December	World AIDS Day

Besides, depending on the region where we are, we can ask for information about the areas of work and financiation ways possible in regional banks of development. Both, the Inter-American Development Bank (IDB) and African Development Bank (AFDB) have started different projects inside gender and health, whose experiences can be really useful for our own project. Other regional banks are: the Central American Bank for Economic Integration (CABEI), the Asian Development Bank (ADB) or the East African Development Bank (EADB). The EU is another big organization that supports and finance

projects in developing countries. Inside the structure of the European Commision, is the General Direction of Development that works simultaneously with gender, health, AIDS and population issues in developing countries focusing on "population topics, sexual and reproductive health, rights and safety in maternity, sexually transmitted illnesses, especially HIV/AIDS and encourages global action against HIV/AIDS, malaria and tuberculosis" [34]. In this General Direction we have a spefic area of finance divided according to the areas of performance (European Development Fund, Asian, Latin American, mediterranean or Middle East countries), topics (HIV/AIDS and population, contagious illnesses and humanitarian aid, etc). In Spain, we have three types of institutions supporting projects on gender and health. First, insitutions of Central Administration, we can go to the organisms in charge of the promotion of equality and the reduction of inequality between men and women. We are speaking about the Instituto de la Mujer, organism that depends on the Ministry of Work and Social Affairs, whose Department of International Co-operation is always ready to support co-operation and development projects dealing with eaquality of oportunities. Through the Program of International Co-operación "Women and Development", they make two public announcements to support co-operation projects not only in Spanish, but also in Latin American, Caribbean, North African and East Eauropean DNGOs. Also depending on the Central Administration, there is another Gender Unit from the Spanish Agency for International Cooperation (AECI) that supports projects with technical assistance and orientation based on the experience gained in previous projects financed by the AECI; it also gives guidelines for gender and health based on international and regional recommendations.

We can also look for support in programs of co-operation for development in all different autonomous communities of Spain. Nowadays, most of them have Women Institutions, or Centers for women or Offices for women affairs, in charge of topics related to equality between men and women; they can provide information on how to access to all kinds of decentralized economic grants for gender and health. Speaking about co-operation projects for development of women, the Basque Institute of Women (Emakunde) and the office for co-operation from the Basque government have been the most generous and pioneering institutions. The Institute of Women in Canary Islands and the Andalusian Institute of Women, have supported and subsidized different specific projects in the field of gender and health. And finally, we have to include all departments for co-operation and development in local governments and town halls, where additional international aids can be provided. We have to ask them about prime groups to be granted, deadlines, application forms and so on. Besides, we can consider some other resources available in associations and local mixed or women-centered collectives; even though they

[34] See Marie Stopes International (2000).

can not provide economical aid, they certainly supply other projects with human capital.

International Level
- UN: health (WHO, UNFPA, UNAIDS...), gender (UNIFEM, Womenwatch, etc.)
- World Bank

Regional Level
- European Union
- Regional Banks

State Level
- International Cooperation Spanish Agency (AECI)
- Institute of Women (equality mechanism)

Local and Autonomous Communities
- Regional institutes of Women
- City Halls
- Associations and collectives

Financiation forms

Once we have identified those institutions with possibilitites to support our projects, we must think carefully about the ways for us to make sure they know gender plays an important role. Normally, institutions like these have very complex forms containing a specific area to write down the impact of our project in gender issues. This is not a blank easy to fill in. First, because it does not make so much sense they include such section. All co-operation projects for development are supposed to deal with gender. So this is absolutely unnecessary. Both technical or specific projects should establish direct and indirect relationships with gender which have to be integrated from the very beginning. However, financing and supporting institutions have not this very clear. Consequently if want to get support for our project, the blanks asking for gender must be filled as clear and complete as possible.

First, we need to prove that general and specific objectives in our project meet the needs and interest of both men and women. Our results would fulfill their practical and strategic needs, and this should appear in the blank for gender. Besides, it is important for us to point out specific indicators of gender that will be used in the follow-up and evaluation of the project; we can take a look at chapter VI from this guide, to check methodological tools. We also have to mention the methods to encourage active participation and decision-making in women and men of the population, describing the activities necessary for it to be more equitable regarding quality and quantity.

As we know, the integration of gender perspective in all kinds of co-operation projects for development takes a lot of common sense and goodwill; we need to demonstrate that our project supports and favours equality between men and women and empowerment of women. Since this form is one of the

formal requirements to save the viability and get support for your project, it is recommendable to write about the integration of gender perspective in all areas of the project.

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Chapter IX

Our Fieldwork Experience

When we are aware of problems and possible effects of gender, we have to start looking for the possible ways it affects also our daily life, including our fieldwork and even our private life. The gender perspective helps us know the causes of many problems we have to face in order to find efficient solutions. Next, we will describe some of our experiences in our fieldwork and will give some practical advice for those interested in making a change.

Case number 1

A 24-year-old woman brings her newborn baby for him to be vaccinated. When you are writing her medical history, she tells you this is her sixth child. She says she is very tired and hopes not to have more babies. She has heard about family planning, but says her husband does not want her to use it.

What can you do?

Start by asking her the reasons why her husband does not want her to use family planning. There could be many possible reasons, including: lack of information about the risk of planning, religious beliefs that prohibit the use of family planning, social norms that promote numerous families or the desire to have a boy if they still do not have one. A popular belief states that women become promiscuous after using contraceptives. Listen to her attentively and and be respectful to her. Ask her what she thinks about family planning. Does she want to use it? How would she feel if her husband wanted to use family planning? If you consider appropriate, give them information about the existing methods. Explain in simple words the way they work in order to prevent pregnancy and the effects of their use in comparison with the possibility of new pregnancies. Give her more information if fear is the only reason not to use

contraceptive methods. Talk to her about natural family planning and coitus interrupts. You can even suggest for to come with her husband. Tell her you would be pleased to talk about possible problems he may have. If she thinks that probably her husband will not want to come over and she wants to avoid future pregnancies, tell her about the possibilities she has and the risk these methods have. Teach her how to negotiate the use of contraceptives with her husband.

Working for a change

a) Provide education. Put information about family planning at everybody's disposal (boys, girls, men and women.)
b) Promote debates with women and couples about topics and experiences related to family planning.
c) Organize mass media campaigns to explain the benefits of family planning for women, families and communities.
d) Try family planning methods to be available and affordable. Make sure couples and adolescents in both rural and urban communities, have access to them.
e) Train male employees to explain other men the benefits of family planning.
f) Consider the relationship between local religion and family planning. If family planning methods are explained respecting local religious beliefs, it will be more easily accepted.

Case number 2

A 35-year-old woman comes moaning about a chronic stomachache. You observe that she is very tired and undernourished. When you examine her, you notice some bruises in her arms and legs. And when you ask about them, she tries to minimize and does not attach importance to them or simply says she had a bad fall. When you ask about her and share information on her medical history, you are told she cama one day with one broken arm. When you make a more detailed interview, she finally admits that her husband beats her and that this is not new and that it has happened some other times before, but she adds that is her business and she later admits she is scared of doing something about it.

What could you do?

First of all, make sure she is in agreement with you, if you decide to do something about that. Try to find out the times that has happened. If you con-

sider she is in danger, help her make up her mind: maybe she really wants to leave her home, or probably not. Create a safety plan to protect her.

Organize a safety plan

Health professionals may help women to protect themselves against domestic violence, even when they do not feel ready to leave their homes or report their couples' mistreatment. When patients have a personal safety plan, they are in conditions to face violent situations. Next, you will find some suggestions to help women create their own safety plan:

a) Identify some of their neighbors, or at least one, to talk about their problems and ask them to go for help in case they listen to arguments or disturbances at home.
b) If it is absolutely unavoidable to have an argument, try to do it in rooms or places where women have the possibility to run away, far from weapons.
c) Practice the safest possibility to get out of their house. Identify appropriate doors, windows, elevators or stairs that can be used.
d) Prepare one bag containing keys, money, important documents and clothes. Leave that bag at a house of a friend or a relative, just in case they may need to escape in a hurry.
e) Choose a clue word to use with their children, families, friends and neighbors when she urgently needs or wants them to call the police.
f) Decide where to go if they have to leave their homes and make a plan to get there (even if they think they will not need it).
g) Use their instinct and reasoning. If the situation if dangerous, consider the possibility to provide what men want, in order to calm them down. Mistreated women have the right to protect themselves and protect their children.

General advice

The best way to detect cases of mistreatment, is making direct questions about it. However, there are some suspicious physical injures, disorders and behaviors that lead us believe women are suffering from domestic violence or sexual mistreatment. When these symptoms or "alarm signals" are identified, proffesionals must feel sure about themselves and ask their patients about possible mistreatments, remembering he/she must be respectul about the private lives of their patients.

a) Chronical complains, without any special origin or physical cause visible.
b) Wounds hard to justify.

c) A man controlling too much his wife.
d) Physical mistreatment in pregnancy.
e) Timing between the injure is produced and the time the woman decides to visit the doctor.

When you examine a women, try to look signals of mistreatment. Very frequently, men beat their women in places where bruises are not very visible. If you see unusual bruises, scars or wounds, ask for the stories behind them. And in case a woman comes moaning about pain, bleeding or with broken bones, ask her if she has been beaten. Remember most women will say they had an accident.

Working for a change

a) The sanitary workers can:
- Get trained about physical, sexual and emotional mistreatment and explore their ideas, fears and prejudices about them.
- Give help and support to victims of domestic violence, without sharing their opinion.
- Make question in a soft, nice and friendly way.

b) Those directing reproductive health programs can:
- Establish policies and procedures to ask women about possible mistreatment.
- Create protocols that indicate adequate care and reference to victims of mistreatment.
- Promote the access to urgent contraceptives.
- Provide places for women to organize groups and meetings.

c) The community can:
- Settle down a "safety house" or refuge for women without houses.
- Try to understand and take care of victims.
- Question those cultural and religious interpretations that justify violence and mistreatment of women.
- Incorporate debates on healthy relations and alternatives for violence.

Part Four Coming Back

Chapter X

A. Our Organization

It has been said that doctors are bad patients. But is that really true? If your answer is affirmative, maybe this example illustrates that integrating the gender perspective in our organization is harder than encouraging our counterparts in the South to do the same. It is possible they perceive these inequalities more easily in our organisms from their point of view, everybody knows that sometimes things are seen more clearly from the outside. DNGOs may consider that since women in the North, do not experience extreme situations of oppression like women in the South do, gender-related problems do not exist. But the same way we can say that "health is not only the absence of disease", we must assimilate that gender equity does not mean that women have only equality of rights and opportunities, or that they do not suffer physical violence. It is more than that. In this chapter, we will approach and understand those elements in our organization. It is now necessary to look at ourselves and start with gender analysis in "at home".

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1. DNGOs Are Gendered Institutions

DNGOs are non-profit making and autonomous entities legally constitued, that work in international solidarity and co-operation for development. They are composed of citizens who believe in the need of solidary co-operation among peoples; they are ruled by a set of ethical values that makes sense of their existence and justifies their work. Similarly to their Code of Conduct, DNGOs promote development, understood as a "process of social, economic, political and cultural change that requires participative organization and democratic use of power by members of the community (…) creates conditions of equality in the access to resources (…) and brings better possibilities for human beings to develop their potential". As long as they define themselves as agents for social transformation, DNGOs participate actively in social changes proposing more

fair relationships and giving more importance to three elements in human development:

- Gender equity.
- Respect for the environment.
- Promotion of human rights.

To integrate the gender perspective in the analysis of their work and their internal dynamics it has to be coherent with all those postulates included in their policies. Though we may consider that all DNGOs should include gender equality in their priorities, sometimes there are doubts, passive resistance or open opposition about the topic. Far from feeling discouraged about this, we fight to make DNGOs more sensitive about gender inequalities, because this may require important changes in both personal and collective concepts and attitudes. These changes are not that simple, and even though DNGOs may be willing, they keep on being living institutions, complex organisms that generate, keep and reproduce social relationships. If we see our organization from this point of view, we will notice that it shares common characteristics with social organizations:

- It reflects and reproduces power relations among very diverse groups.
- It works with people who have incorporated dominant ideologies in social relations (and in gender relations, in particular).
- It promotes a distribution of resources, favouring those having the power.
- It has hierarchical structures.
- It has rules, procedures and practices that reinforce these aspects in its daily functioning.

Gender relations established by the social order that assigns women less resources and power than men, exist in DNGOs as well. For this reason, we can say they can be considered "gendered institutions", that frequently reinforce and perpetuate the internal gender division of work and the unequal access to resources and power. Organizations like DNGOs where comradeship and kinship are common, usually feel exempt from social problems like these. If we accept the existence of unequal relations between men and women in DNGOs, adopting social expressions typical in society, we will be on the right direction to start the revision of our organizational practices.

2. What Is the Importance to Integrate Gender Into an Institution's Life?

To integrate the gender perspective into the functioning of an organization requires a systematic work aimed at institutionalizing a new culture.

▮ Institutionalization: process through which social practices become so regular and continuous that they are part of the daily evolution.

▮ Organizational culture: set of knowledge, ideas, social relations, norms and values shared by people who make part of it.

Our task will be successful only when the gender perspective is integrated as a regular practice, in all contexts and parts of the social organization. In order to do this, objectives and policies of the organization (substantial level), procedures and mechanisms within internal structures (structural level) and beliefs, attitudes and explicit and implicit values of their integrants (cultural level) must be revised. The most necessary condition to transform the three levels is the disposition of the organism to social change. As the DAC states, "the possibilities for success in the integration of gender increase when the organization is flexible and has open attitudes towards new ideas in general, desire to change and incorporate new contributions to diverse areas of the population [35]. If we have already taken the first step (to recognize existing inequalities between men and women in our organization), and we are ready to start with the second (to analyze this with open and flexible attitudes), this is the moment not to forget that integrating the gender perspective into our institutional dynamics is not exempt of conflicts and resistance. There is resistance because the interiorization of gender makes us question about real and symbolic hierarchies that characterize relations between men and women. Changes in the dominant gender relations established in our society and eventually in our organization, is very frequently considered to be a threat to the personnel. It is important to keep in mind that changes in the organization are complex and we can not make only one or two people responsible for those changes. All the staff must be involved, because if not, we can understand that the fact that the organization does not make any progress on gender is a result of inappropriate methods to convince people to take part and/or excesive confrontation. Debating styles are varied and in fact, some can be more efficient than others; however the removal of social relations like gender ones (so deeply rooted and difficult to question) can not be made only by using good methodologies or adequate styles. Besides collective participation and personal desire, in order to make our organization more coherent

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[35] Ministry of Foreign Affairs /SECIPI (1998).

with gender equity, we need to assess the ways inequalities between men and women work in all of the institutional levels formerly mentioned.

Conceptions and policies sensitive to gender equality

Global political conceptions and objectives of our organization must be revised in order to confirm that it aims to promote equitable human development in terms of gender. If this does not exist, it is very difficult to reflect gender equity with goals and strategies used. This does mean to multiply the number of projects involving women as major beneficiaries. These projects rarely solve women's problems and only contribute to widen the breach of inequality between genders, giving validity to the current division of work.

Let's take the classical projects of maternal-child health as good examples. The only name implies that women are exclusively in charge of the responsibility to take care of their children. In fact, this has always been like that. But… should it be this way? We can try to predict your answer because we know it is very difficult to get men involved in the care of their children, even though some of them do it. But… can we give up before taking our first step? Resistence to our revision of conceptions must be varied and strong. Some arguments that would be inadmissible in other contexts of work, are considered insuperable obstacles when including gender relations. Don't we question traditions when the objective is to preserve the environment?

To integrate the gender perspective in the general policies of our organization would imply:

a) To focus on the change of basic approach of intervention and not on the development of simultaneous activities. It is not about perform more activities (meetings with women, for example), but to revise the objectives of those existing ones.

b) To analyze, for example, the conceptions supported by maternal-child health projects we are carrying out: Do they question the absence of parents in prenatal controls? Do they fight against the mistreatment of women in hospitals? Do they criticise the preference for boys as a universal norm humiliating mothers and discriminating girls? Do they train parents, siblings or grandparents to take care of the newborn?

c) To consider interventions of development more than just a way to fulfill concrete needs of women. The general objective is to erradicate inequality between men and women, and specific activities must help us reach that goal.

d) To understand that interventions in health must not be limited to provide the access of women to sanitary services. A big problem like the

unequal distribution of food within families (that follows hierarchical gender patterns and causes higher malnutrition rates in women) must be included in every project involving health. The breach of gender in the access to food will not reduce if issues like these are not included in our projects.

e) To pay special attention to individual and collective empowerment of women and the way men influence on the process.

f) To involve men in the objectives about gender equity, which means, in the first place to consider them coresponsible for reproduction and secondly, coprotagonist in change; it is impossible to imagine that gender relations could change only with the participation of women.

g) To include gender policies into global ones of the organization; better if they have been discussed by all the personnel and approved by directives.

The gender policy must not be merely a document written and known only by a group of experts in gender; to be put into practice, it requires something more than just being published with an attractive and beautiful design. All the organization must be included in the discussion, and directives have the responsibility to write progress reports to periodically inform about the development of this context. The real evidence of the political involvement of an organization in gender equity is the supply of economic, human and technical resources and time for working in this field. If our gender policy is not only united but totally integrated into our global policy, and we do not define the patterns to put into practice, the people, the follow-up, and the indicators used to evaluate, our job will be incomplete.

Procedures and structures encouraging gender equity

It is necessary to assess the structures of our organism, its rules, operative mechanisms and routines of work to make it more sensitive to inequalities between women and men. This implies to have objective information about the type of people who have more or less opportunities to reach directive positions, the characteristics of volunteers and functions assigned, generic division of work (who takes part in strategic discussions, administrative tasks or support; who is always in logistics and co-ordination of projects or countries) and characteristics of expatriates, etc.

To integrate the gender perspective in our organizative structure would imply:

a) To involve criteria for contracting, selecting and promoting the personnel, in such a way that they favour an equitable presence of genders

in all areas and levels of our organization (including headquarters and fieldwork sites).
b) To promote the use of participative methodologies to make sure women in our organization express their real needs and interests and take part in all activities proposed.
c) To use mechanisms to guarantee the participation of women in both the debate of important aspects and decision-making processes.
d) To investigate and create conceptual and analytical tools sensitive to gender, which will be incorporated into manuals, guides, formats and procedures useful in planning, follow-up and evaluation of our interventions in health.
e) To contract specialized personnel to work with gender issues and/or train people from the organization to deal with these topics.

The objective of all these actions is to make the structure of the organization more equitable and democratic in gender. But this can not be done with orders and norms. It is necessary a comprehensive analysis of the roles of people, a collective discussion on the resistance of women to take part in decision activities (and that of men to abandon them), a debate free of prejudice, about the usual ways power is exerted in the organization. We have to admit that the results of these kind of discussions (mainly organized by women) will focus on the role of men that have monopolized directive positions, symbolic power on institutional decisions, important events in the agenda and practices of promotion and representation of our organization. DNGOs also debate about which is the best way to make sure the gender perspective gets involved into the daily dynamics of the organization. Two main alternatives have been polarized: the creation of a commission or a gender group and the integration of all areas of work in the organization.The debates states that on the one hand, the creation of specialized units would discriminate gender topics; on the other hand, if everybody is responsible for them, gender will be just a little part of all major areas of work. DNGOs have concluded that the best is to put both strategies together.

A culture of an organization that does not promote gender inequalities

To get to the bottom of the culture of an organization is very complex and hard, because it implies to get into a non-explicit context of suppositions; a place where collective images and representations are crucial, but hard to recognize and easily confusing resulting in extremely different interpretations.

A Sample Is Not Enough

NOBIB's policy of affirmative action (a dutch NGO) contributed to increase the rate of participation of women in intermediate and superior managerial levels, including the appointment of a feminist as one of the three most important directors. According to reports, the result of this was the integration of gender issues (for example, the supply of resources to women) within the core of the managerial area; while in the culture of the organization, a wide variety of working styles were established. There is no evidence however, that female directors necessarily represented the interest of women. Some investigations showed some ambiguity of women in positions designing policies about being publically considered "feminist"; however, "this does not necessarily mean they are not feminist" or that they have to support those political priorities established by men in order not to lose their positions or avoid arguments with their male colleagues. This is more likely to happen in dominant masculine organizations where women's decisions are not even considered. A significative group or a critical proportion of women in organizations (30 to 35% according to the UN) is the only way to ensure gender issues are taken into account. They must be sensitive to gender and involved in empowerment and equality of women. This certainly makes a difference between the access and a strategic or controlling presence of women.
(Source: Macdonald, M. et al 1997).

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Gender relations are part of the culture of organizations and express through:

a) The concrete presence of men and women in different areas of the organization.
b) Those behaviors permitted and prohibited within formal and informal places of work.
c) The relationships they establish in working places.
d) The recognition of different abilities offered.
e) The individual's identification of his/her needs and interests and his/her attempts to fulfill them.
f) The place in the scale of values attributed to the activities traditionally performed by women and men.
g) The assessment of management styles of men and women.
h) The collective images and ideas of what is masculine and feminine.
i) The importance given to rational and emotional issues and the relationships between them.
j) Symbols, rituals, environment, heroes and heroines, male and female villains recognized by history.

k) The way conflicts are solved.
l) Styles and mechanisms (formal and informal) of communication and decision-making.

All these and other elements related to gender relations are always present in human collectives, whether mixed or separately. The analysis of their influence over work places however, is very recent. We must not forget these ones have been predominantly masculine, therefore they have been defined by their own interest, needs, expectations, motivation, conducts and desires. The predominant social model divides life into two parts: the working context (public) and the family context (private). Men have been socialized to move freely and rule the first one while women have been crowned queens who must be at home. One of the norms of this system of gender relations is that both contexts have to be separated. As a product of hundreds of years, this division which is currently valid keeps alive one of the central elements in men's lives: his work (out of home to earn a salary) which is visible in objectives achieved.

The culture of achievements focuses on data, thinking and analysis, supposedly objective, as well as the measure of the results (number of projects, number of countries in co-operation, number of nets where we participate, amount of money…). On the contrary, goals assigned to women, family-oriented and hardly quantifiable, focus on the construction of relations and personal links that make possible their work. The feminine style to manage usually aims to fulfill emotional deprivation existing in their places of work; however this style is not easily applicable; it has to face the historic tendence to consider affection and feelings as big obstacles to rational discussion and political action. The pressure and the tiring dynamics of work, the lack of time, staff shortages to achieve objectives are very frequent problems and complaints in DNGOs. By revising them, we could ask ourselves if the work emphasizes the importance of achievements or favourable relations in workplaces.

Historically, women's responsibilities for their homes and children, have permitted men to spend more time working, travelling and performing their tasks at work without major problems; in their cases, their private lives do not interfere with their public spheres. But most of women do not enjoy reciprocal rights; as a result they have to join less involved or less demanding areas in the organization, and to question dominant values. **To integrate the gender perspective into the organization, we will have to analyse its culture in detail, in such a way that equality between women and men is assumed as one of the leading values in the organization. That is the only way to ensure a real permanent and meaningful cultural change.**

Some DNGO's have developed indicators to evaluate if the culture is women- friendly and supports gender equity. We must take a look at the following elements in our organization:

a) Are materials exhibited in the place (pictures, posters, announcements…) respectful enough with women?

b) Does the organization provide appropriate locations: clean toilets, nursery rooms…?
c) Are there procedures to deal with sexual harassment?
d) Do men and women abstain from telling misogynist or homophobic jokes?
e) Is the difference in styles of men and women a fortress in the organization? Are they assessed according to their proposals and not their sex?
f) Does the organization offer working arrangements in order to fulfill reproductive and work responsibilities at the same time (part-time jobs, flexi-time, maternity and paternity leave, etc)?
g) Are criteria that favour a traditional masculine model at work evaluated, for example, involving total availability?
h) Are policies of positive action for women planned and carried out?
i) Do they encourage men to take responsibility for caring roles?
j) Is gender equality presented as a heavy load that must be only included in order to get funds? Is it considered a relevant part of personal development and human relations?

3. Gender Training

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In order to make progress in the institutionalization of the gender perspective, some DNGOs have developed a very useful and prized tool: gender training; this is a process of political nature that questions exclusive characteristics of development, clarifies concepts of generic dominance and subordination, understands gender relations as social relations of power and relates these concepts in a personal reflection and an analysis of the DNGOs. Gender training is not a means to incorporate the gender perspective in the programming of work (through planning tools like the frame works of Harvard, Moser, Kabeer, etc.). This is mainly a process to make people aware of the implications of activities regarding unequal relations between women and men. Gender training is mostly a personal and collective transformation process: it aims to change attitudes of people working for the organization by teaching new things. Its main characteristics are:

a) It is a continuous educative process, not limited to the concrete event of formation, that requires a follow-up examination and permanent updating of personal and collective reflection.
b) It is a formative proposal that must be developed in all areas of the organization; from the direction to the volunteers and administrative personnel.
c) Gender training is not neither about women nor for them only; it involves men and women and the power relations they establish. For this reason, men should be trained in gender issues too.

d) This is a professional activity, highly specialized that requires continuous formation from people participating, so that they can adapt it to different contexts, generating special instruments and suitable methodologies.

DNGOs have concluded for training people in gender issues, it is necessary to invest both human and economic resources. Gender training is first of all a continous process and not a one-day activity. Those trained must have the possibility to work in a context to put their knowledge and abilities into practice. Equally important is the role of those managing and making decisions in the organization; the less the support by managers and directors is, the less likely to for practitioners to work. According to DAC, "the experience demonstrates that a course is not enough if we want to call the attention from organizations and involve a gender perspective; it will be necessary to understand the activity and functioning of the organization in order to develop strategies to ensure equality between men and women are part of their daily routine. Making our people aware of the importance of involving gender in our organization will influence our personnel formation; this will imply that our staff must attend seminars, workshops and conferences to improve their understanding and knowledge of gender. It will also exert influence on analysis and internal and external publications (bulletins and specific campaigns) and finally on the relations with the counterparts (nets or projects with organizations from the South working with gender). Even though gender awareness can scare people working for the organization, making them feel they can change their ideas, attitudes and behaviours, previous experiences with other co-operation organisms have demonstrated that changes in these contexts have been minimal.

Summing up, the task to introduce a gender perspective in our organization is not easy and will take too much work. However, this task is politically necessary and offers the organization big possibilities to develop their ability to face a culture that treats people differently because of their biological differences. This is an opportunity to fight against hostility between exclusive masculine and feminine prototypes; an opportunity to widen our minds and a very attractive, exciting and novel adventure.

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B. Men's Work: Fieldwork Notes for Reflection

At this moment, men are comfortably settled down inside a political and legal framework full of guarantees about equality of opportunities for both sexes. This comfort seems obvious for many reasons:

- The current legal framework of guarantees has been mostly created by women (more than men).

- These guarantees for equality find big difficulties to be really introduced in social and laboral contexts.

- As a result of this supposed equality the masculine model of men has not been deep and honestly analyzed. By making this reflexive and responsible analysis, we can ensure authentic equality.

When we analyze the place of public and remunerative work in the life of men, we can find some interesting facts:

- The current division of private and public work, its sections (horizontal) and positions (vertical) have been supported by our biology, reinforced and modulated by social learning, creating personalities, abilities and vocational interests in both men and women.

- Some studies confirming more possible similarities than differences between men and women have been omitted. Far from the interiorized stereotypes, we can say that men are not neither similar to each other nor so different from women.

- Men are really interested in keeping the current separation of roles in their private and public life; this has represented many benefits specially now because of the precarious situation of employment.

- It is necessary to understand and anlyze the gender dimension with other vital situations (age, ethnia, sexual orientation, geography, culture, etc.), because it is useless to generalize the behavior of all men and women.

As men lose their job, we can analyze the reasons why it has always been a priority in their life. A man's job represents the only way to support his family and losing it means difficulties to maintain his quality of life. Why is work so important and crucial in one man's life? Then, what motivates and encourages men's implication and availability (special characteristics that differenciate them from women at work) to be working all time? It is true that:

- Some powers and qualities of the dominant masculine model have been questioned and demolished. Men have always supported their families by providing goods, and probably their role may be considered more important compared to that of women.

- Most of workers feel that are not part of that culture of achievements proposed by public work, because they are far from those positions and places where decisions are made and actions perfomed.

- Leadership, authority and prestige are exclusive assets for some workers only.

In spite of all this, there must be some resons for men not to lose that element of "income-generating work", considered to be inherent in the masculine nature.

- It provides men with a high degree of autonomy and control over the time devoted to work and leisure.

- The principle of authority is intimately related to the possesion of survival goods.

- Men do not feel responsible for the care of their children and family. They usually try to avoid affectionate intimacy and compromise.

With this information, we can see the reasons why men have developed their masculine working identity and why work has a decisive role in their lives. Now, let's see the way they live this identity in their workplaces. We must take into account some other variables, different from gender in order to analyze values, attitudes and conducts of men in their daily routine in order to avoid generalizations:

- Man is no longer the king in his place of work, but he has a leading role in structural and organizative fields.

Many men believe that equality of access to work is the result of a similar formation in women and men and the legal framework regulating these topics. We tend to forget about the "hidden curriculum" [36] that eases and modulates personal interests and expectations according to gender.

Many men blame women for the bad situation of employment. Anyway, they consider feminine work as auxiliary and subordinate to the masculine (which is supposed to be the most important one).

There is still a division of masculine and feminine work. So when a woman enters into areas thought to be masculine, they blame her for goals not achieved and low production.

Nowadays, organizing and leading abilities of men and women are being examined, resulting in possible changes in that hierarchical distribution of work. With no interest to colonize anyone or anything, men could give some proposals for reflection:

We men know, and even better, women know that inequalities can not be justified, explained or rationalized with biological, psychological or sociological causes.

How long are men going to believe they represent all humankind?

How long are we going to take to admit that our privileges exist at women's expense? How many of them can not be considered real privileges, compared with the benefits they would bring to everybody if they disappeared?

If there is going to be a masculine identity, it is necessary to erradicate suspicion, modesty and false heroism, in order to discover the things that must be kept in our masculinity.

We must listen to the man who does not want to compete and/or fight, the weak one, that one who is supported by his wife or couple, the father, that one who has no children, that one who loves another man, that one with unknown identity, that one similar to us and that one who is absolutely different.

We have to listen to them with no prejudice or fear of intimate approach to prove that variety counts and leads us to an authentic human dimension.

[36] The "hidden curriculum" refers to the existence of not very objective criteria used in open competitions for professional promotion, related to prejudices and cultural assumption.

Then, we must speak about us with affection and emotion, without speculations about our convictions. Maybe this way far from freedom, we can perceive the opression of our masculine model.

In opposition to non-critical uniformity, variety is creative and productive in the field of work.

Apart from money and economic remuneration, the importance of our work must be analyzed in terms of the benefits brought to our communities and families.

If we exclude, limit or hinder somebody from working, there will be somebody who will do the same to us.

It is almost impossible to be in the place of anybody else, specially if we still have not found our real place; and this will turn even harder if we have to accept others telling us which is our place.

Chapter XI

Final Reflections About the Experience

In the last pages of this book, there are some final reflections that summarize the main problems and situations reviewed from the perspective of practical experience of practitioners in the field of health. Based on their opinions, expressed in discussion groups held in Médicos del Mundo, some obstacles, alternatives and recommendations have been identified to integrate and work with gender dimension in health projects.

Looking inside ourselves

In order to work with gender issues, as well as with other aspects of identities, attitudes and abilities of people are absolutely decisive. The lack of ethics, together with mysogynist, homophobic or racist attitudes stop the development of equity-oriented projects that can therefore integrate the gender dimension. It is very important and necessary to review our own limitations here. We can find people with eurocentric, racist, mysogynist or homophobic attitudes very easily in our context or in others near to ours. It is difficult to part with the sexist culture where we are immerse. These are things that can be changed only by becoming aware of our prejudices. At this point, it is very important for DNGOs to be careful with the selection of personnel, trying to make a qualitative evaluation of attitudes in co-operators and practitioners. Beneficiaries will eventually identify our organization with the people working for us; for this reason, their attitudes and behavior may exert a positive or pernicious influence on their opinions, trust and respect. Therefore co-operators must be respectful to people and should develop their communication skills. They must be attentive and listen receptively to what people tell and consult, so they can develop the most appropriate ways of action. Co-operators must not get scandalized with comments or actions from people from the receptive country. They have to avoid making premature or too rapid jugdements based on their prejudices, ways of thinking or principles from their own cultures.

But… Who is getting benefited from my work?

Many times, we find differences between what is done in co-operation and what is actually needed. That may be due to the influence of exterior or commercial policies that affect projects, a wrong identification of needs and the own limits of internal policies inside the DNGO. Some difficulties in our jobs are explained by the changing trends of co-operation policies that fluctuate according to the interests or motivations of external relations, or temporary priorities by determined teams in the government. Institutional changes in international agreements, governmental policies and the presence of business interests can generate difficulties for the planning of long-term actions and the achievement of goals proposed. In co-operation for development, coherence and coordination of policies and the concentration of interventions are still unsolved problems. Besides this there is a little room of manoeuvre for DNGOs with respect to their relationships with financing organizations that define their objectives and ways to work. In short, it is not easy to separate the support for development from political, economic or commercial motivations. It is necessary to try to avoid the mixture of objectives that sometimes can be contradictory and can make co-operators and practitioners feel their work is absolutely useless. They can pass through big crises to make sense of their job; as a result they can even feel used in political games and interventions may lose their legitimacy.

Sometimes co-operators prefer to abandon their positions, if they consider their job is absolutely senseless; for this reason, making sense of people's work is so important. **The way to solve this crisis is extremely related to the possibility to go beyond political determining factors for co-operation and bad management and concentrate on the human dimension of projects. It means, in the direct relationship with people to be helped and the possibility to change their reality. Health needs, specially sexual and reproductive health, are so demanding that our help is the only way to make sense of our actions of co-operation.**

Identification requires more attention

In many cases, the actions of co-operation are determined by the central DNGO and the financing organization and they do not pay so much attention to the identification process. Sometimes the announcements demand projects that must be done and proposed rapidly so, they define their own priorities. In general terms, identification is made through a process based on exploratory operations used to reach agreements with local authorities. Later, it is sent to co-operators who are responsible for the identification of the real needs of beneficiaries and the future adaptation of the project proposed. It is really decisive to support this part of the process. The project may succeed or not

depending on this. When identification fails, the project is less likely to succeed. In this case, we must give the project a new direction, providing new patterns and making sure our organization understands it and the financial support is accepted and provided. It is highly recommendable to consider the integration of the projects to local health systems to ensure their synergy and sustainability, trying to avoid structures that can not be sustained for a long time.

The development of a process of identification is extremely crucial in all communities. It will include all the sectors involved. We know the experience of a pregnancy prevention programme for adolescents in schools; in this case, even though it was supported by the director and the sanitary institutions, parents complained about it for religious and cultural reasons, which were not implied in the project. Not only time but resources will be necessary if we are really interested in the development of our project. Short missions (one or two weeks) usually organized are not enough. The best way to do this is to live within the community where the project will be held for a consistent period of time.

How can we work with our counterparts?

To identify our counterpart is also very important. We have to make sure they share our basic principles of co-operation and do not over or undervalue their abilities. Projects should be politically sponsored and included into a governmental program; they must be supported and private and publically accepted. How can we be supported in such a delicate matter like sexual and reproductive health in countries of the arab world. There is no general formula; this will depend on each country and community. This may be a very slow process where we can start working in maternal-child health in order to reduce the maternal mortality rate and very slowly introduce aspects of family planning and reproductive health. It is important to talk to the community and not to force their ways to solve problems and to give solutions. But, do not forget that trying is one of our responsibilities. Projects can be associated with other more ambitious ones under a gender perspective: for example we can work indirectly for the prevention of AIDS, establishing a relation with adolescent pregnancy prevention, which can be more easily accepted by local authorities.

The importance of working together with the central office

Theoretical models do not always repond to our reality. For this reason, it is necessary for people at the central office to know better what we can see in our fieldwork, our limitations and opportunities. In order to do this, it would be necessary for them to start with some previous experience in developing countries, which allows them to develop some strategies to recognize possible situations there. Reality changes and the management of new projects must be flex-

ible to permit adaptation to new circumstances. It is crucial to obtain enough information in the follow-up and people working at the central office must put themselves in the shoes of those working abroad. Equally important is to have the support of the DNGO that must define their principles, policies or gender strategy in order to support the practitioners working on fieldwork, by providing an appropriate framework for negotiation and performance. We have to make sure that our work follows the general guidelines of the organization, so our counterparts and beneficiaries will never have the impression that integrating the gender dimension is our personal goal, but our organization's.

How to work with gender and sexual and reproductive health? Guidelines and principles for good practice

There can be methodologies to work with gender, but not successful recipes at all. You should get involved with open spirit, and persevere to understand all that is different and learn how to adapt to circumstances. Never force situations and avoid creating conflicts.

Listen, observe and learn

Probably it is not necessary to go very slowly, but make sure you go cautiously. If one intervention scheme successfully used in a neighborhood in a Spanish city is copied and applied somewhere else, our project will probably fail. Fist of all, it is deemed necessary to listen and observe with respect for some time. They know more than you about their own community, therefore you should assess and develop an exchange process with the community. Do not be afraid to fail, it is part of the process.

Do not take a single step without consulting all groups in the community including the smallest ones

It is necessary to join the relations processes of the community, which means to identify the pre-existing social nets. These ones are not formal spheres; they are more subtly perceived, less visible but equally important. You must consider all the groups and nets in the community and far from talking to them inquisitively, do it naturally as if you were talking to your neighbors. The project will succeed if everybody takes part in the process, otherwise, it will surely fail.

Count on men

It is extremely necessary and important to count on men. For example, a program of AIDS will surely fail if men are not involved; however, doctors will

necessarily have a separate surgery for them. It is possible that men have been interested in participating in the project all the time and we have not paid enough attention. Sometimes, all our formal ways and methods may not be effective enough, so in those cases, it will be better to use pre-existing social groups where they get together, exchange information and their members respect each other. In all topics related to sexual and reproductive health, it is important to involve women and men as well.

To generate trust and take care of relations

We may have difficulties to establish close relationships and feel really comfortable with beneficiaries of our projects. The problem may be rooted in the past with some other previous co-operation experiences and/or with attitudes of the personnel. Probably beneficiaries do not really trust our team because they feel that projects only mean more work for them. Maybe "we are the only ones who stayed". We have to establish a really close relation, especially if we are staying temporarily. It is then necessary to ensure stability in our relationships: when co-operators leave the place, relations usually deteriorate. To give them false promises or sending people to solve their personal problems is not appropriate. Those in charge of fieldwork are the ones who know the beneficiaries' reality, the ones who stay and take consequences of sporadic visits. Appropriate attitudes on fieldwork are crucial to generate relations of trust and fluid communication. For this, it is important to establish control mechanisms to avoid possible conducts opposed to our ethical principles of co-operation.

To support gradual processes

Sometimes, it is easier to begin with infrastructures, equipment and formation; so we can gradually include and talk about the most basic psychosocial aspects of reproductive health instead of involving SRH since the first actions of co-operation in the community. It is convenient to understand the right moment to deal with gender and SRH in each reality. For this reason, it is essential to involve gender analysis and accept our own limitations.

How to work the women empowerment?

Working with women may be easy if they are already organized in any way: cooperatives or groups around the health center, etc. Besides, depending on the cultural context we are, we will be able to talk about some topics and not about others. Empowerment is one of the most complex processes, where it is necessary to show some respect for the fact that everybody has their own rate. In any case, there will always be enough room to manoeuvre and identi-

fy needs and activities that contribute to empowerment and can be part of the project. Very frequently, it will be easier to work with concrete facts (for example, health problems and even the risk of maternal death derived from the high number of children or the little spacing between them) than working with ideas like "family planning". Empowerment can be more easily promoted with concrete actions than with explanations or speeches about rights. Women for example can feel more familiar with the solution of some problems like the regulation of the number of their children than with their participation in politics. They will participate openly if they can easily visualize concrete benefits.

Our experience has enriched us immensely, let's take advantage of it

All people interviewed have talked about their personal growth coming from experiences from fieldwork. We learn to be more humble. We learn that we could be racist or snob. We went through crises but we kept on growing towards best human communication. We learned to be more tolerating and not to be so fanatic; everything is relative. Co-operators have insisted so firmly that the experience can make you more socially receptive, specially if projects have been developed in small communities. It is important to look for the possibilities to take advantage of that experience after returning. Organizations should be more receptive about this in order to open spaces to meet and debate with emigrants who have taken part in this kind of projects. They could take more advantage of their experience in their organizations, in order to improve the processes of identification, according to their recommendations for each country and each specific reality. It would be interesting to link the action in the Third World with immigration and the Fourth World, here in our own country. We have so much to learn from those who have returned.

Appendix

The following appendix attempts to update the contents of this guide; it has taken into account all the changes occurred in the latest years, so they can be easily checked out and reviewed using the following references:

Gender in Development Goals of Milennium

Links to the UN sites on gender. Web link to the UN site focusing on general information on gender related topics:
http://www.onu.org/temas/mujer/
Internet link to the UN site on women:
http://www.un.org/spanish/womenwatch/

United Nations Millennium Declaration

The United Nations Millennium Declaration was approved and signed by 191 governments in the Millennium Summit of the United Nations held from 6 to 8 September 2000. With the participation of 147 leaders, it became the most numerous political leaders gathering in history. Governments committed themselves to "promoting gender equality and empowerment of women as an effective way to fight against poverty, hunger and illnesses; at the same time, they got involved in the promotion of truly sustainable development." The full text of the Declaration can be downloaded from the following site: http://www.un.org/millennium/declaration

The Millennium Development Goals

The Millennium Development Goals of the United Nations (MDG in English or ODM in Spanish) which were made public by the UN's general secretary in 2001, became the main guidelines for the implementation of the Declaration of the Millennium. A full version of the text is available at:
http://www.un.org/millenniumgoals/

Follow-up and development of the Goals of the Millennium

For the achievement of the Development Goals established, a project called "Millennium Project" was launched; it is related to the Secretariat of United Nations where experts from different countries participate making up ten different Task Forces especialized on each of the goals of the Millennium. Their works, altogether with their diverse contributions and research on the topic may be found in the following link: http://www.unmilleniumproject.org

Other references:

a) Grown, Caren and Gupta, Geeta, et al. (2005): *Taking Action to Improve Women's Health Through Gender Equality and Women's Empowerment*, Millennium Project, New York, 2005.

b) UNFPA (2004). State of World Population 2004: The Cairo Consensus at Ten: Population, Reproductive Health and the Global Effort to End Poverty. Available at: http://www.unfpa.org

c) OMS (2004) The World Health Report 2004–Changing History. Available at: http://www.who.int/en/

d) ONUSIDA (2005) Situación de la pandemia del SIDA. Madrid. Available at: http://www.unaids.org

e) WHO, UNICEF and UNFPA (2003). Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA. Available at: http://www.who.int

Beiging+10

Similarly to what happened in year 2000 with the revision of Beijing+5, as a consequence of the revision of Beijing+10 , an assessment of the commitments and objectives posed was deemed necessary; mostly those referred to reproductive and sexual health had to be revised. However, in the final declaration, though many of the goals have been achieved all along the decade since the Conference of Beijing was held in 1995, many important challenges and obstacles mainly referred to the fight for women's equality remain pending.

The full version of the Declaration of Beijing+10, corresponding to the 49th session of the Commission on the Status of women of the United Nations is available at: http://www.un.org/womenwatch/daw/review/

Cairo, ten years later

Since 1974 and every 10 years the United Nations have organized the International Conference on Population and Development. In the conference

in Cairo in 1974 (CIPD) they arrived at a concensus about a different approach which brought about big qualitative improvements and finally focused on people and their rights and not only in their own demographic goals (you can read about the CIPD on page 47 of the guide).

In Cairo+5, some "Key Measures to Continue with the Programme of Action" were specified. See:
http://www.unfpa.org/spanish/icpd/pdfs/icpd5_poa.pdf

The fact that the International Conference on Population and Development had not been held in 2004, is specially unusual; the goals achieved (Cairo+10) were evaluated in Regional Conferences and the Commission on Population and Development of the Economic and Social Council held in New York, in march and may 2004. The relevant documents can be read at: http://www.unfpa.org/icpd/10/archive.htm#intergovernmental

Gender and health in Spanish Co-operation

a) Strategy of Gender: OPE/SECI. "Strategy of Spanish Co-operation in the Promotion of Equality Between Men and Women". You can find the full text at: http://www.aeci.es/ope/index.htm

b) *Guide on gender: The Practical Guide for the Integration of Equality Between Women and Men in Projects of Spanish Co-operation*, edited in 2004, is a suplementary material if you are interested in the research of topics similar to those included in this guide. You can have access to an electronic version at: http://www.aeci.es/ope/index.htm

c) *Director Plan (2005-2008) The New Director Plan of Spanish Co-operation* that regulates the approach and the main guidelines for action of the Spanish Co-operation for the next four years, has included gender equality both as a very important part of main and secondary fields to be considered. The full document is available at:
http://www.aeci.es/14-Documentacion/Publidocs_secipi/docs_coop/index.htm

d) The VITA program: The Program of Co-operation for Development of Health for Africa, VITA program is an effort made to coordinate and supplement the actions carried out by workers and institutions there. Papers and presentations are available at: http://www.aeci.es/9-Proyectos/vita/index.htm

Glossary

Gender-based analisis: This is the basic tool within the GID approach. It is a process that assesses the different ways in which women and own participate at home, in economy and in society; It makes it possible to identify structures and policies that perpetuate the patterns of disavantage that women face (legislation, social and political institutions, socialization practices, employment practices and policies).

Androcentrism: or male cenderedness, takes male values or practices as the norm for all humans. It explains female values or practices as deviations from, or unsucessful aspiration towards, male ways of doing things.

Condition: of both women and men, refers to their concrete living and material conditions and immediate experience, expressed by means of the work they perform, the place where they live in, and their needs and those of people living with them.

Reproductive rights: They refer to exercise the right of integrity, safety and autonomy regarding how to treat his/her own body; the right of couples to decide on the number of children and the spacing among them; the access to information and education; the right to reach to higher levels in sexual and reproductive health and the right to make decisions in relation to reproduction out of discrimination, coercion and violence.

Empowerment: It can be defined as the process by means women (both individually and collectively) are able to develop their capacities and understand how power relationships exert influence in their own lives in order to be stronger and more self-confident to change gender inequalities at home and in their communities in national, regional and international terms. A complete definition of empowerment includes cognitive, psychological, political and economic factors that get interrelated.

Logical frame approach: It is an analytical tool for planning and managing objective-oriented projects.

Gender: roles, responsibilities and opportunities assigned to men and women according to their sex and the relationships given between them. These attibutes, opportunities and relations are socially build up and are learned through socialization processes. They are specific for each culture and can change over time, among others, as a result of political actions. In most societies, there are differences between women and men, in the activities they perform, in their access and control of resources and in their possibilities they have to make decisions.

Other important criteria of sociocultural analysis include social class, race, sexual orientation, level of poverty, ethnic group and age.

- **Ginotipia:** It is the impossibility to see the feminine part of things, or to accept the autonomous existence of women.
- **Homophilia:** This means to have sympathy for homosexuality.
- **Qualitative indicators:** They are defined as perceptions and judgements people make about a certain topic. For example, the trust people put in the sewing machines they use, gives them economic independence.
- **Quantitative indicators:** They are defined as measures of quantity. For example: the number of owners of sewing machines within a certain population.
- **Sexually transmitted infenctions:** These comprise all infections where sexual transmission has epidemiological importance and becomes the most important cause of bad health and death.
- **Integration (*mainstreaming*):** strategy that gives gender equality the main role in the most important political decisions, in institutional structures and allocation of resources; it includes the points of view of men and women to make decisions about the processes and objectives of development.
- **Gender interests:** Those that women (or men in some cases) can develop by virtue of their social position according to their gender attributes. These can be strategic or practical: each has a different origin and implications for women's subjectivity.
- **Masculinity:** the set of attributes, values, functions and conducts considered essential for men in one specific culture.
- **Morbility:** indicator used in epidemiology to assess the number of people affected by one specific illness in relation to the whole community.
- **Genital mutilation:** procedures involving total or parcial removal of the external female genitalia or any other kind of injure in these organs for cultural or therapeutical reasons.
- **Practical gender needs:** are needs of women playing active roles predetermined by society; they are also responsible for some predetermined social obligations, destined to the family and local community.
- **Strategic gender needs:** they are not derived from women efforts to fulfill their traditional obligations, but from their growing awareness on social impositions like dominance structures and masculine privileges that can be changed.
- **Position of women (or men):** refers to the unequal social, political, economic and cultural situation of women in comparison with men in a specific context. In gender relations, the situation of women is subordinated to men.
- **Gender relations:** this refers to those social relations determined by gender, which create relative differences between men and women in particular contexts. Relative positions are expressed by means of a set of reciprocal rights, obligations and responsibilities interrelated in a dynamic way that can be changed

and may eventually evolve. If economic, social or political circumstances are modified, whether by changes in the conditions of regional or global market, or by changes in the political context, rights and responsibilities defining roles of men and women are redefined according to those changes.

Sexual and reproductive health: a comprehensive approach to analyze and meet the needs of men and women regarding sexuality and reproduction. It comprises terms like rights, equity, dignity, empowerment, self-determination and responsibility in the life of men and women, in society, in the family or inside sexual relations.

Sexism: this means making unjustified hypotheses (or at least non fundamented) on the abilities, objectives and social roles of a person based on his/her sexual differences. Sexism, just like racism or many other attitudes based on prejudices, shows the imposibility to work with other groups different from the one of the individual.

Morbility rate: This is the number of people affected by illness in relation to the whole population.

Community work: refers to the collective organization of social events and services: ceremonies and celebrations, activities to improve the community, participation of groups and organizations, local political activities, etc.

Productive work: Production of goods and services destined to be sold and consumed.

Reproductive work: Refers to the maintenance of the house and the care for members of the family, including pregnancy and care of children, adults and old people, the preparation of food, collection of water and sources or energy, shopping, administration of the house and health care.

Feasibility (sustainability): feasibility or sustainability of actions or development projects is the ability of these actions (or their effects) to continue existing in time once the external support is out.

Acronyms

- DAC: Development Assistance Committee from OECD.
- CCIC: Canadian Council for International Co-operation.
- CEDAW: The Convention on the Elimination of All Forms of Discrimination against Women.
- CIDA: Canadian International Development Agency.
- ICPD: United Nations International Conference on Population and Development.
- LFA: Logical Framework Approach.
- STD: Sexually Transmitted Diseases.
- UNFPA: United Nations Population Fund.
- PCM: Project Cycle Management.
- GID: Gender in Development.
- HAP: The EC's Health AIDS and Population policy.
- STI: Sexually Transmitted Infections.
- WID: Women in Development.
- FGM: Female genital mutilation.
- OECD: Organisation for Economic Co-operation and Development.
- ILO: International Labour Organization.
- WHO: World Health Organization.
- DNGOs: Developmental Non-governmental Organizations.
- PAHO: Pan American Health Organization.
- UNDP: United Nations Development Program.
- AIDS: Acquired Inmune Deficiency Syndrome.
- SRH: Sexual and Reproductive Health.
- EU: European Union.
- UNIFEM: United Nations Fund for Women.
- HIV: Human Immunodeficiency Virus.
- UNESCO: United Nations Educational, Scientific and Cultural Organization.

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Internet Resources

- Agencia Española de Cooperación Internacional: www.aeci.es
- Comité de Ayuda al Desarrollo: www.oecd.org/dac/gender
- Coordinadora de ONGD–España: www.congde.org
- Instituto de la Mujer: www.mtas.es/mujer
- UE: www.europa.eu.int/dgs/development
- IV Conferencia Mundial sobre las Mujeres (Beijing: www.undp.org/fwcw).
- European NGO's for Sexual and Reproductive Health and Rights, Population and Development: www.eurongos.org
- Federación de Planificación Familiar de España: www.fpfe.org
- Fondo de Población de las Naciones Unidas: www.unfpa.org
- Foro de ONG Cairo + 5: www.ngoforum.org
- Global Reproductive Health Forum: www.hsph.harvard.edu/Organizations/healthnet
- Grupo de Trabajo de Igualdad de Género del CAD: www.oecd.org/dac/gender

- FLACSO, Simposio sobre participación masculina en la salud sexual y reproductiva:
  www.flacso.cl/bibliomasc.htm
- Health, Empowerment Rights and Accountability (HERA):
  www.iwhc.org/hera/index.htm
- Institute of Development Studies. Bridge (Briefings on Development and Gender):
  www.ids.ac.uk/bridge
- Isis Internacional:
  www.isis.cl/
- IPPF (Federación Internacional de Planificación Familiar):
  www.ippf.org
- Organización Mundial de la Salud:
  www.who.org
- Qweb Sweden (Red Mundial para la Promoción de la Salud de las Mujeres y la Igualdad entre los Géneros):
  www.qweb.kvinnoforum.se
- Reproductive Health Online–Reproline:
  www.reproline.jhu.edu
- RSMLAC (Red de Salud de las Mujeres Latinoamericanas y del Caribe):
  www.redesalud.web.cl
- Women Watch:
  www.un.org/womenwatch
- MDM España:
  www.medicosdelmundo.org
- Mujeres en Red:
  www.nodo50.org/mujeresred
- Population Information Program, The Johns Hopkins School of Public Health:
  PopRepts@welchlink.welch.jhu.edu
- Population Reports, Serie J, nº 4: Métodos de planificación familiar, nueva orientación, 1996:
  www.jhuccp.org/prs
- Oxfam:
  www.oneworld.org/oxfam/publish@oxfam.org.uk
- Emergency Contraception Website:
  www.opr.princeton.edu/ec/

- UNIFEM (Fondo de las Naciones Unidas para las Mujeres): www.unifem.undp.org
- Engender Health: Improving Women's Health Worldwide: www.avsc.org/
- Center for Health and Gender Equity: www.genderhealth.org/
- The Population Council: www.popcouncil.org/
- The International Women's Health Coalition (IWHC): www.iwhc.org/
- Hivafrica: www.hivafrica.org/
- Female Genital Mutilation Education and Networking Project: www.fgmnetwork.org/
- Maximizing Access and Quality: www.maqweb.org

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