HANDOUTS

COMPONENT A.3

H1

WORKSHOP OBJECTIVES

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

COMPONENT A.3

H2

EXPECTED OUTCOME

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

DEFINITIONS OF SEX AND GENDER

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

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

SIX CASE STUDIES

HOUSEHOLD / FAMILY SITUATION A

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

HOUSEHOLD / FAMILY SITUATION B

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

HOUSEHOLD / FAMILY SITUATION C

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

Continued

SIX CASE STUDIES (CONT.)

HOUSEHOLD / FAMILY SITUATION D

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

HOUSEHOLD / FAMILY SITUATION E

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

HOUSEHOLD / FAMILY SITUATION F

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

24 HOUR DAY CHART

HOUR	WOMEN	MEN
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		

COMPONENT 2.1

H6

DEFINITIONS: GENDER ROLES

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

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

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

COMPONENT 2.2

H7

DEFINITIONS: ACCESS AND CONTROL

ACCESS
is the ability to USE a resource.

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

FIVE TYPES OF RESOURCES

ECONOMIC RESOURCES

- work
- credit
- money
- etc.

POLITICAL RESOURCES

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

INFORMATION / EDUCATION

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

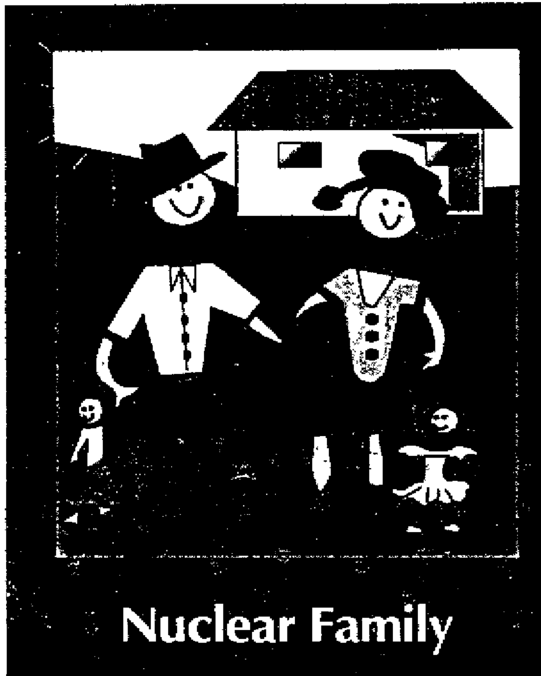
TIME

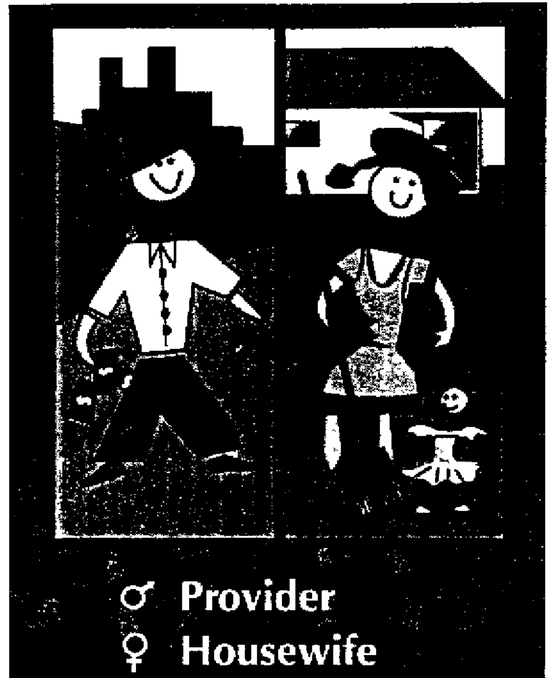
- ours of the day available for discretionary use
- flexible paid work hours

INTERNAL RESOURCES

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

STEREOTYPES 1, 2 and 3





CASE STUDIES: SCENARIO 2

Situation A, Part 2:

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

Situation B, Part 2:

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

Situation C, Part 2:

Sam is diagnosed with terminal lung cancer.

Situation D, Part 2:

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

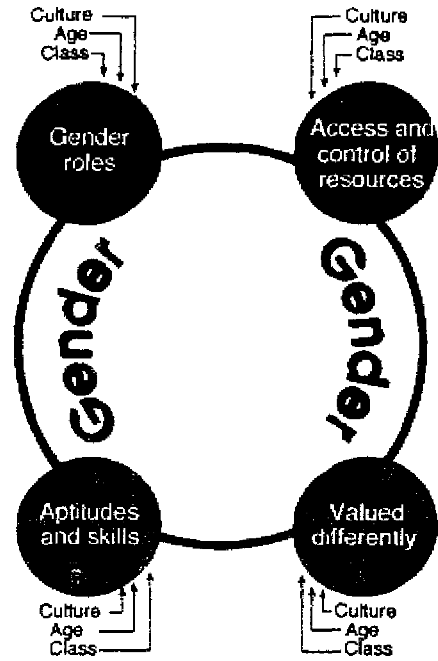
Situation E, Part 2:

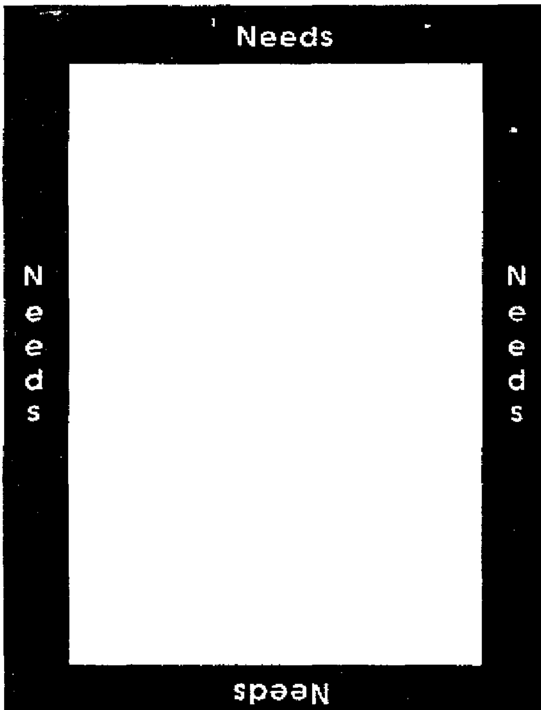
Jorge has an accident at work that cuts off his left hand. He is dismissed with minimal compensation and sent home.

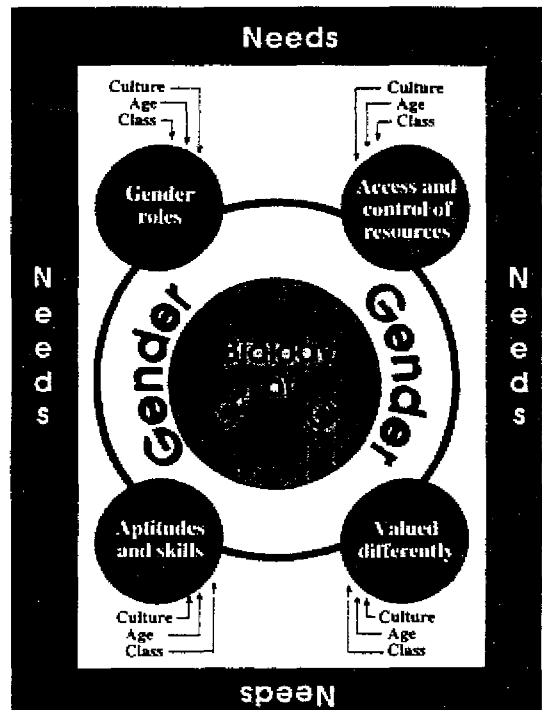
Situation F, Part 2:

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

SOCIAL/BIOLOGICAL







ORIGIN OF MALE/FEMALE DIFFERENCES IN HEALTH PROFILES

BIOLOGICAL DIFFERENCES

a) Anatomical/physiological;
b) Anatomical, Physiological and Genetic susceptibilities;
c) Anatomical, Physiological and Genetic resistances/immunities

SOCIAL DIFFERENCES

a) Roles and responsibilities;
b) Access and control;
c) Cultural influences and expectations;
d) Subjective identity.

HEALTH SITUATIONS CONDITIONS AND/OR PROBLEMS

1. Sex Specific;
2. Higher prevalence in one or other sex;
3. Different characteristics for men and women;
4. Generate different response by individuals/family/institutions depending on whether the person is male or female

PRACTICAL AND STRATEGIC GENDER APPROACHES

A. PRACTICAL GENDER APPROACH

- Responds to short-term needs.
- Responds to needs that are usually easily identifiable by users and suppliers.
- Responds to biological requirements and specific health conditions.
- Gendered health needs met through provision of health goods and services
- Tends to involve women and men as subjects of intervention
- Can improve the health condition of women and men through the access to resources.
- Usually does not change gender roles and relations

B. STRATEGIC GENDER APPROACH

- Tends to be a long-term strategy, as an integral part of sustainable human development.
- Responds to needs not always easily identifiable by people.
- Targets inequities between women and men in responsibilities and power relationships.
- Needs identified through empowerment processes: the creation of awareness, increased self-esteem, education, strengthening organizations, political mobilization, etc.
- Tends to involve people as active subjects or empowers them for this.
- Can improve the position of women by increasing their control over resources.
- Improves the balance of power between men and women in the use of health resources, through control over internal and external factors that affect the ability to protect health.

DEFINITION OF THE EMPOWERMENT PROCESS

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

MECHANISMS OF THE EMPOWERMENT PROCESS

INTERPERSONAL ENCOUNTERS
- Facilitate self-validation through dialogue

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

COMMUNITY ORGANIZATION
- Facilitate organization around common problems that go beyond personal interests

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

CONTINUUM OF EMPOWERMENT
Adapted from Ronald Labonte

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

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

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

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

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

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

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

Continued

LABONTE'S EMPOWERMENT CONTINUUM (CONT.)

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

a. *Interpersonal Encounters:*
Can occur at the level of direct service, where health workers interact directly with users.

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

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

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

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

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

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

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

c. *Community Organization.*
Support groups prompt people to organize around problems or situations that are specific to them.
Community organization, on the other hand, involves the process of organizing people around problems or sit-

Continued

LABONTE'S EMPOWERMENT CONTINUUM (CONT.)

uations that go beyond the particular interests of those involved Support groups allay the particular and specific suffering of each of their members; community organizations try to confront the causes of such suffering. Both types of organization are necessary for generating processes of individual and collective change.

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

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

d *Political Action Coalitions:*

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

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

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

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

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

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

PROMOTING BREAST-FEEDING[1]

General Findings:

1. Scientific evidence and research have demonstrated the benefits of breast-feeding for child survival, health and nutrition, maternal health, and child-spacing. Breast-feeding currently saves 6 million infant lives each year by preventing diarrhea and acute respiratory infections alone, is responsible for 1/4-1/3 of the observed fertility suppression, and can provide high-quality nutrition at a fraction of the cost of high-risk substitutes

2. WHO/UNICEF recommend that to ensure optimal maternal/child health and nutrition, the aim should be to enable all women to breast-feed their infants exclusively from birth for at least the first four months of life, and preferably for six months, and to continue breast-feeding, with the addition of adequate complementary foods, for up to two years and beyond.

3. In Latin America and the Caribbean, urban infants are not breast-fed as long as rural infants, and there is a rapid decline during the first three months in both groups. At 12 months of age, nearly half of the rural infants are still being breast-fed, but only 16% of urban infants apparently receive breast milk at this age.

4. Most studies on the subject show that breast-feeding decreases the case-fatality rate in children. In a case-control study in Brazil (Victoria et al., 1987), infants who received no breast milk were 14 times as likely to die of diarrhea as exclusively breast-fed infants

5. The extent to which hospital personnel and hospital routines foster or discourage breast-feeding practices among new mothers is one of the principal determinants of the rate of initiation of breast-feeding (Winikoff & Baer, 1980; Winikoff & Castle, 1989). Providers should have received adequate training in the practical aspects of lactation management and understand the needs of women who are breast-feeding.

6. The great majority of women in Latin America and the Caribbean have breast-fed their children. However, the recommended practice of exclusive breast-feeding during the first four to six months is rare. In almost all countries the early introduction of liquids such as water, teas, juices and cow's milk is prevalent. For example, in Lima, 80% of children have received water before one month of age (Altobelli, 1991, Brown et al., 1989).

7. Women have positive attitudes towards breast-feeding in the majority of countries but supplement with other liquids almost immediately. Some authors indicate that this supplementing is due to a lack of motivation on the part of the mother to breast-feed, which also is a socially acceptable reason for the introduction of early weaning However, one of the main reasons women give for supplementing breast milk with other liquids is their perception of not having enough breast milk to feed their children.

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

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