Globethics Repository



Mainstreaming Gender at Forum 6

This page was generated automatically upon download from the Globethics Repository. More information on Globethics see https://www.globethics.net. Data and content policy of Globethics Repository see https://repository.globethics.net/pages/policy.

Item Type	Conference proceedings
Authors	Doyal, Lesley
Publisher	Global Forum For Health Research
Rights	With permission of the license/copyright holder
Download date	2026-11-14 03:36:20
Link to Item	http://hdl.handle.net/20.500.12424/182602

Mainstreaming Gender

at Forum 6

A briefing document and resource guide

Lesley Doyal

Contents

Introduction 5

A. Plenary session: Measuring progress in gender issues 7
- Barbara Klugman, *Revaluing research priorities: challenges of mainstreaming gender in health research*
- Ruth Bonita-Beaglehole, *The prevention and control of chronic disease: a gender perspective*
- Geeta Rao Gupta, *Gender issues in HIV/AIDS research*

B. Parallel sessions 18

1. Gender and infectious and tropical diseases 18
- Rachel Tolhurst, *Researching gender issues in malaria management: a case study from the Volta region of Ghana*
- Uche Amazigo, M. Katabarwa, M. Noma, A. Seketeli, *Promoting gender sensitivity in community-directed tropical disease programmes: the case of onchocerciasis control (river blindness)*
- Jeannine Coreil, *Women's support groups for chronic tropical diseases*

2. Gender, mental health and disability 24
- Vikram Patel, *Gender and mental health research in developing countries*
- Ken Bassett, Iman Abou-Gareeb, Lyn Sibley, Susan Lewallan, Paul Courtright, *Is there gender inequity in global blindness?*
- Paul Courtright, *Do women have less access to cataract surgical services?*
- Robert Geneau, *Eye care service decision making by rural Malawians*

3. Gender and noncommunicable diseases 30
- Kate Hunt, Rani Elwy and Mark Petticrew, *Sex, gender and coronary heart disease: the geographical distribution of recent evidence*
- Nicola Christofides, *Why gender issues are an essential component in any research strategy relating to tobacco use in developing countries*

4. **Violence against women** 33
- Claudia Garcia Moreno, *The prevalence of sexual violence in four countries: first results from the WHO multi-country study*
- Mary Koss, Michelle Hynes, Victor Balaban, Jeanne Ward, Kathryn Robertson, Lumnije Decani, *Conducting gender-based violence research in conflict-afflicted populations: lessons learned from two pilot studies*
- Matthew Shaw, *A qualitative evaluation of the impact of the Stepping Stones sexual health programme on domestic violence and relationship power in rural Gambia*

5. Gender, sexual and reproductive health 40
- Sonia Pagliusi and M. Teresa Aguado, *Development of human papillomavirus vaccines for prevention of cervical cancer: a powerful tool to improve global women's health*
- Charles Nzioka, *Understanding the role of men in reproductive health research*

6. Gender, work and occupational health 44
- Suchart Trakoonhutip, Sally Theobald and Bent Gehrt, *Researching and organising to promote better health for electronics workers: lessons from Northern Thailand*
- Sophia Kisting, *Gender, work and reducing the burden of work-related disease: the African Joint Effort of WHO/ILO*
- Sally Theobald and Nanna Bali, *Gender and work: who does the caring in the family and the community and at what cost?*

7. Gender and child health research 50
- Shally Awasthi, *Access to health services for the child from a gender perspective*
- Marian E. Jacobs, *Rights perspective on child health research*
- Shafika Nasser and Mervat El Rafie, *Gender and child health and nutrition*

Conclusion 54

Annex: Gender-specific sessions at Forum 6, Arusha, Tanzania, 12-15 November 2002 55

Introduction

During the last decade there has been a growing acceptance of the importance of gender concerns in public policy. The Platform for Action of the 1995 UN conference in Beijing set out a framework for understanding the negative impact of gender inequalities on individuals and on the wider society. Both national and international policy-makers have now begun to take these issues more seriously as they reshape development policies in the context of global restructuring. This has been especially evident in the health field.

It is against this background that the Global Forum for Health Research has taken up gender issues with considerable vigour over the last two or three years. The aims of this work have been twofold: to ensure better science and to promote gender equity. The Global Forum is now committed to mainstreaming gender through all its work. This was clearly reflected in Forum 6 in Arusha, Tanzania (November 2002) where the programme was planned to ensure that gender issues were high on the agenda. All participants were also given a briefing document and resource guide entitled *Sex, gender and the 10/90 gap.*

One of the plenary sessions at Forum 6 focused on gender and this was followed by seven workshops on related themes (a full list of sessions and speakers can be found in the Annex to this text). These included sessions on sexual and reproductive health and gender violence which have traditionally been seen as 'women's issues'. However most of the presentations were concerned with gender aspects of health problems that affect both sexes. These included HIV/AIDS, malaria and coronary heart disease as well as depression and blindness. Very importantly, these presentations were not concerned only with women's health and the presenters included men as well as women. It is a key part of the Global Forum's position that gender is not just a women's issue. Men are also affected by gender divisions and men also need to take them seriously. That is what we mean by mainstreaming gender.

This briefing document for Forum 7 offers a summary of the main ideas presented in the gender sessions at Forum 6. These are based on the original documents provided by the presenters, to which suggestions for further

reading have been added to follow up the ideas in the session[1]. Though the presentations cover a wide variety of topics, they are held together by a number of key themes: the importance of taking both biological sex and social gender into account in planning and undertaking health research, the value of both quantitative and qualitative methodologies depending on the subject of study, and the importance of pursuing greater equality between women and men as both study participants and researchers.

[1] Some of these resources relate directly to points made in the text and others open up the topic more broadly.

A. Plenary session

Measuring progress in gender issues

The gender stream began with three papers examining the integration of gender concerns into different spheres of health research. Barbara Klugman's paper took a national perspective, reporting on the progress made in mainstreaming gender in health research in South Africa and outlining the many challenges that still remain. Ruth Bonita highlighted the emerging gender issues in tackling noncommunicable diseases while Geeta Rao Gupta reviewed the history of gender in HIV/AIDS research and outlined future priorities.

- **Barbara Klugman**
  Revaluing research priorities: challenges of mainstreaming gender in health research[2]

Mainstreaming gender in health research is designed to achieve two goals: the recognition of groups (usually women) who have been excluded and the redistribution of resources in favour of those groups. There is a need to redress the historical balance that has paid more attention to the men's health and maternal health at the cost of women's health beyond the reproductive arena. Educational and workplace opportunities also need to be redistributed to redress the historical exclusion of women from the research terrain.

If these goals are to be achieved four issues need to be addressed:

— **Content**: what is studied and in what groups of people?
— **Process and methods**: how is the research done and who gains from it?
— **Funding**: who controls the allocation of resources and what criteria are used for this?
— **Doing the research**: what is the gender balance of researchers, who leads research and who is being trained?

[2] The full text of this paper with detailed discussion of the South African experience can be found on the Global Forum's website: www.globalforumhealth.org. The text also includes a gender analysis framework for application in a range of different health settings. At Forum 6, the paper was given by Nicola Christofides on behalf of the author.

The **content** of health-related research needs to be refocused to include much greater emphasis on gender differences in a wide range of issues including determinants of health, vulnerability to disease, health-seeking behaviour, access to services, experiences of health care and treatment options and outcomes. Proper attention will need to be paid to the relationship between biological sex and social gender in shaping the health of both women and men and this will need to be reflected in the use of appropriate disaggregated data.

In South Africa a major step forward has been taken with the introduction of the regular Demographic and Health Surveys. All data are presented for both women and men and important questions are asked relating to male/female differences in topics as diverse as obesity, hypertension, injuries and the division of labour in water-carrying. However much work will be needed to ensure that women and men are also more equally represented in one-off research studies undertaken within South Africa.

An important area for future work will be gender-sensitive evaluation of health interventions. In particular there needs to be much more research incorporating gender analysis of household distribution of resources, use of services, access to information and power and decision-making processes. This shift of focus will be encouraged under the new Gender Policy Guidelines of the South African Department of Health which require senior mangers to conduct gender analyses of their programmes and to make the changes necessary to promote greater gender equity.

If the **process and methods** of health research are also to be more gender sensitive, more efforts will be needed to involve those who are being researched. Particular attention will need to be paid to women who have historically been the most marginalised. Some South African researchers have had a long history of interest in participatory research but this is only now beginning to spread to the mainstream. This has been especially evident in evaluations and operational research. With gender in mind, the Women's Health Project has been involved in a number of projects with provincial departments to develop ways of involving service users in defining problems and creating better services to meet the particular needs of men, women and children.

As well as making studies more participative, it is also important to ensure that the research design is appropriate. One obstacle to achieving this is the lack of researchers with the appropriate skills in gender analysis in health research. This is now beginning to be addressed in South Africa with the introduction of specialist courses. Progress is also being made in developing guidelines for ensuring that all research participants give their full consent especially poor women who may be especially vulnerable.

Gender issues in the **funding** of research will be addressed in part through the requirement that the newly established Essential National Health Research Committee conducts a priority-setting exercise every five years in collaboration with NGOs, community groups, government departments and other key stakeholders. This will focus on the health problems with the biggest impact on morbidity and mortality and particular attention will be paid to the needs of marginalised groups. The committee will also review the spending plans of all government-funded health research bodies. This offers the opportunity for mainstreaming gender alongside other equity issues in the South African research agenda.

As well as reshaping the criteria for determining priorities, further attention also needs to be paid to **who is doing the research**. The proportion of male and female researchers does not necessarily determine the content of studies. However it would appear that, in general, women are more likely than men to be concerned to address gender disparities. The principles of equity also require that they are given equal opportunities to enter and progress through the research community. Thus more work is needed to examine the gendered nature of research institutions as the basis for developing policy to promote greater equity.

In South Africa there have been many policy initiatives to overcome historical disadvantage. They have not always paid attention to gender as well as race but recent figures indicate that black women are now in the majority among those graduating from a Master's degree in public heath. The Health Research Policy has been concerned to increase the capacity for public health research among black people and women. This will need to be combined with a strategy for helping women researchers to have equal access with men to promotion opportunities as specified in the South African Employment Equity Act.

This presentation has highlighted the challenges to be faced if gender equity is to be achieved in medical research. It has shown some of the impressive progress already made in South Africa but has also demonstrated the impossibility of quick fixes. Like other developing countries, South Africa needs a critical mass of local researchers able to do rigorous and relevant work in gender-sensitive ways.

For further information contact: bklugman@sn.apc.org.

Further reading

Department of Health (2001) *Health Research Policy in South Africa* Pretoria: Department of Health

Department of Health (2002) *Gender Policy Guidelines* Pretoria: Department of Health

Fonn S & Khin San Tint (2002) Transforming reproductive health services in South Africa: women's health advocates and governments in partnership in N Haberland & D Measha (eds) *Responding to Cairo – case studies of changing practice in reproductive health and family planning* New York: Population Council

Cornwall A & Gaventa J (2000) From users and chooser to makers and shapers: repositioning participation in social policy *IDS Bulletin* 31 (4) 50-62.

- **Ruth Bonita-Beaglehole**
  The prevention and control of chronic diseases: a gender perspective[3]

The rapid rise in noncommunicable diseases (NCDs) and injuries represents a major challenge to global public health. It disproportionately affects poor and disadvantaged populations and widens the health gaps within and between countries. Many of those countries undergoing the epidemiological transition now have to cope with the 'double burden' of both communicable diseases and NCDs and injuries. This affects women and men in different ways.

In terms of life expectancy women have the advantage over men. This is partly biological and partly due to gender differences in risk behaviour.

[3] This presentation was based on an unpublished paper by Annemieke Brands, Tobacco Free Initiative, WHO.

When this mortality gap is very small it points to the existence of cultural, social or economic discrimination against women which acts to cancel out their 'natural' advantage. But longer life expectancy does not necessarily mean a healthier life. This is especially important as the 'feminisation' of aging means that many more women are entering their later years without having had the necessary health promotion inputs earlier in their lives. This is especially true for those surviving in poverty. Moreover many are now having to continue unpaid caring well into old age as a result of the HIV/AIDS epidemic in particular.

Many different factors are driving the increase in NCDs and injuries, some of which are amenable to intervention while others are not. In each case we can see that there are gender dimensions that affect both women and men. The most immediate cause of the increase is the rapid demographic and social changes that underlie the health transition. These changes are often the result of success in earlier policies but the challenge now is to ensure that as (majority female) populations age they do so in healthy ways.

In 2000 there were about 605 million people aged 60 and over. In just 25 years that number will double to about 1.2 billion. The majority of older people are women (55%) and among those over 80 this increases to 65%. One consequence of these changes will be a global increase in hip fractures from 1.7 million in 1990 to 6.3 million by 2050. At the present time the majority of these fractures occur in the developed counties but 50 years from now 75% will be in developing countries.

The second set of factors driving the increase in NCDs and injuries consists of infectious diseases, under-nutrition and trauma. One example of this is the blindness caused by trachoma, onchocerciasis and vitamin A deficiency. Another example is the human papilloma virus (HPV) which can lead to cancer of the cervix which kills more than 200,000 women each year mostly in developing countries. Efforts are being made to develop vaccines to combat this huge example of global inequity.

Injuries and violence may also lead to chronic disability. Every year some 3.8 million men and 1.9 million women die from injuries. Thus men are much more likely than women to die from this cause. However more than half a million women also die each year from the complications of pregnancy and childbirth, about 90% of them in sub-Saharan Africa and Asia. Around 300 million are left with serious pregnancy-related health problems and disabilities including anaemia, uterine prolapse, fistulae and infertility.

Alongside the impact of infectious diseases and trauma, changing patterns of consumption also contribute to the increase in NCDs. In particular the increase in tobacco consumption has been evident in rising levels of lung and other tobacco-related cancers and chronic respiratory disease as well as in heart disease, stroke and a range of other chronic health problems.

Overall women now make up only one in five of the world's smokers. However their smoking rates are increasing rapidly in some parts of the world. This reflects in part the activities of the tobacco companies who see them as an important new market. Growing evidence suggests that the health consequences of smoking for women may be even worse than they are for men and there may be both social and biological reasons why they find it harder to quit. Hence it is important that tobacco control policies should be gender sensitive.

The fourth group of factors driving the increase in NCDs includes rapid urbanisation, changes in work opportunities and social disintegration. These influences work in complex ways but some of their effects can be observed in the rising incidence of mental disorders especially in disadvantaged countries and communities. Here gender plays a critical role.

Although there are no differences between women and men in the overall prevalence of mental disorders, there are significant differences between them in the pattern of these problems over the life cycle. The most striking differences are evident in adulthood with women experiencing more anxiety and depression, post traumatic stress disorder and eating disorders. A significant factor here is often gender violence. Men are more likely to experience problems with alcohol and drug abuse and anti-social behaviour and are also more likely to commit suicide. Women and men also show significant differences in health-seeking behaviour for problems of this kind.

Finally it is clear that some of the rise in NCDs and injuries is the result of failures in the delivery of health services. In many parts of the world resources are seriously challenged by HIV/AIDS and other infectious diseases. Chronic diseases are harder to treat and the time lag between exposure and emergence of symptoms complicates this still further. The resulting focus on acute disease and mortality rather than morbidity can inadvertently result in discrimination against women. The failure to tackle cervical cancer in resource poor settings offers a good illustration of this.

If the challenges of NCDs and injuries are to be addressed in a gender-sensitive way a five-point programme is suggested:

- Producing more gender-specific information to demonstrate the differences between women and men in the causes and impact of the rise in NCDs
- Addressing the double burden of disease through synergies between existing programmes for infectious diseases and control strategies for NCDs
- Developing global and national multi-sectoral policies to reduce risk factors especially smoking
- Transforming health services to respond to needs of patients with NCDs and reinforcing the importance of primary care in the delivery of gender-sensitive services
- Expanding appropriate partnerships with NGOs and the private sector with a particular focus on alleviating the poverty of poor women.

For further information contact bonitar@who.int.

Further reading

Bonita R (2000) *Women, heart diseases and stroke: a global perspective* paper prepared for First International Conference on Women, Heart Disease and Stroke

WHO (2000) *Women's Mental Health: an evidence based review* Geneva: WHO

WHO (2002) *World Report on Violence and Health* Geneva: WHO

WHO (2001) *World Health Report 2001- Mental Health: New Understanding: New Hope* Geneva: WHO.

- **Geeta Rao Gupta**
  Gender issues in HIV/AIDS research[4]

  Over the past decade, social science researchers have identified the role that gender plays in shaping individual risk and vulnerability in the HIV/AIDS epidemic. They have also shown how gender influences the level and quality of care that women and men receive, the burden of care taken on by women and men when family members are sick as well as the gendered economic and social consequences of HIV/AIDS. This presentation explores the following themes:

  — How HIV researchers discovered the importance of gender.
  — Why gender needs to be more fully integrated into HIV research.
  — Key gaps in gender/HIV research and the challenges that lie ahead in filling them.

  In the early years of the epidemic, the focus was mainly on female sex workers and on men who engaged in high risk behaviour, with the main concern being to encourage the use of condoms. However this narrow focus broadened during the 1990s as it became clear from programme evaluations that behaviour could not be changed without an understanding of the socio-cultural, economic and political contexts within which women (and men) were making sexual choices. At the same time epidemiological evidence showed that more and more women were becoming infected even when they only had one partner. Hence the focus shifted towards investigations into the factors contributing to risk in women.

  Between 1990 and 1997 the International Center for Research on Women (ICRW) funded by USAID carried out 25 different studies using a range of quantitative and qualitative methods. The findings from these and similar studies shifted discourse and practice in the world of HIV/AIDS. It was clear that women's gender put them at a disadvantage and hence they needed to be empowered by improved access to information and productive resources as well as having their sexual and reproductive rights guaranteed. But the 8findings were not heard or seemed too hard to implement so that the primary message remained condom use for men.

[4] The full text of this presentation is available on the Global Forum's website (www.globalforumhealth.org) and offers the author's more personalised account of the history of gender/HIV research.

With no change in practice, the proportion of women infected continued to rise especially in sub-Saharan Africa and the role of gender violence in the epidemic was highlighted. At the same time evidence began to emerge that men too were affected by gender norms. Men who had sex with men talked about the pressure on them to be heterosexual, assertive and self-reliant and other men gradually spoke of similar constraints. Thus it became clear that gender norms made both women and men more vulnerable to HIV. The solution seemed to lie not just in empowering women but in changing definitions of masculinity and femininity in ways that were acceptable to all. Though women were clearly at an overall disadvantage in society, both men and women would be required to change their behaviour if the epidemic was to be controlled.

Since then, a huge amount of data has emerged on gender differences in needs, constraints and outcomes. Epidemiological analysis, programme evaluations and in-depth quantitative and qualitative research on women, men and adolescents have all contributed to the evolution of knowledge of the role that gender plays in the epidemic. It is now possible to summarise the ways in which knowledge of gender issues is central to understanding and controlling the epidemic and why gender needs to be fully integrated into all future research.

Gender analysis helps us to understand the vulnerability of individual women and men, boys and girls. At the same time, it improves our understanding of the epidemiology of HIV/AIDS. It can help to explain for example, why there is such a high rate of new infections in young women aged 15-24. This in turn can help in the design of appropriate policies. Biomedical interventions will often have a different impact on women and men. It may be much more difficult for women to agree to be vaccinated, for example, since this would be likely to lead to much greater stigma. This would be even more problematic if the vaccine had to be administered to young girls and boys prior to the initiation of sexual activity.

Access to HIV/AIDS services can also be increased through gender analysis. This can be illustrated by the example of anti-retrovirals used for preventing mother-to-child transmission. Early attempts at such initiatives had very limited uptake which could only be explained by talking to the women themselves. They were reluctant to be tested at a time when they

were most vulnerable and when they feared their partners might blame them for bringing the infection home. Some men were jealous of services available only to women and the women themselves were afraid of being stigmatized if they were seen leaving the hospital with cans of milk. Only when these concerns were taken into account could the full potential of the drugs be realized.

The final part of this presentation briefly identifies some of the important gaps in our current knowledge of HIV/AIDS and the challenges we face in filling them. The greatest priority must be for more operations research. More work is needed to understand gender constraints on service use and to translate existing knowledge into usable guidelines for policy-makers and service-providers.

In order to do research of this kind, the right indicators need to be developed. The concept of power in relationships needs to be operationalised and tools are needed to measure the construct of empowerment and individual agency. New strategies are also needed for measuring the effectiveness of multi-sector programmes. These are frequently cited as the way forward but more work is needed to determine how these are best delivered.

In the last analysis, tackling the HIV/AIDS epidemic requires normative change. Hence there is also a need to test different models of community mobilization and education. If stigma is to be ended and the culture of silence around sexuality is to be opened up, models of change need to be tested and the findings widely disseminated. At the same time different models of advocacy need to be tested so that a gender-responsive political climate for combatting HIV/AIDS can be put in place.

For further information contact: geeta@icrw.org.

Further reading

ELDIS (2003) *Dossier on Gender and HIV/AIDS* available from http://www.eldis.org/gender/dossiers

Feldman R, Manchester J, Maposhere C *Positive Women: voices and choices (Zimbabwe project)* International Community of Women Living with HIV available from http://www.icw.org/icw/files/VoicesChoices.pdf

Kistner U, Nkosi Z & Fox S (2003) *Gender-based violence and HIV/AIDS in South Africa: a bibliographic review* CAARE/Department of Health available from http://www.genderandaids.org

Rao Gupta G (2000) *Gender, sexuality and HIV/AIDS: the what, the why and the how* Plenary address to the XIII International AIDS conference Durban, South Africa, July 2000 available from http://www.icrw.org.

B. Parallel sessions

1. Gender and infectious and tropical diseases

In this session three papers examined gender aspects of major tropical/ infectious diseases. Rachel Tolhurst focused on malaria management in Ghana, Uche Amazigo discussed the control of onchocerciasis in Africa while Jeannine Coreil evaluated the success of support groups for women with lymphatic filariasis in Haiti.

- **Rachel Tolhurst**
  Researching gender issues in malaria management: a case study from the Volta region of Ghana

This presentation reported on a case study of malaria management from the Volta region of Ghana. The main aim of the project was to analyse the impact of gender and socio-economic inequities on both the burden of malaria and access to related services. This analysis was then used to help health district management teams to identify and prioritise strategies designed to promote greater equity.

The study was undertaken by local health workers who were not trained researchers. They used a number of different qualitatative methods to explore community perceptions of preventive measures, health-seeking behaviour and the impact of the disease. The rapid assessment techniques included focus group discussions, community mapping exercises, seasonal calendars, critical incidence interviews and role plays. The teams themselves analysed the data which was then fed back to different groups of women and men through drama. Strategies for action were discussed at community meetings and plans of action developed by district teams.

All socio-economic groups reported difficulties in accessing treatment but not surprisingly the barriers were greatest for the poor. The poorest group were also found to suffer most from the impact of fever. Women appeared to face particular problems. In the first place they tended to lose more time than men through fever and this affected their livelihood. They also reported on the complex and difficult decisions they often had to face in relation to both their

own treatment and that of their children. Many complained that as caregivers they were expected to pay for the treatment of children who are especially vulnerable to severe and complicated malaria requiring immediate care.

In response to these findings, voluntary, informal, community-based social insurance schemes or 'mutual health organisations' were developed. Within these schemes particular emphasis was placed on promoting men's financial contributions, on the one hand, and on the active participation of women in leadership and decision-making, on the other. Educational campaigns were also designed to encourage couples to plan together for equitable sharing of the burden of health care payments while health education campaigns were targeted at men as well as women.

Community members reported that they had learned from the experience and both women and men did report some changes in patterns of behaviour. However these changes were limited and showed the strength of commitment to traditional gender roles. Though some men now acknowledged that they should be acting more responsibly towards their children they did not shift in their view of the mother as the major carer.

The health workers also felt that they had learned more about the perceptions and problems of the community and gained greater understanding of inequalities and differing needs in the population.

However their own practice as health care workers was often resistant to change and again attitudes to gender issues could be especially strong. Women had low status and were treated accordingly.

One of the main conclusions of the project was that attention to gender is a crucial part of a poverty-focused response to the challenges posed by malaria (and other infectious diseases) in developing countries. Current malaria control strategies use local initiatives to ensure prompt appropriate treatment at the primary level. These will be limited in their effectiveness unless gender issues are taken seriously. However it was clear from this project that changes in this dimension of social relations will not be easy to achieve and creative strategies for change will be required.

For further information contact: rj.tolhurst@liv.ac.uk.

Further reading

Heggenhougen K, Hackethal V, Vivek P (2003) *Behavioural and Social Aspects of Malaria Control* Geneva: WHO ch 6

Molyneux C, Murira G, Masha J, Snow R (2002) Intra-household relations and treatment decision making for childhood illness: a Kenyan case study *Journal of Biosocial Science* 43 (1) 109-31

Tin-Oo, Pe-Thet-Htoon, Khin-Thet-Wai, Parks W, Bryan J (2002) Gender, mosquitoes and malaria: implications for community development programs in Laputta, Myanmar *South East Asia Journal of Tropical Medicine and Public Health* 32 (3) 588-94

Lampietti J, Poulos C, Cropper M, Mitiku H, Whittington D (1999) *Gender and Preferences for Malaria Prevention in Tigray, Ethiopia* Washington DC: World Bank.

- **Uche Amazigo, M Katabarwa, M Noma and A Seketeli**
  Promoting gender sensitivity in community-directed tropical disease programmes: the case of onchocerciasis (river blindness)

  Onchocerciasis currently affects around 18 million people in some of the poorest countries in Africa and the Americas. It is the second most important infectious cause of blindness in the world and more than 884,000 DALYs are lost each year as a result of severe itching from onchocercal skin disease. It is also a major cause of poverty in affected areas. The main public health strategy for dealing with this problem is annual Ivermectin treatment for all eligible people in target communities.

  Over the past few years this community-directed treatment (ComDT) has been implemented in the African region through the African Programme for Onchocerciasis Control (APOC). A recent evaluation of APOC concluded that it had been highly effective. However there is also evidence that its effectiveness could be increased still further if gender issues were taken more seriously in its planning and implementation. This presentation examined the evidence for this claim and discussed its implications.

  Reviewing the work of APOC from a gender perspective, two interconnected problems have been identified: lack of female participation in decision-

making about how community programmes should be implemented, and failure to include women as community directed distributors (CDDs) of Ivermectin and health educators.

Gender bias in the development of programmes was seen to stem from the fact that women were much less likely than men to attend meetings and were also less likely to be active in decision-making. When asked why they had not attended the majority of women said that this was because they had not been informed about the meetings.

A number of factors limit the choice of women as CDDs. These include their generally lower status, lower levels of literacy and in some communities their seclusion within the home. This dominance of men among CDDs has a major impact on patterns of service delivery. The particular needs of women are less likely to be taken seriously as are the cultural dimensions of their attitudes to the disease. In some cases, husbands would not allow other men to enter their houses and as a result women would be denied access to the drugs. Very often health information was given to the male partner rather than the woman and this may not be an effective means of information transmission.

If the work of APOC and similar initiatives is to be improved still further, gender issues need to be mainstreamed through all stages of the planning and delivery of services. In particular there needs to be much more attention to gender-related issues in research. More needs to be known about the impact of gender on decisions about treatment. Do men and women judge the seriousness of the illness differently? Are women afraid of side effects such as miscarriage? What gender-related factors influence the uptake of Ivermectin? In particular how can services be better delivered to women living in seclusion? These questions are unlikely to be answered (or even asked) unless more women become involved as researchers and as CDDs. This in turn will improve not only treatment coverage but the self esteem of the women themselves and their status in the community.

For further information contact: ucamazigo@hotmail.com.

Further reading

Katabarwa et al (2002) Involvement and performance of women in CDTI in Rukunguri District: a knowledge, attitude and practice study *Health and Social Care in the Community* vol 10 issue 5 pp 382-393

Clemmons L, Amazigo U et al (2002) Gender issues in community directed treatment with ivermectin (CDTI) of the African Programme for Onchocerciasis Control (APOC) *Annals of Tropical Medicine and Parasitology* supplement 1 S59-74

Vlassoff C, Weiss M et al (2000) Gender and the stigma of onchocercial skin disease in Africa *Social Science and Medicine* 50 (10) 1353-68.

- **Jeannine Coreil**
  Women's support groups for chronic tropical diseases

Support groups have long been recognised in the developed countries as offering a low cost (or free) psycho-social intervention for those living with chronic diseases. Over the years it has been women who have been at the forefront of many of these developments and there are now over 2000 such groups in the US. In developing countries these groups have received relatively little attention though they are beginning to spring up in a number of different settings, often in the context of the HIV/AIDS pandemic. This presentation reports on the results of an experimental study of support groups for women with lymphatic filariasis carried out Leogane, Haiti in 1998-2001.

Lymphatic filariasis affects 120 million people worldwide and is the second leading cause of disability. Those who contract it are frequently stigmatised and often suffer loss of livelihood. Because of damage to the lymphatic system many suffer from elephantiasis or hydrocele and both these conditions are much more likely to affect women.

Five support groups were set up in the Leogane area and followed up over two years. The effectiveness of the groups was measured in a case control survey at one and two years using both process and impact indicators. In 1999 these surveys involved 79 members and 77 controls while the comparable figures for 2000 were 83 and 101. Overall the groups appeared to be very successful on a number of different levels. Most obviously they

generate high levels of enthusiasm as well as being very quickly 'Haitianised' or adapted to local circumstances.

The activities of the groups had a strong spiritual flavour and they were closely linked with local churches. Much time was spent on expressive activities such as art and music but they also had more practical elements. Many developed the skills of their members in sewing, cooking and other activities as well as offering the opportunity for economic activities and income generation and for broader political organisation. The wider social benefits of participation were therefore clear.

But the study also showed that interventions of this kind could have a positive effect on the disease itself. Those who participated in the groups reported both a lower frequency of acute attacks and also less difficulty in living with the disease. They had a better understanding of the etiology of the vector and were more likely to follow recommended home care practices such as leg elevation and daily foot washing.

More generally some women reported the acquisition of leadership skills, planning and coordination and other group management capacities. This was obviously of benefit both to individuals and to the wider community providing an important increase of social capital. There were some concerns about the sustainability of these particular groups due largely to the lack of resources and the overall political economic situation in Haiti. However the study itself demonstrated the potential value of support groups in helping women in resource-poor settings to cope with chronic disease and disability in what may often be hostile environments.

For further information contact: jcoreil@hsc.usf.edu.

Further reading

Coreil J, Mayard, G & Addiss D (2003) *Self Help Groups for Women with Lymphatic Filariasis in Haiti* Geneva WHO

Coreil J, Mayard G et al (1998) Filarial elephantiasis among Haitian women: social context and behavioural factors in treatment *Tropical Medicine and International Health* 3 (6) 467-73.

2. Gender, mental health and disability

Five papers from this session are included here. The first one by Vikram Patel focused on the disability caused by mental illness in poor women while Florence Baingana explored the possible links between mental health problems in men and the gender gap in mortality in transition societies in Eastern Europe. Three interconnected papers by Ken Bassett and colleagues, Paul Courtright and Robert Geneau then examined different aspects of the physical disability of blindness. All are concerned with the links between socio-economic and gender inequality and the impact that both have on health status and health care.

- **Vikram Patel**
  Gender and mental health research in developing countries

Not only is most health research funding spent on projects directly relevant to the needs of those living in the rich countries. Where studies are focused on developing countries there is also a huge gap in the distribution of resources between different health problems. Thus far, infectious diseases including HIV/AIDS have received most attention while noncommunicable diseases (NCDs) and mental health problems have been largely ignored. A review of the country of origin of articles published in six leading psychiatric journals between 1996 and 1998 found that only 6% came from regions of the world which account for over 90% of the global population.

On a rough estimate, about 10% of health research funds spent in developing countries are concerned with NCDs and about 10% of this relates to mental health. This may not seem surprising given the epidemiological reality of current patterns of mortality especially the re-emergence of some of the most severe infections. However it ignores the huge burden of mental illness in particular borne by some of the world's poorest populations.

Failure to pay attention to mental health is compounded when research also pays little attention to gender issues. Gender has a major impact on mental health status and access to care for both women and men. These links can be illustrated with particular clarity through a review of research on depression and anxiety. Here it is women whose mental health problems

are shown to be shaped by their gender but similar analyses can also be made for men.

Depression is the single largest contributor to DALYs lost across the world according to the World Health Report 2001. Though there continues to be a dearth of relevant research, rates are reported to be especially high in a number of developing countries. Those who are poor appear to be at particular risk of developing such problems which can increase their deprivation. Within these settings women are almost twice as likely to experience depression as men though there are considerable differences between countries in the male: female ratio.

There continues to be considerable debate about the causes of these gender differences. The huge cross-cultural variation in the sex ratio for depression calls into question any simple hormonal explanation for women's higher rates of depression. However there is growing evidence that oppressive relationships built on gender discriminatory attitudes may be important risk factors. At the same time, women may face the greatest brunt of economic problems in the family as well as having to cope with stressful life events including interpersonal violence. There are therefore strong links between the gendered nature of women's daily lives and their greater propensity to report depression.

A study of two townships in Harare, Zimbabawe revealed that 31% of the 172 women screened had a current episode of depression or anxiety while 18% were suffering from a depressive disorder compared with only 9% in a similar district in inner London thought to have high rates. This appeared to reflect the much higher number of severe life events and major difficulties experienced in Harare. In particular the women reported a large number of events involving humiliation and entrapment relating to marital crises, premature death and illness of family members and severe financial difficulties.

A cohort study of mothers attending a district general hospital in Goa investigated their experiences of post-natal depression. Such depression was found to be directly related to marital violence and indirectly to the sex of the newborn child. Violence both during and after pregnancy was a major cause of depression. The birth of a boy appeared to be protective against such an effect while the birth of a girl was not.

There is a growing body of evidence to show that there are also differences in the responses of women and men to mental health problems and in the care they receive. However this evidence is somewhat inconsistent and is confined largely to the developed countries. Anecdotal evidence suggests that women who are depressed rarely get the appropriate treatment. They are also more likely to be stigmatised than men especially if they cannot look after their families. This may result in divorce or abandonment.

Research findings indicate a complex relationship between mental health and reproductive health for women and these linkages need further exploration. Links with childbirth and marital violence have already been identified. An additional theme is the relationship between gynaecological symptoms such as vaginal discharge and depression. Research suggests that women may focus on such problems to express their underlying distress and hence will not receive appropriate support. Those who undergo reproductive tract surgery may also face major problems of adjustment for which there will be little or no help. Added to this are the many mental health problems associated with HIV/AIDS for women both as patients and as carers.

This brief review of gender and mental health has major implications for the future of research in this field. There is a great need to develop the capacity for mental health research in developing countries. And this is one of the cornerstones of WHO's new Global Action Programme for Mental Health. This will need to include the sensitization of researchers to look at issues beyond the immediate field of mental health. And very importantly, there will need to be a clear commitment to the integration of gender into all research designs.

Key areas for future research on depression are the links between gender and culture. There will need to be a much clearer understanding of how women and men in different communities understand their own and other people's mental health and illness. We need a 'local language of depression' that tells us what those who are 'depressed' believe is causing their distress. This in turn will help us to make better sense of why women are more vulnerable than men to this particular problem and hence to design gender sensitive strategies for supporting them.

For further information contact: vikpat@goatelecom.com or vikram.patel@lshtm.ac.uk.

Further reading

World Health Organization (2000) *Women's mental health: an evidence based review* WHO/MHP/00.1 Geneva: WHO

Murthy RS (ed) (2001) *The World Mental Health Report 2001: Mental Health: new understanding, new hope* Geneva: WHO

Patel V, Abas M, Broadhead J, Todd C, Reeler A, (2001) Depression in developing countries: lessons from Zimbabwe *BMJ* 322 482-484

Patel V, Rodrigues M, de Souza, N Gender (2002) Poverty and post-natal depression: a cohort study from Goa, India *American Journal of Psychiatry* 159 43-47

Patel V, Ooman N (1999) Mental health matters too: gynaecological morbidity and depression in South Asia *Reproductive Health Matters* 7 30-38.

- **Ken Bassett, Iman Abou-Gareeb, Lyn Sibley, Susan Lewallan, Paul Courtright**
  Is there gender inequity in global blindness?

  In order to improve understanding of eye disease and gender a meta-analysis of population-based blindness surveys was carried out. A similar study was undertaken to explore gender differences in use of eye care services. Both published and unpublished data were reviewed.

  The overall odds ratio (age adjusted) of blind women to men globally is 1.4, ranging from 1.39 in Africa to 1.41 in Asia. Women account for 64.5% of blind people in population-based prevalence estimates. Most are over 50 and most live in the poorest countries. This finding of an excess burden of blindness for women holds for virtually all individual surveys as well as the pooled results.

  The reasons for this excess of blindness among women is not well understood. It has rarely been studied and has not been given specific attention in WHO's worldwide blindness-prevention strategy Vision 20/20. However the most likely explanation is first that women are more frequently exposed to trachoma and second that they are less likely than men to get access to eye care services especially surgery for cataracts.

  For further information contact: bassett@chspr.ubc.ca.

- **Paul Courtright**
  Do women have less access to cataract surgical services?

  Women bear two thirds of the burden of blindness in developing countries. This project reviewed the global literature to determine the relative proportions of men and women among those blind from cataracts who received surgery. Coverage rates were extracted for males and females from methodologically sound studies from developing countries. These rates were found to be 1.2-1.7 times higher among males than among females. The odds ratio of having surgery for women compared to men was 0.67 (95% CI 0.60, 0.74). Women account for about 63% of all cataract cases in these surveys. If females received surgery at the same rate as males, cataract blindness rates could be reduced by a median of 12.5% (range 4.0-21%).

  For further information contact: kcco@kcmc.ac.tz.

- **Robert Geneau**
  Eye care service decision-making by rural Malawians

  The aim of this study was to assess how socio-cultural factors influence therapeutic choices and how far gender is implicated in health care decision-making. The research design involved multiple case studies with households in two different communities making up the units of analysis. Previous research had suggested that inhabitants of Kubalalika village and Mafunga village had different beliefs about eye health and also different levels of access to care. The implications of these differences were explored through direct observation of daily life, and semi-structured interviews with household members.

  When asked about the efficacy of Western medical treatments for eye problems the answers tended to vary by illness rather than by gender with cataract surgery being regarded by both women and men with much suspicion when compared to drug treatment. Those in the village closest to the district facilities were more likely to use them for the treatment of common eye infections but not for surgery. Those furthest from the facilities were more likely to begin with traditional healers and in both settings these healers were valued because of their easy access, flexible payment and longer sessions with better communication.

As well as these differences between communities, a number of gender differences were also observed. The perceived need for eye care was generally greater among women especially when it related to trachoma in children. Women were also more at risk than men of developing trachoma because of the nature of their daily work. At the same time women faced more barriers in their attempts to access care and these barriers were linked to their position in both the household and the particular community.

Women in the two communities faced different challenges in supporting themselves and their families. Women in Kubalalika were more likely to be lone parents and in paid employment often brewing and selling local beer. However earning money did not always mean control over how it was spent and paid work often meant new responsibilities. Though health was an area in which women could make decisions on spending without their partner's consent this applied only if money was available. Hence necessary treatment for women themselves and for their children was often delayed by the household decision-making process especially when the women had little autonomy.

The overall conclusion of the study was that women in Malawi did face specifically gendered risks of contracting some eye problems and sometimes faced particular problems in accessing treatment. However these gender differences could only be understood in the wider context of different households and communities. The different patterns of family structure and access to resources as well as different cultures of decision-making found in different settings mean that the impact of gender on eye health and use of eye care services cannot be assumed but always needs to be explored in its own right.

For further information contact: kcco@kcmc.ac.tz.

Further reading

Courtright, P (2002) *Gender and Blindness* Geneva: WHO Department of Gender and Women's Health

Abou-Gareeb I, Lewallan S, Bassett K and Courtright P (2001) Gender and blindness: a meta-analysis of population-based prevalence surveys *Ophthalmic Epidemiology* 8 39-56

Lewallan S & Courtright P (2002) Gender and use of cataract services in developing countries *Bulletin of the World Health Organization* 80 300-3

Courtright P & Bassett K (2003) Gender and blindness *Community Eye Health* vol 16 no 45 11-12.

3. Gender and noncommunicable diseases

Research in developing countries has traditionally focused on infectious and tropical diseases. However the epidemiological transition means that the so-called 'diseases of affluence' are now causing an increasing burden of morbidity and mortality in the poorer parts of the world. In this session Kate Hunt and colleagues explored the geographical distribution of studies on gender and coronary heart disease while Nicola Christofides examined the implications of gender for tobacco-control policies in developing countries.

- **Kate Hunt, Rani Elwy and Mark Petticrew**
  Sex, gender and coronary heart disease: the geographical distribution of recent evidence

For many decades, research on coronary heart disease (CHD) has focused mainly on men in developed countries in the northern hemisphere. However around 44% of all deaths from heart disease and stroke occur in developing countries. CHD and stroke are already the leading causes of death in the Americas (17.9% of all deaths), in South-East Asia (13.8%) and in the Western Pacific (11.1%). Contrary to common belief, this is not just a male problem. CHD is a leading cause of mortality in both women (about 15% of deaths) and men (about 13%). It is also a leading cause of morbidity in both sexes.

The aim of this study was to review recent epidemiological papers on CHD to assess both their geographical distribution and also the extent to which they took sex and gender differences into account. The abstracts of 3693 papers were screened to ascertain whether they had data on both women and men; 313 (8.5%) met this criteria and were obtained for more detailed review.

The geographical distribution of these 313 studies showed a preponderance from those countries with the greatest gender difference in life expectancy,

mostly those with higher levels of economic development: 35% came from the USA alone with the recent literature dominated by countries in North America and western and northern Europe. By contrast only eight papers were based on studies from African countries and five from the Eastern Mediterranean.

The detailed reviews of specific studies showed a marked absence of gender focus. Very few of the studies systematically addressed the differences between women and men. Some did 'control' for sex/gender or present parallel models for males and females but the reasons for any observed differences were rarely explored. This can be seen as a wasted opportunity to learn more about the biological and the social factors shaping heart disease in women and men.

The overall conclusion of this study was that the epidemiological evidence on sex/gender and CHD is dominated by studies from one part of the world. This reflects the much greater investment in large epidemiological studies in the USA as well as recent policy initiatives to include women in research projects. As a result the research agenda, definition of salient problems and understanding of risk factors in just a small minority of countries shape the medical understanding of sex/gender and the incidence, origins and consequences of CHD throughout the world.

For further information contact: kate@msoc.mrc.gla.ac.uk.

Further reading

Ebrahim S & Davey Smith G (2001) Exporting failure? Heart disease and stroke in developing countries *International Journal of Epidemiology* vol 30 pp 201-205.

- **Nicola Christofides**
  Why gender issues are an essential component in any research strategy relating to tobacco use in developing countries

Tobacco consumption accounts for about four million deaths per year worldwide and this figure is projected to rise to 10 million by the year 2030. There is evidence that women die faster than man from smoking-related diseases and in some parts of the developed world lung cancer has already

outstripped breast cancer as the major type of cancer death among women. Women who smoke multiply their chances of dying from lung cancer by 12, of bronchitis and emphysema by 10 and of coronary heart disease by 3.

Traditionally few women have smoked in most developing countries. In the African region overall, about 10% of women are now said to smoke cigarettes (plus an unknown number also consuming smokeless tobacco) compared with 48% of men. This figure is low but it may be an underestimate since female smoking is still regarded as unacceptable in many communities. Moreover there is evidence that this pattern is now changing especially among younger women who are becoming smokers in increasing numbers. This is being encouraged by the tobacco industry which has identified women in developing countries as a new target for promotion as some of the market in developed countries shrinks.

Recent studies in rural Zimbabwe found rates of 23% among boys 13-15 and 20% in girls compared with 21.5% and 17.2% in urban areas. In South Africa national figures were 20.7% of boys 11-17 and 15% of girls while among adults the figures were 42% among men and 11% among women. It is therefore important to act now to prevent an epidemic among African women and this will require detailed, localised knowledge and an understanding of the relevant issues. Unless this information is available it will be difficult to develop strategies to maintain the relatively low incidence of tobacco use in women in the African region.

In order to develop the appropriate knowledge base in this area it will be necessary to mainstream gender in all studies. This will need to include the incorporation of more women as senior researchers and also an institutional commitment to developing the skills of younger women researchers. In pursuit of these goals a regional multi-country study is currently being conducted in six southern African countries coordinated by the Women's Health Project in Johannesburg.

This study is examining a number of different aspects of gender and tobacco in this part of the world. The economic importance of tobacco to some women is being explored through their role as informal traders in tobacco in Uganda and South Africa, and as tobacco farmers in Uganda and Kenya. An understanding of why and how women use tobacco is being

developed through studies in Tanzania, Malawi and Nigeria. As specified in the original call for proposals, women are actively involved in senior positions in the local research teams and younger women's skills are being developed. By this means it is hoped to further develop the capacity for gender-sensitive research by both women and men as well as generating an effective knowledge base for tobacco control in Southern Africa.

For further information contact: nicolac@mail.saimr.wits.ac.za.

Further reading

Samet J & Yoon SY (2001) *Women and the Tobacco Epidemic: challenges for the 21st century* Geneva: WHO

Morrow M & Barraclough S (2003) Tobacco control and gender in South East Asia Pt 1 Malaysia and the Philippines *Health Promotion International* vol 18 no 3 255-264

Ernster V, Kaufman N, Nivhter M, Samet J, Yoon SY (2000) Women and tobacco: moving from policy to action *Bulletin of the World Health Organization* vol 78 no 7 891-901.

4. Violence against women

This session consisted of presentations focusing mainly on the ethical and methodological problems inherent in both research and evaluation in this sensitive area[5]. Claudia Garcia Moreno gave a status report of WHO's ongoing multi-country study, while Mary Koss and colleagues described the methods used in a recent comparative survey of sexual violence in conflict situations. Matthew Shaw then reported on the evaluation of a Stepping Stones project in Ghana designed to prevent both HIV and gender violence.

- **Claudia Garcia Moreno**
  The prevalence of sexual violence in four countries: first results from the WHO multi-country study

  There is a dearth of reliable information, particularly from developing countries, on the impact of different forms of violence against women and their impact

[5] An additional paper on models for prevention was presented by Lillian Liberman and can be accessed on the Global Forum's website: www.globalforumhealth.org.

on health. Sexual violence in particular is often highly stigmatised and this may prevent individuals and communities from identifying and addressing the problem. Where individual studies have been done methodological differences mean that findings from different settings cannot be compared with any degree of confidence. In response to these problems WHO is currently undertaking a multi-country study in very diverse communities in Bangladesh, Brazil, Japan, Namibia, Peru, Tanzania and Thailand.

The objectives of the study are to collect data on the prevalence of physical and sexual violence by intimate partners, the prevalence and characteristics of violence during pregnancy and the health consequences of violence against women. The study is also designed to explore the strategies women use to minimise or end violence in intimate relationships. Throughout the study particular attention has been paid to safety and to ethical issues in this very sensitive area.

The research design combines both qualitative and quantitative methods, with the main study consisting of a cross-sectional household survey conducted in two sites in each of the eight participating countries. At each site, 1500 women aged 15-49 were randomly selected for interview and prevalence estimates for various forms of violence were obtained through asking direct questions about their experiences of specific acts. The local interviewers were very carefully prepared for this work and follow-up support was offered to those interviewees requesting it.

The uniqueness of this study lies in the fact that it is the first to research domestic violence against women across countries from a public health and gender perspective. A rigorous and uniform methodology ensures reliable estimates and sound research results that are comparable across different settings. The use of a common methodology in diverse cultural contexts is important not just for assessing prevalence but also for improving our understanding of universal and context-specific risk factors.

A major aim of the study is to transform policy in this field and this is being done in a number of ways. Most importantly of course it will improve the evidence base for policy initiatives. But it goes further than this. In many of the participating countries, the research process itself has generated debate between NGOs, researchers and policy-makers which has then been

translated into policy development. The participative nature of the study has been especially valuable in developing the capacity of local organisations for both research and advocacy.

For further details contact: garciamorenoc@who.int.

Further reading

WHO (2001) *Putting Women First: ethical and safety recommendations for research on domestic violence against women* WHO/FCH/GWH/01.1

WHO (2002) *Multi-country study on Women's health and violence against women* WHO/FCH/GWH/02.2

- **Mary Koss, Michelle Hynes, Victor Balaban, Jeanne Ward, Kathryn Robertson, Lumnije Decani**
  Conducting gender-based violence research in conflict-affected populations: lessons learned from two pilot studies

The Reproductive Health for Refugees Consortium has identified major gaps in our knowledge base of gender-based violence (GBV) in refugee and internal displacement settings. In particular there is a dearth of evidence of prevalence on best practices for documenting the problem with both qualitative and quantitative data. This project was funded by the US State Department's Bureau of Population, Refugees and Migration to fill that gap. It consisted of a cataloguing of existing resources in the field and a survey of current multi-sectoral responses followed by the development and testing of a standardised quantitative survey to assess patterns of GBV[6]. Forms of GBV included were conflict/post conflict rape and sexual assault, family/intimate partner violence, trafficking of women and female genital mutilation.

This presentation reports on the development and pre-testing of a survey designed to assess the prevalence of GBV experienced by women of reproductive age in Asian, African and European post-conflict settings. The questionnaire was developed collaboratively with colleagues in the Centers for Disease Control and the University of Arizona. Field testing has now

[6] For information on the global survey of multi-sectoral responses see further reading.

been concluded in two national settings: one urban and one rural district of East Timor and six villages in the western region of Kosovo.

The study used a cross-sectional design with the first stage being an unclustered equal probability sample of households selected from enumeration lists. The sample target size was 340 on each site but the final size was 283 in East Timor (83% participation rate) and 329 in Kosovo (97% participation rate). Local women experienced in the field of GBV administered the survey orally in private settings outside the respondent's home. The 136 questions (East Timor) and 174 (Kosovo) were designed to generate estimates of the prevalence of sexual and physical violence at different times before, during and after periods of conflict, occupation and displacement. Wherever possible, questions were used from existing studies (including the WHO multi-country study) to facilitate comparison. However more detailed questions on sexual assault had to be specially designed.

Results from the study are not yet available but important lessons were learned about how such research can best be conducted. Very importantly a trade off seemed to exist between protecting women's confidentiality by interviewing them away from home and raising community suspicions. When women went to a new place this made them conspicuous and the flow of willing participants began to decline. It therefore seemed important to try and use enough interviewers to sample an area in one day. Care also had to be taken in explaining both consent and sampling procedures since these were not concepts with which most community members were familiar.

During the training period some interviewers did express concern about the explicit nature of some of the questions but after practice they reported no problems. From a total of over 600 interviews only one was terminated early and this was a woman in the ninth month of her pregnancy who reported feeling ill. However some difficulties were experienced due to inappropriate wording. Value-laden terms such as 'mistreatment' were frequently misunderstood and phrases such as 'treatment' or 'things done to you' would probably have been more effective in getting an accurate response.

No follow-up was undertaken of individual respondents so that it is impossible to know if any were harmed as a result of participating. However no reports of such problems were received. On the contrary a number of good consequences were noted. The collaborating NGO in East Timor continued to collect data from other parts of the country and published a booklet of the results. The Women's Wellness Centre in Kosovo reported that their credibility had improved and they too continued the work. Overall, this part of the project demonstrated the potential and also the challenges of conducting community research on GBV in post-conflict settings. Important ethical and safety issues are raised and these are best resolved through close collaboration with local partners.

For further information contact: mpk@u.arizona.edu.

Further reading

For a copy of the global survey report on current multi-sectoral responses to GBV in refugee and internally displaced settings contact jeanne@theirc.org.

Watts C & Zimmerman C (2002) Violence against women: global scope and magnitude *Lancet 3*59 1232-1237

Vann B (2003) *Gender based violence: emerging issues in programs serving displaced populations* available from http://www.rhrc.org/pdf/gbv_vann.pdf.

- **Matthew Shaw**
  A qualitative evaluation of the impact of the Stepping Stones sexual health programme on domestic violence and relationship power in rural Gambia

  Stepping Stones is currently UNAIDS' best practice for community mobilisation. More than 200 organisations in many countries have now received the package but there is very little information available on whether or how it works. This presentation reported on an evaluation of a community-level HIV-prevention programme carried out in two small villages in the Gambia between 1998 and 2000. The programme aimed to increase communication within sexual relationships and communities to improve sexual health and reduce risk of HIV. Though gender violence was not initially the main focus of concern it soon emerged from the (female) participants and important progress in prevention was later reported.

Stepping Stones is a community-level empowerment programme based on Participatory Learning and Action techniques (PLA). It relies on volunteers who work in age/sex peer groups drawing on a number of techniques to improve conflict resolution, communication and relationship skills. The programme consists of 14 one-day sessions in which there are three intra-peer group sessions. At the end, each group draws up an action plan and participants are encouraged to involve themselves in peer education. Each group also decides on a 'special request' which they present to the whole community who are asked to vote on whether or not to implement it.

In this study in Gambia the different groups were asked to identify reproductive health problems and to prioritise them. All four women's groups identified wife beating as a problem to be dealt with immediately and the two groups of young women mentioned forced sex. All women's groups listed at least one problem related to having sex when they didn't want to: when menstruating heavily, for example, when tired or sick, or having just given birth. The men's groups focused on sexually transmitted infections, infertility and erectile failure as well as more general health problems.

In both villages the young women's special request was that everyone agree that wife beating was wrong and women should be allowed to travel without the permission of their husbands. The young men in both the villages emphasised that parents should warn their children about early sex and the old men said marriage partners should be faithful or if not should use condoms. All these special requests were accepted on a show of hands. The evaluation of this initiative used both quantitative and qualitative methods to determine whether or not the proposed changes happened. Qualitative techniques included 84 in-depth interviews and seven focus group discussions carried out before, immediately after and one year after the intervention. The two villages were visited again in 2001 for a brief period of participant observation and additional interviews. Both a quantitative KAP survey and the results from qualitative evaluation showed evidence of considerable change. Within the community there was more awareness of HIV and risk. Condoms were viewed more favourably and their use increased. Men also endeavoured to improve their support for their wives, largely in an attempt to avoid poverty and greater risk of HIV.

Very importantly, the evaluation also indicated a major decrease in violence against women. Respondents agreed that before the programme wife beating occurred frequently but with the exception of one incident it had now stopped. At the individual level men and women were more willing to work together to defuse potentially violent situations. Men were more likely to listen and to accept sex refusal while women appeared to be more able to use assertiveness techniques. At the community level men's and women's groups worked together to police the ban on wife beating.

This cessation of domestic violence following a community programme is unprecedented and the reasons for it need further investigation. However certain key factors seem to have been important. The first was the inclusion of men from the beginning through a focus on fertility issues about which they were very concerned. Local cultural factors were probably of importance especially the low use of alcohol and the existing strength of village institutions. Local interpretations of Islam seem to emphasise responsibility and fairness in marital relations. But most importantly it seemed that the men felt they were better off if they accepted these demands, potentially avoiding conflict as well as reducing their risk of HIV.

Preliminary evaluation has highlighted the apparent success of this approach in combating both HIV and gender violence. However attempts to fund a prospective community randomised controlled trial have been unsuccessful. This may be because the holistic approach and the emphasis on core skills in couple communication run against current funding culture. In particular vertical funding by problem ignores the value of projects which may be able to address the two apparently very different problems of HIV and gender violence which are intimately connected in the daily lives of individuals. There should be a move away from testing interventions with a specific disease or problem focus towards the commissioning of more complex empowerment projects that place gender and power at the heart of the analysis.

For further information contact: matthew.shaw@lshtm.ac.uk.

Further reading

Cornwall A & Welbourn A (2003) *Realizing Rights: transforming approaches to sexual and reproductive well being* London: Palgrave

Paine K, Hart J, Jawo M, Ceesay S, Jallow M, Morrison L, Walraven G, McAdam K, Shaw M (2002) 'Before we were sleeping, now we are awake' Primary evaluation of a community based sexual health programme in the Gambia *African Journal of AIDS research* 1 41-52

UNAIDS (2000) *Innovative Approaches to HIV Prevention: selected case studies* Geneva: UNAIDS

Welbourn A (1996) *Stepping Stones. A package for facilitators to help you run workshops within communities on HIV /AIDS, communication and relationship skills* London: ACTIONAID Available from TALC, PO Box 49, St Albans, Herts AL1 5TX, UK.

5. Gender, sexual and reproductive health

Two papers in this session covered very different aspects of sexual and reproductive health[7]. Sonia Pagliusi and Teresa Aguada explored the potential of a vaccine in dealing with cervical cancer – a disease that is largely under control in high-income countries but continues to cause massive death and disability among women in developing countries. Charles Nzioka drew on experiences in sub-Saharan Africa to make the case for including men at all stages of sexual and reproductive health research.

- **Sonia Pagliusi and M. Teresa Aguado**
  Development of human papillomavirus vaccines for prevention of cervical cancer: a powerful tool to improve global women's health

Cervical cancer is a major public health problem and remains a major cause of cancer-related mortality among women in developing countries. A conservative estimate of prevalence suggests that there are 1.4 million cases of clinically registered cervical cancer at any one time. About 500, 000 new cases are identified each year and about 80% of these women live in developing countries. Nearly 30% of these cases are in women between 15 and 44. Although cervical cancer mortality has fallen substantially in the

[7] An abstract and powerpoint of the presentation on the sexual and reproductive health of young people by Naana Otoo-Oyortey of the International Planned Parenthood Federation can be accessed on the Global Forum's website.

developed world due primarily to effective cytological screening programmes, similar services are available to very few in poor countries.

Sexually transmitted human papillomavirus (HPV) infections have now been established as a major cause of cervical cancer. This association was first suggested in the mid-1970s and over 99% of cancers of the cervix are now assumed to be linked to at least one of the 15 oncogenic types of HPV. The major risk factors for genital HPV infection include age at first infection, multiple partners, high parity, oral contraceptive use, immunodeficiency and smoking. An effective vaccine against the most common of these viruses could have a huge impact on the global burden of this disease.

WHO has a dual strategy in relation to the development of HPV vaccines. The first is the promotion of clinical studies especially in areas where the disease burden is high. The major focus here is on the clinical evaluation of promising vaccine candidates in populations at high risk to demonstrate safety, immunogenicity and protection against infection. Of particular importance is the testing of vaccines that are potentially protective against a broader spectrum of HPV types than the existing ones.

The second element in the strategy involves the exploration of new and more cost-effective methods of manufacturing vaccines to promote global access even for the poorest women. Ease of administration and lower cost of manufacture are both crucial here. Public-private partnerships involving collaborative research projects are seen as essential to the success of this initiative. High quality vaccine material made available by pharmaceutical manufacturers will be used in clinical settings in developing countries under WHO guidance.

It is hoped that this strategy will provide the basis for tackling a major burden of disease borne largely by the world's poorest women. An effective and widely available vaccine could help to circumvent the problems of implementing effective screening in resource poor settings and by this means could make a significant contribution to promoting global equity in health.

For further information contact: pagliusis@who.int.

Further reading

Varghese C et al (1999) Risk factors for cervical dysplasia in Kerala, India *Bulletin of the World Health Organization* vol 77 (3)

Kitchener H & Symonds P (1999) Commentary: Detecting cervical epithelial neoplasia in developing countries *Lancet* 353 856-7

PATH (1997) *Planning for Appropriate Cervical Cancer Control Programs* PATH, Seattle: Washington

Shanta V, Krishnamurthi S, Gojalakshmi C, Swaminatham R, Ravichandran K (2000) Epidemiology of cancer of the cervix: global and national *Journal of Indian Medical Association* 98 (2) 49-52

Nascimento C & Eluf-Neto J (2001) Cervical Cancer in Latin America *Seminars in Oncology* 28(2) 188-197.

- **Charles Nzioka**
  The role of men in reproductive health research

  Men have been largely invisible in sexual and reproductive health research where much of the focus has been on the needs and interests of women. However men too are key actors in the reproductive health arena and this needs to be reflected in the design of research. If men are to be active participants in the promotion of reproductive health, their perspectives will need to be properly understood. Moreover this knowledge will need to reflect the differences between men themselves. Targeted reproductive health programmes will therefore need to address the specific needs of young and old men, rural and urban men and men from different social classes. This presentation explores the potential for bringing men into research with a particular focus on sub-Saharan Africa.

  There are many reasons for incorporating men into reproductive health research. First, the most common methods of birth control have been those initiated by men. At the same time male participation in wider decisions about family planning is critical. Cultural and economic circumstances in most of the region make men the gatekeepers of decisions about fertility control and all too often these decisions are arbitrary and made without consultation. Men are crucial in sustaining the use of contraception and are unlikely to cooperate unless they feel their views have been taken seriously.

Finally men are more likely than women to take sexual risks which may render them and their partners vulnerable to sexually transmitted diseases including HIV/AIDS.

The importance of male involvement in reproductive health was highlighted at the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing. The consensus document from both meetings stressed the need for more research into new methods of fertility control for men and also into factors inhibiting male participation in family planning, control of sexually transmitted diseases and prevention of infertility. If this is to be achieved, men will need to be involved as the subjects of reproductive health research, as well as being involved in the design and implementation of studies. This presentation identifies the main types of reproductive health research in which more involvement is needed: biomedical, social science and programmatic and policy research.

In the context of biomedical research there is an urgent need to improve male contraceptive methods. Apart from 'natural' methods such as abstinence or withdrawal, vasectomy and condoms are the only options available to men. Some men strongly resist vasectomy seeing it as a form of castration but also rejecting the fact that it is irreversible. Condoms are seen as 'unAfrican'. Biomedical research is therefore needed to develop new technologies that could widen the range of acceptable and affordable methods.

Social science research can be used to develop more detailed knowledge and understanding of men's sexual and reproductive health problems. This work will need to pay particular attention to the diversity of men's needs and desires. An important factor shaping these differences is the existence of particular subcultures shaping men's sexual behaviour. These will also influence male response to any interventions and therefore need careful study before programmes are developed. Research has shown for example, that some men hold traditional beliefs which act as a barrier to their use of modern contraceptive methods. They may associate female methods with promiscuity for example or may believe that such methods make women unresponsive during intercourse. These beliefs need to be properly explored and understood. Programmatic and policy research also needs to take male perspectives

seriously. Evaluations are needed to examine the appropriateness of programme designs for men in a range of settings. The involvement of men in these studies is likely to improve significantly the effectiveness of the initiatives themselves. This participative approach can also be extended to broader policy research with men working to develop policy initiatives which reflect their own needs while also being congruent with national objectives such as HIV/AIDS prevention.

For further information contact: cnzioka@uonbi.ac.ke.

Further reading

Jegede A & Odumoso (2003) Gender and health analysis of sexual behaviour in south-western Nigeria *African Journal of Reproductive Health* 7 (1) 63-70

Nzioka C (2001) Perspectives of adolescent boys on the risks of unwanted pregnancy and sexually transmitted infections in Kenya *Reproductive Health Matters* 9 (17) 108-117

Varga C (2001) The forgotten fifty percent: a review of sexual and reproductive health research focussed on boys and young men in Sub-Saharan Africa *American Journal of Reproductive Health* 5 (3) 175-95

Waites G (2003) Development of methods of male contraception: impact of the EHO task force *Fertility and Sterility* 80 (1) 1-15.

6. Gender, work and occupational health

The papers in this session explored different aspects of the relationship between gender, work and health. The papers took a broad perspective on the concept of work and included the impact of both paid and unpaid labour. Suchart Trakoonhutip and colleagues described a participatory research project in an electronics factory in Thailand, Sally Theobald discussed the health impact of caring for people with HIV/AIDS and TB in the community and Sophia Kisting outlined a new WHO/ILO initiative on occupational health in Africa.

- **Suchart Trakoonhutip, Sally Theobald and Bent Gehrt**
  Researching and organising to promote better health for electronics workers: lessons from northern Thailand

  This paper discusses the use of qualitative and participatory methods to explore the health problems of workers in electronics factories in northern Thailand. The factories were in an export-processing zone and most were owned by multinational companies. The majority of workers were young women between 18 and 25 who came from rural backgrounds.

  The research design was qualitative in approach and a number of methods were used to explore the participants' working lives and what they meant for their health. Informal conversations and more formal interviews were held with both male and female workers. Focus group discussions were then organised where a number of techniques were used to discuss and analyse particular problems in group settings. Body mapping was one method used, with participants putting stickers on a large outline of the body where they experienced pain or disability. Workers then identified common problems and discussed possible causes. This search for greater understanding was aided by factory mapping where workers located and discussed problem areas within the workplace.

  Using these different data-gathering techniques, a number of health problems were uncovered. Many workers reported blisters, dermatitis and other skin problems associated with exposure to chemicals as well as more systemic effects such as nausea. Others talked of eye damage, ear problems and headaches. Pain was experienced in elbows, shoulders, legs and back and injuries were reported both in the workplace and on the way to and from work. Many workers commented on the stress they experienced as a result of shift work and long hours and some women reported being the subjects of gender violence.

  In order to make sense of the complex patterns of causality involved in these experiences, a distinction was made between work processes and work practices. Work processes included the traditional hazards associated with the chemicals and machines used in production. Thus physical, ergonomic, biological and chemical hazards were all discussed under this heading. The gendered aspects of these processes included the allocation of women and

men to particular jobs with different risks. Women also reported particular problems resulting from lack of appropriate protective clothing.

Work practices, on the other hand, included a range of psycho-social factors including the rules, regulations and expectations of those managing the factory. These could be a major source of stress and again they often operated in gendered ways. Young women were at the bottom of the hierarchy and were pushed very hard to maximise production. Diligence pay and bonuses often made it difficult to take time off even during sickness and restricted breaks increased the pressure. Many of the women who lived with their partners or families reported that they had heavy domestic responsibilities in addition to work in the factory.

The political environment and the structure of the workplace meant that both women and men lacked information about workplace risks. The use of participative methods helped them to explore these issues and the formation of the Friends for Friends club in 1998 provided the opportunity to work for change. The club now has over a hundred members, of whom about two thirds are women, and creating a healthier working environment is high on their agenda.

For further information contact: sjt@liv.ac.uk.

Further reading

Theobald S (2002) Gendered bodies, recruitment, management and occupational health *Women and Health* 35 (4) 7-26

Hwei-Mian Lim, Hang-Leng Chee et al (2002) Work and life style factors associated with morbidity of electronic working women in Selangor, Malaysia *Asia Pacific Journal of Public Health* 14 (2) 75-84

Panelli R & Gallagher L (2003) 'It's your whole way of life really' : negotiating work, health and gender *Health and Place* 9 (2) 95-105.

- **Sophia Kisting**
  Gender, work and reducing the burden of work-related disease: the African Joint Effort of WHO/ILO

  There is an underestimation of the contribution of work to the global disease burden and this is especially true for women workers. This failure to

recognise the damaging impact of work contributes to the 10/90 gap in health research since even less funding is spent on studies in developing countries.

Present patterns of global restructuring have increased the occupational health burden for some groups. The poorest countries are marginalised in the global economy and unfair patterns of trade make them very vulnerable. Many companies relocate production to take advantage of lax health and safety legislation, operating with double standards in different parts of the world. In some countries these problems are intensified by war and civil conflict.

These conditions can damage the health of all workers but the circumstances of women need particular attention. Very often they are working in the informal sector where there is no regulation at all. Wherever they work, they are unlikely to be members of trade unions and get little support in promoting healthier working conditions. Two studies in South Africa show how the impact of this labour on women's health is seriously underestimated. A survey of commercial farms in the Western Cape demonstrated the under-reporting of pesticide exposure and poisoning in women workers and the effects of this on their wellbeing. Similarly, a study of the quality of life of asbestos-exposed workers showed that there was little recognition of women's patterns of exposure in both employment and domestic work.

In response to increasing evidence of this kind, a WHO/ILO joint effort was begun in 2001 to improve occupational health and safety (OHS) in Africa. This initiative has four main strands: to develop human resources, to improve national policies and programmes, to disseminate more information and to promote occupational health and safety among vulnerable groups.

The human resource strand involves the strengthening of the capacity of OHS professionals at all levels. This is to be complemented by the development of guidelines to promote new policies at national level in different countries. The information and awareness raising is to be done through a variety of routes including an information centre, website and newsletter.

The promotion of OHS in hazardous occupations and vulnerable groups has involved a particular focus on gender. Pilot projects have been developed for work in the informal sector with improved coordination mechanisms and networks for information sharing. Emphasis has been placed on the need for gender-sensitive surveillance and research in workplaces and for the training of OHS workers to recognise sex and gender issues at work. Above all the WHO/ILO joint effort is promoting partnerships for (gender-sensitive) research, prevention and surveillance of occupational diseases across the range of workplaces.

For further information contact: skisting@cormack.uct.ac.za.

Further reading

Jacobs M & Dinham B (2003) *Silent Invaders: pesticides, livelihood and women's health* London: Zed Press

London L & Kisting S (2002) Ethical concerns in international occupational health and safety *Occupational Medicine* 17 (4) 587-600

London L, Wesseling C, Kisting S, Rother H, Mergler D (2002) Pesticide usage and health consequences for women in developing countries: out of sight out of mind? *International Journal of Occupational and Environmental Health* 8 (1) 46-59.

- **Sally Theobald and Nanna Bali**
  Gender and work: who does the caring in the family and the community and at what cost?

Among people living with HIV, TB can dramatically reduce both quality of life and life expectancy. The HIV epidemic has accelerated the spread of TB and increased its prevalence. In responding to these epidemics, policy-makers have increasingly turned towards the 'community' as a source of care. This in turn has raised important questions about gender differences in vulnerability to TB and in health-seeking behaviour. However there has been very little discussion of how gender roles and relations affect the impact of caring work in the community on those who look after people with HIV/TB. This study was designed to fill that gap.

The project had three aims: to identify the characteristics of carers, to assess the implications of caring for their quality of life and to make

recommendations for future policy. The first part of the study was a secondary data review and this was followed by interviews with key informants including NGO workers, researchers and policy-makers.

The bulk of informal caring at different levels in the community is done by women. Many programmes depend on a cadre of volunteer community health workers and gender differences are apparent in these groups. A recent South African study found that 90% of DOT supporters are women. In Nepal, both women and men provide DOT but the men are mostly (paid) village health workers while the women are (unpaid) female community health volunteers. At the household level most care is done by women though there is growing evidence of men taking on these roles in some contexts as the epidemics spread.

Any assessment of the health impact of this work on carers themselves has to take account of the links between psycho-social impact, time and livelihood and health. The negative psycho-social effects reflect the huge emotional burden of caring for loved ones as well as the fear of disclosure that could lead to stigma and discrimination. Most are also worried about the future. On the positive side many carers reported that they had increased their knowledge and confidence and that they had improved their status within the community. Many talked about the sense of self-worth gained from helping someone get better.

At the same time, it was clear that carers often experienced a reduction in their capacity to support themselves and other family members. They had to cut back on time for productive labour as well as juggling extra domestic burdens. Children (especially girls) often had to be taken out of school to help. On the other hand, new skills and confidence enabled some to go for further training or to take up new opportunities.

The impact of these different processes on the health of carers was difficult to predict. On the negative side, many reported poor health resulting from poverty, isolation stigma and exhaustion. In some cases this might lead to compromised immune systems and make the carers themselves more vulnerable to HIV and TB. On the other hand, some carers talked about the ways in which access to information and support helped them to promote their own health more effectively.

With these findings in mind the project concluded with a number of recommendations designed to enhance the effectiveness, equity and sustainability of care in the community. Above all it is necessary to recognise that women's labour is not infinitely elastic. If the health of carers themselves is to be protected there will need to be appropriate supervision and support structures. Creative and innovative approaches will be needed to encourage men to be more involved in caring at all levels and all carers will need to be given appropriate recognition and rewards within the community.

For further information contact: sjt@liv.ac.uk.

Further reading

Sternberg M, Johnson S et al (2002) *Hitting Home: how households cope with the impact of the HIV epidemic: a survey of households affected by HIV/AIDS in South Africa* Menlo CA: Kaiser Family Foundation

Im-em W and Suwannarat G *Household Responses to HIV/AIDS in Thailand* Geneva: UNRISD.

7. Gender and child health research

This session began with a general overview of current issues in child health from a human rights perspective presented by Marion Jacobs of the University of Cape Town. This outlined the need for a new research agenda if the global challenge of child health is to be effectively tackled. The other two papers in the session focused on gender inequalities in particular as obstacles that prevent many children from realising their potential. Shafika Nasser's paper (presented by Mervat al Rafeei) outlined the experience of gender and child health issues in Egypt and spelled out the importance of broadly based interventions. Shally Awasthi then described the culture of boy preference in many South Asian communities and highlighted the need for gender sensitive interventions in both health care and nutrition.

- **Shafika Nasser**
  Gender and child health nutrition: an Egyptian experience

  A review carried out in Egypt during 1995 showed significant progress in infant and child health with major reductions in mortality. In the 1980s and 1990s selective approaches to address major childhood killers included diarrhoeal disease control, an expanded programme of immunisation and selective nutritional interventions to combat iodine, vitamin A and iron deficiencies. More detailed evaluations are needed but it is clear that these programmes have made obvious improvements in child health and child health survival. However sex-disaggregated analysis shows that infant and child mortality are higher among female than in male children.

  Analysis of mortality data by age groups showed increased mortality of female children in almost all age categories. Despite widespread access to primary care facilities girl children appear to have fewer opportunities for proper care and a number of factors seem to be involved here. Girls are likely to receive less health care than boys. A recent survey showed that 35% of boys suffering from acute diarrhoea received private health care compared with only 11% of girls with the same condition.

  Nutritional factors may also be important. More than 50% of all deaths of under 5s are associated with some form of malnourishment and this in turn is often gender related. Focus group studies of feeding and weaning practices show that some nutritionally valuable foods such as eggs are seen as not suitable for girls. Hence they were given only to boys. In general, studies within rural families showed that girls were more likely than boys to be malnourished.

  Malnourished girls are more prone to disease and are then less likely to receive proper health care, appropriate treatment and proper food. They are therefore more likely to die or to be permanently damaged. The solution to these inequalities lies in part in reshaping the health care system itself. But wider policies are also important. Literacy programmes are especially valuable in ensuring that girls achieve more equal status with boys. In 2001 male and female enrolment levels in primary schools were almost the same and this is likely to lead to a reduction in gender inequalities in health.

  For further information contact: shafika_nasser@yahoo.com.

- **Shally Awasthi**
  Access to health services for the child from a gender perspective

  Around the world there are marked inequalities in access to health care both by age and by sex. Though different communities show different patterns it is often women and children who are worst off. In conditions of poverty it is often girl children who face the greatest problems in accessing appropriate care. This is especially evident in many parts of South Asia.

  In India in particular many communities show a marked preference for male children and this is reflected in gender bias in both preventive and clinical services. Studies carried out in rural India in 1990 showed that only 49.5% of girls had been immunised compared with 60.9% of boys. Another study showed that in different parts of India girls made up only about one third (between 26.9% and 37.4%) of those receiving ambulatory care of acute respiratory infection. A similar figure emerged from a study of children in Lucknow with diarrhoea and some dehydration. Only about one third of those accessing care were female.

  In secondary care too the pattern is one of gender bias. In Lucknow females make up about 29% of those children being admitted to hospital with acute problems, while surgery appears to be significantly less common among girls. Recent studies conducted in both Punjab and Uttar Pradesh showed that overall the expenditure on health care for boys was between two and three times that for girls during the first two years of life. This gender difference appears to continue into adolescence.

  When these differences are combined with gender inequities in nutrition, they contribute to a situation where a girl in India is 30-50 times more likely to die between her first and her third birthday than a boy of the same socio-economic status. If this is to change, gender will need to be mainstreamed through all aspects of Indian social policy.

  For further information contact: sawasthi@sancharnet.in.

  Further reading

  Smith L & Haddad L (2000) **Explaining child malnutrition in developing countries: a cross-country analysis** Research Report 111 Washington DC:

International Food Policy Research Institute

Quisumbing A (2003) Gender**, household decisions and development: a synthesis of recent research** Washington DC: International Food Policy Research Institute.

Conclusion

These presentations from Forum 7 demonstrate the centrality of sex and gender as determinants of health across a range of different settings. This applies not only in the area of sexuality and reproduction where differences between women and men are traditionally seen to be located. Differences in many aspects of daily life also make women and men vulnerable to a range of other health problems which can only be tackled when they are properly understood. This means that the methods used for generating new knowledge must be sensitive to these issues. Failure to take both biological sex and social gender seriously in health research may lead to inaccurate findings and less than optimal interventions. This in turn is likely to lead to wasted resources in settings where there is already too little health care to go around. Gender sensitivity in health research must therefore be an essential element in strategies for closing the 10/90 gap.

Annex

Forum 6, Arusha, Tanzania, 12–15 November 2002
Sessions with a specific gender focus[8]

PLENARY SESSION

Measuring progress in gender issues

Co-Chairs:

- Christina Zarowsky, Senior Scientific Adviser, Program and Partnership Branch, International Development Research Centre, Canada
- Andrew Kitua, Director General, National Institute for Medical Research, Tanzania

with:

- Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom
  - Overview of progress 1990 to 2002
- Ruth Bonita-Beaglehole, Director, Surveillance (CCS), Noncommunicable Diseases and Mental Health (NMH), World Health Organization, Geneva
  - The prevention and control of chronic diseases: a gender perspective
- Geeta Rao Gupta, President, International Center for Research on Women, USA
  - Gender issues in HIV/AIDS research
- Nicola Christofides, Project Manager, Women's Health Project, South African Institute for Medical Research, South Africa [on behalf of Barbara Klugman]
  - Revaluing research priorities: challenges of mainstreaming gender in health research

[8] Presenters are listed with their title and affiliation as of Forum 6.

SESSIONS IN PARALLEL

Gender and child health research

Chair: Mary Ann Lansang, Executive Director, INCLEN Trust, Philippines

with:

- Shally Awasthi, Professor, Paediatrics, King George Medical College, India
  - Access to health services for the child from a gender perspective
- Marian E. Jacobs, Director, Child Health Unit, School of Child and Adolescent Health, University of Cape Town, South Africa
  - Rights perspective on child health research
- Mervat El Rafie, Professor of Public Health, Cairo University, Egypt [on behalf of Shafika Nasser]
  - Gender and child health and nutrition

Gender and infectious and tropical diseases

Chair: Martine Berger, Special Advisor on Public Health, Multilateral Affairs Section, Swiss Agency for Development and Cooperation, Switzerland

with:

- Uche Amazigo, Chief, Sustainable Drug Distribution Unit, African Onchocerciasis Control, WHO Regional Office for Africa (WHO/AFRO), Burkina Faso
  - Promoting gender sensitivity in community-directed tropical disease control programmes: the case of onchocerciasis
- Jeannine Coreil, Professor, Community and Family Health, University of South Florida, USA
  - Women's support groups for chronic tropical diseases
- Rachel Tolhurst, Research Associate, International Health Research Group, Liverpool School of Tropical Medicine, United Kingdom
  - Researching gender issues in malaria management: a case study from the Volta region of Ghana

Gender and noncommunicable diseases

Chair: Nikolai Napalkov, Director Emeritus, N.N. Petrov Research Institute of Oncology, Russian Federation

with:

- Nicola Christofides, Project Manager, Women's Health Project, South African Institute for Medical Research, South Africa
  - Why gender issues are an essential component in any research strategy relating to tobacco use in developing countries
- Kate Hunt, Senior Research Scientist, MRC Social and Public Health Sciences Unit, Glasgow University, United Kingdom
  - Sex, gender and coronary heart disease: the geographical distribution of recent evidence

Gender, mental health and disability

Chair: Rashidah Abdullah, Director, Asian-Pacific Resource & Research Centre for Women, Malaysia

with:

- Florence Baingana, Mental Health Specialist, Human Development Network, Health, Nutrition and Population, World Bank, USA
  - Gender, mortality and the European transition-economy countries
- Ken Bassett, Professor of Ophthalmology, Kilimanjaro Centre for Community Ophthalmology, Tanzania
  - Is there gender inequity in global blindness?
- Paul Courtright, Co-Director, Kilimanjaro Centre for Community Ophthalmology, Tanzania
  - Do women have less access to cataract surgical services?
- Robert Geneau, Consultant, Kilimanjaro Centre for Community Ophthalmology, Tanzania
  - Eye-care service decision-making by rural Malawians
- Vikram Patel, Senior Lecturer, London School of Hygiene and Tropical Medicine, United Kingdom
  - Gender and mental health research in developing countries

Gender, sexual and reproductive health

Chair: Adrienne Germain, President, International Women's Health Coalition, USA

with:

- Geetanjali Misra, Director, Creating Resources for Empowerment in Action, India
  - Developing a gender-sensitive research strategy for sexual and reproductive health
- Charles Nzioka, Professor, Sociology, University of Nairobi, Kenya
  - Understanding the role of men in reproductive health research
- Naana Otoo-Oyortey, Technical Officer, Gender and Youth, International Planned Parenthood Federation, United Kingdom
  - The sexual and reproductive health of young people: research and programme issues
- Sonia Pagliusi Uhe, Scientist, Vaccines and Biologicals, Health Technology and Pharmaceuticals, World Health Organization, Geneva
  - Development of human papillomavirus vaccines for prevention of cervical cancer: a powerful tool to improve global women's health

Gender, work and occupational health

Chair: Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom

with:

- Sophia Kisting, Chief Researcher, Occupational & Environmental Health Research Unit, School of Public Health and Primary Health Care, University of Cape Town, South Africa
  - Gender, work and aspects of the African joint effort of WHO/ILO in occupational health and safety
- Sally Theobald, Lecturer, International Health, Liverpool School of Tropical Medicine, United Kingdom
  - Gender and work: who does the caring in the community and at what cost?
- Suchart Trakoonhutip, Project Coordinator, Friends of Women

Foundation, Thailand
- Research to promote better health for electronics workers: lessons from Northern Thailand

Violence against women

Chair: June Pagaduan-Lopez, Associate Professor, Psychiatry and Behavior Medicine, College of Medicine, De La Salle University, Philippines

with:

- Claudia Garcia-Moreno, Coordinator, Gender and Women's Health, Family and Community Health, World Health Organization, Geneva
  - The prevalence of sexual violence in four countries: first results from the WHO Multi-Country Study on Women's Health and Domestic Violence
- Mary Koss, Professor, Health Promotion Sciences, University of Arizona College of Public Health, USA
  - Conducting gender-based violence research in conflict-afflicted populations: lessons from two pilot sites
- Lillian Liberman, Chairperson, Yaocihuatl A.C., Mexico
  - Proposal of a model to prevent physical, emotional and sexual abuse in children
- Matthew Shaw, Research Fellow, Health Policy Unit, London School of Hygiene and Tropical Medicine, United Kingdom
  - A qualitative evaluation of the impact of the Stepping Stones sexual health programme on domestic violence and relationship power in rural Gambia